

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2012
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NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 31, November 1, 2, 5, 6 and 7, 2012</p> <p>Facility number: 000491</p> <p>Provider number: 155495 AIM number: 100291230</p> <p>Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN</p> <p>Census bed type: SNF: 8 SNF/NF: 45 Total : 53</p> <p>Census Payor type: Medicare: 12 Medicaid: 29 Other: 12 Total: 53</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/14/12 by Suzanne Williams, RN</p>	F000000	<p>This plan of correction is submitted by Lakeland Rehabilitation and Healthcare Center in order to respond to the alleged deficiencies sited during our annual survey which was conducted on November 7, 2012. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective December 7, 2012. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Lakeland Rehabilitation and Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of this Plan of Correction.</p>	
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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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F000156 SS=A	<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 Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>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 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,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide an appeal and liability notice when Medicare coverage ended, for 2 of 3 residents reviewed (Residents #14, #25) for liability notices.</p> <p>Findings include:</p> <p>On 11/06/12 at 1:10 P.M., the Business Office Manager was asked to present the appeal and liability notice for discharged Residents #14 and 25. The Business Office Manager, Employee #13, indicated the Social Services department was responsible for giving the "cut" notices.</p> <p>Interview with the Social Service designee, on 11/06/12 at 1:15 P.M., indicated she did not have a liability and appeal notice for Residents #14 or #25, because she did not know she was supposed to do them at the time those residents were discharged from Medicare coverage. She indicated she was trained, in September 2012.</p> <p>No documentation regarding dates of discharge from Medicare covered services and/or appeal and liability</p>	F000156	Residents #14 and #25 are discharged residents. We are unable to correct the deficient practice with these residents due to time frame. All residents requiring an appeal and liability notice when Medicare coverage ends have the potential to be affected by the same deficient practice. Social Service Director was educated on the liability notices on 7/26/12 by Lacy Behl and Consultants, and has been providing the notices since this date to appropriate residents. 1. Social Service Director/Designee will provide residents or responsible party an appeal and liability notice when Medicare coverage ends as per regulation. 2. Business Office Manager/Designee will audit all residents files when Medicare coverage ends for compliance with facility providing required appeal and liability notice as per regulation. 3. Any non-compliance issues will be addressed and/or corrected immediately. Staff responsible for non-compliance issues will be reeducated and/or disciplined as per facility policy. Executive Director/Designee will bring all audits to QA for review x 3 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012	12/07/2012			

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	<p>documentation was ever presented for Residents #14 and 25.</p> <p>Interview with the Director of Nursing, on 11/07/12 at 11:15 A.M. indicated the facility did not have a policy regarding liability and appeal notices. An undated chart, titled, "SNF - Beneficiary Notice Requirements" indicated examples of circumstances requiring an appeal and liability notice be given, but there were no specific time frames noted on the chart. The Director of Nursing indicated the chart was from a CMS (Centers for Medicare and Medicaid Services) internet site.</p> <p>3.1-4(f)(3)</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of a significant weight loss in a timely manner for 1 of 3 residents reviewed for notifying</p>	F000157	Resident # 63 is deceased and corrections can not be completed. All residents with significant weight loss have potential to be affected by the same deficient practice. All	12/07/2012			

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	<p>physician of weight loss (Resident #63)</p> <p>Findings include:</p> <p>Resident #63's record was reviewed on 11-5-2012 at 1:38 PM. Resident #63's diagnoses included, but were not limited to, dementia, prostate cancer, and arthritis.</p> <p>The Minimum Data Set (MDS) assessment dated 07-17-2012, indicated Resident #63 required one person stand-by assistance for eating.</p> <p>A current nutrition and hydration care plan, dated 10-16-2012, included interventions of pureed diet with honey thick liquids, offer a substitute if consumption is less than 50%, offer snacks between meals, monitor skin integrity, monitor and report weight loss to physician, speech therapy as ordered, and monitor for weight changes.</p> <p>Resident #63's weight was as follows: on 10-2-2012; 145.2. On 10-16-2012; 135.6. On 11-1-2012; 129.8.</p> <p>The dietician notes on 10-16-2012 indicated she was notified and made</p>		<p>residents will be reviewed for significant weight loss and any significant weight loss will be reported to the physician per regulations.1. Director of Health Services/Designee will inservice licensed nursing staff on reporting significant weight loss as indicated per policy to physicians in a timely manner.2. Director of Health Services/Designee will audit residents with significant weight loss for compliance with timely physician notification 1x weekly until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>				

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	<p>a recommendation to increase supplements with meals. On 11-1-2012 the dietician was notified of the significant loss and she made further recommendation.</p> <p>A review of Nurse's Notes did not indicate physician notification of the weight change until 10-29-2012, and there was no note that indicated physician notification of the further loss on 11-1-2012.</p> <p>In an interview on 11-5-2012 at 3:10 PM, the Director of Nursing indicated the physician should have been notified when the weight loss was recognized.</p> <p>3.1-5(a)(2)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 3 residents reviewed with limited range of motion were comprehensively</p>	F000272	Resident #15 has current measurements of her contractures. She has a current ROM assessment and will have ROM services provided by facility. Resident #2 had a ROM	12/07/2012

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	<p>assessed to ensure their range of motion was maintained and/or improved, of 10 residents who met the criteria for limited range of motion. (Residents #2 and 15)</p> <p>Findings include:</p> <p>1. Resident #15 was observed, on 11/05/12 at 10:48 A.M., seated in her wheelchair at her computer desk in her room. The resident had a large soft boot on her left foot and a soft blue Velcro padded covering on her right elbow. The resident's left elbow and hand were contracted and there were no splints on them. The resident was noted to be able to move her right elbow and could use some of fingers on her right hand freely.</p> <p>The clinical record for Resident #15 was reviewed on 11/02/12 at 1:45 P.M. Resident #15 had diagnoses including, but not limited to, muscle weakness, difficulty walking, muscular wasting, contracture of joint, rehabilitation, hemiplegia, lesion of ulnar nerve, dysphasia, cerebral hemorrhage, depression with psychotic features, mental disorder with head injury, and seizure disorder.</p>		<p>assessment completed and will have ROM services provided by facility. All residents with contractures and/or requiring ROM services have the potential to be affected by the same deficient practice. All residents with contracture(s) will have current measurements and assessments regarding their ROM. Therapy has inserviced Director of Health Services and Nursing Management on proper contracture measuring techniques, and completing a ROM assessment. Nursing staff educated on providing and documentation of ROM services for all residents. 1. Director of Health Services/Designee inserviced licensed nursing staff on the protocol of obtaining and documenting ROM assessments. 2.. Director or Health Services/Designee inserviced licensed nursing staff on the protocol of providing and documenting ROM services to all residents to prevent contractures and/or decline in ROM.3. Director of Health Services/Designee inserviced nursing staff on protocol of providing and documenting ROM services to those residents with contracture(s).4. ROM assessments will be completed by licensed nursing staff upon admission, quarterly, and/or as needed. Based on assessments, residents with increase in contracture(s) or anyone</p>				

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	<p>The most recent Minimum Data Set (MDS) assessment, completed on 11/01/12, indicated the resident had impaired limitation to one side in her upper and lower extremities.</p> <p>Physician orders and documentation in the therapy section of the clinical record indicated the resident had received Occupational Therapy treatments from 09/07/12 - 10/26/12, for positioning in the wheelchair and strengthening in right upper extremity. She also received Physical Therapy treatments from 09/07/12 -10/26/12 to increase Range of Motion to contractures of her left ankle utilizing a restorator. The resident was discharged from both Occupational and Physical Therapy on 10/29/12. There was no therapy documentation regarding discharge planning regarding the resident's contracture's or need for range of motion, or splints.</p> <p>The health care plans for Resident #15, current through 01/31/13, included an Alteration in Mobility plan with interventions including: requires 1-2 staff to reposition in bed, left AFO (ankle foot orthotic) and left arm splint when oob (out of bed).</p>		<p>with decline in ROM will be screened by therapy. Staff currently providing and documenting ROM on all residents. 5. Director of Health Services/Designee will audit all residents withcontracture(s) for compliance of current ROM assessment and measurements 1x weekly x 3 months, and then audit quarterly thereafter until QA Committee states otherwise.6. Director of Health Services/Designee will audit ROM documentation being completed on all residents 1x weekly for compliance. Any noted declines will be referred to therapy for screen.7. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: December 7, 2012</p>		

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	<p>The medication orders for Resident #15 included orders for the resident to receive Baclofen, a muscle relaxant, 20 mg one tablet, three times a day.</p> <p>Physician orders regarding the resident's left leg included : "10/31/11 - moon boot to left foot at all times."</p> <p>Interview with the COTA (Certified Occupational Therapy Assistant), who was in charge of the facility's therapy department, Employee #10, on 11/06/12 at 10:15 A.M. indicated range of motion exercises were not recommended because there is no restorative program in place at the facility. She indicated Resident #15 comes to the therapy room daily and does her own exercise routine. Employee #10 indicated she does not measure resident's contracture's on a routine basis, only if they are being seen in skilled therapy for contracture issues. However, she indicated she "screens" residents throughout the year and if she thinks their contracture's are getting worse she "picks them up for therapy." She indicated therapy screening consisted of asking the nursing department if they had noticed any issues, checking to see if the</p>				

