STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN46407

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 19, 20, 21, 22, and 23, 2011 Facility number: 000368 Provider number: 15E187 Aim number: 100275220 Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Heather Tuttle, RN Janet Adams, RN Census bed type: NF: 22 Total: 22 Census payor type: Medicaid: 21 Other: 1 Total: 22 Stage II Sample: 18 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on September 29, 2011 by Bev Faulkner,	F0000	October 13, 2011 Ms. Kim Rhoades, R.N.DirectorIndiana State Department of Health2 North Meridian StreetIndianapolis, IN 46204 Plan of Correction Dear Ms. Rhoades, I am submitting CMS-2567 plan of correction as a credible allegation of compliance to the September 23, 2011 health survey. All corrections will be completed by October 23, 2011. The Q.A. Committee will meet monthly to ensure all deficient practices of the facility have been corrected. After all deficiencies are recognized as being corrected by the State Board of Health Q.A. meetings will resume meeting quarterly but will reserve the right to meet more frequently depending upon the needs of the facility. A signed copy of page 1 Form CmS-2567 was faxed.Please contact me if you have any questions. Sincerely,Herberta B. Miller Mrs. Herberta B. MillerAdministrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interviews, the facility failed to ensure	F0157	AddendumF Tag 157 Physician Notification 1 What corrective action will be accomplished for	10/23/2011

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	the resident's physician and or family was promptly notified of any significant change in status related to weight loss and the Registered Dietitian's recommendations for 2 of 11 residents reviewed for physician notification in the Stage 2 sample of 18. (Residents #2 and #14) Findings include: 1. The record for Resident #2 was reviewed on 9/20/11 at 12:44 p.m. Review of the resident's weights indicated the resident weighed 173 pound on 6/3/11, 150 pounds on 7/7/11, 171 pounds on 8/9/11, and 132 pounds on 9/9/11. The resident had a significant weight loss of 39 pounds in three months. Review of Nursing Progress Notes, dated 6/11, 7/11, 8/11, and up until 9/20/11, indicated there was no documentation the resident's responsible party had been notified of the significant weight loss in the last three months. Interview with LPN #1 on 9/22/11 at 2:34 p.m., indicated the resident's family was not notified of the significant weight loss. She further indicated she just notified the		those residents found to have been affected by the deficient practice? Resident 2 physician and family were notified of weight loss and resident is gaining weight with current treatment regime. Resident 14 diet order and tray card was corrected to read regular diet. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of all resident's diet orders and tray cards was done. Every resident was re-weighed to ensure accuracy and weigh scale was recalibrated. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An In- Service on Physician notification will be presented to nurses. Physician Notification Policy, Change In Condition Policy, and Dietitian Referral & Recommendations Policy were reviewed on Friday, 10/7/11, and Wednesday 10/12/11 and copies of the policies given to each nurse. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. A nurse will be assigned to audit dietitian referral and recommendations so that they will be implemented within 24-48 hours. Weekly reports of physician notification will be	

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	responsible party of the weight loss. 2. The record for Resident #14 was reviewed on 9/20/11 at 10:00 a.m. The resident had diagnoses that included, but were not limited to, diabetes and arthritis. The form titled, "Quarterly Nutrition Progress Note" was reviewed. An entry, dated 4/23/11, and signed by the Registered Dietitian indicated that the resident's January weight was 112, the February weight was 111, the March weight was 111, and the April weight was 108. The note indicated the Registered Dietitian recommended the NCS/NAS (no concentrated sweet/no added salt) diet be discontinued. The form titled, "Dietitian		reviewed by D.O.N. and Medical Director on Wednesdays. Weekly weights will be reviewed with the Medical Director on Wednesdays if resident is at risk of weight loss and all other residents not at risk will be reviewed monthly. The Director of Nursing and or designee will audit and monitor change in condition in weights and dietician recommendations monthly . QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	

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	Recommendations," dated 4/23/11, was reviewed. The Dietitian indicated on the form that her recommendation was to discontinue the NCS/NAS diet and to give a general, regular consistency diet to the resident due to a slow weight loss. The physician's orders were reviewed. There was a physician's order, dated 5/7/11, that indicated the NCS, NAS diet was to be discontinued and to give a regular diet. The physician's order was obtained 14 days after the Registered Dietitian made the recommendation to change the resident's diet. Review of the Nursing Progress Notes, dated 4/23/11 through 5/6/11, indicated there were no attempts to notify the physician of the Registered Dietitian's recommendation to discontinue the NCS/NAS diet. The undated policy titled "Dietitian Referral & Recommendations" was provided by the DON (Director of Nursing) on 9/21/11. She indicated the policy was current. The policy indicated, "Dietitian recommendations will be left with the Director of Nursing. The DON or designee will follow up with the physician regarding the dietitian's recommendation. The			

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	optimal time frame to obtain physician order or denial of recommendation is 24-48 hours." Interview with the Director of Nursing on 9/22/11 at 11:05 a.m., indicated the physician was not notified timely of the Registered Dietitian's recommendations to change the resident's diet. 3.1-5(a)(3)			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to ensure 1 of 3 residents reviewed for physical restraints of the 5 residents who met the criteria for physical restraints had the least restrictive device in place. (Resident #12) Findings include: On 9/20/11 at 9:40 a.m., Resident #12 was observed in her room in a wheelchair. A lap buddy restraint was in use. At 12:15 p.m., the resident was seated in a chair at the dining room table, the lap buddy restraint was in place. At 1:18 p.m. and 3:07 p.m., the resident was observed in	F0221	ADDENDUM F Tag 221 RESRAINT FREE1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 12 lap buddy restraint was updated on care plan and restraint assessment updated documentation was updated to indicate that the lap buddy was the least restrictive restraint at this time. Resident 12 continues to slide when she pushes herself backwards in her wheelchair. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents with restraint were reviewed and	10/23/2011

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	her wheelchair with the lap buddy restraint in place. The resident made no attempts to remove the lap buddy. On 9/21/11 at 8:50 a.m., the resident was seated in a chair at the dining room table. The lap buddy was in place. At 10:00 a.m., 11:23 a.m., and 3:15 p.m., the resident was observed in her wheelchair with the lap buddy restraint in place. The resident made no attempts to remove the restraint and/or get up unassisted. On 9/22/11 at 7:35 a.m. and 10:45 a.m., the resident was observed in her wheelchair. The lap buddy restraint was in use. The resident made no attempts to remove the lap buddy and/or get up unassisted. The record for Resident #12 was reviewed on 9/20/11 at 9:56 a.m. The resident's diagnoses included, but were not limited to, anxiety and dementia. An entry in the Nursing Progress Notes, dated 9/10/11 at 8:30 p.m., indicated, "Resident's alarm sensor sounding alerting staff. Upon entering room, resident had slid to the floor from wheelchair. Gel cushion was also on the floor." The resident indicated that she had slid out of her		restraint is appropriate for the resident at this time. All residents who require restraints assessments were audited. No other residents were noted to be deficient . 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nurses will follow the restraint criteria for residents who require restraint use which includes the following: completing a restraint assessment, restraint implementation starting with the least restrictive device and residents response and outcome of use with the device.An In-Service on Restraint Policy and Protocol was done on Friday, 10/7/11, and Wednesday 10/12/11 and copies of the policies given to each nurse. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. A nurse will be assigned to audit weekly restraint usage.. Restraint use will me evaluated quarterly for restraint reduction or resident change in condition by nurses weekly and by D.O.N. monthly times one month and quarterly thereafter QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	

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	chair. Upon assessment, the resident hit her head on the floor causing a laceration approximately 5 centimeters (cm) to the back of her head. A Physician's Order, dated 9/11/11, indicated to discontinue the alarm sensor at all times. Alarm sensor in place while in bed. Lap buddy in place while up in chair. There was no Restraint Assessment available for review and there was no documentation as to which least restrictive interventions were attempted prior to the lap buddy restraint. The Minimum Data Set Assessment (MDS), dated 6/14/11, indicated the resident understood and understands but she had episodes of disorganized thinking and inattention. The MDS indicated the resident was totally dependent on staff for transfers and was a two person assist. Interview with CNA #1 on 9/22/11 at 10:35 a.m., indicated she was not on duty when the resident slid out of her wheelchair. She did indicate prior to the fall, the resident had a chair alarm in place. She further indicated the resident at times would also use a			

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	geri-chair due to swelling in his legs. She indicated the lap buddy was put into use after the resident's fall. Interview with LPN #1 on 9/22/11 at 1:10 p.m., indicated a restraint assessment was to be completed prior to initiating a restraint. She also indicated the least restrictive device should be tried first. Further interview at 1:50 p.m., indicated a restraint assessment was not completed for the resident and something least restrictive should have been tried before applying the lap buddy. 3.1-3(w) 3.1-26(o) 3.1-26(r)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to apply for a criminal history check within three business days of employment for 2 of 6 employee files reviewed for criminal history checks. (Custodian #1, CNA # 3) Findings include: The facility employee files were	F0226	ADDENDUM F Tag 226 CRIMINAL HISTORY CHECKS1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All new hires criminal history checks will be mailed within 3 business days of employment to the Indiana State Police.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	10/23/2011

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	reviewed on 9/22/11 at 1:45 p.m. There were no results of criminal history checks available for the following employees: 1. CNA #3 was hired on 6/29/11. The request for a criminal history report was mailed out on 7/29/11. The results were not available in the employee's file. 2. Custodian #1 was hired on 7/25/11. The request for a criminal history report was mailed on 8/9/11. The results were not available in the employee's file. The facility policy titled "Prevention and reporting of Suspected Resident Abuse and Neglect" was received from the Social Service Designee on 9/23/11 at 8:00 a.m. There was no date on the policy. The Social Service Designee indicated the policy was current. The policy indicated implementing and ongoing monitoring of abuse procedures included screening of new employees. The policy also indicated all potential employees were to be screened for a history of abuse, neglect, or mistreatment of residents. The screening was to include criminal background checks on all non-professional staff 18 years of age		action will be taken. No new hires at this time. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Administrative assistant will complete a log which will indicate the first date of employment and the date the criminal history check was mailed and the date the report was received back from the Indiana State Police. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The Administrative assistant will monitor the new hires record until the criminal record report is received and then deliver the report to the Administrator for non-nursing staff.The Director of Nursing will audit and monitor criminal history log sheet monthly for competition of new hire record for the nursing department times one month and quarterly times 6 months. QA committee will review ne hire logs quarterly upon hiring of new staff.5. Date completed: October 23, 2011	

