

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00150465.</p> <p>Survey dates: June 9, 10, 11, 12, and 13, 2014</p> <p>Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210</p> <p>Survey team: Angela Halcomb RN, TC Julie Dover RN Jennifer Sartell RN Tammy Forthofer RN Rita Bittner RN Trudy Lytle RN</p> <p>Census bed type: SNF/NF: 108 Total: 108</p> <p>Census payor type: Medicare: 9 Medicaid: 69 Other: 30 Total: 108</p> <p>These deficiencies reflect state findings</p>	F000000		

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

TITLE

(X6) DATE

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

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F000156 SS=B	<p>cited in accordance with 410 IAC 16.2 -3.1.</p> <p>Quality Review completed on June 21, 2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p>				

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	<p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives</p>			

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	<p>requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure written confirmation of Medicare non-coverage appeal rights for 3 of 3 residents reviewed for Medicare non-coverage. (Resident #'s 12, 133, and 104)</p> <p>Finding includes:</p> <p>The "NOTICE OF MEDICARE PROVIDER NON-COVERAGE" forms (Advance Beneficiary Notice of Noncoverage [ABN]) were provided by Social Services Director on 06/11/14 at 2:00 p.m. for Resident #12, Resident #133, and Resident # 104.</p> <p>Resident #12's ABN's notice, dated 02/06/14, indicated a verbal phone consent by the resident's representation regarding notification Medicare A coverage would end 02/12/14. No information was indicated related to</p>	F000156	<p>F 156 1. Residents #12, 104, and 133 no longer reside at the facility. 2. All residents with Medicare provided services have the potential to be affected by this deficient practice. 3. On 6/12/2014 the Regional Case Mix Coordinator (RCMC) re-educated the Social Service Director (SSD) and the Minimum Data Set (MDS) Coordinator on Notice of Medicare Provider Non-Coverage (Advance Beneficiary Notice of Non-coverage). The RDCS will re-educate the Department Managers on the regulation F156. 4. The Business Office Manager (BOM)/ MDS Coordinator will conduct Quality Improvement (QI) monitoring of regulation F 156 to ensure written confirmation of Medicare non-coverage appeal rights. QI monitoring will be conducted 1x weekly for 8 weeks then 1x monthly for 4 months on residents with Medicare A provider. The findings will be brought to two quarterly Quality Assurance Performance</p>	07/13/2014

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	<p>obtaining a signature from this family representative.</p> <p>Resident # 133's ABN's notice, dated 03/07/14, indicated a verbal phone consent by the resident's representation regarding notification Medicare A coverage would end 03/07/14. No information was indicated related to obtaining a signature from this family representative.</p> <p>Resident # 104's ABN's notice, dated 05/28/14, indicated a verbal phone consent by the resident's representation regarding notification Medicare A coverage would end 06/04/14. No information was indicated related to obtaining a signature from this family representative.</p> <p>On 06/12/14 at 1:00 p.m., the Social Services Director indicated she was not unaware of the need to obtain a signature for verbal phone consents.</p> <p>The (Form Instructions for the Notice of Medicare Non-Coverage [NOMNC] CMS-10095) indicated the following:</p> <p>"Valid Notice Delivery</p> <p>... The enrollee must be able to understand that he or she may appeal the</p>		<p>Improvement (QAPI) committee meetings. The QAPI committee consisting of the ED, DCS, Medical Director and 3 other staff members will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>5. Date of Compliance: July 13, 2014</p>		

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F000225 SS=D	<p>termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.</p> <p>...However, a transposed phone number on notice would not be considered a minor non-conformance since the enrollee would not be able to contact the QIO and or health plan to file an appeal."</p> <p>3.1-4(f)(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law</p>			

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	<p>through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of sexual harassment was reported to the Indiana State Department of Health (ISDH) for 1 of 23 residents interviewed for abuse. (Resident #67).</p> <p>Findings include:</p> <p>During an interview on 6/10/2014 at 10:24 a.m., Resident #67 indicated he felt sexually harassed by the Admission Coordinator. He indicated the DON (Director of Nursing) was mad at him for sticking up for people. Resident #67 indicated the DON gave him a 30 day notice to move out of the facility. Resident #67 indicated the Admission Coordinator came to his room to talk</p>	F000225	F 225 1. Resident #67 showed no apparent adverse affect. 2. All residents have the potential to be affected by this deficient practice. The resident concern forms completed 02/01/2014-06/30/2014 will be reviewed by the Regional Director of Clinical Services (RDCS) and the Executive Director (ED) by July 8, 2014; any allegations of abuse not previously reported will be reported immediately. 3. The RDCS will re-educate the ED, the Director of Clinical Services, and the Department Managers on the regulation F225, the facility's abuse policy and the Indiana State Department of Health Reportable Incidents Policy formerly the ISDH Reportable Unusual Occurrence Policy revised 1/15/2013 by July 8, 2014. The Social Service	07/13/2014

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	<p>about the notice. Resident #67 indicated the Admission Coordinator said if you have to move out of the facility, I think we would make great roommates. You like your room cold and don't talk a lot. Resident #67 indicated the Admission Coordinator placed his hand on my leg above my left knee and indicated I don't have a two bedroom apartment, I only have a one bedroom apartment with a big bed, both of us can fit in.</p> <p>Resident #67's clinical record was reviewed on 6/12/14 at 9:07 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, shortness of breathe, depression, joint pain and mixed personality.</p> <p>The Social Service notes and nursing notes indicated there was no information related to any problem that Resident #67 felt sexually harassed by the Admission Coordinator, or any follow up that this was reported to ISDH.</p> <p>A "Risk Notice Statement of Concern Form," dated 2/18/2014, indicated Resident #67 reported that he felt "sexually harassed" by the Admission Coordinator during a conversation and included an investigation the facility conducted. The investigation failed to</p>		<p>Director (SSD)/Nurse Manager will re-educate the staff on the facility's abuse policy emphasis will be placed on reporting alleged violations to be investigated by July 11, 2014. 4. The ED / SSD will conduct Quality Improvement (QI) monitoring of regulation F 225 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the Indiana State Department of Health (ISDH). QI monitoring will be conducted 1x weekly for 8 weeks then 1x monthly for 4 months using a sample size of 5 interviewable residents and 5 staff members. The findings will be brought to two quarterly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee consisting of the ED, DCS, Medical Director and 3 other staff members will determine if further action needs to be taken and determine the continued time schedule for further monitoring. 5. Date of Compliance: July 13, 2014</p>		

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	<p>indicated the allegation had been reported to ISDH.</p> <p>On 6/12/2014 at 11:15 a.m., the Administrator indicated the incident had not been reported to ISDH because the Ombudsman was notified regarding the incident and felt the investigation could not be substantiate beyond how Resident #67 may have interpreted the conversation.</p> <p>A policy and procedure for "Resident Abuse," with a revision date of 01-01-2012, was provided by the social service director on 6/9/2014 at 1:00 p.m. The policy indicated, but was not limited to, "Policy: the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property...1. Employees of The Company are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property...7. Procedure for Reporting Abuse...1. All incidents of resident abuse are to be reported immediately to the Clinical Nurse in Charge, Director of Clinical Services, and the Executive Director. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an</p>			

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F000226 SS=D	<p>investigation...2. The abuse coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations...4. Discipline: 3. The Abuse Coordinator of The Company will refer any or all incidents and reports of resident abuse to the appropriate state agencies...."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>			
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	<p>Based on record review and interview, the facility failed to implement their abuse policy and procedure related to reporting an allegation of abuse for 1 of 1 residents who met the criteria for abuse. (Resident #67)</p> <p>Findings include:</p> <p>During an interview on 6/10/2014 at 10:24 a.m., Resident #67 indicated he felt sexually harassed by the Admission Coordinator. He indicated the DON (Director of Nursing) was mad at him for sticking up for people. Resident #67 indicated the DON gave him a 30 day notice to move out of the facility. Resident #67 indicated the Admission Coordinator came to his room to talk about the notice. Resident #67 indicated the Admission Coordinator said if you have to move out of the facility, I think we would make great roommates. You like your room cold and don't talk a lot. Resident #67 indicated the Admission Coordinator placed his hand on my leg above my left knee and indicated I don't have a two bedroom apartment, I only have a one bedroom apartment with a big bed, both of us can fit in.</p> <p>Resident #67's clinical record was reviewed on 6/12/14 at 9:07 a.m. The resident's diagnoses included, but were</p>	F000226	F 226 1. Resident #67 showed no apparent adverse affect. A second investigation was initiated and the initial report was sent to Indiana State Department of Health on July 3, 2014. 2. All residents have the potential to be affected by this deficient practice. The resident concern forms completed 02/01/2014-06/30/2014 will be reviewed by the RDCS and the ED by July 8, 2014; any allegations of abuse not previously reported will be reported immediately. 3. The RDCS will re-educate the ED, the Director of Clinical Services, and the Department Managers on the regulation F226, the facility's abuse policy and the Indiana State Department of Health Reportable Incidents Policy formerly the ISDH Reportable Unusual Occurrence Policy revised 1/15/2013 by July 8, 2014. The ED / the Social Service Director (SSD) will re-educate the staff on the facility's abuse policy emphasis will be placed on reporting alleged violations to be investigated by July 112014. 4. The ED / SSD will conduct QI monitoring of regulation F 226 by conducting interviews of interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the Indiana State Department of Health (ISDH). QI monitoring will be conducted 1x weekly for 8 weeks	07/13/2014			

