

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 10, 11, 12, & 15, 2015</p> <p>Facility number: 000460 Provider number: 155532 AIM number: 100290620</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicaid: 23 Other: 9 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 By submitting the enclosed material we are not admitting the truth or accuracy of specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of corrections be considered our allegation of compliance effective June 30, 2015 to the annual licensure survey exit date June 15, 2015. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</p>	
F 0166 SS=D Bldg. 00	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by</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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	<p>the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to ensure prompt resolution of a resident's grievance with respect to the behavior of another resident (Resident #15) and failed to ensure prompt resolution of residents' grievance in regard to not having a functional light in their room (Resident #46 and #22).</p> <p>Findings include:</p> <p>1). Resident #15's clinical record was reviewed on 6/15/15 at 9:00 a.m. Diagnosis include, but were not limited to: traumatic brain injury, ataxia (poor coordination due to brain failure) and dysphagia.</p> <p>The current (MDS) Minimum Data Set Assessment dated 3/11/15, indicated a Brief Interview for Mental Status score was a 13, which indicated interviewable and cognitively intact.</p> <p>On 6/11/15 at 10:44 a.m., Resident #15 Indicated she woke up during the middle of the night not to long ago and Resident #50 was in her bed on her feet. Resident #15 indicated Resident #50 had been seen prior staring in her room. "He wanders</p>	F 0166	<p>F- 166 SS= DRight to Prompt Efforts To resolve Grievances <u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> Resident #15 expired. Resident # 50's physician and family were notified regardingwandering behavior. Assessed by Psychiatric services and Behavior tracking formwas started with interventions in place for wandering behavior. Resident #50was prescribed new psychotropic medication as recommended from the PsychiatricAssessment. Resident #46's light fixture now has a new bulb and cover. A new light fixture to restore appropriate lighting has beenordered and will be installed in Resident #22's room. <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> An audit of the grievance log has been conducted to reviewfor unresolved grievances. SSD and Administrator will conduct a Resident/Familymeeting 7/10/2015. The area State Ombudsman will participate and discussResident Rights. An open forum will be allowed for residents and family tovoice any grievances. One on one</p>	07/15/2015			

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	<p>the hall all the time." Resident #15 indicated she told the Certified Nursing Assistant (CNA) #3. Resident #15 indicated CNA #3 removed Resident #50 from her room. "It was not addressed to my satisfaction." Resident #50 continues to wander around the facility.</p> <p>On 6/15/15 at 4:32 p.m., CNA #2 indicated Resident #15 told her Resident #50 was in Resident #15's bed. CNA #2 indicated, Resident #15's room mate (Resident #12) indicated they told CNA #3. CNA #2 put a stop strip in front of Resident #15's room to keep Resident #50 out. CNA #2 did not notify the Director of Nursing nor the Administrator. "I didn't tell anyone, but CNA #3."</p> <p>On 6/15/15 at 4:00 p.m., CNA #3 indicated, she was not aware of the incident with Resident #15 and Resident #50.</p> <p>On 6/15/15 at 4:38 p.m., the (DON) Director of Nursing indicated the CNA's should have reported the incident to her. "Report, report."</p> <p>On 6/11/15 at 1:00 p.m., the Administrator indicated she was not aware of this (indicating Resident #50's behavior) and no one had mentioned</p>		<p>interview's will be conducted with residents and families unable or who choose not to participate in the group meeting. Issues from these meetings will be taken to Quality Assurance with resolutions returned to the effected resident/and or family member. <u>What measures will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> An In-service with staff will be conducted regarding the Grievance Log Policy. Staff will also be re-educated on the use of Work Orders. An Administrator Rounds checklist has been implemented. Administrator will re-educate staff regarding the use of 24hour Report. Resident Council will continue to be held monthly and any issues will be promptly addressed. <u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put in place:</u> Grievance Log, 24 hour report, and Work orders will be brought to the daily Q.A. meetings. Issues will be reviewed with respective departments and plan of action will be started immediately. This will also be monitored thru monthly Social Service Consultant visits. Administrator will utilize Administrator rounds checklist 4 days per week for 30 days and then 2x per week for 6 months.</p>				

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	<p>anything.</p> <p>On 6/15/15 at 9:00 a.m., the Administrator provided an incident report dated 6/12/15, indicating, "On 6/12/15 Resident #145 was asleep in her bed when Resident #50 wandered into her room and sat on her ankles waking her up. Resident #15 turned on her call light for a CNA. [Resident #15] also reported that [Resident #50] has been standing in the doorway to her room and just staring ... Action Taken ...CNA #3 removed Resident #50 from Resident #15's room and escorted him back to his room. ..."</p> <p>2a). On 6/10/15 at 3:00 p.m., Resident #46 indicated, "I haven't had a light in here [indicating his room]. They [indicating staff] keep saying they are gonna put one in so that I can see at night." The light bulb at the head of Resident #46's bed was observed to be missing and the bulb cover was missing from the light fixture. Resident #46 indicated, "I can't see to read." Resident #46 was admitted on 4/20/15.</p> <p>b). On 6/11/15 at 11:34 a.m., Resident #22's wife indicated, "The lightning is poor. It's too dim and when I try to dress him [indicating Resident #22]. If it's dark out you can't make out the colors of his [indicating Resident #22] clothing. I told</p>		Results of thisaudit will be reviewed at Quality Assurance Meetings. <u>By what date the systemic changes will be completed: 7/15/2015</u>	