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	or older and the results of the screening were to be documented and filed with the employees records. Review of the Indiana Code 16-28-13-4 indicated, a health care facility, "shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information." When interviewed on 9/22/11 at 2:30 p.m., the Social Service Designee indicated she was the person responsible for completing criminal history checks on new employees. The Social Service Designee indicated she had sent the requests out but had not received them back. When interviewed on 9/23/11 at 8:33 a.m., the Social Service Designee indicated there were no results of the criminal history checks for the above staff members. 3.1-28(a)			

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F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to chipped paint and mars on heat registers, marred and chipped doors, broken chairs and toilet seats, marred legs on beds and chairs, discolored and broken floor tiles, bent window screen, and broken or missing cove base. This had the potential to affect 22 of 22 residents residing in the facility. Findings include: 1. Observation on 9/19/11 at 12:25 p.m., indicated the bathroom door of Room 104 had chipped paint areas. The heat register unit had black marred areas and chipped paint. One resident resided in the room. 2. The heat register in Room 120 was observed on 9/19/11 at 11:21 a.m. The heat register had chipped paint along the entire length of the unit. Two residents resided in the room. 3. Room 105 was observed on 9/19/11 at 11:27 a.m. The paint on the heat register unit was chipped.	F0253	ADDENDUM F 253 HOUSEKEEPING/MAINTANENC E 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance and custodial staff continued to paint throughout survey.All heat registers were assessed and Rooms 104, 120,105 were painted. All widow sills and door frames were assessed and Room 106 was painted. All toilet seats and handles were assessed for cracks and breakage and Room 120 replaced. All room chairs were assessed and Room 105 chair was tightened. All chair legs and bed frame legs were assessed and Room 107, 109, 113 was painted. All floors were assessed for discoloration and replaced in Room 109 & 113. All window screens were assessed and Room 117 was replaced. All light fixtures were checked for light bulb replacement and East bathroom shower light bulb was replaced. All baseboard was checked and baseboard was replaced near shower stall in Room 117. All tile at exit doors was assessed	10/23/2011

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	Two residents resided in the room. Interview with the Maintenance Supervisor on 9/22/11 at 10:10 a.m., indicated the above areas were noted to be in need of painting and had been painted on 9/20/11 and 9/21/11. 4. During the Environmental Tour on 9/22/11 at 10:10 a.m., the following was observed: a. In Room 106, the window sill in the bathroom had an area of chipped paint that was 4 inches in size. The window sill was in need of paint. The wood on the door frame of the room had chipped areas. Two residents resided in the room. b. In Room 120, the plastic handle on the right side of the toilet seat was cracked and broken off. Two residents resided in the room. c. In Room 105, the back of the chair in the room was loose. The door frame was scraped and gouged. Two residents resided in the room. d. In Room 107, the legs of the room chair were marred. The bed frame legs for bed 2 were marred. Two residents resided in the room.		and broken floor tile near exit door in dining room was replaced.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Scheduled maintenance painting continued and addressed all deficient areas throughout the facility.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-services on preventative maintenance and daily log sheets will be held by Administrator/Administrative Designee who will monitor that all deficient areas have been addressed and repairs completed. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The Administrator is currently getting bids for building upgrades. Custodian will monitor daily for painting and repairs and complete a repair log as repairs are completed the log will be updated. The Administrator/Administrative Designee will monitor building for repairs and audit log sheets and preventative log monthly x 2 months then quarterly for next 6 months QA committee will review preventative maintenance logs and repair logs along with suggested upgrades monthly then quarterly thereafter but reserve the right to meet more often has	

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	e. In Room 109, the bed frame on bed 2 had marred legs. The floor tiles around the toilet were discolored. The door frames to the room and the bathroom were marred. Two residents resided in the room. f. In Room 113, the legs of the bed frame for bed 2 were marred. The chair in the room had a broken arm. The door to the bathroom had marred edges. The floor tile around the toilet was discolored. One resident resided in the room. g. In Room 117, the window screen was bent and did not fit the window properly. A 3 inch piece of cove base was missing near the shower stall. A 5 inch piece of cove base was broken near the shower stall. One resident resided in the room. h. The light in the male shower room did not work. Eleven (11) male residents used the shower room. i. There was a broken floor tile near the exit door of the dining room. Interview with the Maintenance Supervisor at the time of the tour, indicated all of the above areas were in need of repair.		plans are developed and implemented. 5. Date completed: October 23, 2011	

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	3.1-19(f)(5)			
F0278 SS=A	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure comprehensive assessments were coded accurately related to pressure ulcers, active diagnoses, medications for depression, and oral/dental status for 2 of 11 residents reviewed for comprehensive assessments in the	F0278	ADDENDUM F Tag 278 Resident Assessment 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The current MDS for Resident 9 has been reviewed and is correct as related to having no teeth. Resident 13 pressure was	10/23/2011

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	Stage 2 sample of 18. (Residents #9 and #13) Findings include; 1. The record for Resident #9 was reviewed on 9/20/11 at 12:17 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and renal failure. A Dental Treatment Plan, dated 5/27/11, indicated the resident was missing teeth and had been edentulous (having no natural teeth) for the past 20 years and currently did not have dentures. Review of the 5/27/11 Annual MDS and the 8/27/11 quarterly Minimum Data Set (MDS) assessments indicated the line to be checked if the resident had no natural teeth was not marked on either of the above MDS assessments. When interviewed on 9/21/11 at 10:30 a.m., the Director of Nursing indicated the MDS assessments were not coded correctly as the resident had been edentulous. 2. The record for Resident #13 was		corrected to be Stage 3 instead of epithelial tissue and depression was checked on MDS. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Resident who have diagnosis of depression, pressure areas and dentures have been identified and MDS of resident's have been reviewed to ensure that MDS is accurate. No other residents were noted to have this deficiency. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. MDS In –Service was presented on Friday, 10/7/11, and Wednesday 10/12/2011 with focus on assessment accuracy. Charge Nurse will double check the accuracy of the MDS prior to locking her data entry.4. How the corrective action will be monitored to ensure the deficient practice will not recur. A nurse will be assigned to review MDS for accuracy bi-monthly Director of Nursing and or designee will audit MDS for accuracy weekly prior to transmission for one month then bi-monthly thereafter ongoing.QA will review audits and departmental recommendation. 5. Date completed: October 23, 2011	

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	reviewed on 9/20/11 at 10:55 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, degenerative joint disease, and pneumonia. The resident was admitted to the facility on 6/1/11. Review of the Weekly Wound Assessment Flow Record initiated on 6/1/11 indicated the resident had a Stage II (an ulcer with partial thickness loss of the dermis without slough) pressure ulcer to the coccyx. The pressure ulcer to the coccyx was recorded as a Stage III (an ulcer with full thickness tissue loss and slough may be present) ulcer with slough (necrotic or avascular tissue in the process of separating from vascular tissue) on 9/7/11 and 9/14/11. Review of the 9/11 Physician Order Statement indicated there was an order for the resident to receive Celexa (an antidepressant medication) 10 milligrams daily. The medication was originally ordered on 6/3/11. A History and Physical, completed in the hospital on 5/24/11, indicated the resident had a diagnosis of depression. A Minimum Data Set (MDS) quarterly assessment was completed on 9/14/11. The MDS assessment			

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	indicated the resident had two Stage III pressure ulcers and the most severe tissue type for any of the ulcers was marked as "epithelial tissue." The section to be checked if slough was present was not checked on the above assessment. The 9/14/11 MDS quarterly assessment also indicated depression was not checked as an active diagnosis. The assessment also indicated the medication section indicated the resident was not receiving any antidepressant medications. When interviewed on 9/21/11 at 10:30 a.m., the Director of Nursing indicated the MDS assessment was coded incorrectly related to the severity of the tissue on the resident's pressure ulcer as slough was present on the pressure ulcer. When interviewed on 9/23/11 at 8:50 a.m., the Social Service Designee indicated the resident's diagnosis of depression and the ongoing use of the antidepressant medication should have been coded on the MDS assessment. 3.1-31(h)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). Based on observation, record review and interview, the facility failed to ensure a care plan was initiated related to restraint use and nutrition for 1 of 3 of the 5 residents who met the criteria for physical restraints and for 1 of 3 of the 3 residents who met the criteria for acceptable parameters of nutrition. (Residents #2 and #12) Findings include: 1. On 9/20/11 at 9:40 a.m., Resident #12 was observed in her room in a wheelchair. A lap buddy restraint was in use. At 12:15 p.m., the resident	F0279	ADDENDUM F Tag 279 CARE PLAN1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 2 weight loss with current treatment regime was updated on care plan. Resident 12 lap buddy restraint was updated on care plan and restraint assessment updated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents care plan were reviewed to indicate change in plan of care for resident with significant weight loss. Every resident was	10/23/2011

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	was seated in a chair at the dining room table, the lap buddy restraint was in place. At 1:18 p.m. and 3:07 p.m., the resident was observed in her wheelchair with the lap buddy restraint in place. The resident made no attempts to remove the lap buddy. On 9/21/11 at 8:50 a.m., the resident was seated in a chair at the dining room table. The lap buddy was in place. At 10:00 a.m., 11:23 a.m., and 3:15 p.m., the resident was observed in her wheelchair with the lap buddy restraint in place. The resident made no attempts to remove the restraint and/or get up unassisted. On 9/22/11 at 7:35 a.m. and 10:45 a.m., the resident was observed in her wheelchair. The lap buddy restraint was in use. The resident made no attempts to remove the lap buddy and/or get up unassisted. The record for Resident #12 was reviewed on 9/20/11 at 9:56 a.m. A Physician's Order, dated 9/11/11, indicated the resident's sensor alarm was to be discontinued at all times and used while in bed. The resident was to have a lap buddy applied while she was up in her wheelchair. The plan of care, dated 9/10/11,		re-weighed to ensure accuracy and weigh scale was recalibrated. All residents who require restraints assessments were audited. No other residents were noted to be deficient and have such a weight discrepancy. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All residents will be weighed after return from hospitalizations and if weight loss is noted at risk protocol will be implemented (example: weekly weights, close monitor of food intake, dietary supplement if needed and appetite stimulant). An In-Service on Care Plan Protocol for residents at risk for weight loss, Change In Condition Policy, and Dietitian Referral & Recommendations Policy were reviewed on Friday, 10/7/11, and Wednesday 10/12/11 and copies of the policies given to each nurse. Restraint criteria was reviewed which includes the following: completing a restraint assessment, restraint implementation starting with the least restrictive device and residents response and outcome of use with the device.4. How the corrective action will be monitored to ensure the deficient practice will not recur. A nurse will be assigned to audit weekly and monthly weights and residents at risk for weight loss will be identified to the dietitian for	

