

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155444	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2012
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NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 N NORWOOD RD HUNTINGTON, IN 46750
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 7, 8, 9, 10, 13 and 14, 2012</p> <p>Facility number: 000463 Provider number: 155444 AIM number: 100290910</p> <p>Survey team: Shelley Reed, RN-TC Julie Call, RN Virginia Terveer, RN Linn Mackey, RN (August 7, 8, 9, 10 and 13, 2012)</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 7 Medicaid: 37 Other: 19 Total: 63</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/23/12 by Suzanne Williams, RN</p>	F0000	<p>F000 This plan of correction is the facility's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider to the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

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

TITLE

(X6) DATE

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

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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation, interview and record review, the facility failed to display in a prominent place the information on how to apply for Medicare and Medicaid, failed to display a statement that the resident may file a complaint with the state survey agency and failed to display the most recent 1-800 number for the state survey agency complaint line, which could potentially affect 63 of 63 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. On 8-10-2012 at 9:28 a.m., the Residents Rights were observed posted outside the activity room which included information on Medicare and Medicaid. There was not a prominent display on how to apply for Medicare and Medicaid posted on any of the</p>	F0156	<p>F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility shall inform residents of their rights, rules, services and charges at the time of admission and periodically during their stay. How corrective action will be accomplished for those residents potentially affected by the alleged deficient practice. The facility had prominently displayed a Resident's Rights Poster as well as advocacy phone numbers. A posting has been added, prominently displaying "How to file a complaint" [ISDH] and "Medicaid and Medicare" which provides direction on how to apply and receive information on how to apply, use benefits and receive refunds. This has also been added to the admission packet. How the facility will identify other residents that have the potential to be affected by the same</p>	09/05/2012

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	<p>the facility walls.</p> <p>An interview with the Administrator on 8-10-2012 at 9:35 a.m., indicated there is information located within the Resident Rights poster on Medicare and Medicaid but not how to apply for Medicare and Medicaid. The Administrator indicated there was not a separate display on how to apply for Medicare and Medicaid posted on the facility walls in a prominent place.</p> <p>2. During observation on 8-10-2012 at 9:28 a.m., there was not a statement displayed that the resident may file a complaint with the state survey agency with the direct complaint phone number for the Indiana State Department of Health. This statement and phone number was not observed on the advocacy group contact information or in any other posting located in the facility.</p> <p>3. An interview with the Resident Council President on 8-13-2012 at 4:45 p.m., indicated the Resident Council President was not sure how to contact the state for a complaint.</p> <p>In a review of the latest MDS (Minimum Data Set) assessment, the Resident Council President had a BIMS (Brief Interview Mental Status)</p>		<p>alleged deficient practice. On 9/4/12, the Activity Director will review this information and where these postings are with Resident Council. This information will continue to be shared on a monthly basis. What measures will be put into place or systemic changes will the facility make to ensure the alleged deficient practice does not recur. Resident interviews will be conducted weekly to review their understanding of their rights and the location of related contact information. How the facility plans to monitor compliance. The Administrator will ensure each action is completed and will continue to provide monthly reports to the QA committee [monthly] x 6 months or until compliance is established.</p>		

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	<p>score of 15/15 as of 5-23-2012. (The BIMS score indicated orientation to person, place and time and good memory skills.)</p> <p>A review of the Resident Policies, Rules and Regulations, received on 8-9-2012 at 1:45 p.m. from the DON (Director of Nursing), indicated the on page 3, #12 of the Resident's Rights Policies and Procedures Introduction, "...You have the right to file a complaint with the State Survey and Certification Agency..." but did not indicate how to contact the agency or where to look for the information.</p> <p>3.1-4(l) 3.1-4(j)(2) 3.1-4(j)(3)(A)</p>			

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F0159 SS=E	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on observation, interview and record review, the facility failed to provide access to resident personal funds 7 days a week for 5 of 5 residents reviewed for personal funds (Residents #124, 5, 12, 86, and 93).</p> <p>Findings include:</p> <p>An interview with Resident #124 on 8/8/12 at 9:28 a.m. indicated residents cannot get money out of their personal fund account on the weekend. It is only available Monday through Friday.</p> <p>An interview with Resident #12 on 8/7/12 at 3:43 p.m., indicated they cannot get money on the weekend.</p> <p>An interview, with Resident # 86 on 8/7/12 at 11:52 p.m. indicated they cannot get money on the weekend.</p> <p>An interview, with Resident # 93 on 8/8/12 at 11:11 a.m. indicated they can only get money out of their</p>	F0159	F159 FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for personal funds of the resident deposited with the facility. How corrective actions will be accomplished for those residents potentially affected by the alleged deficient practice. The facility properly maintains resident trust funds and provides access on a normal banking hour schedule, these hours are posted. Effective 9/4/12, the facility shall modify this posting to include availability on Saturday and Sunday. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice. The availability of resident trust funds 7 days per week will be reviewed at the 9/4/12 Resident Council Meeting. What measures will be put into place or systemic changes will the facility make to ensure the alleged deficient practice does not recur. Resident interviews, all interviewable residents, will conducted at least every 14 days for the first 30 days	09/05/2012

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	<p>account when the Business Office Manager is in.</p> <p>An interview with Resident #5 on 8/7/12 at 2:55 p.m. indicated they can only get money out of their account during the week, not on the weekend.</p> <p>During an observation on 8/8/12 at 12:00 p.m., a sign was noted next to the receptionist desk that indicated banking hours were 8:00 a.m. to 4:30 p.m. Monday through Friday.</p> <p>During an interview with the Administrator on 8/13/12 at 11:30 a.m., he indicated there was not a policy for availability of funds, and residents were informed on admission the hours funds are available.</p> <p>Review of personal fund accounts indicated Residents #124, 5, 12, 86, and 93 had personal funds accounts with the facility.</p> <p>3.1-6(f)(1)</p>		<p>and then monthly to ensure residents are aware of their rights and the 7 day a week banking hours. How the facility plans to monitor compliance. The Administrator shall monitor and forward compliance information to the QA Committee [monthly] x 6 months or until compliance is established.</p>		

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F0172 SS=C	<p>483.10(j)(1)&amp;(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS</p> <p>The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the</p>			

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	<p>resident's right to deny or withdraw consent at any time.</p> <p>Based on interview and record review, the facility failed to ensure residents were knowledgeable of their State Ombudsman, for 3 of 3 residents interviewed, with a potential to affect all of the residents. (Resident #13, #34, #80)</p> <p>Findings include:</p> <p>Interview on 8/13/12 at 4:45 p.m. with Resident Council President #80 indicated she had not heard the term "Ombudsman." She indicated she did not know who the Ombudsman was or what they did.</p> <p>Interview on 8/14/12 at 10:30 a.m. with Resident #13 indicated she did not know about an Ombudsman or what an Ombudsman was for.</p> <p>Interview on 8/14/12 at 10:50 a.m. with Resident #34 indicated she did not know anything about an Ombudsman or what an Ombudsman was for.</p> <p>Review on 8/13/12 at 11:00 a.m. of monthly Resident Council Minutes, from August 2011 through August 2012, indicated there was no indication of any discussions about</p>	F0172	<p>F172 RIGHT TO/FACILITYPROVISION OF VISITOR ACCESS The resident has the right and the facility must provide immediate access to any resident by the State long term care ombudsman. How corrective action will be accomplished for those residents potentially affected by the alleged deficient practice. The facility shall ensure that residents have been notified and are knowledgeable on who the Ombudsman is and the services they provide. How the facility will identify other residents that have the potential to be affected by the alleged deficient practice. The facility shall make every effort to have each alert resident remember who the ombudsman is and the services they offer. What measures will be put into place or systemic changes will the facility make to ensure the alleged deficient practice does not recur. The Social Worker shall place postings around the facility with this information. On 9/4/2012 the facility has requested that the Ombudsman attend the Resident Council meeting. Each month for the next three months and intermittantly thereafter the Social Worker shall ensure that the Resident Council is reminded of who the Ombudsman is and the services they offer. This shall include how to contact them. How</p>	09/05/2012

