

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F000000	<p>This visit was for Recertification and State Licensure Survey.</p> <p>Survey dates: April 22, 23, 24, 25, 26, and 29, 2013</p> <p>Facility number:000094 Provider number: 155178 AIM number: 903101002</p> <p>Survey Team: Shelly Vice, RN-TL (4/22, 4/23, 4/24, 4/25, and 4/29/2013) Shauna Carlson, RN Julie Baumgartner, RN Sharon Ewing, RN Chris Greeney, QMRP (4/22 and 4/23/13)</p> <p>Census Bed type: SNF/NF: 113 Total: 113</p> <p>Census Payor Type: Medicare: 40 Medicaid: 65 Other:8 Total:113</p> <p>These deficiencies reflect state findings 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 May 9, 2013, by Brenda Meredith, R.N.			

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F000155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on interview and record review, the facility failed to ensure one resident's medical record accurately documented his advanced directive and chosen code status. This deficiency had the potential to affect of 1 of 1 resident's reviewed for advanced directives. (Resident #68)</p> <p>Findings include:</p> <p>On 4/25/13 at 9:45 a.m., review of Resident #68's record indicated his diagnoses included but were not limited to: "...ocd [obsessive compulsive disorder], COPD [chronic obstructive pulmonary disease],</p>	F000155	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advanced directive. This includes a written description of the facility's policies to implement	05/29/2013			

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	<p>generalized anxiety, depressive disorder, acute coronary occlusion without MI [myocardial infarction-heart attack], and coronary arteriosclerosis...." Further review of Resident #68's record indicated he was admitted to the facility on 7/9/10, with a physician order to be a full code.</p> <p>Review of the Social Services progress note for Resident #68, dated 3/26/13 9:29 a.m., indicated "...met with resident 3-25-13 to discuss code status. Originally he stated he wanted to change from full code to DNR [Do Not Resuscitate]. He would prefer to talk with his family first. Offered to contact his family but he wants to do this himself...." Review at this time of the Advanced Directive care plan, initiated 3/25/13, indicated "...Focus: Patient has an advanced directive as evidenced by: Do Not Resuscitate. Created date: 3/25/13...Goals: Patients wishes will be honored...Interventions: Follow facility policy for identification of code status...Obtain advanced directive with physician order and resident/responsible party signature...."</p> <p>Review at this time of "Resuscitation Order" in Resident #68's record,</p>		<p>advanced directives applicable by State law. Consistent with this practice, the following actions have been taken: I. Resident # 68 was interviewed by Social Services to reviewed advance directive and code status. The medical record of resident #68 was updated to reflect advance directive and chosen code status. II. The medical records of all residents' will be audited to ensure that the signed physician order for residents' chosen coded status is accurately reflected in the medical record, including the consent and plan of care. III. All staff will be in-serviced on the resident's right to refuse and formulate advanced directive as well as the facility policy on Advanced Directives. Residents' code status will be reviewed upon admission, at the quarterly care plan review, upon a significant change, and annually during the care plan review for ongoing compliance with this practice. A QAPI tool titled, "F155/F248/F272/F279 " was developed that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that the medical record is reflective of resident's chosen code status and plan of care as reviewed by the Interdisciplinary Team (IDT) during care plan reivews conducted quarterly, with a significant change, and annually. IV. The DNS or</p>		

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	<p>dated 12/7/09, indicated "...the resident or the residents decision maker is aware of the medical condition of the resident. After fully discussing and considering the risks/benefits and alternatives to the initiation of CPR [cardiopulmonary resuscitation] in a cardiac or respiratory arrest, the resident or the resident's representative has made the following decision: [X] In the event of a cardiac and/or respiratory arrest, initiate CPR..." This advanced directive form was signed by Resident #68's physician on 12/9/09.</p> <p>During an interview on 4/25/13 at 1:31 p.m., Employee #3 (Social Worker) indicated the social worker was the one who was responsible for helping facilitate the change if a resident change their code status. Employee #3 further indicated that she was a new employee and during the beginning of her time here a "...consultant social worker came through and verified code status..." for all the residents. Employee #3 indicated Resident #68 had told the consultant "...he was interested in becoming a DNR, so the consultant came back and started the paperwork, including initiating a new advanced directive care plan, but when they went back to Resident #68</p>		<p>designee will review findings weekly and will report to the QAPI Team monthly for 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>		

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	<p>to have him sign the form that was when he said he wanted to talk to his family...." Employee #3 indicated the new care plan should not have been started before the advanced directive was signed by Resident #68 and they had an updated physician order.</p> <p>On 4/25/13 at 4:17 p.m., review of the "Residents' Rights...Advanced Directive..." policy, dated July 2006 and revised 2009, received from Employee #3 indicated "...The resident has a right to execute or refuse to execute an advanced directive that stipulates how decisions regarding his/her medical care will be made...request a copy of all executed advanced directives and place in the resident's current medical chart...."</p> <p>3.1-4(f)(5)</p>						

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F000156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on observation, interview and record review, the facility failed to post the current Ombudsman name and contact information for 3 of 6 survey days. (April 23, 24 and 25, 2013) This deficiency had the potential to affect 113 of 113 residents residing in the facility.</p> <p>Findings include:</p> <p>On 4/22/13 at 10:35 a.m., an observation was made of the advocacy information posted on the wall near the front desk. The Ombudsman contact information had the wrong name and contact number posted.</p> <p>During an interview on 4/22/13 at 10:53 a.m., the facility Administrator indicated she was able to verbalize who was the correct current Ombudsman.</p> <p>On 4/23/13 at 12:10 p.m., an observation was made of the advocacy information posted on the wall near the front desk. The Ombudsman contact information remained to have the wrong name and contact number posted.</p>	F000156	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the state ombudsman program, the protection and advocacy network, and medicaid fraud control unit, and a statement that the residents may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirement. Consistent with this practice, the following actions have been taken: I. Resident # 62 was	05/29/2013	

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	<p>On 4/24/13 at 1:20 p.m., an observation was made of the advocacy information posted on the wall near the front desk. The Ombudsman contact information remained to have the wrong name and contact number posted.</p> <p>During an interview on 4/25/13 at 11:38 a.m., RN #1 indicated she was unsure of the current Ombudsman, "...I'm very new, but I know it is posted in the front area...."</p> <p>During an interview on 4/25/13 at 11:42 a.m., LPN #2 indicated she was unsure of the current Ombudsman. LPN #2 indicated the current information was in "...a book at the nurses station...." When LPN #2 was unable to locate the book she mentioned she indicated "...I also know it is posted in the front...."</p> <p>During an interview on 4/25/13 at 11:50 a.m., Resident #62 indicated she was unaware of the current Ombudsman and was unaware of where she would look for the information. Resident #62 indicated "...I would ask my nurse I guess...."</p> <p>On 4/25/13 1:28 p.m., an observation was made of the advocacy information posted on the wall near</p>		<p>informed of the current ombudsman's name and contact information. The new location of ombudsman's name and contact number were also communicated to resident # 62. A notice identifying the current ombudsman's name and contact information was posited in an easily accessible area to all residents. II. All residents will be notified of the name and contact information related to the current ombudsman. The ombudsman will attend an upcoming resident council meeting to review his role and meet those residents unable to attend the February 2013 meeting he hosted at the facility. III. All staff will be in-serviced on the residents' bill of rights and the new location of the sign age listing ombudsman's name and contact information. A QAPI tool titled, "F166/F241" has been developed that the ED or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks to ensure compliance. IV. The ED or designee will review findings weekly and will report to the QAPI Team monthly for 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>				

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	<p>the front desk. The Ombudsman contact information remained to have the wrong name and contact number posted.</p> <p>3.1-4(j)(3)(C)</p>			

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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interviews and record reviews the facility failed to investigate a report of missing clothing of for one of 40 residents reviewed for missing items. (Resident # 173)</p> <p>Findings included:</p> <p>During an interview on 4/23/13 at 10:00 a.m., Resident #173 indicated that "... 4 pair of pants, 4 shirts, 3 pairs of underwear and 4 pairs of socks were missing." Resident #173 indicated that the clothing items had been brought into the facility and had not been labled for identification. Resident #173 indicated that, "...I didn't know I was suppose to do that..." in referring to placing a label on the clothing articles for identification. Resident #173 indicated, "... they weren't labeled or anything...they were sent to the laundry and they were never returned...." Resident #173 indicated that the articles of clothing had been reported to the nursing staff and further communication had not been</p>	F000166	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to honor the residents' right to prompt efforts to resolve grievances the residents may have, including those with respect to the behavior of other residents. Consistent with this practice, the following actions have been taken: I. A grievance was initiated ed for resident # 173. An investigation and thorough search was conducted for resident's unable clothing items, however the facility was unable to locate them. The facility offered to reimburse the resident and the resident and family agreed to that resolution. The check was dispersed to the resident. Social Service Director conducted a follow up interview with resident and no further items were missing at that time. II. Facility staff will provide assistance to all residents or	05/29/2013			

