

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155430	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/07/2014
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F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: March 3, 4, 5, 6 and 7, 2014</p> <p>Facility number: 000326 Provider number: 155430 AIM number: 100290770</p> <p>Lora Swanson, RN-TC Deb Kammeyer, RN Julie Wagoner, RN Pam Williams, RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 3 Medicaid: 18 Other: 12 Total: 33</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on March 12, 2014, by Brenda Meredith, R.N.</p>	F000000		

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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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure alternatives to physical restraints were attempted prior to the initiation of a full lap tray for 1 of 1 residents reviewed for restraints. (Resident #9) In addition, the facility failed to ensure there was a restraint reduction plan for 1 of 1 residents reviewed for restraints. (Resident #9)</p> <p>Finding includes:</p> <p>1. Resident #9 was observed, on 03/03/14 at 10:05 A.M., seated in the hallway in a wheelchair. She was restrained in the wheelchair with a full lap tray.</p> <p>On 03/05/14 at 11:34 A.M., CNA #1 and CNA #3 ambulated Resident #9</p>	F000221	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 4/6/14 <b>F221</b> – This facility recognizes that all residents have the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The facility also recognizes the residents' right to have the least restrictive device used, if necessary, and the need to have a restraint reduction</p>	04/06/2014
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	<p>from her room, where she had been resting in bed, to the bathroom. She was then ambulated to the front of the building and placed in her wheelchair with a lap tray. She remained in her wheelchair beside the administrator's office, from 11:40 A.M. - 12:09 P.M. At 12:09 P.M., she was assisted to ambulate with CNA #1 and the SSD (Social Services Director) with a gait belt from the wheelchair directly into the dining room.. She was placed in a dining room chair, the gait belt was removed, and a personal alarm was applied.</p> <p>The clinical record for Resident #9 was reviewed on 03/05/14 at 9:30 A.M. Resident #9 was admitted to the facility on 12/04/13. The diagnoses, included but were not limited to, dementia and hypertension.</p> <p>A physician's order, dated 02/12/14, indicated "Apply tray to w/c [wheelchair] at all times except during meals et [and] care due to poor safety awareness secondary to Alzheimer's disease- Begin when available."</p> <p>A Pre-restraining assessment, completed on 02/12/14, listed</p>		<p>plan for any restraints utilized. <u>What corrective action will be done by the facility?</u> Licensed nurses and the interdisciplinary team will be inserviced on the restraint policy by the Director of Nursing by 4/6/14. The responsible party for Resident #9 was educated on the need for the least restrictive restraint to meet this resident's needs. The pre-restraining assessment was updated. The physical restraint elimination assessment was initiated. Orders were obtained to discontinue the lap tray and begin an alarmed Velcro self releasing seatbelt with written consent of the responsible party for Resident #9. The restraint care plan was modified to include a reduction plan. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this deficient practice. There are no other restraints being used in the facility. <u>What measures will be put into place to ensure that this practice does not recur?</u> Prior to initiating any physical restraint, the interdisciplinary team will review the resident record to ensure that restraint alternatives have been tried first, and if not successful, the least restrictive device is utilized. When a physical restraint is ordered, the interdisciplinary team will first</p>				

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	<p>several physical, mental, emotional, environment, and social considerations or impairments and recommended a lap tray wheelchair restraint. No alternatives to restraints were listed on the form in the section to indicate what less restrictive alternatives had been attempted.</p> <p>A Physical Restraint Elimination Assessment form, completed on 02/14/14, indicated the resident scored an 18, which indicated the resident was a "priority" candidate for restraint elimination, however the question related to if the resident was a candidate, was left blank. Lesser restrictive measures to be used were lap tray to w/c and additional comments were "displays poor safety awareness secondary to Alzheimer's Continues to attempt to get out of chair unassisted - lap tray will allow resident to participate in activities such as looking at magazines, coloring, etc while being safe."</p> <p>During an interview on 03/06/14 at 12:37 P.M., the Director of Nursing (DON) indicated they did not attempt any "less restrictive" device because it was felt the resident would stand up with a seatbelt on, and staff</p>		<p>review the restraint in the weekly standards of care meeting, progressing to review every 30 days for the first 90 days, then quarterly thereafter. The restraint use will then be monitored and reviewed by the Interdisciplinary Team (IDT) on a quarterly basis or upon the resident's significant change in condition regarding continued use of the restraint.</p> <p><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Any resident with a physical restraint will be reviewed monthly in the QA&amp;A meeting to ensure that assessments are current, care plans are in place and the least restrictive device is being utilized, based on the current status of the resident. This review will occur monthly on an ongoing basis for any resident who is using a physical restraint. Date of Compliance: 4/6/14</p>				

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	<p>wanted something more substantial to put magazines and craft items on so a lap buddy was not attempted. The DON indicated the resident is so quick when she decides to stand. She indicated there was no alternative they felt was appropriate and safe for the resident.</p> <p>A care plan regarding the lap tray, initiated on 02/17/14, indicated the following: "I require a lap tray buddy, I have been known to be very fast in getting out of my w/c and have fallen often. I can't remember thing very well. [sic] I agree with having the lap tray buddy and my family does as well." The plan was updated on 03/03/14, and the following was added: "Having my lap tray allows me to have increased independence. I can propel myself throughout the building by myself. I can sit up front by the windows, look at the birds and get exercise while being safe. I can also look at magazines, hold by stuffed dog, etc. [sic]." The interventions included the following: "1. I will wear my lap tray as staff states according to my doctor's orders, 2. I want staff to ensure that the lap tray is properly placed and I am checked routinely as ordered. Staff will document accordingly. 3. I will have staff</p>			

