STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	725 S SECOND ST BOONVILLE, IN 47601

(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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 17, 18, 19, 20, 21, and 24, 2012 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Survey team: Terri Walters, RN TC Martha Saull, RN Dorothy Watts, RN Jodi Meyer, RN (9/17, 9/18, 2012) Carole McDaniel, RN (9/24/12) Census bed type: SNF: 3 SNF/NF: 55 Total: 58 Census Payor type: Medicare: 11 Medicaid: 32 Other: 15 Total: 58 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Boonville POC By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 28, 2012 to the complaint survey conducted on September 5 through September 7, 2012.Is paper compliance a possibility?	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency 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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	Quality review completed 9/27/12 Cathy Emswiller RN			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure a female resident was given opportunity to shave facial hair and/or be maintained as clean shaven for 1 of 4 residents reviewed for activities of daily living. Resident #93 Findings include: On 9/18/12 at 10:42 A.M., Resident #93 was observed in her room in bed. She was observed to have facial hair on her chin, at least 1/4 inch long in some areas but long enough in other areas of her chin and jaw line for the hair to curl. The facial hair was observed at the center of her chin and also extended at least an inch to either side of the center of her chin. The hair was observed on, above and below the jaw line in this area. On 9/20/12 at 9:30 A.M., the resident was observed with the facial hair as described above.	F0241	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 24, 2012 to the annual licensure survey conducted on September 17, 2012 through September 24, 2012. **F241** **It is the practice of Transcendent Healthcare of Boonville to assure that residents receive services in a manner that enhances dignity.**	10/24/2012

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	On 9/20/12 at 2:30 P.M., the MDS (Minimum Data Set Assessment) Coordinator was interviewed. She indicated the resident was admitted last week and has an interim plan of care. At this time, she provided a copy of the resident's current interim plan of care. This form was dated 9/12/12 and indicated the following: "Shaving: by staff." At this time, the MDS Coordinator also provided a copy of the resident's admission assessment dated 9/11/12. This form indicated the following for the resident: assistance for tub, shower, bed bath, oral hygiene and shaving, grooming, dressing, and shampoo. On 9/21/12 at 10 A.M., the resident was observed with the facial hair as described on 9/18/12 at 10:42 A.M. On 9/24/12 at 12:55 P.M., CNA # 35 was interviewed. She indicated she was caring for Resident #93 today. She indicated the resident gets showers twice a week. On 9/24/12 at 1 P.M., the DON (Director of Nursing) provided a copy of the resident's Treatment record, where the "shave" was documented. From the date of 9/11/12 -9/24/12, for each shift of days, evening and nights there were either a slash mark across		***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #93 is being shaven on a routine basis. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed for shaving needs and are receiving services in a manner that enhances their dignity. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted with all nursing staff related to the policy of ADL care including shaving. The in-service includes assuring that females as well as males are shaved appropriately. Nursing Charge Nurses and Nursing administration will be making rounds daily to assure that all residents are clean shaven. ***The corrective action taken to monitor performance to***	

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	the square or blank squares. Documentation was lacking of resident refusal for shaving and/or having been shaved. A policy and procedure, undated, was provided by the Director of Nursing (DON) on 9/24/12 at 1:20 P.M. This policy was indicated to be current by the DON and was titled: "ADL (activities of daily living) care." This policy included, but was not limited to, the following: "...Female residents will also be observed for facial hair and trimmed accordingly..." On 9/24/12 at 2 P.M., the resident was observed in bed. At 11 A.M., the resident was observed to have a visitor in her room at the bedside. The resident was observed to continue to have the curly hair noted to her chin and jaw line as initially observed on 9/18/12 at 10:42 A.M. On 9/24/12 at 2:36 P.M., CNA #35 was interviewed. She indicated usually the female residents don't refuse being shaved as they prefer to be clean shaved. On 9/24/12 at 2:52 P.M., the DON (Director of Nursing) was made aware of the resident's continued facial hair growth. The DON then went to ask		***assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes 5 residents related to meeting of shaving needs. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the PI tool. ***The date the systemic changes will be completed:*** October 24, 2012	

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	the resident if she wanted to be shaved. On 9/24/12 at 3:03 P.M. the DON was interviewed. She indicated she went to talk to the resident about being shaved and when she got to the room, Resident #93 had already been shaved. The DON stated she asked the resident if she minded being shaved and the resident stated "no." 3.1-3(t)			

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure an individualized activity programming related to a resident's interests had been provided for 2 of 2 cognitive impaired residents who met the criteria for activity. Resident #21 and Resident #68 Findings include: **1. On** 9/19/12 at 12:50 P.M., Resident # 21's clinical record was reviewed. Her admission date was 7/7/10. Her diagnoses included but were not limited to: coronary artery disease, status post bypass graft, hypertension, dementia, and diabetes mellitus. Her current Minimum Data Set Assessment (MDS) Assessment dated 8/1/12, indicated a cognitive score of 1(severe cognitive impairment).	F0248	**F248** **It is the practice of Transcendent Healthcare of Boonville to assure individualized activity programming related to residents' interest is provided.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Residents #21 and #68 have been reviewed. There care plans have been updated to reflect individualized activities programming based on the residents' interest. ***Other residents that have the potential to be affected have been identified by:*** All resident activity plans of care have been reviewed to assure that residents are receiving activities based on their individual interest.	10/24/2012

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	Her current activity care plan was reviewed on 9/20/12 at 1:40 P.M. This activity care plan was initiated on 1/17/12 and included care plan updates of 4/30/12 , and 8/4/12. This care plan included but was not limited to a goal to attend bingo activity 2-3 times a week due to being a current interest of hers. Interventions included but were not limited to: invite and escort to group activities of interests, assist with playing bingo, seat near other resident's with similar interests, and provide 1:1's visits when Resident #21 declines group activity invites. On 9/21/12 at 11:45 A.M. Resident #21's activity participation logs for May, June, August, and September 2012, were reviewed with the Activity Coordinator. Her May activity log indicated Resident #21 attended 3 bingo activities , 12 sittercise activities, 2 music activities, and 5 other group activities that were not the above activities. Her June activity calendar indicated the resident was hospitalized from 6/15/12 thru 6/27/12. Her June participation calendar indicated attendance of 1 group activity on the first and second week of June and 3		***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The activity personnel will be in-serviced related to assuring that activity programming involves activities based on residents' individual interest and that the plan of care is reflective of the appropriate activities. The in-service also includes that if there is a change in the resident's condition that affects activity attendance, the plan of care is to be revised to assure that the resident's needs are met. Residents will continue to be encouraged to attend activities that are offered in a group setting. See systems for monitoring below. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to their activity involvement related to their	

