

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/26/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
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F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey Dates: November 18, 19, 20, 21, 22, 25, 26, 2013</p> <p>Facility number: 000152 Provider number: 155248 AIM number: 100267510</p> <p>Survey team: Diane Hancock, RN-TC Denise Schwandner, RN Diana Perry, RN November 18, 19, 20, 21, 22, 2013 Anna Villian, RN November 18, 19, 20, 21, 22, 2013 Sylvia Martin, RN November 18, 19, 20, 21, 22, 2013</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type: Medicare: 10 Medicaid: 59 Other: 11 Total: 80</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000		

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

TITLE

(X6) DATE

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

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	Quality Review completed on December 5, 2013, by Jodi Meyer, RN			

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal privacy during personal care provided for 1 of 6 sampled residents observed receiving care. (Resident #97)</p> <p>Finding includes:</p>	F000164	F 0164 It is the policy of this facility to ensure personal privacy during personal care.All residents have the potential to be affected by this citation..CNA #2 and #5 will have individual one on one retraining regarding privacy during personal care. Nursing staff will be in-serviced on accomodation of personal privacy	12/26/2013

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	<p>On 11/21/13 at 9:53 a.m., during an observation of care provided by CNA #2 and CNA #5 to resident #97. The resident was observed laying undressed and uncovered in bed; the privacy curtain was only partially pulled, leaving the resident visible upon entering room.</p> <p>On 11/22/13 at 10:07 a.m., during an interview, CNA #2 indicated during a resident's bath she would change gloves prior to providing peri care and hand wash before and after providing care to residents. CNA #2 did not indicate any steps she would take to protect resident's privacy during the bath.</p> <p>On 11/22/13 at 10:30 a.m., during an interview, CNA #5 indicated she would do hand washing prior to and after providing care to residents. She then indicated during a bath she would change gloves after doing half of the front of a resident, after the back, and again after providing perineal care. CNA #5 did not indicate steps she would take to protect the resident's privacy during a bath.</p> <p>3.1-3(o) 3.1-3(p)(4)</p>		<p>during personal care . Audits of nursing care staff providing personal care will be done daily up to 5 days a week for three weeks, weekly for three weeks and monthly for three months. Review and evaluation of audits will be done at monthly QA to determine if further intervention is needed. Corrective action date will be December 26, 2013.</p>		

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and record review, the facility failed to provide dignity during dining to 6 of 6 randomly observed residents, out of 20 residents in the Alzheimers Unit dining room, and for 1 of 1 randomly observed resident in the main dining room who sat watching other residents eat. (Resident #1)</p> <p>Findings include:</p> <p>1. During the dining observation in the Alzheimer's Unit on 11/19/13 at 11:30 a.m., 6 residents sat at two tables for 1 hour for their lunch to be served. One CNA was serving homestyle lunch to the 20 residents in the dining room. Before all residents were served, the kitchen was called to order more of the entree. At 12:30 p.m., the remaining residents were served.</p> <p>The policy for nursing responsibilities at meal service was provided by the DoN (Director of Nursing) on 11/25/13 at 11:20 a.m. The policy indicated,</p>	F000241	<p>F 0241It is the policy of this facility to provide dignity during the dining of residents.The Alzheimer's unit has implemented tray service for residents to ensure the timely and consistent delivery in meal service. CNA #1 and LPN #10 were in-serviced regarding ensuring that all residents present in the dining room will be provided dignity when being assisted with their meals. The residents will be served and assisted at the same time.In-servicing of Nursing and CNA staff will be implemented regarding serving and assisting of meals to ensure dignity during dining is followed. Audits will be done by the DNS or designee daily up to 5 days a week times two weeks, Bi-weekly times 4 weeks and weekly times 8 weeks.Review and evaluation of audits will be done at monthly QA meetings times three then quarterly times three to determine if further intervention is needed.Corrective Action Date: December 26, 2013</p>	12/26/2013			

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	<p>"Staff should distribute food in a timely manner to patients" and "Provide courteous and professional demeanor in the dining room and ensure that all patients receive the same level of service to provide a positive dining experience."</p> <p>2. On 11/18/13 at 12:00 p.m., as residents in the main dining room were served noon meal, two unidentified residents were assisted with their meals by CNA #2 and LPN #10. During this time, Resident #1 was observed sitting at the same table, with his meal tray in front of him. He was not assisted with his meal until 12:15 p.m., when the other two residents had completed their meals.</p> <p>3.1-3(t)</p>				

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F000244 SS=D	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to address grievances expressed by resident council for 3 of 12 months reviewed, in that residents reported no response and records indicated no response. (July, August, November, 2013)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 11/21/13 at 3:00 p.m., A document titled, "Resident Council Minutes," dated 7/24/13, indicated 10 of 10 residents in attendance for the resident council meeting shared the following concerns: <ol style="list-style-type: none"> a. Trays are out on time but not being passed aides talking on phone or talking on hall to each other. (evening time) b. (AD) Activity Director needs to be more involved with residents and activities. c. Have staff stop walking thru (sic) 	F000244	F 0244 It is the policy of this facility to address grievances expressed by resident council to ensure proposed operational decisions affecting residents are followed up in a timely manner. A resident council grievance tracking system was developed to ensure grievances are logged, assimilated and directed for timely follow up of each concern. The Activity Director was in-serviced regarding resident council grievance follow up procedure. Audits will be done by Executive Director monthly times 6 months and every other month for 6 months. Review and evaluation of audits will be done at monthly QA meetings to determine if further interventions are needed. Corrective Action Date: December 26, 2013	12/26/2013

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	<p>activity room when door is closed when having meetings-even tho (sic) sign is on door.</p> <p>2. Council minutes dated 8/27/13 indicated, under the title of "Old Business," the following concerns were reviewed:</p> <p>a. Have Staff stop walking through activity room when door is closed even when sign up. "Was this issue resolved to your satisfaction?, NO"</p> <p>b. Residents would like activity director be more involved with them and activities. "Was this issue resolved to your satisfaction?, NO"</p> <p>3. Council minutes dated 11/12/13, under the heading old business, indicated the Administrator was supposed to let residents know about the AD's schedule. "Was this issue resolved to your satisfaction?, NO"</p> <p>4. On 11/21/13 at 2:00 p.m., during an interview, the Administrator indicated grievances were communicated to him verbally and by resident council response forms. The resident council response form would then be forwarded to the department named in the concern for a response. If the concerns were not addressed</p>			

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	<p>satisfactorily, it was discussed in the next resident council meeting.</p> <p>5. Documentation was provided by the AD on 11/21/13 at 3:00 p.m.. The document was titled, Resident Council Department Response Form, and dated 7/25/13. The document indicated the resident concerns under the heading, Department response. In that section, documentation also indicated, "I would appreciate being invited to the next meeting to discuss this issue." That response was signed by the Administrator and dated 8/2/13. The section for department response left blank.</p> <p>6. On 11/21/13 at 3:20 p.m., The AD indicated she did not have any further documentation regarding the above concerns, and that often the response forms were sent to the departments and not returned.</p> <p>3.1-3(l)</p>				

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F000246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to ensure call lights were in reach for 3 of 35 residents observed for access to call lights in the stage 1 sample. (Residents #30, #58, #113)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During stage 1 observations on 11/18/13 at 12:51 p.m., Resident #30 was observed in the resident's room. The call light was on the floor, out of reach of the resident. 2. On 11/18/13 at 2:07 p.m., Resident #58 was observed in the resident's room. The call light was on the floor, out of reach of the resident. 3. On 11/18/13 at 1:55 p.m., Resident #113 was observed in the resident's room. The call light was on the floor across the room from the resident. 4. When observations were reviewed 	F000246	<p>F 0246 It is the policy of this facility to ensure call lights are within reach for all residents. In-servicing of staff will be done regarding policy and procedure to ensure residents have call lights within reach to call for assistance when needed. Audits will be done to observe call lights are within reach for residents daily up to 5 days a week for three weeks, weekly times three and monthly times three. Audits for the call lights will be reviewed and evaluated monthly at QA times three and quarterly times three. Corrective completion date December 26, 2013.</p>	12/26/2013			

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	with the Administrator and Director of Nurses on 11/22/13 at 4:00 p.m., they indicated all residents should have the call light in reach. 3.1-3(v)(1)			

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide activities to meet the resident's interest, which included reading and music, for 1 of 3 residents reviewed for activities, in a sample of 7 who met the criteria. (Resident #97)</p> <p>Findings include:</p> <p>Resident #97's record was reviewed on 11/20/13 at 10:29 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, and dementia without behavioral disturbance.</p> <p>A Recreation Service assessment, dated 8/25/13, indicated resident interests were reading, relaxation program, and music. The admission Minimum Data Set (MDS) assessment for activity preferences had not been completed.</p>	F000248	F 0248It is the policy of this facility to provide activities to meet resident's interest and needs. Resident #97 was provided a radio in his room. Activity Director was in-serviced regarding assessment, implementation and documentation of individualized activities to meet residents interests and needs. Audits of activity services will be performed by DNS or designee weekly times four weeks, monthly times three months and quarterly times three.Review and evaluation of the audits will be done at monthly QA meetings to determine if further interventions are needed.Corrective Action Date: December 26, 2013	12/26/2013			