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	<p>not limited to, chronic obstructive pulmonary disease, shortness of breathe, depression, joint pain and mixed personality.</p> <p>The Social Service notes and nursing notes indicated there was no information related to any problem that Resident #67 felt sexually harassed by the Admission Coordinator, or any follow up that this was reported to ISDH.</p> <p>A "Risk Notice Statement of Concern Form" dated 2/18/2014, indicated Resident #67 reported that he felt "sexually harassed" by the admission coordinator during a conversation and included an investigation the facility conducted. The investigation failed to indicated the allegation had been reported to ISDH.</p> <p>On 6/12/2014 at 11:15 a.m., the Administrator indicated the incident had not been reported to ISDH because the Ombudsman was notified regarding the incident and felt the investigation could not be substantiate beyond how Resident #67 may have interpreted the conversation.</p> <p>A policy and procedure for "Resident Abuse", with a revision date of 01-01-2012, was provided by the social</p>		<p>then 1x monthly for 4 months using a sample size of 5 interviewable residents and 5 staff members. The findings will be brought 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: July 13, 2014</p>				

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	<p>service director on 6/9/2014 at 1:00 p.m. The policy indicated, but was not limited to, "Policy: the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property...1. Employees of The Company are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property...7. Procedure for Reporting Abuse...1. All incidents of resident abuse are to be reported immediately to the Clinical Nurse in Charge. Director of Clinical Services, and the Executive Director. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation...2. The abuse coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations...4. Discipline: 3. The Abuse Coordinator of The Company will refer any or all incidents and reports of resident abuse to the appropriate state agencies...."</p> <p>3.1-28(a)</p>						

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to maintain the dignity and respect of a resident by not ensuring the coverage of a Foley catheter bag for 1 of 2 residents observed in the dining room. (Resident #80)</p> <p>Findings include:</p> <p>1. On 6/9/2014 at 12:23 p.m. - Resident #80 was observed to be sitting in the main dining room with no cover on the urinary catheter bag. The urinary catheter bag was observed to have moderate amount of yellow colored urine in the bag.</p> <p>During an interview on 6/11/2014 at 12:50 p.m., CNA #20 indicated we empty the catheter bag every 2 hrs, we put the catheter bag through the resident pant leg</p>	F000241	<p>F 241</p> <p>1. Resident #80 no longer resides at the facility.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>Residents with a urinary catheter will be reviewed by the DCS/Nurse Manager by July 1, 2014 to ensure a privacy bag has been provided.</p> <p>3. The DCS/Nurse Manager will re-educate the nursing staff on the facility's</p>	07/13/2014

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F000248 SS=D	<p>and hook it to the chair.</p> <p>On 6/11/2014 at 4:03 p.m., the corporate clinical nurse presented a copy of the facility's current policy on "Catherization." The policy included, but was not limited to: "Procedure: 21. Foley bag must be covered by a privacy bag at all times to preserve dignity of resident...22. Tubing must be off of the floor at all times..."</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation and record review, the facility failed to promote the</p>	F000248	<p>catheterization policy by July 8, 2014.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring to ensure the use of privacy bags for residents with a urinary catheter. QI monitoring will be conducted weekly for eight weeks then monthly for four months The DCS/Nurse Manager will report the 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: July 13, 2014</p> <p>F 248 1. Resident #77 will be re-evaluated by the Activities Director and the Activity Care</p>	07/13/2014			

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	<p>resident's psychosocial well-being through stimulating activities for example, music, for 1 of 2 residents reviewed for activities during a family interview. (Resident # 77)</p> <p>Findings include:</p> <p>On 06/11/2014 at 10:51 a.m., Resident # 77 was observed sleeping in his bed. No television or music were observed on.</p> <p>On 06/11/2014 at 2:26 p.m., Resident # 77 was observed lying in his bed while being fed pudding by CNA # 26, no conversation was observed. No television or music were on for resident activity.</p> <p>On 06/11/2014 at 5:26 p.m., Resident # 77 was observed to be back in his bed. No television or music were on for resident activity.</p> <p>On 06/12/14 at 1:10 p.m., during an observation accompanied by LPN #18, Resident # 77 was laying in bed with no television or music playing for activity.</p> <p>On 06/12/14 at 9:21 a.m., Resident # 77's clinical record was reviewed. The resident's diagnosis included, but were not limited to Alzheimer's, dementia, anemia, hypertension, diabetes mellitus,</p>		<p>Plan will be updated to reflect the interests, physical, mental and psychosocial well-being of the resident by July 8, 2014. 2. All residents have the potential to be affected by this deficient practice. The Activity Director/ SSD will review the activity care plans for in-house residents requiring 1:1 activity programs by July 11, 2014. 3. The RDCS will re-educate the Department Managers on regulation F248 by July 8, 2014. The RDCS will re-educate the Activity Director (AD) on the facility's policy on participation in activities and the activity program by July 8, 2014. The AD will re-educate the Activity Assistants on the facility's participation in activities and activity program policies by July 11, 2014 emphasis will be placed on implementing and documenting activity programs. 4. The AD/SSD will conduct QI monitoring of regulation F248 to ensure the residents' psychosocial well-being through stimulating activities is promoted using observation and care review. 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 AD/SSD will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action</p>	

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	<p>hyperlipidemia, cerebrovascular accident and depression. The quarterly MDS (Minimum Data Set) assessment, dated 05/15/14, indicated the resident's BIMS (Brief Interview Mental Status) total score was 1 with a total score of 8-15 as interviewable. The resident required total assistance of one to two persons for transfers and ADL's (Activities of Daily Living). The annual MDS, dated 02/27/14, indicated the resident liked to listen to music.</p> <p>The "Activity Level Care Plan," dated 05/22/14, was provided by the Activities Director on 06/13/14 which was updated on 06/13/14. The goal was to have specialized needs met to promote self-esteem, pleasure or comfort by next review, with no date specified for review. The Approaches and Interventions were to provide radio-set according to resident preference, television-station/programs set to resident preference, and speak to resident during care.</p> <p>The 05/22/14 Care Plan Update indicated Resident # 77 responds well to low stimulus activities, his name and his wife's voice. His wife visits often. The resident likes to blow bubbles and look out window. The staff will spend time talking to resident. The resident reclines in a geri-chair and is assisted by staff.</p>		needs to be taken and determine the continued time schedule for further monitoring. 5. Date of Compliance: July 13, 2014				

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F000279 SS=D	<p>Staff will continue encouraging resident.</p> <p>The activities attendance book was reviewed on 06/13/14 at 11:28 a.m. Resident # 77's record of one to one activities indicated no information as records page was blank.</p> <p>3.1-33 (a) 3.1-33 (8)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>						

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	<p>mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan related to a partial plate to assist food consumption for 1 of 1 resident reviewed with a partial plate. (Resident #27)</p> <p>Findings include:</p> <p>During a family interview on 6/10/14 at 10:53 a.m., Resident #27's daughter-in-law indicated the resident had missing teeth and needed her partial plate inserted in order to be able to chew on one side. She also indicated the resident was currently on a mechanical soft diet, and it was working well. The daughter-in-law indicated Resident #27 would quit eating if she was put on a pureed diet because the resident hated the pureed diet.</p> <p>During an interview on 06/13/2014 at 9:38 a.m. Certified Nursing Assistant (CNA) #20 indicated she was unaware of resident's need for a partial plate.</p> <p>The clinical record for Resident #27 was</p>	F000279	<p>F 279</p> <ol style="list-style-type: none"> Resident #27 showed no apparent adverse effects. The Nurse Manager will update the care plan and the Nurse Tech Kardex by July 8, 2014 to reflect the resident's use of a partial plate to assist with food consumption. All residents have the potential to be affected by this deficient practice. The Nurse Manager will review the care plans and Nurse Tech Kardexes for in-house residents with dentures/partials by July 11, 2014. Any discrepancies identified will be corrected immediately. The RDCS will re-educate the Department Managers on the regulation F 	07/13/2014

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	<p>reviewed on 06/13/2014 at 9:00 a.m., and indicated the resident was admitted to the facility on 1/26/13. The resident's diagnoses included, but were not limited to, stroke, depression, diabetes, and anemia.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 5/7/14, indicated no issues with teeth, one person physical assistance with personal hygiene and extensive assistance for bed mobility, transfers, and toileting. The assessment indicated the resident scored a 3 on the Brief Interview for Mental Status, indicating a severe cognitive impairment.</p> <p>The "Care Review" document, dated 1/20/14, indicated the family was concerned about the resident not having her partial plate in.</p> <p>The "Nurse Tech Information Kardex" was provided by the Assistant Director of Nursing, and indicated this was the document the CNA's use as a reference for individual resident's needs. This form did not identify the resident's partial plate. The "Dental Care Plan," dated 1/28/13 and updated 4/16/14, did not identify the resident's "Dentures/partials," but indicated she had natural teeth.</p> <p>3.1-35(b)(1)</p>		<p>279 and the facility's care plan policy by July 8, 2014.</p> <p>The DCS/ Nurse Manager will re-educate the nursing staff on the Nurse Tech Kardex by July 11, 2014.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 279 to ensure the development of a comprehensive care plan. 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 DCS/Nurse Manager will report the 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: July 13, 2014</p>		

