

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN 47720
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaints IN00147830 and IN00147096.</p> <p>Complaints Numbers: IN00147830 Substantiated. Federal/state deficiencies related to the allegations are cited at F314 IN00147096 Substantiated. Federal/state deficiencies related to the allegations are cited at F272</p> <p>Survey dates: May 7, 8, 13, 14, 15, 2014</p> <p>Facility number: 000442 Provider number: 155621 AIM number: 100266510</p> <p>Survey team: Anna Villain, RN TC Barbara Fowler, RN Diana Perry, RN Denise Schwandner, RN Diane Hancock, RN May 7, 8, 13, 14, 2014</p> <p>Census bed type: SNF: 39 SNF/NF: 48 Total: 87</p>	F000000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the validity of the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility requests that this plan of correction be considered as its allegation of compliance, and represents that the corrections of the cited deficiencies have been completed.	

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

TITLE

(X6) DATE

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

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F000272 SS=D	<p>Census Payor Type: Medicare: 11 Medicaid: 32 Other: 44 Total: 87</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 19, 2014 by Jodi Meyer, 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; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;</p>			

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	<p>Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information 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 record review and interview, the facility failed to ensure 1 of 3 residents reviewed for behaviors in a sample of 3 who met the criteria, were correctly assessed on the MDS (Minimum Data Set) assessment. (Resident #51)</p> <p>Findings include:</p> <p>During a closed clinical record review on 5/13/14 at 11:57 a.m., Resident #51 was documented to have numerous behaviors.</p> <p>The quarterly MDS assessment, dated 3/14/14, indicated Resident #51 had no behaviors exhibited.</p> <p>During an interview on 5/14/15 at 8:45 a.m., the SW (Social Worker) indicated Resident #51 had been discharged to another facility. The SW indicated Resident #51 had been having increased behaviors and had been sent to the</p>	F000272	<p>What corrective action(s) have been (or will be) accomplished for those residents found to have been affected by the deficient practice? The problem noted on the MDS assessment for Resident #51 was corrected on May 15, 2014 by the Director of Social Services. Further, Resident #51 no longer resides at the facility. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A facility-wide audit was completed by the Director of Social Services on May 19th & 20th, 2014. The audit included a review of MDS Assessments (i.e., Sections D, E and Q) for accuracy; a review of progress notes for behaviors and/or refusals; a review of each resident's Medication Administration Record, with specific focus on the presence of psychotropic medications; and a review of all Nursing Summaries. No other residents were found to</p>	05/20/2014			

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	<p>behavioral unit at a hospital in February, 2014, in an attempt to help the resident with the behaviors. The SW indicated the hospitalization and medication adjustment had not helped with Resident #51's behaviors.</p> <p>During an interview with the MDS Coordinator on 5/14/14 at 2:07 p.m., the MDS Coordinator indicated the SW (Social Worker) enters the behavior portion of the MDS assessment.</p> <p>During an interview on 5/14/14 at 3:05 p.m., the SW indicated she had not entered the correct data for Resident #51's behaviors for the MDS assessment. The SW indicated she would enter a correction immediately.</p> <p>During an interview with the SW on 5/15/15 at 8:12 a.m., the SW indicated she had made the necessary revisions to Resident #51's MDS assessment.</p> <p>This Federal Tag relates to Complaint Number IN00147096.</p> <p>3.1-31(c)(1)</p>		<p>have been affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An audit "check list" (see Attachment F-272B) has been developed and implemented which the Social Services Director will complete on each resident in accordance with the MDS schedule. The Social Service Director was in-service done May 15, 2014 by the MDS Coordinator regarding Supportive Documentation Guidelines and use of the RAI manual as well as the proper utilization and completion of the check list. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Performance Improvement (PI) tool (see Attachment F-272A) will be utilized by the MDS Coordinator to review five (5) different residents each week for four (4) weeks, and five (5) different residents each month for a period of one year. For a period of at least one year, the results from the PI tool will be reviewed in the weekly meetings of the facility's Interdisciplinary Team, which in turn will submit its findings to the facility's Quality Assurance Committee for its quarterly review and recommendations. Date of</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 1 of 3 residents reviewed for weight loss, in the sample of 10 who met the criteria, received supplements as ordered by the physician, in that the physician's orders were not indicated on the medication administration record and there was no indication they were provided for 3 weeks after admission. (Resident #66)</p> <p>Finding includes:</p> <p>Resident #66's clinical record was reviewed on 5/13/14 at 9:24 a.m. The resident was admitted to the facility on 4/2/14 with diagnoses including, but not limited to, pneumonia, dysphagia, muscle weakness, history of fall, hypoxemia, congestive heart failure, essential hypertension, and osteoarthritis.</p> <p>The admission orders from 4/2/14 indicated a regular diet was ordered. A mechanical soft no added salt diet was ordered on 4/7/14.</p>	F000282	<p>Compliance: May 20,2014</p> <p>What corrective action(s) have been (or will be) accomplished for those residents found to have been affected by the deficient practice? With regard to Resident #66, the physician orders were reviewed on May 15, 2014 and compared to the then-current Medication Administration Record to ensure accuracy and compliance. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A facility-wide audit was conducted on May 20, 2014 by Director of Nursing and the Dietary Manager to determine whether any other residents may have been affected by the alleged deficient practice. No other residents were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? In-services were conducted on May 27 through June 8, 2014 with all nurses regarding the facility's</p>	06/08/2014			