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	<p>who the State Ombudsman was or what the Ombudsman did for the residents.</p> <p>3.1-8(b)(4)</p>		<p>the facility plans to monitor compliance. The Social Worker shall monitor and report progress to the Quality Assurance Committee [monthly] x 6 months or until compliance is satisfied.</p>	

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F0176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview, and record review, the facility failed to assess the ability of a resident to self administer medications, for 1 of 1 resident reviewed for self administration of medication. (Resident # 98)</p> <p>Findings include:</p> <p>Resident # 93's record was reviewed on 8/10/12 at 10:30 a.m.</p> <p>Resident # 93's current diagnoses included, but were not limited to, stage 3 lung cancer squamous cell with metastasis to spine, chronic obstructive pulmonary disease, atrial fibrillation, and osteoporosis. Review of the section of the chart, titled assessment, indicated there was not an assessment for the self administration of medication. Review of the doctor's orders indicated there was not an order for the resident to self administer medication. A signed doctor order, dated 6/12/12, indicated an order for Albuterol 0.083% inhalation solution,</p>	F0176	F176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe. How corrective actions will be accomplished for those residents potentially affected by the alleged deficient practice. The resident has had a medication self administration assessment placed in the chart indicating resident may self administer medication. A physician order for medication self administration has been added to the resident record. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice. Residents who self administer nebulizer treatments have the potential to be affected by the alleged deficient practice. Audits of resident's charts who self administer nebulizer treatments will be completed to ensure appropriate assessment and physician order for self administration are in the resident record by 9/5/2012. What measures will be put into place or systemic changes will the facility make to ensure the alleged	09/05/2012			

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	<p>inhale 3 ml by nebulizer 4 times a day (breathing treatment).</p> <p>During an observation on 8/10/12 at 8:30 a.m., Resident # 93 was observed in her room taking a breathing treatment. There was not a nurse in the room during the observation. The resident was walking around the room while using the nebulizer.</p> <p>An interview on 8/10/12 at 8:30 a.m. with Resident # 93 indicated she was taking a breathing treatment to help her breathe better.</p> <p>During an interview on 8/13/12 at 10:00 a.m. with the Director of Nursing, she indicated there was not an assessment on Resident #93's chart for self administration of medication.</p> <p>Review of a current facility policy, titled Self -Administration of Medication, received from the DON (Director of Nursing) on 8/13/12 at 10:15 a.m., indicated it is the policy of the facility to allow residents to self administer if the facility IDT (Interdisciplinary Team) has determined the resident is capable of doing so in a safe manner. A licensed nurse will complete the self</p>		<p>deficient practice does not recur. Licensed Nurses will be re-educated by the Director of Nursing on facility policy for self administration of medication by 9/5/2012. How the facility plans to monitor compliance. The Director of Nursing will audit records of residents who self administer nebulizer treatments weekly x 4, monthly x 4 and quarterly thereafter or substantial compliance is achieved, for assessment and physician order. Compliance issues will be reported to the Quality Management Committee [monthly] x 6 months for problem analysis, action planning, and additional monitoring needs as indicated.</p>		

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	<p>administration form, and the form will be forwarded to the DON, who will review it with the IDT. If the IDT approves the self administration, the resident's doctor will be contacted for approval.</p> <p>3.1-11(a)</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F0225	F225 INVESTIGATE/REPORT	09/05/2012			

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	<p>review, the facility failed to ensure an allegation of abuse was immediately reported to the Administrator and investigated, for 1 of 6 residents reviewed for abuse, of 6 who met the criteria for abuse. (Resident #124)</p> <p>Findings include:</p> <p>Resident #124's record was reviewed on 8/9/12 at 12:10 p.m.</p> <p>Resident #124's current diagnoses included, but were not limited to, left hip subcapital fracture with combination to greater trochanter (left hip fracture). The current MDS (minimum data set) assessment indicated a BIMS (brief interview of mental status) score of 15. A score of 13 to 15 indicates that a resident is cognitively intact.</p> <p>During an interview on 8/8/12 at 9:10 a.m., Resident #124 indicated when staff were pulling her up in bed, LPN #1 dropped her side of the lift sheet and the resident was dropped to the bed. The LPN #1 then laughed. CNA #2 was in the room assisting with pulling the resident up in bed. The resident indicated it caused her a lot of pain in her left leg and was upset that the nurse laughed when she dropped her. The resident indicated</p>		<p>ALLEGATION/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective</p>				

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	<p>she had told Social Services about this incident.</p> <p>An interview with Social Services on 8/8/12 at 1:00 p.m., indicated when a resident has a complaint, those concerns are listed on a grievances complaint form. Social Services also indicated that she was filling in for the normal social services employee, who was on vacation, and did not know about this incident involving Resident #124.</p> <p>An interview on 8/8/12 at 3:00 p.m. with the Administrator indicated he was not aware of any incidents similar to the one described above involving Resident #124.</p> <p>During an interview on 8/10/12 at 3:30 p.m., with CNA #2 (certified nursing assistant), she indicated the incident did occur as stated above. CNA # 2 was present during the above incident. The CNA did not report this occurrence.</p> <p>Review of a current facility policy titled "Abuse Prevention, Intervention, Investigation and Crime Reporting Policy," received from the Director of Nursing on 8/13/12 at 10:15 a.m., indicated it is the responsibility of all employees to immediately report to</p>		<p>action must be taken. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. This resident no longer resides in the facility. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice and what corrective action will be taken. Residents who have new hip fractures requiring lifting in bed have the potential to be affected by the alleged deficient practice, with none identified. What measures will be put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Re-education on facility policy regarding abuse prevention, intervention, investigation, and reporting will be provided by the Administrator by 9/5/2012. Non-compliance with the facility policy on reporting abuse may result in disciplinary action, up to and including termination. How the facility plans to monitor compliance. The Administrator, the Social Service Director, and the Director of Nursing, will promote and maintain an open door policy for concerns. Weekly rounds will be made by the Administrator or designee to check with residents who have had hip fractures, 5 minimum, for reports of</p>				

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	the facility Administrator as soon as possible.  3.1-28(c)		concerns. Reported concerns will be documented on a grievance form and investigated by the administrator. Compliance issues will be reported to the Quality Management Committee [monthly] x 6 months for problem analysis, action planning, and additional monitoring needs as indicated.		

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure its abuse prevention policy and procedure was implemented, in that an allegation of abuse was not immediately reported and investigated, for 1 of 6 residents reviewed for abuse, of 6 who met the criteria for abuse (Resident#124).</p> <p>Findings include:</p> <p>Resident #124's record was reviewed on 8/9/12 at 12:10 p.m.</p> <p>Resident #124's current diagnoses included, but were not limited to, left hip subcapital fracture with combination to greater trochanter (left hip fracture).</p> <p>The current MDS (minimum data set) assessment indicated a BIMS (brief interview of mental status) score of 15. A score of 13 to 15 indicates that a resident is cognitively intact.</p> <p>During an interview on 8/8/12 at 9:10 a.m., Resident #124 indicated when</p>	F0226	<p>F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. The resident no longer resides at the facility. How the facility will identify other residents that have the same potential to be affected by the same alleged deficient practice and what corrective action will be taken. Residents who have new hip fractures have the potential to be affected by the alleged deficient practice. No other resident has been identified as affected by the alleged deficient practice. What measures will be put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Re-education on facility policy regarding abuse prevention, intervention, investigation, and reporting will be</p>	09/05/2012