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	<p>resident was having increased pain due to contracture issues, and looking at them.</p> <p>Therapy documentation provided regarding contracture measurements, dated 06/26/03, indicated the resident had limited range of motion, less than 50 percent passive to both the left upper and lower extremities. There were no more recent measurements of Resident #15's contractures, so it could not be determined if her contractures had improved, declined, and/or stayed the same.</p> <p>Interview with the Director of Nursing, on 11/06/12 at 1:30 P.M. indicated the facility did not have any recent measurements of Resident #15's contractures.</p> <p>2. Resident #2's record was reviewed on 11-6-2012 at 2:01 PM. Resident #2's diagnoses included, but were not limited to, dementia, brain injury and heart irregularity.</p> <p>Resident #2 was observed on 11-1-2012 at 9:49 AM holding his left hand close to his body in a closed position. When asked if he was having problems moving his hand, Resident #2 indicated he was unable to completely open his hand.</p>			

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	<p>Resident #2 further indicated the staff did not do range of motion (ROM) on his hand, nor did he wear a splint.</p> <p>The quarterly Minimum Data Set assessment dated 9-3-2012 indicated there was no muscular impairment on either side.</p> <p>In an interview on 11-7-2012 at 8:51 AM, LPN #7 indicated Resident #2 had a contracture of the left hand. LPN #7 further indicated Resident #2 had not utilized a splint.</p> <p>In an interview on 11-7-2012 at 8:54 AM, CNA #8 indicated Resident #2 utilized the left hand to grab onto the side rail. There was no formal range of motion program for the hand despite Resident #2 holding his hand in a closed position for most of the day. CNA #8 indicated Resident #2 was not able to open his hand as far as he used to.</p> <p>In an interview on 11-7-2012 at 9:11 AM, COTA (Certified Occupational Therapy Assistant) #9 indicated there was no further assessment documented for Resident #2.</p> <p>In an interview on 11-7-2012 at 9:41 AM, the DON indicated the therapy</p>						

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	<p>company contract included therapy would provide the personnel for the restorative program, but because they hadn't, the facility had not been able to provide restorative programs. Additionally, therapy was to provide the ROM screenings and assessments quarterly to determine if ROM was declining or maintaining. She further indicated no ROM assessments had been completed for Resident #2.</p> <p>3.1-31(a) 3.1-31(b)(4)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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> <p>Based on observation, interview, and record review, the facility failed to initiate care plans for 2 of 15 residents reviewed with care plans, regarding psychotropic medication use and incontinence (Resident #5, and Resident #23).</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 11-5-2012 at 10:05 AM. Resident #5's diagnoses included, but were not limited to, high blood pressure, dementia with behavioral</p>	F000279	Resident #5 has a psychotropic medication use care plan with interventions completed at this time. Resident #23 has a care plan addressing toileting completed at this time. All residents receiving psychotropic medications or residents who are incontinent have potential to be affected by same deficient practice. All residents who receive psychotropic medications have been reviewed for completed psychotropic medication use care plan in place at this time. Residents who are incontinent have been reviewed for completed toileting care plan	12/07/2012	

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	<p>disturbances, and psychosis with delusions.</p> <p>A current physician's order summary, dated 11-2012, indicated Clonazepam (an antipsychotic) 0.25 milligrams (mg) was to be given twice daily, Ativan (an antianxiety) 0.5 mg was to be given twice daily, and Seroquel 25 mg was to be given daily, and 50 mg at bedtime.</p> <p>A care plan titled psychotropic drug use, dated 9-4-2012, did not indicate what interventions were to be implemented.</p> <p>A care plan titled fatigue and energy, dated 5-9-2012, included interventions to report changes in sleeping or energy levels to physician, provide comfortable environment, monitor medication side effects, and encourage activity that can increase energy level.</p> <p>A care plan titled depression, dated 4-19-2012, included interventions of report changes in behavior to physician, share other options for dealing with feelings, administer and monitor for side effects, investigate need for psychological support, and monitor behavior episodes.</p>		<p>in place at this time.1. Director of Health Services/Designee will inservice licensed nursing staff on the importance of implementing psychotropic medication use care plans to include interventions. Inservice also includes importance of implementing toileting care plans for incontinent residents as per regulations.2. Director or Health Services/Designee will audit 5 resident charts 2x weekly x 4 weeks for compliance with psychotropic medication use care plans completed with interventions. Director of Health Services/Designee will audit 5 residents charts 2x weekly x 4 weeks for compliance with incontinent residents having a toileting care plan in place. Both audits will then be completed 1x weekly thereafter until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>		

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	<p>In an interview on 11-6-2012 at 10:55 AM, LPN #5 indicated the care plan should have indicated interventions to follow regarding psychotropic medication use.</p> <p>2. Resident #23's record was reviewed on 11-6-2012 at 1:39 PM. Resident #23's diagnoses included, but were not limited to, heart failure, high blood pressure, and obesity.</p> <p>During an observation on 10-31-2012 at 2:27 PM, a pervasive urine odor was noted. Resident #23 had been observed up in the wheelchair and when placed in bed, the pervasive urine odor was noted, despite Resident #23 not being wet.</p> <p>A review of current care plans indicated no care plan for toileting.</p> <p>A nursing assessment dated 10-11-2012, indicated Resident #23 was dependant with extensive assistance needed to toilet, and was incontinent all of the time.</p> <p>In an interview on 11-6-2012 at 2:43 PM, LPN #5 indicated there should have been a care plan addressing toileting.</p> <p>3.1-35(a)</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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, interview, and record review, the facility failed to provide adaptive equipment while eating as ordered by the physician for 1 of 5 residents reviewed for adaptive equipment during eating (Resident #63).</p> <p>Findings include:</p> <p>Resident #63's record was reviewed on 11-5-2012 at 1:38 PM. Resident #63's diagnoses included, but were not limited to, dementia, stroke, and arthritis.</p> <p>During an observation on 10/31/2012 at 12:59 PM, Resident #63 was observed with family drinking ensure. The ensure was in a regular glass.</p> <p>During an observation on 11-2-2012 at 12:35 PM, Resident #63 was served his lunch in the assisted</p>	F000282	<p>Resident # 63 is deceased and corrections can not be completed. All residents with physician orders for adaptive equipment when eating have the potential to be affected by the same deficient practice. All residents with physician orders for nose cup were reviewed to ensure nose cups are being used as ordered. All residents needing any adaptive equipment when eating have been reviewed for compliance.1. Residents with physician orders for adaptive equipment when eating will have this information placed in the communication binders at the nurses station for staff to reference, as well as, placed in the computerized resident profiles.2. Dietary Food Service Director/Designee will update communication binders with current orders as needed.3. Director of Health Services/Designee will inservice nursing staff on procedure of ensuring any resident with physician orders for</p>	12/07/2012			

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	<p>dining area. Resident #63's liquids were in a regular glass.</p> <p>A nutrition and hydration assessment dated 10-13-2012, indicated Resident #63 was not on thick liquids and needed no assistance eating. The form further indicated Resident #63 was maintaining good hydration despite his risk factor of swallowing difficulty.</p> <p>A current Physician's Order Summary dated 11-2012, indicated Resident #63 was to use a nose cup for all liquids.</p> <p>In an interview on 11-5-2012 at 11:15 AM, CNA #8 indicated she did not know Resident #63's liquids were to be in a different glass, but if that's what was ordered, he should have had his liquids in the type of glass ordered.</p> <p>3.1-35(g)(2)</p>		<p>any adaptive equipment when eating, including nose cup, are utilizing the adaptive equipment as ordered. The inservice will also include, the nursing staff are to reference the communication binders located at the nurses station to know those residents requiring any adaptive equipment when eating.4. Dietary Food Service Director/Designee will audit all residents with physicians orders for any adaptive equipment when eating during any meal 2x weekly x 4 weeks for compliance of following those orders and then audit 1x weekly thereafter until QA Committee states otherwise.5. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy.Dietary Food Service Director/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: December 7, 2012</p>		

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F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>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 observation, record review, and interviews, the facility failed to ensure 3 of 3 residents reviewed who were admitted to the facility with limited range of motion received restorative services to ensure their range of motion was maintained. This affected 3 of 3 residents reviewed for range of motion of 10 residents who met the criteria for limited range of motion. (Residents #2, 15, and 42)</p> <p>Findings include:</p> <p>1. Resident #15 was observed, on 11/05/12 at 10:48 A.M., seated in her wheelchair at her computer desk in her room. The resident had a large soft boot on her left foot and a soft blue Velcro padded covering on her right elbow. The resident's left elbow and hand were contracted and there were no splints on them. The resident was noted to be able to move her right elbow and could use some of the fingers on her right hand freely.</p>	F000311	<p>Resident #15 has current measurements of her contractures. Resident currently does not have an order for a left hand splint. She has a current ROM assessment and will have ROM services provided by facility. Resident #2 had a ROM assessment completed and will have ROM services provided by facility. Resident #42 has current measurements of her contractures. She has a current ROM assessment and will have ROM services provided by facility. All residents with contractures and/or requiring ROM services have the potential to be affected by the same deficient practice. All residents with contracture(s) will have current measurements and assessments regarding their ROM. Therapy has inserviced Director of Health Services and Nursing Management on proper contracture measuring techniques, and completing a ROM assessment. Nursing staff educated on providing and documentation of ROM services for all residents. 1. Director of Health Services/Designee inserviced licensed nursing staff on the protocol of obtaining and</p>	12/07/2012	