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	indicated the resident had a fall causing a laceration to the back of her head. The interventions indicated the lap buddy was to be applied when the resident was up in the wheelchair. There was no care plan initiated related to the use of the restraint as far as monitoring and reduction. Interview with LPN #1 on 9/22/11 at 1:10 p.m., indicated a care plan related to the restraint should have been initiated.		referral and recommendations that will be implemented within 24-48 hours. Dietician and Nursing will developed a care plan to ensure weight gain for the resident and evaluated weekly while resident is on weekly weights then monthly thereafter. Weekly reports of physician notification will be reviewed by D.O.N. and Medical Director on Wednesdays. Weekly weights will be reviewed with the Medical Director on Wednesdays if resident is at risk of weight loss and all other residents not at risk will be reviewed monthly. The Director of Nursing and or designee will audit and monitor change in condition in weights and dietician recommendations monthly and plan of care. . Restraint use will me evaluated quarterly for restraint reduction or resident change in condition by nurses weekly and by D.O.N. monthly x 2 months and quarterly for 6 months.QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	
	2. The record for Resident #2 was reviewed on 9/20/11 at 12:44 p.m. Review of the resident's weight record indicated the resident weighed 173 pounds on 6/3/11; 150 pounds on 7/7/11; 171 pounds on 8/9/11, and			

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	134 pounds on 9/20/11. Review of the quarterly Minimum Data Set (MDS) assessment, dated 7/27/11, indicated the resident's weight was 173 pounds and he was 78 inches tall. The MDS assessment also indicated there was no significant weight loss in the last 6 months or one month. Review of the Current Plan of Care, dated 7/11, indicated there was no care plan for the resident's weight losses in the last several months. Interview with LPN #1 on 9/20/11 at 2:53 p.m., indicated the resident's weight loss was not on the current plan of care. 3.1-35(a)			

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review and interview, the facility failed to ensure the plan of care was periodically reviewed and revised to reflect the range of motion status for the 3 of 3 residents reviewed who met the criteria for limitation in range of motion. (Residents #3, #6, and #12) Findings include: 1. On 9/20/11 at 9:40 a.m., 12:15 p.m., 2:00 p.m., and 3:07 p.m., Resident #3 was observed to have her legs bent at the knee. The resident was not able to fully extend her legs. Interview with LPN #1 on 9/19/11 at	F0280	ADDENDUM F Tag 280 Comprehensive Care Plan 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 3 Restorative care plan was reviewed and update as needed for leg contracture Resident 6 Restorative care plan was reviewed and update as needed for fingers and hand contracture Resident 12 Restorative care plan was reviewed and update as needed for right hand contracture 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All resident with contractures restorative care plans were reviewed and revised	10/23/2011

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	11:00 a.m., indicated the resident had contractures to her legs. The record for Resident #3 was reviewed on 9/20/11 at 2:00 p.m. The Quarterly Minimum Data Set (MDS), dated 6/26/11, indicated the resident had a functional limitation in range of motion on both sides of the upper and lower extremities. The 6/26/11 Quarterly Narrative Summary indicated the resident's bilateral lower extremities were contracted. The June 2011 plan of care indicated the resident had a plan of care for passive range of motion to the elbow. The care plan was not revised to include the contractures to the lower extremities. 2. On 9/20/11 at 9:40 a.m., Resident #12 was observed to have palm protectors in use to each hand. Interview with LPN #1 on 9/19/11 at 11:00 a.m., indicated the resident had contractures to her hands. The record for Resident #12 was reviewed on 9/20/11 at 9:56 a.m. The Minimum Data Set Assessment (MDS), dated 6/14/11, indicated the		as needed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A Care Plan In- Service was held on Friday 10/7/11 and Wednesday 10/12/11 to make sure the restorative plan emphasized the contracted areas of each resident. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. A nurse will be assigned to audit and review care plans monthly and the Director of Nursing and or designee will audit and review care plans quarterly times 6 monthsQ A committee will review audits quarterly and determine need for further audit 5. Date completed: October 23, 2011	

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	resident had a functional limitation in range of motion on one side of the upper extremity. The Range of Motion Care Plan, dated 6/14/11, indicated the resident continued to require assist with bed mobility. The resident also had a plan of care for passive range of motion to flex and extend her hip with straight knee. The plan of care was not revised to include the resident's hand contractures and use of the palm protectors. Interview with LPN #1 on 9/22/11 at 2:10 p.m., indicated the resident's care plan did not address the palm protector and range of motion to her hands. 3. On 9/20/11 at 12:36 p.m., Resident #6 was observed sitting in a wheelchair in the main dining room at his table. At that time, the resident was observed with two anti-contracture devices in both of his hands. The resident's fingers were bent forward toward the devices. The record for Resident #6 was reviewed on 9/21/11 at 2:27 p.m. Review of the Minimum Data Set (MDS) assessment, dated 7/24/11,			

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	indicated the resident had impairment to both sides for upper and lower extremities. The MDS assessment also indicated the resident was receiving passive range of motion through restorative therapy. Review of the 7/24/11 Care Plan, indicated PROM (Passive range of motion), limited range of motion of upper extremities with discomfort. The nursing approaches were to have the resident lie in bed and start with the resident's arm at a 90 degree angle away from the body. Support the arm at the wrist and above the elbow joint. Gently lift the arm of across the body. Return his arm to the starting position and repeat gradually progress to 3-5 minutes. Goal resident will complete 25 repetitions two times a day. There was no Passive Range of Motion indicated for the resident's contracted hands and/or fingers on the current plan of care. Interview with LPN #3 on 9/21/11 at 4:22 p.m., indicated the care plan for PROM was not revised to include the hands and the fingers. 3.1-35(d)(2)(B)			

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F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure physician's orders and/or the plan of care were followed as written related to range of motion for 3 of 3 residents reviewed who met the criteria for limitation in range of motion, a gel cushion not in use for 1 of 15 residents observed, a diet not served as ordered for 1 of 3 residents who met the criteria for acceptable parameters of nutrition and a dressing not in place as ordered for 1 of 1 treatments observed. (Residents #3, #6, #8, #12, #13 and #14) Findings include: 1. On 9/20/11 at 9:40 a.m., Resident #3 was observed in her room in bed. The resident's legs were bent at the knee and not fully extended. The resident had no limitation to her elbows. At 12:15 p.m., 2:00 p.m., and 3:07 p.m., the resident's legs were observed to be bent at the knees. The record for Resident #3 was reviewed on 9/20/11 at 2:00 p.m. The	F0282	ADDENDUM F Tag 282 COMPREHENSIVE CARE PLAN 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 3 restorative care plan reviewed and revised to address contracture of knees. Resident 6 restorative care plan reviewed and revised to address contracture of hands and fingers. Resident 8 a gel cushion was placed in Geri chair as soon as it was brought to the nurse's attention. Resident 12 restorative care plan reviewed and revised to address contracture of right hand. Resident 13 all charge nurses were notified of a C.N.A. removal of dressing. Policy was reviewed with charge nurse and with each C.N.A. on Friday, 10/7/11 and again with charge nurses on Wednesday 10/12/11. Dressing Policy was given to each charge nurse. Resident 14 tray card was immediately corrected after dietary order was clarified and audit of all tray cards was completed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be	10/23/2011

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	resident's diagnoses included, scoliosis and arrested growth development. The June 2011 plan of care, indicated the resident was to receive passive range of motion to the elbow. The Assessment Summary, dated June 2011 and written by nursing, indicated the resident had limited use of upper extremities, extensions and flexions were performed within the resident's limits related to contractures; these passive range of motion exercises were performed totally by staff; the resident tolerated 6-7 repetitions, with frequent rest periods provided; resident will pull away when not interested or not wanting to continue exercises, continue care plan x 90 days. There was no daily documentation completed related to completing range of motion exercises. Interview with LPN #3 on 9/21/11 at 4:22 p.m., indicated there was no daily documentation for range of motion and restorative care. She further indicated there was no documentation for the resident to indicate if staff were completing range of motion on a daily basis.		taken. Restorative care plans of all residents with contractures were reviewed and revised to address the contracted areas of each resident's body. An audit of dietary orders and dietary tray cards was completed. All residents with gel cushion chairs were checked to ensure they were in place. All C.N.A.'s were told of the dressing policy and to notify the charge nurse for removal and application of dressings needed for residents. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In –Service was presented to the staff related to following restorative plan of care and a review of all residents with contractures. Dietary orders were audited with tray cards. A list of resident requiring pressure relieving devises will be provided for staff and monitored by charge nurse on each shift. All nursing staff reviewed the dressing policy and it was stressed no C.N.A. is to remove a resident's dressing. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The nurse will observe gel cushions pressure relieving devise and when making rounds and passing medication daily. FSS will monitor tray cards during all 3 meals bi-weekly times 2	

