

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155665	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2015
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NAME OF PROVIDER OR SUPPLIER  JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00171141.</p> <p>Complaint IN00171141 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 6, 7, 8, 11, 12, and 13, 2015.</p> <p>Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210</p> <p>Census bed type: SNF/NF: 106 TOTAL: 106</p> <p>Census payor type: Medicare: 6 Medicaid: 68 Other: 32 Total: 106</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals, who draft or may be discussed in this response of this plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction as a condition to participate in Title, 18, and Title 19 programs. The submission of the plan of correction should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. The Facility respectfully requests a desk</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 159 SS=E Bldg. 00	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal</p>		review.	

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	<p>representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure residents had ready access to petty cash from their personal funds account, after normal business hours, for 83 residents who had a personal funds account out of 106 residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview on 5/11/2015 at 9:02 A.M., the Business Office Manager (BOM) indicated that the receptionist has a cashbox and can get money for the residents during "normal banking hours." These hours were from 8:30 A.M. to 4:00 P.M., Monday through Friday and 8:30 A.M. to 12:00 P.M. on Saturday. The BOM further indicated that if the receptionist was not there during those hours that someone else can access the money during the normal banking hours, but there was no way for the residents to get money outside of the banking hours.</p>	F 159	<p>1.No resident was identified.</p> <p>2.Residents with a personal fund account have the potential to be affected by this alleged deficient practice. A locked cash box system for 24-hour access to personal funds was put into place on May 13, 2015.</p> <p>3.The Executive Director (ED) will re-educate the Business Office Manager (BOM), nursing staff, and the Admissions Coordinator on the facility's Banking Hours policy by June 05, 2015. A locked cash box system in med room will be maintained for 24-hour access to personal funds by June 05, 2015. The admission packet will include notification to residents regarding banking hours and/or access to personal funds by June 05, 2015. A resident council meeting will be held by June 05, 2015 to inform residents of the availability of their personal funds and how to access them.</p> <p>4.BOM/Social Services Director (SSD)will conduct Quality Improvement (QI) monitoring for</p>	06/12/2015

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	<p>During an interview on 5/11/2015 at 9:34 A.M., Receptionist #5 indicated the hours for residents to get money were 8:30 A.M. to 4:00 P.M. and staff tried to be accommodating if a resident comes a little late and needs money. Receptionist #5 also indicated that Sunday was the only day the residents would not have access to their personal funds.</p> <p>During an interview on 5/11/2015 at 9:46 A.M., RN #3 indicated that no money was kept in the medication carts at night for residents who may need money after the banking hours.</p> <p>During an interview on 5/11/2015 at 2:44 P.M., the Administrator indicated the residents did not have access to petty cash at night or on Sunday.</p> <p>The current policy and procedure for "Banking Hours (Patient Trust Fund)", dated 11/30/2014, was provided by the Administrator on 5/11/2015 at 1:46 P.M. The document indicated, "...The facility will establish "banking hours" to allow patients to have access to their patient funds through the day, during regular business working hours, and for a reasonable time on weekends..."</p> <p>The current admission packet was</p>		<p>the regulation F159 to ensure residents have ready access to their personal funds. QI monitoring will be conducted via interview five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The BOM/SSD will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring. Director of Clinical Services (DCS)/Nurse Manager will conduct Quality Improvement (QI) monitoring for regulation F159 to ensure that locked cash system is in place and admission packets contain banking hours information. QI monitoring will be conducted via observation five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>5.Date of Compliance: June 12, 2015.</p>		

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F 242 SS=D Bldg. 00	<p>provided on 5/11/15 at 1:58 P.M. by the Administrator. The admission packet did not include any notification to residents regarding the restricted banking hours and/or limited access to their personal funds.</p> <p>3.1-6(f)(1)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure that resident choices were honored regarding bathing preferences for 1 of 3 residents reviewed for choices of the 6 residents who met the criteria for choices. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's Annual Minimum Data Set (MDS) assessment, dated 04/10/2015, was reviewed on 05/07/2015 at 10:38 A.M. The assessment indicated the resident's preferences for choosing</p>	F 242	<p>1. The nurse tech kardex and the bath schedule were updated on 5/26/2015 to reflect Resident C's preferences for bathing.2. All residents have the potential to be affected by this alleged deficient practice. A licensed nurse/SSD will interview in-house residents with a Brief Interview Mental Status (BIMS) score of 8-15 for satisfaction with bathing schedule by June 05, 2015. Any discrepancies identified will be corrected immediately.3. The DCS/Nurse Manager will re-educate the nursing staff on the facility's bathing policy and on</p>	06/12/2015

