

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155493	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2012
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NAME OF PROVIDER OR SUPPLIER SCENIC HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 311 E FIRST ST FERDINAND, IN 47532
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: 1/25, 1/26, 1/27, 1/30, 1/31, 2/1 and 2/2/12</p> <p>Facility Number: 000534 Provider Number: 155493 AIM Number: 100267220</p> <p>Survey Team: Carole McDaniel, RN- TC Terri Walters, RN Martha Saull, RN 1/25, 1/30, 1/31, 2/1, 2/2/12</p> <p>Census Bed Type: SNF/NF: 79 Total: 79</p> <p>Census Payor Type: Medicare: 9 Medicaid: 39 Other: 31 Total: 79</p> <p>Stage II Sample: 14</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p>	F0000	<p>The submission of this plan of correction does not indicate an admission by Scenic Hills Care Center that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Scenic Hills Care Center. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.</p> <p>The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	
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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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	Quality review completed on February 8, 2012 by Bev Faulkner, RN			
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F0225 SS=D	<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 review, the facility failed to ensure appropriate reporting and thorough investigation of 1 of 1 known</p>	F0225	<p>F 225 Resident # 70 suffered no ill effect from the alleged practice. Completion Date 3-2-12</p>	03/02/2012	

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	<p>allegation of abuse from 1 of 15 residents interviewed in a stage I sample of 40 with potential to impact 30 of 79 residents residing on the 100/200 unit assignment. Resident # 70</p> <p>Findings include:</p> <p>On 1/25/12 at 11:00 A.M., the medical record of Resident #70 was reviewed. The 12/08/11 Minimum Data Set Assessment (MDS) indicated the resident had intact cognition and normal long and short term memory.</p> <p>Resident #70 was alert and oriented during interview on 1/25/12 at 11:54 A.M. She indicated there had been a "recent" event during which she had been "roughed up in the bathroom" by a CNA. She indicated she had been yelled at by the CNA and told she was not sick and had her toe bent. She indicated she had been fearful to go to bed and sat up in the wheel chair for quite awhile. She indicated she did report the incident to another CNA and she had been visited by 2 staff persons to whom she told about the event. She indicated that "They" had sent the aide in to apologize. Resident #70 indicated she felt the apology didn't stop that from happening to someone else and</p>		<p>All residents in the future that have an investigation conducted as a result of complaint have the potential to be affected by the alleged deficient practice therefore through in servicing and systemic changes stated below we will ensure procedures are followed in accordance with company policy and State/Federal requirements.</p> <p>Completion Date 3-2-12</p> <p>Staff will be in-serviced regarding proper reporting and prevention of abuse and issued policy and procedure. Staff will let HFA immediately know if any resident are expressing any signs/symptoms of a grievance and/or incident which will be handled by HFA according to State and Federal guidelines.</p> <p>Completion Date 3-2-12</p> <p>Systemic change is ED will submit all grievances immediately for review by Division Director of Operations/Clinical Support with all steps in investigation and reporting requirements reviewed and timely submission to agencies ensured per State and Federal Guidelines.</p> <p>HFA or designee , in HFA's absence, will review all concerns forms, incidents, and allegations in morning standup with the interdisciplinary team members. 5 x per week for 1 month then 3 x a week for a 1 month then weekly</p>		

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	<p>nobody should be treated in that fashion.</p> <p>On 1/31/12 at 10:10 A.M., the Administrator (HCFA) and DON were informed of the allegation. They indicated they were not aware of the incident but would look into it.</p> <p>On 1/31/12 at 11:55 A.M., The HCFA and DON indicated the DON had been aware of a concern with Resident #70. She indicated she had been advised by LPN # 10 on the evening of 1/22/12 that Resident #70 had said CNA #12 had been rushed with her and felt CNA # 12 didn't want to take care of her. The DON indicated she had directed that CNA # 12 not return to work until the DON could visit with the CNA and resident in the morning.</p> <p>The DON indicated she "got a note", which was not provided, from LPN #10 informing her Resident #70 had said CNA #12 was rude with her and rushed through her care. The DON indicated when she spoke with Resident #70 "she indicated the alarm was her main frustration and it had made her (the resident) temperamental." The DON indicated the version of the concern which the resident had expressed to her was</p>		<p>with results forwarded to QA committee monthly X 6 months and quarterly thereafter for review and further suggestions/comments Completion Date 3-2-12</p>				