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F 0225 SS=D Bldg. 00	<p>the Director of Nursing and the Maintenance man." Resident #22's wife indicated she was told the lighting would be fixed, but this never happened.</p> <p>On 6/12/15 at the 9:35 a.m., The Maintenance Supervisor indicated, "Everyone is responsible to let me know the condition of the rooms [indicating resident's room]. Everyone is capable of writing a work order." The Maintenance Supervisor indicated housekeeping usually makes him aware of concerns and writes a work order. Again, the Maintenance Supervisor indicated anyone could write and submit a work order. "No one [indicating staff] has told me [indicating about damages in the resident's rooms]."</p> <p>3.1-7(a)(2)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/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</p>			

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	<p>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 review, the facility failed thoroughly investigate and report to other officials in accordance to state law and the facility's policy and procedure 1 of 1 resident reviewed for allegation of abuse. (Resident #4)</p> <p>Findings include:</p> <p>On 6/11/15 at 10:21 a.m., an interview with Resident #4 indicated two months</p>	F 0225	<p>F- 225 SS= DInvestigate/Report Allegations/Individuals <u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice</u>; A State Reportable was completed regarding this incident. Resident# 4 had red and sore perineal area. The DON noticed it and her intervention wasto get this resident in restorative toileting. Resident # 4 is diagnosed with schizophrenia but</p>	07/15/2015

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	<p>ago the DON (Director of Nursing) hurt her when she took her to the bathroom and wiped her perineal area. Resident #4 believed the DON knew it hurt her, because she made a comment about how wiping should not hurt and how she was red on her perineal area. Resident #4 informed the Administrator (ADM) of the incident after it had happened and she did not want the DON to provide care for her ever again, because she caused her severe pain.</p> <p>On 6/12/15 at 10:28 a.m., the ADM indicated she did not know exactly when the incident between Resident #4 and the DON occurred, but she knew it was a couple of months ago. The ADM also indicated she had nothing in writing in regard to an investigation nor did she report the incident to the Indiana State Department of Health.</p> <p>On 6/12/15 at 10:36 a.m., the DON indicated the ADM informed her of the incident, but she was unaware Resident #4 experienced any pain. The DON indicated she remembered making a comment to the resident about how the resident looked a little irritated when she wiped the resident's perineal area.</p> <p>On 6/15/15 at 9:00 a.m., the ADM provided an incident report, dated</p>		<p>refuses all prescribed medications. She will allow staff to care for her and nursing checked the perineal, per direct care the red soreperineal is not a chronic issue. No additional treatment is needed at thistime.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</u> An audit of the grievance log has been conducted to review for unresolved grievances. SSD and Administrator will conduct a Resident/Family meeting 7/10/2015. An open forum will be allowed for residents and family to voice any grievances. One on one interview's will be conducted with residents and families unable or who choose not to participate in the group meeting. Issues from these meetings will be taken to Quality Assurance with resolutions returned to the effected resident/and or family member. <u>What measures will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> An In-service with staff will be conducted regarding the Abuse Policy and Procedures. Staff will be re-educated on Policy for Reporting Incidents/Occurrences. This will include the facility policy for incidents and State regulations. An Administrator Rounds checklist has been</p>	

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	<p>6/12/15, in regard to the incident with Resident #4 and the DON. The report indicated, "... Date and time of the alleged incident is unknown...Resident required assist off toilet and per care. D.O.N. noticed resident flinched. DON assessed peri area and noticed mild redness. ... Resident later approached Administrator... stated that a few days ago the DON probably didn't mean to be but was rough with her. Resident further asked that the DON not provide her care. ..."</p> <p>On 6/12/15 at 1:35 p.m., the ADM provided the facility's current policy "Abuse & Neglect," revised 9/1/14. The policy indicated, "Each resident has the right to be free from abuse... All allegations will be reported according to State and Federal Law and investigated... The facility will... investigate the allegations and report the results of the investigations... to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident or sooner... The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source ...be reported to the appropriate state agency and to other officials in accordance with Federal and State law..."</p>		<p>implemented. Administrator will re-educate staff regarding the use of 24 hour Report. <u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put in place:</u> Grievance Log, 24 hour report, Incident Reports will be brought to the daily Q.A. meetings. Issues will be reviewed with respective departments and plan of action will be started immediately. Social Service designee will audit Nurses Notes 3x per week for 30 days, 2x per week for next 30 days, and 1x per week for 6 months. This will be monitored monthly thru the Social Service Consultations. Results of this audit will be reviewed at Quality Assurance Meetings. <u>By what date the systemic changes will be completed:</u> 7/15/2015</p>	

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F 0226 SS=D Bldg. 00	<p>3.1-28(d) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure implementation of their policy to thoroughly investigation and report allegations of mistreatment to the State survey and certification agency for 1 of 1 resident reviewed for abuse. (Resident #4)</p> <p>Findings include:</p> <p>On 6/11/15 at 10:21 a.m., an interview with Resident #4 indicated two months ago the DON (Director of Nursing) hurt her when she took her to the bathroom and wiped her perineal area. Resident #4 believed the DON knew it hurt her, because she made a comment about how wiping should not hurt and how she was red on her perineal area. Resident #4</p>	F 0226	<p>F- 226 SS= DDevelopment Abuse/Neglect, Etc.Policies <u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> A State Reportable was completed regarding this incident.The conclusion was that Resident # 4 had red and sore perineal area. The DONnoticed it and her intervention was to get this resident in restorativetoileting. Nursing has contacted the Physician and new orders for sore areahave been received and resident receiving treatment. <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> An audit of the grievance log has been conducted to reviewfor unresolved grievances.</p>	07/15/2015

