

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2012
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NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342
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F0000	<p>This visit was for the Investigation of Complaint IN00120614, Complaint IN00119351, Complaint IN00120018 and Complaint IN00117076.</p> <p>Complaint IN00120614 Substantiated. Federal/state deficiencies related to the allegation are cited at F157, F279, F441.</p> <p>Complaint IN00119351 Substantiated. Federal/state deficiencies related to the allegation are cited at F159.</p> <p>Complaint IN00120018 Substantiated. Federal/state deficiencies related to the allegation are cited at F282, F323, F465 and F514.</p> <p>Complaint IN00117076 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: December 5, 6 and 7, 2011</p> <p>Facility number: 000366 Provider number: 155469 Aim number: 100288900</p> <p>Survey team: Kathleen (Kitty) Vargas, RN, TC Shannon Pietrazewski, RN (12/5/12 & 12/6/12)</p>	F0000	<p>Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance. This provider is asking for a desk review of this Plan of Correction for compliance.</p>	

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

TITLE

(X6) DATE

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

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	<p>Census bed type: SNF/NF: 121 Total: 121</p> <p>Census payor type: Medicare: 17 Medicaid: 90 Other: 14 Total: 121</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/13/12 Cathy Emswiler RN</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a physician for a change in condition of a resident who was having loose stools for 1 of 3 residents reviewed with Clostridium difficile (an</p>	F0157	<p>F157 It is the practice of this facility to ensure that family and physician notification is completed timely for significant changes in physical,</p>	01/06/2013	

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	<p>intestinal infection). (Resident #J)</p> <p>Findings include:</p> <p>Resident #J's clinical record was reviewed on 12/6/12 at 2:10 p.m. Resident #J's diagnoses included, but were not limited to, UTI (urinary tract infection), c-diff (Clostridium difficile), dementia, and atrial fibrillation.</p> <p>On 11/12/12 at 12:32 p.m., output documentation indicated the resident had a large amount of loose, liquid stool with foul odor.</p> <p>On 11/13/12 at 1:00 a.m., nursing documentation indicated the resident had diarrhea two times during the shift and Immodium (anti diarrhea medication) was given.</p> <p>On 11/14/12 at 9:41 p.m., output documentation indicated the resident had a medium amount of loose, liquid stool that was tarry/black in color.</p> <p>On 11/16/12 at 4:15 a.m., nursing documentation indicated the resident had blood streaked loose stool with a foul odor and a low grade temperature of 99.4.</p> <p>On 11/17/12 at 5:00 a.m., nursing documentation indicated the resident</p>		<p>mental or psychosocial status or deterioration in health. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident J's family and physician were made aware of her condition and new orders were obtained. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents who have had loose stools have the potential to be affected by the same alleged deficient practice. Audits were completed of residents who have had loose stools to ensure family and physician notification was completed timely. The nursing staff was in serviced on: The importance of notification to physician of residents who have loose stool with emphasis on risk factors such as age, use of antibiotics, and the risk of clostridium difficile infection. · The policy titled "clostridium difficile" · The specific guidelines of 3 loose stools in a 24 hour period as an indicator in determining when to request for a clostridium difficile culture. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The DON/designee is</p>				

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	<p>continued to have loose stools with minimal amount of bright red blood.</p> <p>On 11/21/12 at 2:30 a.m., nursing documentation indicated the resident had a large amount of loose and foul odor stool, twice during the shift.</p> <p>The resident was started on an antibiotic for UTI again on 11/16/12. The facility did not notify the physician until 11/21/12 to obtain a stool specimen to evaluated for possible c-diff infection.</p> <p>During clinical record review, the stool specimen indicated the resident tested positive for c-diff on 11/21/12.</p> <p>There was no evidence in the record that the facility notified the physician of the resident's loose stools until 11/21/12.</p> <p>Interview with the Infection Control Nurse on 12/7/12 at 8:45 a.m., indicated the physician was not notified timely of the resident's loose stools.</p> <p>This Federal tag relates to Complaint #IN00120614.</p> <p>3.1-5(a)(2)</p>		<p>reviewing resident records daily for change in condition such as loose stools · The DON/designee is reviewing 24 hour reports daily for change in condition such as loose stools. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>· The DON/designee will audit residents' medical records that have had loose stools 3 days a week to ensure high risk residents are identified timely and notification to physician has been made. · The DON/designee will audit residents' medical records and if any resident has had 3 loose stools with a 24 hour period that the facility has made a request for a clostridium difficile culture. · The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</p> <p>Compliance Date: 1/06/2013</p>				

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

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to ensure written authorization was obtained from a resident prior to financial transactions conducted with family members for 1 of 3 residents reviewed for personal funds.</p> <p>The facility also failed to provide quarterly statements to the residents whose funds were managed by the facility for 5 of 5 resident interviews in a sample of 11. (Resident #E, Resident #F, Resident #G, Resident #L and Resident #M)</p> <p>Findings include:</p> <p>1. A Trust Fund report was provided on 12/5/12 at 11:20 a.m. by the Business Office Manager. 95 residents were listed as having a Trust Fund account with the facility. The Business Office Manager indicated all the residents listed on the Trust Fund report received quarterly statements.</p> <p>During orientation tour on 12/5/12 at 10:10 a.m., LPN #1 indicated Resident #E</p>	F0159	<p>F159</p> <p>It is the practice of this facility to hold, safeguard, manage and account for the personal funds of residents who have deposited funds with the facility. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Residents E, F, L and M are not identified due to a complaint survey. · Resident G was given a balance of his Trust Fund account and provided written acknowledgement of receipt. · A list of residents that the facility manages money for has been compiled and December statements have been processed and will be given to resident/responsible parties by compliance date. Residents with cognition concerns will be provided statements if requested by a responsible party. · Authorization forms for all Trust Funds accounts have been audited. How will you identify other residents having the potential to be affected by the same deficient practice and</p>	01/06/2013