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	<p>between a shower, bed bath or sponge bath was very important.</p> <p>During an interview on 05/08/2015 at 9:19 A.M., Resident #C indicated the current bathing schedule was not being followed and the requested bathing did not occur. Resident #C indicated the staff had been advised of a request for daily bathing a long time ago.</p> <p>The shower schedule, provided by the DON on 05/12/2015 at 1:15 P.M., indicated Resident #C was scheduled to be showered on Monday, Tuesday, Wednesday, and Friday. The shower schedule notation indicated the resident wanted a shower and hair wash offered every other day and a bed bath daily.</p> <p>Review of the Activities of Daily Living (ADL) flow sheet log, provided by the Assistant Director of Nursing (ADON) on 05/12/2015 at 10:55 A.M., indicated Resident #C received a shower on the following dates:</p> <p>4/01/2015 4/04/2015 4/06/2015 4/15/2015 4/17/2015 4/20/2015 4/21/2015</p>		<p>the regulation F242 by June 05, 2015.4. The Social Services Director (SSD)/Nurse Manager will conduct QI monitoring of the regulation F242 to ensure resident choices were honored regarding bathing preferences. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The SSD/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.5. Date of Compliance: June 12, 2015</p>		

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	<p>4/24/2015 4/27/2015 4/29/2015 5/01/2015 5/04/2015 5/07/2015 5/11/2015</p> <p>The ADL flow sheet log indicated Resident #C received a bed bath on the following dates:</p> <p>4/06/2015 4/21/2015 4/22/2015</p> <p>During an interview on 05/12/2015 at 12:32 P.M., the Director of Nursing (DON) indicated Resident #C had requested an increase in bathing in June, 2014. The DON indicated Resident #C had a bathing care plan in place and the resident was to be offered a shower every other day and a bed bath daily.</p> <p>During an interview on 05/12/2015 at 1:01 P.M., the Administrator indicated Resident #C had refused showers on several occasions. The Administrator indicated, after looking through the resident's chart, she did not see any bathing refusals documented.</p> <p>3.1-3(u)(1)</p>			

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F 244 SS=E Bldg. 00	<p>3.1-3(u)(3)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to respond to and resolve grievances brought forth by the Resident Council in a timely manner for 5 of 11 months reviewed.</p> <p>Findings include:</p> <p>The Resident Council President was interviewed on 05/11/2015 at 10:56 A.M. The President indicated the residents voiced grievances at the meetings, which are held monthly. The President indicated some of the grievances discussed included food quality, food preferences and bingo. The President indicated the facility currently offered bingo twice a week but it used to be offered daily. She indicated the residents had requested more soup and this request</p>	F 244	<p>1. No resident was identified. On May 13, 2015 soup was added to the menu to occur more often. Soup will also be offered as an alternative choice item on the menu. Bingo preferences brought forth by resident council will be resolved by June 05, 2015 and reflective with the Activity Calendar. 2. All residents have the potential to be affected by this alleged deficient practice. The Executive Director (ED) will review 5 months of resident council meeting minutes for unresolved grievances. Any identified will be addressed immediately. 3. Resident council process will be changed to: any concerns addressed during resident council meeting will be placed on concern form and forwarded to appropriate department manager for timely resolution. The ED will educate the Activities Director and</p>	06/12/2015

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	<p>had occurred over multiple months without being resolved by the facility staff. The President indicated when grievances were voiced at the meetings, those grievances were turned over to the appropriate facility staff for review.</p> <p>The Resident Council Minutes from June, 2014 to April, 2015 were provided by the DON (Director of Nursing) on 05/11/2015 at 11:57 A.M. with the permission of the Resident Council President. The minutes included the following:</p> <p>Meeting minutes, dated 10/27/2014, indicated "New Business" issues discussed included residents' request for an increase in soup on the menu.</p> <p>Meeting minutes, dated 12/29/2014, indicated "New Business" issues discussed included residents' request for more soup choices and bingo once a day.</p> <p>Meeting minutes, dated 01/26/2015, indicated, under "Old Business", bingo was scheduled daily at 2:30 P.M. Issues discussed under "New Business" included, but was not limited to, burned grilled cheese being served to residents, resident requests for soup and food quality concerns.</p>		<p>department managers on the process for concerns from resident council and the facility's policy on resident-related concerns/grievances by June 05, 2015.4. The SSD/ED will conduct QI monitoring of the regulation F244 to ensure grievances brought forth by the resident council are responded to and resolved in a timely manner. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months. The SSD/ED will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.5. Date of Compliance: June 12, 2015</p>	