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	Interview with CNA #1 on 9/22/11 at 10:25 a.m., indicated that she takes it upon herself to try and provide range of motion to the resident's arms and legs. She indicated that she usually does this in the mornings after her bath. She indicated there was nowhere to document it was completed. She was told to document on CNA flow sheets but indicated that the sheets basically addressed the resident's behaviors. 2. On 9/20/11 at 9:40 a.m., Resident #12 was observed in her room. The resident was observed in a sitting position on all days of the survey. She was not observed to have contractures to her hips and knees. The record for Resident #12 was reviewed on 9/20/11 at 9:56 a.m. The plan of care, dated 6/14/11, indicated the resident was to receive passive range of motion to flex and extend the hip with straight knee. 15 repetitions were to be completed twice a day. There was no flow sheet to indicate the range of motion was being completed . Interview with LPN #3 on 9/21/11 at		months then quarterly thereafter . FSS will monitor dietician recommendations bi-weekly times 2 months then quarterly thereafter. Dietary communication sheet denotes change in diet order to dietary staff from the nursing staff will be monitored monthly. Dietician will monitor tray cards and diet orders bi-monthly. The nurse will monitor for dressing during treatment and during nursing rounds daily. Director of Nursing and or designee will audit compliance weekly times 1 month then quarterly for 6 months. QA will receive reports and review quarterly and make recommendations as needed. 5. Date completed: October 23, 2011	

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	4:22 p.m., indicated there was no daily documentation for range of motion and restorative care. She further indicated there was no documentation to indicate if staff was completing range of motion on a daily basis. 3. On 9/20/11 at 12:36 p.m., Resident #6 was observed sitting in a wheelchair at the table in the Main Dining Room. At that time, the resident was observed with two anti-contracture devices in both of his hands. Further observation indicated both hands and fingers were bent forward, there were no contractures of the resident's arms. The record for Resident #6 was reviewed on 9/21/11 at 2:27 p.m. Review of the current 7/24/11 Care plan indicated PROM (Passive Range of Motion) Limited range of motion of upper extremities with discomfort. The Nursing approaches were to have the resident lie in bed and perform range of motion. Start with the resident's arm at a 90 degree angle away from the body. Support the arm at the wrist and above the elbow joint. Gently lift the arm of across the body. Return his arm to the starting position and repeat gradually progress to 3-5			

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	minutes. The resident's goal was to complete 25 repetitions two times a day. Interview with CNA #5 who was working the day shift on 9/22/11 at 8:37 a.m., indicated she does not have a CNA flow sheet that specifically indicates what needs to be done for each resident. The CNA indicated she thought that information was in the chart. She further indicated she only massages Resident #6's hands when he asks and it was not necessarily everyday. The CNA indicated sometimes it was twice a day, sometimes just one time, sometimes not at all. The CNA further indicated she was unaware of the resident's range of motion plan of care that was specific to him. Interview with CNA #1 who was working the day shift on 9/22/11 at 8:44 a.m., indicated there were no CNA flow sheets available. She indicated she did not specifically know what the resident's plan of care was for range of motion. The CNA indicated she massages the resident's hands for about 5 to 10 seconds before placing him in the bathtub every morning. After the bath, she then replaces the splints to his hands. She indicated his splints were			

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	removed at night time before he goes to bed, because when she gets him up they are not on him. 4. On 9/20/11 at 10:25 a.m., LPN #1 was observed preparing to perform wound care treatments for Resident #13. The resident was in bed. CNA #2 was also in the room to assist the LPN. The CNA turned the resident to his side and unfastened the resident's incontinence brief. The resident had a pressure ulcer to the left hip. The pressure ulcer was uncovered. When interviewed during the above observation of wound care, CNA #2 indicated she had removed the dressing to the resident's hip earlier in the morning around 7:15 a.m., when she was bathing the resident. The record for Resident #13 was reviewed on 9/20/11 at 10:55 a.m. The resident's diagnoses included, but were not limited to, degenerative joint disease, Parkinson's disease, urinary tract infection, and pneumonia. Review of the 9/7/11 Wound Care Skin Integrity Evaluation form indicated the resident had a partial thickness pressure ulcer to the left hip and the wound size was 4.0 cm. x 3.0			

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	cm. and the wound was unstageable. Interventions ordered were to cleanse the area, apply Santyl (an ointment to debride the wound), then apply Hydrogel 2 x 2 (a medicated dressing) to the area and cover with a foam adhesive bandage twice a day. The "Dressing Change, Clean" policy was received from the Director of Nursing on 9/21/11 at 12:30 p.m. The Director of Nursing indicated the policy was current. There was no date on the policy. The policy indicated dressing changes were the responsibility of the Licensed Nurse. When interviewed on 9/20/11 at 10:45 a.m., LPN #1 indicated she had not removed the dressing to the resident's left hip prior to rendering wound care. The LPN indicated she was not informed that the dressing was not in place. LPN#1 indicated the protocol is for wound dressings to be removed by nurses and not CNAs. When interviewed on 9/20/22 at 1:30 p.m., the Director of Nursing indicated pressure ulcer dressings were to be removed by Nurses and CNAs were not to remove any pressure ulcer dressings.			

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	5. Resident #14 was observed in the dining room on 9/20/11 at 12:15 p.m. Her lunch meal had been served. The tray card indicated the resident had been served a NCS (no concentrated sweet) diet. On 9/21/11 at 8:28 a.m., the resident was observed in the dining room. Breakfast had been served to the resident. The tray card indicated the resident had been served a NCS diet. Resident #14's record was review on 9/20/11 at 10:00 a.m. The resident had diagnoses that included, but were not limited to, diabetes and arthritis. The physician's orders were reviewed. There was a physician's order, dated 5/7/11, that indicated to discontinue the NCS, NAS diet and to give a regular diet. Interview with LPN #1 on 9/22/11 at 9:05 a.m., indicated the resident received a NCS diet on 9/20/11 and 9/21/11. She indicated the diet should have been changed to a regular diet on 5/7/11 as ordered by the physician. Interview with the Director of Nursing on 9/22/11 at 11:05 a.m., indicated the resident was not served the	F0282	ADDENDUM F Tag 282 COMPREHENSIVE CARE PLAN 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 3 restorative care plan reviewed and revised to address contracture of knees. Resident 6 restorative care plan reviewed and revised to address contracture of hands and fingers. Resident 8 a gel cushion was placed in Geri chair as soon as it was brought to the nurse's attention. Resident 12 restorative care plan reviewed and revised to address contracture of right hand. Resident 13 all charge nurses were notified of a C.N.A. removal of dressing. Policy was reviewed with charge nurse and with each C.N.A. on Friday, 10/7/11 and again with charge nurses on Wednesday 10/12/11. Dressing Policy was given to each charge nurse. Resident 14 tray card was immediately corrected after dietary order was clarified and audit of all tray cards was completed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Restorative care plans of all residents with contractures were reviewed and revised to address the contracted areas of each resident's body. An audit of dietary orders and dietary tray cards was completed. All	10/23/2011

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	correct diet. 6. Resident #8 was observed on 9/20/11 at 1:25 p.m. CNA #3 transferred the resident to the bed from the geri-chair. There was no gel cushion in the geri-chair. The resident was observed on 9/21/11 at 12:10 p.m. She was seated in a geri-chair with the lap tray in place, there was no gel cushion in the chair. Interview with CNA #1 on 9/21/11 at 12:10 p.m., indicated there was no gel cushion in the geri-chair. The resident was observed on 9/22/11 at 9:55 a.m. She was seated in a geri-chair. There was no gel cushion in the geri-chair. The record for Resident #8 was reviewed on 9/20/11 at 1:09 p.m. The resident had diagnoses that included, but were not limited to, diabetes and Alzheimer's disease. There was a Care Plan, dated 7/17/11, that indicated, "I am totally dependent for all ADL's [activity of daily living]." One of the interventions indicated, "up in geri-chair daily with gel cushion and tray in place."		residents with gel cushion chairs were checked to ensure they were in place. All C.N.A.'s were told of the dressing policy and to notify the charge nurse for removal and application of dressings needed for residents. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In –Service was presented to the staff related to following restorative plan of care and a review of all residents with contractures. Dietary orders were audited with tray cards. A list of resident requiring pressure relieving devises will be provided for staff and monitored by charge nurse on each shift. All nursing staff reviewed the dressing policy and it was stressed no C.N.A. is to remove a resident's dressing. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The nurse will observe gel cushions pressure relieving devise and when making rounds and passing medication daily. FSS will monitor tray cards during all 3 meals bi-weekly times 2 months then quarterly thereafter . FSS will monitor dietician recommendations bi-weekly times 2 months then quarterly thereafter. Dietary communication sheet denotes change in diet order to	

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	Interview with LPN #1 on 9/22/11 at 10:00 a.m., indicated a gel cushion was to be place in the geri-chair per the care plan. Interview with the Director of Nursing on 9/22/11 at 10:05 a.m., indicated the resident was to have a gel cushion in the geri-chair. 3.1-35(g)(2)		dietary staff from the nursing staff will be monitored monthly. Dietician will monitor tray cards and diet orders bi-monthly. The nurse will monitor for dressing during treatment and during nursing rounds daily. Director of Nursing and or designee will audit compliance weekly times 1 month then quarterly for 6 months. QA will receive reports and review quarterly and make recommendations as needed. 5. Date completed: October 23, 2011	
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure that proper incontinence care was provided for a 1 of 1 dependent residents reviewed who met the criteria for urinary incontinence. (Resident #8) Findings include: Incontinence care for Resident #8 was observed on 9/20/11 at 1:25 p.m. CNA #3 provided incontinence care for the resident. The CNA transferred the resident from the geri-chair to the bed. She applied gloves and then removed the resident's soiled brief.	F0312	ADDENDUM F 312 ADL CARE 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? C.N.A. #3 was in serviced about incontinent care and copy of policy was given to C.N.A. #3. C.N.A. she stated during interview that she does not know why she forgot the soap and water because she uses soap and water when providing incontinent care.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All C.N.A.'s were interviewed and asked the	10/23/2011

