

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2014
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NAME OF PROVIDER OR SUPPLIER  NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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F000000	<p>This visit was for a Recertificaton and State Licensure Survey. This visit included the Investigation of Complaint number IN00145932.</p> <p>Complaint number IN00145932 - Substantiated. Federal/State defidency related to the allegation are cited at F312.</p> <p>Survey dates : April 21, 22, 23, 24, and 28, 2014.</p> <p>Facility number: 000069 Provider number: 155148 AIM number: 100288980</p> <p>Survey Team: Diana Perry RN TC Barb Fowler RN Denise Schwandner RN Anna Villain RN</p> <p>Censor bed type: SNF: 8 SNF/NF: 87 Total: 95</p> <p>Censor payor type: Medicare: 15 Medicaid: 72 Other: 8</p>	F000000	It is our resquest that we be found compliant through paper review.	

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

TITLE

(X6) DATE

Any defenciystatement ending with an asterisk (\*) denotes a defidency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F000272 SS=D	<p>Total: 95</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 5, 2014, by Janelyn Kulik, RN.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information</p>			

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	<p>regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to assess accurately in the MDS (Minimum Data Set) Assessment, mood, behavior, BIMS (Brief Interview for Mental Status) and coded wrongly for incontinence and behaviors for 3 of 28 residents. (Residents #68, #23, #89)</p> <p>Findings include:</p> <p>1. During an observation on 4/23/14 at 3:25 p.m., Resident #68 was noted to be exiting the bathroom without help.</p> <p>During a family interview on 4/22/14 at 1:30 p.m., Resident #68's daughter indicated Resident #68 was able to toilet without assist.</p> <p>The record of Resident #68 was reviewed on 4/23/14 at 9:30 a.m. The record indicated Resident #68 had diagnoses including, but not limited to, depression, psychosis, dysphasia following an intracranial bleed, UTI (urinary tract infections), and dementia.</p> <p>An admission MDS (Minimum Data Set)</p>	F000272	<p>F272 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 68's MDS has been reviewed and updated with the resident's current needs and requirements of care. Resident # 23's MDS has been reviewed and updated with the resident's current needs and requirements of care. Resident # 89's MDS has been reviewed and updated with the resident's current needs and requirements of care. How other residents having the potential to be affected by the deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. All MDS's have been audited to ensure they are complete for BIM's All MDS's have been reviewed for residents requiring incontinence care and refused to ensure complete and accurate. The MDS Coordinator was in-serviced on urinary and bowel continence coding on May 13, 2014 by the RAI Specialist, post test included. The Social Services Director and Memory Care Facilitator were in-serviced on Section C (BIMs staff</p>	05/28/2014	

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	<p>Assessment, dated 12/10/13, indicated Resident #68 was always continent.</p> <p>A Quarterly MDS Assessment, dated 2/27/14, indicated Resident # 68 was frequently incontinent (more than 7 episodes of urinary incontinence, but at least one episode of continent voiding).</p> <p>During an interview on 4/22/14 at 9:45 a.m., RN #1 indicated Resident # 68 was rarely incontinent, had recently had a UTI and had a "couple of accidents." RN #1 indicated Resident # 68 did all self care including bathroom.</p> <p>During an interview on 4/23/14 at 2:32 p.m., LPN #1 indicated the resident was always continent. Record review of " Bladder and Bowel Functions," provided at same time indicated Resident #68 was always continent.</p> <p>During an interview on 4/24/14 at 10:59 a.m., the MDS Coordinator indicated the MDS was coded incorrectly on Resident #68.</p>		<p>assessment) and section D (Mood) May 13, 2014 by the RAI Specialist, post test included. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DNS/designee will review the MDS to ensure complete and accurate prior to submission of the MDS. The MDS Coordinator was in-serviced on urinary and bowel continence coding on May 13, 2014 by RAI Specialist, post test included. The Social Services Director and Memory Care Facilitator were in-serviced on Section C (BIMs, staff assessment) and section D (Mood) May 13, 2014 by the RAI Specialist, post test included. How will the corrective action's will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/designee is responsible for the compliance of the Bladder program and SS MDS validation CQI tools weekly x 4 weeks, bi-monthly times 2 months, monthly times 6 and the quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure services were provided in accordance with the written orders for 3 of 28 residents in the stage 2 sample of 28 residents, whose records were reviewed for physician's orders, in that blood pressures (B/Ps) were not done after being ordered by a physician and a resident received a treatment without a physician's order. ( Resident #23, Resident #127, Resident #125)</p> <p>Findings include:</p> <p>1. On 4/23/14 at 8:31 a.m., Resident #23's record was reviewed. The most recent signed physician's orders for 3/1/14 through 3/31/14 contained orders for: Bystolic (a medication used for the treatment of high blood pressure) 10 mg (milligrams) by mouth twice daily and to record blood pressure.</p> <p>The most recent signed physician orders for 3/1/14 through 3/31/14 also contained orders for: Humalog (a medication used for the treatment of Diabetes) inject sub-q (subcutaneous) per sliding scale before</p>	F000282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 127 has had orders clarified for B/P checks and medication administration of ordered medications. The MD and family were notified of the error. An order has been received for resident # 125 dressing change at gastrostomy site. Resident # 23 has been re-assessed, orders have been verified and proper documentation/procedures are being completed as ordered.</p> <p>How other residents having the potential to be affected by the deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Re-education has been provided to all nursing staff by the DNS/designee to be completed by May 28th, 2014, regarding the importance of doing accurate standardized admission procedures for each resident admitted to the facility. Re-education also included importance of following Physicians orders as received or to clarify orders as needed.</p>	05/28/2014			