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	<p>Meeting minutes, dated 03/30/2015, indicated "New Business" issues discussed included residents' request for soup and residents' request for an increase in bingo, as it was no longer scheduled everyday.</p> <p>Meeting minutes, dated 04/24/2015, indicated "New Business" issues discussed included residents' requests for "soup of the month".</p> <p>The current facility menu (a four week, rotating menu) was provided by the Dietician on 05/11/2015 at 1:46 P.M. Soup was on the menu for 5 of 56 meals (lunch and supper).</p> <p>During an interview on 05/12/2015 at 3:13 P.M., the Dietary Manager (DM) indicated the current menus are on a four week, rotating, cycle and the same menus are repeated every four weeks. The DM indicated the current four-week menu had been in place since December, 2014.</p> <p>3.1-3(1)</p>			

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F 272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p> <p>Based on interview, observation and record review, the facility failed to ensure</p>	F 272	1. Resident #151 had an oral assessment completed by a licensed nurse on May 13,	06/12/2015

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	<p>a dental assessment was completed upon admission to the facility for 1 of 3 residents reviewed for Dental Status and Services of the 7 residents who met the criteria for Dental Status and Services. (Resident #151)</p> <p>Finding includes:</p> <p>An interview was conducted with Resident #151 on 05/07/2015 at 3:25 P.M. The resident indicated dental work was needed, which included extraction of multiple teeth.</p> <p>During an interview on 05/11/2015 at 2:59 P.M., the Administrator indicated the MDS (Minimum Data Set) Coordinator performed all physical assessments for MDS reports.</p> <p>During an interview on 05/11/2015 at 3:10 P.M., the MDS Coordinator indicated the nurses on the floor do the physical evaluations for the MDS assessments.</p> <p>During an interview on 05/12/2015 at 10:11 A.M., Resident #151 indicated the current dental status included a partial plate on the top with some natural teeth left on the top and on the bottom.</p> <p>During an interview on 05/12/2015 at</p>		<p>2015.2. All residents have the potential to be affected by this alleged deficient practice. The Director of Clinical Services (DCS)/Nurse Manager will review in-house residents for a dental assessment. Any issues identified will be corrected immediately.3. The DCS will re-educate licensed nurses on completing dental assessments upon resident admission by June 05, 2015.4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F272 to ensure a dental assessment was completed upon admission to facility. QI monitoring will be conducted five times weekly for four weeks, three times weekly for four weeks, weekly for four weeks, then monthly for three months. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.5. Date of Compliance: June 12, 2015.</p>				

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	<p>10:33 A.M., the unit manager indicated a resident's dental status was evaluated during their admission assessment by the admitting nurse. The unit manager indicated the admitting nurse asks the resident if they have any dental issues and looks into the resident's mouth for potential issues.</p> <p>During an interview on 05/13/2015 at 10:53 A.M., LPN (Licensed Practical Nurse) #1 indicated, on admission, residents are asked if they have any mouth pain or dental issues followed by a visual evaluation of the mouth.</p> <p>An observation and record review was conducted on 05/13/2015 at 11:11 A.M. LPN #1 completed an oral assessment with Resident #151's permission. The Interdisciplinary Progress Note, completed by LPN #1, indicated the resident's oral mucosa was moist and pink, teeth were natural on bottom with chips and decay present, upper partial plate of front teeth with natural teeth present at jaw, also with evidence of fillings and decay.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 04/08/2015, was reviewed on 05/11/2015 at 6:55 A.M. Current diagnoses included, but were not limited to, hypertension,</p>			

