

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155228	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/08/2015
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00180415.</p> <p>Complaint IN00180415 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309.</p> <p>Survey dates: August 31, September 1, 2, 3, 4, and 8, 2015</p> <p>Facility number: 000133 Provider number: 155228 AIM number: 100266080</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type: Medicare: 4 Medicaid: 47 Other: 14 Total: 65</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <p>Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask your consideration for paper compliance.</p>	

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

TITLE

(X6) DATE

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

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F 0272 SS=D Bldg. 00	<p>QR completed by 30576 on September 14, 2015.</p> <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</p>			

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	<p>the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to code a residents admission and quarterly Minimum Data Set (MDS) assessment correctly for a pressure ulcer for 1 of 2 residents reviewed for pressure ulcers of 2 who met the criteria for pressure ulcers. (Resident #45)</p> <p>Findings include:</p> <p>Resident #45's record was reviewed on 9/2/15 at 1:10 p.m. Resident #45 was admitted to the facility on 6/29/15.</p> <p>A Care Plan for Resident #45 initiated 6/29/15, indicated she was admitted to the facility with a non-healing ulcer to her left outer ankle and received treatment to her ulcer at a local Wound Center.</p> <p>Documentation from the local Wound Center for Resident #45 dated 6/30/15, indicated she had been seen for an ulcer on her left lateral malleous and would return for a follow up visit on 7/14/15.</p> <p>Resident #45's admission MDS assessment dated 7/8/15, indicated she had no unhealed pressure ulcers.</p>	F 0272	<p><b>F 272: Comprehensive Assessments</b></p> <p>It is the policy of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>The MDS coordinator completed a modification Admission and Quarterly Assessment on Resident #45 on 9/22/15. Please see attachment #1 and #2.</p> <p>All other residents with a pressure area have a potential to be affected. The skin nurse gave the MDS coordinator an updated weekly pressure skin report. MDS coordinator and skin nurse checked accuracy of all current assessments.</p> <p>Skin nurse will continue to give MDS coordinator skin sheet weekly and the MDS</p>	10/01/2015

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	<p>Documentation from the local Wound Center for Resident #45 dated 7/14/15, indicated she had a full thickness ulcer on her left lateral malleous and would return for a follow up visit on 7/28/15.</p> <p>Documentation from the local Wound Center for Resident #45 dated 7/28/15, indicated she had a stage III pressure ulcer on her left lateral malleous.</p> <p>Resident #45's quarterly MDS assessment dated 7/29/15, indicated she had no unhealed pressure ulcers.</p> <p>On 9/3/15 at 9:30 a.m., Resident #45 was observed receiving a dressing change to a pressure ulcer on her left outer ankle by RN #1. The pressure ulcer was approximately half the size of a dime and the wound bed was pink, red, and yellow in color.</p> <p>An interview with the MDS Coordinator on 9/8/15, indicated she coded Resident #45's admission MDS assessment according to the local Wound Center's documentation dated 6/30/15, and Resident #45's quarterly MDS assessment according to the local Wound Healing Center's documentation dated 7/14/15. She indicated the facility's Wound Care Nurse had informed her the area on</p>		<p>coordinator to assure accuracy of assessment.</p> <p>All pressure areas will be discussed in our weekly IDT Medicare Meeting with both the MDS coordinator and wound nurse in attendance. DON or designee will monitor any new assessments of residents with pressure areas weekly for the next three months, half of all residents with pressure areas for the following three months, and random checks of residents with pressure areas ongoing (See attachment #12). If any errors occur, MDS coordinator and administrator will be notified, any issues will be corrected immediately. The results of the audits will be reviewed by the QA committee and any recommendations will be followed.</p> <p><b>Date of completion: 10/1/15</b></p>	