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a resident was receiving the assistance she needed to complete her personal care (shower) for 2 of 3 residents interviewed for personal care. (Resident #125)</p> <p>Finding includes:</p> <p>During an interview on 6/12/14 at 10:17 a.m., Certified Nurse Aides (CNA) #28 and #29 indicated resident #125 was scheduled for showers on Mondays and</p>	F000280	<p>F 280</p> <p>1. Resident #125 showed no apparent adverse effects. The Nurse Manager updated the shower schedule to reflect the resident's preferences on 6/30/2014.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p>	07/13/2014

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	<p>Fridays. The CNA's indicated they had mentioned to the Assistant Director of Nursing (ADON) a possible change in her shower schedule to days the resident does not have dialysis (resident has dialysis on Mondays, Wednesdays, and Fridays). CNA's indicated they fill out a "Skin Care Alert" form following all showers and give the form to the nurse.</p> <p>Staff interview and record review on 6/13/14 at 9:10 a.m. with the ADON indicated resident #125 usually leaves for dialysis between 11:30. and 12:00 noon on Monday, Wednesday, and Friday. A shower schedule was provided indicating resident was scheduled for showers on Monday and Friday during day shift. LPN #32 indicated resident gets showered either before or after breakfast. The ADON indicated she was unaware there was a problem.</p> <p>During an Interview on 6/10/14 at 10:50 a.m., Resident #125 indicated she did not get to choose how many times a week she gets a bath or shower. Resident #125 indicated she would like too and she had not had a shower "in ages." She indicated she usually gets cleaned up with a wash cloth and they were noted hanging on her walker to dry. Resident #125 indicated she did not get a shower last week and has not had one this week.</p>		<p>DCS/Nurse Managers will assess in-house interviewable residents for their satisfaction with their shower schedule by July 11, 2014. Any discrepancies identified will be corrected immediately.</p> <p>3. The RDCS will re-educate the DCS and Nurse Manager on the regulation F280 and the facility's shower policy by July 8, 2014.</p> <p>The DCS/Nurse Manager will re-educate the nursing staff on the facility's shower policy by July 11, 2014.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 280 to ensure residents receive the assistance needed to complete personal care. 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 DCS/Nurse Manager will</p>				

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F000282 SS=D	<p>Resident #125 also indicated staff acts like they always run out of time. She indicated she could give herself a sponge bath, but was unable to wash her hair without assistance.</p> <p>On 6/12/14 at 10:00 a.m., review of "Skin Care Alert" document, provided by Staff Development #40, indicated resident's last shower was given on 6/2/14.</p> <p>On 6/13/14 at 10:00 a.m., review of the quarterly Minimum Data Set (MDS) assessment, dated 5/13/14, indicated the resident was a one person physical assist with personal hygiene. The assessment indicated the resident scored a 7 on the Brief Interview for Mental Status, indicating mild cognitive impairment.</p> <p>During an interview on 6/13/14 at 10:30 a.m., Resident #125 indicated she had not had a shower this week.</p> <p>3.1-35(d)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>		<p>report the 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: July 13, 2014</p>	

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	<p>persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to follow a residents Care Plan related to bowel assessment for 1 of 1 residents reviewed for bowel assessment care plan. (Resident #91)</p> <p>Finding includes:</p> <p>The clinical record of Resident #91 was reviewed on 6/10/14 at 10:58 a.m. The diagnoses for Resident #91 included, but were not limited to, Heart Failure, Hypertension, Pulmonary Vascular Disease, Diabetes Mellitus, Dementia and Depression. Resident #91 had a Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment with a BIMS Quarterly review score of nine on 2/21/14 and seven on 5/9/14.</p> <p>On 6/10/14 at 11:39 a.m., Resident #91 lying on his left side in bed. The bedding in which Resident #91 was lying on, had brown stains the size of a basket ball. The smeared stains were located at the foot end of the bed. The brown smeared stains were dry and odorless.</p> <p>Resident #91's clinical record was reviewed on 6-11-14 at 10:58 a.m. The</p>	F000282	<p>F 282 1. Resident #91 showed no apparent adverse affect. 2. All residents have the potential to be affected by this deficient practice. The Nurse Manager will review the care plans for in-house residents by July 11, 2014. Any discrepancies will be corrected immediately. 3. The RDCS will re-educate the Department Mangers on the regulation F282 and the facility's care plan policy by July 8, 2014. The DCS/Nurse Manager will re-educate the licensed nurses by July 11, 2014 on the facility's care plan policy emphasis will be placed on following the resident's written plan of care. 4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 282 to ensure the residents care plan is followed. 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 DCS/Nurse Manager will report the 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: July 13, 2014</p>	07/13/2014

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	<p>revised Nursing Care Plan, dated 5/27/14, indicated that Resident #91 was incontinent of bowel. The Nursing Care Plan indicated the Resident #91 was to be observed for skin irritation and redness daily, with assessment of bowel pattern, abdominal distention, impaction and changes and assessment of bowel sounds. Review of the nursing records indicated there was no documentation in the nursing assessment notes that the assessments had been performed from the dates of 1/16/14 through 6/11/14.</p> <p>During an interview on 6/11/14 at 3:34 p.m., Licensed Practical Nurse (LPN) #5 indicated that the daily assessment should be noted in the nursing notes which are located in the resident's chart. LPN #5 indicated she could not locate any bowel assessments from 1/16/14 through 6/11/14.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure the identification and assessment of a open area for 1 of 1 resident reviewed with an open area (Resident #154) and failed to ensure the assessment of a resident before and after dialysis and an open communication between the facility and dialysis for 1 of 1 resident reviewed for dialysis in a sample of 2 residents receiving dialysis. (Resident #149).</p> <p>Findings include:</p> <p>1. On 6/9/2014 at 10:15 a.m., Resident #154 was observed up in his wheelchair in the hallway. The resident was observed with a small amount of red drainage</p>	F000309	<p>F 309 1. Resident #154 no longer resides at the facility. Resident #149 showed no apparent adverse affect. The DCS/Nurse Manager will re-educate the licensed nurses on communicating with dialysis, pre and post dialysis documentation. 2. All residents have the potential to be affected by this deficient practice. In-house residents will receive a head to toe skin assessment by a licensed nurse by July 11, 2014. The physician will be notified of any open area/wound without a treatment order. Any new orders given to the nurse by the physician will be received, noted, and implemented at that time. 3. The RDCS will re-educate the Department Managers on the regulation F309. On 6/16/2014 the RDCS</p>	07/13/2014			

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	<p>dripping from an open half inch area on the top of his left foot. No dressing was observed in place.</p> <p>On 6/09/14 at 12:10 p.m., Resident #154 was observed sitting in the main dining room with the same open area on the top of his left foot. A larger amount of red liquid drainage was observed dripping down the side of left foot with no dressing in place.</p> <p>On 6/12/14 at 10:17 a.m., during an interview, the Assistant Director of Nursing (ADON) indicated she did not follow skin issues unless it was a pressure area. Since his areas were vascular, she did not have anything on them.</p> <p>On 6/12/14 at 10:22 a.m., during an interview, LPN #22 provided the weekly skin sheet for Resident #154. Review of the "Weekly Skin Integrity Review" sheet indicated that that there was no documentation for the month of June. She indicated that when nurses find new areas they fill it out.</p> <p>On 6/12/14 at 10:27 a.m., during an interview, LPN #23 indicated skin sheets were only filled out if the area was new. She indicated Resident #154 had no record of skin sheets since admission.</p>		<p>re-educated the DCS, Assistant Director of Clinical Services (ADCS) and Unit Manager on the facility's Coordination of Hemodialysis Services policy. The DCS/Nurse Manager will re-educate the licensed nurses on the facility's Coordination of Hemodialysis Services policy by July 11, 2014. The DCS/Nurse Manager will re-educate the licensed nurses on the facility's wound assessments and weekly skin assessments policies by July 11, 2014. 4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 309 to ensure to identification and assessment of residents with open areas, the assessment of residents before and after dialysis, and open communication between the facility and dialysis. 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 and one dialysis resident. The DCS/Nurse Manager will report the 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: July 13, 2014</p>		

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	<p>On 6/12/14 at 11:58 a.m., during an interview, Physical Therapy Assistant #24 indicated she had noticed the top of Resident #154's left foot with the cracked open area. She indicated she had reported it to the nurse on 6/9/14. She indicated this nurse had informed her the open area on his left foot was already taken care of.</p> <p>Resident #154 clinical record was reviewed on 6/11/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, Coronary Artery Disease, Cardiovascular Accident, Diabetes, Type II, Hypertension and Peripheral Vascular Disease. The Admission Assessment, dated 5/30/14, indicated reddened area to coccyx and musky (sic) heels. A Physicians Order, dated 6/03/14, indicated skin prep to bilateral heels q (every) shift. A Physicians Order, dated 6/11/14, indicated Foam and helix drsgs (dressings) to (B with circle) (bilateral) feet as preventative. History and Physical, dated 6/5/14, indicated no clubbing, cyanosis or edema to extremities. No information was indicated regarding the top of resident's left foot.</p> <p>The current policy titled "Skin Assessment-Weekly" was provided by the Assistant Director of Nursing, The</p>			