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	<p>A care plan, initiated 10/15/13, included, but was not limited to, the following: "I prefer independent activities rather than doing things in groups, I will continue participating in independent activities, invite me to "sit in" during activity programs you think I might enjoy, allowing me to join in at my own comfort level, monitor my participation in my independent activities with me to ensure that I can still participate at a high level with no signs of decline, offer me activities and supplies for things I can do in my room."</p> <p>The facility's recreation participation record indicated the resident attended activities, "Pre-Meal/chronicle," from 8/1/13 to 11/20/13, daily. In addition, under the heading of Independent activities, "Television/Radio" was documented 10/1/13 to 10/31/13.</p> <p>During an observation on 11/20/13 at 10:36 a.m., Resident #97 was observed in his room laying on his back in bed with his eyes closed. Only the television was observed on. No radio was observed in the room.</p> <p>Resident #97 was observed on 11/20/13 at 1:30 p.m., on 11/21/13 at 8:53 a.m., and on 11/22/13 at 9:00 a.m., with his eyes closed and</p>						

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	<p>television on. No radio was observed in his room.</p> <p>An interview with the activity director on 11/21/13 at 12:12 p.m., indicated, resident #97 was read a daily chronicle (one page news/trivia document) by the activity assistant during or prior to each noon meal.</p> <p>3.1-33(a)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview, observation and record review, the facility failed to ensure medically-related social services were provided, including behavior tracking and monitoring responses to interventions, were provided for 1 of 1 resident reviewed for behaviors. (Resident #35)</p> <p>Findings include:</p> <p>On 11/19/13 at 8:35 a.m., during an interview, Resident #35 indicated Resident # 82, his next door neighbor, made fun of him and called him queer. He indicated if Resident #82 did not stop, he was going to hit him with his cane. Resident #35 indicated he had told LSW (Licensed Social Worker) #1 many times.</p> <p>Resident #35's clinical record was reviewed on 11/19/13 at 11:29 a.m. The resident's diagnoses included, but were not limited to, paranoid schizophrenia, diabetes, insomnia, and unspecified intellectual disabilities.</p> <p>The resident's behavior care plans</p>	F000250	F 0250It is the policy of this facility to ensure medically-related social services are provided to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. Resident #35's care plan was updated with to include interventions providing medical psycho-social support in collaboration with LSW # 2 (LCSW). Updating of care plans of residents who have shown physical or verbal threats will be done by social services ongoing. Audits of care plans of residents who have shown physical or verbal threats in the previous six months will be performed by Unit Managers. Review and evaluation of the audits will be done by QA monthly fo 6 months to determine if further follow up is needed. Corrective Action Date: December 26, 2013	12/26/2013

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	<p>included, but were not limited to, the following:</p> <p>The focus, initiated 6/13/12 ,was " Sometimes I demonstrate inappropriate behaviors exhibited by: hitting self in head, attention seeking and when mad state devil is telling me to kill myself." The interventions included, but were not limited to: "Refer to psychiatrist and his therapy associates as needed." "Treat me with dignity and respect."</p> <p>The focus, initiated 6/13/12, "I have history of expressing negative thought about statement that I would like to "jump in the river" and/or devil is telling me to kill myself and/or if I had a weapon I would use it on others." The interventions included, but were not limited to, the following:</p> <p>"Allow resident to verbalize feelings. Administer meds per physician. Observe resident for decline in mood regulation, signs and symptoms of withdrawal or fearfulness. Separate residents for safety of both parties and notify Director of Nursing Services/Executive Director. Social services follow up daily for 72 hours. Notify physician if mood and behavior</p>			

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	<p>impede optimal daily functioning. Remove objects from resident's room that could be potentially harmful. Provide visual observation as indicated to assure resident's safety, beginning 1:1, then moving to less restricted time frames as indicated by improvement in mood/behaviors."</p> <p>The focus, initiated 11/12/12, "I am at risk for signs and symptoms of fearfulness and/or upset feelings as a result of resident to resident altercation." Interventions included: "15 minute checks for 72 hours Administer medication as prescribed by physician. Separate residents for safety of both parties. Notify Director of Nursing Services/Executive Director. Social services to follow up daily for 72 hours. Visit by therapist. Observe resident for decline in behavior impedes optimal daily functioning."</p> <p>On 11/19/13 at 3:19 p.m., LSW #1 indicated Resident #35 was attention seeking and frequently felt people were saying things about him and did not like him. LSW #1 indicated she would talk to Resident #35 and Resident #82. LSW #1 indicated Resident #35 was Schizophrenic and</p>			

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	<p>heard voices. LSW #1 indicated he was recently hearing the devil, and she had placed crosses in his room because of it.</p> <p>On 11/19/13 at 4:30 p.m., LSW #1 indicated after she had interviewed Resident #35, he indicated Resident #82 didn't say anything to him, never actually called him names, and just stared at him as he passed by the room. LSW#1 indicated she took his cane and walker so he would not hit anyone. She also indicated she had spoken to Resident #82, and he stated he hadn't said anything to Resident #35.</p> <p>On 11/20/13 at 10:30 a.m., Resident #35 was observed sitting at nurses station. He indicated he was waiting on LSW #1 to get there because he wanted his cane back or he was calling the police and was "gonna shut this place down." LPN #5 was listening and said they were aware of his "anger." She indicated he was on 15 minute checks, and they were trying to keep him from other residents. LPN #5 also indicated they were trying to redirect his anger with positive reinforcement. She indicated he did not use his cane for mobility and only used his wheelchair.</p>						

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	<p>On 11/21/13 at 9:40 a.m., during an Interview, Resident #82 indicate he would get along well with everyone. When asked if he would like to have Resident #35 for a roommate, he indicated he was "a pain in the b--t." When asked what was wrong with him, he said, "What's right with him?"</p> <p>On 11/21/13 at 9:03 a.m., Resident #35 indicated everyone was making him mad that day. No specific information was given at the time.</p> <p>On 11/22/13 at 10:45 a.m., on the fourth day of observation, LSW #1 indicated she had not called the physician concerning his recent behavior but would that day. She also indicated she was unaware of the specific interventions used by LSW #2 (a contracted social work counselor) for the resident's frustrations.</p> <p>On 11/22/13 at 12:58 p.m., the Director of Nurses (DoN) was asked for tracking of behaviors. She indicated she was not sure and would check on it. On 11/22/13 at 1:51 p.m., the DoN indicated the CNA behavior notes would be in the behavior care tracker of the computer; that information was</p>						

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	<p>requested at that time.</p> <p>The clinical record was reviewed after the above interviews. The Clinical Note, dated 11/21/13, from LSW #2's routine visit indicated concerns/problems were the resident stated he was frustrated with everyone bothering him. The resident and therapist spoke regarding an incident resident had with another resident. The resident and therapist discussed what were the appropriate actions in handling his frustration. No information was indicated related to this discussion of appropriate action to handle his frustration.</p> <p>On 11/22/13 at 11:30 a.m., the MDS (Minimum Data Set) assessment, dated 10/31/13, indicated no behavior, hallucinations or delusions. The BIMS (Brief Interview for Mental Status) score indicated a score of 11 with a score of 8 to 15 indicating mild cognitive impairment but potentially interviewable.</p> <p>3.1-34(a)</p>				

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to complete the MDS (minimum data set) information for activities, for 1 of 3 residents reviewed for activities, in a</p>	F000272	F 0272It is the policy of this facility to complete the MDS for activities for all residents. All MDS will be reviewed by ADNS or designee before transmission to determine that all sections are	12/26/2013

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	<p>sample of 7 who met the criteria. (Resident #97)</p> <p>Finding includes:</p> <p>The MDS (minimum data set) assessment for resident #97 was reviewed on 11/22/13 at 10:00 a.m. The MDS admission assessment, dated 8/25/13, indicated section F "Preferences for Customary Routines and Activities" of the MDS was blank.</p> <p>On 11/22/13 at 11:00 a.m. during interview, RN #1 (MDS coordinator) indicated that each department was responsible for completing their section of MDS data. If they did not complete, she would mark it as such. She indicated section F was completed by the activity department.</p> <p>3.1-31(c)(1)</p>		<p>complete. All MDS responsible departments will be in-serviced on the completion of their section of the MDS. Auditing of the MDS before transmission will be reviewed and evaluated monthly in QA to determine if further intervention is needed monthly times three and quarterly times three. Corrective action completion date December 26, 2013.</p>		

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F000279 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 interview, observation, and record review, the facility failed to develop a care plan for 1 of 2 residents reviewed for urinary catheter use in the sample of 2 who met the criteria. (Resident #80)</p> <p>Finding includes:</p> <p>Record review on 11/21/13 at 9:07 a.m., indicated a care plan for alteration in elimination of bladder and bowel, however, there was no care plan for urinary catheter use.</p>	F000279	F 0279 It is the policy of this facility to develop review and revise for each resident a care plan that includes measurable objectives and time tables to meet the residents medical, common nursing, and mental psychosocial needs that are identified on the comprehensive assessment. Resident # 80 has a plan of care in place for a urinary catheter use. Residents with urinary catheters have had care plans reviewed and have urinary catheter plan of care in place. LPN # 11 will have one on one retraining on the policy and procedure for care planning	12/26/2013	