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	<p>not abusive and the resident expressed more upset about the alarms being used than the CNA behavior. The DON indicated she had directed the CNA to visit with the resident in the presence of the Unit Manager and the apology the CNA desired to give had seemed to be well received.</p> <p>The DON indicated her investigation of the complaint was that CNA#12 had provided "poor customer service" and CNA #12 "did not intend to provide poor customer service" but she had not identified it as an allegation of abuse.</p> <p>Neither the HCFA nor the DON could recall if the allegation had been reported to the HCFA, but indicated they had not reported to state agencies.</p> <p>The facility Abuse Training/ Education acknowledgement signed by employees included: "...abuse is a violation of Resident Rights, violation of Facility Policy, violation of State Law, and simply unacceptable behavior. Abuse includes rough physical treatment, abusive or disrespectful language, leaving resident/ patient unattended, neglect</p>						

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	<p>or failure to respond to resident /patient need. All suspected or observed abuse must be reported IMMEDIATELY to your supervisor and/or facility administration..."</p> <p>Documentation was lacking of a facility "Resident Concern Form" or "Service Recovery Form", each form being part of the facility system of forms. Documentation was lacking to verify thorough investigation, involved party statements, interviews with other staff and oriented residents, employee counseling, or appropriate reporting.</p> <p>3.1-28(d)</p>			
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F0226 SS=D	<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 facility Abuse policies and procedures were followed for 1 of 1 known allegation from 1 of 15 residents interviewed in a stage I sample of 40 with potential to impact 30 of 79 residents residing on the 100/200 unit assignment. Resident # 70</p> <p>Findings include:</p> <p>On 1/25/12 at 11:00 A.M., the medical record of Resident #70 was reviewed. The 12/08/11 Minimum Data Set Assessment (MDS) indicated the resident had intact cognition and normal long and short term memory.</p> <p>Resident #70 was alert and oriented during interview on 1/25/12 at 11:54 A.M. She indicated there had been a "recent" event during which she had been "roughed up in the bathroom" by a CNA. She indicated she had been yelled at by the CNA and told she was not sick and had her toe bent. She indicated she had been fearful to go to bed and sat up in the wheel chair for quite awhile. She indicated she did report the incident to another CNA</p>	F0226	<p>F 226</p> <p>No residents suffered any ill effects from the alleged deficient practice.</p> <p>Completion Date 3-2-12</p> <p>All residents in the future that have an investigation conducted as a result of a grievance have the potential to be affected by the alleged deficient practice therefore through in servicing and systemic changes stated below we will ensure procedures are followed in accordance with company policy and State/Federal requirements.</p> <p>Completion Date 3-2-12</p> <p>All department leaders will have directed inservice regarding investigation procedures and reporting requirements.</p> <p>Completion Date 3-2-12</p> <p>Systemic change is ED will submit all grievances immediately for review by Division Director of Operations/Clinical Support with all steps in investigation and reporting requirements reviewed and timely submission to agencies ensured per State and Federal Guidelines. Completion Date 3-2-12</p>	03/02/2012			

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	<p>and she had been visited by 2 staff to whom she told about the event. She indicated that "They" had sent the aide in to apologize. Resident #70 indicated she felt the apology didn't stop that from happening to someone else and nobody should be treated in that fashion.</p> <p>On 1/31/12 at 10:10 A.M., the Administrator (HCFA) and DON were informed of the allegation. They indicated they were not aware of the incident but would look into it.</p> <p>On 1/31/12 at 11:55 A.M., The HCFA and DON indicated the DON had been aware of a concern with Resident #70. She indicated she had been advised by LPN # 10 on the evening of 1/22/12 that Resident #70 had said CNA #12 had been rushed with her and felt CNA # 12 didn't want to take care of her. The DON indicated she had directed that CNA # 12 not return to work until the DON could visit with the CNA and resident in the morning.</p> <p>The DON indicated she "got a note", which was not provided, from LPN #10 informing her Resident #70 had said CNA #12 was rude with her and rushed through her care. The DON indicated when she spoke with</p>		<p>ED will forward all allegations of abuse to QA committtee monthly for review of compliance with investigation and reporting requirements x 12 months and quarterly thereafter for review and further recommendations. Completion Date 3-2-12</p>		