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	<p>The clinical record for Resident #15 was reviewed on 11/02/12 at 1:45 P.M. Resident #15 was admitted with diagnoses including, but not limited to, muscle weakness, difficulty walking, muscular wasting, contracture of joint, rehabilitation, hemiplegia, lesion of ulnar nerve, dysphasia, cerebral hemorrhage, depression with psychotic features, mental disorder with head injury, and seizure disorder.</p> <p>Physician orders and documentation in the therapy section of the clinical record indicated the resident had received Occupational Therapy treatments from 09/07/12 - 10/26/12, for positioning in the wheelchair and strengthening in right upper extremity. She also received Physical Therapy treatments from 09/07/12 -10/26/12 to increase Range of Motion due to contractures of her left ankle utilizing a restorator. The resident was discharged from both Occupational and Physical Therapy on 10/29/12. There was no therapy documentation regarding discharge planning regarding the resident's contractures or need for range of motion, or splints.</p> <p>The current health care plans for Resident #15, current through</p>		<p>documenting ROM assessments. 2.. Director or Health Services/Designee inserviced licensed nursing staff on the protocol of providing and documenting ROM services to all residents to prevent contractures and/or decline in ROM.3. Director of Health Services/Designee inserviced nursing staff on protocol of providing and documenting ROM services to those residents with contracture(s).4. ROM assessments will be completed by licensed nursing staff upon admission, quarterly, and/or as needed. Based on assessments, residents with increase in contracture(s) or anyone with decline in ROM will be screened by therapy. Staff currently providing and documenting ROM on all residents. 5. Director of Health Services/Designee will audit all residents withcontracture(s) for compliance of current ROM assessment and measurements 1x weekly x 3 months, and then audit quarterly thereafter until QA Committee states otherwise.6. Director of Health Services/Designee will audit ROM documentation being completed on all residents 1x weekly for compliance. Any noted declines will be referred to therapy for screen.7. Any non-compliance issues will be addressed immediately and staff responsible will be</p>		

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	<p>01/31/13 , included an Alteration in Mobility plan with interventions including: requires 1-2 staff to reposition in bed, left Ankle Foot Orthotic (AFO) and left arm splint when out of bed.</p> <p>The quarterly Minimum Data Set assessment dated 8-29-2012, indicated Resident #15 had impairment in range of motion on one side.</p> <p>The medication orders for Resident #15 included orders for the resident to receive Baclofen, a muscle relaxant, 20 mg one tablet, three times a day.</p> <p>Physician orders regarding the resident's left leg included: "10/31/11 - moon boot to left foot at all times."</p> <p>Interview with the COTA (Certified Occupational Therapy Assistant), who was in charge of the facility's therapy department, Employee #10, on 11/06/12 at 10:15 A.M. indicated range of motion exercises were not recommended because there is no restorative program in place at the facility. She indicated Resident #15 comes to the therapy room daily and does her own exercise routine.</p>		<p>reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>		

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	<p>Employee #10 indicated she does not measure resident's contractures on a routine basis, only if they are being seen in skilled therapy for contracture issues. However, she indicated she "screens" residents throughout the year and if she thinks their contractures are getting worse, she "picks them up for therapy." She indicated therapy screening consisted of asking the nursing department if they had noticed any issues, checking to see if the resident was having increased pain due to contracture issues, and looking at them.</p> <p>She indicated Resident #15 was supposed to be wearing a splint on her left hand, but the splint's location was unknown by therapy when they last worked with the resident. Employee #10 indicated she was instructed not to recommend restorative maintenance plans for residents due to not having a restorative program. Resident #15 was recently seen in therapy for strengthening of her good side for improved transfers.</p> <p>Interview with the Director of Nursing, on 11/06/12 at 1:30 P.M., indicated there was no plan for any maintenance stretching of the resident's extremities and/or</p>						

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	<p>contractures. She indicated she was not aware Resident #15 was not wearing a splint on her left hand. She indicated the nursing assistants would place some residents on restorative plans themselves, but there was no documentation of a restorative plan for Resident #15.</p> <p>2. Resident #42's clinical record was reviewed on 11/7/12 at 10:00 A.M.. The record indicated the resident has a contracture to her right upper extremity and right lower extremity. The record indicated the resident had a CVA in 2003 resulting in right hemiparesis.</p> <p>An observation of Resident #42 on 11/7/12 at 9:45 A.M., revealed the resident had a contracture to her right wrist/hand and was wearing a splint. The observation also revealed the resident had a contracture to her right lower extremity, noted to be foot drop.</p> <p>An interview with Resident #42 on 11/7/12 at 9:45 A.M., indicated the resident was alert and oriented. The resident stated she previously received therapy for her right hand/wrist contracture but has not had any therapy in a long time. Resident #42 indicated she wears</p>						

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	<p>the splint now on her right upper extremity but does not receive any range of motion activities at all. The resident indicated she started physical therapy recently for her right leg and indicated in October she had an increase in pain in her right foot, and her daughter noted her foot drop had gotten worse. Resident #42 indicated her daughter told someone in the facility her foot drop had gotten worse, and she started therapy soon after. The resident indicated she receives no range of motion or stretching to her right foot outside of therapy.</p> <p>Review of Resident #42's physician's orders indicated on 10/12/12 an order for a Physical Therapy (PT) evaluation was to be done for foot drop to the right foot. On 10/15/12 a physician's order was received for: (PT) evaluation was completed and the resident was to start treatment 3 x a week for 4 weeks to include modalities, therapy activities, procedures, splinting and PT/caregiver education.</p> <p>A quarterly Minimum Data Set assessment dated 8-29-2012 indicated Resident #42 had impairment in range of motion on one side of her lower extremities.</p>				

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	<p>An interview on 11/7/12 at 11:45 A.M. with the Therapy Manager indicated the resident does not receive any range of motion exercises for her right upper extremity. The Therapy Manager indicated the department started providing services for the right foot drop after nursing reported in October the resident had right foot drop. The Therapy Manager indicated a Rehabilitation screening was previously completed on 8/17/12 and noted the resident did not demonstrate a significant change in functional mobility at that time and no skilled intervention was needed</p> <p>3. Resident #2's record was reviewed on 11-6-2012 at 2:01 PM. Resident #2's diagnoses included, but were not limited to, dementia, brain injury and heart irregularity.</p> <p>Resident #2 was observed on 11-1-2012 at 9:49 AM holding his left hand close to his body in a closed position. When asked if he was having problems moving his hand, Resident #2 indicated he was unable to completely open his hand. Resident #2 further indicated the staff did not do range of motion</p>						

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	<p>(ROM) on his hand, nor did he wear a splint.</p> <p>A quarterly Minimum Data Set assessment dated 9-3-2012, indicated Resident #2 had no impairment in range of motion on either side of his body.</p> <p>In an interview on 11-7-2012 at 8:51 AM, LPN #7 indicated Resident #2 had a contracture of the left hand. LPN #7 further indicated Resident #2 had not utilized a splint.</p> <p>In an interview on 11-7-2012 at 8:54 AM, CNA #8 indicated Resident #2 utilized the left hand to grab onto the side rail. There was no formal range of motion program for the hand despite Resident #2 holding his hand in a closed position for most of the day. CNA #8 indicated Resident #2 was not able to open his hand as far as he used to.</p> <p>In an interview on 11-7-2012 at 9:11 AM, COTA #9 indicated Resident #2 had an upper extremity contracture, and although he could still use the hand and arm, he would benefit from ROM to maintain his abilities. Additionally, COTA #9 indicated there was no Restorative program at the facility, so restorative and</p>						

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F000312 SS=E	<p>functional maintenance programs were not ordered. COTA #9 further indicated the facility was responsible for providing the restorative personnel to initiate the program.</p> <p>In an interview on 11-7-2012 at 9:41 AM, the DON indicated the therapy company contract included therapy would provide the personnel for the restorative program, but because they hadn't, the facility had not been able to provide restorative programs. Additionally, therapy was to provide the ROM screenings and assessments quarterly to determine if ROM was declining or maintaining.</p> <p>3.1-38(b)(1)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure 3 randomly observed dependent residents in the assisted dining room received</p>	F000312	Resident #24, #34, #55 cannot be corrected due to past compliance. Resident #12 had family bring in a new pair of shoes without any holes the same day it was found by the	12/07/2012			