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	<p>meals. The physician's order for Humalog further indicated if the resident's blood sugar results were greater than 400 to give 20 units and recheck in 2 hours- if still greater than 400, notify physician.</p> <p>The " Physician Telephone Orders" indicated on 3/17/14 an order for Cardizem CD (a medication used for the treatment of high blood pressure) 240 mg daily was documented. The "Care Plan Update" portion of the form indicated Resident #23's blood pressure was to be monitored twice a day in addition to medication therapy.</p> <p>The "Capillary Blood Glucose Monitoring Tool", indicated Resident #23's blood glucose was greater than 400 on 1/29/14, 2/15/14, 3/26/14, and 4/4/14. The tool lacked documentation of a blood glucose recheck 2 hours later.</p> <p>The MAR (Medication Administration Record) for 3/1/14 through 3/31/14 lacked documented blood pressure readings and blood glucose levels.</p> <p>The "Blood Pressure Log", dated 3/31/14 through 4/20/14, lacked twice daily documented blood pressure readings on 3/31/14 through 4/4/14, 4/6/14, 4/10/14 through 4/11/14, and 4/14/14 through</p>		<p>Nurses were also re-educated of the importance of making sure an order is in place for any and all treatments and any other procedure required by the residents. Nurses have been re-educated on the importance of following orders correctly and using facility tools to record findings and procedures. Post test included. Residents with a G-tube were reviewed by the DNS/Designee to ensure all necessary Physician orders were received and followed. Resients with insulin sliding scales and B/P checks were reviewed by the DNS/designee to ensure Physician orders were followed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Re-education has been provided to all nursing staff by the DNS/designee to be completed by May 28th, 2014, regarding the importance of doing accurate standardized admission procedures for each resident admitted to the facility. Education also included importance of following Physicians orders as received or to clarify orders as needed. Nurses were also re-educated of the importance of making sure an order is in place for any and all treatments and any other procedure required by the residents. Nurses have been re-educated on the importance of following orders correctly and</p>		

