

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
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NAME OF PROVIDER OR SUPPLIER HOOSIER CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 S SUGAR ST BROWNSTOWN, IN 47220
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F000000	<p>This visit was for a Recertification and State Licensure survey. This visit also included the investigation of Complaint IN00130674 and Complaint IN00141734.</p> <p>Complaint IN00130674 - Substantiated - Federal/State finding cited at F364. Complaint IN00141734 - Substantiated - no deficiencies related to the allegations are cited.</p> <p>Survey Dates: January 14, 15, 16, 17, 22, 23, and 24, 2014.</p> <p>Facility number: 000277 Provider number: 155611 AIM number: 100290530</p> <p>Survey team: Gloria J. Reisert, MSW/TC Joan Laux, RN Paula Igou, RN (January 14, 15, 16, 17, 22, and 23, 2014) Caitlin Lewis, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 86 Total: 96</p>	F000000	<p>Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provision of Federal and State law. Please accept this evidence in lieu of an onsite follow-up visit for recertification and state licensure survey event ID MBTX11 on January 24,2014.</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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	<p>Census payor type: Medicare: 10 Medicaid: 64 Other: 22 Total: 96</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC.</p> <p>Quality review completed on January 31, 2014 by Cheryl Fielden RN.</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 record review and interview, the facility failed to notify the physician and family when a resident experienced a choking</p>	F000157	Hoosier Christian Village informs 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	02/14/2014			

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	<p>episode which left the resident weakened afterwards and subsequently transferred to the hospital after sustaining a stroke. This deficient practice affected 1 of 2 residents reviewed for death. (Resident #21)</p> <p>Findings include:</p> <p>On 1-17-14 at 9:32 a.m., the resident's record was reviewed.</p> <p>The H and P (history and physical) from (name of hospital) dated 11/1/13, indicated Resident #21 did not have any issues with eating.</p> <p>The MDS (Minimum Data Set) Assessment dated 11/20/13, indicated Resident #21 had no swallowing/nutritional issues.</p> <p>All skilled nursing notes during the month of November, indicated Resident #21 was independent with eating with no help or staff oversight at any time needed.</p> <p>A nurses note dated 11/25/13 at 1722 (5:22 p.m.), indicated Resident #21 was sitting on the edge of her bed during her OT (Occupational Therapy) tx (treatment session) at 9:45 a.m. to eat her breakfast and</p>		<p>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 in either life threatening conditions or clinical complications; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.1. The Unit Managers and D.O.N. review daily in the morning clinical meetings all documented changes in residents' clinical conditions and ensure that physicians and families are notified. There were no residents found to be affected by this alleged deficient practice.2. Residents have the potential to be affected by this alleged deficient practice.3. During the week of February 10, 2014 charge nurses were re-educated on the current policy related to change in condition that included notifying attending physician and responsible party of a change in residents' condition. The physician/responsible party will be notified when: A. the change is sudden. B. represents a marked change in relation to usual signs and symptoms. C. the signs and symptoms are unrelieved by measures already prescribed. The re-education also included if the physician cannot be reached, the Medical Director will be contacted to report the change in condition until the attending</p>				

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	<p>had a coughing episode while eating a muffin. The resident's face turned red, and she was not able to catch her breath. The Occupational Therapist instructed her to keep coughing in order to clear the food. Once she was able to speak, she reported that the food went down the "wrong pipe". Her voice was noted to be weak and she demonstrated wheezing when taking breaths. She also stated that she felt weak and wanted to lie down in bed. The Occupational Therapist assisted her feet into bed in order to lie on her left side. The Occupational Therapist tested her 02 [oxygen] sats [amount of oxygen in her blood stream] which read 93 percent.</p> <p>The note also indicated that although the Occupational Therapist assisted Resident #21 to lie down, when a CNA (certified nursing assistant) entered the room, the resident insisted on taking a shower and the CNA and Occupational Therapist then assisted the resident up and into the shower.</p> <p>The SBAR (form sent to physician on resident's condition) dated 11/25/13, indicated Resident #21 was found with right arm flaccid, only groaned when spoken to, could try</p>		<p>physician can be contacted.</p> <p>4. The Nurse Unit Managers and D.O.N. will continue to review documentation in the morning clinical meetings, on-going, for changes in residents' clinical conditions and proper notification of physicians per policy. Any areas of concern will be addressed 1:1 by unit manager and D.O.N. with the staff nurse involved and also brought to the CQI committee for further review and any recommendations.</p> <p>5. The re-education for charge nurses on the policy for change in conditions has been completed by 2-14-14 and the on-going reviews by D.O.N. and unit managers to ensure compliance will continue.</p>	

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	<p>to open her eyes, had one plus pitting edema in her bilateral feet, had an irregular pulse, and respirations were slightly labored. The notification also indicated the staff had taken in supper tray approximately 10 minute earlier and resident was responding normally, but when checked on, the resident was coughing and would not respond verbally.</p> <p>Documentation was lacking of the physician or family having been notified related to the first choking incident.</p> <p>During an interview with the DON (Director of Nursing) on 1/17/13 at 10:37 a.m., she indicated that the day Resident #21 went to the hospital, they did not notify the physician after the first choking incident because there was no change in condition.</p> <p>During a second interview with the DON at 11:06 a.m., on 1/17/14, she indicated that they did not do an investigation or or have any documentation related to the morning incident. She indicated that the choking incident occurred in the morning and Resident #21 was fine after that so there wasn't anything to</p>				

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	<p>investigate.</p> <p>On 1/17/14 at 10:36 a.m., the DON presented the facility's current policy related to change in condition was received. Review of the policy at this time included, but was not limited to: "It is the policy of Christian Homes that a licensed staff member will notify attending physician and responsible party of a change in the residents condition. The physician/responsible party will be notified when:</p> <p>A. the change is sudden. B. represents a marked change in relation to usual signs and symptoms, C. the signs and symptoms are unrelieved by measures already prescribed.</p> <p>If the physician can not be reached, the Medical Director will be contacted to report the change in condition until the attending physician can be contacted."</p> <p>3.1-5(a)(1) 3.1-5(a)(2)</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	Hoosier Christian Village ensures	02/14/2014			

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	<p>review the facility failed to report an abuse allegation to the state agency. This affected 1 of 2 residents reviewed for abuse. (Resident #7).</p> <p>During clinical record review of Resident #7 on 1/16/2014 at 1:10 p.m., the resident had the diagnosis of, but not limited to, osteoarthritis, atrioventricular block, right bundle branch block, unspecified urethral stricture, unspecified retention of urine, gout, generalized pain and muscle weakness.</p> <p>During an interview on 1/14/2014 at 12:47 p.m., Resident #7 stated "Some girls [CNA's] are rough when they wash me." This was immediately reported to the Administrator.</p> <p>A typed and signed investigation dated 1/14/2013 at 4:20 p.m., was provided, per the Administrator. This investigation was in response to Resident #7 indicating staff being rough with her during a resident interview. The investigation indicated the staff spoke with Resident # 7 regarding their concerns of reports of staff being rough with the resident. "When asked if this was a new allegation or if this was the</p>		<p>that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.1. Allegations from residents or staff are immediately reported to the administrator, investigated and followed up on. There were no other residents found to have been affected by this alleged deficient practice.2. Residents have the potential to be affected by the alleged deficient practice. 3. The Administrator, DON, and SSD reviewed the current policy on reporting abuse allegations. Allegations will be continued to be reported as per policy to the administrator and the administrator will report allegations, investigations, and follow up to ISDH as stated per policy. 4. The Administrator, DON, and SSD were re-educated on the reporting requirements of abuse allegations by the corporate regional nurse. 5. The Administrator will bring allegations to the CQI team, monthly, ongoing, for further review and recommendations as needed.</p>		

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	<p>same that she voiced in Dec., [Resident #7] responded that this was not new, this went back to the time she was admitted. She stated that, "nobody is rough with me now." She stated that anytime her legs are spread apart for peri-care or to change her catheter that it hurts. She stated that she had surgery on both legs and this is the cause of the pain. Explained to her that I will add this to her careplan and we will do our best not to hurt her. I again, asked her if anyone is being rough with her and she denied that this was happening." This was signed by the DON and RN #2.</p> <p>A Resident Concern Form indicating the "Date of Incident" as "November 2013" and was signed and dated by the DON on 12/03/13 stated, "When asked [Resident # 7] about being "rough", resident stated that it bothered her arthritis to be moved." The "Response/Action Taken" was re-education for the staff on second shift on resident rights and treating all residents with "TLC". The RN Supervisor will follow up with the resident weekly for a month and then every month for 3 months for any further issues.</p> <p>An Employee Code of Conduct form,</p>						