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F 0279 SS=D Bldg. 00	<p>Resident #45's left outer ankle was not a pressure ulcer.</p> <p>3.1-31(a)</p> <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 record review and interview the facility fail to provide a care plan for an anti-depressant and a diuretic for 1 of 23 residents reviewed for care plans, Resident #C.</p> <p>Findings include:</p> <p>Review of Resident #C's record on 9/3/15</p>	F 0279	<p><b>F 279: Develop Comprehensive Care Plans</b></p> <p>It is the policy of this facility to use the results of the assessment to develop, review, and revise the</p>	10/01/2015

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	<p>at 8:45 a.m., indicated admission date 7/2/15 and her diagnoses included but were not limited to, dementia, hypertension, asthma, hyperlipidemia and lower extremity edema.</p> <p>Physician's recapitulation orders dated 9/1/15 through 9/30/15 indicated Resident #C was prescribed Lasix 40 mg (milligrams) every day for a diagnosis of edema, medication was started on 7/2/15 and Zoloft 25 mg every day for diagnosis of depression, medication was started on 7/6/15.</p> <p>Review of care plans for anti-depressant and diuretic medication indicated no care plan for anti-depressant or diuretic.</p> <p>Interview on 9/8/15, at 10:45 a.m., with the Director of Nursing indicated she would have staff complete a care plan for the anti-depressant and the diuretic for Resident #C.</p> <p>3.1-35(a)</p>		<p>resident's comprehensive plan of care.</p> <p>Resident C's care plan was reviewed and updated on 9/9/15. She now has a care plan for her antidepressant and for her diuretic. Please see attachment 3.</p> <p>All other residents care plans were reviewed that had the potential to be affected and corrective actions were taken.</p> <p>All new admissions and all new orders will be taken to our morning meeting Monday-Friday with the care plans being updated in our clinical morning meeting.</p> <p>The DON or designee will review all new orders daily in the clinical meeting Monday-Friday and as needed for three months, three times</p>	

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to assess and monitor bruising for 2 of 4 residents reviewed for non pressure related skin conditions. (Resident #C and Resident #D)</p> <p>Findings include:</p> <p>1. On 8/31/15 at 3:37 p.m., Resident #D</p>	F 0309	<p>weekly for the following six months, and randomly ongoing after. Any concerns will be brought to our weekly IDT meeting. All results will be reviewed by QA committee meeting and any recommendations will be followed.</p> <p><b>Completion date: 10/1/15</b></p> <p><b>F309: Provide care/services for highest well being</b></p> <p>It is the policy of this facility that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>	10/01/2015	

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	<p>was observed to have two fading bruises on the top of her right hand.</p> <p>Resident #D's record was reviewed, on 9/02/2015, at 11:40 a.m. Physician's orders dated 9/1/15 through 9/30/15 indicated diagnoses that included, but were not limited to; high blood pressure, coronary artery disease, anxiety, gastro esophageal reflux disease, seizures, low heart rate, mental retardation, depression, congestive heart failure, and anemia.</p> <p>Review of progress notes in the resident's record failed to indicate any current skin conditions or bruising.</p> <p>On 9/03/2015 at 2:47 p.m., Resident #D was observed with the Wound Nurse. The back of Resident #D's right hand had faint green bruising that was approximately 4 centimeters by 3 centimeters. The Wound Nurse indicated the bruising was from a temporary IV the resident had because she had pulled out her gastrostomy tube on 8/13/15.</p> <p>On 9/03/2015 at 3:10 p.m., the Wound Nurse reviewed the wound assessments and indicated there was no assessment for the bruising.</p> <p>2. Observation of Resident #C, on 8/31/15 at 1:00 p.m., indicated a purplish</p>		<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Resident C and D had a skin assessment done on 9/3/15. See attachment #4.</p> <p>All residents have the potential to be affected. All residents will have a skin assessment completed by 9/23/15. Any new areas of concern will be documented, family and MD will be notified.</p> <p>All nursing staff will be inserviced on the skin condition and pressure ulcer assessment on 9/28/15. Please see attachment #5. CNA's will be educated on completing shower sheets to include all alterations in skin integrity. They will also be</p>		