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	<p>was alert and oriented and was interviewable. The resident was listed as having a Trust Fund account with the facility.</p> <p>Resident #E was interviewed on 12/6/12 at 9:45 a.m., she indicated the facility managed her funds. She indicated she was admitted to the facility on 9/16/11. She also indicated she had not received quarterly statements related to her funds.</p> <p>2. During orientation tour on 12/5/12 at 10:10 a.m., LPN #1 indicated Resident #L was alert and oriented and was interviewable. The resident was listed as having a Trust Fund account with the facility.</p> <p>Resident #L was interviewed on 12/6/12 at 9:05 a.m., he indicated the facility managed his funds. He indicated he had resided in the facility for more than 5 years. He also indicated he had not received quarterly statements related to his funds.</p> <p>3. Resident #M was identified as alert and oriented by the Wound Nurse during Orientation Tour on 12/5/12 at 10:15 a.m.</p> <p>Resident #M was listed as having a Trust Fund account with the facility.</p>		<p>what corrective action will be taken. · All residents who have the facility manage their funds have the potential to be affected by this alleged deficient practice.</p> <p>· A list of residents currently with balances in the resident trust fund was completed to determine residents that the facility manages funds for.</p> <p>· A letter was sent to residents/ Responsible Parties to verify who has authorization to access funds from the trust fund and who is authorized to receive quarterly statements.</p> <p>· An acknowledgment form was created to verify receipt of statements personally delivered.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Residents/guardians that request the facility manage their funds will be sent quarterly statements. An acceptance log will be kept of all statements that are personally delivered to residents in the facility. The log will require a signature from the resident or signatures of 2 witnesses if the resident is unable to sign. Residents with cognition concerns will have their statements delivered to the POA/guardian unless otherwise directed.</p> <p>· Authorization to access funds is limited to residents and/or authorized representatives for the resident.</p>				

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	<p>Resident #M was interviewed on 12/6/12 at 8:55 a.m., she indicated the facility managed her funds. She indicated she had resided in the facility for more than 2 years. She also indicated she had not received quarterly statements related to her funds.</p> <p>4. Resident #F's clinical record was reviewed on 12/5/12 at 12:30 p.m. Resident #F's diagnoses included, but were not limited to, MS (multiple sclerosis), dehydration, UTI (urinary tract infection), acute renal failure, failure to thrive, and diarrhea. She was admitted to the facility on 11/3/11.</p> <p>During clinical record review, the quarterly MDS (Minimum Data Set) assessment dated 9/27/12, indicated the resident was cognitively intact.</p> <p>Resident #F was interviewed on 12/6/12 at 8:30 a.m. Resident #F indicated she</p>		<p>How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Each quarter the Administrator/designee will interview 5 residents that have a trust fund account to assure that they did receive a statement if requested. Findings of these interviews will be presented quarterly to the Quality Assurance Committee for review. · The Administrator/designee will review the trust fund withdrawal approval sheets monthly to assure proper authorization is in place for each withdrawal. Results of the audit will be presented to the monthly Quality Assurance Committee. · Compliance Date: 01/06/2013</p>				

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	<p>has never received a quarterly Trust Fund statement from the facility.</p> <p>5. Resident #G's clinical record was reviewed on 12/5/12 at 11:35 a.m. Resident #G's diagnoses included, but were not limited to, dementia, CVA (cerebral vascular accident/stroke) with hemiparesis. The resident was admitted to the facility on 5/6/10.</p> <p>During clinical record review, the quarterly MDS (Minimum Data Set) assessment dated 10/4/12, indicated the resident was cognitively intact. The face sheet indicated a particular family member was to receive quarterly statements and the resident was responsible for himself.</p> <p>Interview with the resident, on 12/5/12 at 1:50 p.m., indicated he had been saving his money of \$52/month. Resident #G indicated he had not been receiving quarterly statements and no one had access to his personal trust account. Resident #G indicated he had recently tried to withdraw money and learned that his account balance was less than anticipated. Interview with the Business Office Manager on 12/5/12 at 2:30 p.m., indicated the residents could get statements at anytime they requested it. The Business Office Manager indicated</p>						

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	<p>who ever signs the resident in will receive the quarterly statements, if the resident was not cognitively intact. She indicated the family would purchase items for the resident and would use money from the account as reimbursement. The Business Office Manager indicated if the resident was cognitively intact, the resident had to sign an authorization form for withdrawal of money. There was no authorization signed by the resident to indicate his brother or his niece could take money out of his account without his permission. There was no authorization for his brother to receive the quarterly statements. The resident's admission paperwork was found incomplete. The Book-keeper indicated the resident had been receiving his quarterly statements. The facility was unable to provide proof of the resident receiving his statements. The Business Office Manager indicated the activities department passed out the statements to the residents.</p> <p>Interview with the Activities Director on 12/5/12 at 3:20 p.m., indicated they did not see the quarterly statements. She indicated mail was placed in the resident's mailbox in the business office and activities personnel would pick it up and deliver it. The Activities Director indicated the resident had been upset for a short while because he was expecting</p>			