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	<p>staff were pulling her up in bed, LPN #1 dropped her side of the lift sheet and the resident was dropped to the bed. The LPN #1 then laughed. CNA #2 was in the room assisting with pulling the resident up in bed. The resident indicated it caused her a lot of pain in her left leg and was upset that the nurse laughed when she dropped her. The resident indicated she had told Social Services about this incident.</p> <p>An interview with Social Services on 8/8/12 at 1:00 p.m., indicated when a resident has a complaint, those concerns are listed on a grievances complaint form. Social Services also indicated that she was filling in for the normal social services employee, who was on vacation, and did not know about this incident involving Resident #124.</p> <p>An interview on 8/8/12 at 3:00 p.m. with the Administrator indicated he was not aware of any incidents similar to the one described above involving Resident #124.</p> <p>During an interview on 8/10/12 at 3:30 p.m., with CNA #2 (certified nursing assistant), she indicated the incident did occur as stated above. CNA # 2 was present during the</p>		<p>provided by the Administrator by 9/5/2012. Non-compliance with the facility policy on reporting abuse may result in disciplinary action, up to and including termination. How the facility plans to monitor compliance. The Administrator, the Social Service Director, and the Director of Nursing, will promote and maintain an open door policy for concerns. Weekly rounds will be made by the Administrator or designee to check with residents who have had hip fractures, minimum of 5, for reports of concerns. Reported concerns will be documented on a grievance form and investigated by the administrator and reported as required by law. Compliance will be monitored by the QA Committee [monthly] x 6 months.</p>		

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	<p>above incident. The CNA did not report this occurrence.</p> <p>Review of a current facility policy titled "Abuse Prevention, Intervention, Investigation and Crime Reporting Policy," received from the Director of Nursing on 8/13/12 at 10:15 a.m., indicated it is the responsibility of all employees to immediately report to the facility Administrator as soon as possible.</p> <p>3.1-28(a)</p>			

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F0242 SS=G	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview, observation and record review, the facility failed to ensure a resident's choices regarding a shower were honored, resulting in the resident becoming embarrassed and tearful, for 1 of 6 residents reviewed in a sample of 6 who met the criteria for choices. (Resident # 13).</p> <p>Findings include:</p> <p>1. During an interview on 8/8/12 at 2:57 p.m., Resident #13 indicated this week a CNA was late getting residents up and around for breakfast, and the resident was unable to get her shower before breakfast. Resident #13 did not indicate who the CNA was, because the CNA did not usually work on the 200 hall. Resident #13 indicated the CNA took her to breakfast in her hospital gown, and the resident indicated she was very embarrassed. She indicated the CNA covered her</p>	F0242	F242 SELF-DETERMINATION RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. The resident was showered and dressed at 9:30am on 8/7/2012. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice and what corrective action will be taken. Residents who prefer showers before breakfast have the potential to be affected by the alleged deficient practice. No other residents have been identified to have been affected by the alleged deficient practice. What measures will be	09/05/2012			

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	<p>shoulders with a sweater and her legs with a lap blanket and moved her into the main dining room with other residents. The resident indicated she had insisted she get her shower before being moved to the dining room, but the CNA indicated she would get her a shower following breakfast. During the interview, Resident #13 was observed to become tearful talking about the incident. The resident denied reporting the incident to any staff member.</p> <p>During an interview on 8/9/12 at 1 p.m., CNA #9 indicated the resident had told her she had cried on 8/7/12 because she was taken to the dining room in her hospital gown by a CNA, did not get her shower prior to breakfast and remained in her gown until 9:30 a.m. CNA #9 indicated another CNA was working on the 200 hall while she was gone and indicated it was CNA #3. CNA #9 indicated the resident has shower days on Monday and Thursdays. CNA #9 indicated Resident #13 told her of the incident and became tearful while talking to her about the incident.</p> <p>During an interview on 8/10/12 at 9:53 a.m., CNA #3 indicated she did take Resident #13 to the dining room</p>		<p>put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Re-education on facility policy regarding self determination and right to make choices will be provided by the Administrator by 9/5/2012. Non-compliance with the facility policy on reporting abuse may result in disciplinary action, up to and including termination. How the facility plans to monitor compliance. The Administrator, the Social Service Director, and the Director of Nursing, will promote and maintain an open door policy for concerns. Weekly rounds will be made by the Administrator or designee to check with residents, minimum of 5, for reports of concerns. Reported concerns will be documented on a grievance form and investigated by the administrator and reported as required by law. Compliance will be monitored by the QA Committee [monthly] x 6 months.</p>		

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	<p>on 8/6/12 in her hospital gown. She indicated the resident agreed to go to the dining room in her gown. CNA #3 indicated Resident #13 was crying when she returned to get the resident a shower and knew the resident was upset. CNA #3 indicated she comes to work at 5:30 a.m., and has several residents to get up for breakfast, and she did not have enough time to get Resident #13 a shower before breakfast.</p> <p>During record review on 8/10/12 at 11:00 a.m., the Minimum Data Set (MDS) assessment, dated 7/12/12, indicated Resident #13 scored a 13 of 15 for the Brief Interview Mental Status (BIMS), indicating the resident was reliably interviewable. Resident #13's diagnoses included, but were not limited to, hip fracture, diabetes mellitus, osteoporosis, hypertension and arthritis.</p> <p>3.1-3(u)(1)</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure residents received proper assistance with daily oral care for 1 of 2 residents reviewed, in a sample of 2 who met the criteria for dental care. (Resident #41)  Findings include:  Resident #41's record was reviewed on 8/13/12 at 3:00 p.m. Resident #41's diagnoses included, but were not limited to, Alzheimer's dementia, diabetes, atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, hypothyroidism, aphasia, history of cerebral vascular accident, gastroesophageal reflux disease, arthritis and osteoporosis. MDS (Minimum Data Set) assessments dated 1/06/2012, 3/22/2012 and 06/13/12, all indicated the resident required extensive assistance for personal hygiene, including combing hair, brushing teeth, shaving, washing face and hands with one person physical assist</p>	F0312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. The resident has received adequate oral hygiene. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice and what corrective action will be taken. Residents who are dependent for oral hygiene have the potential to be affected by the alleged deficient practice. Oral assessments will be completed on dependent residents by 9/5/2012 with dental referrals as needed. What measures will be put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. The Director of Nursing will provide re-education on providing oral care by 9/5/2012 to licensed and non-licensed staff. How the facility	09/05/2012			

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	<p>for personal care. On 06/13/12 the MDS indicated Resident #41 had a BIMS (Brief Interview Mental Status) score of 04. A score of 00 to 07 indicated severe impairment of cognitive ability.</p> <p>Interview with the resident's son on 8/8/12 at 2:24 p.m. indicated he had taken Resident #41 to a dentist on 3/29/12 for evaluation and treatment. The son reported the dentist indicated Resident #41 had horrible oral care and would require two teeth to be pulled.</p> <p>During interview on 8/13/12 at 3:05 p.m., the DON (Director of Nursing) indicated Resident #41 had gone out to the dentist a couple months ago for removal of two teeth.</p> <p>Review of the Dentist's Dental Referral Form, which was not dated, indicated Resident #41 was referred to a private general dentist for, "evaluation, x-ray and treat all remaining teeth where needed.... Note: Main concern: patient complains of pain in dental area lower left side towards back."</p> <p>Review of progress notes for Resident #41, dated 3/29/12, from the private dentist indicated, "...deep</p>		<p>plans to monitor compliance. Oral assessments will be done by licensed staff weekly x 4, monthly x 4 and quarterly thereafter until substantial compliance is achieved. Compliance issues will be reported to the Quality Management Committee [monthly] x 6 months for problem analysis, action planning, and additional monitoring needs as indicated.</p>				