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	<p>Admission orders from 4/2/14 included orders for a house supplement 60 cc (cubic centimeters) po (by mouth) twice a day. A telephone order dated 4/3/14 also indicated a house supplement 60 cc was to be given by mouth twice a day. A telephone order dated 4/8/14 indicated house shakes were to be added three times a day with meals. On 5/8/14, an order was added for "Orange supplement drink daily."</p> <p>Review of the April, 2014 medication administration record (MAR) indicated house shakes three times a day with meals were started on 4/24/14. The house supplement 60 cc twice daily was not included on the April, 2014 MAR and there was no documentation it was ever provided.</p> <p>The May, 2014 MAR was reviewed on 5/13/14 at 3:30 p.m. The house supplement 60 cc twice daily was included on the May MAR with an order date of 4/4/14. The orange supplement was documented as starting on 5/8/14. The house shakes three times a day were not on the May, 2014 MAR.</p> <p>A care plan dated 4/9/14, was for potential altered nutrition related to: therapeutic, mechanically altered diet.</p>		<p>policies on Nutritional Risk Supplementation, as well as Physicians Orders and Documentation including monthly re-writes and transcription. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?</p> <p>A Performance Improvement (PI) tool (see Attachment F-282A) will be utilized by the Director of Nursing or Designee to review each resident's Medical Record including the Medication Administration Record [MAR] to ensure that physician orders are being accurately and completely followed. Another Performance Improvement (PI) tool (see Attachment F-282B) will be utilized by Health Information Manager or Designee to evaluate staff documentation regarding the intake (or refusal) of residents with physician orders for dietary supplements as recommended by the consulting Dietician. The Director of Nursing will provide the HIM a weekly Dietician Report with recommended changes. This PI tool will be used to review five (5) residents each week for four (4) weeks and five(5) different residents each month for a period of one year. For a period of at least one year, results from these PI tools will be reviewed in the weekly meeting of the facility's Interdisciplinary Team, which in turn will submit its findings to the</p>				

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	<p>Interventions included, but were not limited to, the following: Offer replacements if less than 75% of meal is consumed No added salt diet Provide nutrition supplement as ordered - mighty shakes 4/9/14 Provide orange supplement daily 5/9/14 Provide selective menu</p> <p>Resident weights included, but were not limited to, the following: 4/8/14 190 4/12/14 186 4/18/14 183 4/21/14 182 4/28/14 186 5/1/14 175 5/4/14 177</p> <p>The resident was also being treated for congestive heart failure with diuretics, which would account for some of the weight loss. The physician saw the resident on 4/16/14 and documented the significant weight loss was due to fluid and the resident continued to have crackles (audible sounds) in the lungs and swelling.</p> <p>Nurses' notes dated 4/20/14 at 1:55 p.m. indicated the resident was admitted with severe acute congestive heart failure and had increases in diuretic therapy and</p>		<p>facility's Quality Assurance Committee for its quarterly review and recommendations. Date of Compliance: June 8,2014</p>	