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	<p>some statement in the mail and had not received it.</p> <p>On 12/5/12 at 4:00 p.m., the Business Office Manager and Book-keeper provided a Resident Trust Fund Policy Notification and Authorization form and the residents account information. The form indicated "...No funds will be disbursed or purchases made without the appropriate written authorization of the resident or authorized representative. In accordance with state and federal laws, individuals making purchases and withdrawals on behalf of a resident out of the resident's trust fund must sign an affidavit assuring that funds will be used for the resident's benefit. The facility will pay any charges presented to it by contract services such as the barber and the beauty shop or clothing supplies. Payments from trust fund accounts will only be made if the resident has appropriately authorized the purchase. Quarterly statements are issued to all residents detailing account activity."</p> <p>During this time, the Business Office Manager also provided the resident's Trust Fund Account record. Several checks or withdrawals were observed on the account information. Three out of six checks observed were written and dispersed without written authorization</p>						

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	<p>from the resident. On 4/29/11, a check for \$200 was written out to the Resident #G's family member for "personal items." The Business Office Manager indicated the family member did not bring in the receipt for proof of personal items and was given the benefit of the doubt. On 4/20/12, a check for \$11 was written out to H&R block for tax preparation. The Business Office Manager indicated since the resident sat with the tax person, a check was written without authorization. On 9/28/12, a check for \$232.67 was written out to the Resident #G family member for reimbursement of phone payments. The family member did bring in receipts, but there was no written authorization from the resident. When the Business Office Manager was asked about the written authorization, she indicated the family member could have gotten permission from the resident. When asked if she witnessed the verbal authorization or taken the word of the family member, she indicated she had taken the word of the family member. On 7/15/11, a check for \$400 was written for "miscellaneous." On 10/4/11, a check for \$351.64 was written for "miscellaneous." On 4/2/12, a check for \$266.72 was written for "personal items."</p> <p>The resident was interviewed again on 12/6/12 at 3:00 p.m. The resident</p>						

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	<p>indicated a different family member was to be paying his phone bill and his family member in question had not brought in any clothes nor had authorization to take money out of his account without his knowledge. The resident indicated this family member had not mentioned to him about removing money from his account when he visits, which is often.</p> <p>Interview with the Admissions Coordinator on 12/6/12 at 3:30 p.m., indicated she had difficulty getting the resident to sign his admission paperwork. The Admissions Coordinator indicated if the resident refused to sign paperwork, they should contact family to sign the resident into the facility. She was unable to indicate or recall why the resident's admission paperwork was incomplete.</p> <p>A "Resident Personal Trust Fund Policy" (undated) was provided by the Administrator on 12/6/12 at 12:00 p.m. The policy indicated, ". . . Residents will be provided written receipts of any deposits or withdrawals from their trust account and will sign the facility's copy of the receipt indicating their authorization for the transaction. In the event a resident is unable to sign withdrawal drafts for supplies or services . . . a resident funds account withdrawal authorization shall be signed by the legal responsible party in</p>						

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	<p>order to facilitate required purchases . . .</p> <p>The resident or their legal representative must authorize in writing the name(s) of individuals which may withdraw funds from the trust account. A request for an advance to purchase items must not exceed \$200.00 by written check request. If the advance is granted to purchase personal items for the resident then receipts and monies not spent must be returned to the resident's account. Items purchased must be witnessed by the facility and added to the valuables list . . .</p> <p>A quarterly statement is provided that reflects all deposits and withdraws for each month."</p> <p>This Federal tag relates to Complaint #IN00119351.</p> <p>3.1-6(b) 3.1-6(g)</p>			

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F0279 SS=D	<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 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 ensure a care plan was initiated for infections for 3 of 4 residents reviewed for infections, in a sample of 11. (Resident #H, Resident #J and Resident #K)</p> <p>Findings included:</p> <p>1. Resident #K was observed during orientation tour on 12/5/12 at 10:10 a.m. The resident was seated in his wheelchair in his room. During interview at that time, LPN #1 indicated the resident had a diagnosis of Clostridium Difficile (an</p>	F0279	<p>F279</p> <p>It is the practice of this facility to ensure that comprehensive care plans are developed for residents to meet their medical, nursing, and mental and psychosocial needs.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>A comprehensive care</p>	01/06/2013			

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	<p>infection of the intestines with characteristic symptoms of diarrhea, requiring isolation practices to reduce the risk of transmission). Isolation equipment was set up outside of the resident's room.</p> <p>The record for Resident #K was reviewed on 12/6/12 at 9:15 a.m. The resident was admitted to the facility on 10/2/12. He was admitted to the facility with a diagnosis of Clostridium difficile and was placed into contact isolation. The resident's care plans dated October 2012, November 2012 and December 2012, were reviewed. There was no care plan for the Clostridium difficile infection.</p> <p>Interview with the Nurse Consultant on 12/6/12 at 3:40 p.m., indicated there was no care plan for the Clostridium difficile. She indicated a care plan for the infection should have been initiated.</p> <p>2. The closed record for Resident #H was reviewed on 12/6/12 at 8:05 a.m. The resident was admitted to the facility on 6/26/12. He had diagnoses that included, but were not limited to, depression, hypertension, Alzheimer's Disease and urinary tract infection. His admission orders included Levoquin (an antibiotic) 500 milligrams, 1 tablet orally once a day 6/26/12 through 7/3/12, for urinary tract infection.</p>		<p>plan with timetables and measurable goals was developed for resident K based on his diagnosis of clostridium difficile.</p> <ul style="list-style-type: none"> Resident H has been discharged from facility. A comprehensive care plan with timetables and measurable goals was developed for resident J based on her diagnosis of clostridium difficile and orders for isolation. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All facility residents with diagnosis of clostridium difficile or who have orders for isolation due to diagnosis of clostridium difficile have the potential to be affected by the same alleged deficient practice.</p> <p>Audits were completed of</p>		

