

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/23/2014
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NAME OF PROVIDER OR SUPPLIER  ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: May 20, 21, 22, 23, 2014</p> <p>Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360</p> <p>Survey Team: Mary Weyls RN TC Laura Brashear RN Lora Brettnacher RN Megan Burgess RN Kewanna Gordon RN</p> <p>Census Bed Team: SNF/NF: 31 Total: 31</p> <p>Census Payor Type: Medicare: 4 Medicaid: 23 Other: 4 Total: 31</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality review completed 05/30/2014 by Brenda Marshall, RN.</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 22, 2014 to the annual licensure survey conducted on May 20, 2014 through May 23, 2014. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</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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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review,</p>	F000225	<b>F225 It is the practice of this</b>	06/22/2014			

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	<p>the facility failed to report incidents of mistreatment for 2 of 2 residents reviewed for allegations of abuse (Resident #'s 1 and 5).</p> <p>Findings include:</p> <p>During an interview on 5/20/14, at 1:25 p.m., Resident # 1 indicated that an area on her arm covered by steri-strips was caused by staff pushing her into a door while transferring her via wheelchair. Resident #1 stated, "Staff is young and stout and they don't realize it hurts to have your arm held like that. I hate to report her but I am tired of being hurt." Resident #1 indicated that she had told staff about the incidents. She stated, "Whenever you have an accident you are supposed to report it. I have gotten to the place where when they see me coming they take out their pencil to record it."</p> <p>During an interview on 5/23/14 at 9:54 a.m., CNA #2 indicated, Resident #1 complained about staff mistreatment daily. CNA #2 indicated she reported it to a supervisor; however, she was unsure of which one. CNA #2 indicated Resident #1 said staff was rough with her when they took her to the bathroom.</p> <p>During an interview on 5/23/14 at 9:56 a.m., CNA #4 indicated Resident #1 had</p>		<p><b>facility to assure 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). The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident#1 and Resident #5 have been assessed by nursing and the psychologist and no adverse effects werenoted. The C.N.A.'s were suspendedpending the investigation and were allowed to return to work after receiving counseling, disciplinary action and were re-education on all aspects of Abuse and Customer Service.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents have been reviewed to assure that no incidents of mistreatment for allegations of abuse. No additional residents were identified.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not</b></p>				

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	<p>complained of rough transfers and the nurses had been made aware. CNA #4 indicated she witnessed CNA # 1 and CNA # 3 transfer Resident #1 in a rough manner when they were in a hurry. She indicated that the CNA's moved Resident #1 without prior warning. CNA #4 indicated she had not reported what she considered rough treatment to resident #1.</p> <p>During an interview on 5/23/14 at 10:11 a.m., LPN # 9 indicated Resident # 5 has reported the CNAs were rough. LPN #9 indicated Resident #5 yelled and complained whenever they touched her. LPN #9 indicated the staff in the facility knew of Resident #5's complaints because they could hear the resident yelling out throughout the facility. She indicated Resident #1 complained staff was too quick with her. She indicated she had reported this information to the Social Services Director. LPN #9 indicated allegations of abuse should be reported to the Administrator or the DON. LPN #9 indicated she did not witness how Resident #1 had injured the area on her arm that was covered by steri-strips.</p> <p>During an interview on 5/23/14 at 10:45 a.m., the Social Services Director indicated a grievance form was filled out</p>		<p><b>recur include:</b> Re-education for the 2 C.N.A.'s involved was completed. An in-service has been conducted with all staff on Abuse.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly interviews 5 residents and 5 staff members to assure that no incidents of mistreatment for allegations of abuse have occurred. The Administrator or designee, will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately reviewed and appropriate action taken. The Quality Assurance Committee will review the Performance Improvement Tool at the scheduled meetings to assure compliance.</p> <p><b>The date the systemic changes will be completed:</b> <b>June 22, 2014</b></p>				

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	<p>along with the person with the grievance. Staff was in serviced on grievances annually and upon hire. She indicated grievances were discussed every morning with team members along with what actions were in place to resolve the grievances. The Social Services Director reviewed her grievance log and indicated she had not documented any reports regarding Resident #1 or Resident #5.</p> <p>During an interview on 5/23/14 at 10:45 a.m., the Administrator indicated no incidents of staff being rough with residents were reported to her.</p> <p>Review of a document titled, "Progress Notes," received from the DON on 5/23/14 at 12:20 p.m., indicated the resident had a history of accusing staff of being rough with her in a note written by the Social Services Director.</p> <p>Review of a facility policy, dated 7/2011, titled "Abuse Prevention" received from the Administrator on 5/23/14 at 12 noon, indicated, "It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident, suspected incident, or allegation of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property</p>			

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F000226 SS=D	<p>to facility management...."</p> <p>3.1-28(c)</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 implement policies that prohibited mistreatment for 2 of 2 residents identified with reports of mistreatment, in that staff failed to report observations and allegations of staff being rough during care (Resident #'s 1 and 5).  Findings include:  During an interview on 5/23/14 at 9:54 a.m., CNA #2 indicated, Resident #1 complained about staff mistreatment daily. CNA #2 indicated she reported it to a supervisor; however, she was unsure of which one. CNA #2 indicated Resident #1 said staff was rough with her when they took her to the bathroom.  During an interview on 5/23/14 at 9:56 a.m., CNA #4 indicated Resident #1 had complained of rough transfers and the</p>	F000226	<p><b>F226 It is the practice of this facility to assure that staff report observations and allegations of staff being rough during care immediately. The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident #1 and Resident #5 have been assessed by nursing and the psychologist and no adverse effects were noted.  <b>Other residents that have the potential to be affected havebeen identified by:</b> All residents have been reviewed to assure that no incidents of mistreatment for allegations of abuse. No additional residents were identified. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> Re-education took place immediately for the C.N.A.'s and LPN on failure to report the</p>	06/22/2014			