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	<p>Resident #70 "she indicated the alarm was her main frustration and it had made her (the resident) temperamental."</p> <p>The DON indicated her investigation of the complaint was that CNA#12 had provided "poor customer service" and CNA #12 "did not intend to provide poor customer service" but she had not identified it as an allegation of abuse.</p> <p>Neither the HCFA nor the DON could recall if the allegation had been reported to the HCFA, but indicated they had not reported to state agencies.</p> <p>The facility 9/16/11 "Abuse and Neglect Procedural Guidelines" were reviewed on 2/01/12 at 10:50 A.M. The guidelines included "c. Prevention ii 4. Encourage resident/family to report concerns, incidents, and grievances to staff. Note: If a resident/family is unable or unwilling to fill out a service recovery form, an appropriate staff member will be responsible for completion of the form. 5. Staff is required to report concerns, immediately to your manager and/or Executive Director and Director of Health Services....d. 3 ...continuing the reporting process as</p>				

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	<p>follows: Immediately notify the Executive Director (HCFA)... The Executive Director is accountable for investigating and reporting...."</p> <p>The facility Abuse Training/ Education acknowledgement signed by employees included: "...abuse is a violation of Resident Rights, violation of Facility Policy, violation of State Law, and simply unacceptable behavior. Abuse includes rough physical treatment, abusive or disrespectful language, leaving resident/ patient unattended, neglect or failure to respond to resident /patient need.</p> <p>All suspected or observed abuse must be reported IMMEDIATELY to your supervisor and/or facility administration..."</p> <p>Documentation was lacking of a facility "Resident Concern Form" or "Service Recovery Form", each form being part of the facility system of forms provided. Documentation was lacking of thorough investigation or appropriate reporting.</p> <p>3.1-28(a)</p>			
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F0248 SS=D	<p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were encouraged and/or provided opportunity to attend structured activities for 1 of 3 residents reviewed for activities in a stage 2 sample of 14. Resident #77</p> <p>Findings include:</p> <p>The record of Resident # 77 was reviewed on 1/31/12 at 10 A.M. Diagnoses included, but were not limited to, the following: osteoarthritis, dementia, chronic vertigo, behavior disturbance, dementia with psychotic features and neurovascular glaucoma.</p> <p>A plan of care, dated 9/8/11, addressed the following area: Activity: short attention span: interest bingo, turnover, exercise, socializing, watch variety tv, fishing, needlepoint, catholic church services and creative cooking. Interventions included, but not limited to, the following: provide monthly schedule</p>	F0248	<p>F 248</p> <p>Resident # 77 suffered no ill effects for alleged practice and care plan was updated to reflect current needs of the resident Completion Date 3/2/12</p> <p>All residents have the potential by the alleged practice and by alterations process and in servicing the campus will ensure an ongoing program of activities designed to meet in accordance with the comprehensive assessment the interest of the physical, mental, and psychosocial interests of the residents. Completion Date 3/2/12</p> <p>All activity staff has been in serviced concerning documentation or resident activities and requirements of one to one participation. Completion Date 3/2/12</p> <p>Systemic change is Activity Director or designee will attend morning clinical interdisciplinary team meeting to ensure proper notification of change in resident status or plan of care represents current activity needs Completion Date 3/2/12</p>	03/02/2012			

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	<p>of group programs; invite encourage/escort to programs of interest prn (as needed); evaluate and plan adjust as needed.</p> <p>An Activity note, dated 9/8/11, indicated the following: "needs reminders of up coming activities, uses w/c to et (and) from act (activity); attention span is short. Needs extensive cues and reminders."</p> <p>A care plan meeting note, dated 12/28/11, was observed to be "blank" for the review area for activities.</p> <p>On 1/31/12, the resident's care was monitored. She was observed in her room at 8:20 A.M. sitting in her recliner, awake. At 9:45 A.M., communion was starting in the main dining room. At approximately 10:10 A.M., rosary began. At this time, the resident was observed awake in her room, watching TV. At 10:40 A.M., the resident was observed sleeping in her recliner in her room. At 11:30 A.M., the resident was still observed in her room sleeping in her recliner. From 1:30 P.M. until 2:30 P.M., the resident remained in her room in her recliner.</p> <p>On 2/1/12 at 2:44 P.M., the Activity Director was interviewed. The</p>		<p>Activity Directory or designee will audit five (5) resident's daily participation log for completion and accuracy 5 x a week for 1 month, 3 x a week for 1 month, then weekly with results forwarded to QA committee monthly x six month then quarterly thereafter for review and suggestions.</p> <p>Completion Date 3/2/12</p>		