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	<p>decay and probable abscess #12 and #15 (tooth location), also in accessible decay #18 and #20 (tooth location)...Hygiene Terrible!! Must brush teeth 2 times/day!!" An appointment was made for tooth extraction on 4/12/12.</p> <p>Review of the follow-up dental progress note, for Resident #41, dated 4/17/12, indicated "caries (cavities) non-restorable #12 and #15 (tooth location). Discussed sinus complications. Extracted tooth #12 and #15 and separated bridge. A small sinus opening tooth #15, was given sinus precautions (instruction) and start on Augmentin (antibiotic)."</p> <p>Review of dental exam notes on 7/20/12, indicated Resident #41 had "Oral Hygiene: Fair...."</p> <p>Review of the care plan for Resident #41, dated 3/8/10 with current re-evaluation date of 6/12, for Activity of Daily Living (ADL) indicated, "Self-care deficit related to: Personal Hygiene requiring Extensive/Max (amount of assistance required) with Resident Goal: Resident will be clean, dry, well groomed x 90 days. Interventions: Personal Hygiene, Bathing and Oral/Dental Care assistance required: one person</p>			

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	<p>physical assist."</p> <p>Review of CNA Flow Sheet for Resident #41 indicated, two times a day oral care began on 4/10/12.</p> <p>Interview on 8/14/12 at 4:00 p.m. with the Director of Nursing (DON) indicated routine oral care was to be provided with routine a.m. and p.m. care. The DON was unable to provide additional documentation to reflect oral care was provided.</p> <p>3.1-38(a)(3)(C)</p>			

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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to prevent the development of nonstageable deep tissue pressure ulcers to both heels for 1 of 3 residents reviewed for pressure ulcers in a sample of 3 who met the criteria for pressure ulcers. (Resident #34).</p> <p>Findings include:</p> <p>During staff interview on 8/7/12 at 3:19 p.m., RN #19 indicated Resident #34 had deep tissue injuries on both heels. She indicated the resident was admitted on 6/13/12 with stage 2 pressure wounds to right and left buttocks, but they were both healed. RN #19 indicated the resident was currently being treated with a pressure reducing cushion, pressure reducing mattress to bed and repositioning every two hours while in</p>	F0314	<p>F314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. The resident identified has current risk assessments, dietary interventions, treatment orders, protective footwear and attends wound clinic. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice</p>	09/05/2012

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	<p>bed. She also received Braden skin assessments weekly x 4.</p> <p>During an interview on 8/9/12 at 5:45 p.m., Resident #34's daughter indicated she had just brought her mother back from a wound specialist appointment, and the physician indicated the resident has deep tissue injury with necrotic wounds to both feet. Following debridement on 8/8/12, the physician indicated both wounds to be stage IV. The daughter indicated she was very unhappy that her mother developed these wounds. She indicated the facility rarely repositioned her mother and was often in the same position for long periods of time. She indicated the resident notified her of pain in both heels, but was unsure of the date. The daughter indicated she wanted to take her mother to a wound specialist rather than have treatment at the facility.</p> <p>During record review on 8/9/12 at 12:52 p.m., the skin integrity care plan: prevention record, dated 6/13/12, was reviewed and indicated the resident had a pressure reducing mattress, pressure reducing cushion to wheelchair, two assist to turn and reposition and impaired mobility. During the same record review, a</p>		<p>and what corrective action will be taken. Braden Scale assessments will be audited by 9/5/2012 with implementation of preventative treatment initiated as indicated. What measures will be put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Licensed staff will be re-educated by the Director of Nursing on Braden Scale risk assessment and wound prevention by 9/5/2012. The Braden Scale risk assessment score will be utilized to determine recommendations for Pressure Sore interventions indicated, such as, heel protectors, specialty mattresses, etc. How the facility plans to monitor compliance Braden Scale risk assessment audits will be done by the Director of Nursing or designee, with oversight of implementing interventions as needed indicated by risk assessment score, weekly x 4, monthly x 4 for a minimum of 6 months. Pressure Sore interventions will be directly observed by the Director of Nursing or designee at least 3 x weekly for 4 weeks, then monthly for 6 months and quarterly thereafter until substantial compliance is achieved. Compliance issues will be reported to the Quality Management Committee [monthly] x 6 months for problem analysis, action planning, and</p>		

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	<p>nursing admission assessment, dated 6/14/12, indicated the resident to be alert, with history of incontinence, edema to lower extremities and hip precautions. A skin prevention protocol, dated 6/14/12, indicated the resident had a wheelchair cushion, pressure relief mattress, preventative cream if incontinent, Braden skin assessment weekly x 4 and was admitted with an open area and a surgical wound. The resident was to receive wound protocol and initiate further interventions.</p> <p>During record review on 8/10/12 at 9:19 a.m., the Minimum Data Set (MDS) assessment, dated 6/21/12, indicated Resident #34 scored a 15 of 15 for the Brief Interview Mental Status (BIMS), indicating the resident was reliably interviewable. Resident #34's diagnoses included, but were not limited to, hip fracture, osteoporosis, thyroid disease and heart failure. The MDS indicated the resident was a two person assist for bed mobility, transfers and toileting.</p> <p>During the same record review, the Braden scale, dated 6/14/12, indicated the resident received a score of 15, indicating the resident was at mild risk for developing pressure sores. The same</p>		additional monitoring needs as indicated.		

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	<p>assessment scale dated 6/20/12, indicated a score of 14. The assessment indicated the resident was at risk for developing a pressure ulcer. No additional assessment was noted for 6/27/12 or 7/4/12.</p> <p>A pressure ulcer evaluation record, dated 7/18/12 indicated the resident was noted to have a deep tissue injury, stage I, left heel pressure ulcer. The record indicated the length to be 2.5 cm and width 4.0 cm, flat edges and intact surrounding skin. A physician order indicated the resident was to wear Pressure Relief Ankle Foot Orthosis (PRAFO) boots at all times, and skin prep and gauze wrap to left heel. On 7/20/12, Resident #34 developed a pressure ulcer on her right heel. The record indicated the length to be 4.0 cm and width 4.0 cm, flat edges and intact surrounding skin. The record indicated the pressure ulcer to be a deep tissue injury, no staging.</p> <p>A dietary record was reviewed on 8/9/12 at 1:30 p.m., indicating the resident was seen on 7/19/12 by a registered dietician. The resident started receiving Vitamin C, 500 mg daily, L-Arginine (nutritional supplement to promote healing) 500 mg three times daily, Zinc Sulfate</p>			

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	<p>(nutritional supplement to promote healing) 220 mg three times daily.</p> <p>During an interview on 8/10/12 at 2:32 p.m., LPN #6 indicated she has been doing wound care in the facility for approximately four years. She indicated the resident has pressure wounds to both heels that did develop in the facility. She indicated the resident's daughter took the resident to a wound care specialist for treatment and her current treatment is Mepilex Ag (a silver wound, anti microbial dressing for pressure ulcers) three times per week. She indicated the resident would often lie in the same position without turning. She indicated she was on medical leave the last two weeks of June and the first week of July, and LPN # 18 was providing wound care during the time she was gone. She could not provide any additional documentation for skin assessments for the time she was off.</p> <p>During an observation on 8/13/12 at 2:00 p.m., LPN #6 provided wound care to both heels. The right and left heel wounds were necrotic and approximately the size of golf balls. The edges were well-defined with minimal swelling and drainage noted.</p>			

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	<p>Review of a current facility policy, dated March 2005, and updated June 2010, titled "Covenant Care Skin Integrity Standard," which was provided by the Director of Nursing on 8/14/12 at 1:45 p.m., indicated the following:</p> <p>"New admission residents will have a skin risk assessment (Braden or Norton Plus Scale) on admission and then weekly for three weeks (for total of four weekly assessments upon admission), quarterly, and with change in functional ability."</p> <p>3.1-40(a)(1)</p>			