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	<p>revised 04/2012, indicated "we expect our employees to be gentle, kind and compassionate to our residents. This was provided with the inservice sign in sheet.</p> <p>A Resident Council Concern Form dated 12/3/13 indicated the concern of "girls [CNA's] not doing what residents ask or being rough." The investigation report, in response to this form, dated 12/3/13 indicated "[Resident#7] has arthritis- CNAs state she voices that whenever they move her or assist her she complains they are being rough. Will assess pain med regime- inservice staff on telling res (resident) what care is being provided before doing it, explain that they do not want to be rough..." This document was signed by RN #2 and dated 12/3/13.</p> <p>A social service progress note dated 12/30/2013 indicated the SSD (Social Services Director) visited with Resident #7 that day. "She stated that she has been doing well and the cnas have been doing a good job with her care here lately. She had no concerns at this time. SSD will [continue] to [follow up] with her and her [psychosocial] well being."</p>						

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	<p>A social service progress note dated 1/2/2014 indicated the SSD met with Resident #7 that day. "SSD met with [Resident #7] today. She stated that she is happy with her care...."</p> <p>A social service progress note dated 1/8/2014 indicated Resident #7 "is doing well psychosocially. She shows no [signs and symptoms] of distress. She goes to activities and enjoys visiting with staff. She stated that everything is going well with her care at this time."</p> <p>A social service progress note dated 1/14/2014 indicated Resident#7 "stated she is doing fine this morning. SSD asked her how her care is and she said it is going fine. SSD will continue to [follow up] with [Resident #7] and her [psychosocial] wellbeing."</p> <p>A care plan dated 12/17/2013 indicated " [Resident #7] has potential for alteration in comfort [due to] diagnosis of degenerative arthritis. [Complains of] neck pain ". The goals indicated included, but were not limited to, " [Resident #7] will be free from pain or discomfort through next review. [Resident #7] will not have verbalizations of staff being rough with her during peri care</p>			

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	<p>daily thru next review." The interventions included, but were not limited to, "Administer pain medication as prescribed and monitor for effectiveness... When Foley cath is changed may attempt to anchor with [Resident #7] on her side, with upper leg flexed. If unable to do, ask [Resident #7] to spread her legs as far as she can without causing pain. When providing pericare- be gentle, ask [Resident #7] to spread her legs out slightly so care can be provided."</p> <p>A care plan dated 12/17/2013 indicated "[Resident #7] voices that staff hurts her or is "rough" with her whenever they give care to her. [Resident #7] has arthritis. She is on routine pain medication. She uses a motorized wheelchair for mobility due to discomfort upon walking or when propelling a regular wheelchair. Verbalizes that staff doesn't put her to bed when she desires." The goals include, but were not limited to, "[Resident # 7] will decrease verbalizations of staff roughness and that staff didn't assist her to bed when she wanted daily thru next review." The interventions included, but were not limited to, "Approach [Resident #7] slowly and gently, telling her what you are going</p>			

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	<p>to do before doing it. Attempt to provide care shortly after pain medication has been given. Encourage [Resident # 7] to participate in AROM [Active Range of Motion], ambulation to prevent muscle [sic.] stiffness, keep joints limber. Explain to [Resident # 7] that you do not mean to hurt, but only are trying to help her get dressed, bathe or groomed before doing the task. Give rest periods as needed. SSD will meet with [Resident #7] couple [sic.] times a week to ensure she is satisfied [sic.] with care."</p> <p>During an interview on 1/17/2014 at 12:15 p.m., the Administrator indicated she was the Abuse Prevention Coordinator. The facility has an ambassador program, in which management is responsible for certain residents and they speak with those residents daily. The business manager was Resident #7's ambassador on 12/03/2013. On 12/03/2013 he business manager indicated the resident had some concerns and had asked the Administrator to follow up with this resident. During this time, a resident council meeting was held. This is when the resident indicated her concerns, again. She then asked the DON and RN #2 to interview</p>			
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	<p>Resident #7. When interviewed at that time, Resident #7 then indicated when she stated staff was "rough" earlier in the day it was meant that she had arthritis and it hurt for her to be moved. The Administrator indicated staff did not consider this to be an abuse allegation.</p> <p>During an interview on 01/17/2014 at 12:50 p.m., the DON indicated when she interviewed Resident #7, on 12/3/2013, she asked the resident specifically about the resident's statement using the word rough. The DON stated, "the word rough was a red flag." The DON wanted to "negate" any abuse allegations. The DON indicated during her interview with the resident, that the resident said she did not mean that the staff were being rough with her. It was her arthritis pain that was hurting her, whenever she was moved. The DON provided patient care to the resident herself one day. The resident indicated to the DON that it did hurt whenever the care was given due to her arthritis.</p> <p>483.13(c) 3.1-28(a)</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview the facility failed to follow their own policies and procedures on abuse. This affected 1 of 2 residents reviewed for abuse. (Resident #7)</p> <p>During clinical record review of Resident #7 on 1/16/2014 at 1:10 p.m., the resident had the diagnosis of, but not limited to, osteoarthritis, atrioventricular block, right bundle branch block, unspecified urethral stricture, unspecified retention of urine, gout, generalized pain and muscle weakness.</p> <p>A Resident Council Concern Form dated 12/3/13 indicated the concern of "girls [CNA's] not doing what residents ask or being rough." The investigation report, in response to this form, dated 12/3/13 indicated "[Resident#7] has arthritis- CNAs state she voices that whenever they move her or assist her she complains they are being rough. Will assess pain med regime- inservice</p>	F000226	<p>Hoosier Christian Village ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.1. Allegations from residents or staff are immediately reported to the administrator, investigated and followed up on. There were no other residents found to have been affected by this alleged deficient practice.2. Residents have the potential to be affected by the alleged deficient practice. 3. The Administrator, DON, and SSD reviewed the current policy on reporting abuse allegations. Allegations will be continued to be reported as per policy to the administrator and the administrator will report allegations, investigations, and follow up to ISDH as stated per policy. 4. Staff were re-educated regarding the facility abuse policy with emphasis on immediate reporting of allegations of abuse.5. The Administrator</p>	02/14/2014			

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	<p>staff on telling res (resident) what care is being provided before doing it, explain that they do not want to be rough..." This document was signed by RN #2 and dated 12/3/13.</p> <p>A Resident Concern Form indicating the "Date of Incident" as "November 2013" and was signed and dated by the DON on 12/03/13 stated, "When asked [Resident # 7] about being "rough", resident stated that it bothered her arthritis to be moved." The "Response/Action Taken" was re-education for the staff on second shift on resident rights and treating all residents with "TLC". The RN Supervisor will follow up with the resident weekly for a month and then every month for 3 months for any further issues.</p> <p>A care plan dated 12/17/2013 indicated "[Resident #7] voices that staff hurts her or is "rough" with her whenever they give care to her. [Resident #7] has arthritis. She is on routine pain medication. She uses a motorized wheelchair for mobility due to discomfort upon walking or when propelling a regular wheelchair. Verbalizes that staff doesn't put her to bed when she desires." The goals include, but were not limited to, "[Resident # 7]</p>		will bring allegations to the CQI committee team, monthly, ongoing, for further review, and recommendations as needed.		