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F000256 SS=E	<p>assess my seat belt every 30 days for the first 90 days and then quarterly. Staff will document cordingly [sic], 4. Staff will monitor me for increased confusion, especially in the evening. 5. Staff will keep my family updated along with my doctor on any concerns with my lap tray." There was no plan to coordinate and ensure the resident had a restraint reduction plan.</p> <p>3.1-26(a)</p> <p>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to provide adequate overhead room lighting in 8 of 18 rooms. (Room #'s 8, 9, 10, 11, 14, 15, 16 and 18)</p> <p>Finding includes:</p>	F000256	<p>F256. It is the policy and believe of this facility to provide comfortable and adequate lighting levels in all areas of the facility. <u>What corrective action will bedone by the facility?</u> _ The materials for additional lighting have already been on order and is expected to be delivered the week of March 24th- 28th, 2014.</p>	04/06/2014
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	<p>During an interview, on 03/04/2014 at 8:47:47 A.M., Resident #12 and roommate Resident #7 indicated the lighting was too dim in their room because there was no overhead lighting.</p> <p>During an interview, on 3/6/14 at 9:58 A.M., the Maintenance Manager indicated the facility was planning to begin remodeling rooms after the current water project was completed. The rooms would be remodeled one at a time. All the rooms would have a drop ceiling added plus two overhead ceiling lights installed as well as two wall lights and overhead bed light.</p> <p>During an observation, 3/7/14 at 9:30 A.M., room #18 was noted to only have 2 wall lights over the bed. There was no overhead room light or other light.</p> <p>During an observation on 3/7/14 at 9:40 A.M., the resident rooms 8, 9, 10, 11, 14, 15, 16, and 18 were also noted to not have overhead room lighting .</p> <p>3.1-19(dd)</p>		<p>Once materials are here the additional lighting will be added to room #s8,9,10,11,14,15,16,18. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All other resident rooms inthe facility have had additional lighting added and no other lighting concerns have been identified at this time. However, member of the IDT will ask their assigned residents for any concerns regarding lighting levels in their rooms as part of their Guardian Angel rounds that are done at least 5 days a week. Any concerns regarding lighting will be brought to the morning management IDT meeting that same day so the arrangements can be made to add lighting as soon as possible. If concerns regarding lighting are made at other times of the day, the concern will be added to a Resident concern form and that form will be forwarded to the Administrator for further follow up and resolution by the Maintenance Supervisor and the Administrator. <u>What measures will be put into place to ensure that this practice does not recur?</u> In addition to the Guardian Angel rounds as mentioned previously,the Administrator and facility managers will also observe for lighting needs or concerns as part of their frequent rounds throughout the facility</p>				

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			<p>during their tours of duty. Any identified or voiced concerns that arise will be followed up as indicated in the previous section.</p> <p><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Guardian Angel rounds and other routine rounds made by the IDT team that indicate concerns with lighting will be brought to the monthly QA&amp;A Committee meetings for further review and recommendations. The Maintenance Supervisor will follow upon those recommendations and bring the results of his follow up to the next scheduled monthly QA&amp;A meeting. This will continue on an ongoing basis. _ Date of compliance: 04/06/2014</p>	

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews, the facility failed to ensure the care plan related to incontinence needs was individualized for 1 of 1 residents reviewed for incontinence. (Resident #9)</p> <p>Findings include:</p> <p>1. On 03/05/14 at 9:05 A.M., Resident #9 was observed being ambulated with a rolling walker and the assistance of two staff with gait belt to the bathroom. Resident #9</p>	F000279	<p><b>F279</b> - It is the policy of this facility to use the results of resident assessments to develop, review and revise resident's comprehensive care plans. It is also the policy of this facility to 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 assessments, including incontinence needs. It should be noted that the MDS Coordinator's statement regarding the "corporation's"</p>	04/06/2014			

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	<p>required extensive cues and physical assistance to keep ambulating. CNA's #1 and #2 ambulated Resident #9 into the restroom. The resident was very resistant to entering the bathroom and expressed distress verbally by crying out and stating "No." The resident was eventually persuaded to enter the bathroom and was sat on the toilet. Resident #9 was noted to have been incontinent of stool. Resident #9 became upset with care and kept trying to keep her soiled brief on and pull her pants up and stand. The resident did not urinate in the toilet. CNA #1 indicated Resident #9's brief was already wet and soiled. She indicated occasionally Resident #9 was continent when toileted but mostly incontinent of her bladder.</p> <p>On 03/05/14 at 11:34 A.M., CNA #1 and #3 ambulated Resident #9 from her room, where she had been resting in bed, to the bathroom. Her brief was wet with urine and she was also incontinent of a small amount of stool. Resident #9 was very distressed with the toileting process and yelled, resisted care, kept trying to pull up her pants and stand up, and even hit the CNA #1 on the head. She was encouraged to go to</p>		<p>directives for not using specific times as part of the goal or toileting plan for a resident was not an accurate reflection of the company's philosophy and standard of care in this area. The company does discourage the standard statement of "toilet every 2 hours", because residents' toileting plans should be individualized for each resident. Specific times may be appropriate for some residents, while they might not be appropriate for others. The content of the toileting plan should reflect each resident's assessed and individual needs. <u>What corrective action will be done by the facility?</u> Resident #9 has had her bladder assessment updated, a new five day voiding pattern completed and a postvoiding assessment completed including a statement regarding her current bladder function. The care plan for this resident has been updated to reflect the findings of the above assessments including whether or not this resident is a candidate for a restorative toileting program. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> New bladder assessments, five day bladder diaries, and post void assessments were completed on all residents who are currently on restorative toileting programs.</p>				

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	<p>the bathroom by both CNAs, but did not seem to comprehend any of the instructions or process. She was then ambulated to the front of the building and placed in her wheelchair with a lap tray.</p> <p>The clinical record for Resident #9 was reviewed on 03/05/14 at 9:30 A.M. Resident #9 was admitted to the facility on 12/04/13. The diagnoses, included but were not limited to, dementia and hypertension.</p> <p>The Nursing notes, dated 12/04/14 - 12/08/14, indicated the resident was incontinent of her bowel and bladder and was resistant and uncooperative with care. On 12/08/14, the resident was documented as having been combative with incontinence care.</p> <p>A Bladder Assessment Form, completed on 12/04/13, the day the resident was admitted to the facility, indicated the resident was a new admission, frequently had the urge to go to the bathroom, had trouble making it to the bathroom without losing control of her urine, got up at night more than 2 times to urinate, urinated more than 8 times in 24 hours, had problems moving her bowels, wet herself when she</p>		<p>The care plans were updated to reflect the findings of the recent bladder diaries, bladder assessments and post void assessments. Residents who are not currently on restorative toileting programs will be reassessed as to their continence or incontinence status at the time of their next quarterly assessment and care plan review. Any changes in bowel or bladder incontinence will result in new bladder assessments, five day bladder diaries, and post void assessments. Results will be examined by the IDT and the resident's toileting care plan will be updated at that time. <u>What measures will be put into place to ensure that this practice does not recur?</u> The MDS coordinator/designee will review all current toileting restorative nursing programs every month on an ongoing basis to ensure accuracy that reflects the resident's current status. Any changes in resident status will be brought by the MDS Coordinator/designee to the IDT morning management meeting that is held at least 5 days a week for review and discussion. Follow up by means of updated assessments, bladder diaries, and post void assessments will be done as indicated in the previous section and results presented to the IDT for development of an updated toileting care plan. <u>How will</u></p>		