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F000314 SS=G	<p>weight loss was due to losing fluid.</p> <p>The Stocker I Unit Manager was interviewed on 5/13/14 at 3:30 p.m. She indicated the house shakes came out with meals and were usually included on the MAR and documented there and must have been missed on the May MAR. She was unsure why no ordered supplements were included on the April, 2014 MAR prior to 4/24/14. She indicated she would check with medical records to see if a page was missing. No further documentation was provided as of 5/14/14 at 4:30 p.m.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent</p>				

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	<p>infection and prevent new sores from developing.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 4 residents reviewed for pressure ulcers received the necessary treatment and services to prevent pressure ulcers, in that the resident received pressure areas on the buttocks from prolonged time on a bed pan. (Resident #29)</p> <p>Finding includes:</p> <p>Resident #29's clinical record was reviewed on 5/13/14 at 11:10 a.m. The resident was admitted to the facility on 3/21/14 with diagnoses including, but not limited to, edema of both legs, deep vein thrombosis, back pain, arthritis, seizures, osteoporosis, gout, chronic kidney disease, lumbar spinal stenosis, hypertension, cervical disc displacement, cancer of breast, blood transfusion, temporal arteritis, thoracic compression fracture, rheumatoid arthritis, and atrial fibrillation.</p> <p>A pressure ulcer risk assessment, dated 3/30/14, indicated the resident had a score of 17. A score of 8 or above indicated high risk for skin breakdown.</p> <p>Resident #29 was readmitted to the hospital on 3/22/14 due to inability to</p>	F000314	<p>What corrective action(s) have been (or will be) accomplished for those residents found to have been affected by the deficient practice? Resident #29 did not return to the facility following her transfer to the hospital on April 8, 2014. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A facility-wide audit was completed on May 21,-23, 2014 to determine whether other residents had experienced alterations in skin integrity without having appropriate documentation entered into their Medical Records and/or without having received appropriate treatment. No other residents were found to have been affected by the alleged deficient practices. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All nurses were in-serviced on May 15 - June 8, 2014 regarding Pressure Ulcer Prevention, Management and Documentation, Altered Skin Integrity Policy and Procedure, Bruises, Skin Tears, Skin Integrity Checks Policy and Procedures, as well as the facility's Bed Pan</p>	06/08/2014

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	<p>manage her pain, and remained hospitalized until 3/30/14. The Nurses' Admission Record from that date indicated she had a bruise on her left hip and right hip and a red area on the right hip. The resident had received kyphoplasty of thoracic vertebrae during the hospital stay and was to wear a brace when up in a chair.</p> <p>The resident's admission care plan (no date) indicated a risk for pressure sores and indicated she was to be encouraged to turn every 2 hours and as needed.</p> <p>Nurses' notes dated 4/7/14 at 9:46 a.m. indicated the resident experienced increased lethargy and confusion, decreased complaints of pain, physician notification and requests for laboratory tests at that time.</p> <p>The resident was transferred to the hospital on 4/8/14 at 10:22 a.m. The transfer record indicated the diagnoses at time of transfer as "[decreased] hgb [hemoglobin] 6.8." The resident required total assistance with activities of daily living and transfers. The transfer record section titled "Presence of Decubitus" indicated the resident had a "skin tear (L) [left] outer lower leg."</p> <p>The hospital records were reviewed on</p>		<p>Policy. All nursing assistants were in-serviced on May 15 – June 8, 2104 regarding Pressure Ulcer Prevention, Bed Pan Policy, Skin Checks, and Reporting Altered Skin Integrity. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>A mechanism has been incorporated within the facility's "Point Click Care" system of medical records which will identify all residents utilizing bed pans. This list of residents will be used to identify residents for review utilizing a Performance Improvement (PI) tool (see Attachment F-314). A random review of residents will be completed for those who use bedpans. The review will include a review for altered skin integrity, preventative skin measures and adherence to the facility's Bed Pan Policy. The PI tool will be utilized by the Director of Nursing or Designee to review five (5) residents each week for four weeks, and five (5) different residents each month for a period of one year. For a period of at least one year, results from the PI tool will be reviewed in the weekly meetings of the facility's Interdisciplinary Team, which will in turn submit its findings to the facility's Quality Assurance Committee for its quarterly review and recommendations. Date of</p>		