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	<p>discoloration on top of left hand and on top of right hand near wrist area.</p> <p>Review of Resident #C's record on 9/3/15 at 8:45 a.m., indicated diagnoses included but were not limited to, dementia, hypertension, asthma, hyperlipidemia and lower extremity edema.</p> <p>On 9/3/2015 at, 11:04 a.m., an interview with RN #1 indicated she was not aware of bruising on Resident # C's hands, but would investigate it right away. RN #1 informed the Wound Nurse and the Physician, both of whom were present at the nurses station, of the bruising on Resident #C's hands. The Wound Nurse and Physician indicated they would look at it.</p> <p>Review of a skin observation tool, dated 9/3/15 at 2:14 p.m., indicated "bruising to top of left hand measuring length 3.0 x width 3.5. Notes: noted resident to have bruised area to top of left hand, MD assessed and ordered to monitor."</p> <p>Physician's order dated 9/3/15 (no time) indicated "monitor bruise to left hand until resolved."</p> <p>Review of care plan update dated 9/3/15 (no time) indicated "Problem: bruising, Goal: free of bruising, keep skin intact,</p>		<p>educated to report to charge nurse all alterations in skin integrity that was noted while performing routine care. Charge Nurse/s will audit all shower sheets daily and then turn them in to the DON. All new residents will continue to have a skin assessment upon admission. Any areas of concern will be documented, MD will be notified.</p> <p>The DON or designee will use a skin audit tool to monitor 5 residents for new skin concerns with proper follow-up weekly for 3 months(October, November, December) then 3 residents for 2 months(January and February), and randomly ongoing. Audits will be reviewed weekly at IDT meeting. See attachment #6. Any concerns will be corrected immediately. Anyone found to be non-compliant will be reeducated and progressively disciplined. The results of the</p>	

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	<p>Approach: skin check daily with ADL's, shower sheets 2 times weekly, complete body assessment weekly."</p> <p>Interview with DON on 9/4/15 at 1:20 p.m., indicated Resident #C only had bruising on left hand, area on right hand was not bruising.</p> <p>A "Skin Condition and Pressure Ulcer Assessment Policy" was provided by the Director of Nurses on 9/4/15 at 9:40 a.m. The policy indicated, but was not limited to; "Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and pressure or other ulcers and assuring interventions are implemented...Policy: It is the policy of this facility that pressure, other ulcers and skin problems will be assessed and measured at least every seven (7) days by a licensed nurse and recorded on the facility skin report form. Any significant changes between seven (7) days assessments will be recorded in the nursing progress notes and skin report record...1. A Skin Condition assessment and a Pressure Ulcer Risk assessment will be performed at the time of admission, quarterly and as necessary...5. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly</p>		<p>audits will be reviewed at the quarterly QA committee meeting and any recommendations will be followed.</p> <p><b>Completion Date: 10/1/15</b></p>	

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F 0314 SS=D Bldg. 00	<p>reported to the charge nurse who will perform the detail assessment...7. Caregivers are responsible for promptly notifying the charge nurse of skin observations that include...b. Bruises...."</p> <p>This Federal tag relates to Complaint IN00180415.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to assess and document their observations of a resident's pressure ulcer and failed to collaborate with the Dietician to promote wound healing, for 1 of 2 residents reviewed for pressure ulcers of 2 who met the criteria for pressure ulcers. (Resident #45)</p>	F 0314	<p><b>F 314 Treatment/SVCS to prevent/heal pressure sores</b></p> <p>It is the policy of this facility to, based on the comprehensive assessment of a resident, the facility must ensure that a resident who</p>	10/01/2015