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	group activities after return to the facility on the last week of June. The July activity participation calendar indicated the resident was hospitalized from July 1- 4 2012. The July activity participation calendar from return to the facility from 7/5/12 thru 7/31/12 was blank. The resident's August participation calendar was left blank for group activities except documentation of a Loa (leave of absence) on 7/29/12. Review of the September activity calendar indicated no group activities from the 1st thru the 12 th of September. Sittercise activity was documented on 9/13/12. Therapy was documented on 9/10/12, 9/11/12, and 9/12/12. Documentation of activity participation was lacking from 9/13/12- 9/20/12. 9/21/12 at 11:45 A.M., during interview with the Activity Coordinator she indicated the resident had been hospitalized and since return has therapy services. She indicated Resident #21 used to go to bingo activity frequently. She indicated Resident #21 at present had difficulty with numbers r/t the bingo activity. She indicated the resident can't do the bingo numbers like she used to. The Activity Coordinator indicated she had sat the resident at the table next		individual preferences. In addition, the tool will review the activity attendance log to assure that each resident is receiving adequate programming. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools. ***The date the systemic changes will be completed:*** October 24, 2012	

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	to her at bingo but still she felt the resident had been "frustrated" during the bingo activity. The Activity Coordinator indicated she had noticed a difference in Resident #21's activity participation and abilities since hospitalizations. She indicated she had not provided 1:1 activity visits as her care plan had indicated. She indicated the resident's family visited frequently even when the resident had been attending group activities in May 2012. She indicated at this time she needed to provide activities related to resident's current interests and that activity participation was lacking for this resident. 2. On 9/20/12 at 11:45 A.M., Resident # 68's clinical record was reviewed. His Minimum Data Set Assessment (MDS) dated 5/12/12, indicated a cognitive score of 4 (severe cognitive impairment). This MDS Assessment also indicated active diagnoses which included but was not limited to: diabetes mellitus, Alzheimer's disease, and dementia. On 9/20/12 at 11:45 A.M., Resident #68's current activity care plan was reviewed. This plan was initiated on 11/12/10 and last update date was 6/6/12. The goal was that resident will attend 1 group activity of choice			

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	per day. Interventions included but were not limited to: encourage resident to socialize outside room daily, provide resident with movies to watch in his room from bookmobile when they come as requested, and provide reading material as needed. On 9/20/12 at 11:45 A.M., during clinical record review the current activity note dated 5/12/12 was reviewed. This activity note indicated Resident # 68 was alert and oriented to his name. This documentation indicated the resident participated in group activities of his choice. Documentation indicated Resident #68 enjoys music and special events. This note also indicated he enjoys spending majority of time watching TV and visiting with his wife. Documentation indicated will continue to encourage socialization and activities to improve the resident's quality of life. **On 9/21/12 at 8:45 A.M., Resident #68's activity participation calendars and care plan were reviewed with the Activity Coordinator. She indicated at this time she considered Resident #68 in the category of lower cognition function. She indicated the resident will answer questions but**			

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	will not initiate conversation. The Activity Coordinator indicated resident can't answer what he would like to do if asked. She indicated he would answer "don't know." She indicated Resident #68 enjoys piano music and she has a volunteer who plays at the facility every Friday which Resident #68 had really enjoyed. She also indicated he enjoys watching TV and western movies. She indicated he also likes cars and she was looking for magazines related to cars. She indicated she doesn't know if Resident #68 can read at present but maybe he could look at pictures in a magazine. On 9/21/12 at 8:45 A.M., during interview with Activity Coordinator the July 2012 activity calendar indicated the resident had attended piano music on 7/13 and 7/20- Fridays, and sensory group on 7/6, and a pre meal group on 7/5/12. August 2012 activity calendar indicated Resident #68 attended piano music only on Fridays- 7/10, 7/17, 7/24, and 7/31/12. The September calendar thru 9/2012 had only the 9/7/12 piano music documented. On 9/21/12 at 8:45 A.M., the Activity			

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	Coordinator was made aware resident had only attended 4 activities the month of August. She indicated she agreed the resident needed more activity programming related to his interests. She indicated she had been thinking of small group activity for this resident also. She indicated she had not provided any movies from the bookmobile. She indicated Resident # 68 did watch TV in his room. She indicated she did not provide any TV programming related to his music or western movie interest at this time. 3.1-33(a)			

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F0257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation and interview, the facility failed to provide comfortable temperature levels in 1 of 2 dining rooms and in 3 of 4 randomly selected resident rooms on 1 of 2 units. Resident #99, Resident #98, Resident #100, Resident #101 Findings include: 1. During confidential resident and family interviews conducted on 9/17 and 18/2012, there were 3 of 18 Resident's interviewed and 1 of 3 family members interviewed that complained of the facility being too cold. Their comments included: Resident #100 indicated she had been cold since she had been here. She indicated she had told staff. She indicated she had arthritis and can't take too much cold. She indicated she had told all staff. Indicated she wears a sweater and a blanket over her lap. She indicated she did not know how to control the room temperature. Resident #99 indicated,"I freeze to death in the mornings. It is always cold in here,	F0257	**F257** **It is the practice of this facility to assure that facility temperatures are maintained at a level that is comfortable for the residents.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** The dining rooms and resident rooms identified in the 2567 are being maintained between 71 to 81 degrees. ***Other residents that have the potential to be affected have been identified by:*** All resident rooms have been and are routinely being monitored to assure that the temperature is being maintained between 71 to 81 degrees. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not***	10/24/2012