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	<p>policy indicated the following: "Policy A Licenses Nurse will complete a total body assessment on each resident weekly, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure ulcers, lesions, abrasions, reddened areas and skin turgor problems. The purpose of the Skin Assessment is to evaluate the condition of the resident's skin on a regular basis... ...Procedure 1. A Licensed Nurse will complete a total body assessment on each resident weekly and document the assessment on the " Weekly Skin Integrity Review" form. 2. The evaluating nurse must date and sign each assessment. 3. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form...."</p> <p>2: Resident # 149's clinical review was reviewed on 6/11/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, cirrhosis, diabetes mellitus, manic depression, renal failure, end stage renal disease, and schizophrenia. The admission MDS (Minimum Data Set) assessment, dated 05/15/14, indicated the BIMS (Brief Interview for Mental Status) total score was 3 with a total score of 8 to 15 as interviewable. The Resident</p>						

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	<p>required limited assistance of 1 to 2 persons for her ADL's (Activities of Daily Living).</p> <p>No information was indicated in the physician orders for dialysis.</p> <p>The physician order for gentamycin, dated 06/11/14, was gentamycin cream 0.1% (topical antibiotic), send with patient to dialysis for use there. No information was indicated as to the indication for this medication.</p> <p>A physician order was written, on 06/02/14, to start fluid restriction of 1 liter per day (1000 cc's).</p> <p>A faxed FYI (For Your Information) was sent to the physician on 06/10/14. Diagnosis included of renal failure, hemodialysis 4 times weekly, and weekly paracentesis was included.</p> <p>The Nurses notes indicated the following: The "DAILY SKILLED NURSE'S NOTE," dated 05/09/14, indicated the resident will be going to dialysis per her choice.</p> <p>On 05/10/14 at 6:00 a.m. resident leave of absence to dialysis at this time, until approximately 11:30 a.m. "Resident returned in time for lunch... bs (blood</p>			

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	<p>sugar) obtained per MD orders, SSI (sliding scale insulin) continues per MD orders...." No information was indicated related to dialysis.</p> <p>On 05/20/14 resident accompanied by facility transport at 9:45 a.m. to paracentesis.</p> <p>On 05/20/14 nurses notes indicated that the resident returned from paracentesis at approximately 3:00 p.m. Order for dressing to be applied to right mid lower abdomen at shunt site and to change as needed. The notes also indicated a small amount of blood was to be expected, but if bleeding became excessive, the nurse was to call or send to emergency room. Observe for infection and to call physician for symptoms of infection.</p> <p>05/26/14 at 4:00 p.m., resident returned from dialysis. Temperature obtained by nurse at 98.6 degrees.</p> <p>06/02/14 Nurse's notes requested fluid restriction of 1 liter. Dialysis Dietician was aware of non-compliance with fluids.</p> <p>On 06/04/14 at 00:40 (12:40 a.m.), Resident had dialysis catheter in her hand. Resident stated, "I don't know what happened, I was changing my shirt and this just fell out."</p>			

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	<p>On 06/5/14 Nurses note stated dialysis port was checked and a moderate amount of drainage noted and the dressing was intact.</p> <p>There was no further information in the nurse's notes related to dialysis or restriction of fluids.</p> <p>The Care Plan, dated 05/09/14, indicated the goal was Resident # 149 would suffer no complications due to renal dialysis. The interventions indicated to coordinate transportation to the dialysis center as scheduled: monitor fluid intake:and monitor shunt for patency.</p> <p>The "Nutritional Risk Care Plan," dated 0/5/15/14, indicated the goal was to maintain acceptable nutritional parameters. The "Approaches & Interventions" were diet as ordered, monitor weight, monitor intake, honor food preferences as applicable, honor request as applicable, medications as ordered, consult renal doctor as needed, coordinate care with dialysis. No information was indicated related to restriction of fluids.</p> <p>On 06/13/2014 at 9:35 a.m., during an interview, the Interim Director of Nursing (DON) # 25 indicated a form</p>			
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	<p>was sent from dialysis and posted in the resident's chart by the nurse. A dialysis book should be completed, and one was found with partial post treatment information for random days of dialysis. The post treatment form indicated on 05/26/14 the resident had diarrhea with no further information indicated. The post treatment form on 05/28/14 indicated incontinent of bowels with no further information. The one "DIALYSIS COMMUNICATION RECORD' form, dated 05/26/14, was also present in this book and was blank and identified for another resident.</p> <p>On 06/13/14 at 9:35 a.m., during an interview, Interim DON indicated there should be information from dialysis to facility nurses on the chart</p> <p>On 06/13/14 at 9:40 a.m., LPN #17 and CNA # 21 were interviewed. LPN #17 indicated a form, stating any health concerns, weight and diet, was sent with resident to dialysis. When the resident returned from dialysis, we reviewed dialysis notes and chart. Resident # 149 attends (dialysis name) on Monday, Wednesday and Friday. CNA # 21 indicated Resident # 149 took 2 bologna and cheese sandwiches, a fudge round and a bottle of water, with no breakdown of fluids.</p>			

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F000312 SS=D	<p>On 06/13/14 at 9:45 a.m. during an interview, the Assistant DON indicated upon returning from dialysis acknowledgement was needed. She indicated no information was found for Resident # 149.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure a resident was receiving the assistance she needed to complete her personal care (shower) for 2 of 3 residents interviewed for personal</p>	F000312	F 312 1. Resident # 125 showed no apparent adverse affect. The Nurse Manager updated the shower schedule to reflect the resident's preferences on 6/30/2014. 2. All residents have the potential to be affected by this	07/13/2014

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	<p>care. (Resident #125)</p> <p>Findings include:</p> <p>Staff interview on 6/12/14 at 10:17 a.m. with Certified Nurse Aides (CNA) #28 and #29 indicated Resident #125 was scheduled for showers on Mondays and Fridays. The CNA's indicated they had mentioned to the Assistant Director of Nursing (ADON) a possible change in her shower schedule to days the resident does not have dialysis (resident has dialysis on Mondays, Wednesdays, and Fridays). The CNA's indicated they fill out a "Skin Care Alert" form following all showers and give the form to the nurse.</p> <p>Staff interview and record review on 6/13/14 at 9:10 a.m. with the ADON (Assistant Director of Nursing) and LPN #32. The ADON indicated Resident #125 usually leaves for dialysis between 11:30 a.m. and 12:00 noon on Monday, Wednesday, and Friday. A shower schedule was provided indicating Resident #125 was scheduled for showers on Monday and Friday during day shift. LPN #32 indicated resident gets showered either before or after breakfast. ADON indicated she was unaware there was a problem.</p>		<p>deficient practice. The DCS/Nurse Manager will evaluate in-house residents with a Brief Interview Mental Status (BIMS) score of 8-15 for shower preferences by July 11, 2014. Any discrepancies identified will be corrected immediately. 3. The RDCS will re-educate the Department Managers on the regulation F312 and the facility's shower policy by July 8, 2014. The DCS/ Nurse Manager will re-educate the nursing staff on the facility's shower policy by July 11, 2014. 4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 312 to ensure residents receive the assistance needed to complete personal care. 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 DCS/Nurse Manager will report the 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: July 13, 2014</p>				

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	<p>During an interview on 6/10/14 at 10:50 a.m., Resident #125 indicated she did not get to choose how many times a week she gets a bath or shower. Resident #125 indicated she would like too and she had not had a shower "in ages." She indicated she usually gets cleaned up with a wash cloth and they were noted hanging on her walker to dry. Resident #125 indicated she did not get a shower last week and has not had one this week. indicated staff acts like they always run out of time. She indicated she could give herself a sponge bath, but was unable to wash her hair without assistance.</p> <p>Record review of "Skin Care Alert" document provided by Staff Development #40, on 6/12/14 at 1:53 p.m., indicated Resident #125's last shower was given on 6/2/14.</p> <p>On 6/13/14 at 10:00 a.m., record review of the quarterly Minimum Data Set (MDS) assessment, dated 5/13/14, indicated the resident was a one person physical assist with personal hygiene. The assessment indicated the resident scored a 7 on the Brief Interview for Mental Status, indicating mild cognitive impairment.</p> <p>During an interview on 6/13/14 at 10:30</p>			

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F000323 SS=D	<p>a.m., Resident #125 indicated she had not had a shower this week.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, facility failed to ensure potentially hazardous equipment were functional and safe for 2 of 28 residents' beds observed and to ensure handrails were free of rough edges for 4 of 4 hallways observed. (Resident #32 and #113; Hallways A, B, C and D)</p> <p>Findings include:</p> <p>1. On 6/11/14 at 10:45 a.m., Resident #32 siderail on right side of bed was observed to be loose with a 3-4 inch gap between the rail and the mattress.</p> <p>During an interview on 6/11/14 at 10:51</p>	F000323	F 323 1. Resident #32 showed no apparent adverse affect. The side rail was fixed immediately after being brought to the attention of the Maintenance Director on 6/11/2014. Resident #113 showed no apparent adverse affect. The mattress was replaced on 6/9/2014 after being brought to the attention of the ED. The peeling paint and un-sanded areas of handrails of rooms B111 & B109 will be repaired by July 11, 2014. The rough edges of the handrails for Hallways A, B, C, and D will be repaired by July 11, 2014. 2. All residents have the potential to be affected by this deficient practice. The mattresses will be checked to ensure appropriate size for the bed frame by July 11, 2014. Any issues	07/13/2014