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	<p>nurses had been made aware. CNA #4 indicated she witnessed CNA # 1 and CNA # 3 transfer Resident #1 in a rough manner when they were in a hurry. She indicated that the CNAs moved Resident #1 without prior warning. CNA #4 indicated she had not reported what she considered rough treatment to resident #1.</p> <p>During an interview on 5/23/14 at 10:11 a.m., LPN # 9 indicated Resident # 5 reported the CNAs were rough. LPN #9 indicated Resident #5 yelled and complained whenever they touched her. LPN #9 indicated the staff in the facility knew of Resident #5's complaints because they could hear the resident yelling out throughout the facility. She indicated Resident #1 complained staff was too quick with her. She indicated she had reported this information to the Social Services Director. LPN #9 indicated allegations of abuse should be reported to the Administrator or the DON. LPN #9 indicated she did not witness how Resident #1 had injured the area on her arm that was covered by steri-strips.</p> <p>During an interview on 5/23/14 at 10:45 a.m., the Administrator indicated no incidents of staff being rough with residents were reported to her.</p>		<p>allegations of staff being rough during care and reporting immediately. An In-service with all staff has been conducted on reporting observations and allegations of staff being rough during care, Abuse and to report immediately to the Administrator.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly interviews 5 resident and 5 staff members to assure that no incidents of mistreatment for allegations of abuse have occurred. The Administrator or designee will complete this tool weekly x 3, monthly x 3, and quarterly x3. Any issues identified will be immediately reviewed and appropriate action taken. The Quality Assurance Committee will review the Performance Improvement Tool at the scheduled meetings to assure compliance.</p> <p><b>The date the systemic changes will be completed:</b> June 22, 2014</p>	

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F000242 SS=E	<p>Review of a facility policy, dated 7/2011, titled "Abuse Prevention" received from the Administrator on 5/23/14 at 12 noon, indicated, "It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident, suspected incident, or allegation of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to facility management...."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review the facility failed to ensure that residents were allowed to make choices concerning when to wake up and/or how many showers they were assisted with for 4 of 5 residents reviewed for choices. (Resident #'s 1, 7, 13, and 19)</p>	F000242	<b>F242 It is the practice of this facility to assure that residents are allowed to make choices concerning when to wake up and/or how many showers they were assisted with. The correction action taken for those residents found to be affected by the deficient practice include:</b> The Initial	06/22/2014

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	<p>Findings include:</p> <p>1. During interview on 5/21/14 at 2:35 p.m. Resident #7 indicated "would like to sleep till 8 a.m. or 9 a.m., but they don't want me to skip breakfast, so I get up." The resident indicated they usually get me up at 6 a.m.</p> <p>Resident #7's clinical record was reviewed on 5/21/14 at 11:58 a.m.</p> <p>An Annual MDS (minimum data set), dated 11/20/13, indicated choosing bedtime was very important to the resident. The assessment identified the resident as cognitively intact with a BIMS score of 14 (brief interview of mental status)."</p> <p>A quarterly assessment dated, 2/12/14, indicated the resident required limited assistance of one person with dressing.</p> <p>2. During an interview on 5/20/14 at 1:11 p.m., Resident # 1 indicated she was awakened between 5 and 6:30 a.m. She indicated staff gets her up at 5 a.m. and get her dressed and put her back into bed until 6 a.m. She indicated, sometimes staff got her up at 6 a.m., and got her dressed and sat her up in her wheelchair. Resident stated, "I just can't see the sense in it."</p>		<p>Activity Evaluation form has been revised to include bathing frequency and preference for waking up in the morning. Residents have been reviewed and their choices have been updated to reflect their preferences. Resident #1, 7, and 19 have been reviewed for the time that they want to get up in the morning. Resident #19 has been assessed for their bathing schedule and Resident #13 assessed for her preference in regard to bathing frequency.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents had been interviewed regarding their choices in regard to time to get up in the morning and frequency of bathing. All residents are receiving services in accordance with their choices.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> Reinforcement of the facility policy related assuring that residents receive services in accordance with their choices. The staff has been in-serviced related to assuring that resident's choices are honored as part of services provided. The Resident Get-up List and the Resident Shower Schedule has been updated to reflect resident preferences/choices. A new Care Plan will be initialed addressing the residents choices.</p>				

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	<p>During an interview with CNA #3, on 5/23/14 at 9:19 a.m., she indicated she woke resident up at 6:30 a.m. on this day.</p> <p>A document titled, "Initial Activity Evaluation," received from the DON, on 5/23/14 at 12:20 p.m., indicated that resident's preference for wake up time was 7 a.m.</p> <p>3. During an interview on 5/21/14 at 10:03 a.m., Resident #19 indicated that she did not have a choice when staff woke in the morning or how many showers she received weekly. She indicated she received two showers weekly that were assigned to her by the facility.</p> <p>During an interview on 5/22/14 at 11:33 a.m., CNA #3 indicated the night shift CNAs began awakening residents who were part of the "Night Shift Get Up List" at 5 a.m.</p> <p>During an interview on 5/23/14 at 11:33 a.m., Resident #19 indicated that she was awakened by the night shift CNAs before 7 a.m. that morning.</p> <p>During an interview on 5/23/14 at 12:05 p.m., the Social Services Director indicated residents must request extra showers other than their assigned showers throughout the week, which is</p>		<p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly observes 5 residents for honoring of residents' wishes and choices. This tool will specifically observe for residents that have requests to assure that they are honored. The Director of Nursing, or designee, will complete this tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b> <b>June 22, 2014</b></p>	