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	<p>resident's "Daily Participation Log" for January 2012 was reviewed at this time. This log indicated the resident had daily active participation in the following activities: Friendly visits, reading activity, religious service, trivia/quizzes, TV and wheelchair rides/walk. As identified on the resident's plan of care dated 9/8/11, the following are areas of interest to her: Cooking, Bingo and Exercise. On the January 2012 log, documentation was lacking the resident attended and/or was offered and/or refused attendance of these activities. The Activity Director indicated the resident does self directed reading activities in her room, likes to read romance novels and magazines; the resident has a TV in her room and this is a self directed activity. The Activity Director indicated the "friendly visits" are when the staff goes room to room and checks in with the residents; the walks and wheelchair rides are to and from the dining room. She indicated the "Religious Activity" is daily rosary in the dining. For 1/31/12, it was documented on the activity log, the resident actively participated in the religious activity. When the Activity Director was made aware the resident was observed in her room during the time the religious activity was being</p>			
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	<p>held in the dining room, she indicated the resident probably had communion in her room.</p> <p>At this time, the Activity Director was made aware the resident did mostly in room, self directed activities. The Activity Director indicated "That's my error, I should have put her on 1:1's." She indicated she didn't mark the decline and that was her error. She indicated she felt sure the resident was invited to out of room activities but "they just didn't write it down."</p> <p>3.1-33(a)</p>			
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F0311 SS=D	<p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on interview and record review, the facility failed to ensure restorative services were initiated in a timely manner for 2 of 5 residents reviewed who were ordered to receive restorative services.</p> <p>Resident #77, Resident #20</p> <p>Findings include:</p> <p>1. On 1/31/12 at 10 A.M., Resident #77's clinical record was reviewed. Diagnoses included, but were not limited to, the following: Osteoarthritis, dementia, chronic vertigo (dizziness), behavior disturbance, dementia with psychotic features and neurovascular glaucoma.</p> <p>On 12/9/11, a "Therapy Discharge Summary" was written for the resident. This form indicated the resident had begun therapy on 9/2/11. This form included, but was not limited to, the following: "Pt (patient) has demo (demonstrated) inc (increased) strength and balance with skilled PT (physical therapy). Pt</p>	F0311	<p>F 311</p> <p>Residents # 77 and # 20 suffered no ill effects from the alleged practice and screen by therapy services</p> <p>Completion Date 3-2-12</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations, processes, and in servicing the campus will ensure timely implementation of restorative services.</p> <p>Completion Date 3-2-12</p> <p>Meeting held with the Director of Therapy services and Restorative Service Director to establish proper implementation of transition of therapy services to restorative care within 72 hours.</p> <p>Systemic changes will be Rehab Program Director or designee will notify Restorative Director during daily interdisciplinary team meeting of any resident that will be discharged from therapy services that require restorative care within 72 hours.</p> <p>DHS/designee will monitor therapy referrals for restorative care to ensure implementation of program timeliness 5 x per week for one month then 3 x a week for a month then weekly with results</p>	03/02/2012			

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	<p>has pleatu (sic) in progress. Pt. will be D/C (discharged) to restorative program. Staff has been edu (educated) on program."</p> <p>A care plan, dated 12/21/11, addressed the following: "Resident has a need for a Restorative Nursing Walking Program..." Interventions included, but were not limited to the following: "will ambulate daily with rw (rolling walker) et (and) assist of 1 person; monitor for tolerance, resistance and signs and symptoms of pain..."</p> <p>On 2/1/12 at 3 P.M., the DON (Director of Nursing) was interviewed. She provided documentation from the "Resident Restorative Chart" the resident had begun the restorative program on 12/23/11, with the first documentation of restorative ambulation on that date.</p> <p>On 2/2/12 at 8:20 A.M., a copy of the undated facility policy for "Restorative Nursing Program" was received from the DON. (Director of Nursing). She indicated this policy was current. This policy included, but was not limited to the following: "...Resident no longer needs skilled therapy services but has functional goals to be met through practice and</p>		forwarded to QA committee monthly X 6 months and quarterly thereafter for review and further suggestions/comments.				