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	<p>informed the Administrator (ADM) of the incident after it had happened and she did not want the DON to provide care for her ever again, because she caused her severe pain.</p> <p>On 6/12/15 at 10:28 a.m., the ADM indicated she did not know exactly when the incident between Resident #4 and the DON occurred, but she knew it was a couple of months ago. The ADM also indicated she had nothing in writing in regard to an investigation nor did she report the incident to the Indiana State Department of Health.</p> <p>On 6/12/15 at 10:36 a.m., the DON indicated the ADM informed her of the incident, but she was unaware Resident #4 experienced any pain. The DON indicated she remembered making a comment to the resident about how the resident looked a little irritated when she wiped the resident's perineal area.</p> <p>On 6/15/15 at 9:00 a.m., the ADM provided an incident report, dated 6/12/15, in regard to the incident with Resident #4 and the DON. The report indicated, "... Date and time of the alleged incident is unknown...Resident required assist off toilet and per care. D.O.N. noticed resident flinched. DON assessed peri area and noticed mild</p>		<p>SSD and Administrator will conduct a Resident/Familymeeting 7/10/2015. The area Ombudsman will participate and discuss ResidentRights. An open forum will be allowed for residents and family to voice anygrievances. One on one interview's will be conducted with residents and familiesunable or who choose not to participate in the group meeting. Issues from thesemeetings will be taken to Quality Assurance with resolutions returned to theeffected resident/and or family member. <u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> An In-service with staff will be conducted regarding the AbusePolicy and Procedures. Staff will be re-educated on Policy for ReportingIncidents/Occurrences per State regulations. The Administrator Rounds checklisthas been implemented. <u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur, ie;what quality assurance program will be put in place:</u> Grievance Log, 24 hour report, and Incident Reports will bebrought to the daily Q.A. meetings. Issues will be reviewed with respecteddepartments and plan of action will be started immediately. Director of Nursing</p>	

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	<p>redness. ... Resident later approached Administrator... stated that a few days ago the DON probably didn't mean to be but was rough with her. Resident further asked that the DON not provide her care. ..."</p> <p>On 6/12/15 at 1:35 p.m., the ADM provided the facility's current policy "Abuse & Neglect," revised 9/1/14. The policy indicated, "Each resident has the right to be free from abuse... All allegations will be reported according to State and Federal Law and investigated... The facility will... investigate the allegations and report the results of the investigations... to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident or sooner... The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source ...be reported to the appropriate state agency and to other officials in accordance with Federal and State law..."</p> <p>3.1-28(a)</p>		<p>will audit Resident Nurses Notes for documentation of issues that may require Reporting. This will be conducted 3 days per week for 30 days and then 2x per week for the next 30 days, then 1x per week for 6 months. Results of this audit will be reviewed at Quality Assurance Meetings. <u>By what date the systemic changes will be completed: 7/15/2015</u></p>	

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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure a resident who was capable of using a call light had the call light within reach for 1 of 29 resident reviewed during stage 1. (Resident #37)</p> <p>Findings include:</p> <p>Resident #37's clinical record was reviewed on 6/14/15 at 3:00 p.m. Diagnosis included, but was not limited to: hemiparesis (loss of purposeful movement on one side of the body).</p> <p>The current Minimum Data Set assessment (MDS) dated 4/1/15, indicated a Brief Interview for Mental Status score of 12, which indicated interviewable and cognitively intact. The MDS indicated Resident #37 needed extensive assistance of 2 staff person for bed mobility and had functional limitation in range of motion with impairment on one side for upper and lower extremities.</p>	F 0246	<p>F- 246 SS= DReasonable Accommodation of Needs/Preferences <u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> An extension was added to Resident #37's call light cord andchecked to make sure it worked properly. Call light working properly and resident aware of addedextension <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> A Resident Room Audit was conducted to ensure Call Lights arein working order and within reach. A review of residents was completed and alist of residents unable to use a call light was created. The Resident CareRecord has been updated. Checking call lights has been addedalong with clarification of what residents are unable to use call lightindependently. <u>What measures willbe put in place or what systemic change will be made to ensure the</u></p>	07/15/2015

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F 0256	<p>On 6/10/15 at 3:30 p.m., Resident #37's call light was observed wrapped around the left bed rail underneath Resident #37's pillow. Resident #37 indicated he did not know where the call light was at that time. Resident #37 was observed to be paralyzed on his left side and could not use his left hand. LPN #1 indicated Resident #37 was capable of using the call light and could not reach the call light where it was located. LPN #1 was observed to ask Resident #37 if he could reach the call light where it was located and Resident #37 indicated, "No." LPN #1 was observed to place the call light on Resident #37's pillow within his reach.</p> <p>3.1-3(v)(1)</p> <p>483.15(h)(5)</p>		<p><u>deficient practice does not recur:</u> The Resident Care Record with specific needs of each resident and Nursing tasks has been modified to include call light reviews along with identification of residents unable to use call light independently. An in-service on Work Orders will be conducted to ensure prompt attention to repairs that a call light may need. Staff have been in-serviced on the modified Resident Care Record form. <u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put in place:</u> The modified Resident Care Record Form is the tool Aides will use each shift seven days per week to check that call lights are within reach. This tool indicates those residents who are unable to use Call Lights and needs must be anticipated. Work Orders will be reviewed during daily QA Meetings. Maintenance Director will complete Room Inspection 2x per week. Administrator will utilize Administrator rounds checklist 4 days per week for 30 days and then 2x per week for 6 months. Results of this audit will be reviewed at Quality Assurance Meetings. <u>By what date the systemic changes will be completed:</u> 7/15/2015</p>	