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	<p>prompt feeding assistance during 3 of 3 meal observations. (Resident #24, 55, and 34) In addition, the facility failed to provide a meal tray for 1 other dependent resident randomly observed during 2 of 3 meals observed. (Resident #12)</p> <p>Findings include:</p> <ol style="list-style-type: none"> During the noon meal observation, on 10/31/12, in the assisted dining room, at 12:49 P.M., CNA #20 was noted trying to assist residents at two different tables. Residents #24, 55, and 34 were seated at the two tables. CNA #20, at 12:50 P.M., left the dining room to push another resident back to his room. While CNA #20 was gone, no staff were noted to assist Residents #24, 55, and 34. None of the 3 residents were feeding themselves. Nurse #21, looked at the unattended tables then turned around and walked away from the tables. After approximately 3 minutes, at 12:53 P.M., Nurse #21 sat down at one of the tables and helped feed Resident #34. Residents #24 and 55 were not being assisted and neither resident was attempted to feed themselves. At 12:58, CNAs #20 and 22 reentered the dining room and each sat and assisted 		<p>surveyor. All dependent residents who require extensive staff assistance for eating needs have the potential to be affected by the same deficient practice. Seating in the south dining room has been rearranged to better facilitate staff assistance with those residents requiring extensive assistance for eating needs. Staff table assignments have been put in place to ensure the residents are assisted and/or fed in a timely manner. After the hole was found in resident #12 shoe, an in house shoe sweep was completed the same day by staff to ensure no other residents had holes. 1. Director of Health Services/Designee will inservice staff on proper and timely feeding requirements for residents who require extensive staff assistance for eating needs. Inservice to also include the new table assignment protocol for nursing staff. Inservice to also include that staff should report any noted holes or problems with residents shoes immediately to social services/designee for further follow up with responsible party. 2. Laundry staff inservice on checking to make sure all residents personal clothing items are in good condition before delivering back to residents rooms after laundering. If clothing is not in good condition laundry staff will report to supervisor and/or social service for further follow up with</p>				

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	<p>Residents #24, 55, and other residents who required assistance.</p> <p>2. During the noon meal observation, on 11/01/12 in the South Dining room, at 12:30 P.M. Resident #55's food was served but there were no staff assisting the resident to eat. At 12:35 P.M., Resident #24 was brought into the dining room in her wheelchair by staff and pushed to the table. CNA #24 was noted to be sitting and feeding Resident #34 at the back table. The Food Service Supervisor was passing desserts and 3 other staff were passing drinks. Residents #24 and 55 were not being assisted to eat. At 12:38 P.M., a nursing staff member was noted to be feeding Resident #55. Although the nursing staff member was seated between Residents #24 and 55, she was noted to only feed Resident #55 and repeatedly asked Resident #24 if she was going to eat. Resident #24 did not respond to any of the staff member's questions regarding eating and did not attempt to feed herself.</p> <p>3. During the noon meal observations in the South Dining Room, on 11/05/12, the first trays were served at 12:35 P.M. to</p>		<p>families.3. Nursing staff will check residents for proper fitting and clothing in good condition including shoes during hourly rounding.4. Director or Health Services/Designee will audit for compliance of residents receiving timely assistance with eating needs during meals 3x weekly (to include 1 breakfast, 1 lunch, and 1 dinner) x 4weeks, then audit 2x weekly x 4 weeks, and then audit 1x weekly thereafter until QA Committee states otherwise. 5. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits and hourly checks to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>		

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	<p>Residents #34 and her tablemate. Resident #34 was not assisted to eat. At 12:40 P.M., Resident #34 was cued to wake up but was not assisted to eat. At 12:43 P.M., Resident #34 was noted to have attempted to feed herself pureed food, including a soup, with a fork. Most of the resident's food was noted to have fallen on her clothing protector and the table. Residents #24 and 55 had been served their food but were receiving no assistance to eat.</p> <p>At 12:47 P.M., Resident #34 was cued to use a spoon instead of a fork, her fork was removed from her hand and she was given a spoon, but did not receive any other assistance.</p> <p>At 12:49 P.M., two nursing staff sat to feed Residents #24 and 55. Another CNA #25 sat to assist Resident #34. She noticed Resident #34 had spilled most of her food on the tablet and/or her clothing protector. CNA #25 asked for a new plate of food, so the cook then took a plate from the middle of another resident's table and put the pureed food onto it for Resident #34.</p> <p>Interview with CNA #26, on 11/07/12</p>						

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	<p>at 10:30 A.M., indicated Resident #24 would sometimes feed herself but other times had to be fed. She indicated Residents #55 and 34 required total staff assistance to eat and did not usually feed themselves.</p> <p>Review of the clinical record for Resident #55, on 11/07/12 at 9:45 A.M., indicated the most recent MDS assessment, completed on 08/28/12, indicated the resident required extensive staff assistance for eating needs.</p> <p>Review of the clinical record for Resident #24, on 11/07/12 at 9:50 A.M., indicated the most recent MDS assessment, completed on 08/23/12, indicated the resident required extensive staff assistance for eating needs.</p> <p>Review of the clinical record for Resident #34, on 11/07/12 at 8:30 A.M., indicated the most recent MDS assessment, completed on 10/24/12, indicated the resident required extensive staff assistance for eating needs.</p> <p>4) Resident #12's record was reviewed on 11-2-2012 at 1:35 PM. Resident #12's diagnoses included, but were not limited to, stroke, dementia, and high blood pressure.</p>				

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	<p>During an observation on 10/31/2012 at 2:31 PM, Resident #12 was noted sitting in her recliner with feet propped up. Resident #12's left shoe had a hole in the bottom about the location of the ball of her foot, approximately the diameter of a water bottle.</p> <p>During an observation on 11-1-2012 at 9:26 AM, when wheeling self in wheel chair in the hall, Resident #12 was observed to use the ball of her foot to propel her wheelchair through the hall. Resident #12's left shoe still had a hole in the bottom of the shoe.</p> <p>During an observation on 11-2- 2012 at 1:31 PM, Resident #12 was observed sitting in her recliner with her feet propped up. The hole in the bottom of the left shoe was still there.</p> <p>A quarterly Minimum Data Set assessment dated 8-14-2012, indicated Resident #12 was a one person physical assist for mobility in wheel chair and a one person extensive physical assist for dressing and grooming.</p> <p>A quarterly review by therapy, dated 10-23-2012, indicated there was no</p>						

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	<p>significant change in functional status.</p> <p>A review of Social Service notes, between 8-2012 and present, revealed there was no indication of a change in ability to dress self or dress appropriately.</p> <p>A Psychological services note, dated 9-17-2012, indicated Resident #12 had made increasing negative statements, and therapy reviewed for function.</p> <p>A care plan, titled ADL deficit, dated 9-4-12, included interventions of assess self care status changes, report significant changes, provide therapy as ordered, assist with personal hygiene, encourage daily exercise, provide adequate safety equipment, encourage to attend activities that promote increased interest in personal appearance, provide education to include safety awareness, and encourage use of adaptive equipment.</p> <p>In an interview on 11-2-2012 at 2:23 PM, CNA#1 indicated Resident #12 did move about in wheelchair with feet, and staff assisted with putting shoes on and off. She further indicated she had not noticed the</p>						

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	<p>hole in the bottom of Resident #12's shoe.</p> <p>In an interview on 11-2-2012 at 2:27 PM, the Director of Nursing (DON) indicated she did not know there was a hole in the bottom of Resident #12's shoe, nor did she know if there was a reason why.</p> <p>In an interview on 11-2-2012 at 2:32 PM, Resident #12 indicated she did not know there was a hole in the bottom of her shoe, but she needed new shoes if there was a hole in one.</p> <p>In an interview on 11-2-2012 at 2:34 PM, the Social Services Designee indicated she did not know there was a hole in the bottom of Resident #12's shoe, nor did she know why. She further indicated she would call the family to bring in new shoes.</p> <p>In an interview on 11-2-2012 at 2:35 PM, the DON indicated she was unsure when the family had brought in the shoes for Resident #12, and the family was bringing in new shoes.</p> <p>3.1-38(a)(3)</p>						

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</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>Based on observation, interview, and record review, the facility failed to assess urinary bladder incontinence for pattern after catheter removal for 1 of 3 residents reviewed after catheter removal of 10 reviewed with incontinence (Resident #23)</p> <p>Findings include:</p> <p>Resident #23's record was reviewed on 11-6-2012 at 1:39 P.M. Resident #23's diagnoses included, but were not limited to, heart failure, high blood pressure, and obesity.</p> <p>During an observation on 10-31-2012 at 2:27 PM, a pervasive urine odor was noted. Resident #23 had been observed up in the wheelchair and when placed in bed, the pervasive urine odor was noted</p>	F000315	<p>Resident #23 cannot be corrected due to past compliance. Resident had no adverse reactions. All residents with orders to remove a catheter have the potential to be affected by the same deficient practice. Residents with recent orders to have a catheter removed, did have nursing assess urinary bladder incontinence for pattern. 1. Director of Health Services/Designee will inservice licensed nursing staff on the policy to assess urinary bladder incontinence for pattern after the removal of a catheter. 2. Director of Health Services/Designee will audit all residents with a physician order to remove a catheter 1x weekly for compliance that nursing did assess urinary bladder incontinence for pattern. Audits to continue until QA Committee states otherwise. 3. Any non-compliance issues will be addressed immediately and staff</p>	12/07/2012			