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	summer and winter." Resident #98 indicated, "It is cold in this building and the dining room is freezing." Family member of Resident #101 also indicated it had been cold in the main dining room the past 2 weeks. The family member indicated the resident's teeth had chattered and he was physically shaking in the dining room. The family member indicated she had got the resident a sweat shirt and had told staff. 2. On 9/24/12 between 8:20 A.M. and 8:45 A.M.,ambient room temperatures were measured on the East unit as follows: Room 23 68.2 F (Fahrenheit) Room 4 68.9 F Room 19 70 F The outdoor temperature on the same side of the building at that time was 72 F. The large Main dining room, located in the center of the East and West sides of the building, with a high vaulted ceiling, had a temperature of 67.8 F and was occupied by 10 residents at that time, all wearing sweat shirts, sweaters, and or lap robes. . 3. On 9/24/12 at 8:48 A.M., the		***recur include:*** The Director of Maintenance has been in-serviced related to the maintaining of appropriate temperatures throughout the facility. A log has been established that will document randomly selected areas for temperatures throughout the facility each week. If at any time a resident complains of being cold, the temperature will be rechecked to assure that appropriate parameters are being met. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 areas of the building for appropriate temperatures. The tool will also interview residents to assure that they have no complaints of being cold. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any areas	

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	facility Chief Maintenance Engineer was interviewed. He indicated there were 2 separate heating systems to service each of the East and West sides of the building. He indicated this season of the year was difficult to maintain comfortable temperatures since outdoor temperatures varied so greatly from day to day and from nighttime to daytime. He indicated his system of regulating temperatures was to turn up the heat when residents complained. He indicated a system of routine room temperature measurement with consideration of weather temperature forecasts was lacking however " I do have one lady (resident) down this hall who tells me when the temperatures are going down(outdoors) at night so I can adjust it." He indicated the building "heats up so fast that I turn the heat off when I come in first thing like I did this morning earlier" in anticipation of warming outdoor temperatures. On 9/24/12 at 9:00 A.M. the Chief Maintenance Engineer demonstrated his method of checking the Main dining room temperature. Since it had no thermometer or thermostat control dial, he located a temperature control dial which was in the attached small dining area to the West of the Main dining room. The ceiling of the small		identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** October 24, 2012	

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	dining room was normal height and not vaulted. It's control dial was on the wall near the ceiling at approximately 6 foot level. At his height, he indicated he was able to read it and it was "set right up there at 75" and was reading as set. The actual small dining room temperature at that time was measured by thermometer to be 71 F. The Chief Maintenance Engineer indicated he did not log any room temperatures for the facility. 3.1-19(h)			

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F0280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. A. Based on interview and record review the facility failed to ensure care plans were revised to reflect resident's current activity interests for 2 of 2 cognitive impaired residents who met the criteria for activity. Resident #21 and Resident #68 B. Based on interview and record review, the facility failed to ensure family members were invited to resident care conferences for 1 of 3 family interviews. Resident #21 Findings include:	F0280	**F280 It is the practice of Transcendent Healthcare of Boonville to assure that resident activity needs are met and the residents and their families are invited to participate in the care plan conference. *The correction action taken for those residents found to be affected by the deficient practice include:*** Residents #21 and #68 have been reviewed. There care plans have been updated to reflect individualized activities programming based on the residents' interest. A care plan conference has been scheduled for resident #21 and the family has been invited. It should be	10/24/2012

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	A.1. On 9/19/12 at 12:50 P.M., Resident # 21's clinical record was reviewed. Her admission date was 7/7/10. Her diagnoses included but were not limited to: coronary artery disease, status post bypass graft, hypertension, dementia, and diabetes mellitus. Her current Minimum Data Set Assessment (MDS) Assessment dated 8/1/12, indicated a cognitive score of 1 (severe cognitive impairment). **Her current activity care plan was reviewed on 9/20/12 at 1:40 P.M. This activity care plan was initiated on 1/17/12 and included care plan updates of 4/30/12 , and 8/4/12. This care plan included but was not limited to a goal to attend bingo activity 2-3 times a week due to being a current interest of hers. Interventions included but were not limited to: invite and escort to group activities of interests, assist with playing bingo, seat near other resident's with similar interests, and provide 1:1's visits when Resident #21 declines group activity invites. The care plan had updates of 4/30/12 and 8/4/12, but no change in goals or interventions were documented.**		noted that the family is in the facility daily and actively involved with the interdisciplinary team related to this resident's care. ***Other residents that have the potential to be affected have been identified by:*** All resident activity plans of care have been reviewed to assure that residents are receiving activities based on their individual interest. All residents and their families will be invited to participate in any upcoming care plan conferences. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The activity personnel will be in-serviced related to assuring that activity programming involves activities based on residents' individual interest and that the plan of care is reflective of the appropriate activities. The in-service also includes that if there is a change in the resident's condition that affects activity attendance, the plan of care is to be revised to assure that the resident's needs are met. Residents will continue to be encouraged to attend activities that are offered in a group setting. See systems for monitoring below. The interdisciplinary team will be in-serviced related to assuring that residents and their families are invited to participate in the care plan conferences. The Director of Social Services will	

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	On 9/21/12 at 11:45 A.M. Resident #21's activity participation logs for May, June, August, and September 2012, were reviewed with the Activity Coordinator. Her May activity log indicated Resident #21 attended 3 bingo activities , 12 sittercise activities, 2 music activities, and 5 other group activities that were not the above activities. Her June activity calendar indicated the resident was hospitalized from 6/15/12 thru 6/27/12. Her June participation calendar indicated attendance of 1 group activity on the first and second week of June and 3 group activities after return to the facility on the last week of June. The July activity participation calendar indicated the resident was hospitalized from July 1- 4 2012. The July activity participation calendar from return to the facility from 7/5/12 thru 7/31/12 was blank. The resident's August participation calendar was left blank for group activities except documentation of a Loa (leave of absence) on 7/29/12. Review of the September activity calendar indicated no group activities from the 1st thru the 12 th of September. Sittercise activity was documented on 9/13/12. Therapy was documented on 9/10/12, 9/11/12,		schedule the conferences and assure that residents and their families are invited to attend with documentation to support the invitation. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to their activity involvement related to their individual preferences. In addition, the tool will review the activity attendance log to assure that each resident is receiving adequate programming. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools. A Performance Improvement Tool has also been initiated related to inviting residents/families to care plan conference. This tool will be utilized to randomly review 5 residents' care conferences to assure that there is documentation to assure that residents and families were invited to the conference. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified will be	