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	<p>Review of the resident's care plans dated June 2012 and July 2012, indicated a care plan for the urinary tract infection was not initiated.</p> <p>Interview with MDS (Minimum Data Set) Coordinator #1 on 12/7/12 at 10:00 a.m., indicated there was no care plan initiated for the urinary tract infection.</p>		<p>residents with diagnosis clostridium difficile or who have orders for isolation due to diagnosis of clostridium difficile</p> <p>The care plan coordinators, infection control nurse, and nursing staff were in serviced on:</p> <ul style="list-style-type: none"> · The importance of developing comprehensive care plan timely with emphasis on diagnoses of clostridium difficile and isolation. · Notifying the appropriate staff/department of any new diagnoses of clostridium difficile so that the facility may ensure a comprehensive care plan is developed timely with emphasis on diagnoses of clostridium difficile and isolation. <p>What measures will be put into place or what systemic changes you will make to ensure that</p>		

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			<p>the deficient practice does not recur?</p> <ul style="list-style-type: none"> The DON/designee is reviewing admissions and re-admissions for documentation of clostridium difficile diagnoses in order to ensure a comprehensive care plan is developed timely for isolation. The DON/designee will be reviewing existing residents 3 days a week for new orders for diagnoses of clostridium difficile in order to ensure a comprehensive care plan is developed timely for isolation. <p>How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The DON/designee will audit residents' orders that have had loose stools 3 days a week to ensure a 		

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	<p>3. Resident #J's clinical record was reviewed on 12/6/12 at 2:10 p.m. Resident #J's diagnoses included, but were not limited to, UTI (urinary tract infection), c-diff (Clostridium difficile), dementia, and atrial fibrillation.</p> <p>The nursing notes dated 11/21/12 at 3:00 a.m., indicated a stool specimen was collected for testing for c-dif.</p> <p>The lab results indicated the resident tested positive for c-diff on 11/21/12. The lab results indicated the resident</p>		<p>comprehensive care plan is developed timely for isolation.</p> <p>The DON/designee will present a summary of the audit to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</p> <p>Compliance Date: 1/06/2013</p>				

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	<p>continued to test positive for the c-diff antigen on 12/5/12.</p> <p>Review of the November 2012 and December 2012 care plans, indicated there was no care plan initiated for the Resident #J's c-diff/isolation precautions.</p> <p>An interview with the Nursing Consultant on 12/6/12 at 3:50 a.m., indicated there was no care plan for the resident's c-diff/isolation precautions.</p> <p>This Federal tag relates to Complaint #IN00120614.</p> <p>3.1-35(a)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure physician's orders and residents' care plans were followed related to monitoring of intake and out put for 1 of 3 residents reviewed for dehydration in a sample of 11. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's clinical record was reviewed on 12/5/12 at 12:30 p.m. Resident #F's diagnoses included, but were not limited to, MS (multiple sclerosis), dehydration, UTI (urinary tract infection), acute renal failure, failure to thrive, and diarrhea.</p> <p>A care plan, with a review date of 10/27/12, for indwelling urinary catheter indicated the facility was to " . . . assess the drainage q (every) shift. Record the amount, type, color, odor. Observe for leakage. Measure and record output..)</p> <p>The urine output documentation for the month of November, 2012, was reviewed. The facility used three shifts of</p>	F0282	<p>F282</p> <p>It is the practice of this facility to ensure that services are provided by qualified persons/per care plan. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident F output records are up to date per care plan and physician orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents with indwelling Foley catheters orders/care plans to monitor intakes and outputs have the potential to be affected by the same alleged deficient practice. An audit of residents with indwelling Foley catheters has been completed. An audit was completed of residents with diagnosis of dehydration. Care plans for residents with dehydration diagnosis have been reviewed. The nursing staff was in serviced on: · The importance of following Physician orders and the plan of care related to indwelling Foley catheters. · The importance of documenting every</p>	01/06/2013	