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	<p>despite no wetness.</p> <p>A review of current care plans revealed no care plan for toileting.</p> <p>A nursing assessment dated 10-11-2012 indicated Resident #23 was dependant with extensive assistance needed to toilet.</p> <p>A physician's order dated 10-16-2012 indicated to discontinue as necessary straight catheterization.</p> <p>In an interview on 11-6-2012 at 2:13 PM, the Medical Records nurse indicated a three day void pattern was not completed after daily straight caths were discontinued. She further indicated CNAs charted in four hour intervals the results of toileting. There was no hourly three day void to pattern to trend bladder continence.</p> <p>In an interview on 11-6-2012 at 2:43 PM, the Director of Nursing indicated hourly tracking was not completed to trend for bladder pattern.</p> <p>In an interview on 11-6-2012 at 2:48 PM, LPN #3 indicated the bladder tracking should have been</p>		<p>responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>		

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F000318 SS=D	<p>completed to try to establish, if able, a pattern of continence for Resident # 23.</p> <p>3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interviews, the facility failed to ensure 3 of 3 residents reviewed who were admitted to the facility with limited range of motion received periodic comprehensive assessments of their range of motion limitation and received appropriate treatments and services to ensure their range of motion was maintained and did not decline. This affected 3 of 3 residents reviewed for range of motion of 10 residents who met the criteria for limited range of motion. (Residents #2, 15, and 42)</p> <p>Findings include:</p>	F000318	Resident #15 has current measurements of her contractures. Resident currently does not have an order for a left hand splint. She has a current ROM assessment and will have ROM services provided by facility. Resident #2 had a ROM assessment completed and will have ROM services provided by facility. Resident #42 has current measurements of her contractures. She has a current ROM assessment and will have ROM services provided by facility. All residents with contractures and/or requiring ROM services have the potential to be affected by the same deficient practice. All residents with contracture(s) will have current measurements and	12/07/2012

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	<p>1. Resident #15 was observed, on 11/05/12 at 10:48 A.M., seated in her wheelchair at her computer desk in her room. The resident had a large soft boot on her left foot and a soft blue Velcro padded covering on her right elbow. The resident's left elbow and hand were contracted and there were no splints on them. The resident was noted to be able to move her right elbow and could use some of fingers on her right hand freely.</p> <p>The clinical record for Resident #15 was reviewed on 11/02/12 at 1:45 P.M. Resident #15 was admitted with diagnoses including, but not limited to, muscle weakness, difficulty walking, muscular wasting, contracture of joint, rehabilitation, hemiplegia, lesion of ulnar nerve, dysphasia, cerebral hemorrhage, depression with psychotic features, mental disorder with head injury, and seizure disorder.</p> <p>A quarterly Minimum Data Set assessment dated 8-29-2012 indicated Resident #15 had impairment in range of motion on one side.</p> <p>Physician orders and documentation</p>		<p>assessments regarding their ROM. Therapy has inserviced Director of Health Services and Nursing Management on proper contracture measuring techniques, and completing a ROM assessment. Nursing staff educated on providing and documentation of ROM services for all residents. 1. Director of Health Services/Designee inserviced licensed nursing staff on the protocol of obtaining and documenting ROM assessments. 2.. Director or Health Services/Designee inserviced licensed nursing staff on the protocol of providing and documenting ROM services to all residents to prevent contractures and/or decline in ROM.3. Director of Health Services/Designee inserviced nursing staff on protocol of providing and documenting ROM services to those residents with contracture(s).4. ROM assessments will be completed by licensed nursing staff upon admission, quarterly, and/or as needed. Based on assessments, residents with increase in contracture(s) or anyone with decline in ROM will be screened by therapy. Staff currently providing and documenting ROM on all residents. 5. Director of Health Services/Designee will audit all residents withcontracture(s) for compliance of current ROM assessment and measurements</p>				

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	<p>in the therapy section of the clinical record indicated the resident had received Occupational Therapy treatments from 09/07/12 - 10/26/12, for positioning in the wheelchair and strengthening in right upper extremity. She also received Physical Therapy treatments from 09/07/12 -10/26/12 to increase Range of Motion due to contractures of her left ankle utilizing a restorator. The resident was discharged from both Occupational and Physical Therapy on 10/29/12. There was no therapy documentation regarding discharge planning regarding the resident's contractures or need for range of motion, or splints.</p> <p>The current health care plans for Resident #15, current through 01/31/13, included an Alteration in Mobility plan with interventions including: requires 1-2 staff to reposition in bed, left Ankle Foot Orthotic (AFO) and left arm splint when out of bed.</p> <p>The medication orders for Resident #15 included orders for the resident to receive Baclofen, a muscle relaxant, 20 mg one tablet, three times a day.</p> <p>Physician orders regarding the</p>		<p>1x weekly x 3 months, and then audit quarterly thereafter until QA Committee states otherwise.6. Director of Health Services/Designee will audit ROM documentation being completed on all residents 1x weekly for compliance. Any noted declines will be referred to therapy for screen.7. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: December 7, 2012</p>				

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	<p>resident's left leg included: "10/31/11 - moon boot to left foot at all times."</p> <p>Interview with the COTA (Certified Occupational Therapy Assistant), who was in charge of the facility's therapy department, Employee #10, on 11/06/12 at 10:15 A.M., indicated range of motion exercises were not recommended because there is no restorative program in place at the facility. She indicated Resident #15 comes to the therapy room daily and does her own exercise routine. Employee #10 indicated she does not measure resident's contractures on a routine basis, only if they are being seen in skilled therapy for contracture issues. However, she indicated she "screens" residents throughout the year and if she thinks their contractures are getting worse she "picks them up for therapy." She indicated therapy screening consisted of asking the nursing department if they had noticed any issues, checking to see if the resident was having increased pain due to contracture issues, and looking at them. She indicated Resident #15 was supposed to be wearing a splint on her left hand, but the splint's location was unknown by therapy when they</p>						

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	<p>last worked with the resident.</p> <p>Employee #10 indicated she was instructed not to recommend restorative maintenance plans for residents due to not having a restorative program. Resident #15 was recently seen in therapy for strengthening of her good side for improved transfers. Therapy does not measure contractures unless specifically having skilled therapy for contracture issues.</p> <p>Interview with the Director of Nursing, on 11/06/12 at 1:30 P.M. indicated the facility did not have any recent measurements of Resident #15's contractures. She indicated there was no plan for any maintenance stretching of the resident's extremities and/or contractures. She indicated she was not aware Resident #15 was not wearing a splint on her left hand. She indicated the nursing assistants would place some residents on restorative plans themselves, but there was no documentation of a restorative plan for Resident #15.</p> <p>2. Resident #42's clinical record was reviewed on 11/7/12 at 10:00 A.M.. The record indicated the resident has a contracture to her right upper extremity and right lower</p>						

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	<p>extremity. The record indicated the resident had a CVA in 2003 resulting in right hemiparesis.</p> <p>An observation of Resident #42 on 11/7/12 at 9:45 A.M., revealed the resident had a contracture to her right wrist/hand and was wearing a splint. The observation also revealed the resident had a contracture to her right lower extremity, noted to be foot drop.</p> <p>A quarterly Minimum Data Set assessment dated 8-29-2012, indicated Resident #42 had impairment in range of motion on one side.</p> <p>An interview with Resident #42 on 11/7/12 at 9:45 A.M., indicated the resident was alert and oriented. The resident stated she previously received therapy for her right hand/wrist contracture but has not had any therapy in a long time. Resident #42 indicated she wears the splint now on her right upper extremity but does not receive any range of motion activities at all. The resident indicated she started physical therapy recently for her right leg and indicated in October she had an increase in pain in her right foot, and her daughter noted</p>						

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	<p>her foot drop had gotten worse. Resident #42 indicated her daughter told someone in the facility her foot drop had gotten worse and she started therapy soon after. The resident indicated she receives no range of motion or stretching to her right foot outside of therapy.</p> <p>Review of resident #42's physician's orders indicated on 10/12/12 an order for a Physical Therapy (PT) evaluation was to be done for foot drop to the right foot. On 10/15/12 a physician's order was received for: (PT) evaluation was completed and the resident was to start treatment 3 x a week for 4 weeks to include modalities, therapy activities, procedures, splinting and PT/caregiver education.</p> <p>An interview on 11/7/12 at 11:45 A.M. with the Therapy Manager indicated the resident does not receive any range of motion exercises for her right upper extremity. The Therapy Manager indicated the department started providing services for the right foot drop after nursing reported in October the resident had right foot drop. The Therapy Manager indicated a Rehabilitation screening was previously completed on</p>			
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	<p>8/17/12 and noted the resident did not demonstrate a significant change in functional mobility at that time, and no skilled intervention was needed at that time.</p> <p>3. Resident #2's record was reviewed on 11-6-2012 at 2:01 PM. Resident #2's diagnoses included, but were not limited to, dementia, brain injury and heart irregularity.</p> <p>Resident #2 was observed on 11-1-2012 at 9:49 AM holding his left hand close to his body in a closed position. When asked if he was having problems moving his hand, Resident #2 indicated he was unable to completely open his hand. Resident #2 further indicated the staff did not do range of motion (ROM) on his hand, nor did he wear a splint.</p> <p>A quarterly Minimum Data Set assessment dated 9-3-2012 indicated Resident #2 had no impairment in range of motion on either side of his body.</p> <p>In an interview on 11-7-2012 at 8:51 AM, LPN #7 indicated Resident #2 had a contracture of the left hand. LPN #7 further indicated Resident #2 had not utilized a splint.</p>			