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	<p>conducted. A family member for Resident #173 was present during the interview and affirmed that the facility, "...hasn't said a word about it..."</p> <p>During an interview on 4/29/13 at 10:30 a.m., the Laundry Manager indicated that to their knowledge there was not a current outstanding article of clothing missing for a resident in the facility.</p> <p>During an interview on 4/29/13 at 2:00 p.m., the Social Worker indicated that a grievance for missing clothing had been, "... filed with the laundry..." and a record review of a "Grievance Form" was provided for review.</p> <p>On 4/29/13 at 2:01 p.m., a record review was conducted of the Grievance Form filed for the missing clothing of Resident #173. The form was dated, "... 4/22/13..." It was also noted on the Grievance Form that the "Employee assigned "was "Hsk[sic]" for Housekeeping; and the "Investigating department" was "Hsk[sic]" for Housekeeping. The "Nature of Resolution" was "replace clothing unable to locate, send in for reimbursement." A signature of the "ED" was noted on the Grievance Form to be "4/27/13" and the "Social</p>		<p>family of resident if appropriate, to complete a Missing Item Questionnaire. Any missing items identified through this process will be investigated and reimbursed/replaced accordingly. All residents and responsible parties will be notified of items reported and the facility's process to retrieve missing items timely as well as the facility's grievance policy and procedure. III. All staff will be in-serviced on the facility's policy and procedure for completing resident inventory sheets on both new and existing residents. Staff will also be in-serviced on the facility's grievance policy and procedure. A letter was sent to the families as a reminder of the facility policy related to inventory procedure and the grievance policy and procedure. A QAPI tool titled, "F166/F241" has been developed that the ED or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks to ensure compliance. IV. The ED or designee will review findings weekly and will report to the QAPI Team monthly for 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of compliance: 05.29.13</p>				

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	Services reviewed resolution Signature" was not dated. 3.1-7(a)(2)				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545		
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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure a criminal background check was obtained for two of ten employee records reviewed. (Employee #12 and Employee #16)</p> <p>Findings include:</p> <p>On 4/29/2013 at 10:00 A.M., record review of employee records revealed documentation of a pre-employment criminal background check missing from Employee #12 and Employee #16 personnel files.</p> <p>On 4/29/2013 at 11:00 A.M., policy and procedure for background investigations titled "Safety and Loss Control Policies and Procedures" was received from the ED (Executive Director).</p> <p>On 4/29/2013 at 1:25 P.M., interview with Human Resource Employee #13 indicated that no other documentation could be found for Employee #12 or Employee #16.</p>	F000226	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Consistent with this practice, the following actions have been taken: I. Criminal background checks were completed for employees #12 and #16 and are maintained in the employee file. II. A review of all employee files will be completed to ensure that a criminal background check is completed and maintained as part of the employee's file. III. Employee #13 and all hiring managers will be in-serviced on policy titled, "Abuse Policy: Background Investigation for New-hires and Re-Hires. A QAPI tool was developed titled, "F226/F9999"	05/29/2013	

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	<p>On 4/29/13 at 1:43 P.M., review of the policy and procedure for background investigations for new hires and rehires, titled "Safety and Loss Control Policies and Procedures," with an effective/revised date of 03/01/2013, indicated that "All prospective new hires and rehires will have background investigations conducted at the time of employment. Background investigations will include a review of prior employment (including employment with the Company) and a criminal conviction review."</p> <p>3.1-28(a)</p>		<p>that the ED or designee will utilize to monitor all new hires and re-hired for compliance, times 4 weeks. IV. The ED or designee will review findings weekly and report findings to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>		

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F000241 SS=D	<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 interview, the facility failed to provide privacy for 2 of 40 residents reviewed for privacy during activities of daily living. (Resident #173 and Resident #114).</p> <p>Findings included:</p> <p>On 4/23/13 at 10:10 a.m., an observation was made from the room doorway of Resident #173, to have used the urinal at the bedside. The privacy curtain was not pulled and the door to the residents room was wide open.</p> <p>An interview was conducted with Resident #173 at 10:11 a.m. indicating that we were to wait outside the room until told to come in.</p> <p>On 4/23/13 at 10:20 a.m., an observation was made from the shared dresser area by the TV's of the roommates, #114 and #173. It was observed of Resident #114 lying in bed with no clothing or bedsheets to cover-up his lower body from his breast area down. Resident #114 was lying on his side with his backside towards the wall-window. The window measured approximately 11 feet by 6 feet and had no window covering separating</p>	F000241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to 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. Consistent with this practice, the following actions have been taken: I. The assessments of resident # 114 and #173 were completed and care plans of both residents were updated to reflect individual preferences and protection of privacy and dignity. The residents' bill of rights was reviewed with both residents. II. All other residents were observed and no other residents were affected by this alleged deficient practice. All residents' assessments and care plans will be updated to reflect individual preferences and	05/29/2013			

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	<p>the visibility from the room to the outdoors. Another observation was conducted form the outside of the window looking into the room and Resident #114 could be seen lying in the bed. The window visibility included an active driveway for public usage.</p> <p>On 4/23/13 at 10:21 a.m., nursing staff member #5 appeared to offer activity of daily living care for Residents #114 and #173. She indicated that Resident #173, "...sleeps that way... he likes the hospital gown cause its comfortable...."</p> <p>3.1-3(t)</p>		<p>protection of privacy and dignity. The resident's bill of rights will be reviewed with all residents. III. All staff will be in-serviced on resident's right to dignity and privacy, promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of individuality. Guardian Angels will monitor daily times 4 weeks, on scheduled days of work to ensure compliance The results of the Guardian Angel rounds will be reviewed using by the Interdisciplinary Team (IDT) daily. A QAPI tool titled, "F166/F241" was developed that DNS or designee will utilize to monitor daily times 4 weeks, on scheduled days of work to ensure compliance. IV. The DNS or designee will review findings weekly and report findings to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>	

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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 interviews and record reviews the facility failed to provide activities of interest for 1 of 40 residents reviewed for activities. (Resident #40)</p> <p>Findings included:</p> <p>During an interview on 4/23/13 at 9:10 a.m., Resident #40 indicated the facility did not offer evening activities nor weekend activities of their particular interest.</p> <p>During an interview on 4/23/13 at 10:20 a.m., the Activities Director (AD) indicated that the evening activities were as follows: "...Activities helper comes in twice a day with an activities cart and goes room to room till supper time, 5:30 p.m. till 6:30 p.m., then a game in the activity room, for example, Yahtzee; on Thursdays a volunteer plays Yahtzee; on Saturdays a volunteer from a local Catholic church comes in for anyone interested in Mass at the</p>	F000248	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident. Consistent with this practice, the following actions have been taken: I. The Activity Assessment and care plan was completed for resident # 40 to reflect resident's current needs and interests effectively. II. The Activity Assessments of all residents will be reviewed and updated as necessary. The care plans will be updated accordingly to reflect the residents' current needs and interests accurately. III. The Interdisciplinary team (IDT) will be in-serviced on the	05/29/2013	

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	<p>Main Dining Room and Rosary on Saturday afternoons...nothing real organized; then at 1pm BINGO..." It was indicated that approximately,"...20-22 people participate on Saturdays... not as many on the Medicare hall which is the Short-Term Hall, rooms 220 -232; a total of 18 beds... activities do acknowledge their participation by inviting them to BINGO... more rehab[sic] happening on the Saturdays.... we are just now putting into play... those people on the Medicare hall... religious church service... if they are non-denominational.. I let them know about the Sunday service, if interested in Sunday services... I or Act.[sic] staff assure the residents are helped to the program... I get this information when I'm obtaining their assessment... created a baseline assessment upon her initial assessment in 12/2008...." the AD indicated there had not been an updated activities assessment completed since 12/2008, for Resident #40.</p> <p>On 4/24/13 at 10:30 a.m., a Record Review was conducted of the "Activity Preferences," dated 12/09/08, for Resident #40. The review indicated, "... Weaknesses: Not here all the</p>		<p>Care Plan Policy. The Activity Director and Activity Personnel will be in-serviced on Recreational Services Assessment Policy and Person-Centered Care Planning Policy. An QAPI tool titled, " F155/F248/F272/F279" was developed that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, to ensure that the activity assessments and care plans are timely in accordance with the RAI schedule and utilized to develop comprehensive plans of care to meet the resident's needs and interests. IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly for 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>				

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	<p>time due to dialysis 3x Per week... Large group, small group, individual, in room, out-of-room... Functional Status...Vision: Good...Fine motor skills: Very good...Activity preferences: Games: Bingo, Cards, Board Games... Crafts: Painting, Sculpting, Rug Designing... Exercise/ Sports: Basketball, Dancing, Exercising, Walking, Fishing, Swimming, Skating...Music: Likes heavenly gate... Reading/ Writing: Newspaper, Magazine...Gardening/ Horitherapy: likes to take care of plants in the yard... Outings/Trips/ Shopping: Likes to shop- did a little traveling...Helping others/ volunteer work: Always liked to do things for people...Cooking: likes to cook... Animals/Pet Therapy: likes dogs- used to have a Collie...Special Information: Warm and friendly... Time Awake: Morning: gets up early, Afternoon: rarely naps, Evening: Goes to be about 8:30 p.m...."</p> <p>During an interview on 4/24/13 at 2:00 p.m., the AD indicated that Resident #40 seldom participated in the activities of late due to, "... seldom goes out to activities due to her fatigue from the dialysis." The AD indicated the participation of out of facility shopping and carry-in meals continued. The AD also indicated</p>			