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	<p>coughed, sneezed, laughed, or exercised, and lost control of her urine when moving from a bed to a chair. The information regarding how many children the resident had delivered, hysterectomy history, and incontinence history and treatment history were left blank. The form indicated a 5 day voiding pattern should be initiated due to the resident's incontinence.</p> <p>Review of the Bladder Assessment - Post Voiding Pattern, completed on 12/10/13, and the 5 day voiding pattern record from 12/05/13 - 12/10/13, indicated impaired mobility/ambulation, decreased manual dexterity, and Alzheimer's disease, and received a diuretic medication. The assessment form also indicated the resident had incontinence without the sensation of urine loss and exhibited both stress and functional types of incontinence.</p> <p>A February Monthly Restorative Self-Care Program for Resident #9 had the following goal: "I will have one or less episodes of bladder incontinence per shift daily during waking hours with staff cueing me and physically direct me to the bathroom location." (sic)</p>		<p><u>corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The audits completed by the MDS coordinator/designee will be reviewed monthly at the QA&amp;A meeting for six months. After six months has elapsed and the audits demonstrate 100% compliance, the QA&amp;A committee may consider ending the written audits. However, the MDS coordinator/designee will continue to review the bladder assessments, bladder diaries and post void assessments on an ongoing basis and any identified issues will be brought to the next scheduled QA&amp;A meeting for review. Date of Compliance: 4/6/14</p>				

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	<p>The current health care plan, related to incontinence, initiated on 12/03/13 and updated on 12/31/13, indicated the following: "Problem - I am incontinent of bladder and could benefit from a Restorative toileting program. Goal - I will have one or less episodes of bladder incontinence per shift daily during waking hours with staff cueing me and physically directing me to the bathroom location. Interventions - staff will offer to assist me at night if I have to use the restroom. I will use the call light if I need assistance, I would like staff to encourage me to use the restroom on a regular basis. I need encouragement and assistance at times to use the restroom, especially before I go to bed, I want the nursing staff to provide me with incontinent products as necessary, I would like staff to document accordingly how I use the restroom, staff will monitor for any odor, frequency, or any s/s [signs and symptoms] of discomfort during toileting or any s/s of discomfort while using the restroom, I would like my family and doctor updated on my condition."</p> <p>Interview with the MDS (Minimum Data Set assessment) coordinator,</p>			

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F000315 SS=D	<p>RN #7, on 03/06/14 at 1:00 P.M., indicated Resident #9 was toileted "frequently" about every two hours or so and she had been directed by her corporation not to put a specific times on the toileting plan. She indicated "frequently" usually meant about every 2 hours."</p> <p>3.1-35(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interviews, the facility failed to follow their bladder incontinence program to ensure an individualized toileting plan, based on assessment</p>	F000315	<b>F315</b> – It is the policy of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates	04/06/2014

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	<p>information, was formulated to address incontinence issues for 1 of 1 residents reviewed for incontinence. (Resident #9) In addition, the facility failed to ensure 1 of 1 residents observed for indwelling urinary catheter care received appropriate care and service to prevent urinary tract infections. (Resident #16)</p> <p>Finding includes:</p> <p>1. On 03/05/14 at 9:05 A.M., Resident #9 was observed being ambulated with a rolling walker and the assistance of two staff with gait belt to the bathroom.. Resident #9 required extensive cues and physical assistance to keep ambulating. CNA's #1 and #2 ambulated Resident #9 into the restroom. The resident was very resistant to entering the bathroom and expressed distress verbally by crying out and stating "No." The resident was eventually persuaded to enter the bathroom and was seated on the toilet. Resident #9 was noted to have been incontinent of stool. Resident #9 became upset with care and kept trying to keep her soiled brief on and pull her pants up and stand. The resident did not</p>		<p>that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. <u>What corrective action will be done by the facility?</u> Resident #9 has had her bladder assessment updated, a new five day voiding pattern completed and a postvoiding assessment completed including a statement regarding her current bladder function. The care plan for this resident has been updated to reflect the findings of the above assessments including whether or not this resident is a candidate for a restorative toileting program. Nursing staff will be inserviced by the Director of Nursing by 4/6/14 on infection control guidelines including proper placement of catheter tubing and drainage bag. Resident #16 who is alert and oriented was educated on the need to ensure catheter tubing is kept off the floor after she self transfers. Different interventions were attempted to assist the resident with this. On 3/10/14, a rubber band/clip was attached to the catheter and wheelchair to prevent the tubing from dragging but was removed on 3/11/14 after the resident felt the adaptation restricted her ability to self transfer with ease. The use of a leg bag during waking hours was</p>	
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	<p>urinate in the toilet. CNA #1 indicated Resident #9's brief was already wet and soiled. She indicated occasionally Resident #9 was continent when toileted but mostly incontinent of her bladder.</p> <p>On 03/05/14 at 11:34 A.M., CNA #1 and #3 ambulated Resident #9 from her room, where she had been resting in bed, to the bathroom. Her brief was wet with urine and she was also incontinent of a small amount of stool. Resident #9 was very distressed with the toileting process and yelled, resisted care, kept trying to pull up her pants and stand up, and even hit the CNA #1 on the head. She was encouraged to go to the bathroom by both CNAs, but did not seem to comprehend any of the instructions or process. She was then ambulated to the front of the building and placed in her wheelchair with a lap tray.</p> <p>The clinical record for Resident #9 was reviewed on 03/05/14 at 9:30 A.M. Resident #9 was admitted to the facility on 12/04/13, with diagnoses, included but not limited to, dementia and hypertension.</p> <p>Nursing notes, dated 12/04/14 - 12/08/14, indicated the resident was</p>		<p>declined by the resident on 3/11/14. The facility attempted to attach the catheter tubing to the front of the wheelchair seat to allow the resident to loosen the tubing when transferring; this was declined by the resident. A clip was attached to the catheter tubing on 3/11/14. This clip is also attached to the dignity bag or catheter bag hook to keep the tubing off the floor. An order was obtained for occupational therapy to evaluate the resident for catheter tubing management. A careplan has been devised to document all alternatives and education attempted. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> New bladder assessments, five day bladder diaries, and post void assessments were completed on all residents who are currently on restorative toileting programs. The care plans were updated to reflect the findings of the recent bladder diaries, bladder assessments and post void assessments. Residents who are not currently on restorative toileting programs will be reassessed as to their continence or incontinence status at the time of their next quarterly assessment and care plan review. Any changes in bowel or bladder incontinence will result in new bladder assessments, five day bladder diaries, and post void</p>		