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	<p>a.m., the Regional Director of Clinical Services indicated she would have maintenance look at siderail immediately.</p> <p>During an interview on 6/11/14 at 1:40 p.m., Resident #32 indicated he had complained to the nurse a couple of days ago because it was loose and staff indicated would have it fixed. Resident #32 indicated he did not know if it had been fixed.</p> <p>During an interview on 6/12/14 at 1:45 p.m., the Administrator indicated there was not a preventative maintenance policy for siderails. The Administrator provided a copy of the Quality Assessment and Assurance, dated 6/9/14, which indicated the siderail was checked with no concerns.</p> <p>2. On 6/9/14 at 10:15 a.m., Resident #113's bed mattress was observed to be 6-8 inches too short.</p> <p>On 6/9/14 at 1:00 p.m., Resident #113's bed mattress was reported to the Administrator to be 6-8 inches too short. The Administrator indicated she would look at it and replace it. The Administrator also indicated if she did not have one that fit, it would be ordered today.</p>		<p>identified will be corrected immediately. The beds with side rails will be assessed by July 11, 2014. Any issues identified will be corrected immediately. By July 11, 2014 the Hallways A, B, C, and D handrails will be assessed for rough edges and any issues identified will be corrected. 3. The RDCS will re-educate the Department Managers on the regulation F 323 by July 8, 2014. The ED will re-educate the Maintenance Director on the facility's Maintenance and Maintenance Checklist Policies by July 11, 2014. The Maintenance Director/ Nurse Manager will re-educate the staff on the facility's Maintenance Request Form by July 11, 2014 emphasis will be placed on location and indication for use. 4. The ED / Maintenance Director will conduct QI monitoring of the regulation F 323 to ensure potentially hazardous equipment are functional and safe. 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 resident rooms. The ED/ Maintenance Director will report the 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>				

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	<p>On 6/9/14 at 3:00 p.m., the Administrator indicated Resident #113's bed mattress was the wrong size mattress and had been replaced with the correct size. The Administrator also indicated a sweep had been conducted and completed for all mattresses in the building.</p> <p>On 6/13/14 at 8:43 a.m., Resident #113 indicated she had the same mattress since her admission on 4/24/14.</p> <p>3. On 06/09/14 at 10:00 a.m. to 11:00 a.m., during the environment tour, the hallway handrails in the Alzheimer's Unit between rooms B111 & B109 were observed to have peeling paint and unsanded areas, which made the handrails rough to the touch. The same was observed in Halls C and D. During an interview at the this time, the Maintenance Manager indicated the handrails were rough, and he would have to check on when to monitor as he was new at the job.</p> <p>3.1-45(a)(1)</p>		5. Date of Compliance: July 13, 2014		

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F000362 SS=E	<p>483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL</p> <p>The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.</p> <p>Based on observation, interview, and record review, the facility failed to ensure meals were provided timely and as scheduled for three of three dining rooms observed during 1 of 1 lunch observation (6/9/14) and for 2 of 2 breakfast observation (6/12/14 and 6/13/14).</p> <p>Findings include:</p> <p>1. On 6/9/2014 from 11:25 a.m. to 12:30 p.m., lunch was observed in the Azalea dining room. The first meal tray was observed to be served at 12:02 p.m. to an unidentified resident. At 12:05 p.m., Resident #A was awakened and served his meal tray.</p> <p>On 6/09/2014 at 11:50 a.m. in the Blossom Hall Dining Room lunch was observed. Seventeen (17) residents were present in the dining room.</p> <p>At 12:26 p.m. the food cart arrived in the</p>	F000362	<p>F 362 1. Resident #A showed no apparent adverse affect. 2. All residents served from the kitchen have a potential to be affected by this deficient practice. 3. The Regional Director of Nutritional Services (RDNS) will re-educate the Department Managers on the regulation F362 and the facility's meal service policy by July 8, 2014. The DCS/Nurse Manager will re-educate the nursing staff on the facility's meal service policy by July 11, 2014. 4. The ED/Department Manager will conduct QI monitoring of the regulation F 362 to ensure meals are provided timely and as scheduled through observation of alternating meal services. 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 ED/Department Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken</p>	07/13/2014

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	<p>Blossom Dining Room.</p> <p>On 6/12/2014 at 9:21 a.m., QMA #13 was advised from the Assistant Dietary manager to notify CNA's of assistance needed to help serve meals. During an interview at this same time, QMA #13 indicated the normal process was to page or just pass by word of mouth staff was needed to help with meal trays. QMA #13 indicated if the CNA's were busy general support staff would jump in to help. QMA #13 also indicated staff assistance normally happened once a week, but today she indicated the Assistant Dietary Manager was busy and the delay was not identified quickly enough. QMA #13 indicated normally a 10 to 15 min wait could be expected.</p> <p>On 06/13/2014 at 9:30 a.m., during a dining observation in Blossom Hall there were three missing food trays and drinks. The kitchen was called twice. CNA #19 finally went to the kitchen to bring back trays at 9:40 a.m. and the three residents were fed.</p> <p>The following meal times are posted:</p> <p>Azalea Hall Meal Times Breakfast - 7:30 a.m. Lunch - 11:30 a.m. Supper - 5:30 a.m.</p>		and determine the continued time schedule for further monitoring. 5. Date of Compliance: July 13, 2014				

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	<p>Blossom Hall Meal Times Breakfast - 7:45 a.m. Lunch - 11:45 a.m. Supper - 5:45 p.m.</p> <p>Main Dining Room Meal Times Breakfast - 8:15 a.m. Lunch - 12:15 a.m. Supper - 6:15 p.m.</p> <p>2. During a lunch meal observation on 6/9/2014, the following was observed:</p> <p>At 12:58 p.m. - observed the first tray being served in the main dining room, the meal was served 45 minutes late from the scheduled meal time. There were 25 resident's observed in the main dining room.</p> <p>On 6/9/2014 at 11:45 a.m., the DON (Director of Nursing) presented a copy of the facility's meal times. "Main Dining Room Meal Times" Breakfast - 8:15 a.m., Lunch - 12:15 p.m., and Supper - 6:15 p.m.</p> <p>On 6/12/2014 at 8:45 a.m., observed Resident #A and room mate in room eating breakfast. Resident #A's roommate indicated breakfast was late, it was always late, they have new cooks in the kitchen.</p>			
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F000365 SS=D	On 6/13/2014 at 8:55 a.m., CNA #33 was observed passing hall trays on C hall. The trays were observed to be served 40 minutes late. 3.1-21(c) 483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL				

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	<p>NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, record review and interview, the facility failed to ensure the consistency of the food for puree diets for 1 of 1 test trays.</p> <p>Finding includes:</p> <p>On 6/11/14 from 2:31 PM to 3:17 PM, during a kitchen observation a test tray was obtained. The puree meat of pork was observed as stringy in consistency. When tasted, this pork required chewing due to the stringiness. The sample of spinach also had a stringy consistency and a one half inch piece of stem was found in the bite size sample.</p> <p>During an interview at this time, Dietary Aide #16 indicated the consistency of the puree meat and vegetables should be like pudding and slightly runny on the plate.</p> <p>The "Therapeutic/Texture Modified Diets" policy was provided by Assistant Dietary Manager. This current policy indicated the following:</p> <p>"POLICIES: Therapeutic diet, including textured-modified diets, as ordered by the physician are preplanned by Registered Dietitians and prepared and served using</p>	F000365	<p>F 365 1. No resident was identified 2. All residents served from the kitchen have a potential to be affected by this deficient practice. 3. The RDCS will re-educate the Department Managers on regulation F365. The Registered Dietician will re-educate the dietary staff on the Therapeutic/Texture Modified Diets policy by July 11, 2014. 4. The ED/Department Manager will conduct QI monitoring of the regulation F 365 to ensure consistency of the food for puree diets through random observations. 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 ED/Department Manager will report the 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: July 13, 2014</p>	07/13/2014			

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F000371 SS=F	safe, sanitary food practices...." 3.1-21(a)(3) 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 and interview, the facility failed to provide a clean and	F000371	F 371 1. The kitchen door threshold was cleaned by 7/11/14	07/13/2014	

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	<p>sanitary kitchen related to the cleanliness of storage racks, floors, shelves and to ensure proper handwashing. This deficient practice had the potential to impact 106 of 108 residents served from the kitchen.</p> <p>Findings include:</p> <p>1. On 6/09/14 from 9:49 am to 10:13 am, during the initial kitchen tour the following was observed:</p> <p>Upon entering the kitchen, the kitchen door threshold was sticky with dark brown and black residue covering it. Five garbage cans with four of the cans open were positioned in the front of the aisles. The garbage cans were blocking the food preparation areas. The red tile flooring was also sticky throughout the food preparation area and storage area.</p> <p>The Corporate Dietary Manager (CDM) indicated there were two hand washing sinks one in the front upon entering and one in the back area by the entrance to the dry storage room. The back designated handwashing sink was observed with a garbage can with a small foot peddle This garbage can had no liner and contained food particles of noodles and sauce along with paper towels.</p>		<p>and the sticky dark residue was removed. All garbage cans will be covered with lids except during periods of heavy use and positioned away from food preparation areas except during periods of continuous use as allowed by 2013 Food Code Section 5-501.113. The red tile flooring was cleaned by 7/11/14 and the stickiness was removed throughout the food preparation and storage area. In the dry storage room, the floor was cleaned by 7/11/14 removing the stickiness along with the flat pieces of boxes. The wire racks were cleaned removing the dust and the food particles underneath. In the large food storage (walk-in) freezer area, the frozen condensation was removed by 7/11/14 as well as the dust and food particles from under the wire racks. A new motor was installed in the walk-in freezer, and the freezer was serviced by an air-conditioning contractor on 7-2-14 to prevent further condensation build-up. The clean dishes storage area under the steam table was cleaned by 7/11/14 removing the black sticky residue and dust from shelves. The wire rack holding the pots and pans was cleaned by 7/11/14 removing the sticky residue, dust, and other debris. The juice stand was cleaned removing the sticky brown substance from the shelves as well as dust and food</p>	