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F 371 SS=E Bldg. 00	<p>gastroesophageal reflux disorder and depression. The Brief Interview for Mental Status score of 11, indicated moderate cognitive impairment. The assessment further indicated Resident #151 had no dental problems. The Care Area Assessment under Dental Care was unmarked in the MDS.</p> <p>3.1-31(c)(9)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to provide a clean and sanitary kitchen related to the cleanliness of the meat slicer cart, improper drying of a skillet, flour scoop handle lying in closed flour bin, and condensation in the large walk-in freezer for 2 of 2 kitchen observations.</p> <p>Findings include:  During the initial kitchen tour on 05/06/2015 at 10:30 A.M., with the</p>	F 371	<p>1. The area under food preparation area/meat slicer was sanitized thoroughly on May 06, 2015. The skillet was sanitized and properly dried on May 06, 2015. The scoop was removed from flour, contaminated flour discarded, and scoop properly sanitized on May 06, 2015. Maintenance was made aware of need for de-icing of freezer on May 06, 2015. 2. All residents served from the kitchen have a potential to be affected by this alleged deficient practice. The Dietary Manager(DM)/ED will complete a sanitation audit of kitchen completed to identify any</p>	06/12/2015

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	<p>Dietary Manager, the following were observed:</p> <ol style="list-style-type: none"> <li>1. The meat slicer was covered with a clear plastic cover. Under the meat slicer was an area of six inches by one inch of a dark red liquid substance and several small quarter inch pieces of pink to brown particles.</li> <li>2. On the end of the back compartment sink was a large clean skillet lying directly on a flat, white, cloth towel to dry.</li> <li>3. In the dry storage room, a clear plastic bin containing flour was closed with a plastic scoop inside, lying flat, with the handle directly touching the flour.</li> <li>4. In the large walk in freezer area, condensation was observed on the ceiling with several quarter size spots covering a two foot area and an ice formation one and a half inches long hanging off of the right sprinkler head.</li> </ol> <p>During an observation in the kitchen on 05/11/2015 at 11:18 A.M., with the Corporate Dietary Manager, the meat slicer was covered with a clear plastic cover and pushed up against the wall by the dry storage room. Under the meat slicer was an area of six inches by one</p>		<p>other areas of concern, and any noted areas of concern addressed and remedied.3. The DM will re-educate the dietary staff on proper sanitation of food preparation areas and cooking utensils, including proper storage of utensils and not allowing freezer door to be propped open for convenience by June 05, 2015.4. The DM/ED will conduct QI monitoring of the regulation F371 to ensure a clean and sanitary kitchen. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three weeks. The DM/ED will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.5. Date of Compliance: June 12, 2015.</p>	

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F 441 SS=D Bldg. 00	<p>inch of a dark red liquid substance, several small crumbs and several quarter-inch pieces of pink to brown particles.</p> <p>During an interview on 05/11/2015 at 11:20 A.M., Corporate Dietary Manager indicated the area under the meat slicer should have been cleaned. He indicated the meat slicer is very heavy and hard to move.</p> <p>A current policy titled, "Sanitation Inspections, Nutrition, and Food Service", and dated 11/30/2014, was provided by the Administrator on 05/11/2015 at 1:46 P.M. The policy indicated, "...clean and sanitize all kitchen equipment thoroughly after each use, meat chopper, slicers and mechanical mixers require special attention..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>			

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	<p>development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure infection control practices and standards were maintained related to hand washing for 1 of 5 observations during medication pass and 1 of 3 observations of incontinence care. (Resident #12 and</p>	F 441	1. Resident #12 showed no apparent adverse effect. The DCS/Nurse Manager will re-educate LPN #3 on the facility's handwashing technique policy. Resident #52 showed no apparent adverse effect. The DCS/Nurse Manager will re-educate CNA #2 on the	06/12/2015