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	and 9/12/12. Documentation of activity participation was lacking from 9/13/12- 9/20/12. On 9/21/12 at 11:45 A.M., during interview with the Activity Coordinator she indicated the resident had been hospitalized and since return has therapy services. She indicated Resident #21 used to go to bingo activity frequently. She indicated Resident #21 at present had difficulty with numbers r/t the bingo activity. She indicated the resident can't do the bingo numbers like she used to. The Activity Coordinator indicated she had sat the resident at the table next to her at bingo but still she felt the resident had been "frustrated" during the bingo activity. The Activity Coordinator indicated she had noticed a difference in Resident #21's activity participation and abilities since hospitalizations. She indicated she had not provided 1:1 activity visits as her care plan had indicated. On 9/21/12 at 11:45 A.M., the Activity Coordinator was made that Resident #21's current care plan had not been revised since the change in the resident's activity participation and interests. She indicated a this time she agreed the care plan had not been changed to reflect the resident's		immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting with recommendations as needed. ***The date the systemic changes will be completed:*** October 24, 2012	

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	current status. A. 2. On 9/20/12 at 11:45 A.M., Resident # 68's clinical record was reviewed. His Minimum Data Set Assessment (MDS) Assessment dated 5/12/12, indicated a cognitive score of 4 (severe cognitive impairment). This MDS Assessment also indicated active diagnoses which included but was not limited to: diabetes mellitus, Alzheimer's disease, and dementia. On 9/20/12 at 11:45 A.M., Resident #68's current activity care plan was reviewed. This plan was initiated on 11/12/10 and last update date was 6/6/12. Documentation was lacking that the goal or interventions of the care plan had been changed since initiation of the care plan on 11/12/10. The goal was that resident will attend 1 group activity of choice per day. Interventions included but were not limited to: encourage resident to socialize outside room daily, provide resident with movies to watch in his room from bookmobile when they come as requested, and provide reading material as needed. **On 9/21/12 at 8:45 A.M., Resident**			

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	#68's activity participation calendars and care plan were reviewed with the Activity Coordinator. She indicated at this time she considered Resident #68 in the category of lower cognition function. She indicated the resident will answer questions but will not initiate conversation. The Activity Coordinator indicated resident can't answer what he would like to do if asked. She indicated he would answer "don't know." She indicated Resident #68 enjoys piano music and she has a volunteer who plays at the facility every Friday which Resident #68 had really enjoyed. She also indicated he enjoys watching TV and western movies. She indicated he also likes cars and she was looking for magazines related to cars. She indicated she doesn't know if Resident #68 can read at present but maybe he could look at pictures in a magazine. On 9/21/12 at 8:45 A.M., during interview with Activity Coordinator the July 2012 activity calendar indicated the resident had attended piano music on 7/13 and 7/20- Fridays, and sensory group on 7/6, and a pre meal group on 7/5/12. August 2012 activity			

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	calendar indicated Resident #68 attended piano music only on Fridays- 7/10, 7/17, 7/24, and 7/31/12. The September calendar thru 9/2012 had only the 9/7/12 piano music documented. On 9/21/12 at 8:45 A.M., the Activity Coordinator was made aware Resident #68's activity goal of participation in 1 group activity per day had not been met the months of July, August, and September 2012. She was also made aware the care plan intervention of providing movies from the bookmobile and reading material was not being implemented. The Activity Coordinator indicated at this time that she agreed the care plan had not been changed to provide activity programming related to the resident's current interests and abilities. B.1. On 9/17/12 at 11:34 A.M., during family interview of Resident #21, family members indicated they had not been invited to a resident care conference for a "long time." They indicated maybe once in 2 years. On 9/21/12 at 1:00 P.M., the Social Service Director (SSD) was interviewed regarding invitations of			

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	family members to resident care conferences. She indicated she does the scheduling for the resident care conferences. She indicated sometimes she documents the family was invited and sometimes she doesn't. At this time the SSD, indicated she could not find documentation of family notification of resident care conference since January 2012 resident care conference where the family had participated. **3.1-35(a)**			

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F0323 SS=D	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. A. Based on observation and interview, the facility failed to ensure call lights in resident rooms and bathrooms were maintained to be reliably functional for 5 of 40 residents reviewed during the Stage 1 sample of 40 residents on 2 of 3 units in the facility. Room 25, Room 27 (1 bathroom shared by these two rooms), Room 28 and Room 27 (shared a bathroom)(all these are on the locked unit) and Room 6 (on the east unit) (single occupancy bathroom). B. Based on observation, interviews and record review, the facility failed to ensure Hoyer lift slings were safe and in good repair for the 2 residents reviewed, with the potential to impact 4 additional residents who required the use of Hoyer Lifts slings. Resident #44, Resident #16 Findings include: A.1. On 9/17/12 at 11 A.M., the call	F0323	**F323** **It is the practice of this facility to assure that the all residents reside in an environment that remains free of accident hazards as is possible.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident rooms 25, 27, 28, and 6 (and their perspective bathrooms) have had call lights reviewed and they are working appropriately. Residents #44 and #16 have the Hoyer lift slings replaced. ***Other residents that have the potential to be affected have been identified by:*** All resident rooms have been reviewed to assure that the call lights are working properly.	10/24/2012