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure 2 of 2 soiled utility/bio-hazard rooms were locked at all times which potentially affected 4 confused independently mobile residents of 18 identified independently mobile residents in the facility.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure the safe use of a side rail for 1 (Resident #30) of 17 residents observed for use of side rails.</p> <p>Findings include:</p> <p>A. On 8-10-2012 at 10:15 a.m., the soiled utility/bio-hazard room across from the 300 hall nurses' station was observed unlocked and accessible. This room contained two mop buckets with water, a hopper, soiled laundry, bleach wipes, alcohol hand cleanser and a bio-hazard box.</p> <p>An interview with CNA #13 on 8-10-2012 at 10:20 a.m., indicated</p>	F0323	<p>F323 FREE OF ACCIDENTS AND HAZARDS The facility shall ensure the resident environment remains as free from accidents and hazards as possible. How corrective action will be accomplished for those residents potentially affected by the alleged deficient practice. On 8/13/2012, the Maintenance Supervisor, installed alternate door locks on the soiled utility rooms while the key pads were repaired or replaced. Each was checked by the Maintenance Supervisor and is checked daily [M-F] to ensure they are secure and functioning properly. The Maintenance Supervisor removed side rail for resident #30 on 8/28/2012. How the facility will identify other residents that have the potential to be affected by the alleged deficient practice. Weekly Preventative Maintenance Checklist [WPMC], see attachment, will be completed by the Maintenance Supervisor and reported to the Administrator. What measures will be put into place or systemic changes will the facility make to ensure the alleged deficient practice does not recur. Weekly</p>	09/05/2012

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	<p>this room was locked earlier and she demonstrated the door opened without use of the key pad lock.</p> <p>An interview with the Administrator on 8-10-2012 at 10:23 a.m., indicated to access the soiled utility room, "I usually use the key pad lock to enter the room." The Administrator was observed to be able to open the door without the use of the key pad lock. The Administrator indicated the door would be fixed today.</p> <p>On 8-10-2012 at 10:35 a.m. in the 200 hall at the nurse's station, the soiled utility/bio-hazard room was observed unlocked and contained a hopper, dirty laundry, sani wipes and the bio-hazard box.</p> <p>An interview with CNA #5 on 8-10-2012 at 10:35 a.m., indicated the door was usually locked, and she was able to gain entrance to the soiled utility/bio-hazard room without using the keypad lock.</p> <p>An interview with the Administrator on 8-10-2012 at 10:40 a.m., indicated the doors on the soiled utility/bio-hazard rooms should be locked. The soiled utility/bio-hazard room was locked at this time. The Administrator indicated he notified the</p>		<p>Preventative Maintenance Checklist will also be used to identify any other repair or safety concerns. Identified repairs will also be tracked on this checklist. The Maintenance Supervisor shall complete weekly and forward to the Administrator for monitoring. The Administrator shall also make weekly rounds to identify and monitor compliance using the Weekly Preventative Maintenance Checklist. How the facility plans to monitor compliance. The Administrator shall review for compliance and report findings to the Quality Review Committee [monthly] until six months of compliance. Quarterly checks will continue.</p>				

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	<p>Maintenance Supervisor on the malfunctioning key pad locks.</p> <p>On 8-10-2012 at 11:50 a.m., a list of 15 residents who were mobile, either in wheelchairs or walkers without assist, was received from the MDS (Minimum Data Set) nurse with information based on the residents' last MDS assessment scores.</p> <p>An interview with LPN #5 on 200 hall on 8-10-2012 at 2:10 p.m., indicated there were no confused residents who are independently mobile with a wheelchair or walker/cane or adaptive devices.</p> <p>An interview with LPN #15 on 300 hall on 8-10-2012 at 2:25 p.m., indicated one resident on the list of 15 was confused and an additional resident who was not on the list, was confused and independent with mobility.</p> <p>An interview with LPN #18 and LPN #16 on 100 hall on 8-10-2012 at 3:15 p.m., indicated two residents not on the list were confused and independent with walker/wheelchair mobility.</p> <p>An interview with the Maintenance Supervisor on 8-10-2012 at 2:08 p.m., indicated the soiled utility/bio-hazard</p>			

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	<p>room doors were locked.</p> <p>On 8-10-2012 at 2:14 p.m., the soiled utility/bio-hazard room door was observed unlocked and accessible by the 300 hall nurse's station. At 2:20 p.m., CNA #4 opened the soiled utility/bio-hazard room door without using the key pad.</p> <p>An interview with the Maintenance Supervisor on 8-10-2012 at 2:30 p.m., indicated the soiled utility/bio-hazard door in 300 hall was locked now, but the Maintenance Supervisor was notified a few minutes earlier the soiled utility/bio-hazard door was unlocked.</p> <p>An interview with the Maintenance Supervisor on 8-10-2012 at 3:55 p.m., indicated staff must be made aware that these soiled utility/bio-hazard room doors must be locked at all times as there are four independently mobile confused residents in the facility. The Maintenance Supervisor indicated signs would be posted on the two soiled utility/bio-hazard room doors to remind staff to ensure the doors are locked.</p> <p>On 8-13-2012 at 9 a.m., the 200 hall soiled utility/bio-hazard room was observed locked and the 300 hall soiled utility/bio-hazard room was</p>			

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	<p>observed unlocked and accessible. There were no signs on either door to remind staff to lock the doors.</p> <p>An interview with the Maintenance Supervisor on 8-13-2012 at 9:50 a.m., indicated the soiled utility/bio-hazard door in 300 hall was locked 10 minutes earlier when he checked. The Maintenance Supervisor checked at this time and the door was unlocked. The Maintenance Supervisor indicated he had placed signs on the 100 and 300 hall soiled utility/bio-hazard room doors to remind staff to ensure the doors were locked when they left.</p> <p>An interview/observation with CNA #17 on 8-13-2012 at 9:52 a.m., indicated the door was not checked after CNA #17 left the 300 hall soiled utility/bio-hazard room. CNA#17 was able to open the 300 hall soiled utility/bio-hazard room door without use of the key pad lock.</p> <p>An interview with the Director of Nursing (DON) on 8-13-2012 at 10:25 a.m., indicated the signs were moved from the outside of the 100 and 300 hall soiled utility/bio-hazard room doors to inside the doors by the light switch. The DON was notified staff were not ensuring the doors were</p>			

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	<p>locked after leaving the rooms.</p> <p>B. On 8-8-2012 at 12:05 p.m., Resident #30's bed rail was observed in a position of being loose. There was a 5 1/2 inch gap between the rail and mattress. The bed rail was not attached to prevent the resident from being caught between the side rail and the mattress.</p> <p>An interview with the Maintenance Supervisor on 8-8-2012 at 12:10 p.m., indicated these beds belong to hospice and the side rails were problematic.</p> <p>The <u>Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff</u> issued March 10, 2006 indicates the FDA (Food and Drug Administration) recommends openings within the rail, between rail supports, under the rail or next to a single rail support and between the rail and mattress should be small enough to prevent the head from entering or being entrapped. The "Hospital Bed Safety WorkGroup (HBSW)" and the "International Electrotechnical Commission (IEC)" along with the FDA recommend the space be less than 4 ¾ inches.</p>						

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	<p>The FDA recommends the space under the rail at the ends of the rail be small enough to prevent neck entrapment. The HBSW and the IEC along with the FDA recommend this space be less than 2 3/8 inches and greater than a 60 degree angle.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F0353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient staff to provide nursing and related services, related to waiting for the call light to be answered, assistance with toileting and personal hygiene and waiting on pain pills, for 17 of 40 residents interviewed for sufficient staffing (Residents # 124, #5, #12, #39, #86, #35, #13, #93, #56, #133, #63, #128, #42, #34, #58, #57 and #131) and 2 families interviewed (#34, #41).</p>	F0353	F353 SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care	09/05/2012			