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	<p>indicated in the Resident's Right packet that all residents receive on admission.</p> <p>During an interview on 5/23/14 at 12:10 p.m., the Activities Director indicated that the quarterly Minimum Data Set (MDS) does not address the amount of showers the resident would prefer weekly, only the type of bathing.</p> <p>During an interview on 5/23/14 at 12:20 p.m., CNA #1 indicated she had been assigned to care for Resident #19 and the resident was awakened by the night shift CNAs around 5:30 a.m.</p> <p>A document titled "Initial Activity Evaluation", dated 4/20/2012, was provided by the MDS Coordinator on 5/23/14 at 10:38 a.m. and indicated Resident #19 would like to get up at 8:00 a.m. in the morning.</p> <p>A document titled "Resident Shower Schedule", dated 1/10/13, was provided by the DoN on 5/23/14 at 12:20 p.m. This document indicated Resident #19 received showers on Tuesday and Friday.</p> <p>The quarterly MDS assessment, completed on 4/9/14, assessed Resident #19 as requiring total dependence for self-performance with bathing, extensive assistance with transfers and assessed her</p>			

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	<p>Brief Interview for Mental Status (BIMS) score as 12 out of 15,</p> <p>A care plan, dated 1/21/14, indicated Resident #19 had an ADL (Activities of Daily Living) self care performance deficit and required assistance from CNA staff with bathing.</p> <p>4. During an interview on 5/20/2014 at 1:17 P.M., Resident #13 indicated the facility had not asked her what her preference was for frequency of showers. She indicated she received two showers a week but she preferred to take one every night. She indicated she felt "dirty" and when she went home on the weekends the "first" thing she did was take a shower.</p> <p>Resident #13's record was reviewed on 5/22/2014 at 11:59 A.M. Resident #13 had diagnoses which included, but were not limited to, osteoporosis and depression. An annual minimum data set assessment tool (MDS) dated 2/26/14, indicated Resident #13 was cognitively intact with a brief interview mental status (BIMS) score of 13 out of 15 and she required physical help with part of bathing. Resident #13's record lacked documentation the facility had assessed her preferences regarding bathing frequency.</p>			

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	<p>A facility list titled "Night Shift Get-Up List," dated 9/14/12, and identified as current by the MDS (minimum data set) nurse on 5/23/14 at 10:35 A.M., indicated night shift started A.M. care for Resident #7 and #19.</p> <p>During an interview on 5/21/14 at 11:11 A.M., the Director of Nursing (DON) indicated shower schedules were determined by room numbers.</p> <p>During an interview on 5/21/14 at 11:13 A.M., the Activity Director indicated residents were assessed for preferences on admission and during care plan meetings. She indicated the assessments did not include their preference regarding frequency of bathing.</p> <p>During an interview on 5/21/14 at 11:30 A.M., Certified Nursing Assistant (CNA) #3 indicated residents were awakened each morning according to a "set" schedule. She indicated there was a "night shift get up list" which identified which residents were to be gotten up at 5:00 A.M. She indicated day shift staff got the rest of the residents out of bed when they arrived at 6:00 A.M. She indicated this was "set" because breakfast was served at 7:00 A.M.</p> <p>During an interview on 5/23/14 at 11:35</p>				

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F000279 SS=D	<p>a.m., the DON indicated the "Night Shift get up List" was in place when she became the DON. She indicated she had been here almost two years.</p> <p>A policy titled "Resident Rights" dated 2010, identified as a current facility policy by the Administrator on 5/23/14 at 9:41 A.M., indicated, "...Self-determination and Participation-The resident has the right to--- 1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.... Make choices about aspects of his or her life in the facility that are significant to the resident...."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services</p>			

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	<p>that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview the facility failed to develop care plans for 1 of 3 residents reviewed for range of motion services (Resident #28) and 1 of 3 residents reviewed for oral hygiene services (Resident #19).</p> <p>Findings include:</p> <p>1. During an interview on 5/20/2014 at 1:27 P.M., the Director of Nursing (DON) indicated Resident #28 had contractures of "both her hands" and was not receiving range of motion services.</p> <p>Resident #28's record was reviewed 5/22/14 at 12:34 P.M. Resident #28 had diagnoses which included, but were not limited to, dementia, degenerative joint disease, a history of colon and uterine cancer, expressive aphasia, and dysphagia.</p> <p>During an observation on 5/22/14 at 12:05 P.M., Resident #28 was observed sitting at a dining room table with both of her arms bent at her elbows drawn up</p>	F000279	<p><b>F279 It is the practice of this facility to assure that the facility develops care plans for range of motion services and oral hygiene services. The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident #28's care plan has been updated to include ROM, goals, and plan on the C.N.A.'s Nursing Care Plan and Charting Grid. Resident #19's care plan has been updated to include oral hygiene.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents have been reviewed and are receiving services in accordance with the plan of care.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The nursing staff has been in-serviced related to assuring that residents receive services in accordance with the plan of care. The Nursing Care Plan and Charting sheet and the Restorative Care Plan and Charting sheet have been</p>	06/22/2014			