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SS=D Bldg. 00	<p>ADEQUATE & COMFORTABLE LIGHTING LEVELS</p> <p>The facility must provide adequate and comfortable lighting levels in all areas. Based on observation, interview, and record review, the facility failed to ensure residents had adequate lighting for 3 of 29 residents reviewed for lighting levels. (Resident #6, Resident #22, Resident #46)</p> <p>Findings include:</p> <p>1). On 6/10/15 at 3:00 p.m., Resident #46 indicated, "I haven't had a light in here [indicating his room]. They [indicating staff] keep saying they are gonna put one in so that I can see at night." The light bulb at the head of Resident #46's bed was observed to be missing and the bulb cover was missing from the light fixture. Resident #46 indicated, "I can't see to read."</p> <p>2). On 6/11/15 at 11:34 a.m., Resident #22's wife indicated, "The lightning is poor. It's too dim and when I try to dress him [indicating Resident #22]. If it's dark out you can't make out the colors of his [indicating Resident #22] clothing. I told the Director of Nursing and the Maintenance man." Resident #22's wife indicated she was told the lighting would be fixed, but this never happened.</p>	F 0256	<p>F- 256 SS=D Adequate and Comfortable LightingLevels</p> <p><u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> Resident #46's light fixture now has a new bulb and cover. Resident #6's light fixture has been repaired. A new light fixture to restore appropriate lighting has beenordered and will be installed in Resident #22's room. <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> A room Audit was conducted and resident Lighting has beenassessed. Repairs or replacement will be done on rooms with inadequatelighting. <u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> Maintenance Director will complete Room Inspection 2x perweek. These issues will be promptly addressed. Staff have been re-educated onuse of Work Orders. <u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur, ie;what quality assurance</u></p>	07/15/2015			

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	<p>3). On 6/10/15 at 3:30 p.m., Resident #6's light above her bed was observed not to be working.</p> <p>On 6/12/15 at the 9:35 a.m., The Maintenance Supervisor indicated, "Everyone is responsible to let me know the condition of the rooms [indicating resident's room]. Everyone is capable of writing a work order." The Maintenance Supervisor indicated housekeeping usually makes him aware of concerns and writes a work order. Again, the Maintenance Supervisor indicated anyone could write and submit a work order. "No one [indicating staff] has told me [indicating about damages in the resident's rooms]."</p> <p>On 6/15/15 at 9:51 a.m., the Administrator provided documentation labeled "Preventative Maintenance Program" undated, and indicated the documentation is what the facility was currently using. The documentation indicated, "...It gives you the opportunity to deal with relatively minor problems as they come up, before they become a larger issue. All of the checklist and inspection sheets are designed to document your accomplishments and establish a patter of service for the building. ..."</p>		<p><u>program will be put in place:</u> Work orders will be brought to the daily Q.A. meetings. Maintenance Director will complete Room Inspections 2x per week. Issues will bereviewed with respective departments and plan of action will be startedimmediately. Administrator will utilize Administrator rounds checklist 4days per week for 30 days and then 2x per week for 6 months. Results of thisaudit will be reviewed at Quality Assurance Meetings. <u>By what date the systemic changes will be completed:</u> 7/15/2015</p>				

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F 0441 SS=D Bldg. 00	<p>On 6/15/15 at 9:51 a.m., the Administrator provided policy labeled "Environmental Standards" dated 10/1/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...The company maintains its facilities in accordance with all federal, state and local code requirements ... The goal is to provide a safe, functional, and clean environment for residents, ... We educate our staff regarding ... the processes for monitoring and reporting mechanisms on the facility environment. ... A Quality Assurance (QA) system is developed and implemented in order to measure, assess, and improve the facility environment."</p> <p>3.1-19(DD)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents</p>						

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	<p>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with an infectious disease was isolated as indicated by his Medical Doctor (MD) and the Center for Disease Control (CDC) guidelines for 1 of 1 resident reviewed for isolation precautions. (Resident #48).</p> <p>Findings include:</p> <p>On 6/11/2015 at 9:23 a.m., during Stage 1 observations, Resident #48 was noted to have several scabbed sores to both arms. Resident #48 indicated he had a</p>	F 0441	<p>F- 441 SS = DInfection Control, Prevent Spread, Linens</p> <p><u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u></p> <p>Resident #48 is no longer a resident at this facility.Roommates were assessed by skilled nursing staff and educated on necessity oftreatment. A skin sweep was</p>	07/15/2015