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	<p>incontinent of her bowel and bladder and was resistant and uncooperative with care. On 12/08/14, the resident was documented as having been combative during incontinence care.</p> <p>A Bladder Assessment Form, completed on 12/04/13, the day the resident was admitted to the facility, indicated the resident was a new admission, frequently had the urge to go to the bathroom, had trouble making it to the bathroom without losing control of her urine, got up at night more than 2 times to urinate, urinated more than 8 times in 24 hours, had problems moving her bowels, wet herself when she coughed, sneezed, laughed, or exercised, and lost control of her urine when moving from a bed to a chair. The information regarding how many children the resident had delivered, hysterectomy history, and incontinence history and treatment history were left blank. The form indicated a 5 day voiding pattern should be initiated due to the resident's incontinence.</p> <p>Review of the Bladder Assessment - Post Voiding Pattern, completed on 12/10/13, and the 5 day voiding pattern record from 12/05/13 - 12/10/13, indicated impaired</p>		<p>assessments. Results will be examined by the IDT and the resident's toileting care plan will be updated at that time. All residents with catheters have the potential to be affected by this deficient practice. One other resident currently has a foley catheter. This resident was not affected as she does not self transfer and the staff ensure her tubing is placed appropriately. <u>What measures will be put into place to ensure that this practice does not recur?</u> The MDS coordinator/designee will review all current toileting restorative nursing programs every month on an ongoing basis to ensure accuracy that reflects the resident's current status. Any changes in resident status will be brought by the MDS Coordinator/designee to the IDT morning management meeting that is held at least 5 days a week for review and discussion. Follow up by means of updated assessments, bladder diaries, and post void assessments will be done as indicated in the previous section and results presented to the IDT for development of an updated toileting care plan. Resident #16's catheter tubing will be monitored by the Director of Nursing or designee during rounds at least five days per week on an ongoing basis. The resident will be re-educated as needed if the tubing is found to be</p>		

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	<p>mobility/ambulation, decreased manual dexterity, Alzheimer's disease, and a diuretic medication. The assessment form also indicated the resident had incontinence without the sensation of urine loss and exhibited both stress and functional types of incontinence. The Progress/Summary statement at the end of the 5 day bladder pattern record, indicated the resident was able to determine correctly if she was wet or dry more than 50 percent (%) of the time, and was able to void on the toilet more than 50 % of the time. Handwritten on the place to summarize the 5 day pattern record was the following: "Resident was able to determine over 50 % of time appropriate time and place to void. Resident however did experience some incontinent episodes. Resident has diagnosis of Alzheimer's and is currently on hospice. Writer placed resident on toileting program. Staff will continue to assist resident to toilet frequently throughout the day." However, review of the 5 day bladder record for incontinence did not indicate that Resident #9 was able to void correctly in the toilet more than 50 % of the time. The patterning record did indicate the resident was incontinent of her</p>		<p>touching the floor. This resident will continue to receive occupational therapy to assist with catheter tubing management. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The audits completed by the Director of Nursing and MDS Coordinator will be reviewed monthly at the QA&amp;A meeting for six months. After six months has elapsed and the audits demonstrate 100% compliance, the QA&amp;A committee may consider ending the written audits. However, the DON/designee will continue to observe the catheter tubing placement on an ongoing basis and any identified issues will be brought to the next scheduled QA&amp;A meeting for review. The MDS coordinator/designee will continue to review the bladder assessments, bladder diaries and post void assessments on an ongoing basis and any identified issues will be brought to the next scheduled QA&amp;A meeting for review. Date of Compliance: 4/6/14</p>	

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	<p>bladder more than once on 4 of the 5 mornings and more than once on 4 of the 5 afternoons. There was also no place for staff to indicate if the resident was toileted but did not void or if the voiding was stool, urine or both. There was also only documentation of the resident bladder incontinence status on 1 of the 5 nights from 1:00 A.M. - 6:00 A.M.</p> <p>A February Monthly Restorative Self-Care Program for Resident #9 had the following goal: "I will have one or less episodes of bladder incontinence per shift daily during waking hours with staff cueing me and physically direct me to the bathroom location." (sic)</p> <p>The current health care plan, related to incontinence, initiated on 12/03/13 and updated on 12/31/13, indicated the following: "Problem - I am incontinent of bladder and could benefit from a Restorative toileting program. Goal - I will have one or less episodes of bladder incontinence per shift daily during waking hours with staff cueing me and physically directing me to the bathroom location. Interventions - staff will offer to assist me at night if I have to use the restroom. I will use</p>			

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	<p>the call light if I need assistance, I would like staff to encourage me to use the restroom on a regular basis. I need encouragement and assistance at times to use the restroom, especially before I go to bed, I want the nursing staff to provide me with incontinent products as necessary, I would like staff to document accordingly how I use the restroom, staff will monitor for any odor, frequency, or any s/s [signs and symptoms] of discomfort during toileting or any s/s of discomfort while using the restroom, I would like my family and doctor updated on my condition."</p> <p>An interview with the MDS (Minimum Data Set assessment) coordinator, RN #7, on 03/06/14 at 1:00 P.M., indicated Resident #9 was toileted "frequently" about every two hours or so. She further indicated she had been directed by her corporation not to put a specific times on the toileting plan. She indicated "frequently" usually meant about every 2 hours." She indicated the staff were able to determine over 50% of the time if the resident was wet or dry, not the resident, because the staff took her to the bathroom frequently. When "the resident" was pointed out to the MDS coordinator</p>			