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	<p>#52)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 5/11/2015 8:52 A.M., LPN (Licensed Practical Nurse) #3 donned gloves, administered nose spray and eye drops to Resident #12, removed the gloves, and washed her hands for 10 seconds.</p> <p>During an interview with LPN #3 on 5/11/2015 at 9:30 A.M., the LPN indicated hands were to be washed for 20 seconds.</p> <p>2. During an observation of incontinence care, on 5/13/2015 at 1:15 P.M., CNA (Certified Nursing Assistant) #2 washed her hands for 10 seconds, donned gloves, repositioned Resident #52, and removed the resident's incontinence brief. CNA #2 took a clean, warm, wet washcloth and wiped the buttocks of Resident #52 in a front to back motion, removing a small amount of stool. Using a clean, wet washcloth, CNA #2 rinsed the buttocks then dried the buttocks with a clean towel. CNA #2 removed the gloves, donned clean gloves, and applied a barrier cream to the buttocks of Resident #52. A clean incontinence brief was placed on the resident. CNA #2 gathered the soiled linens and trash in separate</p>		<p>facility's handwashing technique policy.2. All residents have the potential to be affected by this alleged deficient practice.3. The DCS/Nurse Manager will re-educate the nursing staff on proper handwashing during incontinence care by June 05, 2015.The DCS/Nurse Manager will re-educate licensed nurses on proper handwashing during medication pass by June 05, 2015. 4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F441 to ensure infection control practices and standards are maintained related to handwashing during medication pass. QI monitoring will be conducted via observations across all three shifts five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months, alternating shifts using a sample size of three random employees. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.The DCS/Nurse Manager will conduct QI monitoring of the regulation F441 to ensure infection control practices and standards are maintained related to handwashing during incontinence</p>				

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F 467 SS=D Bldg. 00	<p>bags, removed the gloves, walked to the sink, and washed her hands for 15 seconds.</p> <p>During an interview with CNA #2 on 5/13/2015 at 1:25 P.M., CNA #2 indicated hands should be washed, before and after glove use and between each resident, for 10 seconds.</p> <p>The current handwashing policy, provided by the Assistant Director of Nursing on 5/11/2015, indicated, "...Continue rubbing your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice..."</p> <p>3.1-18(1)</p> <p>483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside</p>		<p>care. QI monitoring will be conducted via observations across all three shifts five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months, alternating shifts using a sample size of three random employees. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.5. Date of Compliance: June 12, 2015.</p>	

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	<p>ventilation by means of windows, or mechanical ventilation, or a combination of the two.</p> <p>Based on observation and interview, the facility failed to ensure adequate ventilation to maintain acceptable odor levels in 1 of 3 Dining/Activity rooms. (B Hall Dining/Activity room)</p> <p>Finding includes:</p> <p>1. During the initial tour on 05/06/2015 at 10:45 A.M., the B Hall Dining/Activity room had a strong urine odor with very little air movement.</p> <p>During an interview on 05/06/2015 at 2:50 P.M., Resident #91's family members indicated while visiting their family member in the B Hall Dining/Activity room there was a strong urine odor on several occasions. The resident's family member indicated the air was stagnant with no air movement.</p> <p>2. During an observation on 05/11/2015 at 10:06 A.M., the B Hall Dining/Activity room had a strong urine odor with no air movement. There were 13 residents in the room, coloring and putting puzzles together. Two staff members were present.</p> <p>During an interview on 05/11/2015 at</p>	F 467	<p>1. Carpet in Blossom Unit den/dining area deep-/steam-cleaned to improve malodorous environment in room on May 13, 2015.2. All residents have the potential to be affected by this alleged deficient practice.3. The Maintenance Director will install 2 8-inch return lines to Blossom Unit den/dining area to increase ventilation by June 10, 2015.The Maintenance Director will install automatic deodorizers in the Blossom Unit den/dining area to improve air quality in future by June 10, 2015.4. The Maintenance Director/Housekeeping Supervisor will conduct QI monitoring of the regulation F467 to ensure adequate ventilation to maintain acceptable odor levels. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months. The Maintenance Director/Housekeeping Supervisor will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.5. Date of Compliance: June 12, 2015.</p>	06/12/2015

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	<p>10:28 A.M., the Administrator indicated she was aware of the strong urine odor. She indicated, "... the odor had been there since the last survey from a resident whom over-flowed [sic] the toilet on a regular basis and the carpeting was scheduled to be changed on the 18th of this month."</p> <p>3. During a tour on 05/12/2015 at 1:45 P.M., with the Maintenance supervisor, B Hall Dining/Activity room had a strong urine odor.</p> <p>During an interview on 05/12/2015 at 1:47 P.M., the Maintenance supervisor indicated there were no return vents located in the B Hall Dining/Activity room and the closest return vent was through the door in the hallway. He indicated there was no air flow to help with the odor.</p> <p>During an interview on 05/12/15 at 1:50 P.M., LPN (Licensed Practical Nurse) #4 indicated the room has been stuffy and the air seemed stagnant for several months.</p> <p>3.1-19(f)(2)</p>			