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	<p>mite (a minute arachnid that has four pairs of legs) living under his skin. Resident was observed to be rubbing his hands up and down both arms and scratching. Resident #48 was observed to be in a room with 3 beds. One bed was occupied by another resident and the other bed was empty. Resident #48's clinical record was reviewed on 6/11/2015 at 11:00 a.m. Resident # 48 was admitted to the facility on 5/22/2015. Diagnoses included, but were not limited to bipolar disorder and schizophrenia. The Admissions Minimum Data Set (MDS) assessment dated 3/20/2015, indicated a Brief Interview for Mental Status (BIMS) score of 12. When 12-15 was interviewable and cognitively intact. Resident #48 needed oversight supervision of 1 staff member when walking in corridor and locomotion on unit. On 6/12/2015 at 9:00 a.m., during an observation of Resident #48, it was noted he had been moved to a different room which housed one other resident. On 6/12/2015 at 12:00 p.m., Resident #48 was observed to be sitting in the main dining room at a table with 4 other resident's. Resident #48 was observed to ambulate independently to his room after lunch was finished. On 6/9/2015, time unknown, Resident</p>		<p>conducted bynurses on all residents and results were negative. Skin sweeps will continue with focus on signs and symptoms for next eight weeks. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</u> A skin sweep was conducted and the results were negative for anyone needing isolation. Nursing will continue to do skin sweeps with focus on any symptoms of scabies infestation for eight weeks after last positive scabies diagnosis. Any undiagnosed skin rash will be evaluated by an experienced dermatologist for assistance in differentiating skin rashes. and confirming the diagnosis of scabies. Any resident found to be positive for scabies will be isolated until 24 hours after all treatments are completed. Visitors for residents positive for scabies will use the same contact precautions and protective clothing as staff. Nursing will be in-serviced on Contact/Isolation Policies and Procedures. <u>What measures will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> Staff will be in serviced by the Director of Nursing on signs and symptoms of scabies infestation.</p>		

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	<p>#48 was seen by a dermatologist for an itchy, painful, red rash located throughout the body. The MD (Medical Doctor) visit report, located on Resident #48's facility chart, indicated Resident #48's rash had been present for 1 month. A scabies prep was performed on the right radial dorsal hand and revealed the resident was positive for mites and ova (female reproductive cell). Physician's order dated 6/9/2015, indicated Resident #48's medication to include: Ivermectin (an antiparasitic drug used to treat scabies) 3 milligram (mg) tabs, take 6 by mouth times 1 today and Ivermectin 3 mg, take 6 by mouth in 1 week and Permethrin (a first line treatment for scabies) 5% cream, apply from neck down to feet overnight times 12 hours, wash off in AM then repeat in 1 week.</p> <p>On 6/15/2015 at 11:00 a.m., License Practical Nurse #2 (LPN #2) indicated Resident #48 had scabies, but was no longer contagious after the 1st dose of medication.</p> <p>On 6/15/2015 at 11:19 a.m., the Director of Nursing (DON) indicated Resident #48 was admitted with the rash. They originally thought it was from a reaction to an antibiotic, but the dermatologist confirmed scabies. All of Resident #48's clothes had been bagged, privacy curtains washed and all personal clothes were</p>		<p>New patients and staff will be screened for scabies by the nursing staff. Records will be maintained with patient name, age, sex, room number, and roommate name for anyone tested positive for scabies. Contact precautions with protective garments (e.g. gowns, disposable gloves, shoe covers, etc.) will be used when providing care or visiting any patient testing positive for scabies. Contact precautions will be maintained until 24 hours after last treatment, patient area has been cleaned thoroughly, bedding and clothing collected and transported in a plastic bag and washed in hot water and dried on high heat. Items not washable will be sealed in an airtight bag for a minimum of 72 hours.</p> <p><u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put in place:</u> The POC will be reviewed quarterly at nurses meetings to ensure continued understanding and compliance. Monitoring sheets for skin rashes, skin assessments and skin documentation will be completed by every staff nurse X 3 observations for each area to assure compliance; additional monitoring times will be done until 100% compliance is obtained and maintained by nursing staff.</p>	

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	<p>washed on high heat. Resident #48 was not isolated, because she was under the impression he was no longer contagious since the 1st round of medication was completed and per facility policy. The DON also indicated Resident #48 was moved to a different room, because he was having trouble getting along with his roommates.</p> <p>On 6/15/2015 at 11:00 a.m., the DON provided the facility's policy, "Infection Prevention Manual for Long Term Care" dated 2009 and indicated it was the one currently being used by the facility. The policy indicated, " ... Scabies ... Contact Precautions ... Until time specified in hours after initiation of effective therapy ... 24 hours ... "</p> <p>On 6/16/2015 at 3:00 p.m., review of Center for Disease Control at www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf, dated 2007 indicated, " ... A single-patient room is preferred for patients who require Contact Isolation ... "</p> <p>On 6/16/2015 at 3:04 p.m., review of Center for Disease Control at www.cdc.gov/parasites/scabies/health_professionals/control.html, dated 11/2/2010 indicated, "... Until successfully treated, patients with crusted scabies should be isolated from other patients who do not have crusted scabies ... "</p> <p>On 6/15/2015 at 2:59 p.m., during a</p>		<p>Facility policies and procedures will be reviewed annually or as often as needed to ensure compliance and accuracy. Department managers will report findings at monthly departmental meetings, and medical staff meetings; QA reports will be reviewed by the QA committee monthly for 6 months to assure compliance. Nursing Staff evaluation forms will include standards of practice related to their licensure and be evaluated annually; any concerns identified will be addressed immediately and monitored until 100% compliance is achieved. The DON and/or designee are responsible for all nursing actions indicated above and will inform the Medical staff and Administration of any noncompliance by facility staff.</p> <p><u>By what date the systemic changes will be completed:</u> 7/15/2015</p>				