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	<p>that, "...since eyesight has become difficult..." the participation in previous activities had become less.</p> <p>During an interview on 4/24/13 at 10:32 a.m., the Activities Director (AD) indicated that the residents eyesight had became worse and the resident, "...brought all her art supplies to the activities room and told me that we (the facility) could have all these because ...eyesight was so bad, couldn't see to use them any longer... same with her music... she brought all her things down and said she didn't need these things any longer... no longer pushes herself around the (local shopping store) due to fatigue...." it was indicated that the Activities Assessment had not be updated to portray the changes in Resident #40's Activity Preferences and that changes in Resident #40's activity preferences had indeed changed since 2008.</p> <p>On 4/25/13 at 10:30 a.m., a record review was conducted of the progress notes of Resident #40 as follows: Dated 3/1/2013, "...No recent change in room location. Has personal belongings of choice in room. Goes out to dialysis as scheduled. BIMS=15 indicating cognitively intact....No h/a[sic], no glasses</p>						

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	<p>observed. SS[sic] will cont.[sic] to visit prn, assisting with needs as appropriate...." Signature completed electronically. Dated 11/28/13,"... Resident remains alert, oriented and able to make her needs known with clear verbal speech. She is able to hear, understand and able to engage in conversation. Resident continues to appear clean, well-groomed and appropriately dressed. Pleasant demeanor and participates in activities of choice. Requires some assistance with ADL's[sic], able to propel herself in w/c[sic] and makes daily decisions without assistance. BIM's[sic] score shows no impairments in cognition at this time.... Resident continues to receive dialysis 3x[sic] per week...Resident is planned LTC[sic] within facility d/t[sic] nursing needs...." Signature completed electronically. Dated 6/21/2012,"...She requires assistance for ADL's[sic] and some encouragement to participate in activities. Resident has shown an[sic] decline in participation in activities, mostly d/t[sic] being tired from dialysis...." Signature completed electronically.</p> <p>3.1-33(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 interview and record review, the facility failed to complete periodic assessments for one of 40 residents reviewed for activity preferences. (Resident #40)</p>	F000272	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	05/29/2013

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	<p>Finding includes:</p> <p>During an interview on 4/23/13 at 9:10 a.m., Resident #40 indicated the facility did not offer evening activities nor weekend activities of particular interest.</p> <p>On 4/24/13 at 10:30 a.m., a Record Review was conducted of the "Activity Preferences" of Resident #40, and indicated, "... Weaknesses: Not here all the time due to dialysis 3x Per week... Large group, small group, individual, in room, out-of-room... Functional Status... Vision: Good... Fine motor skills: Very good... Activity preferences: Games: Bingo, Cards, Board Games... Crafts: Painting, Sculpting, Rug Designing... Exercise/ Sports: Basketball, Dancing, Exercising, Walking, Fishing, Swimming, Skating... Music: Likes heavenly gate... Reading/ Writing: Newspaper, Magazine... Gardening/ Horitherapy: likes to take care of plants in the yard... Outings/Trips/ Shopping: Likes to shop- did a little traveling... Helping others/ volunteer work: Always liked to do things for people... Cooking: likes to cook... Animals/Pet Therapy: likes dogs- used to have a Collie... Special</p>		<p>statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Consistent with this practice, the following actions have been taken: I. Resident # 40's Activity Assessment was completed and the care plan was updated accordingly. II. The Activity Assessments of all residents will be reviewed and updated as necessary. The care plans will be updated accordingly to reflect the residents' needs and interests accurately. III. Activity personnel and the Interdisciplinary team (IDT) will be in-serviced on the care planning policy to ensure timeliness and accuracy of assessments and care plans. A QAPI tool was developed titled, " F155/F248/F272/F279" that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that the activity assessments and care plans are timely, in accordance with the Federal guidelines as defined in RAI Manual and that assessments are utilized to develop comprehensive plans of care to meet the resident's needs and interests. IV. The DNS or designee will review findings</p>				

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	<p>Information: Warm and friendly... Time Awake: Morning: gets up early, Afternoon: rarely naps, Evening: Goes to be about 8:30 p.m..." signature of interviewer noted yet unable to read and dated "...12/9/08."</p> <p>During an interview on 4/24/13 at 10:32 a.m., the Activities Director indicated that the residents eyesight had became worse and the resident, "...brought all her art supplies to the activities room and told me that we (the facility) could have all these because ...eyesight was so bad, couldn't see to use them any longer... same with her music... she brought all her things down and said she didn't need these things any longer... no longer pushes herself around the (local shopping store) due to fatigue...." it was indicated that the Activities Assessment had not be updated to portray the changes in Resident #40's Activity Preferences and that changes in Resident #40's activity preferences had indeed changed since 2008.</p> <p>During an interview on 4/24/13 at 2:00 p.m., the Activities Director (AD) indicated Resident #40 seldom participated in the activities of late due to, "... seldom goes out to activities due to her fatigue from the</p>		<p>weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>		

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	<p>dialysis.." and indicated the participation of out of facility shopping and carry-in meals continued. It was indicated that,"...since eyesight has become difficult..." the participation in previous activities had become less.</p> <p>3.1-31(a)</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 observation, record review and interviews, the facility failed to accurately assess an incontinency issue and develop a plan for added privacy for one of 10 residents reviewed for incontinency. (Resident #114)</p> <p>Finding includes: On 4/23/13 at 10:20 a.m., an observation was made from the shared dresser area by the TV's of the roommates. It was observed of Resident #114 lying in bed with no</p>	F000279	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to develop comprehensive care plans for each resident that includes measurable objectives and timetables to meet a resident's needs, including but not limited to resident's bladder function. It is	05/29/2013	

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	<p>clothing or bedsheets to cover-up his lower body from his breast area down. A strong urine smell was noted. A urinal was on the over bed side-table and a yellow fluid was inside the urinal. A yellow stain was on the underpad of the bedding of which Resident #114 was lying. Resident #114 was lying on his side with his backside towards the wall-window. The window measured approximately 11 feet by 6 feet and had no window covering separating the visibility from the room to the outdoors. Another observation was conducted from the outside of the window looking into the room and Resident #114 could be seen lying in the bed. The window visibility included an active driveway for public usage.</p> <p>On 4/23/13 at 10:21 a.m., nursing staff member #5 appeared to offer activity of daily living care for Residents #114 and indicated that Resident #114, "...sleeps that way... he likes the hospital gown cause its comfortable...." The nursing staff member #5 did not offer assistance to Resident #114.</p> <p>On 4/25/13 at 2:00 p.m., a record review was conducted of Resident #114's care plans. The following was</p>		<p>likewise the practice of this facility to 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 this or her individuality. Consistent with this practice, the following actions have been taken: I. The bladder assessment was completed for resident #114 and utilized to develop resident's comprehensive care plan related to bladder function. The resident's bill of rights was reviewed with resident #114. Additional measures for added privacy were discussed and included in the plan of care for resident # 114. II. All other residents were observed and no other residents were affected by this alleged deficient practice. The Bladder Assessments of all residents will be completed and results will be utilized to develop comprehensive plans of care to meet the incontinence needs while respecting residents' right to privacy, dignity, and individuality. The resident's bill of rights was reviewed with all residents. III. Members of the IDT will be in-serviced on the Care Plan Policy. All nursing personnel will be in-serviced on the incontinence Management & Bladder Function Policy. The IDT will monitor that assessments are utilized to develop comprehensive plans of care to meet the resident's needs related to</p>	

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	<p>noted:</p> <p>"Dated: 2/19/2013. Focus. I have a physical functioning and deficit related to: Self care impairment due to morbid obesity. Goals. I will improve my current level of physical functioning. Interventions... Call bell within reach...Toileting assistance and incontinence care..."</p> <p>"Dated 2/19/13. Focus. Pressure ulcer at risk due to: Assistance required in bed mobility and at times incontinent of bladder and bowel. Goals. Skin will remain intact. Interventions. Provide thorough skin care after incontinent episodes..."</p> <p>On 4/25/13 at 2:01 p.m., a record review was conducted of the bowel and bladder evaluation grid. The following was noted:</p> <p>"Dated 2/10/13. Evaluation. voids correctly without Urinary incontinence. 3. Always continent with no leakage/ dribbling...Walks to the bathroom or transfers to toilet/ commode... Needs assistance from one side... Potential for Bladder and Bowel Retraining Total Score. 20. 15-21 Good candidate for retraining program. Resident is continent."</p> <p>Dated 2/12/13. Bladder Assessment Form(continued). 6. Incontinence Symptom Profile 9 check all that apply). Stress Urinary Incontinence. No nocturia or incontinence at night.</p>		<p>bladder function, individual preferences, and additional measures necessary to for privacy and dignity. QAPI tools titled, "F155/F248/F272/F279" and "F279" were developed that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that the Bladder Assessments are completed timely and accurately, in accordance with the Federal guidelines as defined in RAI Manual. All staff will be in-serviced on the resident's right to dignity and privacy, promoting care for resident 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. The Guardian Angels will conduct rounds daily times 4 weeks, on scheduled days of work to ensure compliance with this practice. The results of the Guardian Angel rounds will be reviewed by the Interdisciplinary Team (IDT) daily times 4 weeks, during scheduled days of work. A QAPI tool was developed titled, "F166/F241" that DNS or designee will utilize to monitor daily times 4 weeks, on scheduled days of work to ensure compliance with this practice. IV. The DNS or designee will review findings of the audit tools titled, "F279", "F155/F248/F272/F279", and "F166/F241" weekly and will report to the QAPI Team monthly times 6 months to</p>				