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	<p>towards her shoulders.</p> <p>A document titled "Restorative Care Plan And Charting," dated 12/31/2013, indicated, "...(Resident #28 named) had been removed from restorative - CNA's will do ROM (range of motion) to help prevent further contractures..." This record indicated she was at risk for further contractures related to decreased mobility and dementia. This record indicated a goal for Resident #28 was to tolerate five repetitions of prolonged stretching as shown by the therapist to her bilateral upper and bilateral lower extremities six days a week and a plan for her to be able to tolerate prolonged stretching while staff monitored for pain, resistance, redness, or swelling, and for staff to notify therapy if she showed a decline in ROM. The record lacked documentation Resident #28 had been provided range of motion (ROM) services since she was discontinued from restorative nursing services on 12/31/13.</p> <p>During an interview on 5/23/2014 at 11:30 A.M., the Minimum Data Set (MDS) nurse stated, "She did not develop a plan of care for range of motion services for Resident #28. I assumed it was being done but it is not care planned."</p> <p>2. During an interview on 5/21/14 at</p>		<p>revised. The ADL Flow Sheet has been updated to include Oral Hygiene. Any resident that is currently on a restorative program and / or nursing exercise program has been added to the C.N.A. assignment sheet.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to Range of Motion and 5 residents for oral hygiene. The Director of Nursing, or designee, will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool.</p> <p><b>The date the systemic changes will be completed:</b> <b>June 22, 2014</b></p>		

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	<p>10:21 a.m., Resident #19 indicated that her teeth were brushed sometimes in the mornings and during her showers with assistance from the CNAs.</p> <p>During an interview on 5/22/14 at 11:35 a.m., CNA #3 indicated night shift provided oral care to Resident #19.</p> <p>During an interview on 5/22/14 at 3:00 p.m., CNA #10 indicated Resident #19 required assistance with standing at the sink and brushing her teeth. She indicated she sometimes brushed her teeth in the evening and documented this occurrence on her CNA assignment sheet.</p> <p>During an interview on 5/22/14 at 3:02 p.m., the MDS Coordinator indicated she did not have a care plan addressing oral care for Resident #19.</p> <p>During an interview on 5/22/14 at 3:08 p.m., the DoN indicated the activities of daily living (ADL) assignment sheets for the CNAs did not address oral care. She indicated she expected CNAs to perform oral care in the mornings and evenings, but there was no documentation requirement.</p> <p>During an interview on 5/23/14 at 2:00 p.m., the DoN indicated, "There is no facility policy for ADL care for</p>			

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	<p>dependent residents, I expect staff to have common sense to brush residents' teeth."</p> <p>A care plan dated 1/21/14 indicated Resident #19 had an ADL self care performance deficit and did not address interventions for oral hygiene.</p> <p>The quarterly Minimum Data Assessment (MDS), completed on 4/9/14 assessed Resident #19 to require extensive assistance with personal hygiene, which included brushing teeth.</p> <p>A policy titled "Care Planning- Interdisciplinary Team" dated August 2006 and identified as current by the Administrator on 5/23/14 at 9:41 a.m. indicated the following: "Development of the Care Plan: A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). Developing the Comprehensive Care Plan: Our facility's Care Planning/Interdisciplinary Team...develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Purpose of the Care Plan: Each resident's Comprehensive Care Plan has been</p>			
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	<p>designed to: ...incorporate identified problem areas...build on the resident's strengths...aid in preventing or reducing declines in the resident's functional status and/or functioning levels...enhance the optimal functioning of the resident by focusing on a rehabilitative program...."</p> <p>A policy titled "Identifying, Structuring, Implementing, Care Planning, Documenting Restorative Needs and Programs" dated 8/2009 and identified as current by the Administrator on 5/23/14 at 9:30 a.m. indicated the following: "POLICY: IDENTIFYING RESTORATIVE NEEDS- A nursing assessment will be done on all residents on admission, readmission, quarterly and after a significant change in condition... STRUCTURING, IMPLEMENTING RESTORATIVE PROGRAMS- Restorative programs will be set up for individual residents and implemented when functional needs are identified. CARE PLANNING RESTORATIVE PROGRAMS- All restorative programs will be care planned. Care plan changes in the goals and programs will be made in response to a resident's functional improvement or decline. DOCUMENTING RESTORATIVE PROGRAMS- ....Narrative notes will reflect when and why a resident's</p>			

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F000312 SS=D	<p>program was started and discontinued, when, what and why changes were made in the program and the resident's ongoing response to their program...."</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure a resident unable to carry out activities of daily living independently received the necessary services to maintain oral hygiene for 1 of 1 residents reviewed who met the criteria for oral hygiene. (Resident #19)</p> <p>Findings include:</p> <p>During an interview on 5/21/14 at 10:21 a.m., Resident #19 indicated her teeth were brushed sometimes in the mornings and during her showers with assistance from the CNAs.</p> <p>During an interview on 5/22/14 at 11:35 a.m., CNA #3 indicated night shift provided oral care to Resident #19.</p>	F000312	<p><b>F312 It is the practice of this facility to assure that the residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident #19's care plan has been updated to include oral hygiene. The ADL Flow Sheet has been updated to reflect oral hygiene. <b>Other residents that have the potential to be affected have been identified by:</b> All residents have been reviewed and are receiving services in accordance with the plan of care. <b>The measures or systematic changes that have been put</b></p>	06/22/2014			