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	<p>In an interview on 11-7-2012 at 8:54 AM, CNA #8 indicated Resident #2 utilized the left hand to grab onto the side rail. There was no formal range of motion program for the hand despite Resident #2 holding his hand in a closed position for most of the day. CNA #8 indicated Resident #2 was not able to open his hand as far as he used to.</p> <p>In an interview on 11-7-2012 at 9:11 AM, COTA #9 indicated Resident #2 had an upper extremity contracture, and although he could still use the hand and arm, he would benefit from ROM to maintain his abilities. Additionally, COTA #9 indicated there was no Restorative program at the facility so restorative and functional maintenance programs were not ordered. COTA #9 further indicated the facility was responsible for providing the restorative personnel to initiate the program.</p> <p>In an interview on 11-7-2012 at 9:41 AM, the DON indicated the therapy company contract included therapy would provide the personnel for the restorative program, but because they hadn't, the facility had not been able to provide restorative programs. Additionally, therapy was to provide the ROM screenings and</p>						

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F000325 SS=D	<p>assessments quarterly to determine if ROM was declining or maintaining. She further indicated no ROM assessments had been completed for Resident #2.</p> <p>3.1-42(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to provide nutritional intake for 1 of 5 residents reviewed for nutrition of 9 residents who met the criteria for nutrition. (Resident #63)</p> <p>Findings include: Resident #63's record was reviewed on 11-5-2012 at 1:38 PM. Resident #63's diagnoses included, but were not limited to, dementia, prostate cancer, and arthritis.</p>	F000325	Resident # 63 is deceased and corrections can not be completed. All residents receiving room trays have the potential to be affected by same deficient practice. Nursing staff working during the time of the deficient practice have been educated on room tray delivery and how to properly document any refusals. 1. Director of Health Services/Designee will inservice nursing staff on procedure of delivering all room trays to resident rooms when prepared, as well as, offering assistance with nutritional intake to those residents as needed. 2. Director of Health Services/Designee will	12/07/2012			

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	<p>The Minimum Data Set (MDS) assessment, dated 07-17-2012, indicated Resident #63 required one person stand-by assist for eating.</p> <p>During an observation on 10/31/2012 between 12:15 PM and 12:59 PM, Resident #63 did not get a lunch tray. The family was observed in the room assisting Resident #63 to drink ensure.</p> <p>In an interview on 10-31-2012 at 12:59 PM, the family indicated Resident #63 was not eating well and wanted ensure, but did not request no lunch tray.</p> <p>During a continuous observation on 11-5-2012 between 12:09 PM and 1:19 PM, Resident #63 was observed in bed. Room trays were passed at 12:18 PM, but Resident #63 remained in bed without a lunch tray. At 12:35 PM, all room trays had been passed, but Resident #63 received no lunch tray. At 12:49 PM hall trays had been completed and gathered, but Resident #63 still had no lunch tray. At 1:19 PM, Resident #63 remained in bed without a lunch tray. No substitute or supplement was offered during the observation period.</p>		<p>audit all residents requiring a room tray during one meal 3x weekly x 4 weeks for compliance the residents received the room tray, then audit 1x weekly until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>				

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	<p>A current nutrition and hydration care plan, dated 10-16-2012, included interventions of pureed diet with honey thick liquids, offer a substitute if consumption is less than 50%, offer snacks between meals, monitor skin integrity, monitor and report weight loss to physician, speech therapy as ordered, and monitor for weight changes.</p> <p>Resident #63's weights were as follows: on 10-2-2012; 145.2. On 10-16-2012; 135.6. On 11-1-2012; 129.8.</p> <p>The dietician notes on 10-16-2012 indicated she was notified and made a recommendation to increase supplements with meals. On 11-1-2012 the dietician was notified of the significant loss and she made further recommendation.</p> <p>In an interview on 11-5-2012 at 2:45 PM, the Director of Nursing indicated Resident #63 should have received a lunch tray, and was unsure why he had not.</p> <p>In an interview on 11-5-2012 at 2:52 PM, the DON indicated Resident #63's lunch tray had been made up in the kitchen, but no one went to get it.</p>				

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F000329 SS=D	<p>3.1-46(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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to provide non pharmacological interventions prior to as needed medication administration for 2 of 10 residents reviewed for unnecessary medications (Resident #4 and Resident #40)</p>	F000329	Resident #4 and #40 are unable to correct deficient practice due to time frame. No ill effects noted. All residents receiving Ambien (PRN) have the potential to be affected by the same deficient practice. All residents receiving Ambien (PRN) have been reviewed for proper non pharmacological interventions attempted before	12/07/2012

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	<p>Findings include:</p> <p>1. Resident #4's record was reviewed on 11-6-2012 at 9:03 AM. Resident #4's diagnoses included, but were not limited to, high blood pressure, dementia, and anemia.</p> <p>A current Physician's Order Summary dated 11-2012, indicated Ambien (a hypnotic) was to be given at bedtime as necessary for insomnia.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 8-7-2012, indicated Resident #4 felt down 1 day in the assessment reference period, tired 2-6 days in the assessment reference period, sad almost every day, and moving or speaking slowly almost everyday in the assessment reference period. The MDS further indicated Resident #4 had no delusions, hallucinations or behaviors in the assessment reference period.</p> <p>A care plan dated 3-13-2012, titled fatigue, indicated Resident #4 had low energy and trouble falling asleep. Interventions included report changes, provide quiet, comfortable environment, monitor for side</p>		<p>receiving the Ambien (PRN). Nurses responsible for not providing the non pharmacological interventions before providing Ambien (PRN) for resident #4 and #40 have been reeducated on this process. All (PRN) medications have been audited for proper non pharmacological interventions tried first as per policy.1. Director of Health Services/Designee will inservice licensed nursing staff on the procedure of documenting non pharmacological interventions tried first and if those interventions are not successful, then provide Ambien (PRN) as indicated by physician ordered. Nursing staff educated to document non pharmacological interventions tried before administering any (PRN) medication.2. Director of Health Services/Designee will audit all residents MARS/TARS with physician orders for PRN medication(s) 3x weekly x 4 weeks for compliance of proper documentation of non pharmacological interventions were tried and unsuccessful before providing the PRN medication(s) to the resident, then audit 2x weekly x 4 weeks, and then audit weekly 1x weekly thereafter until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be</p>		

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	<p>effects, and encourage activities to increase energy level.</p> <p>A review of the Medication Administration Record dated 9-2012, indicated Ambien had been given on 9-1, 2, 6, and 11. No non pharmacological interventions were attempted in notes for 9-1, 2, 6, and 11.</p> <p>A review of information for 9-1 through 9-30-2012, indicated no insomnia was noted in the kiosk.</p> <p>In an interview on 11-6-2012 at 10:16 AM, the Social Services Designee indicated non-pharmacological interventions should have been attempted prior to as necessary administration of Ambien</p> <p>2. Resident #40's record was reviewed on 11-5-2012 at 2:35 PM. Resident #40's diagnoses included, but were not limited to, heart disease, depression, and high blood pressure.</p> <p>A current Physician's Order Summary dated 11-2012, indicated Ambien (a hypnotic) 5 mg was to be given as needed at bedtime.</p>		<p>reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>		

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	<p>A review of the Medication Administration Record dated October 2012, indicated Ambien had been administered on 10-6 with no nonpharmacologic interventions charted, 10-11 with no nonpharmacological interventions charted, and 10-16 with no nonpharmacological interventions charted.</p> <p>A care plan titled psychotropic drug use, dated 9-4-2012, included interventions of monitor for medication side effects, report to negative outcomes to physician, administer medications as ordered, educate family on risks and benefits, monitor for effectiveness of psychotropic medications, and work with physician and pharmacy to get lowest dose.</p> <p>A quarterly Minimum Data Set assessment, dated 9-23-2012, indicated Resident #40 had no behaviors in the assessment reference period, had issues with sleep for 1 day, was tired almost every day and had a problem with appetite almost every day in the assessment reference period.</p> <p>In an interview on 11-5-2012 at 3:39 PM, Social Services Designee</p>				

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F000369 SS=D	<p>(SSD) indicated Ambien use was due to roommate snoring. The Ambien use was an attempt to sleep through the snoring. The SSD indicated there was no other intervention to use to help her sleep through the snoring. She further indicated Resident #40 had a roommate change on 9-10-2012, but had no idea why she was still taking the Ambien in October, because she had no diagnosis or reason for Ambien use. The SSD further indicated non-pharmacological interventions should have been attempted prior to the as needed Ambien use.</p> <p>3.1-48(a)(4)</p> <p>483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them.</p> <p>Based on observation, interview, and record review, the facility failed to provide adaptive equipment while eating as ordered by the physician for 1 of 5 residents reviewed for adaptive equipment during eating (Resident #63).</p>	F000369	Resident # 63 is deceased and corrections can not be completed. All residents with physician orders for adaptive equipment when eating have the potential to be affected by the same deficient practice. All residents with physician orders for nose cup were reviewed to ensure nose cups are being used as ordered.	12/07/2012