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	<p>nursing staff in a 24 hour period. The review indicated urine output documentation/recording was incomplete. On November 2nd, 4th, 5th, 6th, 13th, 14th, 19th, 20th, 25th, and 26th only one shift documented outputs. On November 3rd, 7th, 15th, 17th, 18th, and 21st two shifts documented output. On November 1st, 9th, 11th, 12th, 16th, 22nd, and 24th no shifts documented outputs.</p> <p>An "Output, Measuring and Recording" policy dated 09/2005, provided by the MDS (Minimum Data Set) Assistant on 12/6/12 at 11:00 a.m., indicated, "The purpose of the procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period . . . The following information should be recorded on the bedside intake and output record and/or in the resident's medical record: The date and time the resident's urine output was measured and recorded . . . The amount (in ml's) of output . . . The amount of character of output . . . "</p> <p>A "Catheter Care, Urinary" policy dated 09/2005, provided by the MDS Assistant on 12/6/12 at 11:00 a.m., indicated, " . . . Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to your supervisor . . . Maintain an accurate record of the resident's daily</p>		<p>shift on urine outputs. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The DON/designee is reviewing admissions, re-admissions and new orders for indwelling Foley catheters. · The DON/designee will audit residents with indwelling Foley catheters 3 days a week for required documentation of intake and output. · 3 days a week, the DON/designee will audit residents with care pans and/or orders to monitor intakes and outputs to ensure the documentation is being recorded every shift. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DON/designee will audit residents with indwelling Foley catheters 3 days a week for required documentation of intake and output. · 3 days a week, the DON/designee will audit residents with care pans and/or orders to monitor intakes and outputs to ensure the documentation is being recorded every shift. · The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented</p>				

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	<p>output, per facility policy and procedure . . . Empty the collection bag at least every eight (8) hours . . . Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor . . ."</p> <p>This Federal tag relates to Complaint #IN00120018.</p> <p>3.1-35(g)(2)</p>		<p>quarterly at the QA meeting. Monitoring will be on going.</p> <p>Compliance Date: 1/06/2013</p>		

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F0323 SS=D	<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, record review and interview, the facility failed to ensure each resident was free from accidents related to the proper use of fall preventions devices for 1 of 3 residents reviewed for accidents in a sample of 11. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D was observed on 12/6/12 at 3:15 p.m. The resident was in a high backed wheelchair in the hall. The resident was taken into his room by CNA #1. The resident was lifted by CNA #1 and LPN #2. There was no chair alarm in place on the resident's chair.</p> <p>Interview with CNA #1 on 12/7/12 at 9:10 a.m., indicated there was no chair alarm on the chair on 12/6/12 at 3:15 p.m. He indicated he knew the resident was to have a bed alarm, but did not know he was to have a chair alarm.</p> <p>The CNA care card in the resident's room, on the inside of the closet door, was</p>	F0323	<p>F323</p> <p>It is the practice of this facility to ensure that resident's environment remains as free of accident hazards as is possible.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Re-educated C.N.A #1 and L.P.N#2 · Resident D's fall interventions, care plans, and care card were reviewed. All interventions are in place and appropriate. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p>	01/06/2013			

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	<p>observed on 12/7/12 at 9:10 a.m. The care card indicated the resident was to have dycem to his wheelchair and he was to have a wheelchair alarm.</p> <p>Resident #D was observed on 12/7/12 at 11:55 a.m. He was seated in a high backed wheelchair in the dining room. The resident was taken to the shower room by the Restorative Nurse. Observation of the resident's chair cushion indicated there was no dycem (a plastic film used to reduce the risk of sliding) between the resident's body and the top of the chair cushion. Interview with the Restorative Nurse at that time, indicated the dycem should have been placed on top of the cushion to prevent the resident from sliding out of the chair.</p> <p>The record for Resident #D was reviewed on 12/6/12 at 2:10 p.m. The resident had diagnoses that included, but were not limited to, anxiety, hypertension and dementia. The resident had a history of falls. He fell on 7/20/12, 9/23/12, 10/4/12 and on 10/8/12.</p> <p>The Falls Assessment completed on 11/2/12 indicated the resident's fall risk was '23'. A score greater than 10 was "high risk."</p> <p>The Significant Change Minimum Data</p>		<p>All facility residents with fall interventions ordered have the potential to be affected by the same alleged deficient practice.</p> <p>Audits were completed of residents who have fall interventions ordered and the facility ensured all interventions were appropriate and in place.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The nursing staff was re-in serviced on:</p> <ul style="list-style-type: none"> · All fall interventions and ensuring all interventions are placed in the care plan and on the care card. · Where to find/how to read care cards. · Completing routine rounds and monitoring to ensure fall interventions 				

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	<p>Set (MDS) assessment dated 11/9/12, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. The resident required extensive assistance with transfers, and his balance was not steady during transfers and when standing.</p> <p>There was a care plan that was initiated on 7/23/12 that indicated the resident had a history of falling related to decreased mobility and poor safety awareness. Some of the approaches to the care plan were -bed alarm in bed -chair alarm in chair.</p> <p>There were Physician Orders dated 11/2/12, that indicated dycem was to be placed in the wheelchair, bed alarm was to be used in bed and a chair alarm was to be used in the wheelchair.</p> <p>Review of the resident's fall event dated 10/4/12, indicated, "resident rocked forward and began to slide onto floor on buttocks, activity aide unable to get to resident. He did not hit his head."</p> <p>The form titled, "Incident Questionnaire" dated 10/4/12, indicated that when the resident fell on 10/4/12, "the alarm was not properly functioning dycem was not properly placed under resident."</p>		<p>listed on the care cards are in place at all times.</p> <p>How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Restorative Nurse/designee will randomly audit 10 residents daily on alternative shifts 7 times a week to ensure fall interventions are in place. The Restorative Nurse/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</p> <p>Compliance Date: 1/06/2013</p>		

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	<p>Interview with the Restorative Nurse on 12/7/12 at 12:10 p.m., indicated the wheelchair alarm was not functioning properly and the dycem was not in place properly when the resident fell on 10/4/12.</p> <p>This Federal tag relates to Complaint #IN00120018.</p> <p>3.1-45(a)(2)</p>			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <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 record review and interview, the facility failed to implement the policy for</p>	F0441	F441	01/06/2013			