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	<p>During an interview on 5/22/14 at 3:00 p.m., CNA #10 indicated Resident #19 required assistance with standing at the sink and brushing her teeth. She indicated she sometimes brushed her teeth in the evening and documented this occurrence on her CNA assignment sheet.</p> <p>During an interview on 5/22/14 at 3:02 p.m., the MDS Coordinator indicated she did not have a care plan addressing oral care for Resident #19.</p> <p>During an interview on 5/22/14 at 3:08 p.m., the DoN indicated the activities of daily living (ADL) assignment sheets for the CNAs did not address oral care. She indicated she expected CNAs to perform oral care in the mornings and evenings, but there was no documentation requirement.</p> <p>During an interview on 5/23/14 at 2:00 p.m., the DoN indicated, "There is no facility policy for ADL care for dependent residents, I expect staff to have common sense to brush residents' teeth."</p> <p>A care plan dated 1/21/14 indicated Resident #19 had an ADL self care performance deficit and did not address interventions for oral hygiene.</p>		<p><b>into place to ensure that the deficient practice does not recur include:</b> The nursing staff has been in-serviced related to assuring that residents receive services in accordance with the plan of care. The ADL Flow Sheet has been updated to include Oral Hygiene</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 residents for oral hygiene. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool.</p> <p><b>The date the systemic changes will be completed:</b> <b>June 22, 2014</b></p>		

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F000318 SS=G	<p>The quarterly Minimum Data Assessment (MDS), completed on 4/9/14 assessed Resident #19 to require extensive assistance with personal hygiene, which included brushing teeth.</p> <p>3.1- 38(a)(3)(C)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to ensure residents with limited range of motion were provided services to prevent further decrease in range of motion for 2 of 3 residents reviewed out of 6 who met the criteria for contractures without range of motion/splint services (Resident #28 and #29). This deficient practiced resulted in harm due to Resident #28's increased dependence on staff for eating due to decreased range of motion in bilateral upper extremities.</p> <p>Findings include:</p> <p>1. During an interview on 5/20/2014 at 1:27 P.M., the Director of Nursing</p>	F000318	<p><b>F318 It is the practice of this facility to assure that the residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident 28's and 29's care plans has been updated to include ROM, goals, and the Nursing Care Plan and Charting Grid.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents have been reviewed and are receiving services in accordance with the plan of care.</p>	06/22/2014			

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	<p>(DON) indicated Resident #28 had contractures of "both her hands" and was not receiving range of motion services.</p> <p>Resident #28's record was reviewed 5/22/14 at 12:34 P.M. Resident #28 had diagnoses which included, but were not limited to, dementia, degenerative joint disease, a history of colon and uterine cancer, expressive aphasia, and dysphagia.</p> <p>During an observation on 5/22/14 at 12:05 P.M., Resident #28 was observed sitting at a dining room table with both of her arms bent at her elbows and drawn up towards her shoulders. Two cups of thickened liquids were observed sitting on the table in front of her. During an interview on 5/22/14 at 12:05 P.M., Resident #28 stated, "I would dearly love to have them in my hand but I can't reach them. I want both of them. Will you help me? I am thirsty."</p> <p>During an observation on 5/22/14 at 12:09 P.M., Certified Nursing Assistant (CNA) #3 was observed feeding Resident #28. Resident #28's upper extremities remained contracted and drawn up towards her shoulders while CNA #3 fed her.</p> <p>A document titled "OT (Occupational</p>		<p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The nursing staff has been in-serviced related to assuring that residents receive services in accordance with the restorative plan of care. Each C.N.A. has been re-education on the Restorative Care Plan and Charting and Nursing Care Plan and Charting. The IDT Team has been in-service on Restorative Programs and Nursing Range of Motion Programs. During the weekly Medicare/Therapy meeting the MDS Coordinator will review residents on restorative programs and nursing range of motion programs. The IDT will receive a list on restorative programs and those that have been discharged from the restorative programs and add them to the ROM programs to help prevent further contractures.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 residents for Restorative Plan of Care and Nursing Plan of Care. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed.</p>		

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	<p>Therapist) Progress and Updated Plan of Care" dated 8/7/13, indicated Resident #28 had been evaluated and treated by therapy due to osteoarthritis in her hands. She was discharged from OT on 11/29/13. This record indicated at the time she was discharged she "effectively utilizes after set-up to get food to mouth requiring set-up..." This document indicated Resident #28 would be discharged from therapy to the restorative nursing program with a long term goal of, "The care givers will complete 100 percent return demonstration of restorative nursing program to facilitate ROM, positioning, and use of BUE (Bilateral Upper Extremities)..."</p> <p>A document titled "Restorative Care Plan And Charting" dated 12/31/2013, indicated, "... (Resident #28 named) had been removed from restorative - CNA's will do ROM (range of motion) to help prevent further contractures..." This record indicated she was at risk for further contractures related to decreased mobility and dementia. This record indicated a goal for Resident #28 to tolerate five repetitions of prolonged stretching as shown by the therapist to her bilateral upper and bilateral lower extremities six days a week and a plan for her to be able to tolerate prolonged stretching while staff monitored for pain,</p>		<p>The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool.</p> <p><b>The date the systemic changes will be completed: June 22, 2014</b></p>	

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	<p>resistance, redness, or swelling, and for staff to notify therapy if she showed a decline in ROM. The record lacked documentation Resident #28 had been provided range of motion (ROM) services since she was discontinued from restorative nursing services on 12/31/13.</p> <p>An annual minimum data set assessment tool (MDS) dated 1/26/2014, Resident #28 required extensive assistance (physical assistance of one staff with resident involved in some of the activity) for eating and had limitation with range of motion in both her upper and lower extremities.</p> <p>A document titled "ADL (Activity of Daily Living) Grid" dated May 2014, indicated Resident #28 was totally dependent on "one person physical assist" for eating and drinking.</p> <p>2. During an interview on 5/20/14 at 12:39 P.M., the DON indicated Resident #29 had contractures of his left hand, fingers, and wrist and he was not receiving range of motion or splint services.</p> <p>Resident #29's record was reviewed on 5/22/2014 at 12:08 P.M. Resident #29 had diagnoses which included, but were not limited to, Parkinson's disease,</p>			