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F000312 SS=D	<p>4/20/14.</p> <p>On 4/24/14 at 8:40 a.m., the DoN (Director of Nursing) was interviewed. The DoN indicated the blood pressures should be charted either on the blood pressure flow sheet and/or the MAR. The DoN further indicated blood pressures were not documented per updated care plan. The DoN also indicated blood glucose monitoring should be documented on the blood glucose flow sheet and if rechecks were performed per MD orders, results would be documented on the flow sheet.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the</p>		<p>using facility tools to record findings and procedures. Post test included. How will the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/designee is responsible for the completion of the enteral therapy, admission/re-admission/orders CQI tools weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The DNS/designee will conduct chart audits daily, 5 times weekly, times 4 weeks, then weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters to ensure Physician orders are present and followed for residents with G-tubes, Insulin sliding scales and B/P checks. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of over 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 3 of 35 residents reviewed for grooming and cleanliness received assistance as needed, in that the residents did not receive proper bathing or oral care. (Resident # 54, Resident #38, Resident #9)</p> <p>Findings include:</p> <p>1. During an observation on 4/21/14 at 11:29 a.m., Resident #54 was observed to be lying in bed. Resident #54 was observed to wearing a shirt which had food debris on the sleeve and no teeth in his mouth. Resident #54's bed was observed to have 5 pads on it and dried, white-yellow colored food debris and wrappers were observed to be in his bed.</p> <p>During an observation on 4/22/14 at 9:05 a.m., Resident #54 was observed to be lying in bed with 5 pads on the bed. Resident #54 did not have any teeth in his mouth and food wrappers were observed in the bed.</p> <p>Resident #54's record was reviewed on 4/23/14 at 10:07 a.m. Resident #54 had diagnoses including, but not limited to,</p>	F000312	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 54 shower was completed, clothes were changed, bed changed and cleared of debris. Resident # 38's oral care was completed and care planned. Resident # 9 was given a shower, nails were cleaned and care plan updated. How other residents having the potential to be affected by the deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Re-education has been provided to all nursing staff by the DNS/designee to be completed by May 28, 2014, post test included, regarding following the plan of care for each resident and documenting the care accurately when done. Nursing staff has also been re-educated on the importance of assuring that grooming and personal hygiene to include incontinent care are done daily and as needed. The charge nurses will observe all residents each shift to ensure residents are well groomed, clean, receive proper bathing, oral care, and beds are clean. What measures will be put into place or what systemic changes will be made to ensure</p>	05/28/2014	

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	<p>prostate cancer, kidney disease, dementia, urinary retention.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 2/14/14, indicated the resident had a BIMS (Brief Interview for Mental Status) assessment which indicated moderate cognitive impairment. The MDS further indicated Resident #54 was totally dependent of 1 person for bathing.</p> <p>A care plan, dated 9/19/13, indicated Resident #54 was to have a shower two (2) times per week with a partial bath in between.</p> <p>A CNA (certified nursing assistant) assignment sheet, dated 4/18/14, indicated Resident #54 was to receive a shower every Tuesday and Friday evening.</p> <p>The "Point of Care ADL (activity of daily living) Category Report," dated 2/23/14 - 3/31/14, indicated Resident #54 did not receive a shower between 3/23/14 - 3/31/14.</p> <p>During an interview on 4/28/14 at 8:00 a.m., CNA #1 indicated if a resident did not want to have care or take a shower, she would offer to give the bath at a later time. CNA #1 further indicated the nurse</p>		<p>that the deficient practice does not recur? Re-education has been provided to all nursing staff by the DNS/designee to be completed by May 28, 2014, post test included, regarding following the plan of care for each resident and documenting the care accurately when done. Nursing staff has also been re-educated on the importance of assuring that grooming and personal hygiene to include incontinent care are done daily and as needed. Shower sheets will be reviewed daily by the DNS/Designee to ensure resident received. The Charge nurse will conduct rounds every shift to observe for personal hygiene, grooming, oral care, and that beds are clean. How will the corrective action(s) will be maintained to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the accommodation of needs CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

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	<p>on the unit would be notified and the shower sheet would be filled out. CNA #1 indicated Resident #54 always took a shower whenever it was offered.</p> <p>2. During an observation on 4/23/14 at 10:21 a.m., Resident #38 was observed to be sitting a wheelchair in the dining room. Resident #38 was observed to have yellowish brown debris on his teeth.</p> <p>During an observation on 4/23/14 at 9:54 a.m., Resident #38 was observed to be sitting in a wheelchair in the lobby on the unit. Resident #38's face was unshaven and the resident's teeth were yellowish brown debris on the resident's teeth.</p> <p>Resident #38's record was reviewed on 4/23/14 at 10:32 a.m. Resident #38 had diagnoses including, but not limited to, dementia with behavior disturbances, Alzheimer's disease, anxiety, bladder incontinence, and chronic kidney disease. The Quarterly MDS (Minimum Data Set) Assessment, dated 2/4/14, indicated Resident #38 had a BIMS (Brief Interview for Mental Status) which indicated the resident had severe cognitive impairment. The MDS further indicated Resident #38 required physical help of 1 assist for bathing and extensive assist of 1 person for personal hygiene.</p>			