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	<p>repetition...."</p> <p>On 2/2/12 at 10:45 A.M., the MDS (Minimum Data Set Assessment) Coordinator was interviewed. She indicated when a resident is discharged to the restorative program, she tries to initiate the program within 72 hours of receipt of the order.</p> <p>2. The clinical record of Resident #20 was reviewed on 1/31/12 at 11 A.M. Diagnosis included, but was not limited to, the following: Osteoarthritis bilateral hips. The resident had been admitted to the facility on 11/14/11.</p> <p>A Therapy note, dated 11/15/11, indicated the following: "Reason for Referral: Pt (patient) will undergo THR (total hip replacement) in future. Pt referred to skilled OT (occupational therapy) for pre-operative therapy prior to THR. Skilled OT necessary to maximize hip musculature strength, transfers, and ambulation... tx (treatment) may include ADL (activities of daily living) training...to progress toward goal achievement of increased independence with ADLs transfers and mobility and return to prior level of function."</p> <p>A PT (physical therapy) note, dated</p>				

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	<p>1/23/12, indicated the following: Pt (patient) met goal to be I (independent) with bed mobility...Discussed pts potential surgery to B (bilateral) hips...Discussed potential DC (discharge) to restorative until surgery date set d/t (due to) pt limited with further progress d/t hip pain at this point. Pt will require strengthening in preparation for upcoming B hip replacement once surgery is scheduled.</p> <p>A physician order, dated 1/26/12, indicated the following: D/C PT (discontinue physical therapy), Pt may participate in restorative for there ex (exercise) and ambulation.</p> <p>A Rehab (rehabilitation) screening form, dated 1/30/12, indicated the following: "Pt recently DC/ No further changes."</p> <p>On 2/1/12 at 7:45 A.M., the DON (Director of Nursing) was interviewed. She indicated the MDS (Minimum Data Set Assessmen) Coordinator "just received a care program" form for this resident. At this time, the DON provided a copy of this form. This form indicated the resident was discharged from PT on 1/25/12 and the goals for the restorative program</p>						

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	<p>are "1. Maintain functional mobility; 2. Maintain joint mobility. Approaches/recommendations for implementation of above goals: pt will ambulate with rolling walker with cga/min (caregiver assist/minimum) A (assistance) x 30 ft. or more as tolerated. 2. AROM (active range of motion) to B LE (bilateral lower extremities) in all planes. The DON indicated this restorative program has not yet been started and the above form was received 1 wk ago.</p> <p>3.1-38(a)(2)(B)</p>			
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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food temperatures were obtained prior to food service, failed to ensure potentially hazardous foods were monitored for disposal dates on 1 of 1 tour of the kitchen. In addition, the facility failed to ensure 2 of 3 ice machines were clean and failed to ensure ice was not potentially contaminated. This deficient practice had the potential to affect 78 of 78 residents receiving meals from the kitchen.</p> <p>Findings include:</p> <p>1. On initial tour of the kitchen on 1/25/12 at 9:30 A.M., the following was observed in the walk in refrigerator: An opened bag of corned beef, with approximately 1 lb remaining in the bag, had a handwritten date of 1/17; 1 opened package of turkey, dated with a hand written date of 1/17/12. At this time, Cook #1 was interviewed. She indicated the date handwritten on the package is the date the package was opened. She indicated they</p>	F0371	<p>F371</p> <p>No residents suffered ill effects from alleged deficient practice. Completion Date 3/2/12</p> <p>All residents have the potential to be affected by the alleged practice and through alterations processes, and in servicing the campus will ensure food is stored, prepared, and distributed under sanitary conditions. Completion Date 3/2/12</p> <p>In service all dietary staff concerning dating, disposal, and taking temperatures of food items. In service Plant Operation Director of proper cleaning and monitoring of ice machines on 100-200 nursing station, kitchen, and 400 hall units. Completion Date 3/2/12</p> <p>Systemic change dietary team will dispose all food items in the evening with the expiration date dated for the following day. DFS or designee will monitor food temperature prior to any food leaving service line. Plant Operation Dir. to monitor cleanliness of ice machines weekly and document accordingly. Completion Date 3/2/12</p>	03/02/2012			