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	<p>Findings include:</p> <p>Resident #45's record was reviewed on 9/2/15 at 1:10 p.m. Resident #45 was admitted to the facility on 6/29/15.</p> <p>A Care Plan for Resident #45 initiated 6/29/15, indicated she was admitted to the facility with a non-healing ulcer to her left outer ankle and received treatment to her ulcer at a local Wound Center.</p> <p>Documentation from the local Wound Center for Resident #45 dated 6/30/15, indicated she had been seen for an ulcer on her left lateral malleous and would return for a follow up visit on 7/14/15.</p> <p>Documentation from the local Wound Center for Resident #45 dated 7/14/15, indicated she had a full thickness ulcer on her left lateral malleous. The ulcer post debridement measured 1.2 centimeters (cm) long by 0.9 cm wide by 0.3 cm deep.</p> <p>Documentation from the local Wound Center for Resident #45 dated 7/28/15, indicated she had a stage III pressure ulcer on her left lateral malleous. The ulcer post debridement measured 1.1 cm long by 0.5 cm wide by 0.4 cm deep.</p>		<p>enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Resident #45 had a skin assessment completed and documented on 9/15/15. See attachment #7. Care plan was updated on 9/15/15. See attachment #8.</p> <p>Skin assessments on each resident was completed by 9/23/15. All residents have the potential to be affected. Any new areas if found were noted and given to the Registered Dietician and brought to the IDT meeting.</p>	

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	<p>Documentation from the local Wound Center for Resident #45 dated 8/11/15, indicated she had a non-stageable ulcer on her left lateral malleous. The ulcer post debridement measured 0.8 cm long by 0.6 cm wide by 0.3 cm deep.</p> <p>Documentation from the local Wound Center for Resident #45 dated 8/18/15, indicated she had a non-stageable pressure ulcer on her left lateral malleous. The ulcer measured 0.5 cm long by 0.5 cm wide. The wound bed was dry and black.</p> <p>Documentation from the local Wound Center for Resident #45 dated 9/1/15, indicated she had a full thickness ulcer on her left lateral malleous. The ulcer measured 1 cm long by 0.6 cm wide and was scabbed over.</p> <p>The facility's Skilled Charting documentation for Resident #45 dated 9/3/15, indicated she had a treatable wound and received a dressing change every other day. The wound had no new changes noted and her treatment was ordered by a local Wound Center.</p> <p>On 9/3/15 at 9:30 a.m., Resident #45 was observed receiving a dressing change to a pressure ulcer on her left outer ankle by RN #1. The pressure ulcer was</p>		<p>Skin nurse will give copies of skin sheet detailing any pressure areas to the Registered Dietician for their review and recommendations.</p> <p>All pressure areas will be discussed in addition to Registered Dieticians recommendation during weekly IDT meeting. IDT meeting will sign off that they have reviewed. DON or designee will meet with dietician weekly or upon every visit for three months, bi-weekly for six months, and randomly thereafter to assure dietician is aware of all pressure areas. Dietician and DON or designee will sign that they are aware of every pressure area. Any errors will be brought to QA committee for recommendations of systematic changes. This facility will follow all recommendations of QA committee.</p>	

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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374
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	<p>approximately half the size of a dime and the wound bed was pink, red, and yellow in color. The soiled dressing removed from the wound had a small amount of reddish drainage.</p> <p>A telephone interview with the facility's Dietician on 9/8/15 at 10:00 a.m., indicated she had not been aware Resident #45 had a wound. She indicated the facility provided her with a list of residents with pressure ulcers and Resident #45 had not been on the pressure ulcer list.</p> <p>An interview with the Wound Nurse on 9/8/15 at 10:14 a.m., indicated she provided the Dietician with the facility's pressure wound report but Resident #45 was not on the report. The local Wound Center documented Resident #45's wound as a non-healing wound, not a pressure ulcer.</p> <p>An interview with the Wound Nurse on 9/8/15 at 12:58 p.m., indicated Resident #45 received a dressing change to the wound on her left outer ankle every other day at the facility and was seen at a local Wound Center every 2 weeks. Herself or the nursing staff had not documented any wound assessments or wound measurement. The nursing staff documented any new orders and if there</p>		<p><b>Completion Date: 10/1/15</b></p>	