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	lights on the Alzheimer's Unit were observed. The bathroom call light (of the bathroom that is shared by resident rooms #25 and #27) when activated, did sound but did not light up over the outside of the door in the hall, allowing staff to visually determine which call light was activated. The call light in the bathroom of in Room 28 was observed at this time. The call light was placed on the same wall as the back of the toilet. The call light was observed to be a rectangular tab on the wall that was to be activated by pulling a string. The tab was 1/2 the size of a standard light switch tab. When the call light string was pulled, the call light did not activate. The string was difficult to pull and did not trigger the tab to activate the light. The call light string was adhered to the wall approximately 12 inches below the level of the tab. When the call light tab was manually moved with a fingernail, the call light did light up over the door in the hall and did sound. At 11:30 A.M., a resident was observed ambulating into this bathroom independently and exited. In resident room 26, both call lights at the bed side were activated, they had sounded but had not lit up over the door in the hall. At the nurses station, a control panel had been observed on the wall behind the desk. When these call lights had been activated, the light for room 26 had not lit up at the nurses station panel. At this time, it was not possible to tell which call lights had been activated by looking at the control panel at the nurse's station and/or looking down the hall at the lights over the doors. In the bathroom of this resident room, when the		All residents that utilize a Hoyer lift for transfers have had the slings replaced. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The checking of call lights is now part of the preventive maintenance plan with documentation to show what lights have been checked and what the results are. All call lights throughout the building will be checked a minimum of monthly to assure that they are functioning properly and easily activated. The Maintenance Director has been in-serviced related to the checking of the call lights. All staff has been in-serviced that if they identify a call light not working properly that they are to notify maintenance immediately so that it can be corrected. All of the previous Hoyer lift slings have been replaced with a sling that is appropriate. Nursing has been in-serviced related to	

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	bathroom call light string is attempted to be pulled, the tab on the wall doesn't move at all. When the tab is manually moved, the call light doesn't light up and there is no sound. On 9/17/12 at 3:54 P.M., the Administrator was made aware of the above problems with the call lights in rooms 26, 25, 28 and 27. The Administrator directly observed the concerns with the call light in rooms 26 and 28. The Administrator indicated he understood the concern with the call lights. On 9/18/12 at 7:30 A.M., the bathroom call light in room #6 was activated. The light over the resident door in the hallway, did not light up. The control panel down the hall at the nurses station did not identify which call light in the hall had been activated. At this time, LPN #33 was interviewed. She indicated to identify which call light was on, she would look down the hall, to the lights over the doors. The call light over the door of room #6 was not lite up but was sounding. Approximately 1 minute after the call light was activated (and not lit up over the door), the light over the door randomly began blinking. At 7:40 A.M., the DON was made aware of the above observations. On 9/18/12 at 8:15 A.M., the Administrator, DON (Director of Nursing) and Maintenance Supervisor (MS) were in resident room #6. The MS went into the room and pulled the call light in the bathroom and it did light up over the door in the hallway. At this time, they were made aware the call light in this bathroom had just been activated approximately 45 minutes earlier and was observed to sound but not to light up in the hall over the door. The MS indicated he didn't know why the call lights didn't always work.		the new slings. Both nursing staff and laundry staff have been in-serviced related to assuring that the DNS is contacted if it is identified that the sling starts to fray or that the manufacturer's tag is unreadable so it can be replaced. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated will review proper functioning of call lights. The tool will randomly review 5 resident rooms/bathrooms to assure that the call light system is functioning properly. The Administrator, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the	

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	On 9/19/12 at 12:30 P.M., the MS (maintenance supervisor) was interviewed. He indicated if a call light isn't working, staff log it down at the nurses station and he picks up the slips, from the log, at the nurses station. He stated he just checks the logs and goes and then repairs the broken call lights but sometimes they have to call (name of repair company). The MS stated the facility got hit by lightening about 4 years ago and they have had some call lights entirely replaced. He stated that some of the pull call lights were hard to activate by pulling the string and so he took the surrounding plates off and applied WD 40 and now they work just fine. Stated he goes through the facility and does room checks and checks the call lights every 3 - 4 months. The MS stated he doesn't document when he does these room checks or specifically what he checks in each room. Stated he did the room checks just last week. The MM stated he checked every call light in the building. The MS stated he has been made aware of the unreliability of the call lights. At this time, the MS was made aware of the problem on the locked unit when the call light from a room is pushed and the light over the door doesn't light up and then the light at the nursing station didn't light either. The MS indicated he fixed that problem and it was a problem with the wire. The MS indicated he doesn't document when he does all these room checks, including the call light function. The MS indicated he doesn't have a written policy regarding what each room check includes. On 9/24/12 at 2:40 P.M. the Administrator was interviewed. He indicated he didn't think there was a policy and procedure regarding		outcome of the audit. A PI tool has been established that observes up to 5 Hoyer Lift slings to assure they are appropriate and in good working condition. The Director of Nursing, or designee, is responsible for completion of the tool. This tool will be completed monthly x3 then quarterly x3. Laundry will be observing the slings on an on-going basis to assure they remain in good working order and the tag remains readable. Slings that are frayed or have unreadable manufacturer tags will be replaced. The quality assurance committee will review the PI tools at the regularly scheduled meetings with additional recommendations if there is any negative outcome on the PI tools. ***The date the systemic changes will be completed:*** October 24, 2012	

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	monitoring the functional status of resident call lights. The Administrator indicated the maintenance man stated he checked the call lights in the rooms but wasn't sure if checks the call lights in the bathrooms were. The Administrator stated he was going to formulate a more detailed log for the maintenance man to use when he checks the call lights. The Administrator indicated he thought the resident call lights were checked quarterly but now they would be done much more frequently than that. B.1. On 9/24/12 at 9:48 A.M., during observation an Arjo 4 point Sling with gray attachment clips was being used for the transferring of resident #44. The sling was laid open in the wheelchair seat. The gray clips attached to the sling were missing the 2 inserts that assist retention of the clip when fitted to a spreader bar. During an interview with LPN 12 on 9/24/12 at 9:50 A.M., she indicated the staff used the Hoyer Sling Lift everyday to assist Resident 44 with all transfers. During an observation on 9/24/12 A.M. at 12:30 P.M., Resident #44 was seen sitting in the restorative dining room, in a wheelchair in which the Arjo 4 Point Sling was located underneath the resident and ready for			