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	<p>Findings include:</p> <p>During an interview on 8/8/12 at 9:46 a.m., Resident # 124 indicated on night shift they will pull the aide down to another hall, and the nurse will go on break, and that leaves no one on the hall.</p> <p>During an interview on 8/7/12 at 11:16 a.m., Resident # 5 indicated the resident has to wait at night for help.</p> <p>During an interview on 8/7/12 at 3:36 p.m., Resident # 12 indicated the resident had to wait 35 minutes on the toilet.</p> <p>During an interview on 8/7/12 at 4:28 p.m., Resident # 39 indicated sometimes at night there is not enough staff to help.</p> <p>During an interview on 8/7/12 at 11:48 a.m., Resident # 86 indicated a girl told the resident she was going to shave him; she never came back and found out later she went home.</p> <p>During an interview on 8/8/12 at 4:27 p.m., Resident # 35 indicated there is not enough staff. "They tell you they will do something and be right back, and then they forget and it never gets done."</p>		<p>plans. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. Care has been provided to the residents allegedly affected. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice and what corrective action will be taken. Residents requiring staff assistance have the potential to be affected by the alleged deficient practice. Sufficient staff and the new call light system are in place. What measures will be put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Staff re-education of job description and new call light system will be provided by the Director of Nursing by 9/5/2012. How the facility plans to monitor compliance The Interdisciplinary Team will conduct resident interviews on resident satisfaction on sufficient staffing to meet resident needs, during quarterly IDT/Walking Rounds. Any concerns voiced by Resident Council shall be communicated to the Administrator and/or Director of Nursing for follow up. Random Call light audits will be conducted by the Administrator and the Director of Nursing on various halls, and various shifts weekly x 4, monthly x 4, quarterly thereafter or until substantial</p>				

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	<p>During an interview on 8/8/12 at 3:04 p.m., Resident # 13 indicated staffing is worse at night and some in the morning, and had to wait over an hour for a pain pill.</p> <p>During an interview on 8/8/12 at 10:54 a.m., Resident # 93 indicated she takes extended release medication, and sometimes it is two hours late.</p> <p>During an interview on 8/8/12 at 11:01 a.m., Resident # 56 indicated they need more people working and sometimes has to wait 20 minutes to ½ hour before they come in to assist. Sometimes someone will check the call light and then have to wait for assistance. The resident indicated they did not like to sit on the stool that long. Sometimes the staff is so rushed they forget to put the call light close enough to use.</p> <p>During an interview on 8/7/12 at 3:00 p.m., Resident #133 indicated having to wait for some stuff to get done, but knows they are busy with other residents.</p> <p>During an interview on 8/8/12 at 9:12 a.m., Resident #63 indicated staffing is worse on the weekends, and there</p>		<p>compliance is achieved. Compliance will be monitored by the QA Committee [monthly] x 6 months. Additional staff has been hired and is undergoing job performance training.</p>	

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	<p>are small numbers of staff on nights. Staff will state someone did not show up or they are the only one on the floor.</p> <p>During an interview on 8/7/12 at 11:24 a.m., Resident # 128 indicated a nurse came in crying because she is over worked, and the facility will not get her any extra help.</p> <p>During an interview on 8/8/12 at 9:56 a.m., Resident # 42 indicated sometimes you have to wait to go to the bathroom, up to an hour. They say there is not enough staff.</p> <p>During an interview on 8/8/12 at 9:46 a.m., Resident # 34 indicated staffing is worse early in the morning.</p> <p>During an interview on 8/8/12 at 3:46 p.m., Resident # 58 indicated she is supposed to get her showers on Wednesday and Saturday, but does not always get a shower two times a week because they are too busy.</p> <p>During an interview on 8/8/12 at 2:01 p.m., Resident # 57 indicated having to wait for help at various times during the day and night.</p> <p>During an interview on 8/8/12 at 10:01 a.m., Resident # 131 indicated</p>			

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	<p>he requires two assist for activities of daily living (transfers). When the call light is on and the aide checks on him, then the aide has to get another aide to help him and that is when it takes more time. Resident indicated when he returns to his room in his wheelchair, he would like to return to bed as he gets tired of sitting, and they do not have enough staff or time to put him to bed.</p> <p>During a family interview on 8/8/12 at 2:19 a.m., the family member of Resident # 41 indicated staff is stretched thin, and the facility wanted the resident in a hospital gown because it was easier to take care of him.</p> <p>During a family interview on 8/9/12 at 5:45 p.m., the family members of Resident # 34 indicated the staff never turn the resident, there is never enough staff for the residents, and a nurse told them it is the resident's responsibility to tell them when the dressing needs changed.</p> <p>During an interview on 8/9/12 at 1:30 p.m., CNA #4 indicated some days it is hard to get everything done to meet the residents' needs.</p> <p>During an interview on 8/9/12 at 1:00</p>			

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	<p>p.m., CNA # 3 indicated that depending on which hall you worked, depends on whether you can get everything done.</p> <p>During an interview on 8/10/12 at 2:32 p.m., LPN # 6 indicated that staffing is an issue when getting her job done.</p> <p>During an observation on 8/10/12 at 9:07 a.m., there were three call lights going off in rooms 206, 207 and 208. Room 207 was a bathroom light. Additional lights were going off at 9:17 a.m. in rooms 201 and 212. The light in room 207 was turned off at 9:17 a.m. There was no CNA or nurse seen on the hall since 9:07 a.m.</p> <p>During an interview on 8/10/12 at 10:23 a.m., CNA # 3 indicated she was on break and the nurse was also on break.</p> <p>During an interview on 8/10/12 at 10:30 a.m., CNA # 5 indicated when both staff members are off the floor, the therapy department watches the lights.</p> <p>Review of a custom report taken from the MDS (Minimum Data Set) on the amount of support given for bed</p>			

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	<p>mobility, transfer and toilet use, received from the MDS Coordinator on 8/10/12 at 11:49 a.m., indicated there were 42 residents out of 63 who required extensive assistance with transfers.</p> <p>Review of the CNA assignment sheets received from the DON on 8/10/12, indicated on the 200 hall, there are 11 residents and there are 2 residents who need the assistance of 2 people for transfers. On the 100 hall there are 26 residents, and 6 of the residents need the assistance of 2 people for transfers. On the 300 hall there are 24 residents, and 5 of the residents need the assistance of 2 people for transfers.</p> <p>3.1-17(a)</p>				

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on record review and interview, the facility failed ensure the staff posting was in a readable format for 1 resident and 1 family interviewed regarding staff posting (#35, #61) and potentially affecting 63 of 63 residents</p>	F0356	F356 POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:Facility name.The current date.The total number and the actual hours worked by the	09/05/2012			

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	<p>residing in the facility.</p> <p>Findings include:</p> <p>A review of Today's Staffing on 8-7-2012 at 9:20 a.m., provided by Receptionist #20, indicated the staffing for RNs (Registered Nurses), LPNs (Licensed Practical Nurses) and Assistants (Certified Nursing Assistants) in hours and FTEs (full time equivalency).</p> <p>For example, the posted staffing for 8/09/12 indicated 1.5 FTE and 12 hours for RNs; 7.31 FTEs and 58.5 hours for LPNs; and 14.94 FTEs and 119.5 hours for Assistants. One RN was working a 12 hour shift, and should have been counted as one staff member for that shift, rather than 1.5 FTE.</p> <p>An interview on 8-13-2012 at 9:40 a.m. with Resident #35 indicated no knowledge of the acronym FTE on the Today's Staffing.</p> <p>An interview on 8-13-2012 at 10:15 a.m. with family of Resident #61 indicated no knowledge of the Today's Staffing or what the FTE meant.</p> <p>3.1-13(a)</p>		<p>following categories of licensed and unlicensed staff directly responsible for resident care per shift: Registered Nurses. Licensed Practical Nurses. Certified Nurses Aides. Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: Clear and readable format. In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. No residents have been identified to have been affected by the alleged deficient practice. Clear staff posting is prominently displayed. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice and what corrective action will be taken. Residents wanting to know the daily staffing have the potential to be affected by the alleged deficient practice. Residents will be informed of staff posting by 9/5/2012 and reminded at Resident Council Meetings at least quarterly. What measures will be put into place or</p>				