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	The CNA did not cleanse the resident's perineal area with soap and water or a cleansing cloth. The CNA then applied a clean brief. She then transferred the resident to the geri-chair. The record for Resident #8 was reviewed on 9/20/11 at 1:09 p.m. The resident had diagnoses that included, but were not limited to Alzheimer's disease and diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 7/10/11, was reviewed. The MDS indicated the resident was dependent on one staff member for toileting and personal hygiene. It also indicated the resident was always incontinent of bladder and bowel. A Quarterly Progress Note, dated 7/10/11, indicated "... dependent in all ADL's [activity of daily living] with staff anticipating and meeting all of resident's needs ... remains immobile, with geri-chair being resident's means of transportation ... pericare rendered per staff, per incontinent episode adult briefs, pads and protective barriers utilized ..." The policy titled, "Incontinence Care" that was undated, was provided by		procedures for providing incontinent care to residents. All C.N.A.'s were able to state incontinent care properly. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An In- Service on Incontinent Care was provided to all nursing staff. Each charge nurse will evaluate C.N.A.'s for proper incontinent care and problems reported to D.O.N. All nursing staff received a copy of Incontinent Care Policy on Friday, 10/7/11.4. How the corrective action will be monitored to ensure the deficient practice will not recur. The charge nurse will complete and evaluation of C.N.A.'s incontinent care on their shift.. The D.O.N. will do a skill test on charge nurses and randomly test C.N.A. times 1 month then quarterly for 6 months. QA committee will review skill performance test quarterly for 6 months then semi-annually. 5. Date completed: October 23, 2011	

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	the Director of Nursing on 9/21/11. She indicated the policy was current. The procedure for incontinence care indicated, "Wash all soiled skin areas, washing from front to back, rinse and dry very well, especially between skin folds." Interview with CNA #2 on 9/21/11 at 10:45 a.m., indicated the resident was incontinent of bladder and bowel at all times and required total assistance with perineal care. She indicated that when briefs were changed, the brief was to be removed and then the resident's perineal area was to be cleansed with Dial soap and water and a washcloth. Interview with the Director of Nursing on 9/22/11 at 10:05 a.m., indicated the CNAs were to cleanse the resident's perineal area with soap and water during incontinence care. She indicated that just changing the resident's brief was not adequate for incontinence care. 3.1-38(a)(3)(A)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure a pressure ulcer dressing was in place as ordered by the physician for 1 of 1 residents reviewed for pressure ulcers of the 2 who met the criteria for pressure ulcers. (Resident #13) (CNA # 2) Findings include: On 9/20/11 at 10:25 a.m., LPN #1 was observed preparing to perform wound care treatments for Resident #13. The resident was in bed. CNA #2 was also in the room to assist the LPN. The CNA turned the resident to his side and unfastened the resident's incontinence brief. The resident had a pressure ulcer to the left hip. The pressure ulcer was uncovered. The wound measured approximately 3 cm. (centimeters) x 4 cm. There were yellow areas to the wound and the sides were dark.	F0314	ADDENDUM F Tag 3141 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 13 all charge nurses were notified of a C.N.A. removal of dressing. Policy was reviewed with charge nurse and with each C.N.A. on Friday, 10/7/11 and again with charge nurses on Wednesday 10/12/11. Dressing Policy was given to each charge nurse. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All C.N.A.'s were told of the dressing policy and to notify the charge nurse for removal and application of dressings needed for residents. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In –Service was presented to the staff related to all nursing staff reviewed the dressing policy and it was stressed no C.N.A. is to remove a resident's dressing. 4. How the	10/23/2011

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	When interviewed during the above observation of wound care, CNA #2 indicated she had removed the dressing to the resident's hip earlier in the morning around 7:15 a.m., when she was bathing the resident. The record for Resident #13 was reviewed on 9/20/11 at 10:55 a.m. The resident's diagnoses included, but were not limited to, degenerative joint disease, Parkinson's disease, urinary tract infection, and pneumonia. Review of the 9/7/11 Wound Care Skin Integrity Evaluation form indicated the resident had a partial thickness pressure ulcer to the left hip and the wound size was 4.0 cm. x 3.0 cm. and unstageable. The form also indicated the wound had brown eschar and slough. Interventions ordered were to cleanse the area, apply Santyl (an ointment to debride the wound), then apply Hydrogel 2 x 2 (a medicated dressing) to the area and cover with a foam adhesive bandage twice a day. The Weekly Wound Assessment Flow Record form was reviewed. The form indicated the presence of a wound to the left hip. An entry made		corrective action will be monitored to ensure the deficient practice will not recur. The nurse will monitor for dressing during treatment and during nursing rounds. Director of Nursing and or designee will audit compliance weekly for 1 month then quarterly for 6 months then semi-annually. QA will receive reports and review quarterly and make recommendations as needed. 5. Date completed: October 23, 2011	

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	on 9/14/11 indicated the pressure ulcer had a dark center and the ulcer measured 5 cm. x 3 cm. The "Dressing Change, Clean" policy was received from the Director of Nursing on 9/21/11 at 12:30 p.m. The Director of Nursing indicated the policy was current. There was no date on the policy. The policy indicated dressing changes were the responsibility of the Licensed Nurse. When interviewed on 9/20/11 at 10:45 a.m., LPN #1 indicated she had not removed the dressing to the resident's left hip prior to rendering wound care. The LPN indicated she was not informed that the dressing was not in place. LPN#1 indicated the protocol is for wound dressings to be removed by nurses and not CNAs. When interviewed on 9/20/22 at 1:30 p.m., the Director of Nursing indicated pressure ulcer dressings were to be removed by Nurses and CNAs were not to remove any pressure ulcer dressings. 3.1-40(a)(2)			

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F0318 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to ensure the appropriate treatment and services were provided related to ensuring range of motion exercises were provided for 3 of 3 residents reviewed who met the criteria for limitation in range of motion. (Residents #3, #6, and #12) Findings include: 1. On 9/20/11 at 9:40 a.m., Resident #3 was observed in her room in bed. The resident's legs were bent at the knee and not fully extended. At 12:15 p.m., the resident was seated in a high back chair with a lap tray in use. The resident's legs remained bent at the knee and were not fully extended. At 2:00 p.m. and 3:07 p.m., the resident's legs remained bent at the knee and not fully extended. On 9/21/11 at 8:50 a.m., 10:00 a.m., and 3:15 p.m., the resident was observed in a high back chair with a lap tray. The resident's legs were bent at the knee and not fully	F0318	ADDENDUM F Tag 318 ROM/RESTORATIVE LOG1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 3 Restorative care plan was reviewed and update as needed for leg contracture restorative log updated to address leg contractureResident 6 Restorative care plan was reviewed and update as needed for fingers and hand contracture and restorative log updated to address finger and hand contractureResident 12 Restorative care plan was reviewed and update as needed for right hand contracture and restorative log to address right hand contracture 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All resident with contractures restorative care plans and restorative logs were reviewed and revised as needed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A Care Plan In- Service was held	10/23/2011

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	extended. On 9/22/11 at 7:35 a.m., the resident was observed sitting up right in a pack and play. The resident's legs were bent at the knee and not fully extended. At 8:43 a.m., the resident was seated in a high back chair with a lap tray. The resident's legs were bent at the knee and not fully extended. The record for Resident #3 was reviewed on 9/20/11 at 2:00 p.m. The resident's diagnoses included, but were not limited to, mental retardation, scoliosis, and arrested growth development. The Quarterly Minimum Data Set (MDS) Assessment, dated 6/26/11, indicated the resident had a functional limitation in range of motion on both sides of her upper and lower extremities. The MDS indicated passive range of motion had been performed the last 7 days. The 6/26/11 Quarterly Narrative Summary indicated the resident's bilateral lower extremities were contracted and restorative exercises continue daily as tolerated or until the resident resists.		on Friday 10/7/11 to make sure the restorative plan emphasized the contracted areas of each resident. The restorative program was explained to all C.N.A.'s so that they would understand the right terminology for the restorative program. The restorative form was in-serviced to ensure proper completion. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Restorative Licensed Nurse will monitor direct observation of C.N.A.'s performing R.O.M. to residents during all shifts. A nurse will be assigned to audit and review care plans and restorative forms monthly . Director of Nursing and or designee will audit and review care plans and restorative forms quarterly for 6 months. Q A committee will review audits quarterly and determine need for further audit 5. Date completed: October 23, 2011	

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	The plan of care initiated on 3/26/11 and reviewed on 6/11, indicated the resident was to receive passive range of motion exercises to the elbow. There was no plan of care related to passive range of motion for the resident's lower extremities. There was no daily documentation completed to ensure the resident was receiving the passive range of motion. Interview with LPN #3 on 9/21/11 at 4:22 p.m., indicated there was no daily documentation for range of motion and restorative care. She further indicated there was no documentation for this resident to indicate if staff was completing on a daily basis. Interview with CNA #1 on 9/22/11 at 10:25 a.m., indicated that she takes it upon herself to try and provide range of motion to the resident's arms and legs. She does not know what the other staff members do. She indicated that she was told to document the range of motion on the CNA flow sheets but she indicated there was no area to document this. She indicated the flow sheets just basically address the resident's behaviors.			

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	2. On 9/20/11 at 9:40 a.m., Resident #12 was observed in her room. The resident had a palm protector in each hand. At 12:15 p.m., the resident was seated at a chair in the dining room table. The right hand palm protector had been removed while the resident was eating. At 1:18 p.m., 2:00 p.m. and 3:07 p.m., the resident was observed with the palm protectors in place to both hands. On 9/21/11 at 8:50 a.m., the resident was in the main dining room eating breakfast. The resident's palm protectors were not in use. The resident's right hand was clinched in a fist. At 10:00 a.m. and 11:23 a.m., the palm protectors were in place to both of the resident's hands. At 3:15 p.m., the palm protector to the resident's left hand was not in place. On 9/22/11 at 7:35 a.m., the palm protectors were in place to both hands. At 7:53 a.m., the resident was drinking coffee, the palm protectors were not removed. At 10:45 a.m., the palm protectors were in place to both hands. The record for Resident #12 was reviewed on 9/20/11 at 9:56 a.m. The resident's diagnoses included, but			

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	were not limited to, anxiety and dementia. The Minimum Data Set Assessment (MDS), dated 6/14/11, indicated the resident had a functional limitation in range of motion related to impairment on one side of the upper extremity. Passive range of motion and bed mobility had been coded for 7 days. The MDS Observation Period Restorative Log was completed in 6/11 for passive range of motion and bed mobility. The Joint Mobility Assessment, completed 10/28/10, indicated the resident's left hand/fingers were within full limits. The resident's right hand/fingers had moderate to severe joint mobility limitation. The assessment was last reviewed on 7/28/11, which indicated the resident maintained her joint mobility, no changes were noted, and refer to restorative. The plan of care, dated 6/14/11, indicated the resident had a care plan for bed mobility and passive range of motion to flex and extend the hip with straight knee. There was no care plan related to passive range of motion to the upper extremities as			