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	<p>Clostridium difficile (an intestinal infection) related to not identifying residents considered at high risk of developing the infection who exhibited symptoms of diarrhea for 2 of 3 residents reviewed for Clostridium difficile infection in a sample of 11. (Resident #H and Resident #J)</p> <p>Findings include:</p> <p>1. Resident #J's clinical record was reviewed on 12/6/12 at 2:10 p.m. Resident J's diagnoses included, but were not limited to, UTI (urinary tract infection), c-diff (Clostridium difficile), dementia, and atrial fibrillation.</p> <p>The resident was started on an antibiotic for UTI on 10/29/12.</p> <p>On 11/12/12 at 12:32 p.m., output documentation indicated the resident had a large amount of loose, liquid stool with a foul odor.</p> <p>On 11/13/12 at 1:00 a.m., nursing documentation indicated the resident had diarrhea two times during the shift and Immodium (anti diarrhea medication) was given.</p> <p>On 11/14/12 at 9:41 p.m., output documentation indicated the resident had</p>		<p>It is the practice of this facility to ensure that we maintain an infection control program designed to provide safe, sanitary and comfortable environment and help prevent the development and spread of a disease or infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident J's physician ordered, and facility obtained a stool culture with positive results for clostridium difficile. She was placed in isolation and began antibiotic therapy. She no longer has loose stools. · Resident H has been discharged from facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents who have had loose stools have the potential to be affected by the same alleged deficient practice. Audits were completed of residents who have had loose stools in the past week. The nursing staff was in serviced on: · The importance of notification to physician of residents who have loose stool with emphasis on high risk residents with risk factors such as age, use of antibiotics, and the increase risk of clostridium difficile infection. · The specific guidelines of 3 loose stools in a 24 hour period as an indicator in</p>	

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	<p>a medium amount of loose, liquid stool that was tarry/black in color.</p> <p>On 11/16/12 at 4:15 a.m., nursing documentation indicated the resident had blood streaked loose stool with a foul odor and a low grade temperature of 99.4 degrees.</p> <p>On 11/17/12 at 5:00 a.m., nursing documentation indicated the resident continued to have loose stools with minimal a amount of bright red blood.</p> <p>On 11/21/12 at 2:30 a.m., nursing documentation indicated the resident had a large amount of loose stool with a foul odor twice during the shift.</p> <p>The resident was started on an antibiotic for UTI again on 11/16/12. The facility did not notify the physician until 11/21/12 to obtain a stool specimen to evaluated for possible c-diff infection.</p> <p>During clinical record review, the stool specimen indicated the resident tested positive for c-diff on 11/21/12.</p> <p>The policy titled "Clostridium Difficile" dated 2001, was provided on 12/6/12 by the Director of Nursing. She indicated the policy was current. The policy indicated: "The purposes of this procedure are to</p>		<p>determining when to request for a clostridium difficile culture. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The DON/designee is reviewing resident records daily for change in condition such as loose stools · The DON/designee is reviewing 24 hour reports daily for change in condition such as loose stools. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DON/designee will audit residents' medical records that have had loose stools 3 days a week to ensure high risk residents are identified timely and notification to physician has been made. · The DON/designee will audit residents' medical records and if any resident has had 3 loose stools with a 24 hour period assure the facility has made a request for a clostridium difficile culture. · The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</p>	

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	<p>provide guidelines for the care of persons with diarrhea associate with Clostridium difficile and to prevent transmission of Clostridium difficile to others. Residents considered at high risk of developing symptoms associated with Clostridium difficile include those with advancing age, gastrointestinal manipulation (especially nasogastric tube insertions), previous gastrointestinal illness caused by Clostridium difficile, and antibiotic or anti-neoplastic therapy. When a resident with these risks have symptoms of diarrhea (i.e., three (3) loose stools in a twenty-four (24) hour period) , Clostridium difficile should be considered as a cause."</p> <p>An interview with the Nursing Consultant and DON on 12/6/12 at 3:50 a.m., indicated the resident should have been tested prior to 11/21/12. They indicated treatment for c-diff and isolation precautions should have been initiated sooner.</p> <p>2. The closed record for Resident #H was reviewed on 12/6/12 at 8:05 a.m. The resident was admitted to the facility on 6/26/12. His date of birth was 5/11/29. He had diagnoses that included, but were not limited to, depression, hypertension, Alzheimer's Disease and urinary tract infection. His admission orders included Levoquin (an antibiotic) 500 milligrams,</p>		<p>Compliance Date: 1/06/2013</p>	
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	<p>1 tablet orally once a day 6/26/12 through 7/3/12, for urinary tract infection.</p> <p>The Bowel Movement (BM) flow record completed by the CNAs indicated the resident's movements were as follows:</p> <p>On 6/27/12 at 2:28 a.m., a loose medium sized BM On 6/30/12 at 1:39 p.m., a loose medium sized BM On 7/2/12 at 1:30 a.m., a loose medium sized BM On 7/9/12 at 2:24 p.m., a liquid medium sized BM</p> <p>At other times on 6/29/12 at 2:52 p.m., on 7/2/12 at 4:14 a.m., on 7/3/12 at 10:01 a.m., on 7/5/12 at 4:47 a.m., 10:10 a.m., 1:54 p.m., and 9:39 p.m., on 7/7/12 at 9:44 a.m. and 8:18 p.m., on 7/8/12 at 1:18 a.m., 9:40 a.m., 1:22 p.m., and on 7/9/12 at 2:01 a.m. , the resident had BM's recorded. There was no documentation on the Bowel Movement flow record of the consistency of those bowel movements.</p> <p>The Progress Notes were reviewed. An entry dated 6/29/12 at 2:01 p.m., indicated the resident had diarrhea. An entry dated 6/29/12 at 9:20 p.m., indicated the resident had one episode of diarrhea. An entry dated 7/1/12 at 3:30 a.m., indicated the resident had one episode of diarrhea</p>			