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	<p>During interview with LPN #11 on 11/21/13 at 3:10 p.m., she indicated the resident had a urinary catheter for retention and skin breakdown. She was unable to locate a care plan for the urinary catheter use.</p> <p>Observation of the resident on 11/20/13 at 2:40 p.m., 11/21/13 at 3:00 p.m., and 11/22/13 at 9:00 a.m., indicated the resident's urinary catheter was patent and draining slightly cloudy, yellow urine.</p> <p>The medical record failed to have a care plan addressing urinary catheter use.</p> <p>3.1-35(a)</p>		<p>urinary catheter use. Nurses will be in-serviced on policy and procedure for care planning urinary catheter use for residents with a urinary catheter. Audits of foley catheter care plans will be done by DNS or designee weekly times three and monthly times three for three months. Audits of foley catheter care plans will be reviewed and evaluated at QA to determine the need for further intervention needed monthly times three and quarterly times three. Corrective Action Date: December 26, 2013</p>		

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observations, interview, and record review, the facility failed to ensure a care plan for behaviors was revised and/or updated related to additional interventions to assist the resident to cope with his frustration and/or anger, for 1 of 1 resident reviewed for behaviors. (Resident #35)</p> <p>Findings include:</p> <p>On 11/19/2013 at 8:35 a.m., during an interview, Resident #35 indicated Resident #82, his next door neighbor, made fun of him and called him</p>	F000280	F 0280It is the policy of this facility to ensure comprehensive care plans are revised and updated to include additional interventions implemented related to behaviors. Resident #35's care plan was updated to include interventions implemented as a result of behaviors. LSW #1 was in-serviced regarding updating of care plans. Social service staff and nurses will be in-serviced regarding the revisions of care plans when interventions are implemented. Audits of residents with behavioral history will be performed by DNS or designee weekly times three weeks, monthly times three months and quarterly times three. Review	12/26/2013	

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	<p>queer. He indicated if Resident #82 did not stop, he was going to hit him with his cane. Resident #35 indicated he had told LSW (Licensed Social Worker) #1 many times.</p> <p>The record for Resident #35 record was reviewed on 11/19/13 at 11:29 a.m. The resident's diagnoses included, but were not limited to, paranoid schizophrenia, diabetes, insomnia, and unspecified intellectual disabilities.</p> <p>The care plans included, but were not limited to, the following:</p> <p>The focus, initiated 6/13/12 ,was " Sometimes I demonstrate inappropriate behaviors exhibited by: hitting self in head ,attention seeking and when mad, state devil is telling me to kill myself."</p> <p>Interventions included, but were not limited to, refer to psychiatrist and his therapy associates as needed, and treat me with dignity and respect.</p> <p>The focus, initiated 6/13/12, "I have history of expressing negative thought aeb [as evidenced by] statement that I would like to "jump in the river" and/or devil is telling me to kill myself and/or if I had a weapon I would use it on others." The interventions included,but were not limited to:</p>		<p>and evaluation of the audits will be done at monthly QA to determine if further intervention is needed. Corrective Action Date: December 26, 2013</p>		

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	<p>"Will remain safe and free from injury. No signs and symptoms of emotional distress. Allow resident to verbalize feelings. Administer meds per physician. Observe resident for decline in mood regulation, signs and symptoms of withdrawal or fearfulness. Separate residents for safety of both parties and notify Director of Nursing Services/Executive Director. Social services follow up daily for 72 hours. Notify physician of mood and behavior impede optimal daily functioning. Remove objects from resident's room that could be potentially harmful. Provide visual observation as indicated to assure resident's safety, beginning 1:1, then moving to less restricted time frames as indicated by improvement in mood/behaviors."</p> <p>The focus, initiated 11/12/12, " I am at risk for signs and symptoms of fearfulness and/or upset feelings as a result of resident to resident altercation." The interventions included, but were not limited to, the following: "15 minute checks for 72 hours. Administer medication as prescribed by physician. Separate residents for safety of both</p>			

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	<p>parties. Notify Director of Nursing Services/Executive Director. Social services to follow up daily for 72 hours. Visit by therapist. Observe resident for decline in behavior impedes optimal daily functioning."</p> <p>On 11/19/2013 at 3:19 p.m., LSW #1 indicated Resident #35 was attention seeking and frequently felt people were saying things about him and did not like him. LSW #1 indicated she would talk to Resident #35 and Resident #82. LSW #1 indicated Resident #35 was Schizophrenic and heard voices. LSW #1 indicated he was recently hearing the devil, and she had placed crosses in his room.</p> <p>On 11/19/13 at 4:30 p.m., LSW #1 indicated after she had interviewed Resident #35, he indicated Resident #82 didn't say anything to him, never actually called him names, and just stared at him as he passed by the room. LSW #1 indicated she took his cane and walker so he could not hit anyone. She also indicated she spoke to Resident #82, and he indicated he hadn't said anything to him.</p> <p>On 11/20/13 at 10:30 a.m., Resident</p>						

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	<p>#35 was observed sitting at the nurses station. He indicated he was waiting on LSW #1 to get there because he wanted his cane back or he was calling the police and was "gonna shut this place down." LPN #5 was listening and said they were aware of his "anger." She indicated he was on 15 minute checks, and they were trying to keep him from other residents. LPN #5 also indicated they were trying to redirect his anger with positive reinforcement. She indicated he did not use his cane for mobility only used his wheelchair.</p> <p>On 11/21/13 at 9:03 a.m., Resident #35 indicated everyone was making him mad that day. No specific information was given.</p> <p>On 11/21/13 at 9:40 a.m., during an Interview, Resident #82 indicated he would get along well with everyone. When asked if he would like to have Resident #35 for a roommate, he indicated he was "a pain in the b--t." When asked what was wrong with him, he said, " What's right with him?"</p> <p>On 11/22/13 at 10:45 a.m., during an interview, LSW #1 indicated she had not called the physician concerning his recent behavior but would that day. She indicated she was unaware</p>						

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	<p>of the interventions used by LSW #2 (a contracted counselor) for his frustrations.</p> <p>On 11/22/13 at 1:25 p.m., LSW #1 indicated she was also waiting on a return call from LSW #2 regarding the interventions used related to his frustrations.</p> <p>The "Clinical Note" form, dated 11/21/13, from LSW #2's routine visit, indicated the concerns/problems were the resident indicated he was frustrated with everyone bothering him. She indicated they spoke regarding an incident the resident had with another resident. She also indicated they had discussed what were the appropriate actions in handling his frustration. No information was indicated related to this discussion, to identify the recommended appropriate actions to handle his frustrations.</p> <p>There was no indication the care plans were revised to address on-going behaviors of the resident.</p> <p>3.1-35(c)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure 3 of 3 residents reviewed for pain management, in the sample of 4 who met the criteria, were evaluated for their level of pain, and degree of effectiveness of their pain medication to determine if their pain was being managed. (Residents #11, #76, #111)</p> <p>Findings include:</p> <p>1. Resident #11 was interviewed on 11/18/13 at 2:26 p.m. The resident indicated she had pain in her left hip all the time.</p> <p>Resident #11's clinical record was reviewed on 11/22/13 at 11:22 a.m. An annual minimum data set (MDS) assessment, dated 2/7/13, indicated the resident had frequent pain at a level of 7 out of 10, indicating moderately severe pain. The quarterly assessment, dated 8/10/13, indicated the resident experienced</p>	F000309	F 0309It is the policy of this facility to ensure residents pain is being managed by evaluating their level of pain and evaluating the degree of effectiveness of their pain medication. Resident #11, #76, and #111 have had their level of pain and pain medications evaluated by the medical doctor. Nurses have been in-serviced on the policy and procedure pre and post pain levels and effectiveness of pain medication. If pain medication is not effective the nurse will notify the physician reporting status of residents pain level to obtain further orders. Audits of residents with identified pain management difficulties will be done by DNS and or designee of E Mars to determine if pain medication is effective daily up to 5 days a week times three weeks and weekly times four weeks and monthly times three.A review of the audits will be done in monthly QA for determination if further intervention is needed for pain management effectiveness. Corrective Action Completion Date: December 26,	12/26/2013			

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	<p>pain.</p> <p>Resident #11 had a care plan, initiated 7/6/11, with interventions including, but not limited to, "administer pain medication as ordered, evaluate and establish level of pain on numeric scale/evaluation tool."</p> <p>Resident #11 had physician's orders, initiated 2/17/11, for Lortab 10-500 milligrams (narcotic pain medication), give one tablet by mouth every 4 hours as needed for pain less than 5 on the pain scale. Orders were to give Lortab 10-500 milligrams by mouth every 4 hours as needed for pain greater than 5 on the pain scale. The medication administration record (MAR) indicated the resident had been given two Lortab tablets 10-500 milligrams by mouth on 11/12/13 at 12:35 p.m. The MAR and nurses' progress notes were reviewed and neither had documentation of assessment of the level of pain. The only documentation of the effectiveness of the pain medication was in the progress notes and indicated, "PRN [as needed] administration was: effective."</p> <p>LPN #7 was interviewed on 11/21/13 at 3:00 p.m. She indicated she</p>		2013	