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	<p>will decrease verbalizations of staff roughness and that staff didn't assist her to bed when she wanted daily thru next review." The interventions included, but were not limited to, "Approach [Resident #7] slowly and gently, telling her what you are going to do before doing it. Attempt to provide care shortly after pain medication has been given. Encourage [Resident # 7] to participate in AROM [Active Range of Motion], ambulation to prevent muscle [sic.] stiffness, keep joints limber. Explain to [Resident # 7] that you do not mean to hurt, but only are trying to help her get dressed, bathe or groomed before doing the task. Give rest periods as needed. SSD will meet with [Resident #7] couple [sic.] times a week to ensure she is satisfied [sic.] with care."</p> <p>During an interview on 1/17/2014 at 12:15 p.m., the Administrator indicated she was the Abuse Prevention Coordinator. The facility has an ambassador program, in which management is responsible for certain residents and they speak with those residents daily. The business manager was Resident #7's ambassador on 12/03/2013. On 12/03/2013 he business manager indicated the resident had some</p>						

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	<p>concerns and had asked the Administrator to follow up with this resident. During this time, a resident council meeting was held. This is when the resident indicated her concerns, again. She then asked the DON and RN #2 to interview Resident #7. When interviewed at that time, Resident #7 then indicated when she stated staff was "rough" earlier in the day it was meant that she had arthritis and it hurt for her to be moved. The Administrator indicated staff did not consider this to be an abuse allegation.</p> <p>During an interview on 01/17/2014 at 12:50 p.m., the DON indicated when she interviewed Resident #7, on 12/3/2013, she asked the resident specifically about the resident's statement using the word rough. The DON stated, "the word rough was a red flag." The DON wanted to "negate" any abuse allegations. The DON indicated during her interview with the resident, that the resident said she did not mean that the staff were being rough with her. It was her arthritis pain that was hurting her, whenever she was moved. The DON provided patient care to the resident herself one day. The resident indicated to the DON that it</p>			
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	<p>did hurt whenever the care was given due to her arthritis.</p> <p>A policy titled, "Prevention of Abuse" indicated, "When staff are aware of any type of abuse, such as witnessing or hearing any action that could constitute abuse... they are to immediately report it to the Abuse Coordinator. As soon as possible without delay an initial report will be made to the appropriate state department."</p> <p>A policy titled, "Resident Abuse Investigation" indicated, "ALL allegations of abuse will be reported to the state authorities as soon as practical, local law enforcement, and to the facility owner or licensee in accordance with current state and/or federal regulations." The procedure indicated, "The Abuse Prevention Coordinator or his/her designee will notify the State regulatory agency and the facility licensee (if state required) via facsimile (with confirmation of receipt attached to the retained fax) of the alleged abuse immediately not to exceed 24 hours of the receipt of allegation. All reports will be reviewed by RCN prior to sending."</p> <p>483.13(c)</p>			

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F000279 SS=D	<p>3.1-28(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and</p>	F000279	Hoosier Christian Village develops comprehensive care plans for each resident that	02/14/2014			

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	<p>interview, the facility failed to develop a care plan which included precautions for a resident on dialysis and for a resident who had chewing problems and had missing lower dentures. (Residents #81 and #107)</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #81 on 1/16/14 at 1:17 p.m. indicated the resident was admitted on 10/4/13 and had diagnoses which included, but were not limited to: chronic kidney disease 4, hypotension of hemodialysis, arteriovenous fistula - acquired, renal dialysis, history of venous thrombosis and embolism, and vitamin D deficiency.</p> <p>A 10/23/13 Care Plan with a review date on 1/13/14 indicated: "Resident needs dialysis r/t [related to] DX [diagnosis] of Renal Failure." "Goal: Resident will have no s/sx [signs/symptoms] of complications from dialysis through next review." "Approaches included: encourage resident go to dialysis appointment scheduled; monitor/document for peripheral edema; monitor/document/report to MD PRN [as needed] any s/sx of infection to access site, redness, swelling,</p>		<p>includes measurable objectives and time tables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.1. Resident #81 was discharged to home on 1/16/14. Resident #107 was interviewed upon admission to facility by SSD and declined dental services at time of admission. On 1/17/14, Resident #107's Care Plan was updated to include no lower dentures with appropriate interventions to meet resident's needs.2. Residents have the potential to be affected by this alleged deficient practice. During the weeks of 1/20/14, 1/27/14, and 2/3/14, the Interdisciplinary team audited residents' care plans to ensure measurable objectives and time tables are in place to meet residents' needs who have chewing problems or do not have dentures, no other residents were identified to be affected by this alleged deficient practice. 3. During the week of 1/20/14, the interdisciplinary team was re-educated on developing a comprehensive care plan for each resident that includes measurable objectives and time tables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.4. Upon IDT ongoing weekly care plan</p>		

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	<p>warmth, or drainage."</p> <p>10/25/13 admission treatment orders included: wash incision to left arm daily with antibacterial soap and water, dry completely, wrap with Kerlix and ace wrap. Documentation was lacking of these approaches having been included in the care plan.</p> <p>The Dialysis center contract presented by the Administrator on 1/15/14 at 9:00 a.m. included: "Policy:..#7 Care of the Access Site: The Facility will cooperate in monitoring and caring for the patient's access sites including: a. Avoidance of blood pressure readings, venipuncture, and trauma in dialysis extremity. b. Evaluation of patency of dialysis access, including but not limited to, shunts and fistulas..." Documentation of these approaches were lacking of being included in the resident's care plan.</p> <p>On 1/17/14 at 1:00 p.m., the DON indicated "We have no set policy on Care Planning, but follow the RAI [Resident Assessment Instrument] as to what to care plan."</p> <p>2. Review of the clinical record for Resident #107 on 1/23/14 at 2:00</p>		<p>meetings, the RACs will ensure that all resident's needs are included on the care plan, as identified per the comprehensive assessments with appropriate interventions ensuring needs are met. Any identified concerns will be brought to the CQI committee meeting for further review and recommendations. 5. The systemic changes were completed as of 2/6/14.</p>				

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	<p>p.m., indicated the resident had diagnoses which included, but were not limited to stroke with right side hemiparesis and dementia.</p> <p>During a family interview on 1/14/14 at 11:46 a.m., the family indicated the resident had chewing issues due to missing lower dentures.</p> <p>Review of the 11/25/13 care plans indicated the resident "Has a potential for nutritional problem (weight loss) r/t [related to] diagnosis of cva [stroke] with right hemiparesis and dementia, and alteration in food consistency. She is on a pureed diet." "Goal - will maintain adequate nutritional status as evidenced by maintaining weight within 5% of admission weight of 100 lbs., be free from s/sx of malnutrition, and consuming at least 50% of each meal daily thru review date." "Approaches: Feed resident as needed; provide, serve pureed diet as ordered. Monitor intake and record Q [every] meal.; RD [Registered Dietitian] to evaluate and make diet change recommendations PRN [as needed].;Weigh resident weekly."</p> <p>Documentation was lacking of having addressed the resident</p>						

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F000282 SS=D	<p>having chewing problems due to no lower dentures.</p> <p>During the final exit meeting with the Administrator, Director of Nursing [DoN] and Corporate Nurse, the DoN indicated the lack of lower dentures should have been care planned.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure daily assessments of the resident's shunt/fistula site were being performed to prevent potential complications. This deficient practice</p>	F000282	Hoosier Christian Village ensures that services are provided by qualified persons in accordance with each resident's written plan of care.1. Resident #81 was discharged to home with shunt/fistula site without complications. 2. There are no other residents in the facility	02/14/2014

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	<p>affected 1 of 1 resident reviewed for dialysis. (Resident #81)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #81 on 1/16/14 at 1:17 p.m., indicated the resident was admitted on 10/4/13 and had diagnoses which included, but were not limited to: chronic kidney disease 4, hypotension of hemodialysis, arteriovenous fistula - acquired, renal dialysis, history of venous thrombosis and embolism, and vitamin D deficiency.</p> <p>On 1/17/14 at 9:20 a.m., the DON [Director of Nursing] presented a copy of the facility's current policy titled "Central Venous Dialysis Catheter". The DON indicated that the policy dictated a daily assessment of the dialysis catheter was supposed to be completed and documented on the MAR [Medication Administration Record].</p> <p>She indicated that upon her review of the clinical record, she failed to locate documentation of the assessments. She also indicated that after speaking with her nursing staff, they had indicated they were doing the assessment but just were</p>		<p>receiving dialysis. 3. During the week of 2/10/14, charge nurses were re-educated on admitting orders for residents receiving dialysis services. This re-education includes ensuring that assessments of resident's fistula/shunt site are being performed to prevent complications and documentation of assessments on the treatment administration record. 4. The DON and nurse managers will review all new admission orders, ongoing, to ensure that any resident receiving dialysis services, will have shunt/fistula site assessed and completed documentation. Any identified concerns will be brought to the CQI committee for further review and recommendations.5. The systemic changes will be completed by 2/14/14.</p>				