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	use. Review of the Medication Record on 9/24/12 at 11:30 P.M. indicated that the Hoyer Lift should be used for all transfers. All three shifts had signed they were using the Hoyer Lifts. Observation on 9/24/12 at 10:30 AM. indicated that a Hoyer Lift sling storage closet, next to the West hall nurses station, stored a worn, blue lift sling with gray clips bearing a faded Arjo manufacturers' label. The gray clips attached to the sling were missing the 2 inserts that assist retention of the clip when fitted to a spreader bar. Review of Clinical Record on 9/24/12 at 9:30 A.M. indicated that Resident #16 was on contact isolation for a MRSA infection. Located in the room was a Hoyer Lift Sling that was used for the resident's transfers. The worn, stained and tattered canvas sling had been torn and repaired on one side and the manufacturers' label with the maintenance instruction was faded and unreadable. A physician order for Resident #16 dated 7/27/12, was reviewed on 9/24/12 at 10:35 A.M., and it read as follows,"Mechanical lift for all			

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	transfers." During an interview with LPN 12 on 9/24/12 at 9:52 A.M., LPN indicated that the resident only gets out of bed every 2 to 3 days, and that the staff uses the Hoyer Lift each time they get the resident out of bed. During an interview with the Director of Nursing on 9/24/12 at 3:00 P.M., the DON indicated that she was unaware there had been a recall on all the Arjo Slings with gray clips. The DON indicated she had placed an order for the replacement slings and they were to arrive the next day. 3.1-19(a) 3.1-19(b)			

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview the facility failed to ensure proper temperature ranges for storage of drugs and biologicals on 1	F0431	**F431** **It is the practice of this facility to assure that residents' medications are stored appropriately at proper temperature ranges for the**	10/24/2012

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	of 2 units. East Unit Findings include: On the East unit on 9/24/12 at 10:50 A.M. the medication room refrigerator storage for drugs and biologicals registered 20 F (Fahrenheit degrees). The refrigerator was observed to contain drugs and biologicals requiring specific temperature storage ranges according to labeling and enclosed manufacturer directions reviewed at that time. The items were each labeled store 36 F-46 F and/or "DO NOT FREEZE." These liquid items were not frozen solid but had increased thickness from usual appearance. The liquids became thinner and more usual appearing with handling, outside the refrigerator. The items included: Lantus insulin 3 vials 36 F-46 F Lorazepam Liquid 2 bottles 36 F-46 F Engerix vitamin B 1 vial labeled DO NOT FREEZE Pneumovax vaccine 1 vial 36 F-46 F Purified Protein Derivative Tuberculosis testing 3 vials 36 F-46 F The refrigerator also stored a locked Emergency Drug Kit which contained liquid Lorazepam, and several types of insulin (Humulin, Lantus, Novolog).		**medications.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** The East Unit Medication Refrigerator is now at appropriate temperature for the storage of medications. ***Other residents that have the potential to be affected have been identified by:*** All Medication Refrigerators throughout the building have been reviewed and are at the appropriate temperature for the storage of medications. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses and QMAs have been in-serviced related to the appropriate temperatures of the medication refrigerators. In addition, new thermometers, if needed, have been purchased to assure an accurate reading. Nursing Administration will observed the temperature readings on the medication refrigerators as they make daily rounds. ***The corrective action taken to monitor performance to assure***	

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	The kit had 2 blue labels on it with dark black lettering DO NOT FREEZE. There was a posted daily temperature log for the month of September. On 21 of the first 24 days of September the refrigerator temperatures were documented to have been below freezing at 32 F. On those days the temperatures ranged from 21 F to 31 F. On 14 of the 21 days freezing temperatures were logged at 28 F or below. The Director of Nursing was interviewed on 9/24/12 at 11:30 A.M. regarding the findings which she had also observed. She indicated staff were in need of inservicing about required temperature ranges in relation to the logged values. She indicated the drugs and biologicals listed above would be discarded according to pharmacy recommendations. 3.1-25(m)		***compliance through quality assurance is:*** A Performance Improvement tool has been established that reviews the medication refrigerators in the facility. This tool will review the actual thermometer reading at the time of review as well as review the documented temperature logs to assure that documented temperatures are within the acceptable range. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** October 24, 2012	

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F0441 SS=D	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441		10/24/2012

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	ensure infection control practices to prevent the transmission of contagious infection during a dressing change for 1 of 1 dressing changes observed. Resident #16 Findings include: On 9/19/12 at 10:52 A.M., resident #16's clinical record was reviewed. Diagnoses included, but were not limited to: paraplegic, MRSA (Methicillin Resistant Staff Aureus) cultured from the Stage 2 pressure ulcer on the sacrum, and supra pubic catheter. During an observation of a dressing change on 9/20/12 at 10:05 A.M., of Resident 16's pressure ulcers located on the sacrum, LPN 13 was observed assisting with the dressing change. LPN 12 was changing the dressing. LPN 13 was observed wearing a gown and gloves, standing on the right side of the bed. LPN 13 had rolled Resident 16 on her right side to expose the buttocks for the dressing change. LPN 13 had her left gloved hand on Resident 16's left shoulder and her right gloved hand on Residents 16's left hip and buttock.		**F441** **It is the practice of Transcendent Healthcare of Boonville to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #16 now receives services related to dressing changes within acceptable parameters of infection control ***Other residents that have the potential to be affected have been identified by:*** All residents with any type of treatment changes are receiving those services within acceptable parameters of infection control. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted for nurses related to proper infection control	

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	While LPN 12 was changing the dressing on the 2nd pressure ulcer located on Resident 16's left buttock, LPN 13's right gloved hand slipped down over both of the Resident 16's buttocks, exposing the gloved hand to Resident 16's skin on the inter gluteal fold. After the dressing change was completed and Resident 16 was rolled on her back, LPN 12 then took a 4 X 4 sterile gauze pad and tried to place it around the insertion site of Resident 16's supra pubic catheter. At that time, LPN 13 reached out and took the same 4 x 4 gauze pad from LPN 12 and placed it around the insertion site of the catheter , using the same gloved right hand that just minutes before came into contact with Resident 16's inter gluteal fold on Resident 16's buttocks. LPN 13 then helped LPN 12 roll up the dirty lift sheet, which was soiled with a brown unknown substance. LPN 13 then assisted LPN 12 placing the new lift sheet beneath Resident 16, and LPN 13 proceeded to pull the sheet and covers over Resident 16. LPN 13 fluffed the pillows under Resident 16's head. At this point, LPN 13 removed her gloves and went into the bathroom to wash her hands.		practices. The in-service addresses proper hand washing and proper changing of gloves. The facility will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes 5 resident treatment changes (if applicable) related to following of proper infection control procedures during the provision of services. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with	