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	<p>she indicated the resident was probably not able to tell if she was wet or dry, but they had not answered the question from the resident's ability but the staff's point of view. She indicated it was unclear on the voiding pattern forms if the resident had voided urine, stool or both. There was also no place for staff to document if the resident was unable to void.</p> <p>The Bladder Incontinence Program policy and procedure, dated May 2006 and revised on 02/09, provided by the Director of Nursing, on 03/07/14 at 10:00 A.M., included the following: "Bladder Rehabilitation/Bladder Retraining" is a behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void. Depending upon the resident's successful ability to control the urge to void, the intervals between voiding may be increased progressively. Bladder training generally consists of education, scheduled voiding with systematic delay of voiding, and positive reinforcement. This program is difficult to implement in cognitively</p>						

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	<p>impaired residents and may not be successful in frail, elderly, or dependent residents.... The policy information indicated there were three programs available for residents who were dependent on staff involvement: Prompted voiding, habit training, or scheduled toileting. All three types of toileting plans had instructions for toileting the resident at specific times or schedules. The following steps were included for the Bladder Assessment- Post voiding Pattern:</p> <p>"1. When the 5 day bladder record is completed, the MDS Coordinator will complete the "Bladder Assessment - Post voiding Pattern", HC-N-21, in order to finalize the development of a toileting plan. 2. Once the form is completed, the MDS Coordinator will formulate the type of treatment program that appears to be best suited to the resident, based on the information obtained through the admission history, the 5 day bladder record, and the results of the areas #1 - #5 on the post voiding bladder assessment. 3. The MDS Coordinator will indicate the most likely type of incontinence being experienced by the resident in #6, and then will indicate the type of treatment program and other</p>			

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	<p>interventions that might benefit the resident. 4. Once the form is completed...."</p> <p>2. On 3/5/14 at 11:39 A.M., Resident #16 was observed wheeling herself into the dining room with the catheter dignity bag and tubing dragging on floor. Cloudy yellow urine was noted in the tubing.</p> <p>On 3/6/14 at 9:30 A.M., the clinical record for Resident #16 was reviewed. The diagnoses included, but were not limited to, neurogenic bladder.</p> <p>On 3/6/14 at 9:54 A.M., Resident #16 was observed sitting in assist dining room with the catheter dignity bag and tubing dragging on floor. Cloudy yellow urine noted in the tubing.</p> <p>On 3/6/14 at 12:26 P.M., Resident #16 was observed sitting in the independent dining room with the catheter dignity bag and tubing dragging on floor. Cloudy yellow urine noted the in tubing.</p> <p>On 3/6/14 at 1:50 P.M., the DON (Director of Nursing) provided the "Catheter Care-General Information" policy dated June 2004, and</p>			

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	<p>indicated it was the one currently used by the facility. The DON indicated there were no specific policy or procedure describing the exact manner of how indwelling Foley catheter tubing should be positioned.</p> <p>During an interview on 3/6/14 at 2:05 P.M., CNA #6 indicated catheter tubing should be coiled up in dignity bag with Foley catheter bag and neither the tubing nor the dignity bag should be dragging on the floor.</p> <p>On 3/6/14 at 2:10 P.M., Resident #16 was observed in activities with the catheter dignity bag and tubing dragging on floor. Cloudy yellow urine was noted in the tubing.</p> <p>During an interview on 3/6/14 at 2:25 P.M., the DON indicated catheter tubing should be coiled and in the dignity bag, not dragging or lying on floor. Catheter bags are emptied at the end of each shift and if tubing is lying on floor it is then placed back in dignity bag.</p> <p>On 3/6/14 at 2:45 P.M. Resident #16 was observed sitting in her wheel chair in her room with catheter tubing lying on the floor.</p>			

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F000323 SS=E	<p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure the resident environment was free of hazards related to chemical and personal care items stored unlocked in 3 of 4 bathrooms.</p> <p>Finding includes:</p> <p>During the initial tour on 3/3/24 at 10:10 A.M., observation of bathroom #1 indicated an unlocked cabinet with the key hanging in the door. The cabinet contained low acid bowl cleaner, odor eliminator and Neutral Quat Disinfectant. The label on cabinet read, "cabinet should be locked at all times." Observation in bathroom #2 indicated there was a package of cleansing wipe towelettes on the back off the toilet. Observation in bathroom #4</p>	F000323	<p><b>F323</b> – It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible and to ensure each resident receives adequate supervision and assistance to prevent accidents. <u>What corrective action will be done by the facility?</u> Nursing staff and housekeeping staff will be inserviced on the proper storage of chemicals and personal care items by 4/6/14. A new soap dispenser was hung in bathroom #4's shower to properly store soap. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this deficient practice. The Director of Nursing reviewed all incident logs for the past six months. No incidents were related to improper storage of chemicals and personal care</p>	04/06/2014	

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	<p>indicated there was a bottle of shampoo/ body wash, a can of fresh scent shaving cream and 3 in 1 lotion cream sitting on the counter.</p> <p>During an interview, on 3/7/14 at 9:42 A.M., the DON (Director of Nursing) indicated all cabinets in the restrooms should be locked at all times. Shampoo, body wash , shaving cream and lotions should all be locked in the supply cabinet when not in use during showers. Products should not be left in the showers. The DON indicated there was no facility policy regarding chemical storage.</p> <p>3.1-45(a)(1)</p>		<p>items. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing/designee will monitor the bathrooms for unlocked chemicals and personal care items a minimum of three times daily five days per week for thirty days then five times weekly on an ongoing basis. The Director of Nursing/designee will immediately secure any found items and re-educate the staff responsible. Progressive disciplinary action will be taken for continued noncompliance. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Director of Nursing will bring the results of the rounding audits to the QA&amp;A committee monthly for further review and suggestions for improvement. After six months has elapsed and the audits demonstrate 100% compliance, the QA&amp;A committee may consider ending the written audits. However, the Director of Nursing/designee will continue to observe the bathrooms for improper storage of chemical and personal care items on an ongoing basis. Any identified issues will be brought to the next scheduled QA&amp;A meeting for review. Date of compliance: 4/6/14</p>	