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	<p>keep opened meat items for 3 days.</p> <p>On initial tour, in the reach-in refrigerator, the following was observed: a covered container of chicken salad and bologna sandwiches on sandwich bread, which were cut in half. There were approximately 12 sandwich halves stacked in the container. The container these sandwiches were stored in was dated 1/17.</p> <p>On 1/25/12 at 11:45 A.M. Cook #2 was observed placing food items on the steam table in the kitchen. At 11:55 A.M., Cook #2 was observed to being plating food. Cook #2 was not observed to have checked the food temperatures while on the steam prior to plating the food. The FSM (Food Service Manager) was in the kitchen at this time and was interviewed. She indicated after reviewing the food temperature log for the current meal being served, no food temperatures were logged for this meal. The FSM indicated Cook #2 had not checked the food temperatures while on the steam table prior to beginning the food service. At this time, the FSM did check the hot food temperatures and all were over 147.9 degrees F (Fahrenheit).</p>		<p>DFS/Designee will audit walk in for expired food and temperature logs for compliance 5 days a week for a month then 3 days a week for a month then weekly with results forwarded to QA committee monthly for six month then quarterly thereafter for further suggestions and comments. Completion Date 3/2/12</p> <p>ED/ designee will monitor Plant Operations Log weekly for compliance per POC weekly for 3 month then quarterly thereafter with results forwarded to QA committee monthly for six month then quarterly thereafter for further suggestions and comments. Completion Date 3/2/12</p>		

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	<p>On 1/25/12 at 2 40 P.M. the FSM was interviewed. She indicated they keep the chicken salad and meat(bologna) sandwiches for up to 7 days. She stated they threw out the sandwiches that were in the reach-in refrigerator now as the "made date was 1/17." At this time, the FSM was made aware of the opened bags of the following lunchmeats: corned beef dated 1/17, package of turkey dated 1/17. The FSM indicated these should have been thrown out.</p> <p>On 2/1/12 at 3:20 P.M., a copy of the policy and procedure for "Date Marking" was received from the FSM. This policy and procedure had the following note at the bottom of the page: "2009 Armstrong Nutrition Management..." The policy included the following: "All prepared foods that are stored will be properly dated to ensure food safety." The procedure included, but was not limited to, the following: Date marking is an identification system. The system helps identify when the food was prepared and when it is to be discarded; when to date mark: If an opened food item is not used within 24 hours; the food requires refrigeration; a commercially-prepared item is opened; when a ready-to-eat food item is stored regardless of</p>						

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	<p>temperature; when potentially hazardous foods are stored...When to discard: Refrigerated items that are open must be discarded used (sic)or discarded within 7 days; Leftover food items must be used or discarded within 72 hours;</p> <p>On 2/1/12 at 3:20 P.M., a copy of the policy and procedure for "Food Temperatures - Serving Line" was received from the FSM. This policy and procedure had the following note at the bottom of the page: "2009 Armstrong Nutrition Management..." The policy indicated the following: "The temperature of all foods on the serving line will be measured and recorded at every meal." The procedure included, but was not limited to, the following: "Hot foods in the steam table are maintained at > 135 degrees F (Fahrenheit) so that items arrive at approximately >120 degrees F when the resident is served...Temperatures are taken prior to service to ensure hot foods and cold foods are maintained at above temperatures...Temperatures are recorded on the Steam Table Temperature form..."</p> <p>2. On 1/26/12 at 12 P.M., the ice machine for the 100-200 unit was</p>			
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	<p>observed in the nursing unit pantry area. A light brown moist matter was observed on the interior of the ice machine on the upper inside bin. Dust and dirt had accumulated in the lid rim above the ice machine. QMA (Qualified Medication Aide) #1 indicated the maintenance man had just emptied and cleaned the ice machine in the last week or 2.</p> <p>On 1/26/12 at 12:15 P.M., the ice machine for the 400 and Legacy units was observed in the pantry on the 400 unit. Black matter and brownish red rust was observed on the inside of the bin. There were flakes of rust on top of the ice cubes in the bin. The rust flakes appeared like 2 teaspoons of cornflakes scattered. The Administrator was made aware of the above ice machine conditions at this time.</p> <p>On 2/2/12 at 1:50 P.M., the Maintenance Man was interviewed. He indicated he cleans the ice machine twice a year by running a chemical through it. He also indicated he thought dietary "looked at it (the ice machines) quite a bit."</p> <p>On 2/2/12 at 1:50 P.M., a copy of the facility policy and procedure for "Cleaning Instructions: Ice Machine</p>			
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	<p>and Scoop" was received from the Administrator. This policy had the following located at the bottom of the page: "2009 Armstrong Nutrition Management." The policy indicated the following: "The ice machine and scoop will be cleaned and sanitized on a routine basis according to defined procedures." The Procedure included, but was not limited to, the following: "Scrub all machine surfaces and door gaskets inside and out with a hot detergent solution...Note: if machine is self dispensing, wash and clean only the outside of the machine. Maintenance will clean and maintain the inside."</p> <p>On 2/2/12 at 2 P.M., the Food Service Manager (FSM) was interviewed. She indicated the Dietary Department does not clean the ice machines.</p> <p>3.1-21(i)(3)</p>			
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F0441 SS=F	<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.</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, record review and interview, the facility failed to ensure infection control measures</p>	F0441	F441 Resident # 6, 38, 47, 1, 86, 74, 22, 100, 94, 90, 84, 68, 91, 85, 70, 24, 9, 32, 80, 21, 102, and 54	03/02/2012			