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	<p>Functional urinary Incontinence." The following were possible choices, and none were chosen. "...Mobility/ manual dexterity impairments, Lack of toilet or toilet substitute..."</p> <p>Dated from 2/12/13 to 2/14/13, Bowel and Bladder Record Data Collection Tool. This tool is used as part of the analysis for determining a resident's bowel and bladder status and for developing a toileting plan. Complete B&B[sic] record for 3 days." The following are the targeted categories: Urine. C=continent; I= incontinent. Resident aware of urge to void; asked or indicated need to use toilet, bedpan, urinal or commode (circle one).</p> <p>If Incontinent, saturation of pad. S= slightly wet. M= most of pad wet. L=outside clothing wet (circle one) Prompt to void: S= small amount. M=Medium amount. L=Large amount. R=refused. O= didn't void. (circle one) Activity when incontinence occurred. W=walking. S= sleeping. E=Eating. B=bathing (circle one) BM: C=Continent. I=Incontinenet. O= none. (circle one).</p> <p>The following are the items indicated as being chosen for incontinency and dates recorded: "2/12/13." No items of incontinency indicated. No activity of incontinency indicated.</p>		determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13				

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	<p>"2/13/13." No items of incontinency indicated. Activity of incontinency indicated:"... 9 am. E. PM E. 2 am E. 5 am E."</p> <p>"2/14/13." Incontinency indicated:"...6am. S., 11am. S., 10p through 5am. S." Activity of incontinency indicated:"...11 am. S., 10p through 5am. S."</p> <p>On 4/25/13 at 2:02 p.m., a record review was completed of the MDS dated,"...Feb 6, 2013." for the Functional Status. The following was noted: "Dated 2/16/13. ADL Self-Performance...I. Toilet use- how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; ...Do not include emptying of bedpan, urinal... 1. Self-performance. 3. Extensive assistance- resident involved in activity, staff provide weight bearing assistance...2. Support. 2. One person physical assist...Section H. Bladder and Bowel...H0200. Urinary Toileting Program. A. Has a trial of a toileting program(e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since incontinence was noted in this facility?...Enter</p>						

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	<p>Code:0..). No. Skip to H0300, Urinary continence....H0300. Urinary Incontinence. Enter Code:0. 0. Always continent..."</p> <p>Upon review of the records of concern, there was not a care plan or assessment to support Resident #114 to lay in his bed, naked from the breast area down, in a hospital gown in front of a uncovered window being exposed to the outside.</p> <p>On 4/29/13 at 10:00 am, an observation was made of Resident #114 lying in his bed with the urinal on the bedside over the bed table with a yellow fluid inside.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>				

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F000309 SS=E	<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 record review and interview, the facility failed to consistently assess, document and follow up on abnormal assessment of the fistula checks for 2 of 2 residents reviewed for dialysis. (Resident #40 and #165).</p> <p>Findings include:</p> <p>On 4/22/13 at 2:00 p.m., an record review was conducted for Resident #40 and Resident #165, indicating that both residents were actively receiving dialysis treatments. A fistula site was noted for both in regards to receiving dialysis treatments.</p> <p>On 4/29/13 at 11:00 a.m., an interview was conducted with the C-Wing Unit Manager indicating that the documentation for the fistula checks and assessments for Residents #40 and #165 were incomplete in the documentation.</p>	F000309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to 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. Consistent with this practice, the following actions have been taken: I. A full assessment was completed on residents #40 and #165 and no abnormalities were noted. The physician's orders were reviewed for residents #40 and #165 and care plans were updated as needed. II. A full assessment was completed on all other residents receiving dialysis services and no abnormalities were noted. The physician orders	05/29/2013

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	<p>On 4/29/13 at 11:01 a.m., a record review was conducted of the elements comprising a 'fistula check' in regards to accuracy and complete documentation.</p> <p>A complete and accurate fistula check is as ordered below: "Assess dialysis graft site Q[sic] Shift Record absence (-) or presence (+) of swelling. Every shift... Assess dialysis graft site Q[sic] shift, Record absence (-) or presence (+) of thrill. Every shift... Assess dialysis graft site Q[sic] shift, Record absence(-) or presence (+) of redness. Every shift.... Assess dialysis graft site Q[sic] shift, Record absence (-) or presence (+) of tenderness. Every shift... Assess dialysis graft site Q[sic] shift, record absence (-) or presence (+) of warmth. Every shift... Assess dialysis graft site Q[sic] shift, record absence (-) or presence (+) of bruit. Every shift..."</p> <p>On 4/29 /13 at 11:01 a.m., a record review was conducted of Resident #40's Medical Administration Record (MAR) for complete and accurate fistula check documentation of skill provided. The following was noted: MAR dated: "3/1/2013- 3/31/2013..." "Monday, 3/4/13" an absence "(-)" was indicated for a thrill and bruit at</p>		<p>were reviewed and care plans were updated as needed. III. All licensed nursing staff will be in-serviced on the dialysis policy and procedures. The DNS or designee will in-service the contracted dialysis center will be in-serviced on this facility's dialysis policy and procedure. A QAPI tool titled, "F309/F431" was developed that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, to ensure compliance. IV. The DNS or designer will review findings weekly and report findings to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>				

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	<p>the site of the fistula. No further directions or follow-up were noted. "Wednesday, 3/6/13" an absence "-" was indicated for a thrill and bruit at the site of the fistula. No further directions or follow-up were noted. "Monday, 3/18/13" a presence (+) was indicated for presence of swelling at the site and a follow-up code of "1" was noted. A code of "1" is noted as, "Away from home with meds." "Sunday, 3/24/13" a "+" was indicated for presence of warmth to the site of the fistula. No further directions or follow-up were noted. " Monday, 3/25/13 and Tuesday 3/26/13" a "-" was indicated for an absence of a thrill at the fistula site. No further directions or follow- up was noted. MAR dated, "4/1/2013- 4/30/13..." "Wednesday, 4/10/13" a "+" was indicated for a presence of redness at the site of the fistula. No further directions or follow-up were noted. "Wednesday, 4/17/13" a "+" was indicated for a presence of tenderness for the day shift at the site of the fistula, and no documentation was noted for the evening shift for redness, tenderness, bruit or warmth. No further directions of follow-up was noted.</p> <p>On 4/29 /13 at 11:02 a.m., a record</p>						

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	<p>review was conducted of Resident #165's Medical Administration Record (MAR) for complete and accurate fistula check documentation of skill provided. The following was noted: MAR dated: "4/1/2013- 4/30/2013..." "Friday, 4/12/13," there was no documentation noted for the evening shift for swelling, thrill, redness, tenderness, bruit or warmth. No further directions of follow-up was noted.</p> <p>" Wednesday, 4/17/13," an (-) absence of a thrill is noted. No further directions or follow-up was noted.</p> <p>"Thursday, 4/18/13," a (+) presence of swelling at the site of the fistula is indicated. No further directions or follow-up was noted.</p> <p>"Sunday, 4/21/13," an (-) absence of a thrill is noted at the site of the fistula. No further directions of follow-up was noted.</p> <p>"Tuesday, 4/23/13," an (-) absence of a thrill is noted at the site of the fistula. No further directions of follow-up was noted.</p> <p>"Sunday, 4/28/13," an (-) absence of a thrill is noted at the site of the fistula. No further directions of follow-up are noted.</p> <p>On 4/29/13 at 3:00 p.m., a policy and procedure was provided by the</p>			

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	<p>Interim Director of Nursing titled, "Hemodialysis Care Protocol." Upon review of the protocol, no indication is provided within the policy/ procedure concerning the actual assessment of the fistula site and no directives for follow-up upon finding an alteration from the normal with the assessment. it was noted within the protocol document provided, "... Access Site Care Assessment & Care. usually the dialysis center will provide care to the fistula or graft. Two types of access: 1. Fistula (AVF arteriovenous fistula) or Graft (AVG- arteriovenous graft). Usually the dialysis center will provide routine care to the fistula or graft. Observe for patency- bruit or thrill. Infection- excess warmth, redness, rash or drainage. Bleeding- hematoma, bleeding- ecchymosis. Pain or Tenderness..."</p> <p>On 4/29/13 at 3:10 p.m., a record review was conducted of the rewords titled, " SNF[sic] Outpatient Dialysis Services Agreement...B. Obligations of the ESRD[sic] Dialysis Unit and/or Company...1....D. To provide to the Nursing Facility information on all aspects of the management of the ESRD[sic] Resident's care related to the provision of Services, including directions on management of medical</p>			

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	<p>and non-medical emergencies, including but not limited tom, bleeding, infection, and care of dialysis access site...."</p> <p>On 4/29/13 at 3:11 p.m., no further records were made available upon directions for the follow-up care of an abnormal assessment to a fistula dialysis site.</p> <p>On 4/29/13 at 3:13 p.m., an interview was conducted with the C-Wing Unit Manager in relation to the incomplete documentation and follow-up for the fistula checks indicating that the documentation was not complete and offered no follow-up for the abnormal assessments for Resident #40 and #165.</p> <p>3.1-37(a)</p>			