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	well as for the palm protectors. The 6/14/11 care plan narrative, indicated staff continued to perform passive range of motion exercises to bilateral lower extremities. There was no daily documentation to indicate if range of motion exercises were being provided. Interview with LPN #3 on 9/21/11 at 4:22 p.m., indicated there was no daily documentation for range of motion and restorative care. She indicated documentation was completed during the resident's assessment reference period. Interview with CNA #1 on 9/22/11 at 10:35 a.m., indicated the resident's palm protectors were in use at all times and removed at meals. She indicated that she had no CNA care card but a picture of the hand rolls were on a picture above the resident's bed. Observation of the picture above the head of the resident's bed did not indicate the frequency of how long the palm protectors were to be worn. Interview with LPN #1 on 9/22/11 at 2:10 p.m., indicated the resident did not have a formal order for the palm protectors and that they were usually			

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	on. She indicated she will try and range the resident's fingers when she puts on the palm protectors. She also indicated the resident's care plan did not address the palm protector and range of motion to her hands. The LPN removed the resident's palm protectors, the resident's right hand was contracted and she was unable to extend her fingers without discomfort. The middle and ring fingers on the resident's left hand were not able to be fully extended. 3. On 9/20/11 at 12:36 p.m., Resident #6 was observed sitting in a wheelchair at the table in the Main Dining Room. At that time, the resident was observed with two anti-contracture devices in both of his hands. Further observation indicated both hands and fingers were bent forward The record for Resident #6 was reviewed on 9/21/11 at 2:27 p.m. The resident's diagnoses included, but were not limited to, Depression, hemiplegia, dementia, and DJD (degenerative joint disease). Review of the Minimum Data Set (MDS) assessment, dated 7/24/11,			

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	indicated the resident had impairment to both sides for upper and lower extremities. The MDS assessment also indicated the resident was receiving passive range of motion through restorative therapy. Review of the current 7/24/11 Care plan indicated PROM (Passive Range of Motion) Limited range of motion of upper extremities with discomfort. The Nursing approaches were to have the resident lie in bed and perform range of motion. Start with the resident's arm at a 90 degree angle away from the body. Support the arm at the wrist and above the elbow joint. Gently lift the arm of across the body. Return his arm to the starting position and repeat gradually progress to 3-5 minutes. The resident's goal was to complete 25 repetitions two times a day. There was no Passive Range of Motion indicated for the resident's contracted hands and/or fingers on the current plan of care. Review of the Restorative Nursing range of motion assessment, dated 7/24/11, indicated no change in joint mobility and his joint mobility was maintained. The resident continues to use hand grips daily. Refer to			

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	restorative therapy. Review of the Monthly Nursing Summary, dated 5/16/11, (the only available one on the chart) indicated the resident receives restorative therapy and has contractures: two extremities affected. Review of Physician Orders the months of 6/11, 7/11, 8/11, and 9/11 indicated there were no Physician Orders for the anti-contracture devices or the passive range of motion. Interview with LPN #3 on 9/21/11 at 4:22 p.m., indicated there was only one care plan for PROM and that was for shoulder upper extremity range of motion. There was no care plan for range of motion to the fingers and hands. Further interview with the LPN indicated the only daily documentation they have for passive range of motion was the seven day documentation they do for the MDS assessment reference date. She indicated they do not do daily documentation of passive range of motion therapy. Interview with CNA #5 who was working the day shift on 9/22/11 at 8:37 a.m., indicated she does not			

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	have a CNA flow sheet that specifically indicates what needs to be done for each resident. The CNA indicated she thought that information was in the chart. She further indicated she only massages Resident #6's hands when he asks and it was not necessarily everyday. The CNA indicated sometimes it was twice a day, sometimes just one time, sometimes not at all. The CNA further indicated she was unaware of the resident's range of motion plan of care that was specific to him. Interview with CNA #1 who was working the day shift on 9/22/11 at 8:44 a.m., indicated there were no CNA flow sheets available. She indicated she did not specifically know what the resident's plan of care was for range of motion. The CNA indicated she massages the resident's hands for about 5 to 10 seconds before placing him in the bathtub every morning. After the bath she then replaces the splints to his hands. She indicated his splints were removed at night time before he goes to bed, because when she gets him up they are not on him. 3.1-42(a)(2)			

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to ensure a resident maintained acceptable nutritional status related to a significant weight loss that was not identified by the Registered Dietitian for 1 of 3 residents of the 3 who met the criteria for acceptable parameters of nutrition. (Resident #2) Findings include: 1. On 9/20/11 9/20/11 at 12:13 p.m., Resident #2 was observed sitting up in his wheelchair, eating his lunch all by himself. The resident was served 1 chicken leg, a bowl of chicken and dumpling soup, a bowl of cole slaw, a cup of fruit and green peas. The resident was observed to eat everything except the green peas. The resident also had a four ounce cup of juice and milk. On 9/21/11 at 5:36 p.m., the resident	F0325	ADDENDUM F Tag 325 MAINTAIN NUTRITIONAL STATUS1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 2 physician and family were notified of weight loss and resident is gaining weight with current treatment regime. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Every resident was re-weighed to ensure accuracy and weigh scale was recalibrated. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All residents will be weighed after return from hospitalizations and if weight loss is noted at risk protocol will be implemented (example: weekly weights, close monitor of food intake, dietary supplement if needed and	10/23/2011

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	was observed eating his supper meal. The resident was served a whole bologna sandwich, lettuce salad and jello. The record for Resident #2 was reviewed on 9/20/11 at 12:44 p.m. The resident's diagnoses included, but were not limited to, anemia, CHF, malnutrition, history of a stroke, and aphasia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 7/27/11, indicated the resident had no swallowing problems and chewing problems, his weight was 173 pounds and he was 78 inches tall. The resident had no history of a weight loss and was receiving a therapeutic diet. Review of the resident's weight history indicated the resident's recorded weight for June 2011 was 173 pounds. The resident was admitted to the hospital on July 6 for congestive heart failure and the recorded hospital weight was 150 pounds. The resident was receiving Lasix (a diuretic) 20 mg (milligrams) twice daily prior to the hospitalization. He continued to receive the Lasix 20 mg twice daily upon return from the hospital. The resident was sent back		appetite stimulant). An In-Service on Physician notification was presented to nurses. Physician Notification Policy, Change In Condition Policy, and Dietitian Referral & Recommendations Policy were reviewed on Friday, 10/7/11, and Wednesday 10/12/11 and copies of the policies given to each nurse. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. A nurse will be assigned to audit weekly and monthly weights and residents at risk for weight loss will be identified to the dietitian for referral and recommendations that will be implemented within 24-48 hours. Weekly reports of physician notification will be reviewed by D.O.N. and Medical Director on Wednesdays. Weekly weights will be reviewed with the Medical Director on Wednesdays if resident is at risk of weight loss and all other residents not at risk will be reviewed monthly. The Director of Nursing and or designee will audit and monitor change in condition in weights and dietician recommendations monthly times 3 months then quarterly for 6 months. . QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	

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	to the facility on July 7, 2011 with the recorded weight of 146 pounds. Further record review indicated the resident was having trouble breathing with shortness of breath and was readmitted back into the hospital on July 8, 2011 and returned back to the facility on July 14, 2011. Review of the Nursing Admission Summary, dated 7/14/11, indicated the resident weighed 184 upon readmission to the facility. The hospital discharge notes, dated 7/14/11, indicated the last recorded weight was 185 pounds, it did not indicate on which date the weight was obtained. Review of the Dietary Food Manager notes, dated 7/12/11, indicated the resident's current weight was 173 pounds, and that he consumes 75% -100% of all meals that were served each day. His appetite was good and his intakes were good. The resident did not need assistance with eating. Review of the Registered Dietitian (RD) note, dated 7/17/11, indicated the RD to follow up after readmission. The resident was readmitted following hospitalization for shortness of breath. The RD addressed the resident's current diet order regular pureed, his			

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	medications, and two small skin tears. The RD did not address any of the weight fluctuations or recommend another weight to check for accuracy. The RD recommended to change the resident's diet to regular. Review of Physician orders, dated 7/14/11, indicated the resident was started on Megace (an appetite stimulant) 200 milligrams daily. Physician orders, dated 7/17/11, indicated the resident's diet was changed to regular. There were no other supplements ordered for the resident from 7/17-8/14/11. Review of the resident's weight record indicated the resident's recorded weight on 8/9/11 was 171 pounds. There was no other weights recorded. The resident had 13 pound weight loss in one month. Further record review indicated the RD was not notified of the weight loss. Review of Nursing Progress Notes, dated 8/14/11, indicated the resident was having chest pain and difficulty breathing and was admitted to the hospital with the diagnosis of pneumonia. The resident was readmitted back to the facility on 8/21/11.			

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	Review of discharge summary from the hospital, dated 8/21/11, indicated the resident's weight was 131 pounds. The next recorded weight was on 9/9/11 which indicated the resident weighed 133 pounds. Review of Dietary Progress Notes indicated the first documented entry completed by the RD was not until 9/11/11 (21 days after the resident had returned from the hospital). The RD note indicated it was a readmission note following evaluation of chest pain. The RD addressed the resident's medications, his food intakes, and an open area on the resident's coccyx. The RD indicated the resident was currently on a pureed diet. There was no documentation regarding the resident's weight loss. The RD did not address the resident's weight at all. The RD recommended to change the resident's diet to regular, offer supercereal every morning, and do weekly weights through September. The next documented entry by RD was on 9/17/11, which indicated it was a follow up with the supercereal and the clarification of the resident's diet. Again there was no documentation regarding the resident's weight loss.			