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	<p>were any changes to the wound after Resident #45 returned from the local Wound Center. The nursing staff would document on a Skin Sheet if there had been any changes to the wound, and there had been none.</p> <p>A "Skin Condition And Pressure Ulcer, Assessment Policy" provided by the Director of Nursing on 9/8/15 at 2:00 p.m., indicated the following: "Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and pressure or other ulcers and assuring interventions are implemented. To provide a system and tools to evaluate the response to medical, nursing and dietary treatment and interventions. Policy: It is the policy of this facility that pressure, other ulcers and skin problems will be assessed and measured at least every seven (7) days by a licensed nurse and recorded on the facility skin report form. Any significant changes between seven (7) day assessments will be recorded in the nursing progress notes and skin report record. Action: ... 3. An individual Skin Condition Report will be maintained with the resident's treatment record until the wound or ulcer is healed. 4. Pressure or other ulcers present will be documented onto the Wound Summary form and updated weekly, using the Skin Condition</p>			

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F 0371 SS=E Bldg. 00	<p>Report as a guide to document same... 10. A disposable measuring device (one time use) will be used to measure dimensions, and as necessary, a sterile cotton tipped applicator used to measure wound depth. 11. A separate Skin Report Form for each identified skin problem and for each resident will be completed and include: a. Site b. Size (length by width by depth) c. Stage of pressure area d. Odor f. Description g. Date, time, signature and title of the individual performing the assessment... 18. A licensed nurse is responsible for completing the Skin Condition Report and Wound Care Summary reports on the day assigned. These reports will also be forwarded to the Dietician and Administrator."</p> <p>3.1-40(a)(2) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to ensure the chemical test strips were not expired and the dishes were sanitized for 63 of 65 residents served from the kitchen.</p>	F 0371	<b>F371-Food Procure, Store/Prepare/Serve-Sanitary</b>	10/01/2015			

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	<p>Findings include:</p> <p>Observation on 8/31/15 9:55 a.m., indicated the Dietary Manager tested the dishwasher rinse cycle with a chemical test strip, there was no change in test strip color. The temperature gauge on dishwasher for rinse water was 120 degrees.</p> <p>Requested manufactures guidelines from the DON on 8/31/15 at 10:15 a.m.</p> <p>Review of a document titled owners manual provided by the DON on 8/31/15 at 10:27 a.m., indicated... Sanitizer: sanitizer should be 6% solution of sodium hypochlorite. The initial setting is 5 cc and this should be checked regularly with a chlorine test kit. Free chlorine in the final rinse should be 50 PPM to 100 PPM (parts per million)...</p> <p>8/31/15 at 11:45 a.m., Dietary Staff #2 tested dish washer with a chemical test strip, temperature of dish washer rinse water reached 129 degrees, chemical test strip did not change in color, chemical test strips expired on 4/2014.</p> <p>Review of dish machine temperature/sanitizer report dated August 2015, provided by the DON on 9/1/15 at</p>		<p>It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and served food under sanitary conditions.</p> <p>As indicated in the 2567, the dishwasher tubing was replaced on 8/31/15 once it was noticed the chemical wasn't always reaching the machine.</p> <p>All residents who are not on feeding tubes have the potential to be affected. Dietary staff will use the new test strips to assure the ppm is at the proper measurement.</p> <p>Dietary staff were inserviced on 9/1/15 on the proper use of the chemical test strips and how to record the readings.</p>		