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	<p>cerebral vascular accident (stroke), dementia, hemiparesis, weakness, and osteoporosis.</p> <p>During an observation on 5/22/14 at 10:00 A.M., Resident #29 was observed to have contractures of his left wrist, hand, and fingers.</p> <p>A document titled "OT (Occupational Therapist) Daily Treatment Note dated 8/7/13, indicated Resident #29 had been screened and treated by therapy for contractures and limited range of motion to his left upper extremity. This document indicated Resident #29 had completed therapy and was discharged to a "Restorative Nursing Program."</p> <p>A document titled "Restorative Care Plan and Charting" dated April 2014, indicated Resident # 29 had been discontinued from restorative nursing services due to "refusing to allow ROM and refusing to leave splint on..." The document indicated staff would continue to encourage and provide services during daily care..."</p> <p>A current care plan dated 4/22/14 indicated Resident #29 had contractures and would be provided gentle range of motion as tolerated with daily care. The record lacked documentation Resident</p>			

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	<p>#29 had been provided range of motion services since he was discontinued from a restorative nursing program on April 22, 2014.</p> <p>During an interview on 5/22/14 at 3:22 P.M., the Director of Nursing (DON) indicated MDS (Minimum Data Set) coordinator informed her via a "list" when residents were discontinued from the restorative program. She indicated when she obtained this information she would add range of motion services to the CNA's assignment sheets so they would know when and whom to provide the services. The DON stated, "If she doesn't give it to me I have no idea. No (Resident #28 and #29 named) do not receive range of motion. I thought (Resident #29 named) was still on the restorative program. I am not sure when he was discontinued."</p> <p>During an interview on 5/22/14 at 3:26 P.M., the MDS coordinator indicated she failed to inform the DON when Resident #28 and #29 were discontinued from the restorative program.</p> <p>During an interview on 5/22/14 at 3:29 P.M., Certified Nursing Assistant (CNA) #10 indicated range of motion services were not provided to residents unless it was on the assignment sheets. She</p>			

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F000323 SS=D	<p>stated, "I do not do it unless it is on the assignment sheet. The only way we know to do it is if it is on the assignment sheet..." She indicated Resident #28 and #29 had not been provide ROM services.</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure side rails did not have a gap greater than 4 3/4 inches wide and were not a potential accident hazard for 1 of 11 residents reviewed for side rail safety (Resident #16).</p> <p>Findings include:</p> <p>During an observation on 5/20/14 at 1:32 P.M., Resident #16 was observed in bed. Bilateral quarter rails were raised. There were three large openings on each of the side rails.</p> <p>During an observation on 5/20/14 at 1:39 P.M., the Director of Nursing measured the width and length of the openings of</p>	F000323	<p><b>F323 It is the practice of this facility to assure that residents' environment is safe and free of hazards. The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident #16's was immediately changed to a bed with appropriate side rails. The side rails of the bed in question were discarded and appropriate side rails were ordered. <b>Other residents that have the potential to be affected have been identified by:</b> All of the beds have been assessed to assure that the environment is free from hazards. No other beds and/or residents were identified. <b>The measures or systematic changes that have been put into place to ensure that the</b></p>	06/22/2014			

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F000371 SS=E	<p>the side rail. The middle opening measured 10 inches in length and 8 inches in width.</p> <p>During an interview on 5/20/14 at 1:39 P.M., the Director of Nursing (DON) indicated she was not aware of the requirements or measurements for safe side rails.</p> <p>Resident #16's record was reviewed on 5/23/14 at 9:26 A.M. Resident #16 had diagnoses which included, but were not limited to, Alzheimer's disease, convulsions, contractures, and a history of a stroke.</p> <p>A policy titled "Proper Use of Side Rails" dated April 2007, identified as current by the Minimum Data Assessment Nurse on 5/23/14 at 10:59 A.M., failed to indicate measurement requirements to ensure safe use of side rails.</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p>		<p><b>deficient practice does not recur include:</b> Maintenance will be checking resident equipment when it is put in use and as part of preventive maintenance to assure proper function. There will be routine monitoring via nursing and guardian angel rounds</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to a safe environment. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b> June 22, 2014</p>	

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	<p>A. Based on observation, interview, and record review, the facility failed to ensure food and juices were labeled with a date of preparation or "use by" date; failed to ensure adequate hand sanitation during food preparation; and failed to prepare food under sanitary conditions during 2 of 2 kitchen observations. This deficiency had the potential to impact 30 of 30 residents who consumed food from the kitchen.</p> <p>B. Based on observation, interview and record review the facility failed to ensure adequate hand sanitation during food distribution; and failed to maintain drinking glasses in a sanitary manner for 1 of 2 random dietary observations.</p> <p>Findings include:</p> <p>A. During the initial Kitchen Sanitation tour on 5/20/14 at 10:40 A.M. with Dietary Cook #1 present, the following was observed in the reach in cooler:</p> <ol style="list-style-type: none"> <li>1. A clear storage bag which contained sliced pears was not labeled with an open date or use by date.</li> <li>2. A clear bag which contained ham was not labeled with an open date or use by date.</li> </ol>	F000371	<p><b>F371 It is the practice of this facility to assure that the facility must store, prepare, distribute and serve food under sanitary conditions. The correction action taken for those residents found to be affected by the deficient practice include:</b> After surveyor's conversation with the Dietary Manager, the day shift cook was not allowed to return to work until she was re-educated. Disciplinary action took place. All other Dietary Staff were re-educated on 5-23-14 with Teachable Moments given as a Disciplinary Action.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents have the potential to be affected although none were affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The Dietary Manager's Daily Sanitation Inspection checklist has been revised. The Cook's Daily Checklist has been revised to include open dates on already dated items. All Staff has been in-serviced related to assure proper storage, preparation, distribution and serving food under sanitary conditions</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance</p>	06/22/2014	