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	The facility's Policy and Procedure for wound care was reviewed on 9/24/12 at 2:45 P.M. The Policy and Procedure included, but was not limited to, the following procedures: "...wash and dry your hands...put on gloves...apply treatments...discard disposable items...discard soiled laundry...remove disposable gloves and discard into designated container. Wash and dry hands thoroughly. Reposition the bed covers. Make the resident comfortable..." During an interview on 9/24/12 at 4:00 P.M., the DON indicated she would schedule an inservice on dressing changes. 3.1-18(l)		recommendations for new interventions as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** October 24, 2012	

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F0497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.			
	Based on record review and interview, the facility failed adequate ongoing Dementia specific training for 22 of 22 staff reviewed for required dementia training who had been employed for over 12 months. Findings include: On 9/24/12 at 2:30 P.M., the inservicing of staff members, having regular contact with residents and employed more than one year, were reviewed for Dementia training. Documentation of any dementia training for 22 of 22 staff reviewed was lacking. On 9/24/12 at 3:00 P.M., the Director of Nursing was interviewed regarding	F0497	**F497** **It is the practice of Transcendent Healthcare of Boonville to assure that on-going dementia training occurs in accordance with the regulations** ***The correction action taken for those residents found to be affected by the deficient practice include:*** There were no specific residents identified. Please see below for systems implemented ***Other residents that have the potential to be affected have been identified by:*** Since potentially any of the	10/24/2012

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	inservicing. She indicated she was aware of staff, having contact with residents, being required to have 3 hours of specific dementia training annually and it was the facility policy to require that. She indicated she had begun training all new hires since she assumed her position on 7/9/12 and provided documentation for those 3 employees. She indicated she did not know if training had been provided for anyone prior to her assuming her position since there was virtually no documentation available from the prior staff who had been responsible to ensure it was given. 3.1-14(u)		residents with dementia could potentially be affected, staff training has occurred related to the dementia. Please see below for systems implemented. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff has been reviewed related to dementia training. Any staff members that lack documentation of dementia training have had the appropriate training provided in accordance with the regulation. A schedule which covers the next 12 months has been implemented that includes the required in-servicing for dementia training. Individual staff tracking has been implemented which will identify the hours attended for the dementia training. The Director of Nursing is responsible for assuring that required dementia training is provided for the staff. All department heads have been	

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			in-serviced related to requirements for dementia training. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes 5 staff members in-service attendance records to assure that the employee has attended the required dementia training in the appropriate time frames in accordance with the regulations. The Director of Nursing, or designee, will complete these tools monthly x3 then quarterly x3. Any issues identified will be immediately corrected with additional dementia training provided as needed. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the review of the PI tools. ***The date the systemic changes will be completed:***	

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			October 24, 2012	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to ensure clinical records were complete for 1 of 1 hospice residents reviewed and/or 2 of 3 residents reviewed who met the criteria for ADLs (Activities of Daily Living). The facility also failed to document the daily removal and daily skin assessment for areas in contact with a leg brace for 1 of 3 residents reviewed for pressure rulers. Resident #16, Resident #5, Resident #21, Resident #68 Findings include: 1. On 9/21/12 at 9:32 A.M., the clinical record of Resident # 16 was reviewed. Diagnoses included, but	F0514	**F514** **It is the practice of Transcendent Healthcare of Boonville to assure that clinical records are complete and documented accurately** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #16 has had the TAR updated to show an assessment of the skin under the brace. Resident #5 Hospice Notes are present in the chart for the month of September 2012 and for the week of July 15, 2012.	10/24/2012

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	were not limited to, the following: paraplegic, diabetic, depression, anemia, hypokalemia. Review of the Physician's Orders dated 7/27/12, indicated, "Immobilizer to right lower extremity at all times for uncontrollable muscle spasms. Remove daily for skin care." Review of the Physician's orders dated 9/11/12 indicated, "Patient to wear brace at night, may have off some during the day." Interview of LPN 12 on 9/21/12 at 11:43 A.M. indicated the resident had been admitted to the facility wearing the leg brace and that he had a pressure area where the brace rubbed against the skin, but it had healed. LPN 12 said, "The brace can be off for a short period of time, but they don't take it off much because the leg draws up and it is painful to put it back on." Interview with LPN 12 on 9/22/12 at 10:50 A.M. indicated she removed Resident #16's leg brace every day and assessed the skin under the leg brace, but she stated she did not document the assessment anywhere on the record.		Resident #21 documentation of showers will be accurately documented by the CNAs. Resident #68 documentation of showers will be accurately documented by the CNAs, ***Other residents that have the potential to be affected have been identified by:*** All residents with braces have been identified and have had documentation of skin assessment added to their treatment record. All residents that receive hospice services have been reviewed to assure that documented is complete and present in the medical record. All residents have been reviewed related to proper documentation of showers. The CNAs will be documenting the showers appropriately in the medical record ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted for nurses related to assessing skin with	

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	Review of the clinical record on 9/24/12 at 10:45 A.M. indicated documentation was lacking to verify the brace was being removed daily and that skin assessment was completed daily. Interview with the Director of Nursing on 9/24/12 at 3:00 P.M. indicated that the DON reviewed the clinical record and was unable to find where the skin assessment was documented. The DON indicated that she personally completed a weekly skin assessment, but a daily skin assessment by the staff was not documented in the clinical record. The DON indicated she could see where the staff documented daily observations that the leg brace was in place, but not where the staff completed a skin assessment under the brace .The DON said, "They should be assessing that every shift."		documentation for any resident that utilizes a brace. The documentation will occur on the Treatment Record as evidence of the assessment. All Hospice Agencies that service this facility have been contacted related to documentation requirements on the medical record. All expressed understanding and would assure that their staff was aware of the presence of the clinical documentation. Please refer to the systems for monitoring related to Hospice clinical notes. Nursing staff has been in-serviced related to assuring accurate documentation of resident showers. The CNAs are responsible for assuring accurate documentation is present related to the showers that they have provided on their designated shifts. The charge nurses are responsible for assuring that any scheduled showers are provided and documented appropriately on their designated shifts. ***The corrective action taken to***	