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	<p>Findings include:</p> <p>Resident #63's record was reviewed on 11-5-2012 at 1:38 PM. Resident #63's diagnoses included, but were not limited to, dementia, stroke, and arthritis.</p> <p>During an observation on 10/31/2012 at 12:59 PM, Resident #63 was observed with family drinking ensure. The ensure was in a regular glass.</p> <p>During an observation on 11-2-2012 at 12:35 PM, Resident #63 was served his lunch in the assisted dining area. Resident #63's liquids were in a regular glass.</p> <p>A nutrition and hydration assessment dated 10-13-2012, indicated Resident #63 was not on thick liquids and needed no assistance eating. The form further indicated Resident #63 was maintaining good hydration despite his risk factor of swallowing difficulty.</p> <p>A current Physician's Order Summary dated 11-2012, indicated Resident #63 was to use a nose cup for all liquids.</p> <p>In an interview on 11-5-2012 at</p>		<p>All residents needing any adaptive equipment when eating have been reviewed for compliance.1. Residents with physician orders for adaptive equipment when eating will have this information placed in the communication binders at the nurses station for staff to reference, as well as, placed in the computerized resident profiles.2. Dietary Food Service Director/Designee will update communication binders with current orders as needed.3. Director of Health Services/Designee will inservice nursing staff on procedure of ensuring any resident with physician orders for any adaptive equipment when eating, including nose cup, are utilizing the adaptive equipment as ordered. The inservice will also include, the nursing staff are to reference the communication binders located at the nurses station to know those residents requiring any adaptive equipment when eating.4. Dietary Food Service Director/Designee will audit all residents with physicians orders for any adaptive equipment when eating during any meal 2x weekly x 4 weeks for compliance of following those orders and then audit 1x weekly thereafter until QA Committee states otherwise.5. Any non-compliance issues will be addressed immediately and staff responsible</p>		

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F000371 SS=F	<p>11:15 AM, CNA #8 indicated she did not know Resident #63's liquids were to be in a different glass, but if that's what was ordered, he should have had his liquids in the type of glass ordered.</p> <p>3.1-21(h)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interviews, the facility failed to ensure the ice machine in the kitchen was maintained in a sanitary condition. In addition, the facility failed to ensure 3 of 3 kitchen staff observed prepared and served food in a sanitary manner. This potentially affected 59 of 60 residents who consumed food. (Employees #11, 12, and 15)</p> <p>Findings include:</p> <p>1. During the Dietary sanitation tour, conducted on 10/31/12 between 10:30 A.M. - 10:45 A.M., there was a black fuzzy residue on the inside</p>	F000371	<p>will be reeducated/disciplined as appropriate per facility policy. Dietary Food Service Director/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p> <p>Ice machine was cleaned immediately and the black fuzzy residue on the inside edge under the lid was removed. Air gap has been corrected. All residents have the potential to be affected by the same deficient practice. Plant Ops Director set up the ice machine to be thoroughly cleaned and inspected on a quarterly basis by outside contractor. Plant Ops/ Environmental Services will provide any needed cleaning to the ice machine between the scheduled quarterly cleanings. Employees 11, 12, and 15 were inserviced regarding sanitation and safety of proper food handling. 1. Home office support/Designee will inservice dietary department on proper sanitation and safety</p>	12/07/2012			

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	<p>edge under the lid of the ice machine. A sticker on the ice machine indicated it was last cleaned on 04/27/12. In addition, there was an inadequate air gap directly underneath the ice machine. The drainage pipe was touching the rim of the receptacle pipe. The Food Service Supervisor, Employee #12, indicated a new floor was put in underneath the ice machine, and the drain might have been shoved back and impaired the air gap.</p> <p>2. On 11/05/12 at 12:49 P.M., CNA #16 sat to help Resident #34 with her lunch. CNA #16 noticed Resident #34 had spilt most of her food on the table and/or her clothing protector. CNA #16 asked Cook #11 for a new plate of food. Cook #11 indicated he did not have anymore dishes in the assist dining room. Nurse #17 indicated there was an "extra" plate sitting in the middle of another table of residents who had already been served. Cook #11 then took the plate from the middle of another resident's table, put the pureed food for Resident #34 onto the plate, and served it. It was unclear if anything had previously been placed on the plate, if any other resident had touched the food surface, and whether the plate</p>		<p>guidelines regarding proper food handling.2. Dietary Food Service Director/designee will audit 3x weekly (consisting of 1 breakfast, 1 lunch, and 1 dinner meal) for proper sanitation and safety with food handling.3. Any non-compliance issues will be addressed and/or corrected immediately. Staff responsible for the non compliance issues will be reeducated/disciplined as appropriate per facility policy.4. Plant Ops Director/Designee will audit ice machine weekly for proper cleanliness to include no evidence of black fuzzy residue. Plant Ops Director/Designee and Dietary Food Service Director/Designee will bring all their audits to QA for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: December 7, 2012</p>		

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	<p>was clean.</p> <p>3. On 10/31/12 between 11:26 A.M. - 12:15 P.M., the following was noted:</p> <p>Cook #11 was noted to be making cheeseburgers and french fries. Cook #11 had donned gloves, then handled the handle of deep fryer, a spatula handle, a plastic bag containing cheese slices, and then without changing his gloves, touched cheese slices and buns with same gloved hands.</p> <p>Cook #15 was making fruit plates for residents. She had donned a pair of gloves, then handled a scoop for peaches and a scoop for cottage cheese then without changing her gloves, directly handled orange and banana and sliced them and arranged them on the plate touching them with her gloved hands.</p> <p>The Food Service Supervisor, Employee #12, was observed preparing chicken tenders. Employee #12 had donned a pair of gloves, had handled a plastic bag which had spices and flour in it, and put chicken pieces into bag. She then shifted the chicken pieces in the bag of flour by handling the</p>						

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	<p>outside of plastic bag with both hands. Then, without changing her gloves or using tongs, she reached into the bag, grabbed the chicken pieces with her gloved hands, and placed the meat into the fryer baskets.</p> <p>Cook #11, who was serving the noon meal onto plates, was also noted to handle cornbread with his gloved hands that had touched handles of serving utensils, the side of the steam table, his apron, and paper menu tickets.</p> <p>4. On 11/05/12 between 11:30 A.M. - 12:15 P.M., the following was noted during the preparation and serving of the noon meal:</p> <p>Cook #11 put on gloves, then removed chicken tenderloins from a bag, placed them into large baggies with flour, shook them around, touched the handle of the deep fryer basket, touched the outside of the baggies, then grabbed the now floured chicken tenderloins with his gloved hands and put them into the deep fryer basket.</p> <p>At 12:10 P.M., Cook #15 was noted to be handling cornbread with contaminated gloved hands. Cook</p>			

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	<p>was putting cornbread onto plates touching the edges of the pieces of cornbread directly after touching the large serving trays and paper menu cards.</p> <p>5. Review of a facility policy, titled, "Food Production Guidelines - Sanitation and Safety", dated 2009, included the following: "...9. Suitable utensils, such as forks, knives, tongs or scoops shall be provided to minimize handling of food..."</p> <p>3.1-21(i)(3)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</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.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	Resident #61 is unable to have deficient practice corrected due to	12/07/2012			

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	<p>provide adequate handwashing during a procedure for 1 of 2 residents reviewed during dressing change (Resident #61)</p> <p>Findings include:</p> <p>Resident #61's record was reviewed on 11-5-2012 at 9:58 AM. Resident #61's diagnoses included, but were not limited to, heart failure, heart irregularity and breast cancer.</p> <p>In an observation on 11-6-2012 at 9:26 AM, LPN #4 washed hands, gloved, then removed the old dressing off Resident #61's coccyx area. LPN #4 washed the area with wound wash and changed gloves but did not wash her hands. LPN #4 then put the new dressing on the coccyx area. LPN #4 then removed gloves and washed hands.</p> <p>In an interview on 11-6-2012 at 2:12 PM LPN #5 indicated gloves should have been changed and hands washed between removing old dressing and applying new one.</p> <p>A current undated policy, titled General Wound and Skin Care Guidelines, provided by LPN #4 on 11-6-2012 at 2:10 PM, indicated to change dressings with care and to</p>		<p>time frame. All residents with physician orders for dressing changes have the potential to be affected by the same deficient practice. LPN #4 was inserviced on proper handwashing techniques when providing dressing changes. LPN #4 showed a return demonstration of proper handwashing technique while providing dressing changes with Director of Health Services. 1. Director of Health Services/Designee will inservice licensed nursing staff on proper handwashing techniques required when providing dressing changes with residents. 2. Director or Health Services/Designee will audit all residents with physician orders for dressing changes 1x weekly for compliance of staff demonstration of proper handwashing techniques while providing the dressing changes. Audits to continue until QA Committee states otherwise. 3. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy. Director of Health Services/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>		

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F000520 SS=D	<p>dress wounds using clean technique. The policy did not indicate handwashing was involved in clean technique.</p> <p>3.1-18(l)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility failed to address issues with the Restorative program in QAA. This had the potential to affected 3 of 3 residents reviewed with limited</p>	F000520	Resident #15, #42 and #2 deficiencies cannot be corrected due to past compliance. All three residents were assessed for ROM and contractures measured, and will be placed on ROM services provided by	12/07/2012