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	<p>not documenting it on the MAR like they were supposed to. The DON indicated everyone had been re-inserviced on the policy and proper protocol and that the 2 unit managers will double-check each other on each new admissions to ensure all applicable orders are written related to care needs, i.e. order to assess shunt site daily.</p> <p>At 10:43 a.m., on the same day, the DON indicated that she thought the staff were not documenting their assessment of what the resident's shunt site looked like daily was because there was no formal order to do so. She indicated that she has contacted their Corporate IT [internet technology] person who was going to create an order set for dialysis patients in the future so that there will be automatic set of orders of things to be monitored and done for that patient.</p> <p>The Dialysis contract between center and facility addressed the responsibility of each party including: "Policy:... #7 Care of the Access Site: The Facility will cooperate in monitoring and caring for the patient's access sites including: a. Avoidance of blood pressure readings, venipuncture, and trauma</p>			

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F000314 SS=D	<p>in dialysis extremity. b. Evaluation of patency of dialysis access, including but not limited to, shunts and fistulas..."</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 monitor the skin condition by documented assessments and perform sanitary wound care. This deficient practice affected 1 of 3 residents reviewed for pressure ulcer care. (Resident #47).</p> <p>Findings include:</p>	F000314	<p>Hoosier Christian Village ensures 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. 1. On 1/26/14, Resident #47, hospice patient, expired in facility. 2. Residents with dressing changes</p>	02/14/2014

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	<p>On 1/22/14 at 12:40 p.m., the Weekly Wound Flow Sheet dated 1/13/14 was reviewed. It indicated that Resident #47 had an unstageable pressure ulcer measuring 2cm x 1cm and an undetermined depth. "Has open area on coccyx that has grayish black slough throughout wound bed. No drainage noted. No redness around periwound. Hospice nurse informed of open area and treatment order requested. New order received: Apply Santyl collagenase to bed of wound to coccyx after cleansing with normal saline. Cover with foam dressing/abd pad. Change dressing daily." This flow sheet is the only one the facility had on record. The resident was admitted on 10/14/2013.</p> <p>There were no skin assessments noted in the record from admission to 12/26/13 as noted below.</p> <p>A review on 1/23/14 at 9:35 a.m. of the Hospice Facility Coordination Record indicated the following:</p> <p>Dated 12/26/13-"skin intact"</p> <p>Dated 1/3/14- "skin pink and moist"</p> <p>Dated 1/9/14- "skin pale, intact"</p>		<p>have the potential to be affected by this alleged deficient practice. Residents with high risk for skin breakdown, as identified per Braden Scale, have the potential to be affected by this alleged deficient practice. During the week of 1/17/14, DON and nurse managers audited resident's Braden Scales; no residents were identified to be affected by this alleged deficient practice. On 1/20/14, the DON assessed LPN #1 performing the sanitary dressing change correctly. On 1/20/14, charge nurses were re-educated on the policy and procedure of skin management, which included completion of weekly skin evaluations on all residents with accurate documentation to ensure continuity of care. During the weeks of 1/20/14, 1/27/14, 2/3/14, and 2/10/14, nurse unit managers and DON audited charge nurses for completion of dressing changes per compliance of policy.</p> <p>3. During weekly CQI meetings, ongoing, the nurse managers and DON will audit documentation to ensure completion of weekly skin evaluations. Any concerns will be brought to the CQI committee for further review and recommendations. The DON and nurse managers will ensure the nurse competency skill for dressing changes will be completed upon hire, yearly, and as recommended by the CQI</p>				

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	<p>Dated 1/14/14- "Coccyx pressure open area present. Cleansed with normal saline, applied Silvadene to open area and covered with Mepilex dressing. Wound measures 2cm x 0.1cm, pink wound bed, minimal clear drainage. Wound orders written. All care coordinated with facility."</p> <p>Dated 1/16/14- "Patient has pressure sore on coccyx. Wound care completed...no drainage present. Moderate amount white slough with pink around slough."</p> <p>A review on 1/22/14 at 12:50 p.m., of the Skin Assessment Worksheet dated 1/8/13 indicated "Normal at this time."</p> <p>On 1/17/14 at 1:45 p.m., the Daily Skin checks dated from 1/10/14 to 1/12/14 were provided. These are the only skin check sheets that the facility had on record. These forms indicated that "no issues were observed."</p> <p>On 1/22/14 at 12:40 p.m., the DON indicated that they did not have a CNA (Certified Nursing Assistant) change form or IDT (Interdisciplinary Team) comprehensive evaluation</p>		<p>committee.4. The CQI committee will review monthly, ongoing, the completed weekly audits by the DON and nurse managers to ensure completion of weekly skin evaluations. 5. Completion date for the systemic changes will be 2/14/14.</p>	

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	<p>done when the wound was found as the Hospice nurse had found the pressure ulcer. She further indicated that the only weekly skin check sheets that they had was the one provided that was dated 1/13/14 and the only daily skin check sheets she had were the ones provided that were dated 1/10/14 to 1/12/14.</p> <p>On 1/16/14 at 2:30 p.m., a review of the nurse's notes dated 1/13/14 indicated "Resident #47 is end stage cancer of the larynx as well as other sites and is receiving hospice services and comfort care. Has open area on coccyx. Husband at bedside and saw open area. Action: Hospice nurse notified and requesting treatment orders. Has alternating mattress on bed. Staff instructed to keep off this area as much as possible. Response: New order received: Apply Santyl collagenase to bed of wound to coccyx after cleansing with normal saline. Cover with foam/abd pad. Change dressing daily."</p> <p>On 1/16/14 at 2:40 p.m., a review of the Unavoidable Pressure Ulcer Form indicated: "the resident's pressure ulcer is unavoidable because the resident has impaired mobility and 2 of the clinical</p>			

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	<p>conditions (terminal cancer and bowel incontinence). Head of bed up. Resident cannot be turned to left side due to damage from her cancer."</p> <p>On 1/17/14 at 10:53 a.m., during an interview with LPN #3, she indicated that "the wound on her coccyx was red. The Hospice nurse found it first. We reported it to a nurse. I (LPN #3) don't remember who. There is no paperwork on this issue as I was with the Hospice nurse that morning that it was found, so a nurse saw it first."</p> <p>On 1/17/14 at 9:55 a.m., during an observation of wound care for Resident #47, LPN #1 gathered supplies, knocked on the door and entered the room. LPN #1 indicated that the bedside table had been cavi-wiped. She laid the supplies on the bedside table and washed her hands and applied gloves. A new pad was placed under the Resident. New gloves were applied and the old dressing to the coccyx was removed, and then placed in to a plastic bag. LPN #1 washed her hands and applied new gloves. Optifoam and 4 x 4 dressings were opened and the scissors were wiped down with alcohol prep by LPN #1.</p>				

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	LPN #1 then removed her gloves, washed her hands and applied new gloves. LPN #1 cut the Optifoam dressing to the size she needed, then decided it needed to be smaller and used the same scissors and gloves she cut the piece smaller. LPN #1 then proceeded to open a new tube of Santyl ointment without cleaning the top of the Santyl tube. LPN #1 cleaned the wound with normal saline and a 4 x 4 gauze pad, and then pats it dry. Using the same gloves and without washing her hands, LPN #1 picked up the Santyl ointment and pushed out a small amount onto her gloved left pointer finger and smeared it with that gloved finger directly onto the wound bed. LPN #1 removed her gloves and applied new ones. She applied the Optifoam onto the wound bed on Resident #47's coccyx, then turned to pick up the ABD (absorbent) dressing, then turned back around. Seeing the Optifoam had come off of the wound and was lying on the pad under the Resident, LPN #1 picked it up and placed it again over the wound, then laid the ABD over the Optifoam dressing and applied tape to the ABD. LPN #1 removed her gloves and applied new gloves then dated the dressing with that days date and						

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	<p>her initials. She rewashed the scissors with alcohol prep, removed her gloves and washed her hands. New gloves were applied and a new pad was placed underneath the resident, then the resident was repositioned. LPN #1 removed her gloves and washed her hands. She gathered the remaining supplies after bagging all of the soiled and used equipment. The left over Optifoam dressing was placed back into the opened package it was originally in and carried out of the room with the rest of the supplies. LPN #1 opened the treatment cart and took out a small Ziploc bag and placed the left over Optifoam dressing and packaging into it and wrote the resident's name onto the bag and placed this small bag into a larger Ziploc bag that had the resident's name already on it.</p> <p>On 1/24/14 at 2:45 p.m., the DON stated that "the nurse who did the wound dressing change admitted to me right after she was done doing the wound care that she had messed up. That she was nervous."</p> <p>On 1/16/14 at 2:28 p.m., Resident #47 was observed resting in her bed on her right side with pillows propped behind her back. She had</p>						