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F 0460 SS=D Bldg. 00	<p>phone interview, the nurse for the M.D. at the dermatology clinic who saw Resident #48 on 6/9/2015, indicated any roommates of Resident #48 would be considered contaminated with Scabies and Resident #48 would still be considered contagious until the 2nd round of Ivermectin and Permethrin had been completed. Resident #48 was scheduled for the 2nd round of medication on 6/17/2015. 3.1-18(j)</p> <p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. Based on observation, interview, and record review, the facility failed to ensure</p>	F 0460	F- 460 SS= DBedrooms Assure Full Visual Privacy <u>What correctiveaction will be</u>	07/15/2015

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	<p>residents rooms were equipped to ensure visual privacy for 1 of 17 rooms observed during stage 1. (Room #11)</p> <p>Findings include:</p> <p>On 6/12/15 at 9:30 a.m., the following was observed during the environmental observation with the Maintenance supervisor present:</p> <p>There were no privacy curtains observed hanging in Room #11. The Maintenance Supervisor indicated there should be privacy curtains hanging in that room.</p> <p>On 6/12/15 at the 9:35 a.m., The Maintenance Supervisor indicated, "Everyone is responsible to let me know the condition of the rooms [indicating resident's room]. Everyone is capable of writing a work order." The Maintenance Supervisor indicated housekeeping usually makes him aware of concerns and writes a work order. Again, the Maintenance Supervisor indicated anyone could write and submit a work order. "No one has told me [indicating about the condition of the resident's rooms]."</p> <p>On 6/15/15 at 9:51 a.m., the Administrator provided documentation labeled "Housekeeping" dated 2/18/15. The documentation indicated "...All</p>		<p><u>accomplished for those residents found to have been affected by the deficient practice:</u> The Privacy curtain for Room # 11 has been installed.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</u> A Resident Room Audit was conducted to ensure all rooms have Privacy Curtains. Inventory of curtains was conducted. Housekeeping staff will be in-serviced on proper procedure for cleaning Privacy Curtains, specifically, that they will put a clean curtain up immediately after removing the curtain to be cleaned. The Resident Care Record has been updated. Checking Privacy Curtains has been added to this checklist. <u>What measures will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> The Resident Care Form has been implemented that will be part of shift to shift checks. Housekeeping staff will utilize new Room/Deep Cleaning Schedule. Maintenance Director will complete Room Inspections 2x per week. <u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put in place:</u> Administrator will utilize</p>				

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F 0465 SS=E Bldg. 00	<p>buildings have their housekeeper doing a room each day for deep cleaning. At that time the divider curtains are taken down and sent to laundry. ..."</p> <p>On 6/15/15 at 9:51 a.m., the Administrator provided policy labeled "Environmental Standards" dated 10/1/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...The company recognizes the resident's needs and understand the importance of addressing the issues while maintaining a homelike atmosphere. This ensures the safety of residents, ...while maintaining the residents' comfort and dignity.</p> <p>3.1-19(1)(6)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the housekeeping and maintenance staff maintained a comfortable, orderly, and clean interior for 14 of 17 rooms observed during the stage 1 with 2 residents observed to reside in each the 14 rooms.</p>	F 0465	<p>Administrator rounds checklist 4days per week for 30 days and then 2x per week for 6 months. Results of thisaudit will be reviewed at Quality Assurance Meetings. <u>By what date thesystemic changes will be completed: 7/15/2015</u></p> <p>F- 465 SS= DSafe/Functional/Sanitary/Comfortable/Environment</p> <p><u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient</u></p>	07/15/2015			

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	<p>Findings include:</p> <p>On 6/12/15 at 9:30 a.m., the following was observed during the environmental observation with the Maintenance supervisor present:</p> <p>1). Room #1 had dirty trim above the air conditioner unit, the paint around the trim on the closet door frame was peeling. The room was dirty behind the beds and a dead bug was on the ledge behind bed B.</p> <p>2). Room #2 had dirty window seals, the privacy curtains were dirty, and the facing on the air conditioner was loose. The trim by the sink was damaged and loose at the base of the floor and the side of the wall. Resident #46's light bulb was observed to be missing from the overhead light fixture and Resident #46 indicated, "I haven't had a light in here since I've been here. They keep saying they are gonna put one in so I can see at night. I can't see to read." Resident #46 was admitted on 4/20/15.</p> <p>3). Room #3's window ledge was observed to be cracked and the floor tile by the door was broken. The privacy curtains were dirty.</p> <p>4). Room #4 was observed to have dim</p>		<p><u>practice:</u></p> <ul style="list-style-type: none"> - Room #1: The trim above the Ac unit has been cleaned. The paint around the trim on the closet door frame that was peeling has been re-painted. The room was deep cleaned and dirt behind beds and deadbug on the ledge behind bed B was cleaned. - Room #2: The window seals and privacy curtains have been cleaned. The loose facing on A/C unit has been repaired. The damaged, loose trim at the base of floor and side of the wall have been repaired. Resident #46's light bulb was replaced and light is working. - Room #3: The cracked window ledge has been repaired and the broken tile has been replaced. - Room #4: A new light fixture has been ordered and the holes in the walls at the head of beds have been repaired. The damaged trim around the air conditioning unit has been repaired and cleaned. - Room #7: the chipped paint next to bed and under A/C Unit has been repaired. - Room #10: The floor tile has been stripped and waxed. - Room #11: The walls have been re-painted, removing the scuff marks. New closet doors have been added and the tile floor will be stripped and waxed. The trim around the sink has been repaired and cleaned. The 		