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			monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents (if applicable) with braces for documentation of skin assessments, 5 residents (if applicable) on hospice service for clinical records, and 5 residents related to proper documentation of showers. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** October 24, 2012	
	2. On 9/24/12 at 10 A.M. the clinical record of Resident #5 was reviewed. A physician order indicated the resident			

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	became a hospice patient on 6/22/12. Diagnosis included but were not limited to: Adult failure to thrive. Review of the nurse notes indicated the following dates nurses notes were documented in the clinical record: 7/5/12, 7/9/12 , 7/24/12, 8/3/12, 8/8/12, 8/22/12 and 8/29/12. Current review of the Hospice chart nursing notes indicated documentation was lacking for the entire month of September 2012 as well as the week of 7/15/12. At this time, review of the clinical Hospice record indicated on the "(name of hospice) Sign in Sheet the RN signed in on the following dates: 8/15/12 (first date on the sheet), 8/22/12, 8/29/12, 9/5/12, 9/12/12 and 9/19/12. At this time, the content of each nursing note was reviewed. Each nursing note included the following information: vital signs, cardiopulmonary, mental neurological, musculoskeletal, pain rating scale, aide supervisory visit, summary, plan of care, spiritual/cultural, genitourinary, endocrine, gastrointestinal, skin, nutritional, vascular and psychosocial information.			

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	On 9/24/12 at 10:12 A.M., the DON (Director of Nursing) was interviewed. She indicated the resident is to be seen by the hospice nurse one to two times a week. After she reviewed the current Hospice chart, she indicated she didn't see any nurses notes for September 2012 and the week of 7/16/12. At this time, she called the Hospice office and spoke to Hospice Staff Member (HSM) #1. HSM #1 verified the resident is seen by the Hospice RN 1 - 2 times a week. At this time, the DON made the HSM #1 aware documentation was lacking on the current clinical record of the nurse visit notes for 7/12/12 , 7/18/12 and 8/15/12. At this time, the DON made the HSM #1 aware the last documented nurses note on the resident's clinical record was 8/29/12. The HSM #1 indicated she reviewed Resident #5's Hospice record and did not see any documentation of the resident having had a missed visit. HSM #1 indicated documentation was lacking of any of Resident #5's visits in their processing file and the Hospice office did not have any September 2012 documentation for Resident #5. HSM #1 indicated Resident #5's nurse is off today and that the RN probably has her			

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	September 2012 documentation for Resident #5 in her folder, which is with the nurse. On 9/2412 at 11 A.M., the DON was interviewed. She indicated she had spoken to the HSM #1 who indicated there is a turn around time for paperwork . On 9/24/12 at 11:30 A.M., the DON provided a copy of a fax received from (name of hospice). This fax included, but was not limited to, the following: "...nurses doc (document) on paper and are expected to leave at the end of every visit..." On 9/24/12 at 1:20 P.M., the DON provided a copy of the facility policy and procedure for "Hospice Program." This policy was dated October 2010 and was included, but not limited to, the following: "...the hospice and facility will communicate with each other when any changes are indicated or made to the plan of care. Hospice will keep a separate folder with all pertinent documentation within the facility..." 3.. On 9/20/12 at 9:20 A.M., Resident #21's treatment records for August and September 2012, in regard to baths and showers were reviewed. These treatment			

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	records were completed by CNAs. Instructions for the bath section indicated to document a S for shower, a B for bed bath, and a R for refusal. Instructions also included if pt (patient) refuses to offer again later. The August 2012 treatment record for Resident #21 indicated a S for documentation of a shower on the 18 th and the 21st evening shift this month. One bed bath was documented on the 4th on the evening shift. Fifteen blanks were documented and the rest were documented as partials the rest of the month. The September 2012 treatment record (thru 9/21/12) for Resident #21 indicated a S for documentation of a shower on the evening shifts the 8, 11th, 15th, and the 20th. Bed baths were documented 7 times and 11 blanks were left. Partials were documented the rest of the shifts. On 9/24/12 at 1:44 P.M., the Director of Nursing (DON) was interviewed regarding documentation of showers provided on the treatment sheet of the clinical record. She indicated at this time that the CNAs also documented on a sheet entitled Body Diagram Tool. She indicated this sheet was used for			

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	documentation of skin areas by the CNAs during showers. The DON indicated this was a way to ensure new CNAs were providing showers. She also indicated she kept this shower/skin sheet in a file in her office (not a part of the medical record). On 9/24/12 at 3:35 P.M., the DON provided Resident # 21's Body Diagram Tool sheets for August and September 2012. The dates of these sheets were 8/14, 8/18,8/21, 8/25, 8/28, 9/1,9/4, 9/8, 9/11,9/15, and 9/18/12. The DON was made aware at this time the treatment record documenting showers were incomplete when compared to the Body Diagram Tool the CNAs were using to provide skin assessments during shower. The DON provided no further information. 4. Resident #68's clinical record was reviewed on 9/20/12 at 10:15 A.M. His August and September 2012 treatment records including bath and shower records were reviewed. CNAs completed the documentation of these treatment sheets. Instructions for the bath section indicated to document a S for shower, a B for bed bath, and a R for refusal. Instructions also included if pt (patient) refuses to offer again later.			

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	The August 2012 treatment record indicated documentation of a S for shower on evenings of the 13th and the 19th. Fourteen blanks were left and partials were documented for the rest of the shifts. Resident #68's September 2012 treatment record thru 9/21/12 indicated documentation of a S for a shower on the 3rd, the 6th, and the 10th of this month. Thirty one blanks were left and the rest of the shifts were documented as partial baths. On 9/24/12 at 3:35 P.M., the DON provided Resident # 68's Body Diagram Tool sheets for August and September 2012. The dates of these sheets were 8/16/12, 8/20, 8/24, 8/30, 9/7, 9/10, 9/13, 9/17, 9/20, and 9/24/12. The DON was made aware at this time the treatment record documenting showers were incomplete when compared to the Body Diagram Tool the CNAs were using to provide skin assessments during shower. The DON provided no further information. 3.1-50(a)(1)			

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	3.1-50(a)(2)			