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	<p>labored breathing with a reddened face. The indwelling Foley catheter was secured on the side of the bed below the level of the Resident. Resident #47 lying on a low air flow mattress.</p> <p>On 1/17/14 at 8:53 a.m., during an interview with LPN #1, she indicated that "Resident #47 receives wound care. The resident's dressing gets changed every day on the day shift. The Hospice Nurse does that also and assesses it and it gets changed as needed. Assessments of wounds are done on Mondays at this facility. The wound is very recent. She has terminal cancer and a g (gastrostomy) tube. She gets proper nutrition and has a low air loss mattress. She has had laryngeal cancer and has very hard time breathing and has to lay on her right side. The problem with breathing was at her home too. She came here because her family could not take care of her at this point."</p> <p>At 9:00 a.m., during an interview with the Dietary Manager, she indicated that "this resident is NPO (nothing by mouth) and she is on Argenade per her g-tube."</p> <p>At 9:08 a.m., during an interview</p>			

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	<p>with LPN #2 and LPN #3, they indicated that "we turn her every hour and prop her with pillows. A nurse does the treatments for the resident. We make sure she has no bowel movements on the wound, red spots, drainage, or bleeding. Any changes at all we would report to the nurse."</p> <p>At 10:55 a.m., during an interview with LPN #1, she indicated that "what I looked at was the charting and the 13th (January, 2014) is what it looks like to me that it (the coccyx pressure ulcer) first appeared. They started doing the dressing changes before I worked with her (Resident #47). The first time I was it was today. I haven ' t seen it before this. When changing a dressing, you should wash your hands, put on new gloves, and take off the old dressing. Wash hands again, put new gloves on, get supplies ready, and then change the dressing. I had the Santyl on my glove during dressing change and after the Santyl, and after everything was completed I would have taken off my gloves and gathered supplies. With open, used dressings I may not have done it right. My thinking is why throw something away that you can use again and it was not a sterile</p>			

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	<p>dressings change. If it had been a sterile dressing change, I would have thrown it away."</p> <p>At 12:10 p.m., during an interview with the DON, she indicated that "Resident #47 had a decrease in tube feedings. The Dr. said it was causing her to choke. She didn't get the protein she needed. It caused her skin to break down very quickly. Our wound care nurse said it was unavoidable; we can't turn her to the left side, so we don't have many sides to move her to. She is on an alternating air mattress. This is how the wound was found by us and the Hospice nurse. Her skin was in good shape, and then it was an unstageable pressure ulcer. It went from that quickly. We got orders to take care of it right away."</p> <p>On 1/16/14 at 12:55 p.m., a review of the clinical records indicated diagnosis including, but not limited to: urinary retention, palliative care, atrial fibrillation, and laryngeal cancer.</p> <p>A review of the admission MDS (Minimum Data Set) dated 10/21/13, indicated the following:</p>						

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	<p>BIMS (Brief Interview for Mental Status) not assessed, but did complete the assessment for mental status that indicated "no behaviors, a good memory. The resident was sleeping allot when she arrived. She was in and out of it and very lethargic at times, so was unable to wake her up enough to interview, so a staff assessment was done."</p> <p>Extensive assistance needed, eating as total dependence, an indwelling Foley catheter on admit, admitted on palliative care, terminal illness, g-tube, and no pressure ulcer on admit.</p> <p>Resident is at risk for pressure ulcers and was on hospice care.</p> <p>A review of the Quarterly MDS dated 1/21/14 indicated that Resident #47 had an indwelling Foley Catheter and was on palliative care. This MDS is not yet completed.</p> <p>A review of the Physician Orders indicated:</p> <p>Dated 1/13/14: " Santyl ointment. Apply to bed of wound to coccyx after cleansing with NS (normal saline). Cover with foam dressing/ABD (absorbent) pad.</p>				

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	<p>Change dressing daily. "</p> <p>Dated 1/14/14: " Hospice services/terminal. Nothing by mouth. Skin checks. "</p> <p>On 1/17/14 at 12:15 p.m., a review of a local hospice center certification of terminal illness dated 12/9/13 indicated "resident is an 82 year old female with history of head and neck cancer. She wishes no further disease directed treatment. She receives tube feedings but these had to be decreased due to choking episodes. She has lost 4 pounds in the past few weeks. She is bedbound."</p> <p>A review on 1/22/14 at 1:00 p.m., of the Medication Administration Record dated January, 2014 indicated that Santyl ointment and dressing changes began on 1/15/14 for the pressure ulcer on the resident's coccyx.</p> <p>On 1/23/14 at 10:00 a.m., a review of the plan of care was reviewed, indicating:</p> <p>Dated 1/13/14, revision on 1/18/14-Goal "Resident #47 has an open area on coccyx, findings consistent with a Kennedy Ulcer</p>				

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	<p>related to decreased mobility...cancer...receiving comfort services from hospice. Has poor nutrition due to inability to tolerate amount of fluid/nutrition with end of life functions. Goals: Cancelled: open area will not worsen and will close by next review. Interventions: alternating air mattress, dressing changes daily, monitor progress of wound weekly and notify hospice physician of changes as needed. Initiated on 1/17/14 check skin daily with care. Cancelled on 1/18/14. "</p> <p>Date initiated 10/24/13, revision on 1/17/14-Cancelled/Resolved 1/17/14: Potential for skin breakdown related to fragile skin and decreased mobility. Goals: Resolved 1/17/14: Resident will be free from skin breakdown daily through review date. Interventions: Resolved 1/17/14: even though she cannot lie on the left side, ensure that she has position changes to decrease skin breakdown, keep skin clean and dry, monitor for signs and symptoms of skin breakdown and treat as needed. Initiated 10/24/13: complete Braden skin assessment quarterly. Resolved 1/17/14. "</p> <p>Date initiated 10/21/13, " Resident is receiving hospice services " .</p>			

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	<p>Date initiated 1/13/14; " Resident has open area on coccyx related to decreased mobility. Goals: open area will not worsen and will close by next review. Interventions: alternating air mattress, apply Santyl to bed of wound to coccyx after cleansing with normal saline. Cover with foam dressing/abd pad. Change dressing daily. Monitor progress of wound weekly. Notify hospice physician of changes as needed. "</p> <p>Policy and Procedures was reviewed on 1/23/14:</p> <p>Wound Cleansing policy and procedure indicated: "To promote a consistent and effective method of wound cleaning with each dressing change. Procedure: Gather equipment...provide hand hygiene and apply clean gloves...remove soiled dressing...remove gloves and provide hand hygiene...reapply gloves and prepare clean field...use cleanser and dressing per physician orders...remove gloves and provide hand hygiene."</p> <p>Wound Dressing policy and procedure: "To assure a safe and effective procedure for changing wound dressings...these procedures</p>			

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	<p>will be used in conjunction with good hand washing technique. Procedure: Good hand washing technique should be used when removing dressings in order to avoid contamination...do not contaminate dressing supplies and wound care container with gloves that have been in contact with the ulcer."</p> <p>Skin/Pressure Ulcer Risk Evaluation policy and procedure: "It is the policy of this facility to evaluate all residents for additional factors that place them at risk for developing pressure ulcers. Procedure: All residents will be assessed for pressure ulcer risk...on admission to the facility...all residents will be re-evaluated weekly for the first four weeks, then quarterly or with a significant change in cognition or functional ability...residents will be evaluated using the Braden Scale. All residents will have a documented weekly review of skin condition by a licensed nurse. The CNA (certified nursing aide) Skin Attention Form will be utilized as a communication tool to alert the nurse of potential skin changes...the CNA's will document changes in skin condition on the CNA Skin Attention Form."</p> <p>Identifying New Skin Area policy and</p>			

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	<p>procedure indicated: "Document findings, stage on the weekly wound documentation form...initiate alert charting...the DON (Director of Nursing) in tandem with the IDT will complete comprehensive evaluation of wounds during the weekly at risk meeting to identify if the wounds were avoidable or unavoidable...weekly rounds are to be completed by the DON or designee and findings documented on the weekly wound documentation form."</p> <p>Risk Evaluation Tools indicated: "skin care and early treatment...evaluations must continue on a daily basis for all residents who are at risk for skin breakdown...a weekly skin evaluation should be completed on all residents...accurate documentation is needed to ensure continuity of care...residents at the end of life...must continue to have care to prevent and treat the pressure ulcer unless the resident refuses this specific care."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>						