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	<p>sometimes asked the resident for a numerical level of pain prior to giving medication, but was not routinely having residents rate pain after medication. "Usually just chart medication was effective."</p> <p>A policy entitled "Pain Management Guideline," dated 2003 and revised 2013, was provided by the Director of Nurses on 11/21/13 at 4:30 p.m. Functions of an appropriate pain management program included, but were not limited to, "assessing pain and evaluating response to pain management interventions using a pain management scale based on resident self-report or objective assessment for the cognitively impaired." The policy indicated, "documenting pain assessment, interventions prior to giving medication, and evaluation activities should be recorded in a clean and concise manner per the plan of care. If facility is utilizing EMAR [electronic medication administration record], the nursing staff should utilize the electronic pain evaluation and nursing note link..."</p> <p>2. Resident #76 indicated, during interview on 11/18/13 at 11:39 a.m., he had pain in his hands and wrists and lower legs due to neuropathy.</p>			

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	<p>He indicated the pain never completely went away. On 11/20/13 at 1:25 p.m., the resident was observed to be up in his wheelchair in his room. He indicated his pain level was a 4 out of 10, with 10 being the worst pain.</p> <p>Resident #76's clinical record was reviewed on 11/20/13 at 9:30 a.m. The resident's Minimum Data Set (MDS) assessment, dated 10/15/13, indicated he experienced frequent pain at a level of 8 out of 10. The resident's care plan for pain management, initiated 10/9/12, included, but was not limited to, an intervention to assess the level of pain experienced by the resident.</p> <p>Resident #76's physician's orders included, but were not limited to, the following medications for pain: Voltaren Gel 1% (anti-inflammatory topical medication) transdermally as needed for hand pain apply topically as needed four times a day. Norco 7.5-325 milligrams (narcotic pain medication) one tablet by mouth every 6 hours routinely.</p> <p>The medication administration record for November, 2013 was reviewed and Voltaren Gel had not been used during the month.</p>			

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	<p>The only documented pain assessment in the clinical record was dated 9/19/13. Documentation indicated mild pain in the right buttock at that time, no numeric rating. The pain assessment indicated the resident's acceptable level of pain was "0." It also indicated the current pain medication of routine Norco was "effective."</p> <p>On 11/22/13 at 10:00 a.m., Resident #76 indicated he always had pain from neuropathy in his hands and legs. He was observed to have spastic type motions of his hands, causing hands to contract. He indicated his pain level stayed at a 3 or 4 out of 10 when he felt good.</p> <p>3. On 11/20/13 at 9:00 a.m., during an interview with Resident #111, she indicated she was having pain at that time. The resident expressed that she often had a hard time getting pain medications when she would like them and even after receiving them, she still experienced moderate pain.</p> <p>At 11:25 a.m., Resident #111 indicated she continued to experience pain. The resident indicated she had</p>				

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	<p>pain medications, but still had not experienced relief.</p> <p>The clinical record for Resident #111 was reviewed on 11/21/13 at 10:00 a.m. Diagnoses included, but were not limited to, osteoarthritis, peripheral vascular disease and Lupus (an inflammatory disease that causes pain).</p> <p>The signed physician's orders, dated 10/31/13, indicated the resident was to receive "Hydrocodone-Acetaminophen [narcotic pain medication] Solution 7.5-325 mg (milligrams) in 15ml (milliliters) give 15 ml every four hours as needed for pain." The resident received medication as follows: 11/1-3 times, 11/2-4 times, 11/3- 4 times, 11/4- 2 times, 11/5- 3 times, 11/6- 3 times, 11/7- 3 times, 11/8- 3 times, 11/9- 3 times, 11/10- 3 times, 11/11- 3 times, 11/12- 3 times, 11/13- 3 times, 11/14- 2 times, 11/15- 5 times, 11/16- 6 times, 11/17-5 times, 11/18- 4 times, 11/19- 3 times, 11/20- 3 times, 11/21- 3 times.</p> <p>The signed physician's order, dated 10/31/13, indicated the resident was to receive "Hydromorphone HCL Liquid [narcotic pain medication] 1 mg/ml, Give 1 mg by mouth every 6</p>			

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	<p>hours as needed for pain." The resident received the medication as follows: 11/1- 1 time, 11/5- 1 time, 11/6- 2 times, 11/7- 3 times, 11/9- 2 times, 11/10- 2 times, 11/11- 1 time, 11/12- 1 time, 11/13- 3 times, 11/14- 1 time, 11/15- 1 times, 11/16- 1 time, 11/17- 3 times, 11/18- 3 time, 11/19- 1 times, 11/20- 3 times, 11/21- 3 times.</p> <p>The majority assessment of the effectiveness of the received pain medication was indicated as "E," identified as effective. No pain rating related to numerical or verbal pain scale was indicated.</p> <p>The prn (as needed) Hydrocodone acetaminophen pain medication assessment was "I" (coded as ineffective) on 11/2 at 4:50 p.m., 11/7 at 6:10 a.m., 11/10 5:25 p.m., on 11/11 at 6 p.m., 11/13 at 10:14 a.m., 11/14 at 4:58 p.m., 11/16 at 8:30 a.m., 11/17 at 3:10 and 11/20 at 4:23 p.m. This pain medication response was coded as "U" (unknown) on 11/4 6:31 p.m., 11/8 at 1:20 p.m. and 5:50 p.m.</p> <p>The hydromorphone as needed pain medication was coded "I" on 11/7 at 3:14 p.m. on 11/10 at 3:55 p.m., 11/11 at 4:29 p.m., and 11/13 at 8:33</p>			

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	<p>p.m., with one unknown on 11/16 at 2:35 p.m.</p> <p>On 11/21/13 at 11:34 a.m., during an interview with LPN #9, she indicated the electronic medical record would prompt nursing to enter pain level prior to administration and follow up 1 hour post administration. LPN #9 indicated that she would be responsible for reassessing resident's pain medications if needed.</p> <p>On 11/21/13 at 3:00 p.m., Resident #111 indicated she was experiencing pain, had been given pain medication that day, but it barely helped.</p> <p>On 11/22/13 at 2:50 p.m., Resident #111 indicated she had received pain medication and was still experiencing moderate pain.</p> <p>The level of relief the resident was experiencing could not be assessed, and even though medications were indicated as "ineffective," there was no indication the pain management plan was being reviewed.</p> <p>3.1-37(a)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to provide a dependent resident with oral care and continence care to maintain dignity and personal appearance, for 1 of 3 residents reviewed for ADLs (activities of daily living) in a sample of 7 who met the criteria. (Resident #97)</p> <p>Finding includes:</p> <p>A CNA worksheet, dated 11/14/13, provided by ADON on 11/20/13 at 8:49 a.m., indicated Resident #97 was NPO (nothing by mouth), dependent on tube feedings, incontinent of urine and bowel, required check and change, one assist with transfers and ADLs, and had special needs including a high back w/c (wheel chair) with cushion. Showers were scheduled on Monday and Friday on day shift.</p> <p>On 11/20/13 at 9:30 a.m., at 10:36 a.m. and at 1:29 p.m., Resident #97 was observed laying in bed, dressed</p>	F000312	<p>It is the policy of this facility to ensure that residents receive oral care and continent care to maintain dignity and personal appearance. Resident # 97 oral care and incontinent care is audited daily up to 5 days for four weeks, weekly times 3 weeks and monthly times three months to maintain dignity and personal appearance. In-servicing of policy and procedure for provision of oral care and incontinent care to dependent residents has been given to direct care staff. Audits of dependent residents needing oral care and incontinent care will be done on a daily up to 5 days a week times three weeks, weekly times four weeks and monthly times three months. Review and evaluation of audits will be done in QA monthly times three months and quarterly times three to determine if further intervention is needed to maintain dignity and personal appearance. Corrective Action Date: December 26, 2013</p>	12/26/2013			

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	<p>in a hospital gown with a large amount of white, green phlegm present in his mouth. Continuous feeding infusing at 65 milliliters per hour.</p> <p>The clinical record for Resident #97 was reviewed on 11/20/13 at 10:29 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, pneumonia, osteoarthritis, dysphagia, narcolepsy, and hypertrophy of the prostate.</p> <p>MDS (minimum data set) assessment for Resident #97, dated 8/25/13, indicated the resident required extensive assistance with support of two persons for bed mobility, transfers, dressing, and limited assist with support of 2 persons with toileting and personal hygiene.</p> <p>Care plans initiated 10/13/13 for Resident #97 included, but were not limited to, "I would like to make plans to remain at (this facility) long term care ... Provide total ADL care.</p> <p>A care plan initiated 10/30/13 included, but was not limited to, "Dependent on tube feeding/inadequate oral Intake due to: Dysphasia NPO diet potential risk of</p>						