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	<p>A care plan, dated 10/26/12, indicated Resident #38 had a self care deficit. The care plan indicated Resident #38 was to be encouraged to make choices in shower time preference.</p> <p>A CNA (certified nursing assistant) assignment sheet, dated 4/18/14, indicated Resident #38 was to receive a shower every Monday and Thursday evenings.</p> <p>The "Point of Care ADL (activity of daily living) Category Report," dated 2/23/14 - 3/31/14, indicated Resident #38 had received a shower on 3/27/14.</p> <p>During an interview on 4/28/14 at 8:00 a.m., CNA #1 indicated if a resident did not want to have care or take a shower, she would offer to give the bath at a later time. CNA #1 further indicated the nurse on the unit would be notified and the shower sheet would be filled out. CNA #1 indicated Resident #38 always took a shower whenever it was offered.</p> <p>A procedure titled, "A.M. Care," and reviewed, 4/2012, indicated the resident was to be assisted with oral hygiene and shaved if needed.</p> <p>A procedure titled, "H.S. Care," and reviewed on 3/2012, indicated the</p>			

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F000371 SS=F	<p>resident was to be assisted with oral hygiene at bedtime.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions. This had the potential to affect 94 of 95 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>During initial tour on 4/20/14 at 8:55 a.m., the storage area was observed to have a box of Club crackers with the date of 3/30/14 and 4/29/14 on it but the box lid was open and one of the packages was opened in the box. An opened box of "Potato Pearls" was on a shelf in the storage area with no date on it. A soiled slicer was observed on a cart in the food prep area and an uncovered, open bowl of corn flakes was observed to be sitting on a tray. The floor in the kitchen was sticky, wet, and had gray and white dirt</p>	F000371	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The sanitation issues found with the kitchen floors were immediately corrected. The labeling, dating and storing of food was immediately corrected. All dishes found with kitchen were ran through dish machine and properly sanitized. Outdated food was discarded. Dish machine temperature and sanitation log is to be completed. How other residents having the potential to be affected by the deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The dietary staff were in-serviced on sanitation requirements and proper food storage by the DM on 05/19/14. The staff members responsible for specific sanitation</p>	05/28/2014

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	<p>and onion peels on it.</p> <p>Upon observation of the dishwashing room on 4/20/14 at 9:10 a.m., it was observed to be cycling properly with the correct temperature obtained but no sanitizer was observed in the container for the sanitizing stage. The DM (dietary manager) was notified and indicated she did not know how long the sanitizer had been empty. The DM proceeded to obtain a new container of sanitizer and it was connected and the tubing was primed. The DM indicated the facility would need to re-wash the dishes that had been previously washed. The DM indicated the normal dishwasher had not come into work that day and another dishwasher was taking his place.</p> <p>During an observation on 4/24/14 at 11:45 a.m., the kitchen floor was observed to be sticky and had dirt on it and a pitcher was observed to be sitting in a bin of oats under the prep table.</p> <p>During an interview with the DM on 4/20/14 at 9:10 a.m., the DM indicated she had only been working at the facility for a short time. She further indicated she knew the kitchen had several problems that she had been trying to correct.</p>		<p>tasks will initial the tasks when completed. The Dietary Manager/Designee will check the daily What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The dietary staff were in-serviced on sanitation requirements and proper food storage by the DM on 05/19/14. The staff members responsible for specific sanitation tasks will initial the tasks when completed. The DM/Designee will check the daily, weekly and monthly sanitation checklists to ensure that all required sanitation items are completed appropriately. The DM/Designee will conduct a walk-through of the kitchen at least daily to ensure checklists are complete, and kitchen is clean and sanitary. How will the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the Dietary Manager/Designee is responsible for the completion of the Kitchen Sanitation/Environmental review log CQI tool daily 5 times a week for 4 weeks, 3 times a week for 4 weeks and then weekly for two weeks to encompass all shifts and to maintain continued compliance. The results will be reviewed by CQI Committee overseen by the ED. The Safety and Sanitation Review will be</p>		