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F000364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on record review, interview and observation, the facility failed to ensure food temperatures were maintained on the steam table and food delivered to the residents were maintained at a temperature to their satisfaction. This deficient practice affected 4 of 35 residents reviewed for food quality and 1 of 2 meal observations. (Residents #7, 26, 124 and 120)</p> <p>Findings included:</p> <p>1. During an interview with Resident</p>	F000364	<p>Hoosier Christian Village ensures that each resident receives food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature.1. During the week of 2-10-14, the Dietary Manager met with Residents #7, #26, and #120 (resident #124 discharged to home). No concerns were voiced regarding food temperatures or coffee temperatures. 2. On 2/11/14, a food council meeting was held with the Dietary Manager and residents. No other residents voiced concern of cold food or coffee. 3. On 1/22/14, dietary staff were re-educated on</p>	02/14/2014			

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	<p>#7 on 1/14/14 at 1:10 p.m., she indicated "Coffee isn't hot enough."</p> <p>2. During an interview with Resident #26 on 1/15/2014 at 9:16 a.m., she indicated "Soup is not always at temperature of being warm. Have asked them to heat it up. Happens quite often."</p> <p>3. During an interview with Residents #120 and #124 on 1/14/2014 at 1:16 p.m., they indicated "Coffee cold past 2 days and the eggs - no hot plate under the plate and we get our trays after the dining room is served."</p> <p>During a second interview with Resident #120 on 1/23/14 at noon, he indicated "The food fluctuated from being cold at times and warm at others - still got cold eggs the other morning and the coffee is still not as warm as I would like."</p> <p>4. Upon entrance to the kitchen on 1/22/14 at 10:50 a.m., lunch items of french fries, salmon patties, puree foods and gravy were observed on the steam table uncovered.</p> <p>During the meal observation at 11:09 a.m., the cook was observed to serve one resident tray of french</p>		<p>maintaining appropriate food temperatures on the steam table. During the week of 1/22/14, and ongoing, a food temperature log is being kept for all meals to ensure that each resident receives food at the proper temperature. During the week of 2/3/14, new thermal insulated bowls, cups, and plates were received and utilized for trays sent to resident's rooms. Food Council will continue to meet monthly, and ongoing, with any concerns brought to the CQI committee for review and any further recommendations. 4. The Dietary Manager will meet with Residents #7, #26, and #120 individually weekly, for one month, to ensure the food and coffee they receive is at proper temperature. The Dietary Manager will bring the food temperature log for review at the daily clinical meeting. The Administrator will review and address any concerns daily for two weeks, then weekly for one month. The Dietary Manager will bring the food temperature logs to the monthly CQI meetings, ongoing, for review and any further recommendations.5. These systemic changes will be completed on 2/14/14.</p>				

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	<p>fries and a salmon patty sandwich. When asked to check the temperatures right after this, the fries had a temperature of 105.6 F [Fahrenheit] and the salmon patties had a temperature of 105.7 F.</p> <p>The cook indicated at 11:15 a.m., that the foods were at a higher temperature when she put them on the steam table earlier and that she tried to keep everything at 150 - 170 degrees F. She indicated that she guessed she would need to re-heat everything before serving again.</p> <p>A re-check of the salmon patties at 11:30 a.m., observed them to be at 145 degrees and were placed back into the oven; another check of them at 11:38 a.m., observed them to be at 160 degrees. The cook was then observed to cover the patties with foil on the steam table while waiting on the fries.</p> <p>A re-check of the french fries at 11:40 a.m., observed the temperature to be at 180 degrees and the meal was then able to be served.</p> <p>During an interview with the Dietary manager at 11:20 a.m., she tested the temperature of the carafe of</p>			

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	<p>coffee that was being served to the residents and observed it to be at 126 degrees F. She indicated "We send out the coffee in a carafe no hotter than 140 degrees F due to possible burning the resident. We then refill the carafe when empty. Coffee is poured each time a cup is needed."</p> <p>When asked about the soup served to residents, she indicated "We send out individual cans of soup if not on the menu to those residents who request it. The nurse on the floor will heat it up for them. There is a thermometer on the floor for nursing to use to check the temperatures of the soup and other things."</p> <p>At 11:36 a.m., the Dietary Manager indicated "I have new bowls, cups and plates on order that will keep the food warmer for when staff take the tray directly back to the resident. We are debating between a plate warmer system and a warming carts but it is not in budget at this time. I have had some c/os [complaints] of cool/cold food."</p> <p>On 1/23/14 at 1:30 p.m., during an interview with LPN #6, she indicated "Did not know there was a thermometer on the unit. We will</p>						

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	<p>heat up the food if the resident asks - we check to be sure they have everything they need before we leave the room, but if they haven't tasted it before we leave, we may not know it was not to their satisfaction until we come around and pick up the tray."</p> <p>On 1/24/14 at 11:00 a.m., the Dietary Manager presented an invoice for the new lids she ordered in hopes of keeping the food warmer. Upon review of this invoice, it was noted that the lids were ordered in November 2013. The Dietary Manager indicated she was unaware of why it was taking so long for the order to come and that she had not checked on the order since it was placed.</p> <p>During observations of the tray pass on 1/14/14 between 11:15 a.m., and 12:30 p.m., and on 1/22/14 between 11:05 a.m., and 12:20 p.m., no plate warmers were observed being used to keep food hot as the tray was carried directly from the serving door to the resident's room. No specific pattern/order to the food delivery to residents' rooms was observed as trays were being passed to residents in the dining room and resident rooms at the same time depending</p>						

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F000371 SS=F	<p>on the tray card/menu stack.</p> <p>This Federal Tag is related to Complaint IN00130674.</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</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</p> <p>A. Based on observation and interview, the facility failed to serve the residents in a sanitary manner during 2 of 2 dining observations in that staff were observed touching the tops of the residents' glasses as they were served.</p> <p>B. Based on observation, record review and interview, the facility failed to follow proper handwashing, ensure expired foods were disposed of and equipment was in good</p>	F000371	<p>Hoosier Christian Village stores, prepares, distributes, and serves food under sanitary conditions.</p> <p>1. On 1/24/14, DON and Nurse Managers re-educated staff to serve glasses without touching the rim of the glass. During the week of 2/10/14, the Dietary Manager cleaned the shelves in the condiment cabinet, removing the grease build up. On 2/14/14, the ice machine was thoroughly cleaned and repainted. On 1/14/14, the Dietary Manager removed the tuna salad and bean salad from the walk-in refrigerator that was</p>	02/14/2014

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	<p>working order and free of dust and food particles during 2 of 2 kitchen observations. This deficient practice had the potential to affect 93 of 96 residents currently residing in the facility.</p> <p>Findings included:</p> <p>A.1. During a dining observation on 1/14/2014 at 11:42 a.m., LPN #5 grabbed a drinking glass from the top and placed her fingers around the rim of the glass. She then served the glass to Resident #49. This resident was witnessed drinking from the glass.</p> <p>During a dining observation on 1/14/2014 at 11:44 a.m., LPN #6 grabbed a drinking glass from the top of the glass and placed her fingers around the rim of the glass. She then served the drinking glass to Resident #19. This resident was witnessed drinking from the glass.</p> <p>During a dining observation on 1/14/2014 at 11:50 a.m., CNA #2 grabbed a drinking glass from the top, placing her fingers around the rim of the glass. She then served the drinking glass to Resident #118. This resident was witnessed drinking from the glass.</p>		<p>dated 1/10/14, and two large containers and two cases of large containers of yogurt with expiration dates of 1/6 and 1/9/14 were removed on 1/14/14. On 1/29/14, the Registered Dietician Consultant re-educated dietary staff and dietary manager on preparation, distribution, and serving of food under sanitary conditions. On 1/22/14, the condenser fan grill in the walk-in refrigerator was cleaned by the maintenance supervisor. During the week of 1/27/14, the Ansul pull ring, fire extinguisher, wall box, upper left corner of stove hood near the extinguisher system, and the wall surrounding the system were cleaned by the Maintenance supervisor and Dietary Manager.2. Residents who are served in the main dining room have the potential to be affected by this alleged deficient practice. During the weeks of 1/27/14, 2/3/14, and 2/10/14 the Administrator, DON, and Nurse Managers completed audits of beverages being served in the dining room without the rim of the glass being touched. 3. The Dietary Manager and Unit Managers will continue beverage serving audits weekly, for one month, then monthly, ongoing, to ensure staff are serving beverages without touching the rim of the glass. The Dietary Manager will audit the cleanliness of the ice machine and the shelves in the condiment cabinet</p>				