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	<p>In the dry storage room the floor was sticky with flat pieces of boxes lying in the center of the room. The wire racks, which held the canned goods and boxed goods, was observed with piles of dust and food particles underneath the racks.</p> <p>In the large food storage refrigerator upon entering one mountain dew bottle half full was observed sitting on the right top shelf. The Corporate Dietary Manager removed the Mountain Dew bottle out of the refrigerator.</p> <p>At the same time during an interview. the CDM indicated the Mountain Dew bottle belonged to him and was half full of water.</p> <p>In the large food storage freezer area, condensation was observed with an ice formation the size of a dinner plate on the top left ceiling surface. The floor under the wire racks holding the frozen food was visible of small piles of dust and food particles.</p> <p>In the back food preparation area, pears were observed sitting in a strainer down in the right side of a two compartment sink. The strainer was a large metal bowl with holes on the sides and bottom. The strainer rested directly on</p>		<p>particles under the stand by 7/11/14. The food particles found in the steam table were removed while discarding the water in the steam table wells on 6/11/14. 2. All residents served from the kitchen have a potential to be affected by this deficient practice. 3. The Regional Director of Nutritional Services (RDNS) will re-educate the ED, DCS and Department Managers on the regulation F371 and the facility's meal service policy by July 8, 2014. The DCS/Nurse Manager will re-educate the nursing staff on the facility's meal service policy by July 11, 2014. The DCS/Nurse Manager will re-educate the nursing staff on the facility's hand washing policy by July 11, 2014. The RDNS will re-educate the contracted dietary district manager, (referred to as the "Corporate Dietary Manager (CDM)" and the contracted interim Dietary Manager (DM) on the regulation F371, the facility's cleaning schedule and the dietary hand washing policies by July 8, 2014. The CDM or DM will re-educate the dietary staff on the facility's cleaning schedule and the dietary hand washing policies by July 11, 2014. The RDNS will educate the CDM and DM that the two compartment sink is to be used for food preparation, proportioning/dishing up, and service only and not for the disposal of coffee ground of other foods which are to be disposed</p>	

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	<p>the bottom of the sink. Under the strainer holding the pears, which were being spooned into dishes for the next meal, coffee grounds and other food particles were observed. In the left side of the sink there was two containers of food covered with foil.</p> <p>While observing the pears being spooned into dishes and during an interview at this same time, Dietary Aide (DA) #14 indicated she was unsure if the food sitting in the left side of the sink was current for use or garbage. She also had no information concerning the coffee grounds.</p> <p>During an interview at this time, the CDM indicated the food containers on the left side of the sink were garbage waiting to be thrown away.</p> <p>The clean dishes storage area under the steam table was observed with black sticky residue and dusty shelves. The wire rack holding the pots and pans was observed with brown sticky residue, dust and a piece of hair hanging off of the right side edge of the rack.</p> <p>The juice stand was observed to have a sticky brown substance on the shelves with dust and food particles under the stand. Some of the food particles were</p>		<p>of. Any foods which are to be disposed of will be taken directly to a trash can or placed on a separate cart to be disposed of. The RCNS will educate the CDM & DM that personal foods & beverages will not be stored in the facility's large food storage refrigerator by 7/11/14. The CDM &/or DM will educate the dietary staff that personal foods & beverages shall not be stored in the large food storage refrigerator by 7/11/14 and will monitor for dietary staff foods & beverages in the large food storage refrigerator by 7/11/14. The CDM &/or DM will inspect the steam table well water for food particles and replace with clean water as needed. The CDM &/or DM will in-service the cooks on the need to inspect the steam table well water for food particles and replace with clean water as needed by 7/11/14. By 7/11/14, the dietary staff will be in-serviced by the CDM &/or DM that the steam table, shelving, and flooring are to be cleaned on an as needed basis in addition to regular cleaning according to the kitchen cleaning schedule. By 7/11/14, facility staff will be in-serviced on not crossing the dietary department threshold for requests. 4. The ED/Department Manager will conduct QI monitoring of the regulation F 371 to ensure the facility has provided a clean and sanitary kitchen through alternating meal service observations and random kitchen</p>		

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	<p>quarter size.</p> <p>On 6/11/14 from 2:31 PM to 3:17 PM, during a second observation of the kitchen the following was observed:</p> <p>Upon entering the kitchen for a second observation the kitchen door threshold continued to be sticky with dark brown and black residue covering the threshold.</p> <p>The observation of the flooring appeared moped with the edges sticky and dust and food particles still visible under the racks and shelves.</p> <p>An observation of the steam-table found food particles floating and lying on the bottom of the steam water reservoir. The food particles appeared to be left from prior food preparation. The water reservoirs where steaming in preparation for the next meal.</p> <p>At this same time during an interview, the CDM indicated the policy of the kitchen was the steam table, shelving and flooring are cleaned after every meal time. He also indicated he was aware of the need for improved cleaning and was working on the issue.</p> <p>Certified Nurse's Aide #11 was observed to enter the kitchen. She was observed to</p>		<p>observations. 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 ED/Department Manager will report the 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. Date of Compliance: July 13, 2014</p>		

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	<p>open the large food freezer and obtain a Dilly bar (ice cream bar). No handwashing was observed upon entering or exiting the kitchen. At this same time during an interview, CNA #11 indicated she normally made a request from the door of the kitchen for kitchen staff to acquire items from inside the kitchen.</p> <p>On 06/09/14 from 11:50 a.m. to 12:48 p.m., CNA # 19 was observed carrying clothing protectors against her uniform. She was also observed to pick up magazines multiple times and was touching residents while handling clothing protectors. She was then observed to serve drinks to the residents in the dining room. The clothing protectors were adjusted on residents in between serving of drinks. As she picked up the water pitcher used for the drinks she was observed to pick it up by it's spout. No hand washing or hand sanitizer was observed to be used during this observation.</p> <p>LPN # 18 was observed to reposition Resident # 108 in her chair. She then obtained a cup by the rim and began to assist Resident # 138 with her meal. No hand washing or hand sanitizer was observed during observation of this meal.</p> <p>On 06/11/14 at 12:09 p.m. lunch was observed in the B Hall dining room.</p>			

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F000431 SS=E	<p>CNA # 26 was observed to remove 2 dirty cups, and picked up a food tray for Resident # 100 and then Resident # 127 and assisted to feed them. No hand washing or hand sanitizer was observed.</p> <p>Dining room observation on 6/12/14 at 1:30 p.m. in Azalea Dining Room, indicated resident #27 sitting at a table trying to drink from a cup with a lid. The lid was noted as being turned the wrong way, preventing resident from being able to drink from the cup. Dietary aid #8, who was collecting dirty dishes, put on one glove, turned the lid around to the proper position, removed the glove and continued with her duties with no hand washing observed.</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility</p>				

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	<p>must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure disposal of expired medications for 1 of 1 medication room and and the accuracy of narcotic counts for 2 of 4 narcotic counts observed (Hall A and Hall C).</p> <p>Findings include:</p> <p>On 6/9/14 from 10:30 to 11:00 a.m., the Medication Room was observed with Qualified Medication Aide (QMA) #13. The following was observed:</p> <p>In the refrigerator containing the</p>	F000431	F 431 1. On 6/09/2014 the expired and unlabeled medications were removed from the refrigerator along with the medications without an open date after being brought to the attention of Qualified Medication Aide (QMA). The Assistant Director of Clinical Services (ADCS) will re-educate LPN #35 on the facility's Medication Administration policy by July 8, 2014. Residents #113 & 14 suffered no apparent adverse affects. The ADCS will re-educate LPN#23 &36 on the facility's Medication Administration policy by July 8, 2014. 2. All residents have the	07/13/2014