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	<p>lighting, and a large hole at the head of both beds. The trim around the air conditioner was observed to be damaged and dirty. Resident #22's wife indicated there was poor lighting in her husbands room. "When I try to dress him, if it is dark outside I can't make out the colors." Resident #22's wife indicated the Director of Nursing was made aware of this [indicating the hole in the wall and the lighting] as well as the Maintenance Supervisor.</p> <p>5). Room #7 had chipped pain next to the bed, and chipped paint under the air conditioner.</p> <p>6). Room #10 was observed to have dirty floor tile.</p> <p>7). Room #11 walls were observed to have multiple scuff marks on them. There were no closet doors, and the floor tile was dirty. The trim around the sink was loose, dirty, and the string for the overhead light was broken.</p> <p>8). Room #12's walls were observed to have multiple scuff marks, the closet had only 1 door and it swung outward. The floor under the closet was dirty with black spots throughout. The light above Resident #6's bed was observed to not be working.</p>		<p>string for the overhead light has been replaced.</p> <ul style="list-style-type: none"> - Room #12: The scuff marks on walls have been removed. A new closet door has been added. The floor will be stripped and waxed to remove dirt and black spots. The electrical outlet has been replaced. - Room #13: The broken blind rod has been replaced. The floor will be stripped and waxed. The loose trim by the sink has been repaired. The broken outlet has been replaced. - Room #14: The cable outlet behind Resident #36's bed has been repaired. The cobwebs have been removed on the right side of frame above the window. The wall with several screw holes will be repaired. The closet door has been repaired. - Room #15: The trim by the closet door has been repaired and no longer has tape on it. The trim on the floor by the sink has been cleaned. The hole in wall with pipe has been caulked and painted correctly. The privacy curtains have been cleaned. The floor will be stripped and waxed. The curtains by the window were cleaned and cobwebs removed by Resident #15's bed. - Room #16: A closet door has been installed for Resident #16. - Room #17: The closet door has been repaired. - Room #18: The drywall will be repaired and painted to remove 	

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	<p>9). Room #13 was observed to have a broken blind rod lying on the window seal. The floor was observed to be dirty and the trim by the sink was loose. There was a broken electrical outlet at the head of bed B.</p> <p>10). Room #14 was observed to have a detached cable outlet behind Resident #36's bed. There were cobwebs above the window on the right side of the frame. The drywall underneath the corkboard by bed B was observed to have several small screw holes in the wall. The closet door was observed to be loose and dangling.</p> <p>11). Room #15 was observed to have dirty trim by the closet door and tape on the trim holding it in place on the side of the wall by the closet. The trim on the floor by the sink was observed to be dirty and had a hole in the wall with a pipe coming through it. The privacy curtains were dirty, the floor had black stains throughout. The curtains by the window were observed to be dirty and the window had cobwebs by Resident #15's bed.</p> <p>12). Room #16 was observed to have the closet doors missing from the closet. There was one closet door observed on the floor leaning against the wall by the resident's bed. The maintenance</p>		<p>scuffs. The closet doors have been repainted. The privacycurtains have been cleaned.</p> <p><u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> A Resident Room Audit was conducted to identify similarissues. Housekeeping staff will be in-serviced on proper procedure for DeepCleaning and a new schedule has been created. Maintenance Director willcomplete Room Inspections 2x per week.</p> <p><u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> Housekeeping staff will utilize new Room Deep Cleaningschedule. Maintenance Director will complete Room Inspection 2x weekly toidentify areas where repairs are needed. Staff has been in-serviced on usingWork Orders.</p> <p><u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur, ie;what quality assurance program will be put in place:</u></p>	

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	<p>supervisor indicated he was not aware of the closet door being on the floor.</p> <p>13).Room #17 was observed to have a loose dangling closet door.</p> <p>14). Room #18 was observed to have several torn places on the drywall and the closet door was scuffed from the top to the bottom. The privacy curtains were observed to be dirty.</p> <p>On 6/12/15 at the 9:35 a.m., The Maintenance Supervisor indicated, all the closet doors were not in good shape. "Everyone is responsible to let me know the condition of the rooms [indicating resident's room]. Everyone is capable of writing a work order." The Maintenance Supervisor indicated housekeeping usually makes him aware of concerns and writes a work order. Again, the Maintenance Supervisor indicated anyone could write and submit a work order. "No one has told me [indicating about damages in the resident's rooms]."</p> <p>On 6/15/15 at 9:51 a.m., the Administrator provided documentation labeled "Preventative Maintenance Program" undated, and indicated the documentation is what the facility was currently using. The documentation indicated, "...It gives you the opportunity</p>		<p>The 24 hour book and Work Orders will be brought to daily QAmeeting. Maintenance Director will complete Room Inspections 2x weekly. Administrator will utilize Administrator rounds checklist 4days per week for 30 days and then 2x per week for 6 months. Results of thisaudit will be reviewed at Quality Assurance Meetings.</p> <p>By what date the systemic changes will be completed: 7/15/2015</p>	