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			<p>what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Daily staff posting will clearly identify number of staff per shift and be displayed daily in a prominent location. How the facility plans to monitor compliance The Director of Nursing or designee will post clearly identified staffing in a prominent location daily. The Administrator will conduct audits weekly until substantial compliance is achieved. Compliance will be monitored by the QA Committee [monthly] x 6 months.</p>		

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F0431 SS=B	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure the tubes and bottles of topical medications were properly labeled with resident</p>	F0431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who	09/05/2012			

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	<p>names and Physician's name for 1 of 3 treatment carts reviewed, potentially affecting 25 residents living on 100 Hall. The facility also failed to ensure the topical medicated ointments were not expired and the medications were properly discarded for residents no longer living at the facility.</p> <p>Findings include:</p> <p>1. On 8/14/12 at 2:45 p.m., while observing medication storage, tubes of medicated ointments and creams, were found without labels to identify to which resident the medication belonged on the treatment cart for Hall 100.</p> <p>The treatment cart for 100 Hall contained the following tubes of ointments and creams without resident or physician specific label: Santyl/mupirocin 1:1 [topical treatments used for skin wound and ulcers], Bacitracin [topical antibiotic], Hydrocortisone 1% cream [topical steroidal anti-inflammatory], bactroban 2% [topical anti-infective], and voltaren gel 1% [topical nonsteroidal anti-inflammatory, analgesic].</p> <p>The treatment cart for 100 Hall contained the following tubes of</p>		<p>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 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 the storage of controlled drugs and other drugs subject to abuse, except when the facility uses single unit package distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. No residents have been identified to have been affected by the alleged deficient practice. How the facility will identify other residents that have the potential to be affected by the same alleged deficient</p>				

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	<p>topical medicated ointments and creams that were past their expiration date: Voltaren gel 1% and Triamcinolone 0.5% [steroidal anti-inflammatory].</p> <p>The treatment cart for 100 Hall contained the following bottle of topical medicated powder for a discharged resident; Nystop [topical antifungal].</p> <p>Interview on 8/14/12 at 4:00 p.m. with Director of Nursing (DON) indicated the Pharmacy Consultant reviews and checks the medication and treatment carts monthly and were last checked on 7/19/12.</p> <p>3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(o) 3.1-25(r)</p>		<p>practice and what corrective action will be taken. Residents with orders for ointments and creams have the potential to be affected by the alleged deficient practice. The treatment cart has been audited for expired of discontinued creams and ointments. What measures will be put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Licensed staff will be re-educated on proper disposal, labeling and storage of ointments and creams by 9/5/2012. Weekly audits of the treatment carts will be completed by the wound nurse. How the facility plans to monitor compliance Monthly pharmacy audits will be completed by pharmacy tech and reported to the Director of Nursing and Administrator. Compliance issues will be reported to the Quality Management Committee [monthly] x 6 months for problem analysis, action planning, and additional monitoring needs as indicated.</p>		

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F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F0441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS	09/05/2012			

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	<p>provide proper hand hygiene for 1 of 1 resident reviewed during wound care. (Resident #34).</p> <p>Findings include:</p> <p>During observation on 8/13/12 at 2:05 p.m., LPN #6 was providing wound care to Resident #34. LPN #6 set up her clean area by placing a clean pad under Resident #34's feet, she donned gloves to remove the dressing, she then dropped the old dressing on the floor, picked it up with a gloved hand and threw it into the trash. She removed soiled gloves and washed her hands in the bathroom for 12 seconds. She returned to provide wound care to Resident #34, donned gloves, provided wound care to right heel, removed soiled gloves and washed her hands for 10 seconds. She returned to provide wound care to the left heel. She donned gloves, removed the dressing and washed her hands for 13 seconds. She donned gloves, provided treatment to left heel, removed soiled gloves and removed trash and left resident's room to place items into the soiled linen room without washing her hands.</p> <p>Review of a current facility policy,</p>		<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Infection Control ProgramThe facility must establish an Infection Control Program under which it- Investigates, controls, and prevents infections in the facility. Decides what procedures, such as isolation, should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. Preventing spread of infectionWhen the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with the residents or their food, if direct contact will transmit the disease. The facility must require staff to wash their hands after each direct residents or their food, if direct contact will transmit the disease. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Linens Personnel must handle, store, process, and</p>		

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	<p>undated, titled "Hand Hygiene", which was provided by the Director of Nursing on 8/14/12 at 8:55 a.m., indicated the following:</p> <p>C. "Wash well under running water for a minimum of 15 seconds, using a rotary motion and friction."</p> <p>During an interview on 8/14/12 at 5:30 p.m., LPN #6 indicated she was really nervous and was unaware she did not wash her hands for at least 15 seconds.</p> <p>3.1-18(l)</p>		<p>transport linens so as to prevent the spread of infection. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. No residents have been identified to have been affected by the alleged deficient practice. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice and what corrective action will be taken. Resident receiving wound care have the potential to be affected by the alleged deficient practice. None have been identified to have been affected. What measures will be put into place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. Hand washing procedure re-education will be provided by the Director of Nursing by 9/5/2012. How the facility plans to monitor compliance. Hand washing return demonstration will be audited by the Director of Nursing by 9/5/2012. A minimum of 3 random weekly hand washing audits will be conducted on each shift, for a total of 36 per month by the Director of Nursing, weekly x 4, monthly x 4 then quarterly thereafter for at least 6 months or until substantial compliance is achieved. Compliance issues will be reported to the Quality Management Committee [monthly] x 6 months for problem</p>	

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			analysis, action planning, and additional monitoring needs as indicated.		

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F0465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the resident rooms were free from wall/door damage (Rooms 105, 107, 301, 304, 308, 309 and 314); failed to ensure resident floor tile was not worn (Rooms 105, 107 and 111); failed to ensure a resident room had an intact window sill (Room 314); failed to ensure the resident bathroom faucet was in good repair (Room 110 and 314); failed to ensure the resident room baseboard was secured to the wall (Room 110) for 9 of 31 resident rooms observed. The facility also failed to ensure the handrails in the common environment were clean and dust free; failed to ensure 2 ceiling vents (dining room and 100 hall nurse's station) and 1 wall vent (200 hall nurse's station) were free of accumulated dust and failed to ensure the wallpaper was secure to the walls in the dining room, which potentially affected 63 of 63 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The following was observed in</p>	F0465	<p>F465 SAFE/FUNCTIONAL SANITARY/COMFORTABLE ENVIRONMENT The facility shall ensure a safe, functional, sanitary and comfortable environment. How corrective actions will be accomplished for those residents potentially affected by the alleged deficient practice. The Maintenance Supervisor will complete all repairs by 9/4/2012. The Housekeeping Supervisor corrected all identified housekeeping areas, 8/30/2012. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice. The Maintenance Supervisor shall monitor the identification and correction of all repairs and cleaning on a Weekly Preventative Maintenance form. What measures will be put into place or systemic changes will the facility make to ensure the alleged deficient practice does not recur. The Weekly Preventative Maintenance Checklist will be used to identify all areas of the facility to identify repair or cleaning problems. The checklist will also be used to track their completion. The Maintenance Supervisor will</p>	09/05/2012
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	<p>resident rooms:</p> <p>Room 308 on 8-7-2012 at 11:55 a.m. had 2 dime sized holes across from toilet in bathroom.</p> <p>Room 301 on 8-7-2012 at 3:41 p.m. had 4 holes in the wall and old grab bar marks. Part of the drywall was not painted.</p> <p>Room 304 on 8-7-2012 at 3:52 p.m. had a large scratch mark on the bathroom wall.</p> <p>Room 309 on 8-7-2012 at 3:58 p.m. had scuffed bathroom walls and door.</p> <p>Room 314 on 8-7-2012 at 4:35 p.m. had scuffed bathroom walls and door. There were holes on the bathroom wall where a hand rail was removed and another hole in the wall across from the toilet. The faucet was leaking on the hot water side. The marble-like window sill was cracked, overly glued and taped with blue masking tape.</p> <p>Room 110 on 8-8-2012 at 8:55 a.m. had a missing handle from the faucet and the baseboard was pulled away in the room.</p> <p>Rooms 105 and 107 on 8-8-2012 at</p>		<p>forward the form at least weekly to the Administrator for monitoring. The Administrator shall make facility wide rounds to identify and monitor completion of areas on the Weekly Preventative Maintenance Checklist. How the facility plans to monitor compliance. The Administrator shall report compliance to the Quality Assurance Committee for monitoring and compliance. This will be on-going on a monthly basis.</p>		