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	<p>dehydration due to tube feeding and flushes 530 ...Provide oral care daily or prn...."</p> <p>On 11/21/13 at 8:53 a.m., Resident #97 observed in bed, eyes closed.</p> <p>On 11/21/13 at 9:53 a.m., during an observation of personal care of resident #97, the resident was observed to be laying in bed. The sheet under the resident was wet with large yellow ring with brown discoloration around outside, extending from the resident's mid-back to the knees. The room had a strong odor of urine.</p> <p>On 11/22/13 at 2:50 p.m., during a family interview, the resident's family member indicated the resident's mouth was frequently dry, the room had a strong urine odor, and they always washed him in bed every day, and the family member had to clean the resident when visiting.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(C)</p>						

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure treatment orders were obtained timely for a pressure sore, for 2 of 2 residents reviewed with pressure sores, in the sample of 9 who had pressure sores. (Resident #57, #97)</p> <p>Findings include:</p> <p>1. Resident #57's clinical record was reviewed on 11/21/13 at 11:00 a.m. Diagnoses included, but were not limited to, a history of septic shock, hypertension, cerebrovascular disease, peripheral vascular disease, anoxic brain injury, sacral decubitus, right foot ischemic decubitus, diabetes mellitus, and coronary artery disease. The resident's readmission Minimum Data Set (MDS) assessment, dated 8/13/13, indicated</p>	F000314	F 0314 It is the policy of this facility to ensure treatment orders are obtained timely for pressure areas. Resident #57 orders were obtained and implemented. Resident #97 orders are followed by nursing staff. Nurses will be in-serviced on pressure ulcer prevention, objectives for skin integrity / wound care, and positioning of resident, obtaining and following orders for treatment. Nurse Aides will be in-serviced on pressure ulcer prevention, and positioning of resident. Newly identified skin open area audits will be done by DNS or designee weekly times three weeks, monthly times three months, and quarterly times three. Review and evaluation of audits will be done at monthly QA meetings to determine if further intervention is needed to ensure treatment orders are obtained timely and followed. Corrective Action Date: December 26, 2013	12/26/2013			

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	<p>she had one stage 1 pressure area, one stage 3 pressure area, and one stage 4 pressure area. The assessment indicated the resident required extensive assistance of two persons for bed mobility and total assistance of one person for transfers.</p> <p>Resident #57 had a care plan, initiated 8/30/13, for actual pressure ulcer or at risk due to assistance required for bed mobility, bedfast, diagnosis of peripheral vascular disease, diagnosis of diabetes, and actual area to the right hip. Interventions included, but were not limited to, conduct weekly skin inspection, and treatments as ordered. Areas were being treated on the right heel, the right foot, the coccyx, the right anterior and posterior leg.</p> <p>Nursing progress notes, dated 11/9/13, included a change of condition SBAR form. "Situation: Res. has new open areas. Background: Res. has current open areas and is bedbound. Assessment: Res. has open area to left hip measuring 2 X 1.2 X 0.1. Eschar area to right heel beginning to open measuring 0.2 X 0.3 X 0.1. Areas cleansed and dressed.</p>			

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	<p>Response: Message left for Res. son [name]. MD notified, awaiting order for treatment plan."</p> <p>A progress note dated 11/13/13 at 11:22 a.m. indicated, "New tx[treatment] orders rec'd for right heel and left hip..." The treatment record indicated the order, dated 11/13/13, was for betadine solution apply to left hip topically every day shift for open area, cleanse area to left hip with NS [normal saline], apply betadine and cover with allevyn [foam dressing] daily until healed."</p> <p>LPN #4 was observed to provide treatment to Resident #57's left hip pressure ulcer. The area was observed to be a stage 2 pressure area, measuring 1 centimeter (cm) X 1.5 cm X less than 0.1 cm deep. Stage 2 areas indicate partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. The open wound was surrounded by darker tissue on the African American resident, .5 centimeters surrounding the open area. The nurse indicated the area developed in the facility.</p> <p>Treatment orders were not obtained for the area for four days after it was discovered; the resident already had</p>			

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	<p>pressure areas and was at high risk for developing new areas. The information was reviewed with the Director of Nurses on 11/22/13 at 4:00 p.m. No further information was provided.</p> <p>The policy and procedure for pressure ulcer prevention, dated 2006, was provided by the Director of Nurses on 11/21/13 at 4:50 p.m. The policy included, but was not limited to, "if a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective."</p> <p>2. On 11/20/13 at 1:29 p.m., LPN #4 was observed to remove the heel protector from Resident #97's right heel. She then proceeded to remove a podus boot (a boot designed to take pressure off of the heel area) from left heel. After the treatment was completed to both heels, the heel protector was returned to right heel and podus boot to left heel. At that time, during an interview, LPN #4</p>				

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	<p>indicated the podus boot should be on the right heel which had a pressure ulcer and not on the left as she replaced boots. At the time LPN #4 performed the treatment to the right heel, the heel area was dark in color and and appeared hard.</p> <p>Resident #97's record was reviewed on 11/21/13 at 2:40 p.m. The record included a care plan initiated on 11/4/13, titled, "Pressure ulcer actual or at risk due to: Pressure Ulcer Present and discoloration to right heel...Heel boots..."</p> <p>A progress note, dated 11/5/13 at 4:03 a.m., indicated resident had a new open area to right heel.</p> <p>Progress notes, dated 11/5/13 at 2:43 p.m., indicated, "order to use skin prep daily on dark areas to bilateral feet and heels. Resident with multi podus boot in place."</p> <p>A progress note, dated 11/19/13, by LPN #4, indicated the right heel area measured 5 centimeters by 4 centimeters and remained dark/black in color.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to identify the reason for use of a foley catheter (Resident #75) and failed to ensure infection control practices were followed in the handling of the foley catheter (Resident # 62) for 2 of 3 residents reviewed with foley catheters, in a sample of 13 who met the criteria.</p> <p>Findings include:</p> <p>1. On 11/19/13 at 10:34 a.m., during interview, LPN #7 indicated Resident #75's diagnosis for her foley catheter was urinary tract infections.</p> <p>Resident #75's clinical record was reviewed on 11/20/13 at 8:43 a.m. The resident's diagnoses included, but were not limited to, bipolar disorder, schizophrenia, anxiety,</p>	F000315	<p>F 0315 It is the policy of this facility to identify the reason for use of a foley catheter and ensure infection control practices are followed in the handling of the foley catheter. Resident #75 diagnosis was clarified by physician for use of the foley catheter. The foley was removed for bladder re-training which failed and the catheter was re-placed due to urinary retention and diagnosis was confirmed and documented. Resident #62 foley catheter was secured for infection control. In-servicing of nursing staff for appropriate diagnosis for use of foley catheter, infection control, and provision of infection control interventions for prevention of urinary tract infections has been implemented, and implementation of bladder re-training programs where appropriate has been done. Audits will be done of all patients with catheters by DNS or designee weekly times three</p>	12/26/2013

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	<p>dysphagia, hypertension, and urinary tract infections. No specific diagnosis was documented for the foley catheter.</p> <p>A physician's order, dated 11/13/13, indicated, "monitor I&O (intake and output) for 24 hours, if no output in 8 hours, do in and out cath, if residual is over 250cc collect UA [urinalysis] and anchor 16/10 [size 16, 10 cubic centimeter balloon] foley."</p> <p>The "Progress note", dated 11/14/13 at 2:15 a.m., indicated "catheterized resident d/t (due to) no output in 8 hours, placed on bed pan several times without result. Immediate return 300 ml [milliliters], anchored foley 16fr/10ml as directed...."</p> <p>A Lab report, dated 11/14/13, indicated urinalysis was negative and "try bladder training to get catheter out".</p> <p>Care plans included, but were not limited to, alteration in elimination of bladder: Indwelling Urinary Catheter; at risk for infection, initiated on 5/22/13. Interventions included, but were not limited to, monitor and report S&S (signs and symptoms) of UTI (urinary tract infection).</p>		<p>weeks, monthly times three months and quarterly times two for appropriate diagnosis, implementation of infection control interventions in place to prevent urinary tract infections. Review and evaluation of audits will be done at monthly QA for three months and quarterly times three. Corrective Action Date: December 26, 2013</p>		

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	<p>The "Bowel and Bladder Evaluation Tool," dated 2/12/13, indicated the resident was a fair candidate for a RNP (Restorative Nursing Program). This tool indicated the resident could proceed to complete bowel and bladder tracking tool.</p> <p>2. Resident #62 was observed on 11/21/13 at 12:08 p.m., 2:00 p.m., and 4:00 p.m., to have urinary catheter laying on floor. A small amount of yellow urine with white sediment was observed in the Foley catheter tubing.</p> <p>Resident #62's clinical record was reviewed on 11/21/13 at 2:40 p.m. The resident's diagnoses included, but were not limited to, urinary tract infection (UTI), diabetes and pressure ulcers. The urine culture laboratory result, dated 11/17/13, indicated the growth of Pseudomonas Aeruginosa bacteria. The physican's order, dated 11/19/13, was Cipro (antibiotic) 500 mg (milligrams) two times a day for 14 days for a diagnosis of UTI.</p> <p>3.1-41(a)(1) 3.1-41(a)(2)</p>				