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	Review of Physician Progress Notes, dated 7/20/11, indicated the resident was hospitalized for CHF and was out for a week and doing ok. Review of Physician Progress Notes, dated 8/31/11, indicated the resident returned from the hospital after having pneumonia. Review of Physician Orders, dated 9/11/11, indicated to discontinue the pureed diet and change to regular and add supercereal for the breakfast meal. The resident was to have weekly weights throughout month of September. The last recorded weight for the resident was on 9/2011, which indicated he weighed 134 pounds. Interview with LPN #1 on 9/20/11 at 2:53 p.m., indicated she did not think the resident's weights were accurate from month to month. She indicated there was only one scale in the facility and it was a chair scale that the resident had to sit on. She also indicated she did not know when the scale was last calibrated. She indicated she was aware of the weight losses, and could not understand the accuracy of the weights from the			

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	hospitalizations and with the facility's weight. The LPN indicated there were no other supplements ordered for the resident, nor had the RD addressed the resident's weight losses. She further indicated there were no reweighs obtained from all of the recorded losses. 3.1-46(a)(1)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure there was an indication for the continued use of	F0329	ADDENDUM329 Unnecessary Drugs 1 What corrective action will be accomplished for those residents found to have been	10/23/2011

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	an anti-anxiety medication for 1 of 10 residents who were reviewed for unnecessary medications. (Resident #12) Findings include: The record for Resident #12 was reviewed on 9/20/11 at 9:56 a.m. The resident's diagnoses included, but were not limited to, anxiety, dementia, and depression. A Pharmacy Recommendation, dated 5/9/11, indicated the resident was receiving Ativan (an anti-anxiety medication) 1 milligram (mg) daily. The pharmacy recommendation was for a dose reduction to 0.5 mg daily. There was a check mark in the "yes" column and then it was crossed out and documentation indicated the resident was in the hospital. The form was signed by the physician on 5/11/11. The resident was readmitted to the facility on 5/17/11 with an order for Ativan 2 mg by mouth daily. The CNA flow sheets for the months of July and August 2011, indicated the resident had no episodes of documented behaviors. The resident had one episode of documented		affected by the deficient practice? Resident 12 The physician was informed of dose reduction prior to hospitalization of .5mg Ativan and upon return 2mg Ativan. Dose reduction to .5mg was ordered and resident is being monitored due to dose reduction. Family was notified of medication change. . 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Charge nurse will monitor doses upon hospital return with medication dose prior to hospitalizations in reference to psychotropic medication. The pharmacist consultant will continue to review all of the physician orders for unnecessary drugs and will make recommendations as needed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An Unnecessary Drug In-Service was presented to nurses on Wednesday 10/12/11. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The consultant pharmacist will review physician orders monthly Director of Nursing and or designee will review and audit physician orders for unnecessary medications weekly times 4 weeks then monthly for 3 months then every 6 months. QA will review audits quarterly and make	

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	behaviors on the day shift on 9/3/11. Interview with LPN #1 on 9/22/11 at 2:10 p.m., indicated that she was not sure why the resident's Ativan had not been reduced after her return from the hospital. She further indicated behaviors were to be documented on the CNA flow sheets. Interview with the Pharmacist on 9/21/11 at 11:00 a.m., indicated she would initiate another recommendation to the physician to decrease the Ativan. 3.1-48(a)(4)		recommendation as needed. 5. Date completed: October 23, 2011	

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F0334 SS=D	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes			

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	documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview, the facility failed to ensure the influenza vaccine was offered to 1 of 5 alert and oriented residents who resided in the facility. (Resident #14) Findings include: On 9/22/11 at 2:30 p.m., interview with the Director of Nursing indicated that all the residents in the facility refused the flu vaccine last year. Review of the flu and pneumonia consent book on 9/22/11 at 2:45 p.m., indicated the families and/or residents were informed of the information but all declined the flu vaccine. Review of the consent form for Resident #14,	F0334	ADDENDUMF 334 INFLUENZA & PNEUMOCOCCAL IMMUNIZATION 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Influenza and Pneumococcal Vaccine will continued to be offered every year during flu season, October 1-March 31 to every resident. Resident #14 will be offered the 2011-2012 influenza vaccine and once consent is signed she will receive the vaccine. All cognitive residents and families are explained the influenza vaccine and are offered the vaccine.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other	10/23/2011

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	indicated the resident's son refused the flu vaccine for his mother. Interview with Resident #14 on 9/23/11 at 9:00 a.m., indicated that she had always taken the flu shot and she would never refuse. The resident did not remember being offered the flu vaccine last year. The resident was identified as being alert and oriented. Resident #14's record was review on 9/20/11 at 10:00 a.m. The resident had diagnoses that included, but were not limited to, diabetes and arthritis. The Quarterly MDS (minimum Data Set) assessment, completed on 7/7/11, was reviewed. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 14, indicating she was cognitively intact. The facility policy titled "Influenza/Pneumococcal Immunization-Informed Consent" was provided by the Director of Nursing and identified as current. The policy was reviewed on 9/23/11 at 9:30 a.m. The policy indicated if the resident was competent and consents to be vaccinated, obtain the resident's signature and date. If the resident was not competent or otherwise unable to sign, obtain the signature		resident's affected.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A Social Service In-Service held on proper consent and authorization of influenza vaccine and all cognitive residents may make their own decision and family members will be informed of their decision. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Social Service will maintain a log of consent forms and refusal to the influenza and pneumococcal immunization records. This log will be reviewed by the D.O.N. during flu season monthly during the months of October to March of each year.QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	

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	and date of the resident's representative. Interview with the Social Service Designee on 9/23/11 at 10:00 a.m., indicated the resident should have been asked if she wanted the flu vaccine rather than her son. 3.1-13(a)			
F0363 SS=F	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interview, the facility failed to ensure the planned menu was followed as directed by the Registered Dietitian related to serving the menued sandwich and ensuring the mechanical and pureed diets received the menued items for 1 of 5 pureed diets served and for 1 of 5 mechanical diets served. (Residents #5 and #6) This had the potential to effect 22 residents who resided in the facility. Findings include:	F0363	ADDENDUM F 363 MENUS 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? To hire a new dietary staff member to take the place of current cook. Resident #5 and #6 will be served meals according to the planned menu.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All pureed diets will be served the planned pureed menu listed on spread sheet for the	10/23/2011

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	During observation of the supper meal on 9/21/11 at 5:25 p.m., the main menu was observed posted on the wall in the Main Dining Room. The menu indicated the supper meal for that day was supposed to be a salami sandwich, lettuce salad, and jello. The pureed and mechanical diets were to receive the same thing but with tomato juice rather than the lettuce salad. At 5:28 a.m., the first tray was passed to the residents in the dining room. The residents received a bologna sandwich, lettuce salad, and jello. Interview with the Dietary Cook at that time, indicated he used the bologna because he did not have salami. He further indicated he did not change the menu that was posted in the dining room to ensure the residents were aware of the menu change. Continued observation indicated Resident #6 received a ground bologna sandwich and a bowl of jello. Resident #6's tray card indicated he was to receive a mechanical diet with ground meat. He did not receive a glass of tomato juice. Further observation indicated Resident #5		week.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The dietary staff will serve the menu as planned. All menus were reviewed by the dietician and an in-service will be held by the dietician prior to 10/23/11.In-services will be ongoing until they fully retain information given. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Menu served log will be used daily and monitored daily by administrative designee for 1 month then quarterly for 6 months. Menu served log will be monitored bi-weekly by the dietician. Ongoing in-services will continue to be done and reminders will be placed on the serve tray line. Search for new dietary staff will be initiated, but until new staff can be hired this cook will be monitored during each meal he serves to ensure compliance.QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	

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	received a hot brown pureed meat, and a hot orange pureed vegetable. Resident #5's tray card indicated he was to have a pureed diet. The resident did not receive any of the menued items. Interview with the Dietary Cook at the time, indicated there was no tomato juice to serve the residents so he gave them apple or cranberry juice, he did indicate he knew the tomato juice was on the menu to be served. Further interview with the Dietary Cook, indicated the hot pureed meat and hot pureed vegetable were left out for him to serve to the pureed diets. He indicated it was turkey loaf and mixed vegetables that was left over from lunch . He further indicated all the mechanical ground meat diets did not receive any tomato juice and all of the pureed diets received the left over turkey loaf and mixed vegetables from the lunch meal. Interview with the Dietary Food Manager on 9/22/11 at 7:35 a.m., indicated he was not aware the residents did not receive the tomato juice last night, he also indicated he prefers the residents who eat the pureed diets to have something warm. He indicated he did not have a recipe to puree the salami			

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	sandwiches, he further indicated the recipe books were from the old dietitian somewhere in an office and he did not have new recipe books from this dietitian. 3.1-20(i)(4)			
F0368 SS=F	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on observation and interviews, the facility failed to ensure the breakfast meal was promptly served at 7:30 a.m., for 3 of 3 breakfast meal observations. This had the potential to effect 22 residents who resided in the facility. Findings include:	F0368	ADDENDUM F 368 FREQUENCY OF MEALS 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will schedule new menu time schedule to ensure there is no more than 14 hours between the evening meal and breakfast. 2. How other residents having the potential to be affected	10/23/2011

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	1. On 9/19/11 at 7:20 a.m., the Dietary Food Manager was observed in the kitchen preparing the breakfast meal. He indicated at that time, that he had not made the eggs or the oatmeal. The bacon was the only item finished in which he had just pulled out of the oven. Observation during the breakfast meal on 9/19/11 at 8:20 a.m., indicated the residents were observed seated at their tables with coffee and water in front of them. The first breakfast tray to come out of the kitchen was served at 8:35 a.m., (1 hours and 5 minutes late). Observation on 9/20/11 at 8:23 a.m., indicated the first breakfast tray was brought out of the kitchen and served to the residents. This was 53 minutes late. On 9/22/11 at 7:30 a.m. residents were observed to be seated in the dining room waiting for breakfast to be served. On 9/22/11 at 7:33 a.m., the Dietary food manager was observed preparing the breakfast meal. He indicated the grits were cooked and on the steam table, the pancakes were almost done, and he was		by the same deficient practice will be identified and what corrective action will be taken. Everyone was affected my the time schedule of meals. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-services will be scheduled on importance of serving meals on time and no more than 14 hours should be between the evening meal and breakfast. . 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The dietician will monitor the time schedule of mealtime bi-monthly. Administrator/Administrative Designee will monitor the time of meals being served and place the time on a log sheet. Administrator will determine the change in mealtime. Q.A. committee will monitor the resident response and determine if new mealtime is effective. This will be reviewed monthly and then quarterly thereafter.5. Date completed: October 23, 2011	