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	<p>were maintained during water pass and medication pass and failed to implement infection control policies related to data collection and surveillance of a current infection. This potentially affected 12 of 16 residents observed during water and medication pass and affected 11 of 11 residents with symptoms of gastroenteritis. The failed practices had the potential to affect 79 of 79 residents in the facility.</p> <p>Resident # 6 Resident # 38 Resident #47 Resident #1 Resident #86 Resident # 74 Resident # 22 Resident #100 Resident #94 Resident #90 Resident # 84 Resident #68 Resident #91 Resident #85 Resident #70 Resident #24 Resident # 9 Resident #32 Resident #80 Resident #21 Resident #102 Resident # 54</p> <p>Findings include:</p> <p>1. On 1/26/12 at 10:07 A.M., CNA # 13 was observed passing ice and water on the 100 Hall. She was working from room to room and from resident to resident without hand sanitizing. She was observed to fill the pitcher from the bedside of Resident #80, handling and repositioning the straw during removal</p>		<p>suffered no ill affects form alleged deficit practice. Completion Date 3/2/12</p> <p>All residents have the potential to be affected by the alleged practice and through alterations, processes, and in-servicing the campus will ensure services provided will meet infection control standards. Completion Date 3/2/12</p> <p>In service provided for all staff concerning hand washing and preventative infection control measures. In service for nursing staff concerning infection control measures when passing of ice water. In service for nurses on completion of infection control circumstance forms for proper surveillance and tracking system. Completion Date 3/2/12</p> <p>Systemic change is staff to complete hand washing/cross contamination competency now and annually. Nurses to complete infection control circumstance when definitions of Infections for Surveillance in Long Term Care met for surveillance purpose Completion Date 3/2/12</p> <p>DHS or designee will complete observation of ice water/medication pass of 3 random residents 5 x a week for 1 month then 3 x a week for a month then weekly with results</p>				

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	<p>and replacement of the lid. The pitcher and straw had been used with approximately 1/4 contents remaining. The CNA then went directly to assist Activity Assistant #1 to get Resident #21 toileted in the bathroom, hand washing only after care of Resident #21. CNA #13 then returned to water pass for Resident #38, contaminating her hands in the same manner and then handled the contents of her pocket, pen, a door handle and touched her face before leaving the unit.</p> <p>On 1/27/12 at 10:20 A.M., CNA #13 was observed during ice pass. Resident #102, who was in the front lounge, was done with a glass of lemonade and handed the glass to CNA#13. The CNA received back the empty glass and handled the top rim of the glass with her right hand. Without hand sanitizing, she went directly to continue her water pass going first to the room of Residents #6 and #47 and continuing to pass ice down the hall.</p> <p>On 2/01/12 at 9:53 A.M., CNA # 10 was observed passing ice water between Resident #84, Resident #1, Resident # 86, and Resident #74 on the Legacy unit. She went from bedside to bedside removing lids and</p>		<p>forwarded to QA committee for further comments or suggestions. Completion Date 3/2/12</p>				

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	<p>straws and contacting straws with her hands, including the tips at times. The CNA did not hand sanitize.</p> <p>2. On 1/26/12 at 4:00 P.M., QMA #1 was observed giving medications. She administered pills crushed in applesauce to Resident #54, while supporting the residents head with her hand and arm. She hugged the resident and received a kiss. She went to the medication cart without hand sanitizing. There she directly placed her fingers into the inside of the first of a stack of plastic medication cups to use it for the administration of medication to Resident #22. She did hand sanitize but put the medications for Resident #22 into the soiled cup. After administration of medications to Resident #22 she returned to the cart, charted medications with her pen leafed through the medication administration book and then hand sanitized.</p> <p>3. On 2/1/12 at 9:15 A.M., during interview, the Social Service Director indicated she was fighting a wave of nausea.</p> <p>On 2/1/12 at 10:30 A.M., CNA #11</p>						