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	<p>uncontrolled substances, the following medications were noted:</p> <ul style="list-style-type: none"> -Phenadoz suppositories had an expiration date of 5/14. -A multi-dose flu vaccine vial had an expiration date of 4/14. -Phenadoz suppositories (12 in package) had an expiration date of 5/14. -There was no open date on a package of acetaminophen suppositories. -There were 6 unlabeled Ducolax suppositories without a resident label. <p>On 6/11/14 at 2:19 p.m., the narcotics count on the medication cart for Hall A was observed with LPN #32 and LPN #35 and indicated the following:</p> <ul style="list-style-type: none"> -Resident #59 had a card of hydrocodone 5/325 with 9 tabs left in the card that should have been 10. -Resident #28 had a card of hydrocodone 5/325 with 14 tabs left in card that should have been 13. -Each resident's prescription is 1 tablet twice daily. LPN #35 indicated she accidentally took two tabs out of Resident #59's card but gave the right dose to Resident #59 and Resident #28. <p>On 6/12/14 at 2:51 p.m., observation of narcotic count for Medication cart for Hall C with LPN #23 and LPN #36 indicated the following:</p> <ul style="list-style-type: none"> -Resident #113's Hydrocodone 325 had a 		<p>potential to be affected by this deficient practice. The DCS/ Nurse Manager will re-educate the licensed nurses on the facility's Medication Administration policy by July 11, 2014. 3. The RDCS will re-educate the Department Managers on the regulation F431. The DCS/ Nurse Manager will re-educate the licensed nurses on the facility's Medication Administration policy by July 11, 2014. 4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 431 to ensure disposal of expired medications and the accuracy of narcotic counts. 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 observation of both the medication room and medication administration. The DCS/Nurse Manager will report the 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: July 13, 2014</p>				

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	<p>count of 31, 32 were needed. The dose was marked on the Medication Administration Record (MAR) but was not marked on the Narcotics Record.</p> <p>-Resident #113 had Clonipin 0.5 mg (milligrams) recorded as given on the MAR but not recorded on the Narcotics Record.</p> <p>-Resident #14 had a recorded Hydrocodone 7.5/325 on the MAR, but was not recorded on the Narcotics record.</p> <p>During an interview on 6/13/14 at 2:17 p.m., Interim Director of Nursing (IDON) and LPN #32 indicated when a resident asks for a pain pill the nurse reads the label on the card to verify the right route, right dose, right resident, pops the med out of the card, signs off on the narcotics sheet, administers the medication, and signs off on the MAR.</p> <p>During an interview on 6/13/14 at 2:34 p.m., The IDON indicated she could not find a policy and procedure on actual medication administration.</p> <p>3.1-25(o)</p>						

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>			
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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to follow infection control practices related to uncovered open areas for 1 of 1 open area observed (Resident #154), Foley catheter tubing on the floor for 1 of 2 Foley catheters observed (Resident #52), and hand washing technique for 1 of 1 nursing staff observed. (CNA #1)</p> <p>Finding includes:</p> <p>During the lunch meal observation on 6/9/2014, the following was observed:</p> <p>At 12:04 p.m. - Resident #154 was observed to have red liquid substance dripped down his left foot. Resident #154's left foot was observed to be discolored and no dressing covering the red liquid substance.</p> <p>At 12:10 p.m.- CNA #1 repositioned Resident #3 in the dining room and then started serving drinks to resident's sitting in the dining room - no hand washing or hand gel was observed.</p> <p>At 12:26 p.m. - Resident #52 Foley catheter tubing was observed to be laying on the floor in the dining room, the Foley catheter tubing was observed to have</p>	F000441	<p>F 441 1. Resident #154 no longer resides at the facility. Resident #52 showed no apparent adverse affect. The catheter tubing was repositioned so it wouldn't come in contact with the floor after it was brought to the attention of the licensed nurse. 2. All residents have the potential to be affected by this deficient practice. 3. The RDCS will re-educate the Department Managers on regulation F441. On 6/16/2014 the RDCS re-educated the DCS, ADCS and Unit Manager on the facility's Hand Washing Technique policy. The DCS/ Nurse Manager will re-educate the nursing staff on the facility's Hand Washing Technique policy by July 11, 2014. 4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 441 to ensure the infection control practices related to hand washing technique, uncovered open areas, and Foley catheter tubing on the floor are followed. 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 and one resident with a Foley catheter. The DCS/Nurse Manager will report the findings to two quarterly QAPI committee meetings. The</p>	07/13/2014

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	<p>slightly cloudy urine with small amount of red substance in the tubing.</p> <p>At 12:34 p.m. - CNA #1 repositioned Resident #3 in the dining room and then at 12:58 p.m., CNA #1 retrieved a meal tray from the kitchen window and started serving resident's in the dining room - no hand washing or hand gel was observed during this time.</p> <p>At 12:52 p.m. - Resident #154 was observed to have a spot of red liquid substance on the floor under left foot, where the red substance was observed to be dripping from left foot in a earlier observation.</p> <p>On 6/11/14 at 12:35 p.m. - Resident #52 Foley catheter tubing was observed to be laying on the floor in the dining room, the tubing contained slightly cloudy urine with small amount of red substance in the tubing.</p> <p>On 6/11/14 at 12:50 p.m., during an interview, CNA #20 indicated we empty the catheter bag every 2 hrs, we put the catheter bag through the resident pant leg and hook it to the chair.</p> <p>On 6/11/2014 at 4:03 p.m., the corporate clinical nurse presented a copy of the facility's current policy on "Hand</p>		<p>QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring. 5. Date of Compliance: July 13, 2014</p>		

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F000465	<p>Washing Technique." Review of this policy at this time included, but was not limited to: "Policy: All personnel will wash hands to remove dirt, organic material, and transient microorganisms to prevent the spread of infection...."</p> <p>On 6/11/2014 at 4:03 p.m., the corporate clinical nurse presented a copy of the facility's current policy on "Catheterization." review of this policy at this time included, but was not limited to: "Procedure: 21. Foley bag must be covered by a privacy bag at all times to preserve dignity of resident...22. Tubing must be off of the floor at all times...."</p> <p>3.1-18(b)(2) 3.1-18(l)</p>			
	483.70(h)			

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SS=F	<p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observations, interview and record review, the facility failed to ensure a clean and sanitary environment for 4 of 4 halls and for 13 of 40 resident's room observed. (Hall A,B,C and D; Resident #'s 80, 68, 03, 14, 64, 91, 62, 27, 125, 66, 142, 101 and 32 rooms)</p> <p>Findings include:</p> <p>1. On 6/9/14 at 12:09 p.m., during the lunch observation in Hall B, the beige rocking chair was observed with a large dark brown to black stain on the cushion of the chair. The couch next to this rocking chair was observed with stains along the front of the couch. The carpeting throughout the dining room was observed with scattered snagged threads of carpeting. A 18 inch piece of duct tape was observed in front of the floral couch. At this same time during an interview, CNA #19 indicated the piece of black duct tape was covering a hole in the carpet.</p> <p>2. The following observations were observed on C Hall :</p> <p>-On 06/10/14 at 9:12 a.m., in Resident #</p>	F000465	<p>F 465 1. The stains on the cushion of the beige rocking chair and along the front of the couch next to it will be removed by July 11, 2014. The carpeting throughout the B Hall dining room will be repaired /replaced. Resident #68 showed no apparent adverse affect. The chipped paint on the wall on the left side of the window along with the ripped area of drywall at the head of the bed will be repaired by July 11, 2014. Resident #80 showed no apparent adverse affect. The red stain on the tile in front of the bathroom door will be removed by July 11, 2014. Resident # 03 showed no apparent adverse affect. The brown substance around the bottom of the toilet along with the stickiness of the bathroom floor will be removed by July 11, 2014. Resident #14 showed no apparent adverse affect. The stickiness of the room and bathroom floors will be removed by July 11, 2014. Resident #91 showed no apparent adverse affect and the stickiness will be removed from the room and bathroom floors by July 11, 2014. Resident #62 showed no apparent adverse affect. The glass window will be replaced by July 11, 2014. Resident #27</p>	07/13/2014	

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	<p>68's room a 6 inch length of chipped paint was observed on the wall on the left side of the window with a ripped area of drywall at the head of her bed.</p> <p>-On 06/10/14 at 9:46 a.m., observation of Resident # 80's floor had a red stain on the tile in front of the bathroom door.</p> <p>-On 06/10/14 at 10:03 a.m., Resident # 03's bathroom floor was sticky when walked on with a dark brown substance observed around the bottom of the toilet.</p> <p>-On 06/10/14 at 10:33 a.m., Resident # 14's room and bathroom floors were sticky when walked on.</p> <p>-On 06/10/14 at 10:50 a.m., observation of Resident # 64's bathroom indicated a black substance on the wall and ceiling. The paint was observed to have had an attempted previous repair.</p> <p>-On 06/10/14 at 11:38 a.m., Resident # 91's room floor and bathroom floor were sticky when walked on.</p> <p>-On 06/10/14 at 4:40 p.m., Resident # 62's room glass window was observed with a patch of duct tape over a crack on the window.</p> <p>3. The following observations were observed on A Hall :</p> <p>-On 06/09/14 at 3:10 p.m., the bathroom wall in Resident # 27's room was observed to be marred with black stains. The floor was observed to have brown</p>		<p>showed no apparent adverse affect. The bathroom will be repaired or removed of the marred black stains on the wall, brown stains around the toilet and the chipped drywall by July 11, 2014. Resident #92 showed no apparent adverse affect. The tiles with gapping areas, the brown substance around the toilet along with the scattered black stained areas to the wall and floor will be repaired /removed by July 11, 2014. Resident #125 showed no apparent adverse affect. The bedside table will be replaced and the privacy curtain will be cleaned removing the stain by July 11, 2014. Resident #66 showed no apparent adverse affect. The bathroom wall, the grab bar, and the floor will be repaired by July 11, 2014. Resident #142 showed no apparent adverse affect. The bedside table will be replaced; the privacy curtain and the bathroom floor will be cleaned removing the stains by July 11, 2014. Resident #101 showed no apparent adverse affect. The privacy curtain will be cleaned removing the stains and the bathroom floor tiles will be repaired /replaced by July 11, 2014. Resident #32 showed no apparent adverse affect. The bathroom floor will be cleaned removing the stickiness and the brown substance around the bottom of the toilet by July 11, 2014. The floor in room D115 will be cleaned removing the stains and the caulking area around the</p>				