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F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation and interview, the facility failed to maintain the oxygen cylinders secure and the oxygen rooms in a clean and orderly fashion. This affected 2 of 2 oxygen rooms.</p> <p>Finding includes:</p> <p>On 4/25/13 from 2:00 p.m. until 3:30 p.m., an environmental tour was conducted of the facility along with the Director of Maintenance and the Weekend Manager of the C-Wing unit. The following are observations of the tour.</p> <p>At 2:45 p.m., an observation was conducted of the 'oxygen room' on the 'C' unit. The room was cluttered with debris. There were several large silver oxygen cylinders that were not secured and could be manually repositioned. An outdated policy and</p>	F000328	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of the facility to ensure that residents receive proper treatment and care for the following special services: injections, parenteral and enteral fluids, colostomy, ureterostomy, or ileostomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses. Consistent with this practice, the following actions have been taken: I. Oxygen storage areas on 'C Unit' and 'B Unit' were deep cleaned, removing all debris and clutter. A copy of current policy titled, Liquid Storage, Safety, and Usage was posted. Cylinders	05/29/2013

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	<p>procedure was tapped to the interior door. It indicated that it was from, "Beverly Health Systems" and indicated that the oxygen room was to be kept,"...clutter free and clean..."</p> <p>At 3:10 p.m., an observation was made of the 'B' unit oxygen room. Several oxygen condenser machines were located behind several large silver oxygen cylinders and were difficult to get to. The cylinders were not secured and could be manually repositioned. Several portable oxygen containers for resident use were hanging on the hooks on the wall. One portable oxygen container was missing a cover to the face of the device and appeared broken. The Maintenance Director could not provide information about either closet yet did note that both closets were dirty and unkempt.</p> <p>During an interview on 4/29/13 at 3:30 p.m., the Interim Director of Nursing Services indicated that the Beverly Health Care Policy and Procedure found in the oxygen storage room was not of the current corporation yet,"...we (the current corporation) have adapted some of their (Beverly Health Systems) Policy and Procedures..." A Policy and Procedure titled, "Liquid</p>		<p>were secured to prevent damage. All oxygen cylinders and portable oxygen tanks were inspected and only properly functioning tanks are secured for safe storage. II. Oxygen storage areas on 'C Unit' and 'B Unit' were deep cleaned, removing all debris and clutter. A copy of current policy titled, Liquid Storage, Safety, and Usage was posted. Cylinders were secured to prevent damage. All oxygen cylinders and portable oxygen tanks were inspected and only properly functioning tanks are secured for safe storage. III. All staff in-serviced on Liquid Storage, Safety, and Usage Policy. An QAPI tool titled, "F156/F328/F371/F441/F465" was developed that DNS or designee will utilize to monitor daily times 4 weeks, on scheduled days of work to ensure compliance. IV. The DNS or designee will review findings weekly and report findings to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>		

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	<p>Oxygen-Storage, Safety and Usage" of Golden Living Centers was reviewed. The following was noted upon review: "Overview... the use of liquid oxygen within long term care facilities presents several associate and resident safety issues as well as a significant hazard...Inside Storage/ Refilling Requirements... Refilling portable containers from the base unit can be done in interior rooms that are separated from any portion of a facility where residents are housed (never performed in resident rooms, common areas or nurses stations), examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction... The room must have a dedicated mechanical ventilation system exhausting directly to the outside...The room shall be free of combustible or flammable storage,... cylinders shall be secured by racks or fastening to prevent accidental damage..."</p> <p>3.1-47(a)(6)</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>1. Based on observation, record review and interview, the facility failed to clean and maintain refrigerator/ freezer units for residents nourishment storage. This affected 2 of 2 units and potentially all residents in the facility.</p> <p>2. Based on observation and record review, the facility failed to ensure food and drinks were being prepared and served in sanitary conditions in regards to improper use and positioning of beard guards and hairnets. This deficiency had the potential to affect 107 of 107 residents who received meals from the facility kitchen.</p> <p>Findings include:</p> <p>1. On 2/25/13 from 2:00 p.m. until 3:30 p.m., an environmental tour was conducted of the facility along with the Director of Maintenance and the Weekend Manager of the C-Wing unit. The following are observations</p>	F000371	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute, and service food under sanitary conditions. Consistent with this practice, the following actions have been taken: 1. The refrigerator and freezer units were cleaned and a revised cleaning log was placed in the 'B Wing nourishment pantry. Accurately functioning thermometers were placed in cooler units and a revised Refrigerator/Freezer temperature Log was placed in the 'B Wing nourishment pantry. All Dietary Staff including, employees # 5, #8, #6, #7, and #11, were in-serviced on the following policies: Storage of	05/29/2013			

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	<p>of the tour.</p> <p>At 3:05 p.m., an observation was made of the 'B' unit nourishment room. The refrigerator/ freezer unit was observed. It was noted to have 1(one) sandwich and 1 (one) carton of nutritional supplement in the refrigerator and 1 (one) nutritional supplement in the freezer. The unit was dirty and food debris was noted. The Registered Dietician (RD) indicated that the food in the unit had been removed due to the temperatures not being accurate. The thermometers of the units were not located.</p> <p>At 3:06 p.m., a "Refrigerator/ Freezer Temp Log" was reviewed. It was indicated that the dietary department maintained the quality control of the nourishment units on both units. It was noted on the temp log,"... Record all unit temperatures daily and initial. Refrigerator should be below 41 degrees and Freezer should be below 0 degrees. If temperature is out of range, please notify DSM or Designee immediately and document corrective action on the back of form. " The logs provided had nothing documented on the back of the forms.</p> <p>At 3:07 p.m., an interview was</p>		<p>Refrigerated Food, Cleaning Reach-In Refrigerators, and Dining Services hair. II. The refrigerator and freezer units located in all nourishment pantries of the facility were cleaned and a revised cleaning log was placed in all pantries. Accurately functioning thermometers were placed in cooler units and a revised Refrigerator/Freezer temperature Log was placed in all nourishment pantries. III. All Nursing and Dietary staff will be in-serviced on Storage of Refrigerated Food, Cleaning Reach-In Refrigerators, and Dining Services hair Policies. A QAPI Tool titled, " F156/F328/F371/F441/F465" was developed that ED or designee will utilize to monitor daily times 4 weeks, on scheduled days of work to ensure compliance. IV. The ED or designee will review findings weekly and report findings to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% compliance is reached. Date of Compliance: 05.29.13</p>		

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	<p>conducted with the RD indicating that the supplements left in the refrigerator should not be there and the cleanliness of the unit was not acceptable.</p> <p>On 4/29/13 at 9:30 a.m., an observation was made of the 'C' unit nourishment room. The refrigerator/ freezer unit was observed. It was noted to have the following items outdated in the refrigerator: Resident #7: HS (hour of sleep) snack and 6 ounce of nectar fluid times 2 dated 4/28/13. Resident #84: HS snack and 6 ounce of nectar fluid times 2 dated 4/28/13. Resident #84: AM (morning) and HS snack and 6 ounce nectar fluid dated 4/27/13. Resident #74: HS snack, a sandwich and a 6 ounce juice dated 4/28/13. Resident #74: AM whole sandwiches for 4/27 and 4/28/13. Resident # 158: A magic cup nutritional supplement dated for 2 p.m. 4/28/13. Also included: Sandwiches for residents after dining hours: 3 dated for 4/27/13 and 3 dated for 4/28/13.</p> <p>An interview was conducted with the Dietary Manager at 9:40 a.m.,</p>			

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	<p>indicating that the nourishments were provided by the dietary department, yet giving the nourishments out to the residents was the nursing services department. It was also indicated that the nourishments were outdated and should had been provided to the Residents on unit C over the weekend.</p> <p>At 9:41 a.m. the refrigerator/ freezer unit was noted to have inaccurate temperatures. The Laundry Supervisor simultaneously made a reading to the 2 (two) thermometers in the refrigerator section. A thermometer located on the second shelf of the refrigerator read: 50 degrees and the thermometer located in the door of the refrigerator read: 42 degrees. Both temperatures were over the limit. A reading of the freezer thermometer was conducted. A kitchen-food thermometer was observed. The thermometer was inside a sheath and was lying in the freezer. The temperature reading was above zero at approximately 4 degrees. 1 (one) ice cream pop was in the freezer and was soft to touch.</p> <p>An interview was conducted with the Dietary Manager at 9:42 a.m. indicating that the thermometer was accurately used by removing the</p>				

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	<p>thermometer from the sheath and temping without the sheath. It was indicated that the thermometer found located in the C unit nourishment freezer was designed to be used for temping foods.</p> <p>On 4/29/13 at 2:00 p.m., an interview with the Registered Dietician indicated that using a food thermometer while in the sheath was an acceptable practice for quality control of a freezer unit.</p> <p>On 4/29/13 at 3:00 p.m., the Interim Director of Nursing indicated that the facility did not have a policy or procedure to address the responsibility and practice of providing nourishments to residents of the facility.</p> <p>2. On 4/22/13 at 12:21 p.m., an observation was made of the kitchen during lunch service. Kitchen Aide #6 and Kitchen Aide #7 were observed to be assisting in the kitchen. Both Kitchen Aide #6 and Kitchen Aide #7 were observed to have facial hair and no beard guard in place.</p> <p>On 4/22/13 at 12:25 p.m., Kitchen Aide #5 and Employee #8 (Dietary Manager) were observed in the kitchen with hairnets on but with hair at the nape of their neck falling out of</p>						