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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to post current nurse staffing information that included the daily resident census on 4 of 5 days of the survey. (March 3, 4, 5 and 6, 2014)</p>	F000356	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.	04/06/2014

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	<p>Finding includes:</p> <p>On 3-3-14 at 10:00 A.M., a form titled "Report of Nursing Staff Directly Responsible for Resident Care" was observed near the nurse's station upon entrance to the facility. The form was dated 2-28-14 and did not contain the current resident census.</p> <p>During an observation on 3-3-14 at 2:35 P.M., the nurse staffing form was changed to reflect the current date, but did not have the resident census information completed.</p> <p>On 3-4-14 at 8:35 A.M. the form titled "Report of Nursing Staff Directly Responsible for Resident Care," dated 3-4-14, was observed to have the resident census line left blank.</p> <p>On 3-5-14 at 10:46 A.M., the form titled "Report of Nursing Staff Directly Responsible for Resident Care," dated 3-4-14, was observed to have the resident census information left blank.</p> <p>On 3-6-14 at 12:45 P.M. copies of the form titled "Report of Nursing Staff Directly Responsible for</p>		<p>This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 03/26/2014. F356. It is the policy of this facility to post the required nursing staffing information and census including actual hours worked for RN's, LPN's and CNA's 7 days a week.</p> <p><u>What corrective action will be done by the facility?</u> A facility oversight occurred that in addition to posting the nursing staff hours by category the facility would also report the census as of 12:00 AM and updated through the day if necessary. Our office manager would place the census on the report form at the end of the day. This now be added by night shift at 12:00 AM each day. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Even though the census entry was made later in the day there were no residents affected by this practice. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Daily Nursing Staffing form will be used daily by the business office manager as a method to notify residents and concerned parties of daily RN, LPN, and CNA work/ census</p>				

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	<p>Resident Care" were requested and included forms for the following dates: 2-28-14 thru 3-6-14. Each copy from 2-28-14 thru 3-5-14 had a resident census penciled in on the form. A copy of the staff posting form, dated 3-6-14, taken down from the wall, did not have the census line completed.</p> <p>During an interview, on 3-6-14 at 1:00 P.M., the Business Office Manager indicated the March staffing forms were not posted for 3-1-14 thru 3-3-14 because she hadn't made them for March until she returned to work on 3-3-14. She further indicated she was not aware the census line needed to be completed at the beginning of the day, as she completed the census line on the next day.</p> <p>3.1-13(a)</p>		<p>during assignment hours. This form will be posted daily by the office manager or nursing designee. The Administrator or designee will check the posted form as part of daily round at least 5 days a week to make sure that the correct form is used and the census is present. The manager of the day will check to see that the correct form is in place and with census noted on weekends. The staffing forms from previous days will be retained by the Administrator/ Office Manager for 18 month as per facility policy. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> <u>The Administrator will bring copies of this report to the monthly QA committee meeting for review. This will be confirmed at the Quality Assurance monthly meeting for review for the next two month.</u> <u>The QA&amp;A committee may decide that monthly review of this staffing form is no longer necessary at the end of the two month review period when 100% compliance is reached. Date of compliance 04/06/2014.</u></p>		

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interviews, the facility failed to ensure food was prepared and served under sanitary conditions in one of one kitchens, and one of two dining rooms. This included cleanliness and storage of equipment, glove use and handwashing. This potentially affected all 31 of 33 residents in the facility who consumed food.</p> <p>Findings include:</p> <p>1. During the kitchen sanitation tour, conducted on 03/03/14 at 10:10 A.M., the following was noted: the metal shelf above stove, on which clean steam table pans and stock pans were stored had a greasy dusty film, one spatula was melted and the inside material was exposed, and two skillets had the black antistick Teflon surface peeling.</p> <p>During the observation of meal</p>	F000371	F371. It is the policy of this facility to establish and maintain the procurement of food from sources approved and considered satisfactory by Federal, State and local authorities;and to store, prepare, distribute and serve food under sanitary conditions. <u>What corrective action will be done by the facility?</u> On 03/19/2014 the dietary staff was in-serviced by the facility dietician regarding concepts of serving food under sanitary conditions. This included but not limited to general cleanliness, storage and use of equipment, glove use, hand washing, and damaged equipment. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this deficient practice. The Director of Nursing reviewed infection control logs for the past six month. No trends were identified to indicate infection transmission that could be tracked to improper hand hygiene or Food handling in the dietary department. <u>What</u>	04/06/2014			

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	<p>service, conducted on 03/03/14 from 11:45 A.M. - 12:45 P.M., the following was noted: Cook #1 handled a marker, a butter wrapper, the refrigerator handle and a pan her bare hands and then handled fish fillets to coat them in breading. She also was noted to place the robo coupe in the dishwasher, then without washing her hands, retrieved it once it was washed and touched the blade with her bare hands when she was getting ready to puree the chicken and dumplings.</p> <p>The Registered Dietician, who was making spinach salad, had washed her hands, put on gloves, and then touched the outside of a bag of spinach with both hands before she reached in and put handfuls of spinach into bowls for 7 residents.</p> <p>Cook #1, when she did wash her hands, was noted to only was her hands for 5 seconds at a time.</p> <p>Cook #1, who was pureeing broccoli, exited the kitchen, obtained a bag of bread, reentered the kitchen and took out two slices of bread with her bare hands and placed the bread into the robo coupe.</p>		<p><u>measures will be put into place to ensure that this practice does not recur?</u> The Registered Dietician and kitchen managers with training in sanitation will complete 4 weeks of audits for cooks and other dietary staff related to sanitary food handling. Any concerns observed during these audits will be addressed at that time with retraining of the correct procedure. This will be followed by observation and work with those workers who are not consistently in compliance with the facility policy. Continued noncompliance will be addressed with progressive disciplinary action. For addressing sanitation concerns in dining areas please refer to F441 part 2 for approaches for personnel working in dining areas. This will address concerns raised on pages 22 and 23 of the CMS 2657, finding 2 and 3. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The results of the <u>kitchen personnel audits and the dining room hand hygiene audit as explained in F441 will be reviewed monthly at the QA &amp; A meeting. After six months has elapsed and the audits demonstrate 100 % compliance, the QA&amp;A committee may consider ending the written audits. However, observations of hand hygiene, glove use, and meal service will continue on an</u></p>		