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	<p>10:06 a.m. have a shared bathroom with floor tile worn around the toilet and both bathroom doors were scuffed on the inside.</p> <p>Room 111 on 8-8-2012 at 11:41 a.m. had dirty and worn floor tile.</p> <p>2. On 8-9-2012 at 2:45 p.m., the hand rail across from dining room was observed to be dirty and had dried, crusty material on the backside of the rail. The wallpaper under windows in the dining room was peeling and the cold air vent in the ceiling had an accumulation of dust on it.</p> <p>On 8-10-2012 at 9:58 a.m., the hand rails in 300 hall were observed to have a white powder and dirt on them under the area where the call lights were replaced earlier in the week. Some areas of the handrails were sticky.</p> <p>An interview with Housekeeper #14 on 8-10-2012 at 10 a.m., indicated the common areas are cleaned daily, including the handrails.</p> <p>On 8-10-2012 at 10:05 a.m., the hand rails in 100 hall were observed to have a white powder and dirt on them under the area where the call lights</p>			

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	<p>were replaced earlier in week.</p> <p>On 8-10-2012 at 10:30 a.m., the hand rails in 200 hall were observed to have a white powder on them. A vent by the nurse's station had dust accumulated on it.</p> <p>3.1-19(f)</p>			

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F0469 SS=C	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation and interview, the facility failed to ensure it was free from insects, flies, a moth, and dead bugs in 4 residents' rooms which affected 5 residents (#5, #86, #99, #35, #56) out of 31 rooms observed; 1 of 3 shower rooms and the assisted dining/activity room which could potentially affect 63 of 63 residents living in the facility.</p> <p>Findings include:</p> <p>On 8-7-2012 at 12:09 p.m. in the room of Residents #5 and #86, a fly was observed flying around the room.</p> <p>An interview on 8-7-2012 at 12:53 p.m. with the Director of Nursing indicated there had not been bugs earlier in the summer as she was observed waving a fly away from the resident's food in the assisted dining/activities room.</p> <p>On 8-7-2012 at 3:32 p.m., there were flies observed in Resident #99's room.</p> <p>On 8-8-2012 at 11:19 a.m., a fly was</p>	F0469	F469 MAINTAINS EFFECTIVE PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. How corrective actions will be accomplished for those residents potentially affected by the alleged deficient practice. The facility explained that there had been no significant fly problem prior to the week long installation activity for the new call light system and their activity going in and out of doorways. This was going on just prior to and during the annual survey. The facility shall manage an active and effective pest control program is in place to ensure, to the extent avoidable, that the facility is free of pests and rodents. How the facility will identify other residents that have the potential to be affected by the same alleged deficient practice. A monthly pest control is in place. An additional exterminator was added to the kitchen area during the survey review. What measures will be put into place or systemic change will the facility make to ensure the alleged deficient practice does not recur. The Maintenance Supervisor will include assessment of evidence of a fly	09/05/2012	

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	<p>observed in the room of Resident #56, and the resident swatted at the fly several times during the interview in her room.</p> <p>On 8-8-2012 at 4:41 p.m., a fly was observed buzzing around Resident #35's room and it bothered the resident. An interview with Resident #35 indicated she has a fly swatter she had brought from home.</p> <p>An interview on 8-10-2012 at 2:50 p.m. with the Maintenance Supervisor during the environmental tour, indicated a pest control company sprays the facility on a monthly basis.</p> <p>On 8-13-2012 at 10:05 a.m., the 200 hall shower room was observed to have dead bugs on the window sill, a dead moth on floor and two live insects on the wall in the toilet area.</p> <p>3.1-19(f)(4)</p>		<p>or other pest problems during each Weekly Preventative Maintenance Checklist. Reports will be forwarded to the Administrator for monitoring. How the facility plans to monitor compliance. Compliance will be reviewed by the Quality Assurance Committee at least monthly x 6 months.</p>		

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F9999	<p>STATE FINDINGS:</p> <p>1.) 3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work.</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the</p>	F9999	<p>F9999 1] The facility shall ensure each employee has a tuberculosis test within one month prior or at the time of employment. A second step performed one to three weeks after the initial and annually thereafter [12 months]. The Receptioninst and the Director of Staff Development or designee shall keep duplicate records, double monitoring compliance. No employee shall be allowed to start work if compliance is not managed. The Receptionist shall report any examples of non compliance to the Administrator. Compliance will be monitored by the QA Committee [monthly] x 6 months. 2] At least annually the facility shall hold a fire drill in conjunction with the local fire department. The Maintenance Supervisor made arrangements with the Fire Chief on 8/30/2012 to complete a fire drill at least annually with the local fire department. The Fire Chief indicated he was not doing this for any other facility in Huntington, but agreed with this request. This will be completed on 9/4/2012. Any identified problems will be monitored by the Administrator and reported to the Quality Assurrance Committee [monthly] x 6 months until compliance is maintained.</p>	09/05/2012	

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	<p>two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure employees were properly screened for Tuberculosis for 4 of 11 employees reviewed. (LPN # 21 and 5, housekeeping #23 and cook #21).</p> <p>Findings include:</p> <p>During employee record review on 8/7/12 at 1:30 p.m., LPN # 21 did not have a current Tuberculin skin test on file. The facility indicated they could not find her most recent skin test. Hire date for LPN #21 was 3/7/12.</p> <p>During same record review, LPN # 5 did not have a current Tuberculin skin test on file. The facility indicated they could not find her most recent skin test. Hire date for LPN #5 was 5/9/12.</p> <p>During the same record review, Cook #22 started work on 7/26/12 and her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155444	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2012
NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 N NORWOOD RD HUNTINGTON, IN 46750		
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	<p>first Tuberculin skin test was read on 7/27/12.</p> <p>During the same record review, Housekeeping #23 did not have her first Tuberculin skin test until 7/25/12. Hire date for Housekeeping #23 was 6/15/12.</p> <p>3.1-14(t)(1)</p> <p>2.) 3.1-51 DISASTER AND EMERGENCY PREPAREDNESS</p> <p>(d) At least annually, a facility shall attempt to hold a fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to hold or attempt to hold a fire and disaster drill in conjunction with the local fire department during the past 12 months with the potential to affect 63 of 63 residents who resided in the facility.</p>				

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	<p>Findings include:</p> <p>The Maintenance Supervisor was interviewed on 8-10-2012 at 2:30 p.m. and indicated none of the fire drills over the last 12 months had been held in conjunction with the fire department. The Maintenance Supervisor indicated the alarm company was notified of the fire drills and the alarm company contacted the fire department.</p> <p>Review of the Fire Drill Reports for the past 12 months indicated the facility did not provide documentation of an attempt to hold a fire drill in conjunction with the fire department for at least one of the fire drills.</p> <p>3.1-51(d)</p>				