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to maintain the resident in an elevated position, in that, the head of bed was lowered to provide personal care for a resident who received a continuous tube feeding, for 1 of 2 residents reviewed with continuous feeding tubes. (Resident #97)</p> <p>Findings include:</p> <p>Resident #97's clinical record was reviewed on 11/20/13 at 10:29 a.m.</p> <p>Diagnoses included, but were not limited to, Alzheimer's, dysphasia and pneumonia.</p>	F000322	F 0322It is the policy of this facility to ensure proper positioning of residents who are being provided personal care while on continuous G tube feedings. Resident #97 will have the head of the bed up while on continuous feeding. Nurse will discontinue feeding to obtain personal care by direct care staff to ensure aspiration does not occur. In-servicing of all direct care nursing staff regarding positioning patients on tube feedings during personal care was implemented. Audits will be done by DNS or designee to ensure proper positioning of tube feeding residents is followed during personal care to prevent aspiration daily up to 5 days a week for three weeks, weekly for three weeks, monthly for three	12/26/2013			

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	<p>A physician's order dated 8/19/13 indicated, Enteral Feeding Order "Jevity 1.5 at 65 cubic centimeter per hour via peg tube" was to be given continuously.</p> <p>Care plans dated 8/20/13 indicated, "Dependent on tube feeding/inadequate oral intake due to: dysphasia, Alzheimer's, anorexia"... "Elevate HOB [head of bed] at least 30-45 degrees during (sic) and for 30-60 minutes after feeding..."</p> <p>On 11/21/13 at 9:53 a.m., Resident #97's personal care was observed. In preparation, CNA #2 and CNA #5 were observed to place the resident in a flat position in bed. The resident was observed to have a continuous feeding per pump at a rate of 65 cubic centimeters per hour, while laying flat during care. CNA #2 and CNA #5 were observed to complete personal care and elevate head of bed back to 30 degrees. Resident #97 did not show any signs of distress during the 15 minutes of care.</p> <p>On 11/21/13 at 10:22 a.m., LPN #10 indicated CNAs were instructed to notify nurse prior to providing care to residents with continuous tube feeding so the feedings could be</p>		<p>months. Review and evaluation of audits will be done monthly at the QA for three months and quarterly times three. Corrective Action Date: December 26, 2013</p>		

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	<p>turned off.</p> <p>On 11/21/13 at 10:26 a.m., CNA #2 indicated during care of resident #97, she was unaware of any special precautions for the resident.</p> <p>On 11/21/13 at 10:30 a.m., CNA #5 indicated during care of resident #97, they were to keep the head of bed elevated at "90" degrees due to resident's risk of choking.</p> <p>A policy provided by DoN on 11/22/13 at 10:55 a.m., titled Care of Enteral Feeding Tube had no information to indicate proper placement for residents receiving continuous feeding.</p> <p>Indiana Nurse Aide Curriculum Lesson 14 section III reviewed 11/22/13 at 7:00 p.m. indicated "...The resident <u>with a feeding infusing</u> should not lie flat. The head of the bed should be elevated at least 30°. Some procedures will need to be changed slightly for the resident with a feeding tube. For example, an occupied bed cannot be flattened to change the linen or to provide incontinence care with the feeding infusing. If the bed must be flattened, seek the nurse ' s assistance to turn off the pump prior to the procedure</p>			

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	and turn the pump back on after the procedure...." 3.1-44(a)(2)			

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F000323 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, interview, and record review, the facility failed to ensure planned interventions were implemented, in that, personal body alarms were not in place and/or functioning in the preventions of falls for 1 of 2 residents reviewed for falls in a sample of 2 who met the criteria. (Resident #22)</p> <p>Finding includes:</p> <p>On 11/20/13 at 2:16 p.m., Resident #22 was observed in the activity room in her wheelchair with her personal body alarm (PBA) unattached to her but attached to her wheelchair. No nursing supervision was observed in the activity room. At 2:32 p.m., Resident #22 was observed to raise from her wheelchair. The PBA remained unattached. CNA #3 was notified at that time and assisted the resident.</p> <p>On 11/20/13 at 10:03 a.m., Resident #22's clinical record was reviewed. Diagnoses included, but were not</p>	F000323	<p>F 0323It is the policy of this facility to ensure planned interventions are implemented and body alarms are in place and functioning when ordered. Resident #22's tab alarm was secured. CNA # 6 and LPN #2 was provided training regarding policy and procedure for ensuring alarms are secured for residents with personal alarm orders. In-servicing of direct care staff in securing personal alarms for residents who have orders for personal alarms who are at fall risk has been implemented. Audits of residents with personal alarms will be done daily up to 5 days a weeks times three weeks, weekly times three weeks, monthly times three months. Review and evaluation of audits will be done at monthly QA meeting to determine if further intervention is needed regarding personal safety alarms. Corrective Action Date: December 26, 2013</p>	12/26/2013

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	<p>limited to, Alzheimer's disease, urinary tract infection, dementia with behavior disturbances, and bipolar disorder.</p> <p>The physician's recapitulation orders, signed 11/1/13, included, but were not limited to, tabs alarm to w/c (wheelchair).</p> <p>The "Progress Notes", indicated on 10/11/13 at 1:18 p.m., the resident was leaning forward and fell out of w/c resulting in red abrasion to forehead. No information indicated alarm was sounding.</p> <p>The "Progress Notes", dated 10/22/13 at 11:32 a.m., indicated Resident #22 had poor safety awareness and had fallen on 10/10/13 on the evening shift. Resident noted to have abrasion to forehead. Staff were to ensure alarms in place and functioning properly.</p> <p>On 11/20/13 at 10:49 a.m., care plans were reviewed. Care plans included, but were not limited to, "At risk for falls related to: use of medication, history of falls." Interventions included, but were not limited to, tabs alarm to w/c (initiated 8/16/13).</p> <p>On 11/21/13 at 9:13 a.m., the annual</p>			

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	<p>MDS (minimum data set) assessment, dated 9/6/13, indicated the BIMS (Brief Interview for Mental Status) score was 1 with a score of 8-15 as interviewable. The resident required extensive assistance of 2 persons for transfer. Resident had a history of falls.</p> <p>On 11/21/13 at 2:33 p.m., CNA #6 indicated CNA's should check alarm placements every hour.</p> <p>On 11/22/13 at 9:26 a.m., LPN #2 indicated alarms are checked before and after each shift.</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the pharmacist recommendations were acknowledged by the physician in 1 of 5 residents reviewed for unnecessary medications in a sample of 5. (Resident #58)</p> <p>Findings include:</p> <p>On 11/20/13 at 9:25 a.m., Resident #58 was observed sleeping in bed.</p>	F000329	F 0329It is the policy of this facility to ensure pharmacy recommendations are acknowledged by the physician and reviewed for unnecessary medication orders. Residents #58 medications were reviewed by the physician to determine if there were unnecessary medications based on pharmacy recommendations. Nurses will be in-serviced on follow up to physicians on pharmacy recommendations. Audits done by DNS or designee to ensure all pharmacy recommendations	12/26/2013			

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	<p>On 11/20/13 at 11:08 a.m., Resident #58 observed eating lunch in ACU (Alzheimer Care Unit) dining room.</p> <p>On 11/20/13 at 1:35 p.m., Resident #58 observed sleeping in bed.</p> <p>On 11/20/13 at 1:38 p.m., Resident #58's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, delirium, epilepsy, depressive disorder, and diabetes.</p> <p>Resident #58's medications included, but were not limited to, Risperdal 1 mg (milligram) every night. Cymbalta was not included in the physician's orders.</p> <p>The MDS (minimum data set) assessment, dated 9/11/13, indicated BIMS (Brief Interview for Mental Status) score of 3, 8-15 indicated interviewable status. MDS mood score 00, no behaviors documented.</p> <p>The "Progress Note", dated 10/15/13, indicated IDT (interdisciplinary team) behavioral management meeting with pharmacist present. Pharmacist recommended reduction of Risperdal and addition of Cymbalta.</p>		<p>receive follow up by the physician and medication orders are changed accordingly will be done monthly times 6 months. Review and evaluation of audits will be done at QA monthly times three and quarterly times three. corrective Action Date: December 26, 20013</p>				

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	<p>The "Progress Note", dated 11/13/13, indicated IDT behavior management meeting with pharmacist present. Pharmacist recommended reduction in Risperdal and addition of Cymbalta.</p> <p>The "Clinical Pharmacist Letter to Physician Services", dated 10/15/13, indicated Pharmacist recommended reduction of Risperdal from 1 mg to 0.5 mg, and addition of 30 mg of Cymbalta. The form lacked a physician's signature to indicate acceptance or rejection of recommendation. No information was indicated the form was mailed or faxed to physician.</p> <p>The "Behavioral Health Progress Note", dated 11/1/13 lacked acknowledgement of pharmacist recommendation.</p> <p>On 11/21/13 at 9:38 a.m., Resident #58 was observed sleeping in bed.</p> <p>On 11/22/13 at 4:15 p.m., the Administrator indicated pharmacist's recommendations for dose reduction were mailed to physician.</p> <p>3.1-48(b)(2)</p>						