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	<p>the hairnet.</p> <p>On 4/25/13 at 07:48 a.m., Kitchen Aide #6 and Kitchen Aide #7 were observed to be in the kitchen assisting with breakfast service. Both Kitchen Aide #6 and Kitchen Aide #7 were observed to be wearing beard guards but both were being worn in a way to only cover the beard portion of their facial hair, leaving the mustache portion exposed. Kitchen Aide #5 was observed to be serving breakfast trays at this time while wearing a hairnet which had hair falling out of it at the nape of her neck.</p> <p>On 4/25/13 at 8:01 a.m., an observation was made of Employee #8 (Dietary Manager) and Employee #11 (Registered Dietician) standing in the kitchen overseeing breakfast service. Employee #8 was observed to be wearing a hairnet but with hair at the nape of her neck falling out of the hair net. Employee #11 was observed to be wearing a hairnet but with a large section of hair near her right ear to be hanging out of the hair net.</p> <p>On 4/29/13 at 10:20 a.m., an observation was made of Kitchen Aide #7 washing dishes in the kitchen with no beard guard. At 10:22 a.m.,</p>				

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	<p>Kitchen Aide #7 was observed to be pushing a cart of clean dishes on and was wearing a beard guard appropriately.</p> <p>On 4/29/13 at 11:27 a.m., review of the "Dining Services Employee Hair Guidelines" policy received from RN #10 (Director of Nursing) indicated "...Dining Services employees must wear hair restraints, such as hair coverings or nets, and beard restraints...Hairnets or disposable bouffant caps must cover all hair completely. Two hairnets or bouffant caps may be worn to cover hair completely...."</p> <p>3.1-21(i)(3)</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 there was an accurate system in place for reconciliation of liquid</p>	F000431	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	05/29/2013			

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	<p>controlled substances for 3 of 4 med carts observed. (B wing- Hall 1, 2, and 3 carts). This deficiency had the potential to affect 4 of 4 resident's whose medications reviewed for reconciliation. (Resident #64, #149, #55, #57)</p> <p>Findings include:</p> <p>1. On 4/29/13 at 2:35 p.m., liquid Morphine Sulfate (medicine for pain) was observed in the hall 1 medication cart ordered for Resident #64. The narcotic count log sheet indicated this was a new bottle and was filled with 30mL's (milliliters). Observation of the new bottle showed there was more than 30mL's in the bottle. Interview with LPN #9 at this time indicated there was more than 30mL's in the bottle because "...that is how they always come..." Interview with RN #1 indicated there was about "...32 mL's in there..." Resident #64's prescribed dose was "...0.25mL (5mg) by mouth every 2 hours as needed...."</p> <p>2A. On 4/29/13 at 2:45 p.m., 2 bottles of liquid Morphine Sulfate was observed in the hall 2 medication cart ordered for Resident #55. The narcotic count log sheet for bottle #1 indicated this was a new bottle and was filled with 30mL's. Observation of</p>		<p>conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to 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 determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Consistent with this practice, the following actions have been taken: I. The medical records of residents #64, #149, #55, #57 were reviewed and as prescribed, did received liquid narcotics which are measured using a marked syringe, provided by the pharmacy. Residents #64, #149, #55, #57 were assessed and have shown no negative outcome as a result of this practice. II. A pharmacy review of all medications will be conducted and any discrepancies will be reported to the DNS, investigated, and corrective actions will be taken as needed. III. All licensed nursing staff will be in-serviced on the Controlled Substance Policy to ensure compliance. A QAPI Tool titled, "F309/F431" was developed that the DNS or designee will utilize to monitor</p>				

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	<p>bottle #1 showed this was a new sealed bottle but had more than 30mL's in it. Interview with RN #1 indicated there was about "...32 mL's..." in bottle #1. Resident #55's prescribed dose was "...0.25mL (5mg) by mouth/sublingually every 2 hours as needed...."</p> <p>The narcotic count log sheet for bottle #2 of liquid Morphine Sulfate for Resident #55 indicated Resident #55's prescribed dose was "...0.25mL (5mg) by mouth/sublingually every 2 hours as needed...". The narcotic count log sheet further indicated 8 doses had been given out of this bottle and bottle #2 should have 28mL's left. Observation at this time of bottle #2 showed that there was more than 28mL's in it. Interview with RN #1 at this time indicated there was about "...30 mL's..." left in it.</p> <p>2B. On 4/29/13 at 2:50 p.m., liquid Morphine Sulfate was observed in the hall 2 medication cart ordered for Resident #57. The narcotic count log sheet indicated this was a new sealed bottle and was filled to 30mL's. Resident #57's prescribed dose was "...0.25mL (5mg) SL [sublingual] or PO [by mouth] every 2 hours as needed...." Observation at this time for Resident #57's liquid morphine</p>		<p>daily times 4 weeks, and weekly thereafter, on scheduled days of work to ensure compliance with Controlled Substance Policy and procedure. The Pharmacist will review monthly times 6 months the narcotic count sheets for accuracy and policy compliance. IV. The DNS or designee will review findings weekly and report findings to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>				

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	<p>showed this was a new sealed bottle. The observed bottle was made out of a dark brown glass and the liquid inside was clear, making observation difficult to see the actual measurement. The highest line on the bottle label that was being used as a liquid measuring tool was 22mL's. The 22mL measuring line on the outside of the bottle was approximately 3/4 of the way up the bottle. The liquid morphine inside the bottle could not be visualized due to be filled so high that it was to the bottom of the cap of the bottle. Interview with RN #1 at this time indicated it would be impossible to accurately measure the correct number of mL's in the observed bottle due to the way it was designed and filled, there seemed to be more than 30mL's but there was no way to know for sure.</p> <p>3. On 4/29/13 at 2:40 p.m., liquid Roxicet (medication for pain) was observed in the hall 3 medication cart ordered for Resident #149. Resident #149's prescribed dose was "...5mL (5/325mg) per g tube [gastric tube] twice daily...". The narcotic count log sheet for Resident #149 indicated there was 20mL's left in the bottle. Observation of the Roxicet bottle at this time showed there was less than</p>						

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	<p>20mL's in the bottle. Interview at this time with RN #1 indicated there was about "...15mL's left..." RN #1 reviewed the narcotic log sheet for this medication to ensure the nurses math was correct. RN #1 indicated she was unsure of what happened to the missing 5mL's but she would tell the DON and help her investigate to find out.</p> <p>On 4/29/13 at 3:04 p.m., review of the "Medication Administration - Controlled Substances" policy received from RN #1 indicated "...Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping at the nursing care center...2. The Director of Nursing and the consultant pharmacist monitor for compliance...in the handling of controlled medications...7. At each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record. 8. Current controlled medication accountability records and audit records are kept by the nursing care center...9. Any discrepancy in a controlled substance medication</p>			

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	<p>count is reported to the director of nursing immediately. The director...investigates and makes every reasonable effort to reconcile all reported discrepancies...."</p> <p>3.1-25(e)(2) 3.1-25(e)(3)</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	Preparation and/or execution of this plan of correction does not	05/29/2013			

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	<p>ensure licensed nurses washed their hands appropriately while passing medications. This deficiency had the potential to affect 4 of 4 observed residents whose medication passes were observed. (Resident #41, #83, #87, and #127)</p> <p>Findings include:</p> <p>On 4/25/13 at 8:34 a.m., LPN #9 was observed to be passing medications for Resident #41. LPN #9 retrieved the medications for Resident #41 from the medication cart, walked into the resident room, and washed hands for 9 seconds before giving the medications and exiting room. LPN then proceeded to retrieve medication for Resident #83 and administering them without washing hands in between.</p> <p>On 4/25/13 at 8:56 a.m., LPN #9 was observed to be passing medication for Resident #87. LPN #9 retrieved the medications for Resident #87 from the medication cart, including Albuterol (medication used in a breathing treatment), and entered the resident room. LPN #9 passed Resident #87's medication pills and was preparing to set up the breathing treatment machine when she dropped the oxygen tubing on the floor. LPN</p>		<p>constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to 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. Consistent with this practice, the following actions have been taken: I. LPN #9, LPN # 2, and RN #10 were in-serviced and provided with a teachable moment on the facility's Hand Washing/Hygiene Policy and provided a return demonstration of this practice. II. All other LPNs and RNs will be in-serviced on the facility's Hand Washing/Hygiene Policy. III. All staff will be in-serviced on Hand Washing/ Hygiene Policy. A QAPI Tool titled, " F156/F328/F371/F441/F465" was developed that the DNS or designee will review daily times 4 weeks, on scheduled days of work to monitor compliance. IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is</p>				

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	<p>#9 discarded the dirty oxygen tubing that was dropped and proceeded to wash her hands for 5 seconds before leaving room to retrieve new tubing. After returning to Resident #87's room from the clean supply room, LPN did not wash hands or wear gloves when setting up new oxygen tubing to be used when administering the breathing treatment. After starting the breathing treatment for Resident #87, LPN #9 left the room to do medications for another resident without washing her hands. At 9:15 a.m., LPN #9 entered Resident #87's room when her breathing treatment was completed to disconnect her from the machine and proceeded to wash her hands for 6 seconds before exiting room.</p> <p>On 4/29/13 at 10:52 a.m., LPN #2 was observed to check the blood sugar for Resident #127 and upon completion washed her hands for 6 seconds.</p> <p>On 4/29/13 at 3:00 p.m., interview with RN #10 (Director of Nursing) indicated she was currently the acting infection control nurse for this facility and when educating the floor nurses about handwashing she would tell them "...to sing. You know "that song" they need to sing. They sing it 3</p>		reached. Date of Compliance: 05.29.13				