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	<p>3. Ravioli in a clear plastic container was not labeled with an open or use by date.</p> <p>4. Pudding in a clear plastic container was not labeled with an open or use by date.</p> <p>5. Tomato juice in a plastic pitcher was dated with an open date of "5/6/2014."</p> <p>6. A jar of teriyaki marinade was not labeled with an open date.</p> <p>7. Cooked carrots in plastic container were not labeled with an open or use by date.</p> <p>8. A clear plastic container with a label which indicated "Carmel" had an open date of "4/29/14."</p> <p>9. A clear plastic container which contained sliced fruit was not labeled with an open date or use by date.</p> <p>10. Three dessert bowls which contained chocolate pudding was not covered or labeled with an open date or use by date.</p> <p>11. Shaved turkey sandwich meat in an opened plastic bag was not labeled with an open or use by date.</p> <p>12. A tray with several plastic bags of a</p>		<p>Improvement Tool has been initiated that randomly reviews 5 kitchen and dining room observations to include 5 residents that need assisted feeding. The Dietary Manager, or designee, will complete this tool weekly x 3, monthly x 3, and quarterly x3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool.</p> <p><b><i>The date the systemic changes will be completed: June 22, 2014</i></b></p>	

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	<p>yellow substance (identified as thawing eggs by Dietary Cook #1) and a ham were observed laying in liquid in a shallow tray in the stand-up refrigerator.</p> <p>During an interview on 5/20/14 at Dietary Cook #1 indicated left overs were to be discarded after two days and all opened foods should have been labeled.</p> <p>During the full Kitchen Sanitation tour on 5/20/14 at 11:30 A.M., with Dietary Cook #1 present ,the following observations were made:</p> <ol style="list-style-type: none"> <li>Two trays of dessert cups were stacked on top of each other and identified as clean and ready for use by Dietary Cook #1. The trays on which the clean cups were stored had a brown substances splattered on them.</li> <li>Dietary Cook #1 was observed to puree meat, carry the blender over to the dirty sink which contained dirty dishes, used the sprayer to rinse out the blender, and then, without washing or running the blender through the dishwasher to be sanitized, she prepared vegetables in the same blender. After she pureed the vegetables she rinsed the blender out with water, and without washing it or running it through the dish washer, she prepared meat for "mechanical soft" diets in the</li> </ol>			

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	<p>same blender. Dietary Cook #1 did not sanitize her hands after touching equipment on the "dirty" side of the sink and before she prepared food.</p> <p>3. At 11:45 P.M., Dietary Cook #1 was observed putting cooked rolls into individual bags. She was wearing plastic gloves. While still wearing plastic gloves she picked up keys from the food prep area and placed them in her jean pocket. Without changing gloves she proceeded to touch the cooked rolls as she placed them into individual bags.</p> <p>During an interview on 5/22/14 at 3:09 P.M., the Dietary Manager indicated the following:</p> <ol style="list-style-type: none"> <li>1. All prepared food should have been labeled with the date prepared.</li> <li>2. All food items should have been labeled when opened with an open and expiration date (unless a manufacture's expiration date is indicated).</li> <li>3. All leftovers should have been discarded after 72 hours.</li> <li>4. Eggs and meat were to be kept on the bottom shelf of the refrigerator and thawed separately.</li> <li>5. Staff should have washed their hands as soon as they walk into the kitchen, before they touched food, after they put dirty dishes in the sink, after they touched</li> </ol>			

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	<p>the dirty side of the sink and before they touched the clean side, and between glove changes.</p> <p>6. Staff should have washed there hands at least thirty seconds.</p> <p>7. Equipment used to puree food should have been rinsed and ran through the dishwasher before it was used to prepare another food.</p> <p>A Policy titled "Food Labeling and Dating" dated 4/03, and identified as current by the Administrator on 5/23/14 at 9:40 A.M., indicated, "...Foods are labeled and dated for identification purposes and to ensure they are discarded within acceptable time frames... all food products that are purchased and brought into the Dietary department inventory are dated upon delivery and storage. A red permanent marker is used for this purpose. 2. Leftover foods and all opened, perishable items are dated with the current date and discarded after 72 hours. If an item is not readily identifiable, the name of the item is also written on the label. 3. Items that are not considered perishable...are dated when the original container is opened...these should be discarded monthly, at minimum..."</p> <p>A document titled "Self Inspection Checklist" identified as current by the</p>			

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	<p>Administrator on 5/23/14 at 9:40 A.M., indicated, "...Thaw food (covered, labeled, dated) in a refrigerator...Place raw meats in separate pans on the bottom shelf of the refrigerator away from other foods..."</p> <p>A policy titled "Environmental Sanitation/Infection Control" dated 2014, provided by the Administrator on 5/23/14 at 9:40 A.M., indicated, "The food processor/blender is cleaned and sanitized after each use... The bowl, lid, gasket and blade assembly are removed from the motor unit and washed in the pot and pan sink taking care to avoid cuts. Parts may also be run through dish machine for though cleaning and sanitizing..."</p> <p>An undated policy titled "Proper handwashing Technique" identified as current by the Administrator on 5/23/14 at 9:40 A.M., indicated, "...Handwashing Guidelines...when working with food, employees should recognize that it is important to wash there hands often especially...before and after handling raw or cooked goods... the food handler may contaminate the gloves by touching...equipment, etc. Food handlers will pick up items from the floor, ripen boxes, and touch the outside of equipment...gloves be changed as soon as</p>			