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	preparing the superceral. He also indicated the ham was still in the oven and he needed to puree the ham. At 8:04 a.m., the Dietary Food Manager was observed pureeing the ham. The first breakfast tray out the kitchen and passed to the residents was at 8:10 a.m. Interview with the Administrator on 9/22/11 at 1:23 p.m., indicated she was unaware the breakfast meal was not starting at 7:30 a.m. She further indicated that the Dietary Food Manager had recently complained the residents were not in the dining room at 7:30 a.m. and ready to eat. 3.1-21(c)			
F0371 SS=F	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 Based on observation and interview, the facility failed to ensure food was served under sanitary conditions related beard restraints and soap in the dispenser for 1 of 1 kitchen areas. (The Main Kitchen) This had the potential to effect 22 residents who resided in the facility.	F0371	ADDENDUM F 371 FOOD SANITATION 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Beard covers were purchased for cooks who have beardsCustodian replaced soap in dispenserCook labeled butter in cooler with a	10/23/2011

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	Findings include: During the Full Kitchen Sanitation Tour on 9/21/11 at 11:37 a.m., the following was observed: A. There were 18 pads of butter floating in a bowl of melted ice water in the reach in cooler. There was also a tan liquid substance in a large container with no label or date on it. B. There was no hand soap or soap in the dispenser by the handwashing sink. C. The Dietary Food Manager was observed preparing the noon meal without a beard guard in place, therefore his facial hair was exposed to the food. Interview with the Dietary Food Manager at the time, indicated the butter pads were left over from breakfast, the unidentified substance was applesauce but did not have a label or date on it, and there should be soap in a dispenser at the handwashing sink. 3.1-21(i)(3)		dated label.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficient practices relative to food sanitation noted.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-services will be ongoing until they fully retain information given. Custodian will monitor soap dispenser and hand sanitizers daily according to his work log. Hand-washing and universal signs will be used as reminders for staff. In-service will be held with dietary staff on universal precautions, beard covers and proper labeling of food items in storage according to facility policy and daily work log sheet. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. All sanitation rules and menu served logs were reviewed by the dietician during in-services on 10/21/11 Menu served log will be used daily and monitored daily by administrative designee times 2 months then quarterly for 6 months. This log will be used to ensure proper labeling of food items in storage areas. Universal Precautions and Hand washing in-services will be done quarterly and as needed by D.O.N.	

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			designeeQA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	
F0425 SS=E	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure a vial of Tuberculin was discarded 30 days after opening as per the manufacturer guidelines in 1 of 1 Medication Room. This deficient practice had the potential to affect all new admissions requiring tuberculin testing and current residents scheduled for annual testing from 9/16/11 through 9/22/11. (The Main Medication Room)	F0425	ADDENDUM F 425 PHARMACEUTICAL 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Pharmacist removed and destroyed expired TB solution.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficient practices noted at this time.3. What measures will be put into place or what systemic changes	10/23/2011

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	Finding include: Medications in the refrigerator of the Main Medication Room were checked on 9/22/11 at 10:23 a.m. There was an opened vial of Tuberculin solution stored on a tray in the refrigerator. The date opened of 8/17/11 was written on the Tuberculin. The manufacturer's instructions in the carton the Tuberculin vial was stored in indicated a vial in use for more than 30 days should be discarded due to the possible oxidation and degradation which could affect the potency. When interviewed on 9/22/11 at 10:23 a.m., the facility consultant Pharmacist indicated the vial should have been discarded 30 days after it was first opened. 3.1-35(o)		will be made to ensure that the deficient practice does not recur. In-services will be held for nursing staff to monitor refrigerator monthly and remove expired medication. Log sheet will be made to indicate when vials are opened and placed on the refrigerator door. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Charge nurse will label and date when medication vial is opened and place date on log sheet. One nurse will be assigned to monthly removal of expired medication.Pharmacist will monitor for expired medication monthly. D.O.N. will monitor monthly.QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	

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F0441 SS=E	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure hand washing was completed after the removal of gloves during incontinence care for 1 of 1 residents	F0441	ADDENDUM F 441 INFECTION CONTROL 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? RN#1 was	10/23/2011

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	observed for incontinence care. The facility also failed to ensure a blood sugar testing machine (glucometer) was disinfected between resident use for 2 of 6 residents with physician orders for glucometer testing. This deficient practice had the potential to affect 6 of 6 residents with orders for glucometer (blood sugar testing) of the total of 22 residents in the facility. (Residents #1, #8, and #18) (RN #1 and CNA #3) Findings include: 1. On 9/21/11 at 5:56 a.m., RN # 1 was observed preparing to perform a glucometer test (a test to check blood sugar levels) for Resident #18. The RN cleansed her hands, put on disposable gloves, and inserted a test strip into the glucometer device. The RN then stuck the resident's finger with a lancet to obtain a blood sample. The end of the test strip that came into contact with the resident's blood did not come into direct contact with the glucometer device. When the test was completed, the RN exited the resident's room with the glucometer device. The RN placed the glucometer device into the Medication Cart without cleansing it.		provided with the Assure Platinum Blood Glucose Monitoring System procedure manual. A review of the Disinfecting Guidelines was discussed and she was able to perform the proper mixture of disinfecting solution and clean the accu-check machine after each use. C.N.A. #3 was in serviced about incontinent care and hand washing procedure and copy of policy was given to C.N.A. #3. C.N.A.#3 was shown all of the hand washing procedures located throughout the facility with emphasis on washing hands after providing incontinent care.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All nurses were asked about the Disinfecting Procedures of the Accu-Check Machine and were able to state proper procedure. No residents are exhibiting any signs of blood pathogen infections. .All C.N.A.'s were interviewed and asked the procedures for providing incontinent care to residents and proper hand washing procedure. All C.N.A.'s were able to state incontinent care and hand washing procedures properly. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An In-Service on	

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	RN #1 was interviewed at the time she placed the glucometer device back into the Medication Cart without cleaning it. The RN indicated she uses an alcohol wipe pad to wipe the machine and this is done about every other day or sometimes between residents. The RN indicated this was not done every time. RN #1 indicated the facility has a policy related to cleaning the device, but she had not read it On 9/21/11 at 6:13 a.m., RN#1 located the glucometer policy book in the cabinet at the Nurses' Station. The book was titled "Assure Platinum Blood Glucose Monitoring System." The policy indicated healthcare professionals were to clean and disinfect the meters between each resident test to avoid cross-contamination. The Disinfecting Guidelines indicated the device was to disinfected with a bleach solution, bleach wipe, or a germicidal disposable wipe. When interviewed at this time, the RN indicated she was not aware the machine had to be disinfected with a bleach solution or germicidal between residents. RN #1 indicated she had used the glucometer to test Resident #1's blood glucose prior to using the device to test Resident #18's blood		Disinfecting Guidelines for Accu-Check machine was given to licensed nurses followed by return demonstration. A copy of the policy was given to each licensed nurse. Sani-Cloth Germicidal Disposable Wipes were purchased to ensure proper cleaning of the accu-check machine and bleach solution will be used if Sani-Cloth is unavailable.An In- Service on Incontinent Care was provided to all nursing staff. Each charge nurse will evaluate C.N.A.'s for proper incontinent care and hand washing technique. and problems reported to D.O.N. All nursing staff received a copy of Incontinent Care Policy and Hand washing Policy on Friday, 10/7/11.4. How the corrective action will be monitored to ensure the deficient practice will not recur. Sani-Cloth Germicidal Disposable Wipes will be used to clean accu-check machine and all charge nurses were in serviced on procedure. Pharmacy Consultant will monitor proper cleaning of Accu-Check Machine quarterly. D.O.N. will monitor germicidal cleaning of machine on every shift weekly times 4 weeks then quarterly for 6 months then as needed thereafter.The charge nurse will complete and evaluation of C.N.A.'s incontinent care and hand washing procedure on every C.N.A. of all assigned shift.	

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	glucose and she did not disinfect the device between using it on the above two residents. After the RN read the guidelines for disinfecting the glucometer, she obtained a bleach solution and disinfected the glucometer as required. The current "Diabetic Flow Records Med Book" was reviewed on 9/21/11 at 6:30 a.m. There were a total of (6) residents with current physician orders for glucometer testing. All of the glucometers were to be done by the night shift nurse at 6:00 a.m. or 7:00 a.m. There was only one nurse working on the night shift on 9/21/11. Review of the records for the six residents receiving glucometer readings, indicated there were no diagnose of infections with blood born pathogens. Review of the infection control logs on 9/20/11, indicated no infections with blood born pathogens were identified in the past 6 months. During initial tour of the facility on 9/19/11 at 7:15 a.m., no residents requiring isolation were identified.		The D.O.N. will evaluate incontinent care and hand washing procedure of charge nurses and C.N.A.'s quarterly for 6 months then as needed. All new hires for the nursing department will have the Incontinent Care and Hand washing Evaluation Form added to orientation packet. . QA committee will review audits quarterly and determine of audits to continue or if changes need to be made. 5. Date completed: October 23, 2011	

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	When interviewed on 9/21/11 at 10:20 a.m., the Director of Nursing indicated the blood glucose testing machine should be disinfected between resident use as per the policy. 2. Incontinence care for Resident #8 was observed on 9/20/11 at 1:25 p.m. CNA #3 provided incontinence care for the resident. The CNA transferred the resident from the geri-chair to the bed. She applied gloves and then removed the resident's soiled brief. She applied a clean brief to the resident. She then transferred the resident to the geri-chair. She put the lap tray on the chair. The CNA then removed her gloves and walked out of the resident's room. She did not wash her hands with soap and water after removing the gloves and prior to leaving the resident's room. The undated policy, titled "Hand Washing Policy" was provided by the Director of Nursing on 9/21/11. She indicated the policy was current. The policy indicated, "Indications for anti-bacterial soap and water hand hygiene -contact with resident's skin -contact with environmental surfaces in the immediate vicinity of residents -after glove removal" Interview with the Director of Nursing			

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	on 9/22/11 at 10:05 a.m., indicated the CNA's were to wash their hands with soap and water after gloves were removed and after incontinence care was provided. 3.1-18(b)(4) 3.1-18(l)			