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	<p>times. I can't remember...They wash their hands for 1 minute...No...They wash their hands for 30 seconds..."</p> <p>On 4/29/13 at 3:20 p.m., review of the "Handwashing/Hand Hygiene" policy received from RN #10 indicated "...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); d. before and after performing any invasive procedure (e.g. fingerstick blood sampling);...u. After removing gloves...."</p> <p>3.1-18(l)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>1. Based on observation and interview, the facility failed to maintain the front double doors without a visible gap. This effected the main entrance doors.</p> <p>2. Based on observations and interview, the facility failed to ensure water did not pool in one shared bathroom after completing remodeling construction work on the bathroom sink and that the floors were adequately cleaned. (Resident #51 and #2)</p> <p>3. Based on observation and interview, the facility failed to ensure an raised toilet seat was properly positioned to assure urine did not run onto the floor of the shared bathroom of 2 residents. (Resident #106 and #24)</p> <p>4. Based on observation and interview, the facility failed to ensure floors were clean and not sticky for 6 of 40 residents sampled. (Resident #51, #2, #167, #162, #106 and #24)</p> <p>5. Based on observation, the facility</p>	F000465	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Consistent with this practice, the following actions have been taken: I. The bathroom of residents # 51 and #2 was adequately cleaned is free of pooling water. The raised toilet seat and the bathroom floor, located in bathroom shared by residents #106 and #24 was cleaned. The raised toilet seat was repositioned to prevent urine from going onto the floor. The floors of residents # 51, #2, #167, #162, #106, and # 24 were cleaned and are free of 'sticky' residue. An action plan was developed to identify, correct, and monitor ongoing painting and repair needs throughout the resident living areas. The sanitizer identified was not taken	05/29/2013			

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	<p>failed to maintain the painting and condition of the walls, doors, floors and fixtures throughout the residents living areas.</p> <p>6. Based on observation, record review and interview, the facility failed to maintain a dishwasher/ sterilizer in a sanitary, and orderly fashion. This affected 1 of 1 sanitizing dishwasher units.</p> <p>7. Based on observation, the facility failed to maintain the facility without the presence of the urine smell. This affected all areas of the facility.</p> <p>Findings include:</p> <p>1. On 4/29/13 at 10:30 a.m., an observation was made of the front double doors to the main entrance of the facility. It was noted to have a gap between the meeting of the double doors and to have a gap at the bottom of the double doors. It was also noted that the doors were dirty and in need of painting.</p> <p>During an interview on 4/29/13 at 10:31 am, the Director of Maintenance indicated the condition of the double doors needed to be addressed.</p>		<p>out of the room at the time it was no longer in use. The sanitizer was since removed and staff in-serviced on procedure for sanitizing reusable care items. To eliminate the odor as identified, the soiled linen and trash was removed from the soiled utility rooms and resident living areas. All resident rooms were observed and necessary cleaning was completed. The frequency of scheduled removal times of the soiled linen and trash was increased from the original removal times. the containers located on halls were removed from all of the hallways. Daily rounds initiated to ensure that residents are provided with adequate assistance. The gaps between the front double doors were eliminated with the application of weather strips. The doors were also cleaned. The commode of resident # 51 was repaired and the floor was cleaned and are free of 'sticky' residue. The raised toilet seat in bathroom shared by residents #106 and #24 was removed and adequately cleaned . The bathroom shared by residents #106 and #24 was deep cleaned. The rooms identified, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #123, #125, #126, #127, #128, #131, #133, #134, and #135 will receive the necessary cleaning to remove</p>				

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	<p>2. On 4/25/13 at 2:30 p.m., an observation was made of Resident #51 and Resident #2's shared bathroom noting standing water at the base of the commode and a sticky floor under foot.</p> <p>During an interview on 4/25/13 at 2:31 p.m., Resident #51's family indicated the facility had repaired a dislodged bathroom sink that had separated from the wall. The family also indicated that the facility repaired the sink and since that work had been provided, the water seeped out from under the commode. The family further indicated the water had routinely pooled at the commode base and that the facility was aware.</p> <p>During and interview on 4/25/13 at 2:32 p.m., the Maintenance Director indicated the repair work had been conducted and the water at the base of the commode would need addressed.</p> <p>3. On 4/25/13 at 2:45 p.m., an observation was conducted of the shared bathroom of Resident #106 and #24. A raised toilet seat was noted to be on the commode. A strong urine smell was noted.</p> <p>During an interview on 4/25/13 at</p>		<p>dark marks/scuffs. The walls requiring repair of gouges or holes will be repaired and painted. The baseboard was replaced in room #107. The Phone Jack was repaired in room #107. II. The raised toilet seats of all other residents were observed, positioned, and cleaned as necessary. All resident floors were observed and cleaned as necessary to ensure that floors are free of 'sticky' residue. An action plan titled, "Environment: Resident Room" was developed to identify, correct, and monitor ongoing painting needs throughout the resident living areas. The sanitizer identified was not taken out of the soiled utility room at the time it was no longer utilized. The sanitizer has been removed and staff in-serviced on procedure for sanitizing reusable care items. To eliminate the odor identified, the soiled linen and trash was removed from the soiled utility rooms and resident living areas. All resident rooms were observed and any necessary cleaning was completed. The frequency of scheduled removal times of the soiled linen and trash was increased from the original removal times. the containers located on halls were removed from all of the hallways. Daily Rounds initiated to ensure that residents are provided with adequate assistance. All exit doors will be observed, repaired,</p>				

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	<p>2:46 p.m., Resident #106 indicated the raised toilet seat did not fit properly. "...every time we use that seat in there, we end up peeing on the floor... that's why it stinks in there so bad... we've told them and told them, but nothing gets done about it...."</p> <p>On 4/29/13 at 11:00 a.m., an interview was conducted with the Manger of Housekeeping and the Maintenance Director. The Maintenance Director indicated that the bathroom assistive devices should fit the commodes properly.</p> <p>4. On 4/25/13 at 2:30 p.m., an observation was made of Resident #51, #2, #167, #162, #106 and #24's floors of their rooms. It was noted that the floors were to be sticky under foot.</p> <p>During an interview on 4/29/13 at 10:45 a.m., the Manager of Housekeeping indicated the floors should not be sticky under foot.</p> <p>5. During the Environment Tour of resident rooms on B wing on 4/25/13 from 2:15-3:20 p.m., the walls, doors, floors, fixtures of the following rooms were found to be in disrepair: Room 101: the inside panel of the</p>		<p>and cleaned as necessary. All resident commodes were observed and found to be functioning appropriately. resident floors were observed and cleaned as necessary to ensure that floors are free of 'sticky' residue. An Action Plan was developed to identify, correct, and monitor ongoing painting and repair needs throughout the resident living areas. The baseboards of all resident rooms were observed and those in need of repair were included in the action plan titled, "Environment: Resident Room" . . The Phone Jacks of all resident rooms were observed and those in need of repair were included in the action plan titled, "Environment: Resident Room".</p> <p>III. All staff will be in-serviced on the Cleaning and Disinfecting: Non-Critical Resident-Care Items Policy and Procedure." A QAPI tool titled, "F156/F328/F371/F441/F465" was developed that the ED or designee will review daily times 4 weeks, on scheduled days of work to monitor compliance with the action plan titled, "Environment: Resident Room." The ED or designee will monitor the preventative maintenance completion log weekly times 4 weeks and monthly thereafter to ensure compliance with Preventative Maintenance Program, including routine work orders. IV. The ED or designee will review findings weekly and</p>		

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	<p>door to the room and the inside and outside panel of the bathroom door were found to have dark marks/scuffs on them, the closet door was found with dark marks/scuffs, and the wall beside both resident's beds to the left side of the room was found with gouges in the wall.</p> <p>Room 102: the outside panel of the door to the room was found to have dark marks/scuffs on them, and the metal pipe below the sink in the bathroom was found to be rusted with a line of rust down the wall from water dripping.</p> <p>Room 103: the inside panel of the door to the bathroom was found to have dark marks/scuffs, the base board on the right inside the bathroom was warped/peeling from the wall, and the outside panel of the closet door was found to have dark marks/scuffs.</p> <p>Room 104: the outside panel of the door to the room and the inside and outside panel of the door to the bathroom was found to have dark marks/scuffs.</p> <p>Room 105: the outside panel of the door to the room and the inside panel of the door to the bathroom was found to have dark marks/scuffs.</p> <p>Room 106: the inside panel of the door to the bathroom and the wall to the left side of the bathroom was</p>		<p>will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached. Date of Compliance: 05.29.13</p>				