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	<p>they become soiled..."</p> <p>B. During a continuous observation of the dining service on 5/20/14 from 11:50 a.m. until 12:40 p.m., CNA #1 and CNA #2 served ice tea, water, and lemonade from pitchers that were not covered. CNA #1 touched the rim of Resident #5's cup with her bare hand. CNA #1 was observed feeding Resident # 28 and Resident #6. She touched the rim of Resident # 28's cup of nectar thick liquid and then wiped her hand off on the table cloth then resumed feeding Resident #6 with the same hand. CNA #1 then wiped Resident #28's mouth with a cloth and resumed feeding Resident #6. Resident #28 indicated that her mouth needed to be wiped again and CNA #1 picked up the soiled cloth and wiped Resident #28's mouth again. CNA #1 resumed feeding both Resident #28 and Resident #6 with no hand wash or use of hand sanitizing gel during the observation period. Staff # 5 was observed buttering Resident #9's roll with his bare hand. He was overheard explaining to Resident #9 that it is hard to butter bread without touching it, and his hands were clean as he did so.</p> <p>During an interview with the Dietary Manager on 5/23/14 at 11:50 a.m., she indicated that serving pitchers should have been covered during dining room service. She further indicated that food</p>			

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F000441 SS=D	<p>should not have been handled with staff's bare hands during service. She also indicated that cups should not have been handled by the rim.</p> <p>A document entitled, "Rules for Serving and Removing Food," received on 5/23/14 at 1:26 p.m., from the Dietary Manager indicated that staff should, "Avoid touching the rims of glasses," during service. A document entitled, "Hand Washing &amp; Glove Use for Food Workers-Questions and Answers," received from the Dietary Manager on 5/23/14 at 1:26 p.m. indicated that, "ready-to-eat food be prepared and served without bare hand contact." The Dietary Manager indicated that she was unable to locate a policy regarding the covering of pitchers that was requested on 5/23/14 at 11:55 a.m.</p> <p>3.1-21(i)(3)</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 -</p>			

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NAME OF PROVIDER OR SUPPLIER  ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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	<p>(1) Investigates, controls, and prevents 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 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 sanitary environment to prevent infections and cross contamination for random observations of 1 of 1 dressing change (Resident #25) and 1 of 1 insulin injection (Resident #44).</p> <p>Findings include:</p> <p>1. On 5/21/14 at 11:47 a.m., LPN #11 was observed to provide a wound vac</p>	F000441	<b>F441 It is the practice of this facility to assure that to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The correction action taken for those residents found to be affected by the deficient practice include:</b> A Teachable Moment was given to LPN #11 regarding DressingsDry/Clean and Subcutaneous Injections. <b>Other residents that have the</b>	06/22/2014

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	<p>dressing change to Resident #25. CNA #1 was observed to assist. While wearing gloves, the staff members positioned the resident in bed on her left side. LPN #11 disconnected the two part wound vac tubing. Drainage was observed in the tubing. The LPN removed a glove from each hand by inverting the glove over both ends of the tubing as they were removed from the LPN's hands. The LPN hands were sanitized with gel and new gloves applied. The foam dressing was cut to size and packed into the wound with gloved hands. A new black sponge dressing was cut to size and packed into the wound. With the same gloves on, the outside "Opsite" dressing was applied over the entire area and an area cut out to avoid contact with the rectal area. With the same gloves on the LPN continued to apply the exterior adhesive dressing and connect the new drain tubing from the dressing kit to the tubing attached to the wound vac. The LPN removed the gloves, checked the setting on the wound vac and restarted, without sanitizing hands.</p> <p>A facility policy and procedure titled "Dressings, Dry/Clean," provided by the DON on 5/22/14 at 3:29 p.m., included, but was not limited to, "POLICY: Handwashing should be performed: ...After gloves are removed...Before and</p>		<p><b>potential to be affected have been identified by:</b> All residents have the potential to be affected although none were affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> Nursing Staff has been in-serviced related to Dressing ChangeDry/Clean, Subcutaneous Injections and Infection Control.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 3 residents and nurses related to dressing changes, subcutaneous injections and infection control. The Director of Nursing, or designee, will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool.</p> <p><b>The date the systemic changes will be completed:</b> <b>June 22, 2014</b></p>		

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	<p>after touching wounds and changing wound dressings. ...After situations during which microbial contamination of hands is likely to occur...When otherwise indicated to avoid transfer of microorganisms to other residents and environments ...When indicated between tasks and procedures on the same resident to prevent cross contamination..."</p> <p>2. During an observation on 5/20/14 at 11:59 a.m., LPN #11 administered 5 units of Humalog subcutaneous to resident #44's left upper arm without wearing disposable gloves.</p> <p>During an interview on 5/23/14 at 11:00 a.m., the DON indicated that she would have expected her nursing staff to wash their hands and wear gloves when providing a subcutaneous insulin injection.</p> <p>A policy titled "Subcutaneous Injections" dated April 2007 and identified as current by the Administrator on 5/23/14 at 9:30 a.m. indicated the following: "Purpose: The purpose of this procedure is to provide guidelines for the administration of medication by subcutaneous injection. Steps in the procedure: 1. Perform hand antisepsis. 2. Put on gloves...."</p> <p>3.1- 18(1)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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