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	<p>noted. An entry dated 7/1/12 at 9:30 p.m., indicated the resident had loose stools times two.</p> <p>Review of the Medication Administration Record for July 2012 indicated an entry dated 7/2/12 at 1:30 a.m., that indicated the resident had loose stools times 3.</p> <p>An entry dated 7/2/12 at 1:30 a.m., indicated the Physician was notified of the resident's loose stools and orders were obtained for Immodium (an antidiarrheal medication). There was no evidence in the record that indicated the Physician was informed that the resident was at high risk for developing Clostridium difficile due to symptoms of diarrhea, 3 loose stools in a 24 hour period, antibiotic therapy and advanced age. There was no evidence in the record that indicated the resident was evaluated for possible Clostridium difficile.</p> <p>Continued review of the Progress Notes indicated the resident continued to have diarrhea. On 7/3/12 at 1:11 p.m., the resident had one episode of diarrhea. On 7/4/12 at 1:00 a.m., the resident had one episode of diarrhea. On 7/6/12 at 9:00 a.m. the resident had a loose stool. On 7/6/12 at 4:07 p.m., the resident had a loose stool. On 7/8/12 at 11:04 a.m., the resident had loose stools twice with a foul</p>			

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	<p>odor.</p> <p>On 7/9/12 at 11:25 a.m., the Physician was informed the resident had a large amount of light green liquid stools. There was no evidence the resident was to be evaluated for possible Clostridium difficile infection.</p> <p>On 7/9/12 at 2:43 p.m., the Physician ordered a Complete Blood Count due to a planned surgical procedure for the insertion of a gastric tube.</p> <p>On 7/9/12 at 9:53 p.m., the resident had a large amount of light green liquid stools.</p> <p>The Complete Blood Count obtained on 7/10/12, indicated the resident had a White Blood Count of 26.27 (high) reference range is 4.80 - 10.8.</p> <p>"Information and Resources for Complete Blood Count" was retrieved on 12/10/12 at 12:00 p.m., from the www.webmd.com website. The website indicated the white blood count could be elevated when there was an infection in the body.</p> <p>The Physician was notified of the abnormal lab results on 7/10/12 at 3:00 p.m. The Physician ordered the resident to be sent to the hospital for evaluation. The resident was discharged to the hospital on 7/10/12 at 4:00 p.m.</p>			

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	<p>Review of the hospital lab reports indicated a stool specimen was obtained on 7/11/12 at the hospital. The stool was positive for Clostridium difficile toxins, A and B.</p> <p>Interview with the Director of Nursing on 12/7/12 at 12:30 p.m., indicated the resident had Clostridium difficile when he was evaluated in the hospital. She indicated the resident was not evaluated for Clostridium difficile in the facility. She indicated he had symptoms of diarrhea, was on an antibiotic and was at risk for developing Clostridium difficile. She indicated the policy for Clostridium difficile was not followed, the resident should have been evaluated for Clostridium difficile on 7/2/12 when he was noted to have 3 loose stools in a 24 hour period.</p> <p>This Federal tag relates to Complaint #IN00120614.</p> <p>3.1-18(a)</p>			

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F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the windows in 2 of 6 rooms on the Special Care Unit, were in good condition and functioned properly. (Room 64 and Room 71)</p> <p>Findings include:</p> <p>1. The window in Room 64 was observed on 12/6/12 at 9:45 a.m. The window was slightly ajar, with a 1/4 inch opening observed. Interview with the Special Care Unit Director at that time, indicated she was not able to close the window completely. Two residents resided in the room.</p> <p>Interview with the Administrator on 12/6/12 at 9:55 a.m., indicated he had been informed in the past that the window in Room 64 could not be closed completely. He indicated he informed the Maintenance Supervisor.</p> <p>Interview with the Maintenance Supervisor on 12/6/12 at 10:20 a.m., indicated the window in Room 64 could not be closed completely. He indicated the metal on the windows on the west side</p>	F0465	<p>F465 It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · A vendor has been contracted to repair the windows in rooms 64 and 71. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <ul style="list-style-type: none"> · All residents located on the special care unit have the potential of being affected by this alleged deficient practice. · A vendor has been 	01/06/2013			

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	<p>of the building had warped.</p> <p>2. The windows of the 6 rooms on the west side of the building, in the Special Care Unit, were observed on 12/7/12 at 8:50 a.m. The widow in Room 71 was not latched closed. Two residents resided in the room. Interview with LPN #3 at that time, indicated she was not able to close the window and latch it. There was a 1/4 inch gap allowing cold air to enter the room.</p> <p>This Federal tag relates to Complaint #IN00120018.</p> <p>3.1-19(f)</p>		<p>contacted to assess all the windows on the special care unit to determine which windows may need to be need of repair.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> The Maintenance Director/designee is completing random checks of windows on this unit to assure they are closing properly and checking for air leaks when windows are closed. Windows not closing properly or exhibiting air leaks will be repaired by the vendor as reported. <p>How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> Staff has been in-serviced on the importance of observing 		