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	<p>2. On 3/3/14 at 12:50 P.M., CNA #1 was observed feeding Resident #3 her lunch. While CNA #1 was feeding Resident #3 she was observed rubbing her hand under her nose and readjusting the glasses on her face, she then picked the spoon back up and continued to feed Resident #3 without washing her hands or using hand sanitizing gel.</p> <p>On 3/5/14 at 12:15 P.M., CNA #2 was observed removing the lids from Resident #3's lunch tray. Once the resident was seated at the table CNA #2 repositioned the resident in the wheelchair and locked the wheelchair brakes. CNA #2 was then observed removing the paper covering from the resident's straw, she then touched the top and the end of the straw with her hands and placed the straw in the resident's milk and gave the resident a drink of her milk. CNA #2 was not observed to wash her hands or use a hand sanitizing gel.</p>		<p><u>ongoing basis and any identified issues will be brought to the next scheduled QA&amp; A committee meeting for review and further recommendations for process improvement.</u> Date of compliance: 04/06/2014</p>		

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	<p>On 3/5/14 at 1:50 P.M., an interview with CNA #1 indicated she should sanitize her hands after every tray is served and she should wash her hands after every 3rd tray is served. CNA #1 further indicated if she assists more than one resident at a time with their meal she should sanitize her hands between each resident.</p> <p>On 3/5/14 at 1:55 P.M., an interview with CNA #2 indicated she should sanitize her hands between every resident. CNA #2 further indicated she should sanitize her hands after delivering every tray and wash her hands for 20 seconds after delivering every 3rd tray.</p> <p>On 3/6/14 at 12:30 P.M., review of the current policy titled "Handwashing/Alcohol-Based Hand Rub," received from the Director of Nursing (DON), indicated "...The absolute indications for and the ideal frequency of handwashing are not known. However, in the absence of a true emergency, personnel should always wash their hands...After touching your hair, face, etc...Before and after each resident contact...After touching a resident or handling his/her belongings...When</p>			

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	<p>to use Alcohol-Based Hand Rub...After contact with inanimate objects..."</p> <p>3. On 3/3/14 at 12:46 P.M., CNA #5 was observed removing bread from a plastic bag with her bare hands while cutting it for Resident #29 .</p> <p>On 3/7/14 at 9:00 A.M., review of a current undated policy provided by the DON, titled " Food preparation - Employee Sanitary Practices and Proper Food Handling" indicated: "...</p> <p>6. Use utensils to handle food or wear disposable gloves when it is necessary to handle food with your hands...3. Food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact of prepared foods with hands...."</p> <p>During an interview, on 3/7/14 at 10:27 A.M., CNA #5 indicated bread should be held using the plastic bag the bread comes in. She indicated the bread should be held with the bag while cutting it and applying butter and at no time should the bread be touched with bare hands.</p> <p>3.1-21(i)(3)</p>			

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F000441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interviews, the facility</p>	F000441	F441 – It is the policy of this facility to establish and maintain	04/06/2014			

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	<p>failed to ensure staff followed infection control procedures for the use of gloves, handwashing, and linen handling and storage. This potentially affected all 33 residents in the facility.</p> <p>Findings include:</p> <p>1. On 03/05/14 at 9:05 A.M., Resident #9 was ambulated with rolling walker by CNA #1 and #2 to the bathroom. Both CNA's donned disposable gloves and assisted Resident #9 with pulling down her pants. CNA #2 removed the incontinence brief, which was soiled with urine and stool, and placed the brief into the trash can. CNA #2 proceeded to wipe stool from the resident's backside. CNA #2, without changing her soiled gloves, then proceeded to tape one side of a clean brief and pull the resident's outside pants up before removing her soiled gloves and washing her hands.</p>		<p>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. <u>What corrective action will be done by the facility?</u> Nursing staff will be in-serviced by the Director of Nursing by 4/6/14 regarding the proper procedures for glove use during pericare with return demonstration. Department managers and nursing staff will be in-serviced by the Director of Nursing/designee regarding proper hand hygiene during meal service with return demonstration by 4/6/14. The housekeeping staff will be in-serviced by the Director of Nursing regarding the proper handling of linens by 4/6/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this deficient practice. The Director of Nursing reviewed the infection control logs for the past six months. No trends were identified to indicate infection transmission that could be traced to improper hand hygiene or linen handling. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing/designee will complete five observations of staff members washing hands per week for 30days, followed by</p>		

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			randomly observing three staff members washing hands per week for the next 30 days, followed by randomly observing one staff member per week for another 30 days. The Director of Nursing/designee will observe three staff members per week for appropriate glove use during pericare for 30 days, then observe two staff members per week for appropriate glove use during peri-care for another 30 days, then observe one staff member per week for appropriate glove use during peri-care for the next 30 days. The department managers or charge nurses scheduled for each meal will observe staff for proper hand hygiene during meal service on an ongoing basis. The manager or charge nurse will complete a "dining room hand hygiene audit" which will be brought to the next scheduled morning management meeting which meets 5 days a week for review and discussion. If a concern with hand hygiene is observed at any time, the manager or charge nurse will immediately stop the staff member and re-educate him/her on the proper technique for hand hygiene. This re-education will be documented on the hygiene audit tool. The appropriate manager of the department will then follow up with the employee on re-education and progressive disciplinary action for	

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	<p>2. On 3/5/14 at 12:14 P.M., the Social Services Director was observed washing her hands in a resident room for 8 seconds then returned and served a lunch tray to Resident #14.</p> <p>During an Interview, on 3/6/14 at 9:25 A.M., the Social Services</p>		<p>noncompliance. The Environmental Servicesmanager/designee will observe the housekeeping staff for appropriate linen handling at least three times weekly for 90 days using the linen handling audit tool. The audit tool will be turned into the administrator weekly. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The results of the linen handling audit, peri care/glove use audit and dining room hand hygiene audit will be reviewed at the monthly QA&amp;A meeting. After six months has elapsed and the audits demonstrate 100% compliance, the QA&amp;A committee may consider ending the written audits. However, observations of hand hygiene, glove use, and meal service will continue on an ongoing basis and any identified issues will be brought to the next scheduled QA&amp;A committee meeting forreview. Date of Compliance: 4/6/14</p>		