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F 0514	<p>to deal with relatively minor problems as they come up, before they become a larger issue. All of the checklist and inspection sheets are designed to document your accomplishments and establish a pattern of service for the building. ..."</p> <p>On 6/15/15 at 9:51 a.m., the Administrator provided policy labeled "Environmental Standards" dated 10/1/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...The company maintains its facilities in accordance with all federal, state and local code requirements ... The goal is to provide a safe, functional, and clean environment for residents, ... We educate our staff regarding ... the processes for monitoring and reporting mechanisms on the facility environment. ... A Quality Assurance (QA) system is developed and implemented in order to measure , assess, and improve the facility environment."</p> <p>3.1-19(f)(5)</p>				

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SS=D Bldg. 00	<p>RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were accurately assessed upon admission for 1 of 2 residents reviewed for dental status and services. (Resident #47)</p> <p>Findings include:</p> <p>On 6/11/15 at 9:46 a.m., Resident #47 was observed to be missing multiple teeth.</p> <p>Resident #47's clinical record was reviewed on 6/12/15 at 1:18 p.m. The resident was admitted on 5/6/15.</p> <p>Resident #47's Admission Nursing Assessment, dated 5/6/15, did not indicate the resident had any missing teeth.</p>	F 0514	<p>F- 514 SS = DResident Records-Complete/Accurate/Accessible <u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> Resident #47 Nursing Assessments, Nutrition Assessment havebeen updated to indicate that resident has multiple teeth missing. Thisinformation was added to the Resident Care Record that is used by Nurse Aidesshift to shift. <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> A dental audit was conducted of the residents to ensure theNursing Assessments accurately identified the dental needs of our residents.Nursing will be in-serviced on Admission Assessments. <u>What measures</u></p>	07/15/2015

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	<p>Resident #47's Nutrition Assessment, dated 5/11/15, did not indicate the resident had any missing teeth.</p> <p>On 6/12/15 the following interviews took place:</p> <p>At 2:24 p.m., CNA #1 indicated she was unaware of any dental problems for Resident #47.</p> <p>At 2:39 p.m., the DON (Director of Nursing) indicated Resident #47 is missing some teeth, however, she needed to reassess the resident in order to determine how many natural teeth he had.</p> <p>At 2:44 p.m., the MDS (Minimum Data Set) Coordinator indicated the Nursing and Nutrition Assessments are the only forms which staff would use to document the oral status for the residents.</p> <p>At 2:48 p.m., DON indicated the Admission Nursing Assessment form was inaccurate for Resident #47, because missing teeth was not indicated on his form. She further indicated that he only has 14 natural teeth.</p> <p>3.1-50(a)(2)</p>		<p><u>will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> Nursing Assessments are to be reviewed by the Director of Nursing/designee within the first 24 hours of an admission. This review will include dental issues along with accuracy of entire assessment. Those found to be incomplete will be audited 24 hours after, and then 24 hours later to ensure Assessments completed. <u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put in place:</u> The Director of Nursing/designee will audit the admission Assessments at 24 hours, 48 hours and at 72 hours after admission. MDS Coordinator will complete an audit of Admission Assessments monthly and will bring results to QA meetings each month for 6 months then quarterly thereafter. <u>By what date the systemic changes will be completed:</u> 7/15/2015</p>				

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F 9999 Bldg. 00	<p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>(ee) Each facility shall have a policy concerning pets. Pets may be permitted in a facility but shall not be allowed to create a nuisance or safety hazard. Any pet housed in a facility shall have periodic veterinary examinations and required immunizations in accordance with state and local health regulations.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure cats immunization records were current for 2 of 2 cats who reside in the facility.</p> <p>Findings include:</p> <p>On 6/10/15 at 1:30 p.m., observed 2 cats roaming freely in the facility.</p> <p>On 6/11/15 at 10:00 a.m., the Administrator indicated she was not sure about the cats vaccinations. "I will check."</p> <p>On 6/15/15 at 8:31 a.m., the</p>	F 9999	<p>F 9999 Environment and Physical Standard <u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> This facility only has one cat. On June 12th itreceived vaccinations per regulations for pets living in Health Facilities. <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> A Pet Binder has been created that will allow facility staffto keep track of vaccinations, treatment records, and have easy access. <u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> Decisions to have animals will be determined by the CarePlan Team. Vaccination records will be received and maintained with Pet Policyin the Pet Binder. <u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur, ie;what quality assurance program will be put in place:</u> Administrator will bring Pet Binder to the QA meetingsmonthly for 6 months and quarterly thereafter. <u>By what date the systemic</u></p>	07/15/2015			

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	<p>Administrator provided "RABIES VACCINATION CERTIFICATE ..." dated 6/12/15, and indicated this was the current cat vaccination record. The Administrator had also provided documentation of the previous cat vaccination with expiration date of 2/6/14.</p> <p>On 6/12/15 at 1:35 p.m., the Administrator provided policy "PETS IN FACILITY" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...1. Any pet must be up to date on all immunizations and those records will be maintained at the facility. ...".</p>		<p><u>changes will be completed:</u> 7/15/2015</p>		