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	<p>found to have dark marks/scuffs. The far end of the wall to the right side of the room was found to have large areas that were patched but never painted.</p> <p>Room 107: the outside panel of the closet door was found to have dark marks/scuffs. The wall on the right side of the room was found to have a portion of the baseboard missing, the phone jack was off the wall and hanging by the cable, and there were several holes in the wall.</p> <p>Room 108: the inside panel of the door to the room and the inside panel of the door to the bathroom were found to have dark marks/scuffs. The wall to the left inside the bathroom was found to have scuffs/gouges in it.</p> <p>Room 109: the outside panel of the door to the room and the inside panel of the door to the bathroom and the door to the closet were found to have dark marks/scuffs in them.</p> <p>Room 110: the inside panel of the door to the bathroom was found to have dark marks/scuffs on it.</p> <p>Room 111: the outside panel of the door to the room, the inside and outside panel of the door to the bathroom, the closet door, and the wall portion behind the door to the room were found to have dark marks/scuffs on them. The wall near bed #1 was found to have</p>			

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	<p>scuffs/gouges. in it.</p> <p>Room 112: the closet door and the wall to the right of the room were found to have dark marks/scuffs. The baseboard in the back corner of the room to the left was found to be torn up/peeling.</p> <p>Room 113: The inside panel of the door to the bathroom was found to have dark marks/scuffs.</p> <p>Room 114: The wall on the right side of the room was found to have dark marks/gouges in it.</p> <p>Room 115: The outside panel of the door to the room and the inside and outside panel of the door to the bathroom were found to have dark marks/scuffs. The door jam to the bathroom door was found to be very marked up/gouged.</p> <p>Room 116: The inside panel of the door to the bathroom was found to have dark marks/scuffs on it. The wall near bed #1 was found to have scuffs/gouges on it.</p> <p>Room 117: The outside panel of the door to the room, the inside panel of the door to the bathroom, and the closet door were found to have dark marks/scuffs. The wall near the corner of the right side of the room was found to have a scuff/gouge in the wall.</p> <p>Room 118: the outside panel of the door to the room, the outside panel of</p>			

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	<p>the door to the bathroom and the wall to the right side of the bathroom was found to have dark marks/gouges on them.</p> <p>Room 119: the inside panel of the door to the bathroom was found to have dark marks/scuffs. Both walls on the left and the right inside the bathroom found to have scuffs/gouges. The wall by the heater near the window was found to have holes in it that had been patches but never painted.</p> <p>Room 120: The inside panel of the door to the bathroom was found to have dark marks/scuffs.</p> <p>Room 121: The outside panel of the door to the bathroom and the inside walls of the bathroom were found to have dark marks/scuffs/gouges. There was also noted to be a raised toilet seat in the bathroom that had feces on the back inside portion.</p> <p>Room 123: The inside and outside panel of the bathroom and the wall near bed #1 was noted to have dark marks/scuffs/gouges.</p> <p>Room 125: The closet door and the inside panel of the bathroom door were found to have dark marks/scuffs. In the bathroom, below the toilet there was found to be a hole in the wall near the toilet pipes.</p> <p>Room 126: The inside panel of the bathroom door was found to have</p>						

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	<p>dark marks/scuffs.</p> <p>Room 127: The inside panel of the bathroom door was found to have dark marks/scuffs.</p> <p>Room 128: The inside and outside panel of both the room door and the bathroom door were found to have dark marks/scuffs.</p> <p>Room 131: The inside panel of the bathroom door was found to have dark marks/scuffs. The wall to the left side of the room was found to have scuffs/gouges in it.</p> <p>Room 133: The outside panel of the door to the room was found to have dark marks/scuffs.</p> <p>Room 134: The outside panel of the door to the room and the closet door were found to have dark marks/scuffs.</p> <p>Room 135: The inside panel of the door to the room and the outside panel of the bathroom door were found to have dark marks/scuffs on them and the left wall of the bathroom near the toilet was found to have dark marks/gouges in the wall.</p> <p>6. On 4/25/13 from 2:00 p.m. until 3:30 p.m., an environmental tour was conducted of the facility along with the Director of Maintenance and the Weekend Manager of the C-Wing unit. The following are observations of the tour.</p>						

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	<p>At 2:47 p.m., an observation was conducted of the 'dirty utility room' on the 'C' unit. It was noted to house a dishwasher used for sterilizing reusable direct patient care equipment such as urinals, bedpans, and plastic basins. Upon observation of the dishwasher it was noted that the outside was filthy. Upon opening the unit, it was noted that rust, dirt and grime were along the edges of the unit and reusable items of patient care were observed to be inside the dishwasher on the racks.</p> <p>On 4/29/13 at 10:30 p.m., an observation was conducted along with the Manager of Housekeeping and Laundry of the 'dirty utility room' on the 'C' unit. It was noted that the dishwasher had been removed and a board covered the area. An interview with the Housekeeping and Laundry Manager indicated that the dishwasher had been removed and the sterilization of the reusable items was no longer being used and that reusable items were now thrown in the trash. It was observed that several patient care reusable items were stacked in the laundry tub sinks and the excretion odor was very strong.</p> <p>On 4/29/13 at 3:40 p.m., a record</p>				

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	<p>review was conducted of the Policy and procedure titled, "Cleaning and Disinfecting Non-Critical Resident-Care Items." It noted the following: "...General Guidelines...3. d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). (1) Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals).</p> <p>7. On 4/22/13 at 12:00 noon a tour was conducted of the facility upon entry. it was noted to have a urine smell upon entry in the Lobby area.</p> <p>On 4/22/13 at 2:00 p.m., a urine smell was noted on the 'B' unit.</p> <p>On 4/22/13 at 3:00 p.m., a urine smell was noted on the 'C' unit.</p> <p>On 4/23/13 at 10:30 a.m., a strong urine smell was noted on the 'B' unit at Room 117.</p> <p>On 4/23/13 at 3:00 p.m., a strong urine smell was noted on the 'C' unit at Room 217/218.</p> <p>On 4/24/13 at 11:00 a.m., a urine smell was noted on the 'C' unit at</p>			

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	<p>Room 211/210.</p> <p>On 4/24/13 at 3:15 p.m., a urine smell was noted on the 'B' unit at Room 117/118.</p> <p>On 4/25/13 at 11:00 a.m., a urine smell was noted close to the Candle-Light Dining Room area.</p> <p>On 4/25/13 at 3:00 p.m., a urine smell was noted on the 'B' unit at Room 130.</p> <p>On 4/29/13 at 9:30 a.m., a urine smell was noted on both the 'B' and 'C' units upon a walking tour of the facility.</p> <p>On 4/29/13 at 10:00 a.m., a strong urine smell was noted on the dirty utility room on the 'C' unit.</p> <p>3.1-19(f)</p>				

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F009999 SS=D	<p>3.1-14</p> <p>Sec. 14.(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>(p) Initial orientation of all staff must be conducted and documented and shall include the following:</p> <p>(1) Instructions on the needs of the specialized population or populations served in the facility, for example:</p> <p>(A) aged;</p> <p>(E) care of the cognitively impaired; residents.</p> <p>(2) A review of the residents' rights and other pertinent portions of the facility's policy manual.</p> <p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall</p>	F009999	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to have specific procedures written and implemented for screening of prospective employees. Consistent with this practice, the following actions have been taken: I. Criminal background checks were completed for employees #12 , #14, and #16 and are maintained in the employee file. TB skin tests were administered to employees #15 and #16. Physical Examinations were conducted on employees #16, #19, and #20. A reference check was completed on employee # 16. Dementia training was provided to employees #15, #13, #16, #17, #18, #19, #20, and # 21. Abuse prevention training was provided to employee #19. II. All employee files will be audited to ensure that all files are complete, including but not limited to the following: criminal background checks, dementia training, abuse prevention training, TB skin tests are administered, references	05/29/2013			

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	<p>include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes:</p> <p>(A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations.</p> <p>(u) in addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs</p>		<p>obtained, Physicals are received, and is completed and maintained as part of the employee's file.</p> <p>III. Employee #13 and all hiring managers will be in-serviced on the policy titled, "Background Investigation for New-hires and Re-Hires. A QAPI tool titled, "F166/F226" was developed that the ED or designee will utilize to monitor new hires and re-hires for compliance, times 4 weeks. IV. The ED or designee will review findings weekly and report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a 100% threshold is reached. Date of Compliance: 05.29.13</p>		

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	<p>or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>The facility failed to meet this regulation as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation for ten of ten employee personnel files as current and accurate. (Employee #12, #14, #15, #13, #16, #17, #18, #19, #20 and #21)</p> <p>Findings included:</p> <p>Employee #12 personnel file did not include a pre-employment screening criminal background check, dementia inservice, or abuse inservice.</p> <p>Employee #14 personnel file did not include a pre-employment screening reference background check, resident rights inservice, or dementia inservice.</p> <p>Employee # 15 personnel file did not include a second step TB (tuberculin) skin test or dementia inservice.</p> <p>Employee #13 personnel file did not</p>			

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	<p>include a second step TB skin test or dementia inservice.</p> <p>Employee # 16 personnel file did not include a pre-employment screening criminal background check, a pre-employment screening reference background check, an incomplete physical exam, a second step TB skin test or dementia inservice.</p> <p>Employee #17 personnel file did not include dementia inservice.</p> <p>Employee #18 personnel file did not include dementia inservice.</p> <p>Employee #19 personnel file did not include a pre-employment physical exam, resident rights inservice, dementia inservice, or abuse inservice.</p> <p>Employee # 20 personnel file did not include a pre-employment physical exam or dementia inservice.</p> <p>Employee #21 personnel file did not include dementia inservice.</p> <p>On 4/29/2013 at 1:25 P.M., an interview with Human Resource Employee #13 indicated that no other documentation was available for these employees.</p>				

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