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	<p>Director indicated she washed her hands before donning gloves and then after removing gloves and after touching residents. She further indicated she sings "happy birthday" while washing her hands, washing for 15-20 seconds. She also indicated she could use hand sanitizer up to three times in a row and then she must wash her hands with soap and water.</p> <p>On 3/3/14 at 11:50 A.M., Housekeeper #4 was observed carrying a soiled tablecloth next to her body into the soiled utility room.</p> <p>On 3/4/14 at 3:10 P.M., Housekeeper #4 was observed delivering clean resident clothes into room 18, leaving the cart uncovered in the hallway. She then pushed the cart down the hallway uncovered.</p> <p>On 3/6/14 at 12:30 P.M., the DON (Director of Nursing) provided the current policy titled, "Hand washing/Alcohol-Based Hand Rub" dated June 2004, which indicated: "...2. Do this for at least 20 seconds, or as long as it takes to sing "Happy Birthday " to yourself twice...."</p> <p>During an interview, on 3/6/14 at 12:50 P.M., the housekeeper #4</p>						

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F009999	<p>indicated soiled linens should be bagged and carried to soiled utility room away from the body. Clean resident linens should be covered at all times when transporting through the hallway and while staff was in resident room hanging clothes up.</p> <p>On 3/6/14 at 1:50 P.M., the DON provided "Linen Handling" policy dated June 2004, and indicated it was the one currently used by the facility. The policy indicated, " ...9. DO NOT carry soiled linen close to your clothing. Hold soiled linen away from the body and do not carry large armloads...." The policy does not address how resident linens are to be transported.</p> <p>3.1-18(l) 3.1-19(g)(1)</p>	F009999	HickoryCreek at Rochester will assure that each resident room is equipped with clothing storage which includes a closet. The current <b>free standing wardrobes</b> (the wardrobe closets/drawers are not built in to	04/06/2014
	<p>3.1-19 (5) Environmental and Physical standards</p> <p>Each resident room shall have clothing storage, which includes a closet at least two (2) feet wide and</p>			

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	<p>two(2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. The closet should be tall enough that clothing does not drag on the floor and to provide air circulation. A dresser, or its equivalent in shelf and drawer space equal to a dresser with an area of at least four hundred thirty two (432) square inches, equipped with at least two (2) drawers six(6) inches deep to provide for clothing, toilet articles and other personal belongings shall also be provided.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure proper closet space was provided in 17 of 18 rooms. This potentially affected 32 of 33 residents.</p> <p>Finding includes:</p> <p>During an interview, on 3/4/14 at 9:40 A.M., resident #33 indicated the cupboard/closet was way too small, especially with her winter coat in it. She indicated there was no other place for them to store out of season</p>		<p>the walls as indicated in the survey) that Hickory Creek at Rochester has, was purchased as part of an extensive resident room furniture replacement consisting of all new electrici-low beds, wardrobes, bedside cabinets and over-the-bed tables in August 2010at a cost of \$62,686.00. The2 door wardrobes per the manufacturer's specifications are 24.00" wide, 21.75" in depth and are 76.00" tall, consisting of 2 drawers at the bottom which are5.00" deep, a shelf above the closet rod for storage and an adjustable closet rod adjustable from 58.50" down to 44.85". In addition, Hickory Creek atRochester provides each resident with a 3 drawer bedside cabinet which is21.25" wide, 17.12" in depth and 30.00" tall, with 3 drawers that are 5.00"deep. See attached drawing and (picture – not sure if you cantake and download a picture of a wardrobe or not – both external and then open the doors and show the interior) of this wardrobe unit.</p> <p><u>1.What corrective action will be done by the facility?</u> Resident#33 was interviewed and an accommodation was made to add a hook for this resident to hang her coat exterior of the free standing wardrobe. Due to the bulkiness of the coat, the issue wasn't the depth of the closet, rather the width which meets the State specific rule. Therefore, a</p>		

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	<p>clothes or bulky items.</p> <p>During an interview, on 3/6/14 at 9:58 A.M., the Maintenance Manager indicated he was unaware of any closet specifications.</p> <p>On 3/7/14 at 10:42 A.M., during the Environmental tour an observation indicated the wardrobe closet for room 5-1 measured 22.5" wide, 45" high and 21" deep. The built in drawers measured 19" length, 20.5" wide and 4 " deep. The wardrobe closets were built in to the walls with the closet space above the drawers.</p> <p>During an interview on 3/7/14 at 11:00 A.M., the Administrator indicated all wardrobe closets were the same size. He indicated the built in closet/drawer units were purchased together during a remodel several years ago.</p> <p>3.1-19(5)</p>		<p>reasonable accommodation was necessary for storage of the coat. Resident voiced concurrence with the accommodation and is happy with the placement of her coat.</p> <p><u>1.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>The actual depth of the closets is 2.125" smaller than the State specific requirement, thus all residents are adversely affected by the requirement. Each resident will be interviewed and Hickory Creek at Rochester staff will assist residents who indicate that they believe they have inadequate closet space, to encourage resident family members to remove non-seasonal clothing allowing room for the residents current clothing needs. If a resident has no family, or the family is unable to store non-seasonal clothing, Hickory Creek at Rochester will arrange for the safe storage of these non-seasonal items for the resident. For bulkier items, Hickory Creek at Rochester staff will make accommodations to add additional storage space, hooks to hang larger, bulky coats just as they did for resident #33. Where room space permits, Hickory Creek at Rochester is not opposed to add additional closets to be used by a resident, or shared by both residents of the room.</p>		

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			<p><u>2.What measures will be put into place to ensure this practice does not recur?</u> During assigned guardian angel rounds, assigned staff members will periodically review with the resident their clothing needs and storage of such items, including clothing, toilet articles and other personal belongings. Where necessary,accommodations will be made to assist the resident for the storage of these items.</p> <p><u>1.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the Guardian Angel rounds and any resident concerns regarding storage space to the monthly QA&amp;A Committee for review and recommendations. The Administrator and Maintenance Supervisor will follow any recommendations made and report the results to the next scheduled QA&amp;A meeting. This will continue on an ongoing basis. Dateof Compliance: 4/6/14</p>		