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F 0441 SS=D Bldg. 00	<p>1:10 p.m., indicated on 8/31/15 (no time) breakfast Rinse/PPM-129/100 signed by dietary staff #2, lunch Rinse/PPM 129/100 signed by dietary staff #2.</p> <p>9/1/15 at 1:15 p.m., interview with Administrator indicated he called Eco Lab to check dishwasher on 8/31/15 and found the tubing for the chemical sanitizer was kinked and would not let sanitizer go through, tubing was replaced and it is working correctly now.</p> <p>Observation on 9/1/15 at 1:25 p.m., indicated the dishwasher was tested with chemical test strip by the Dietary Manager and was 100 ppm. Dietary Manager indicated she had received new chemical test strips from another facility on 8/31/15 that were not expired.</p> <p>Interview on 9/8/15 at 4:35 p.m., with the manufacturers Customer Service Representative indicated the incoming rinse water temperature of the dishwasher machine the facility uses should be at least 120 degrees and the chemical testing strip should be 50 PPM to 100 PPM for proper sanitization of the dishes.</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p>		<p>Dietary manager will continue to train all new employees on proper usage of the dish machine. Any failure of the machine to meet the right reading will be reported to the dietary manager. Dietary manager or designee will do 5 random test audits weekly for three months, twice weekly for six months, and randomly ongoing (See Attachment 13). Anyone found to be noncompliant will be reeducated on proper technique and progressively disciplined. The results of the audit will be reviewed quarterly by the QA committee and any recommendations will be followed.</p> <p><b>Completion date: 10/1/15</b></p>		

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	<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 wash their hands after handling a soiled</p>	F 0441	<b>F 441 Infection control, prevent spread, linens</b>	10/01/2015

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	<p>dressing and prior to donning clean gloves during a dressing change observation for 1 of 2 dressing change observations of 2 residents who met the criteria for pressure ulcers. (Resident #45)</p> <p>Findings include:</p> <p>Resident #45's record was reviewed on 9/2/15 at 1:10 p.m. Documentation on a local Wound Clinic assessment for Resident #45 dated 9/1/15, indicated a diagnosis of a full thickness wound on her left lateral malleous.</p> <p>A physician's order on Resident #45's September 2015 recapitulation, initiated 6/30/15, indicated every other day her left lateral malleous wound would be cleansed with normal saline and clean collagen AG would be applied over the wound. Clean felt foam would be applied around the collagen AG and the dressing would be secured.</p> <p>On 9/3/15 at 9:30 a.m., RN #1 was observed changing Resident #45's dressing on her left outer ankle. RN #1 removed Resident #45's dressing. The collagen AG dressing covering the wound contained a small amount of reddish drainage. RN #1 disposed of the dressing and changed her gloves without</p>		<p>It is the policy of this facility to 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>Staff will wash hands when they change their gloves during a dressing change on resident #45.</p> <p>All other residents that have a dressing change have the potential to be affected. Nursing staff will follow the policy on hand washing and dressing changes. Please see attachment #9 and #10.</p> <p>Nursing staff will be inserviced on hand washing and dressing changes on 9/28/15. Wound nurse will randomly observe</p>	

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	<p>washing her hands. After donning clean gloves RN #1 completed the dressing change. RN #1 indicated she had not washed her hands after removing the soiled dressing but had changed her gloves.</p> <p>A "Dressing-Clean Technique" procedure provided by the Director of Nursing (DON) on 9/4/15 at 9:40 a.m., indicated the following. "Purpose: A clean dressing is used to provide an appropriate and safe environment conducive to wound healing. Policy: All dressings are performed by licensed personnel according to physician order using clean technique, unless another technique is specified by the physician... Procedure: ... 3. Wash hands. Put on gloves. 4. Remove soiled dressing and discard into designated waste receptacle. 5. Remove gloves, wash hands, and put on a pair of clean gloves...."</p> <p>A "Handwashing Procedure" provided by the DON on 9/8/15 at 3:05 p.m., indicated the following: "Purpose: Handwashing is the single most important measure for preventing the spread of infection. Policy: The employee should wash his/her hands routinely after each direct Resident contact (as indicated by accepted professional practice) and after handling</p>		<p>dressing and handwashing and continue to inservice staff as needed. A log will be kept. Please see attachment #11.</p> <p>DON or designee will monitor 2 times a week for 3 months, then 1 time a week for 3 months, and randomly thereafter. Any staff found to not be proficient in their handwashing will be in-serviced and given any additional training as needed. Any issues will be brought to quarterly QA meeting to determine if systematic changes need to be put in place. This facility will follow all recommendations of the QA committee.</p> <p><b>Completion Date: 10/1/15</b></p>		