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	<p>5/14/14 at 8:35 a.m. The hospital history and physical, dated 4/8/14, indicated "skin excoriated in perineal area and red mark like from being on bed pan in lower back/gluteal area..."</p> <p>Hospital wound documentation, dated 4/8/14 at 6:19 p.m., indicated the following wounds: -Shear, right hip, abrasion to right hip. -Abrasion, right buttocks, open area and redness on right buttocks.</p> <p>Copies of pictures, obtained from the hospital risk manager on 5/14/14 at 8:40 a.m., indicated the following: The resident was positioned on the left side. The resident's bilateral buttocks were dark pink. A reddened curved 1-2 inch wide line was observed curving from the upper right buttock to the upper right thigh. Three to four areas appeared open along the line. The upper left thigh also had a line of redness. According to the hospital risk manager, the pictures were taken on 4/10/14.</p> <p>CNA #1 was interviewed on 5/14/14 at 11:00 a.m. She indicated the resident required total care, "we had to do everything for her." She indicated the resident was incontinent at times and wore incontinence briefs. She indicated the resident occasionally would tell them</p>		Compliance: June 8,2014	

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	<p>she had to go and they could use the bed pan. She indicated she had cared for the resident on 4/8/14 prior to her being sent to the hospital and the resident had not been placed on the bed pan during that morning. She thought there had been a problem with the bed pan the day before the resident went to the hospital. CNA #1 was interviewed again on 5/14/14 at 1:20 p.m. She indicated she had seen the resident's skin on 4/8/14 prior to the transfer to the hospital and there had been a large red ring on the buttocks; it looked like she had sat on the bed pan too long.</p> <p>The Director of Nurses (DoN) and the Administrator were interviewed on 5/14/14 11:15 a.m. The DoN indicated the night shift nurse had reported to him on the morning of 4/8/14 the resident had redness on her bottom and her condition had declined. He indicated he had interviewed the day shift nurse, LPN #1, that morning and she had told him there was a reddened area on the resident's bottom, but the skin was intact and nothing was mentioned about it looking like the rim of a bed pan. The resident was in the process of being transferred to the hospital and he did not have the opportunity to assess the area.</p> <p>The Administrator indicated they had</p>			

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	<p>interviewed a CNA from the night before and the CNA had denied the resident had been on the bed pan. The facility had investigated by interviewing nurses and CNAs who cared for the resident and no one would admit seeing the resident on the bed pan or knowing the resident had been on the bed pan. The night shift nurse had indicated to the Administrator she had noticed redness, but had not documented anything, and no one had indicated to her the redness appeared to be from a bed pan. The DoN indicated he found out about the concern over the resident potentially being left on the bed pan when hospital records were reviewed. The Administrator indicated she terminated three nurses and one CNA because she couldn't get a straight story. She indicated staff had been inserviced to leave the call light on if they put someone on the bed pan, so it would remind them to check on the resident and take them off.</p> <p>A Bed Pan Policy, dated 4/2014, was provided by the DoN on 5/14/14 at 3:51 p.m. The policy included, but was not limited to, the following: "Stay with resident in area, but give privacy and dignity @ all times. If you have to leave resident while on bed pan. Turn on call light until resident's need is met & resident is off bed pan."</p>			