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	<p>A form titled, "Low Temperature Dishmachine Temperature Sanitizer Log," dated 4/2014, and obtained from the DM on 4/21/14 at 8:15 a.m., indicated the temperature of the dishwasher along with the sanitizer concentration parts per million (PPM) should be taken daily at breakfast, lunch, and supper. The form indicated the temperatures and the sanitizer PPMs had not been obtained on the following dates:</p> <ol style="list-style-type: none"> <li>1. 4/2/14 at supper</li> <li>2. 4/3/14 at supper</li> <li>3. 4/4/14 at breakfast and lunch</li> <li>4. 4/7/14 at breakfast, lunch, or supper,</li> <li>5. 4/8/14 at supper</li> <li>6. 4/9/14 at supper</li> <li>7. 4/10/14 at lunch and supper</li> <li>8. 4/11/14 at breakfast, lunch, or supper</li> <li>9. 4/12/14 at breakfast, lunch, or supper</li> <li>10. 4/12/14 at breakfast, lunch, or supper</li> <li>11. 4/13/14 at breakfast and lunch</li> <li>12. 4/16/14 at supper</li> <li>13. 4/17/14 at supper</li> <li>14. 4/18/14 at supper</li> </ol> <p>A policy titled, "Cleaning Dishes and Dish Machine," and revised on 5/06, indicated the temperature and pressure are to be checked.</p> <p>The "Dietary Daily Cleaning Assignments 2014," obtained from the</p>		completed weekly times 4 weeks, bi-monthly for one month and then monthly thereafter.	

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F000441 SS=D	<p>DoN (Director of Nursing) in 4/28/14 at 12:37 p.m., indicated the "AM Cook" was to sweep/mop daily , the "AM Aide" was to sweep/mop daily, the "AM Dishwasher" was to sweep/mop the dish room and the dish room storage hall daily, the "PM Aide" was to sweep/mop daily, and the "PM DIshwasher" was to seep and mop daily. The assignments further indicated the "AM Cook" was to clean the slicer daily.</p> <p>During an interview with the Adm on 4/28/14 at 11:15 a.m., the Adm (Administrator) indicated he was aware the facility was dirty and he had been working on fixing it. The Adm indicated he had been doing a lot of education to the staff and he would continue to do so.</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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>			

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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review, the facility failed to provide care in a manner to prevent potential infections for 1 of 2 residents observed during care, in a total sample of 35, in that soiled and clean items were commingled. (Resident #6)</p> <p>Findings include:</p>	F000441	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 is receiving trach care and medication administered per infection control procedures. How other residents having the potential to be affected by the deficient practice will be identified and what corrective action(s) will be taken? All residents have the	05/28/2014

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	<p>1. RN (registered nurse) #2 was observed performing tracheostomy care on 04/23/14 at 10:05 a.m. to Resident #6. The resident opened his eyes with the procedure, but was otherwise unresponsive. Sterile technique was followed during care and with suctioning. Appropriate hand washing and glove use was noted. Upon cleaning up the area, RN #2 placed the suction tubing in a plastic bag that had fallen on the floor and placed it on the shelf with the resident's supplies.</p> <p>2. RN #2 was observed during the medication pass to Resident #6 on 4/23/14 at 11:45 a.m. Medication cups containing medication, were placed on the Resident's #6 roommate's bedside table beside a urinal containing urine and a glasses case. The wash cloth that was used during the medication administration per gastrostomy tube, was placed on the roommate's table touching the glasses case.</p> <p>3. The policy on "Transmission-Based Precaution Guidelines" was obtained from the DoN (Director of Nursing) on 4/28/14 at 3:45 p.m. The policy included, but was not limited to, the following: "...The facility shall utilize the appropriate infection control precaution guidelines based on the</p>		<p>potential to be affected by the alleged deficient practice. All nurses providing trach care and medication pass were observed using the skills validation for trach care and medication pass by the CEC/Designee to be completed by May 28, 2014, to ensure infection control practices were followed. The DNS/Designee will conduct rounds each shift to ensure trach care and medications are passed following the infection control procedures. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur. All nurses providing trach care and medication pass were observed using the skills validation for trach care and medication pass by the CEC/Designee to be completed by May 28, 2014, to ensure infection control practices were followed. The DNS/Designee will conduct rounds each shift to ensure trach care and medications are passed following the infection control procedures. How will the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the infection control review CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly x 6 and then</p>				