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	<p>range of motion in the facility. (Residents #15, #42 and #2)</p> <p>Findings include:</p> <p>1. Resident #15 was observed, on 11/05/12 at 10:48 A.M., seated in her wheelchair at her computer desk in her room. The resident had a large soft boot on her left foot and a soft blue Velcro padded covering on her right elbow. The resident's left elbow and hand were contracted and there were no splints on them. The resident was noted to be able to move her right elbow and could use some of the fingers on her right hand freely.</p> <p>The clinical record for Resident #15 was reviewed on 11/02/12 at 1:45 P.M. Resident #15 was admitted with diagnoses including, but not limited to, muscle weakness, difficulty walking, muscular wasting, contracture of joint, rehabilitation, hemiplegia, lesion of ulnar nerve, dysphasia, cerebral hemorrhage, depression with psychotic features, mental disorder with head injury, and seizure disorder.</p> <p>Physician orders and documentation in the therapy section of the clinical record indicated the resident had</p>		<p>facility. All residents with contractures have the potential to be affected by the same deficient practice. An action plan for ensuring ROM assessments and measurements for residents with contractures has been implemented by IDT. Nursing staff educated on providing and documentation of ROM services for all residents. An action plan for ensuring nursing staff is providing and documenting ROM services for all residents has been implemented as well. 1. Nursing, IDT members will be responsible to review action plans during QA meeting and make any changes or recommendations by reviewing audits completed by Director of Health Services/Designee regarding the compliance of ROM assessments and measurements for contractures, and ROM services being provided and documented on the residents. 2. Director of Health Services/Designee will audit all residents with contracture(s) for compliance of current ROM assessment and measurements 1x weekly x 3 months, and then audit quarterly thereafter until QA Committee states otherwise. 3. Director of Health Services/Designee will audit ROM documentation being completed on all residents 1x weekly for compliance. Any noted declines will be referred to therapy for screen. 4. Any</p>				

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	<p>received Occupational Therapy treatments from 09/07/12 - 10/26/12, for positioning in the wheelchair and strengthening in right upper extremity. She also received Physical Therapy treatments from 09/07/12 -10/26/12 to increase Range of Motion due to contractures of her left ankle utilizing a restorator. The resident was discharged from both Occupational and Physical Therapy on 10/29/12. There was no therapy documentation regarding discharge planning regarding the resident's contractures or need for range of motion, or splints.</p> <p>The current health care plans for Resident #15, current through 01/31/13 , included an Alteration in Mobility plan with interventions including: requires 1-2 staff to reposition in bed, left Ankle Foot Orthotic (AFO) and left arm splint when out of bed.</p> <p>The quarterly Minimum Data Set assessment dated 8-29-2012, indicated Resident #15 had impairment in range of motion on one side.</p> <p>The medication orders for Resident #15 included orders for the resident to receive Baclofen, a muscle</p>		<p>non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility policy residents. Director of Health Services/Designee will bring all audits and action plans to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 7, 2012</p>		

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	<p>relaxant, 20 mg one tablet, three times a day.</p> <p>Physician orders regarding the resident's left leg included: "10/31/11 - moon boot to left foot at all times."</p> <p>Interview with the COTA (Certified Occupational Therapy Assistant), who was in charge of the facility's therapy department, Employee #10, on 11/06/12 at 10:15 A.M. indicated range of motion exercises were not recommended because there is no restorative program in place at the facility. She indicated Resident #15 comes to the therapy room daily and does her own exercise routine. Employee #10 indicated she does not measure resident's contractures on a routine basis, only if they are being seen in skilled therapy for contracture issues. However, she indicated she "screens" residents throughout the year and if she thinks their contractures are getting worse, she "picks them up for therapy." She indicated therapy screening consisted of asking the nursing department if they had noticed any issues, checking to see if the resident was having increased pain due to contracture issues, and looking at them.</p>						

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	<p>She indicated Resident #15 was supposed to be wearing a splint on her left hand, but the splint's location was unknown by therapy when they last worked with the resident. Employee #10 indicated she was instructed not to recommend restorative maintenance plans for residents due to not having a restorative program. Resident #15 was recently seen in therapy for strengthening of her good side for improved transfers.</p> <p>Interview with the Director of Nursing, on 11/06/12 at 1:30 P.M., indicated there was no plan for any maintenance stretching of the resident's extremities and/or contractures. She indicated she was not aware Resident #15 was not wearing a splint on her left hand. She indicated the nursing assistants would place some residents on restorative plans themselves, but there was no documentation of a restorative plan for Resident #15.</p> <p>2. Resident #42's clinical record was reviewed on 11/7/12 at 10:00 A.M.. The record indicated the resident has a contracture to her right upper extremity and right lower extremity. The record indicated the resident had a CVA in 2003 resulting</p>				

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	<p>in right hemiparesis.</p> <p>An observation of Resident #42 on 11/7/12 at 9:45 A.M., revealed the resident had a contracture to her right wrist/hand and was wearing a splint. The observation also revealed the resident had a contracture to her right lower extremity, noted to be foot drop.</p> <p>An interview with Resident #42 on 11/7/12 at 9:45 A.M., indicated the resident was alert and oriented. The resident stated she previously received therapy for her right hand/wrist contracture but has not had any therapy in a long time. Resident #42 indicated she wears the splint now on her right upper extremity but does not receive any range of motion activities at all. The resident indicated she started physical therapy recently for her right leg and indicated in October she had an increase in pain in her right foot, and her daughter noted her foot drop had gotten worse. Resident #42 indicated her daughter told someone in the facility her foot drop had gotten worse, and she started therapy soon after. The resident indicated she receives no range of motion or stretching to her right foot outside of therapy.</p>				

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	<p>Review of Resident #42's physician's orders indicated on 10/12/12 an order for a Physical Therapy (PT) evaluation was to be done for foot drop to the right foot. On 10/15/12 a physician's order was received for: (PT) evaluation was completed and the resident was to start treatment 3 x a week for 4 weeks to include modalities, therapy activities, procedures, splinting and PT/caregiver education.</p> <p>A quarterly Minimum Data Set assessment dated 8-29-2012 indicated Resident #42 had impairment in range of motion on one side of her lower extremities.</p> <p>An interview on 11/7/12 at 11:45 A.M. with the Therapy Manager indicated the resident does not receive any range of motion exercises for her right upper extremity. The Therapy Manager indicated the department started providing services for the right foot drop after nursing reported in October the resident had right foot drop. The Therapy Manager indicated a Rehabilitation screening was previously completed on 8/17/12 and noted the resident did not demonstrate a significant</p>			

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	<p>change in functional mobility at that time and no skilled intervention was needed</p> <p>3. Resident #2's record was reviewed on 11-6-2012 at 2:01 PM. Resident #2's diagnoses included, but were not limited to, dementia, brain injury and heart irregularity.</p> <p>Resident #2 was observed on 11-1-2012 at 9:49 AM holding his left hand close to his body in a closed position. When asked if he was having problems moving his hand, Resident #2 indicated he was unable to completely open his hand. Resident #2 further indicated the staff did not do range of motion (ROM) on his hand, nor did he wear a splint.</p> <p>A quarterly Minimum Data Set assessment dated 9-3-2012, indicated Resident #2 had no impairment in range of motion on either side of his body.</p> <p>In an interview on 11-7-2012 at 8:51 AM, LPN #7 indicated Resident #2 had a contracture of the left hand. LPN #7 further indicated Resident #2 had not utilized a splint.</p> <p>In an interview on 11-7-2012 at 8:54</p>						

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	<p>AM, CNA #8 indicated Resident #2 utilized the left hand to grab onto the side rail. There was no formal range of motion program for the hand despite Resident #2 holding his hand in a closed position for most of the day. CNA #8 indicated Resident #2 was not able to open his hand as far as he used to.</p> <p>In an interview on 11-7-2012 at 9:11 AM, COTA #9 indicated Resident #2 had an upper extremity contracture, and although he could still use the hand and arm, he would benefit from ROM to maintain his abilities. Additionally, COTA #9 indicated there was no Restorative program at the facility, so restorative and functional maintenance programs were not ordered. COTA #9 further indicated the facility was responsible for providing the restorative personnel to initiate the program.</p> <p>In an interview on 11-7-2012 at 9:41 AM, the DON indicated the therapy company contract included therapy would provide the personnel for the restorative program, but because they hadn't, the facility had not been able to provide restorative programs. Additionally, therapy was to provide the ROM screenings and assessments quarterly to determine</p>				

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	<p>if ROM was declining or maintaining.</p> <p>In an interview on 11-7-2012 at 10:32 AM, the DON indicated there was a problem with the restorative program. She indicated she takes things to QA by reviewing everything on the QA report for DONs which included, but was not limited to, hospital discharges, falls, weights, and restraints. She further indicated the facility tracks and trends from that report. The DON indicated the Administrator does QA with maintenance and ancillary services. She further indicated QA for therapy is completed by the program director. Every department presents their own information at the monthly meeting. She further indicated the Restorative program had not been reviewed by QA for a while.</p> <p>In an interview on 11-7-2012 at 10:49 AM the Administrator indicated the facility had known about the issue with restorative for a while, but had not addressed the issue in QA or formulated an action plan.</p> <p>3.1-52(a)(3)</p>				