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			<p>these windows for air leaks or drafts and the importance of reporting any concerns immediately and completing a maintenance request form.</p> <ul style="list-style-type: none"> Any reports of window air leak or closing concerns will be reported to the Maintenance Director and the Administrator. Administrator will assure that any needed repairs are completed timely. A summary of window concerns and resolution will be presented to the monthly Quality Assurance Meeting for review. <p>Compliance Date: 01/06/2012</p>		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on clinical record review and interview, the facility failed to keep complete and accurate intake and output documentation for 1 of 3 residents reviewed for dehydration. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's clinical record was reviewed on 12/5/12 at 12:30 p.m. Resident #F's diagnoses included, but were not limited to, MS (multiple sclerosis), dehydration, UTI (urinary tract infection), acute renal failure, failure to thrive, and diarrhea.</p> <p>A care plan, dated 12/12/2011, for indwelling urinary catheter, indicated the facility was to " . . . assess the drainage q (every) shift. Record the amount, type,</p>	F0514	<p>F514</p> <p>It is the practice of this facility to ensure that resident records are complete, accurate, and accessible. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident F intake and output records are up to date per care plan and physician orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents with diagnosis of dehydration or who have indwelling urinary catheter have the potential to be affected by the same alleged deficient practice. Audits were completed of residents with diagnosis of dehydration and residents with</p>	01/06/2013			

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	<p>color, odor. Observe for leakage. Measure and record output . . .)</p> <p>During clinical record review, the November 2012 physician recapitulation orders indicated the resident was to have enteral intake every shift. The order was discontinued on 11/19/12.</p> <p>On 12/5/12 at 3:09 p.m., intake documentation in the month of November, 2012 indicated incomplete oral intakes between 11/1/12 to 11/19/12.</p> <p>On 12/6/12 at 9:42 a.m., output documentation in the month of November, 2012 for urine output indicated incomplete documentation/recording. On November 2nd, 4th, 5th, 6th, 13th, 14th, 19th, 20th, 25th, and 26th indicated only one shift documented outputs. On November 3rd, 7th, 15th, 17th, 18th, and 21st indicated two shifts documented output. On November 1st, 9th, 11th, 12th, 16th, 22nd, and 24th indicated no shifts documented outputs.</p> <p>On 12/6/12 at 9:52 a.m., output documentation in the month of November, 2012 for bowel movements indicated incomplete documentation/recording. On November 1, 4, 7, 8, 10, 14, 15, and 22 indicated</p>		<p>indwelling urinary catheter. The nursing staff was in serviced on:</p> <ul style="list-style-type: none"> · The importance of completing accurate medical records related to diagnosis of dehydration, indwelling urinary catheter use and monitoring intake and output every shift in order to accurately determine the amount of liquid a resident consumes and excretes in a 24-hour period. · Documenting the date and time the resident's fluid intake in milliliters. Document the amount (in milliliters) of liquid consumed · Documenting the date and time the resident's output in milliliters with emphasis on the character of output. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The DON/designee is reviewing admissions and re-admissions for documentation of dehydration diagnoses. · The DON/designee will be reviewing new orders daily for diagnoses of dehydration. · The DON/designee will be reviewing admission, readmissions, and new orders daily for residents with new and/or existing indwelling urinary catheters. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DON/designee will audit residents with diagnoses of 	

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	<p>only one shift documented outputs. On November 15, 21, and 23 indicated two shifts documented output. The remaining days of the month indicated no shifts documented outputs.</p> <p>An "Intake, Measuring and Recording" policy dated 09/2005, provided by the MDS (Minimum Data Set) Assistant on 12/6/12 at 11:00 a.m., indicated, "The purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period . . . The following information should be recorded in the resident's medical record, per facility guidelines: The date and time the resident's fluid intake was measured and recorded . . . The amount [in ml's (milliliters)] of liquid consumed . . . If the resident refused the treatment, the reason why and the intervention taken . . . Notify the supervisor if the resident if the resident refuses the procedure. Report other information in accordance with facility policy and professional standards of practice."</p> <p>An "Output, Measuring and Recording" policy dated 09/2005, provided by the MDS Assistant on 12/6/12 at 11:00 a.m., indicated, "The purpose of the procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period . . . The following information</p>		<p>dehydration and indwelling urinary catheters 3 days a week for required documentation of intake and output. · The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</p> <p>Compliance Date: 01/06/2013</p>				

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	<p>should be recorded on the bedside intake and output record and/or in the resident's medical record: The date and time the resident's urine output was measured and recorded . . . The amount (in ml's) of output . . . The amount of character of output . . ."</p> <p>A "Catheter Care, Urinary" policy dated 09/2005, provided by the MDS Assistant on 12/6/12 at 11:00 a.m., indicated, ". . . Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to your supervisor . . . Maintain an accurate record of the resident's daily output, per facility policy and procedure . . . Empty the collection bag at least every eight (8) hours . . . Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor . . ."</p> <p>This Federal tag relates to Complaint #IN00120018.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			