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F000465 SS=E	<p>identified concerns and issues."</p> <p>3.1-18(b)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and record review, the facility failed to ensure a safe, functional, and sanitary environment, in that floors were soiled, cove base, tiles, wallpaper, and furniture were in poor repair, and heating units were not covered for 18 out of 28 rooms reviewed during Stage I. This affected 34 residents who resided in these rooms. (Room #148,</p>	F000465	<p>quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Trach care and medication pass skills validation checks will be completed on all shifts daily for one week, weekly x 2 weeks and monthly for 6 months by the CEC/designee. Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Rooms 148, 160, 166, 165, 119, 120, 123, 151, 154, 150, 144, 127, 122, 125, 115, 141, 128 and 134 have been cleaned and minor repairs have been done. How other residents having the potential to be affected by the</p>	05/28/2014
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	<p>160, 166, 165, 119, 120, 123, 151, 154, 150, 144, 127, 122, 125, 115, 141, 128, and 134)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 4/21/14 at 11:31 a.m., Room #148 was observed with dirt and debris built up on the floors, chipped paint on the walls, a soiled cove base, clothes hangers present on the floor, a sticky floor, and an accumulation of candy wrappers present in the bed. On 4/24/14 at 2:08 p.m., observed dirt and debris built up on the floors, chipped paint, a dirty cove base, and a sticky floor.</li> <li>On 4/21/14 at 11:40 a.m., Room #160 was observed with a missing closet door knob, broken and yellowed window blinds, and a bathroom door that was difficult to shut. On 4/24/14 at 2:17 p.m., observed a missing closet door knob, broken and yellowed window blinds, a bathroom door that was difficult to shut, a strong urine odor present, and an accumulation of dirt and debris under the beds.</li> <li>On 4/21/14 at 1:40 p.m., Room #166 was observed with the tiles falling off the wall in the bathroom and the cove base coming apart from the wall in the bathroom. On 4/24/14 at 2:20 p.m.,</li> </ol>		<p>deficient practice will be identified and what corrective action(s) will be taken? All resident have the potential to be affected by the alleged deficient practice. All resident rooms were inspected by the Maintenance supervisor/Designee to be completed by May 28, 2014, to ensure all resident rooms are clean and safe. Any necessary cleaning and repairs were completed immediately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All resident rooms were inspected by the Maintenance supervisor/Designee to be completed by May 28, 2014, to ensure all resident rooms are clean and safe. Any necessary cleaning and repairs were completed immediately. The Maintenance Supervisor/designee will conduct rounds daily, 5 times per week, to ensure resident rooms are in proper repair and cleaned appropriately. How will the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the Maintenance Supervisor/Designee is responsible for the completion of the Environmental Safety CQI tool weekly x 4, bi-monthly times 2 months, monthly times 6 and</p>	