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure timely disposal of medications with shortened expiration dates and</p>	F000431	F 0431It is the policy of this facility to ensure timely disposal of medications with shortened expiration dates and the sanitary condition of medication rooms	12/26/2013

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	<p>sanitary condition of medication rooms and medication carts, for 2 of 3 medication rooms (400/500 hall and ACU (Alzheimer's Care Unit) and 3 of 4 medication carts (200 hall, 400/500 hall, ACU).</p> <p>Findings include:</p> <p>On 11/21/13 at 2:35 p.m., the 200 hall medication room was observed:</p> <ol style="list-style-type: none"> 1. An open can of mountain dew was observed on the countertop. 2. The medication cart on the 200 hall was observed with a Lantus (long-acting insulin) bottle with an open date of 10/20/13. <p>On 11/21/13 at 2:57 p.m., the 400/500 hall was observed:</p> <ol style="list-style-type: none"> 3. Refrigerator in the medication storage room on the 400/500 hall had ice build up of one inch thick in the freezer area. Refrigerator temperature measured 32 degrees Fahrenheit. 4. The 400/500 hall medication cart was observed to include white disposable wipes in clear plastic bags. Bags had handwritten "bleach" on the side of the bag. LPN #5 		<p>and medication carts. In-servicing implemented on disposal of medications with appropriate expiration date and maintenance of sanitary conditions of med carts and med rooms. Cart audits and medication room audits will be done by DNS or designee weekly times three weeks, monthly times three months. Review and evaluation of the audits will be done at monthly QA to determine if further intervention is needed to ensure proper disposal of medications and sanitation of med rooms and med carts. Corrective Action Date: December 26, 2013</p>		

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	<p>indicated wipes should be kept in the original container.</p> <p>On 11/21/13 at 2:57 p.m., interview with LPN #5 indicated insulin expired after 30 days of being opened. LPN #5 indicated eye drops expired 30 days after the open date</p> <p>5. On 11/21/13 at 3:15 p.m., observation of medication cart in ACU included the following: Timolol (eye drops) not dated with open date; Lumingan (eye drops) not dated with open date; opened Liquitears (eye drops) dated 8/21/13. LPN #6 indicated eye drops expired in 60 days.</p> <p>6. On 11/21/13 at 3:15 p.m., observed medication storage room in ACU included the following: Tuberculin vial dated 1/21/13.</p> <p>7. On 11/21/13 at 3:15 p.m. LPN #6 indicated insulin expired 30 days after open date.</p> <p>8. On 11/22/13 at 9:00 a.m., reviewed Alixa Rx "Medications with Shortened Expiration Dates" related to medication storage. The current policy was provided by the DON on 11/21/13 at 4:50 p.m. Appendix indicated insulin expired 28 days after</p>			

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	<p>open date. Tuberculin PPD/Mantoux expired 28 days after initial use. Lantus expired 28 days after open date. Policy and procedure indicated open date should be noted on each container vial of medication known to have shortened beyond use date or expiration date.</p> <p>3.1-25(m) 3.1-25(o)</p>			

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F000441 SS=E	<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 observation, interview, and record review, the facility failed to</p>	F000441	F 0441It is the policy of this facility to establish and maintain	12/26/2013			

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	<p>ensure infection control procedures were followed for 7 of 35 stage 2 sample residents observed during care, and for 12 of 24 staff observed providing care and/or services to the residents. (Residents #57, #72, #54, #61, #30, #97, #22) (LPN #12, PT #1, LPN #2, LPN #7, Hsk #1, CNA #2, CNA #5, CNA #3, CNA #1, ACU director, LPN #8)</p> <p>Findings include:</p> <p>1. On 11/20/13 at 4:05 p.m., LPN #12 was observed in Resident #57's room. The LPN was observed wearing a gown over her clothes, and gloves. She indicated she had already checked Resident #57's blood sugar. The resident was on contact precautions for a wound infection, she stated. The glucometer was observed setting on the overbed table in the resident's room. LPN #12 was observed to take off her gown and gloves, exit the room with the blood glucometer in her hands, and place the glucometer on the top of the medication cart. She then opened up the computer on the cart and began using it. It was at that time that she obtained alcohol gel and used it to clean her hands.</p> <p>The blood glucometer remained</p>		<p>an infection control program designed to provide safe and sanitary comfortable environment and to help and prevent the development and transmission of disease and infection. All staff will be in-serviced on infection control, universal precautions and blood borne pathogens to minimize risk of infection for residents. Audits will be performed of all reportedly involved departments random weekly times three weeks, bi-weekly times three months and monthly times three months. Audits will be reviewed and evaluated at monthly QA meetings to determine if further intervention is needed. Corrective Action Date: December 26, 2013</p>		

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	<p>setting on top of the medication cart as LPN #12 administered medications to other residents. At 4:36 p.m. on 11/20/13, LPN #12 picked up the blood glucometer from the medication cart and was carrying it to Resident #72's room. As she reached the resident's door, she was stopped. When queried about any procedures for the blood glucometer between residents, she stated, "if they have one I don't know about it..." She was requested to check with other facility staff and she went to the nurse's station. She returned with a ziplock bag with white disposable towelettes in it and hand-written on the bag was "bleach wipes." She used one of the towelettes to wipe off the blood glucometer.</p> <p>The policy and procedure for "Blood Glucose Monitor Decontamination," dated 2007, revised 2012, included, but was not limited to, the following: "A wipe that is an EPA registered as tuberculocidal; effective against HIV, HBV, and a broad spectrum of bacteria will be utilized to clean the monitor. It is 0.525% sodium hypochlorite which is equivalent to a 1:10 bleach dilution solution, and meets recommendation for use on equipment from Clostridium difficile rooms. If a product wipe is not</p>			

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	<p>available, a 1:10 bleach solution may be substituted."</p> <p>The procedure continued as follows: "...After performing the glucose testing, the nurse, wearing gloves, will use a dispatch wipe to clean all external parts of the monitor. A second wipe will be used to disinfect the blood glucose monitor. The disinfected monitor will be placed on another clean surface..."</p> <p>2. Resident #54's room was observed on 11/18/13 at 12:22 p.m. Dirty linens and towels were observed on the floor in the bathroom.</p> <p>3. Resident #57's room was observed on 11/20/13 at 4:10 p.m. Soiled wash cloths were setting on the overbed table. Resident #57 was on contact precautions due to an infected coccyx wound.</p> <p>4. During observation of a medication pass, on 11/22/13 at 8:10 a.m., LPN #2 administered medications to Resident #61. She then went to the sink in the dining room of the Alzheimer's Unit and rinsed her hands for two seconds; she used no soap. She then administered medications to Resident #53. After administering medications to the resident, she</p>						

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	<p>rinsed her hands for two seconds in the sink. She then passed medications to Resident #116.</p> <p>5. A policy and procedure for "Hand Washing," dated 2006, was provided by the Director of Nurses on 11/21/13 at 4:50 p.m. The policy and procedure included, but was not limited to, the following: "Wash hands before and after resident contact." "Wash hands when soiled." "Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); Before and after performing any invasive procedure; Before and after entering isolation precaution settings; Before and after assisting a resident with meals; Before and after assisting a resident with personal care; Before and after changing a dressing; Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or</p>			
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	<p>used linens, dressings, bedpans, catheters and urinals; After removing gloves or aprons..." "The use of gloves does not replace handwashing/hand hygiene."</p> <p>6. On 11/2/13 at 9:58 A.M., as PT (physical therapist) #1 was preparing to provide Electro-stimulation to Resident # 30's foot wound, PT #1 was observed to wash her hands for 8 seconds. She then donned a pair of gloves and proceeded to connect the electro-stimulation probes, which had fallen on the floor, to the electronic pads on the resident's lower right leg. She then was observed to start the treatment.</p> <p>7. On 11/20/13 at 1:29 p.m., during preparation to provide care to Resident #97, LPN #7 was observed to wash hands for eleven seconds, shut off faucet with her wet hand, and then dried her hands.</p> <p>8. On 11/20/13 at 10:10 a.m., Housekeeper #1 was observed walking out of the isolation Room # 501 wearing an isolation gown, gloves and mask. She then was observed to walk across hallway into the opposite room. Housekeeper #1 then reentered room # 501 proceeding to</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
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	<p>clean. Upon exit of room Housekeeper #1 took off gloves, gown and mask and placed in trash on housekeeping cart.</p> <p>A policy provided by DoN on 11/22/13 at 2:16 p.m. titled Universal Precautions for Laundry Employees revised 2/1/13 indicated on pg 6 section C subtitled Personal Protective Equipment (PPE) "...After cleaning in medical treatment, laundry service or resident areas, the used gloves must be placed in red bag trash prior to leaving the work area...." pg 7 "...all PPE must be removed and disposed of in red bag trash prior to leaving the work area....".</p> <p>9. On 11/21/13 at 9:53 a.m., during observation of Resident #97's personal care, CNA #2 and CNA #5 with gloved hands were observed to provide a full bed bath. During the bath, CNA #2 completed perineal care and proceeded to dress and reposition the resident. No hand washing/hand gel, or glove changing was observed during care.</p> <p>On 11/22/13 at 10:07 a.m., during an interview CNA #2 indicated during a resident's bath she would change gloves prior to providing peri care and handwash before and after providing</p>			