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F 0465 SS=E Bldg. 00	<p>contaminated articles... Following are instances when handwashing MUST be done:... after handling used dressings... after removing gloves...."</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to ensure residents doors, door facings, and walls were free of areas where the paint was rubbed or scratched off, a light switch cover had intact plaster behind it, and a door rubbed against the floor. This affected 6 of 35 residents in 6 of 47 rooms.</p> <p>Findings include:</p> <p>1. On 8/31/2015 at 11:21 a.m., the first bed in room 37 was observed to have a large scratched area on the wall behind the head of the bed. The wall behind the recliner, on the right side of the bed, was scuffed.</p> <p>On 9/8/15 at 11:28 a.m., with the Maintenance Director, room 37 was observed and had 7 deep scratches on the</p>	F 0465	<p><b>F465-Safe/Functional/Sanitary/ Comfortable Environment</b> It is the policy of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and public. All areas of concern were corrected, this include painting of the scratches in room 37, room 34, room 29, room 30, and ceiling in room 8. The door to room 14 was fixed to allow closing without rubbing on the floor. Kick plates were installed where needed. The other residents would have the potential to be affected if they were to visit those rooms, these scratches are caused by the wheelchairs in the facility rubbing against the wood. The facility will continue to repaint and repair any building issues as they arrive. The facility maintains a full-time maintenance man in addition to access to a maintenance man within our home office and additional contractors. The facility</p>	10/01/2015

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	<p>wall behind the head board on where the paint had been scratched off. On the wall behind the recliner were multiple scratched areas. The Maintenance Director indicated it is an ongoing battle to keep the areas painted.</p> <p>2. On 8/31/15 at 12:31 p.m., in room 14, the bedroom door was observed to rub against the floor when opened.</p> <p>During an observation, on 9/8/15 at 11:28 a.m., with the Maintenance Director, the door rubbed on the floor when closed. The Maintenance Director indicated the door had been split, it is difficult to close the door, the door doesn't line up, and had 4 sets of hinges instead of 2.</p> <p>3. On 8/31/15 at 3:38 p.m., the bathroom door in room 34 was observed and had deep rubbed areas in the door facing where the paint has been worn off deep into the wood and the wood was exposed. The door had deeply rubbed areas on the right side of the open door, next to the hinged sides, and on the door trip outside the bathroom door.</p> <p>4. On 8/31/15, at 2:23 p.m., in room 29, the bathroom door had horizontal marks rubbed into the door and the door facings. The light switch cover in the bathroom had loose plaster visible on the right side</p>		<p>staff was inserviced on 9/28/15 in regards to how to address areas that are in need of repair. Managers will do daily rounds(mon-fri) for the next week, twice weekly for the following two weeks, and weekly thereafter. (See attachment 14) These issues will be brought to our morning manager meeting to be addressed with maintenance supervisor. Administrator or designee will verify weekly for the next six weeks on repairs, biweekly for six months following, and randomly ongoing after(See attachment 15). Any continuing issues will be brought to QA for consideration of systematic changes. This facility will follow all recommendations of the QA committee. <b>Date of completion: 10/2/15</b></p>		

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	<p>of the switch plate, with some of the plaster missing in a vertical, quarter inch line on the right side of the plate.</p> <p>5. On 9/1/15 at 1:34 p.m., in room 8, the bathroom had a large yellow stain on the ceiling above the commode.</p> <p>On 9/8/15 at 11:22 a.m., with the Maintenance Director, the yellow stain was observed. The Maintenance Direct indicated the water stain was from an old sprinkler repair and he has not received a work order about this.</p> <p>6. On 8/31/15, at 4:06 p.m., the bathroom in room 30 was observed. Both doors that opened into the bathroom had deep rubs through the paint that exposed the wood underneath.</p> <p>On 9/08/2015 at 11:33 a.m. The bathroom in room 30 was observed with the Maintenance Director. Both doors had deep rubs through the paint into the wood.</p> <p>3.1-19(f)</p>			