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	<p>was observed in the 200 hall checking residents. She stated "Maybe we only have 2 of them sick with the flu down here today, not near as bad as yesterday."</p> <p>Upon seeking entry to the Social Service Office on 1/31/12 between 8:45 A.M. and 9:30 A.M., the Medical Records Director, The Social Service Director and the Assistant Director of Nursing/ Infection Control Nurse indicated " We are all sick in here."</p> <p>On 2/2/12 at 8:40 A.M. the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed regarding the incidence of residents with symptoms of nausea, vomiting and or diarrhea. They indicated there was no ongoing tracking or surveillance being done; however, the DON had kept some copies of doctors orders, to treat symptoms with Phenergan (for nausea) and Immodium (for diarrhea) medication, in her infection control binder.</p> <p>The DON indicated the symptoms were thought to have been begun on the Legacy unit, and had possibly been brought in by a spouse. The ADON indicated when there is an incidence of "multiple cases of flu, the</p>			
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	<p>facility posts an advisory for the public, but since this is more a stomach virus we did not do that." The DON and ADON indicated no changes had been made to volunteers or visitors activities. There had been no change in location, number or character of group activity programming or meals. They indicated staff generally worked the same assignment but due to the illness among the staff, they were limited in flexibility of staffing patterns. They indicated they were not tracking the number of current cases, their location or dates of onset and resolution. They indicated Universal precautions were in place as always and residents were encouraged not to come out of their rooms if they were ill but "you can't make them" stay in their rooms.</p> <p>After being informed of the problem, the DON indicated she would look for a related Policy and Procedure for Infection Control Surveillance.</p> <p>On 2/02/12 at 10:00 A.M., the HCFA and DON provided an undated policy and procedure for Infection Control Surveillance which they indicated the facility followed. The DON indicated since the symptoms were not those of Flu by definition in the policy and</p>						

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	<p>were more nearly those of gastroenteritis in the definition of the policy she believed surveillance was not warranted.</p> <p>The Policy was for the facility to have an "Infection surveillance program that investigates, controls, and prevents infections in the facility and maintains a record of incidents and corrective action related to infections... Infection surveillance is designed to accomplish several goals:</p> <ol style="list-style-type: none"> 1. Enable the facility to quickly identify clusters and/or significant increases in the occurrence of infection. 2. Observe and evaluate the effectiveness of nosocomial infection prevention techniques of resident care delivery. 3. Evaluate changes in infection control policy and procedure. 4. Identify potential occupational exposures." <p>The policy directed the Infection Control Practitioner (ICP) to "1. Collect data, at least weekly, on specific forms... 2 Determine presence of a nosocomial infection, using criteria in "Definitions of Infection for surveillance in Long -Term Care" The list of definitions of</p>			
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	<p>infections for surveillance in Long Term Care included both Influenza-Like symptoms and Gastroenteritis.</p> <p>Another portion of the Policy, Section B included "Is an infection present?...". 1991: Definitions of Infection for surveillance in Long Term Care...are included in this manual... They are of limited use in an outbreak investigation, since the first step required is development of a case definition specific to the outbreak." The Definition list also included the notation "These definitions focus on infections that are commonly acquired and detected in Long Term Care. They are NOT all-inclusive..."</p> <p>Following review of the above Policy and Procedure with the DON and HCFA, they collected data regarding known cases, their location in the facility and their date of onset. These were reviewed on 2/2/12 at 11:15 A.M. The cases known to the facility included:</p> <p>Onset 1/28/12 Resident #100 Legacy unit</p> <p>Onset 1/28/12 Resident #94 Legacy unit</p>			
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	<p>Onset 1/29/12 Resident #90 200 hall</p> <p>Onset 1/29/12 Resident #84 Legacy unit</p> <p>Onset 1/29/12 Resident #68 200 hall</p> <p>Onset 1/30/12 Resident #91 200 hall</p> <p>Onset 1/30/12 Resident #85 200 unit</p> <p>Onset 2/1/12 Resident #70 100 unit</p> <p>4. There were 3 Residents who indicated during interviews they were feeling ill but were not captured in facility data collection:</p> <p>On 2/01/12 at 1:15 P.M., Resident #24 indicated she had reported "I have the flu."</p> <p>On 2/1/12 at 2:15 P.M., Resident #9 indicated she had the flu all week.</p> <p>On 2/1/12 at 2:15 P.M., Resident # 32 indicated she had the flu all last weekend.</p> <p>3.1-18(b)(1)</p>			
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