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	<p>Inservice records, dated 4/11/14, indicated nursing staff were inserviced on the revised and updated policy.</p> <p>A Pressure Ulcer Prevention and Management policy and procedure was provided by the DoN on 5/14/14 at 3:52 p.m. Definitions on the policy included, but were not limited to, the following: "Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Stage I Pressure Ulcer - An observable pressure-related alteration of intact skin whose indicators as compared to the adjacent or opposite area of the body may include changes in one or more of the following: -Skin temperature (warmth/coolness) -Tissue consistency (firm/boggy) -Sensation (pain/itching) and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues. Stage II Pressure Ulcer - Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater." "If a resident is triggered at risk on the Pressure Ulcer Risk Assessment,</p>			

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F000441 SS=D	<p>preventive measures must be identified, implemented and recorded..."</p> <p>This Federal Tag relates to Complaint Number IN00147830.</p> <p>3.1-40(a)(1)</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> <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>			

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper handwashing procedures were performed on 2 of 5 residents observed receiving personal hygiene. (Resident #72, Resident #113)</p> <p>Findings include:</p> <p>1. During an observation on 5/14/14 at 8:43 a.m., Resident #72 was observed to be assisted to the commode. CNA (certified nursing assistant) #2 wore gloves. After Resident #71 had completed voiding, CNA #2 washed the resident's perianal area with soap and water, rinsed, and dried the area. CNA #2 removed her gloves and, without</p>	F000441	<p>What corrective action(s) have been (or will be) accomplished for those residents found to have been affected by the deficient practice? Resident #71 and Resident #113 were evaluated on May 15, 2014 for signs and symptoms of infection related to the alleged deficient practice. No such signs and/or symptoms were detected at that time. Residents are being cared for by competent and knowledgeable staff. The nursing assistant identified as CNA #2 has received one-to-one follow-up training on proper glove use and hand washing procedures. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All</p>	06/14/2014			

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	<p>performing any hand hygiene, assisted pulling up Resident #71's briefs and pants. CNA #2 assisted with transferring Resident #71 into the wheelchair. CNA #3 placed the bagged dirty laundry in a receptacle in the hall. CNA #2 proceeded to push the resident out of the bathroom and into her room. CNA #2 then performed hand hygiene.</p> <p>2. During an observation on 5/14/14 at 9:54 a.m., Resident #113 was observed to be receiving a shower. During the shower, CNA #2 was observed to change gloves during the shower with no evidence of hand hygiene being performed. After the shower, CNA #2 was observed to dry, apply lotion, and dress Resident #113 without changing gloves or performing hand hygiene.</p> <p>During an interview on 5/14/14 at 3:15 p.m., the ADoN (Assistant Director of Nursing) indicated handwashing and glove use were monitored frequently.</p> <p>During an interview on 5/15/14 at 9:44 a.m., CNA #3 indicated hand hygiene should be performed whenever gloves are removed and when the CNA goes from a dirty area to a clean area when giving care.</p> <p>A policy titled, "Handwashing," revised</p>		<p>facility residents have the <i>potential</i> to be affected by the alleged deficient practice. With regard to corrective actions taken, please see below. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All nursing, laundry and housekeeping staff members were in-serviced on May 27 - June 14, 2014 regarding proper Hand Washing procedures, as well as the proper Handling of Clean Linen and Soiled Linens. A Performance Improvement (PI) tool (see Attachment F-441) will be utilized to monitor adherence to the above stated policies and procedures. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The PI tool will be utilized by the Director of Nursing or Designee to observe the care of five (5) residents each week for four (4) weeks, and five (5) different residents each month for a period of one year. For a period of at least one year, results from the PI tool will be reviewed in the weekly meetings of the facility's Interdisciplinary Team, which in turn will submit its findings to the facility's Quality Assurance Committee for its quarterly review and recommendations. Date of Compliance: June 14, 2014</p>				