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	<p>During a dining observation on 1/14/2014 at 11:57 a.m., CNA #3 grabbed a drinking glass from the top of the glass and placed her fingers around the rim of the glass. She then served the glass to Resident # 24. This resident was witnessed drinking from the glass.</p> <p>During a dining observation on 1/14/2014 at 11:59 a.m., CNA #3 grabbed a drinking glass from the top of the glass and placed her fingers around the rim of the glass. She then served the drinking glass to Resident #86. This resident was witnessed drinking from the glass.</p> <p>During a dining observation on 1/23/2014 at 11:48 a.m., CNA #4, grabbed the top of a drinking glass and placed her fingers around the rim of the drinking glass. She then served the glass to Resident #30. The resident was witnessed drinking from the glass.</p> <p>During an interview on 01/24/2014 at 11:58 a.m., the DON indicated drinking glasses should be served from around the outside of the glass. She demonstrated by grabbing from the middle portion of the outside of a drinking cup.</p>		<p>daily for two weeks, then weekly for one month, and every month ongoing. The Dietary Manager will audit the walk-in refrigerator daily, beginning 1/14/14 through 2/14/14. These audits will continue weekly beginning 2/17/14, ongoing. The Dietary Manager will complete audits to ensure that the dietary staff are preparing, distributing, and serving food under sanitary conditions. These audits will be completed weekly for four weeks, and every month ongoing. The Dietary Manager will audit the cleanliness of the Ansul fire system pull ring, fire extinguisher, wall box, upper left corner of stove hood near the extinguisher system, and the wall surrounding the system weekly, for one month, then monthly ongoing.4. The Dietary Manager will bring the beverage serving audits, ice machine, and condiment cabinet shelves audits to the monthly CQI meetings for review and any further recommendations. The Dietary Manager will bring the walk-in refrigerator expiration checks, weekly audits of dietary staff and cleanliness of kitchen audits to the CQI committee for review and any further recommendations. 5. These systemic changes will be completed 2/14/14.</p>				

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	<p>B.1. During the initial kitchen tour on 1/14/14 between 9:14 a.m., and 10:00 a.m., the following was observed:</p> <ul style="list-style-type: none"> - ice machine had rusted areas on the right side at the joint with areas chipping and a lime residue in the rust. - condiment cabinet in front of stove - shelves with heavy greasy dark dirt build-up which was able to be scraped. - tuna salad and bean salad in the walk-in refrigerator had a date of 1/10/14 on it. An interview with the Dietary Manager at this time indicated that the left over policy was that the items were disposed of the next day if they were not going to be used again. - 2 large containers and 2 cases of large containers of yogurt had an expiration date of 1/6 and 1/9/14. - condenser fan in walk-in refrigerator had a moderate build-up of gray greasy dust on the grill, especially on the right side and was observed to be blowing across the open boxes of raw vegetables. 			

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	<p>- At 10:00 a.m., the Dietary Manager was informed of the issues in the walk-in.</p> <p>2. During a meal observation on 1/22/14 between 11:05 a.m., and 12:30 p.m., the following was observed:</p> <p>- 11:05 a.m. - cook was observed to take 2 buns out of the plastic with bare hands, touch the buns while closing them after putting salmon patties on them; and then she was observed to wipe her hands on her apron;</p> <p>- 11:47 a.m. - cook touched top of the bun with her bare hand while re-arranging it on the plate</p> <p>- 11:53 a.m. - cook touched the top of the bun to straighten it on the plate.</p> <p>- 11:58 a.m. - cook stopped, pulled up her pants and then straightened her uniform, then went and dipped up a salad from a pan and then resumed tray line serving.</p> <p>- 12:12 p.m. - Dietary Manager observed to rub her hairnet on her head with gloved Right hand, retrieved large stack of plate covers</p>						

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	<p>holding them against her uniform, then resumed tray line with the same gloved hands.</p> <p>- 12:14 p.m. - Cook pushed sandwich aside on plate to make room for taco salad with her bare hand.</p> <p>- 12:15 p.m. - cook wiped her hand on apron, then dipped up a bowl of peaches.</p> <p>- 12:20 p.m. - cook observed to pull up her pants and straighten her uniform.</p> <p>No handwashing or glove change was observed by the cook or the Dietary Manager throughout this meal service.</p> <p>During an interview with the Dietary Manager on 1/22/14 at 12:25 p.m., she indicated that hands were to be washed upon entering the kitchen, after the handling of each different cleaning task or food or when going from task to task, or touching face/hair or any other part of the body.</p> <p>She also indicated that gloves were to be used and/or changed when wrapping silverware, handling food</p>			

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	<p>raw or cooked, or moving from task to task.</p> <p>The condenser fan grill was again observed with a moderate greasy dusty coating and was blowing across the raw vegetables.</p> <p>The ANsul Fire System pull ring, fire extinguisher, wall box and upper left corner of stove hood near this extinguisher system had a coating of gray greasy dust. The wall surrounding the system also had greasy dust on it and was above the 6 burner stove.</p> <p>On 1/23/14 at 1:30 p.m., an interview with the Maintenance Director indicated "The Ansol System in the kitchen is officially cleaned every 6 months and was last done 12/11/13 by the worker who comes in. If I happen to be in the kitchen and notice it, then I might wipe it down. The condenser coils in the reach-in refrigerator were last cleaned on 10/15/13 and is done Q [every] 6 months also unless I happen to notice it needed it more often."</p> <p>3.1-21(i)(3)</p>						

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F000412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on record review and interview, the facility failed to ensure dental services were provided to a resident who had chewing difficulties with missing lower dentures. This deficient practice affected 1 of 1 residents' reviewed for dental services. (Resident #107)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #107 on 1/23/14 at 2:00</p>	F000412	<p>Hoosier Christian Village provides an outside resource and emergency dental services to meet the needs of each resident.</p> <p>1. On 1/14/14, a dentist authorization form was signed by resident's family and dental visit was scheduled on 1/14/14.2. During the week of 1/27/14, the SSD conducted an audit to ensure dental services were provided to residents with chewing problems or missing dentures. No other residents were found to be affected by this alleged deficient practice.3. Upon admission to the facility, and quarterly thereafter, the SSD</p>	02/14/2014

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	<p>p.m., indicated the resident had diagnoses which included, but were not limited to stroke with Right side hemiparesis and dementia.</p> <p>During a family interview on 1/14/14 11:46 a.m., they indicated the resident had chewing and eating problems due to no lower dentures and have wanted her to be seen by the dentist. When asked if the resident had seen a dentist since admission in June 2013, they indicated no but had been asking as they thought maybe if her diet could be changed from puree to something else, she might eat better.</p> <p>Review of the 6/7/13 Physician Admission orders indicated the resident could be seen by dentist.</p> <p>A 6/7/13 ST [Speech Therapy] evaluation indicated the resident only had upper dentures with some decaying teeth and lower dentures were absent.</p> <p>During an interview with the Social Worker on 1/23/14 11:15 a.m., she indicated "the family sign at admission in their contract if they want to see the dentist and who they might want to see - someone from</p>		<p>will continue to provide information on dental services to the resident and family and follow up as needed to ensure services are received. 4. The SSD will complete documentation of ancillary services being offered quarterly to residents. The RAC will review this documentation quarterly to ensure documentation of offered ancillary services. Any concerns will be brought to the CQI committee for review and any further recommendations.5. The systemic change will be completed 2/14/14.</p>				

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	<p>the outside or the in-house group. I ask the residents at each quarterly visit if they are having any problems or need to see the dentist etc. The resident is capable of telling me if she wants to be seen or not, and her family keeps in close touch with us too."</p> <p>When the Social Worker presented the contract the family signed at admission at 11:33 a.m., the section regarding the "Dentist" was left blank. She indicated that the family just recently signed the agreement for the resident to be seen by a dentist.</p> <p>Review of the Social Worker Assessments/Notes dated: 12/5/13, 9/13/13, 9/6/13, 8/2/13, 6/21/13 and under the "Miscellaneous" section of the clinical record - no documentation could be located of the resident having been seen by the dentist or of having asked family or the resident if she would like to see the dentist.</p> <p>During an interview with the resident and her family on 1/24/14 at noon, she indicated she would like to have bottom dentures.</p> <p>3.1-24(a)</p>				