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	<p>stains around the toilet. The drywall was observed to be chipped.</p> <p>-On 06/10/14 at 9:18 a.m., Resident # 92's had a separate shower room and bathroom in his room. The shower room was observed with loose cove base on both sides of the doorway inside the shower room. In the bathroom the floor tiles had gapping areas surrounding the toilet with a dark brown substance around the bottom of the toilet. The floor and the wall was observed with scattered black stained areas.</p> <p>-On 06/10/14 at 11:45 a.m., Resident # 125's bedside table was observed coming apart at the edges. Small scattered stained areas were observed on the privacy curtain hung between the two beds.</p> <p>-On 06/10/14 at 3:06 p.m., in Resident # 66's bathroom the walls were observed marred and chipped. The flange on the grab bar was loose from the wall. The bathroom floor was observed stained and discolored with scattered areas of loose cove base.</p> <p>-On 06/10/14 at 3:25 p.m., Resident # 142's bedside table was observed coming apart at the edges. The privacy curtain was observed with small scattered stained areas. The bathroom floor was observed stained and discolored.</p> <p>-On 06/10/14 at 4:14 p.m., Resident # 101's privacy curtain was observed with</p>		<p>bottom of the toilet will be cleaned /replaced by July 11, 2014. In room D110 the small holes in the wall and the grab bar will be repaired by July 11, 2014. In room D113 the floor and the bathroom floor will be cleaned removing the stains by July 11, 2014. At the D Hall nurses' station to the exit door, the floor tiles will be replaced /repaired by July 11, 2014. The D Hall biohazard room will be cleaned removing the dirty bag, debris, dust and stains from the tiles by July 11, 2014. The A Hall shower room and the C Hall shower room referenced in the statement of deficiencies are the same room. The two door shower room is at the end of A and C Halls. The shower stalls and the tiles will be repaired by July 11, 2014. The paint along the ceiling facing the entry way to the A hall near the nurses' station will be finished by July 11, 2014. The privacy curtain in room A103 will be cleaned removing the stains by July 11, 2014. The C Hall biohazard room will have the peeling paint repaired and the debris cleared from the floor by July 11, 2014. The peeling wallpaper on the walls on the right on B Hall will be repaired by July 11, 2014. In the B Hall dining room the missing trim and cover for heating/air unit will be replaced by July 11, 2014. The dust will be removed from the vent in the oxygen room by July</p>				

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	<p>scattered stained areas. The bathroom floor tile was observed gapping between them.</p> <p>4. The following observations were observed on D Hall :</p> <p>-On 06/10/14 at 2:09 p.m., Resident # 32's bathroom floor was sticky when walked upon with a dark brown substance around the bottom of the toilet.</p> <p>5. On 06/12/14 from 9:30 a.m. to 10:40 a.m., the environmental tour was completed with the Maintenance Manager and the Housekeeping Supervisor. The following was observed:</p> <p>On the D-Hall:</p> <p>-Room D115 bathroom the caulking area around the bottom of the toilet was dark brown. The floor was observed discolored and stained.</p> <p>-Housekeeping Supervisor indicated Room D110 was recently cleaned. She indicated the walls are washed down. In the same room the wall was observed with scattered small holes in the wall with a loose grab bar. She indicated the stuffed chairs and sofas are wiped down on schedule.</p> <p>-The Housekeeping Supervisor indicated D114 was recently cleaned and she compared it to D113, which had not</p>		<p>11, 2014. 2. All residents have the potential to be affected by this deficient practice. The furniture in the dining rooms and common areas will be assessed for stains by July 11, 2014 and any areas identified will be corrected. The wall paper throughout the facility will be assessed for peeling by July 11, 2014. Any areas identified will be corrected. The floors in the resident rooms and bathrooms will be assessed for stickiness, stains and stains around the bottom of the toilet by July 11, 2014. Any areas identified will be corrected. The privacy curtains will be assessed for stains and any areas identified will be cleaned/ replaced by July 11, 2014. The grab bars in the resident bathrooms will be assessed and any issues identified will be repaired by July 11, 2014. The bedside tables in the resident rooms will be assessed by July 11, 2014 and any issues identified will be repaired/ replaced. 3. The RDCS will re-educate the Department Managers on the regulation F 465 by July 8, 2014. The ED will re-educate the Maintenance Director on the facility's Maintenance and Maintenance Checklist Policies by July 11, 2014. The Maintenance Director/ Nurse Manager will re-educated the staff on the facility's Maintenance Request Form by July 11, 2014 emphasis will be placed on location and indication</p>	

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	<p>been cleaned. Room D 113's room floor and bathroom floors were observed stained and discolored as throughout the building.</p> <p>-At the D Hall nurses station to the exit door the floor tiles were observed with gapping between tiles with a dark brown substance between the gaps.</p> <p>-The biohazard room in D Hall was observed with a dirty bag on the floor. Biohazard room in entrance to D Hall-floor was observed with debris and dust scattered throughout and stained tiles.</p> <p>In A Hall:</p> <p>-The A Hall shower two shower stalls were observed. The tile wall between the shower stalls was missing 4 tiles. The first shower stall was observed with one wall bulging outwardly and measured a length of 6- 4x4 tiles and the width of 8 4x4 tiles. The second shower stall was in similar condition. A bug observed around decayed tile area.</p> <p>-The paint along the ceiling facing the entry way to the A hall near nurses station was observed to be unfinished. The Maintenance Manager indicated that this was done by the previous maintenance.</p> <p>-In Room A103-1, the privacy curtain was observed to have scattered, quarter sized red stains on it.</p>		<p>for use. The Housekeeping Supervisor will place the privacy curtains on a routine cleaning schedule by July 11, 2014. 4. The ED / Maintenance Director will conduct QI monitoring of the regulation F 465 to ensure a clean and sanitary environment. 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 resident rooms and one other area (i.e. dining room, shower room or common sitting area). The ED/ Maintenance Director will report the 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. Date of Compliance: July 13, 2014</p>				

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	<p>In C Hall:</p> <ul style="list-style-type: none"> -The C hall shower stalls were observed. The tile was observed to be stained and discolored with damaged tiles measured at a length of 6 -4x4 and a width of 8 -4x4 tiles. -The Biohazard room in C Hall was observed to have paint peeling in a 5 inch by 6 inch area on wall above a pipe to the right as one entered the room. The floor was observed to have scattered debris throughout the area. <p>In B Hall:</p> <ul style="list-style-type: none"> -The walls on the right in B Hall were observed with peeling wallpaper from the seams. The Maintenance manager indicated the wallpaper was replaced when needed. He indicated he was not aware of the areas as he relies on the staff to notify him. -The trim was missing in the B Hall dining room as well as the cover over the controls of the heating/air conditioning units was missing -In the oxygen room a layer of dust was observed in the vent. <p>During an interview the Maintenance Manager indicated the furnishings were cleaned by housekeeping as needed. He also indicated the privacy curtains are cleaned and replaced by housekeeping.</p>			

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	<p>6. During an interview on 6/11/14 at 10:00 a.m., the Administrator and Housekeeping Supervisor were interviewed. The Administrator indicated the furniture was old, it was cleaned after an inspection showed the need. The Housekeeping Supervisor indicated the rooms are cleaned once daily. If further cleaning was needed, then they were more thoroughly cleaned. The Housekeeping Supervisor indicated a room was deep cleaned once per month on a schedule and daily cleaning was a 5 step cleaning method.</p> <p>7. The "Housekeeping" policy was provided by the Housekeeping Supervisor on 06/12/14 at 11:30 a.m. This current policy indicated the 5 step method included was cleaning surfaces washed-both vertical and horizontal, trash emptied, dust mop the floors, then damp mop the floors.</p> <p>3.1-19(f)</p>			

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F009999	<p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin</p>	F009999	<p>F9999 1. Employee #38 is no longer an employee of the facility. Employee #39 has received the two step screening for tuberculosis. 2. All residents have the potential to be affected by this deficient practice. 3. The RDCS will re-educate the Department Managers on the state rule and the facility's tuberculosis policy. 4. Human Resources (HR) /Nurse Manager will conduct QI monitoring of the state rule to ensure employees receive the required two step screening for tuberculosis weekly for eight weeks then monthly for four months. HR/ Nurse Manager will report the 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: July 13, 2014</p>	07/13/2014	

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	<p>testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to insure employees received the required two step screening for tuberculosis for two of five employee files reviewed. (Employee #38 and Employee #39)</p> <p>Finding include:</p> <p>On 6/13/2014 at 10:30 a.m., the employee files were reviewed. Employee #38's tuberculosis screening form was blank indicating no screening had been preformed. Employee # 38 was hired on 2/14/2014. Employee #39's tuberculosis screening form indicated the first screening was done 6/13/2014 and no second screening had been done. Employee #39 was hired on 5/28/2014.</p> <p>During an interview on 6/13/2014 at 1:05 p.m., the corporate Clinical Nurse indicated the facility "dropped the ball" and did not get the employees the proper</p>			

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	tuberculosis screening. 3.1-14(t)(1)				