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	<p>care to residents.</p> <p>On 11/22/13 at 10:30 a.m., during an interview CNA #5 indicated she would do handwashing prior to and after providing care to residents. She then indicated during a bath she would change gloves after doing half of the front of a resident, after the back and again after providing perineal care.</p> <p>10. On 11/22/13 at 9:54 a.m., in preparation for Resident #97's skin check, the ADON was observed to handwash for five seconds, turned off faucet with her wet hand, then dried her hands with paper towels.</p> <p>11. On 11/20/13 at 2:33 p.m., Resident #22's personal care was observed. After CNA #3 donned a pair of gloves and applied the gait belt, she assisted resident to commode. After resident indicated she was finished, CNA #3 wiped her with toilet paper. CNA #3 indicated resident had small bowel movement. She then assisted the resident to wheelchair, assisted resident to wash resident's hands, provided resident with paper towel, and loosened resident's gait belt before removing her gloves and washing hands.</p>			

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	<p>12. On 11/21/13 at 11:44 a.m., during lunch observation in the dining room, CNA #1 was observed to hand wash for 6 seconds, turned off the water faucet with her bare hands and then dried her hands. She was then observed to served resident's in ACU (Alzheimer's Care Unit) family style noon meal.</p> <p>13. On 11/21/13 at 11:52 a.m., during lunch observation in the dining room, ACU (Alzheimer's Care Unit) Director was observed to hand wash for 12 seconds. She then assisted residents in ACU with noon meal.</p> <p>14. On 11/21/13 at 12:08 p.m., during lunch observation in the dining room, LPN #8 was observed to hand wash for 15 seconds. She then assisted residents in ACU with noon meal.</p> <p>15. On 11/21/13 at 12:11 p.m., during lunch observation in the dining room, an interview with Dietary Manager indicated during dining activities hands should be washed between every task for a minimum of 20 seconds.</p> <p>3.1-18(b)(1)</p>						

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a sanitary and comfortable environment for residents, staff, and the public, for 2 of 17 residents interviewed in the stage 1 sample, for 15 of 32 rooms observed in the stage 1 sample, and for 1 of 4 shower rooms observed. (Residents #9, #59) (Rooms 521, 210, 202, 503, 208, 211, 500, 509, 108, 111, 106, 101, 212, 109, 506) (200 hall shower room)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #9 was interviewed on 11/18/13 at 3:24 p.m. The resident indicated the floors in the room were dirty. 2. Resident #59 was interviewed on 11/19/13 at 9:48 a.m. The resident indicated, "I think the floors could look better, lots of crumbs." The resident indicated the room floor. 3. Room 521 was observed on 11/18/13 at 3:42 p.m. The floor was soiled along the baseboards in the room. 	F000465	<p>F 0465It is the policy of this facility to ensure a sanitary and comfortable environment for residents, staff and the public. All survey identified rooms and areas were corrected to ensure sanitation and comfort of the environments. Audits will be performed in all rooms to ensure no further residents, staff or public will be affected. Facility Guardian Angel times 5 will be done weekly ongoing. Audits will be reviewed and evaluated at monthly QA meetings to determine if further intervention is necessary. Corrective Action Date: December 26, 2013</p>	12/26/2013			

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	<p>4. Room 210 was observed on 11/19/13 at 10:40 a.m. The bathroom floor had an accumulation of brown substance soiling the floor, especially around the toilet. The caulking was dark brown in color and some odor was present in the bathroom. The corners and edges of the floor were soiled with dirt and debris.</p> <p>5. Room 202 was observed on 11/18/13 at 2:02 p.m. The corners and edges of the floor were soiled with dirt and debris. The bathroom floor was soiled. A soiled toilet seat extender was setting on the floor in the bathroom. An unlabeled wash basin was setting on the counter in the bathroom with a soiled wash cloth in it.</p> <p>6. Room 208 was observed on 11/18/13 at 11:52 a.m. The walls were marred with black marks to the left and right of the bathroom door. The edges and corners of the floors were soiled with dirt and debris. The bathroom had a bedpan with a soiled towel on the floor and another soiled towel on the floor. A robe was hanging from a hook in the bathroom. The robe was very soiled with a brown substance.</p>			

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	<p>7. Room 503 was observed on 11/18 at 11:00 a.m. The bathroom and room floors were soiled with dirt and debris around the edges and corners.</p> <p>8. Room 211 was observed on 11/18/13 at 2:37 p.m. The room and bathroom floors were soiled along the edges and in the corners.</p> <p>9. Room 500 was observed on 11/18/13 at 3:46 p.m. The floors around the edges were soiled with dirt and debris. There were two bedpans on the floor in the bathroom.</p> <p>10. Room 509 was observed on 11/18/13 at 12:50 p.m. The paint on the walls was chipped. There was a large piece of flooring missing in the entry way. The floors were soiled with dirt and debris along the edges and corners.</p> <p>11. Room 108 was observed on 11/18/13 at 3:31 p.m. The floors were scuffed. The floor around the commode was soiled with black substance.</p> <p>12. Room 111 was observed on 11/18/13 at 2:07 p.m. The floor around the commode was soiled with brown substance.</p>			

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	<p>13. Room 106 was observed on 11/18/13 at 3:16 p.m. The bathroom floor was soiled and stained.</p> <p>14. Room 101 was observed on 11/18/13 at 1:54 p.m. There were black scuffs on the wall. The floor area around the commode was soiled with black/brown substance. There was a strong urine odor in the bathroom and the floor was sticky.</p> <p>15. Room 212 was observed on 11/18/13 at 11:25 a.m. The walls were soiled with dried substance. The floors were soiled. The bathroom floor was soiled around the commode with a black/brown substance. There was a urine odor in the bathroom.</p> <p>16. Room 109 was observed on 11/18/13 at 3:13 p.m. The floors were scuffed with black marks.</p> <p>17. Room 506 was observed on 11/18/13 at 12:35 p.m. The floor around the toilet was soiled.</p> <p>18. The unoccupied 200 hall shower room was observed on 11/22/13 at 1:18 p.m. There was paper trash and a soiled band-aid on the floor of the shower stall.</p> <p>3.1-19(f)</p>			

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F000514 SS=E	<p>483.75(I)(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 interview and record review, the facility failed to ensure documentation was complete and accurate, for 3 of 35 residents in the stage 2 sample, in that documentation was lacking for dialysis access site monitoring, activity participation, and blood sugars. (Residents #76, #97, #58)</p> <p>Findings include:</p> <p>1. Resident #76's clinical record was reviewed on 11/21/13 at 2:20 p.m. Diagnoses included, but were not limited to, end stage renal disease with hemodialysis, diabetes, neuropathy, coronary artery disease, and anemia. The record indicated the resident went out for hemodialysis three days a week.</p>	F000514	F 0514It is the policy of this facility to ensure documentation is complete and accurate. Resident #76 orders were implemented to reflect assessment of the renal dialysis site for monitoring based on standards of care. Resident #97 activity record was completed reflecting his attendance at pre meal / chronicle participation. Resident #58 glucose readings are documented in the E-Mar. In-services was completed for nurses and the documentation of blood glucose and assessments of dialysis sites and the supporting documentation. Activity staff was in-serviced regarding activity participation and the supporting documentation. Audits will be done by DNS or designee weekly times three weeks, monthly times three months, and quarterly times three. Review and evaluation of	12/26/2013			

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	<p>The resident had a care plan regarding the end stage renal disease, risk for bleeding from the access site, and risk for infection related to the fistula site, dated 10/18/12. Interventions included, but were not limited to, monitoring for thrill and bruit daily and documenting findings. The record lacked any documentation of monitoring for thrill and bruit of the access site.</p> <p>LPN #7 was interviewed on 11/22/13 at 8:35 a.m. regarding care of dialysis residents. She described pre- and post-dialysis procedures. She indicated she checked for thrill and bruit every day. When queried about where this was documented, she indicated there was no place to document it.</p> <p>2. Resident # 97"s clinical record was reviewed on 11/20/13 at 10:29 a.m. The resident's admission date was 8/19/13. The facility's recreation participation record indicated resident attended the activities "Pre-Meal/chronical" from 8/1/13 to 8/18/13. These dates were prior to resident's admission to facility.</p>		the above will be done in monthly QA meetings to ensure documentation is complete and accurate. Corrective Action Date: December 26, 2013				

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	<p>3. On 11/21/13 at 9:45 a.m., Resident #58's clinical record was reviewed. The resident's MAR (medication administration record) indicated resident's blood sugar results were not recorded on 11/10, 11/11, 11/19, 11/20, 11/21, and 11/22, but were coded as "SS", which indicated BS (blood sugar) levels required no insulin needed.</p> <p>On 11/22/13 at 9:33 a.m., LPN #9 indicated blood sugar level should be charted even when blood sugar level does not require insulin. LPN #9 indicated blood sugar should be documented in order to notify physician of levels.</p> <p>On 11/22/13 at 10:40 a.m., Director of Nursing (DON) indicated nurses should document blood sugar results even if the blood sugar does not require insulin.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				

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