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F000465 SS=E	<p>3.1-24(a)(1) 3.1-24(a)(3) 3.1-24(b)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review the facility failed to ensure a clean and sanitary environment that was in good repair as evidenced by resident rooms and bathrooms having peeling wallpaper, missing tiles, and soiled floors and wallpaper. This deficient practice affected 17 of 35 residents observed with the potential to affect an additional 61 residents in the facility.</p>	F000465	<p>Hoosier Christian Village provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.1. During the weeks of 1/27/14, 2/3/14, and 2/10/14, the Maintenance Supervisor and maintenance staff checked resident's rooms for peeling wallpaper and missing tiles in bathrooms. Wallpaper was repaired and tiles were replaced as needed. During these weeks, the Housekeeping supervisor and</p>	02/14/2014

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	<p>(Residents #4, 25, 26, 29, 37, 40, 44, 46, 49, 50, 57, 65, 87, 89, 90, 91, and 104).</p> <p>Findings include:</p> <p>On 1/14/14 during observation of Resident's rooms from 9:00 a.m., to 3:00 p.m., the following was noted:</p> <p>Room #124-Residents #25 and #87: The bathroom in the Resident's room had stains on the floor surrounding the toilet, the walls surrounding the toilet was soiled and stained, and the toilet had dark stains in the bottom of the bowl.</p> <p>Room #321-Resident #65: The wallpaper above the sink in the bathroom was peeling.</p> <p>Room #130-Residents #4 and #89: The wallpaper behind the toilet was soiled, both corners of the floor directly behind the toilet had a black substance on the floor, and a piece of tile was missing from the floor in the right hand corner behind the toilet.</p> <p>Room #133-Resident #57: The wallpaper by the side of the bed was tearing, the wallpaper behind the toilet was soiled from the seat of the</p>		<p>housekeeping staff audited all rooms and bathrooms for soiled toilets, walls, and floors. These areas were cleaned thoroughly.</p> <p>2. During the weeks of 1/27/14, 2/3/14, and 2/10/14, the Housekeeping Supervisor, Maintenance Supervisor, and Administrator conducted daily environmental rounds to ensure a safe, functional, sanitary and comfortable environment for residents, staff, and the public. During the week of 2/10/14, the Maintenance Supervisor re-educated staff on notifying him via log and communication board of any missing tiles, peeling wallpaper, or environmental concerns. During the week of 2/10/14, Administrator contacted professional wallpapering company to consult for removal of wallpaper stains. Plans for refurbishment in spring of 2014 continue, for removal of wallpaper and tiles in residents' rooms.</p> <p>3. The Housekeeping supervisor will continue weekly environmental audits, ongoing, and bring any concerns to the CQI committee for further review and recommendations. Upon the Housekeeping supervisor's weekly audits, any maintenance concerns, i.e. missing tiles, torn wallpaper, will be placed on the maintenance log and the Maintenance supervisor will bring any concerns to the CQI committee for further review and recommendations.</p> <p>4. The</p>		

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	<p>toilet to the floor, both corners of the floor, behind the toilet had a black substance built up, and on the right side of the toilet, a piece of tile was missing.</p> <p>Room #325-Resident #29: The wallpaper on the upper left hand corner of the heat register was peeling.</p> <p>Room #143-Resident #49: A black substance was built up around the base of the toilet and the walls of the bathroom were soiled.</p> <p>Room #145-Resident #44: A black substance was built up around the base of the toilet and a piece of tile was missing from the floor in the bathroom.</p> <p>Room #114-Resident #50: The floor surrounding the toilet was soiled, with a brown substance underneath the soiled area.</p> <p>Room #112-Resident #90: The bathroom and shower walls were soiled with a black substance.</p> <p>Room #120-Resident #104: The corners of the bathroom floor were soiled and the toilet had black stains in the bowl.</p>		<p>maintenance supervisor will bring the maintenance logs to the monthly CQI meetings for further review and recommendations as needed. The Housekeeping supervisor will bring weekly audits, and any concerns to the monthly CQI meeting for further review and recommendations.5. The systemic changes will be completed 2/14/14.</p>		

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	<p>Room #342-Resident #26: The right side of the entrance to the shower had an area on the wall with blue colored tape holding up a 1 foot area of wall tile in place.</p> <p>On 1/15/14 during observation of Resident's rooms from 9:00 a.m., to 3:00 p.m., the following was noted:</p> <p>Room #131-Residents #40 and #46: Wallpaper was peeling off of the wall on the upper left side of the heat register, wallpaper tears were on the right side of the wall next to the dresser and closet. The bathroom had wallpaper peeling from the wall by the shower. Behind and on the sides of the toilet, the wallpaper is soiled. On the bottom left side of the toilet area, there were reddish stains on the tiles next to the floor. The back of the door leading to the room was soiled.</p> <p>Room #132-Residents #37 and #91: Wallpaper was peeling and loosened on the wall next to Resident #91's bed. The rubber border across from the sink was bent in. Tile was missing on floor behind the toilet on the right side and the wall behind the toilet was soiled and stained.</p>			

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	<p>On 1/23/14 at 9:54 a.m., during an interview with the Maintenance Supervisor, he indicated that "a lot of what we fix is prioritized with what needs to be fixed and what doesn't, like heating, air, or a water problem. Those we get to pretty quick. The wallpaper thing in the rooms we do a weekly walk through the rooms and check. Once a month we check the smoke detectors, water, leaks, and wallpaper. We try to get most of it fixed as quick as possible. The tiles in the rooms get busted and we try to get back in there. Sometimes the aides and nurses tell us about it. I don't normally keep a log of what needs fixed and what has been fixed. Normally, most of the time, it comes through point click care or most times just walking up and down the hallway someone tells me something needs fixed. At the end of the day I (Maintenance Director) write some things down. We try hard with sinks, commodes, air conditioning, and heating we get to quickly."</p> <p>On 1/23/14 at 10:25 a.m., during an interview with the Director of Housekeeping, she indicated that "our bathrooms are very old and they are in the process of being</p>						

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	<p>redone. When we scrub the floor, the tiles come off of the walls and the floors because they are so old. The wallpaper is bad. I know the bathrooms are in bad shape. We do the showers every week. The thing is, if there is a stain on the wallpaper or dirt, it won't come off. We have tried scrubbing it many times. It is permanent. I do talk to the Administrator about what is wrong. She (Administrator) knows they are in bad shape. That is one of our reconstruction plans, to do the bathrooms. We are taking the wallpaper off and putting new flooring in, and painting those (bathrooms). The bathrooms are cleaned every day."</p> <p>On 1/23/14 at 10:33 a.m., during an interview with the Administrator, she indicated that "the bathrooms are very old. We have remodel plans starting this spring. We are getting rid of the tile. We recently got rid of the tile on the floors that are from the 70's. They look bad, I know, but we bleach them and keep them as clean as we can."</p> <p>On 1/23/14 at 1:24 p.m., during an interview with the Administrator, she indicated that the facility had been approved for a budget to remodel</p>			

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	<p>the south wing and bathrooms for approximately 6 months, around June, 2013 the money was approved to spend for this.</p> <p>A review of the Task Completed log for the Director of Maintenance at 12:07 p.m., indicated that the resident bathing tubs had been inspected for the months of October, November, and December, 2013 and January, 2014.</p> <p>A review on 1/22/14 at 12:47 a.m., of the Daily Monday through Friday Cleaning Schedule as performed between the dates of 1/7/14 to 1/20/14 indicated that these schedules had been checked off as being done for cleaning toilets, mopping bathroom floors, and cleaning toilets.</p> <p>A review of the Bed Cleaning Schedule at 1:00 p.m., dated between 1/8/14 to 1/16/14 indicated that walls had been checked for spots, floors were mopped, and the bathroom and shower stalls was bleached.</p> <p>A review of the November, 2013 repair log at 1:30 p.m., indicated that on 11/6/14 wallpaper had been fixed in room 144. On 12/3/14 wallpaper</p>			

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	<p>had been repaired in rooms 125-136. On 12/10/13 bathroom tile repair was done on rooms 313-315. No repairs indicated on log for 1/14 concerning repair of tile or wallpaper in any resident's rooms.</p> <p>A review of the requests for repairs at 1:40 p.m., submitted by staff for the month of January, 2014 indicated no requests for repair of wallpaper or tiles in resident's rooms.</p> <p>On 1/23/14 at 1:24 p.m., during a review of the 2014 Capital Submittal Form indicated that the facility had a budget approval of \$200,000 for phase 3 remodel-partial south wing and bathrooms available.</p> <p>3.1-19(f)</p>						