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F000465 SS=E	<p>on 2/2013, and obtained from the DoN (Director of Nursing) on 5/14/14 at 4:20 p.m., indicated handwashing is to be performed before and after each resident contact.</p> <p>3.1-18(l)</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, interview, and record review, the facility failed to ensure a safe, functional, and sanitary environment, in that, caulking was cracked, tile was cracked, built up dirt and debris was present, yellow stains on the walls, and brown substance was present at the base of the commode for 8 of 31 rooms reviewed during Stage 1. (Room #103, 202, 310, 308, 306, 313, 204, 207)</p> <p>Finding includes:</p> <p>1. On 5/7/14 at 11:46 a.m., Room #103</p>	F000465	<p>What corrective action(s) have been (or will be) accomplished for those residents found to have been affected by the alleged deficient practice? All alleged physical plant deficiencies identified in rooms numbers 103, 202, 204, 207, 306, 308, 310, and 313 will be addressed and corrected by appropriate actions (e.g., cleaning, repair, or replacement) no later than June 14, 2014 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A facility- audit was conducted on May 16, 2014</p>	06/14/2014

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	<p>was observed with a missing floor tile. On 5/14/14 at 3:01 p.m., the same was observed.</p> <p>2. On 5/7/14 at 2:12 p.m., Room #202 was observed with dirt and debris built up in the corners and edges of the floor and yellow colored streaks down the bathroom walls beside the sink. On 5/14/14 at 2:54 p.m., the same was observed.</p> <p>3. On 5/7/14 at 2:47 p.m., Room #310 was observed with cracked caulking behind the bathroom sink. On 5/14/14 at 3:42 p.m., the same was observed.</p> <p>4. On 5/7/14 at 3:13 p.m., Room #308 was observed with a brown substance at the base of the commode and cracked caulking behind the bathroom sink. On 5/14/14 at 3:44 p.m., the same was observed.</p> <p>5. On 5/7/14 at 3:32 p.m., Room #306 was observed with cracked caulking behind the bathroom sink, bathroom tiles cracked outside of the shower, and the bathroom walls were chipped with paint. On 5/14/14 at 3:46 p.m., the same was observed.</p> <p>6. On 5/7/14 at 3:57 p.m., Room #313 was observed with cracked caulking</p>		<p>to identify additional areas that might be affected by the alleged deficient practices. Other areas of concern so identified will also be appropriately addressed no later than June 14, 2014. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? Housekeeping and maintenance staff members were in-serviced on May 30, 2014 regarding the appropriate use of the existing Maintenance Request Form, and with respect to the facility's obligation to provide a safe, functional, sanitary and comfortable environment for residents, residents' families, facility staff and the general public in relation to the alleged deficiencies. How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur, ie., what quality assurance program will be put into place? A Performance Improvement (PI) tool (see Attachment F-465) will be utilized by the Administrator or Designee to review all rooms throughout the facility on a monthly basis for a period of one year. For a period of at least one year, results from the PI tool will be reviewed in the weekly meetings of the facility's Interdisciplinary Team, which in turn will submit its findings to the facility's Quality Assurance Committee for its quarterly review</p>				

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	<p>behind the bathroom sink, chipped paint in the bathroom, and scuffed bedroom walls. On 5/14/14 at 3:40 p.m., the same was observed.</p> <p>7. On 5/8/14 at 8:48 a.m., Room #204 was observed with chipped paint on the heating unit. On 5/14/14 at 2:57 p.m., the same was observed.</p> <p>8. On 5/8/14 at 9:11 a.m., Room #207 was observed with a brown substance present at the base of the commode. On 5/14/14 at 251 p.m., Room #207 was observed with a brown substance at the base of the commode and a cracked bathroom tile.</p> <p>On 5/15/14 at 8:36 a.m., the HS (Housekeeping Supervisor) was interviewed. The HS indicated housekeeping staff has a daily check list for cleaning. The HS further indicated rooms are deep cleaned on a rotating scheduled one per day, which included but was not limited to, cleaning the cove base, walls behind the commode, and the commodes.</p> <p>The "Housekeeping Policy and Procedure" provided by the Administrator at 10:33 a.m., was reviewed. The policy indicated, "all</p>		and recommendations. Date Compliance: June 14,2014	

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	horizontal surfaces...will be cleaned daily". 3.1-19(f)				