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	<p>observed a sticky bathroom floor, a strong feces odor, tiles falling of the wall in the bathroom, and the cove base coming apart from the wall in the bathroom.</p> <p>4. On 4/21/14 at 1:42 p.m., Room #165 was observed with the cove base becoming detached from the wall by the heating unit. On 4/24/14 at 2:23 p.m., observed the same.</p> <p>5. On 4/22/14 at 1:55 p.m., Room #119 was observed with dirt and debris built up along the walls of the floor. On 4/24/14 at 11:20 a.m., observed the same.</p> <p>6. On 4/21/14 at 2:00 p.m., Room #120 was observed with dirt and debris built up on the floor of the bathroom and bedroom and a green substance present on the floor. On 4/24/14 at 1:57 p.m., observed dirt and debris built up on the floor of the bathroom and bedroom.</p> <p>7. On 4/21/14 at 2:12 p.m., Room #123 was observed with a cracked tile behind the bathroom sink, the caulking around the sink becoming detached from the wall, a brown and yellow substance present around the commode, and dirt and debris built up on the floor. On 4/24/14 at 11:14 a.m., observed the same.</p>		<p>then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>8. On 4/21/14 at 2:22 p.m., Room #151 was observed with a sticky bathroom floor and the cove base missing by the closet door. On 4/24/14 at 2:27 p.m., the same was observed.</p> <p>9. On 4/21/14 at 2:17 p.m., Room #154 was observed with a loose bathroom door panel. On 4/24/14 at 2:13 p.m., observed a loose bathroom door panel and a urine hat uncovered on the back of the toilet.</p> <p>10. On 4/21/14 at 2:37 p.m., Room #150 was observed with an unlabeled denture cup and body wash sitting on the sink, a brown color at the base of the commode, a wet brief stored on the back of the commode. On 4/24/14 at 2:29 p.m., observed an unlabeled denture cup and body wash sitting on the sink, a brown color at the base of the commode, a clean brief stored on the back of the commode, and built up dirt and debris on the floor.</p> <p>11. On 4/21/14 at 3:13 p.m., Room #144 with a urine odor present and dirt and debris built up along the edges and in the corners of the floor. On 4/24/14 at 3:03 p.m., observed a urine odor, dirt and debris built up along the edges and in the corners of the floor, and the tiles behind the commode soiled with brown substance.</p>			

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	<p>12. On 4/22/14 at 8:09 a.m., Room #127 was observed with a urine odor present, dirt and debris built up along the edges and in the corners of the floor, the bathroom floor soiled with a wet substance, and the caulking around the fixture behind the commode cracked. On 4/24/14 at 2:47 p.m., observed the caulking around the fixture behind the commode cracked and a missing tile by the assistance bars.</p> <p>13. On 4/22/14 at 8:42 a.m., Room #122 was observed with dirt and debris built up along the edges and in the corners of the floor and a running toilet. On 4/25/14 at 11:08 a.m., the same was observed.</p> <p>14. On 4/22/14 at 8:52 a.m., Room #125 was observed with a cracked and unlevelled tile floor. On 4/24/14 at 11:14 a.m., the same was observed.</p> <p>15. On 4/22/14 at 9:02 a.m., Room #115 was observed with an I.V. (intravenous) pole soiled with dried feeding formula, a brown substance on the wall behind the bed, and paint chipped off the wall behind the headboard. On 4/24/14 at 1:53 p.m., the same was observed.</p> <p>16. On 4/22/14 at 9:38 a.m., Room #141 was observed with dirt and debris built</p>			

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	<p>up along the edges of the floor. On 4/24/14 at 1:42 p.m., the same was observed.</p> <p>17. On 4/22/14 at 9:48 a.m., Room #128 was observed with the heating unit coils exposed, a black substance at the base of the commode, the caulking missing at the base of the commode, and a urine odor present. On 4/24/14 at 11:11 a.m., observed a black substance at the base of the commode and the caulking missing at the base of the commode.</p> <p>18. On 4/22/14 at 10:04 a.m., Room #134 was observed with built up dirt and debris on the bathroom floor. On 4/24/14 at 1:45 p.m., observed the same.</p> <p>19. On 4/24/14 at 11:23 a.m., observed the wallpaper outside of the main dining room becoming detached from the wall and scotch tape used to reattach the wallpaper to the wall.</p> <p>20. On 4/24/14 at 2:56 p.m., observed a Hoyer Lift with duct tape placed around the foam handles.</p> <p>21. On 4/24/14 at 3: 57 p.m., the Resident Council Minutes provided by the AD (Activity Director) were reviewed. The Resident Council voiced complaints about Housekeeping 6/25/13,</p>			

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NAME OF PROVIDER OR SUPPLIER  NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>7/30/13, 9/24/13, 11/26/13, 12/17/13, and 1/28/14.</p> <p>22. On 4/28/14 at 12:37 p.m., the "Cleaning Guidelines" provided by the DoN (Director of Nursing) was reviewed. The guidelines indicated daily cleaning duties included, but were not limited to, clean and disinfect restroom, remove refuse, clean horizontal surfaces, and sweep and mop floor. Additional weekly duties included, but were not limited to, wipe down walls were apparent dirt, food debris, ect is apparent, and wipe down cove base, edging and corners where accessible.</p> <p>3.1-19(f)</p>			