

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/27/2012
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NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN 46580
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey date: July 23, 24, 25, 26, and 27, 2012</p> <p>Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600</p> <p>Survey team: Julie Wagoner, RN, TC Tim Long, RN Christine Fodrea, RN Susie Scott, RN</p> <p>Census bed type: SNF: 01 SNF/NF: 86 Total: 87</p> <p>Census payor type: Medicare: 18 Medicaid: 58 Other: 11 Total: 87</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 8/3/12 Cathy Emswiller RN</p>	F0000	<p>August 17, 2012</p> <p>Mrs. Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 N. Meridian Street Indianapolis, Indiana 46204</p> <p>Re: Mason Health Care Provider Number: 155003 Survey Dates: July 23-27, 2012</p> <p>Dear Mrs. Rhoades:</p> <p>Enclosed please find our completed plan of correction responding to the recertification survey conducted at our facility ending 7/27/12 and the 2567 dated 7/27/12. All POC measures have been or will be fully implemented by August 26, 2012. Mason Health Care respectfully asks that our plan of correction be considered to serve as our allegation of compliance for the cited tags, as of that date. I hereby request a quick return of the survey team to clear all cited tags.</p> <p>As noted on the plan of correction, the POC should not be construed as an admission as to the validity of any of the citations. Please be assured, however, that although the facility disagrees with the citations, we have</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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			<p>considered the survey concerns very seriously and have undertaken the necessary measures to ensure findings of compliance as of August 26, 2012. Quality monitoring and in-services will be provided on a continuing basis to assure an ongoing understanding and implementation of policies and procedures to ensure continued compliance.</p> <p>Please contact me with any questions or concerns you may have. Thank you in advance for your cooperation and assistance in this matter.</p> <p>Sincerely,</p> <p>Lillian J. Horton, HFA, MHA Mason Health Care Administrator</p>		

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F0156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</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 notify and explain the Medicare and/or Medicaid costs and benefits for 2 of 3 residents family's reviewed. (Residents #5 and #117)</p> <p>Findings include:</p> <p>During an interview with the Business Office Manager, during the personal funds review on 07/26/12 at 9:30 A.M. she indicated the Admission staff informed residents of the cost of supplies and services.</p> <p>Interview with RN #9, on 07/26/12 at 10:36 A.M. indicated she was unsure of the forms given to residents but would look through the admission packet and try to figure it out. She</p>	F0156	<p>1.) Facility Disclaimer 2.) Credible Allegation of Substantial Compliance</p> <p>This Plan of Correction (POC) is prepared and executed because it is required by the provisions of State and Federal Law, and not because Mason Health Care agrees with the allegations contained there-in. Mason Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capability to render adequate care.</p> <p>Please let these POC responses serve as the facilities Credible Allegation of Compliance 8/26/12.</p> <p>- - <u>F-156 Notice of Rights, Rules, Services, Charges:</u></p>	08/26/2012

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	presented three forms, on 07/26/12 at 10:40 A.M., one titled, facility admission agreement, one untitled form, and one titled 2012 Medicare Information brochure. The only information in the admission agreement indicated the following: "The Resident and the Legal representative shall pay for services and supplies, other than the Basic Services, that the Facility provides and which are not covered by the daily rate then in effect. These Ancillary Charges are charged to the Resident in accordance with the Ancillary Charges then in effect as reflected on the Ancillary Charge Listing. In addition to the Facility's Basic Services and Ancillary Services and Supplies charges, the Resident and the Resident's Legal Representative shall pay all fees and costs for goods or services furnished to or for the Resident by anyone other than the Facility, unless these charges are reimbursed through Medicare, Medicaid or some other authorized third party payor." The 2012 Medicare Information brochure, published by the facility's corporation indicated the following under the uncovered skilled care portion of the chart: "All personal supplies and conveniences such as barber/beautician, private telephone,		This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. It is facility practice to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. It is facility practice to provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. It is facility practice to make such notification prior to or upon admission and during the resident's stay and receipt of information, and any amendments to it, must be acknowledged in writing. It is facility practice to 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		

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	and television." The untitled form, indicated the following: "...We will continue charging per day utilization for medical, nursing, and incontinent supplies. Oxygen and 'specialty wound care bed' will be billed separately as utilized. Sample included supplies: blood glucose management, disposable incontinence supplies, general nursing supplies, gloves, nourishments/supplements, ostomy, personal care, sharps, urological, wound care supplies. Your all inclusive charge for these items will be \$5.76 per day, effective January 1, 2012....If you have any questions or need clarification, please feel free to contact (business office manager's name) and the Administrator's name...." When queried regarding any specific information given to residents and families about items covered by Medicare and Medicaid specifically, RN #9 presented a form, titled "Notice of Exclusions from Medicare Benefits" which informed those residents of items not covered by Medicare however, included on the list were routine physical and most tests for screening, routine foot care, physician services, most prescription drugs, items or services furnished to an individual who is a resident of a skilled nursing facility...physical and		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. It is facility practice to inform each resident before, or at the time of admission, and periodically during the residents 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. It is facility practice to furnish a written description of legal rights which includes; A description of the manner of protecting personal funds, under paragraph c) of this section. 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.				

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	<p>occupational therapy..."</p> <p>During interview on 07/26/12 at 12:40 P.M., RN #9 indicated if a family or resident had any questions regarding the charges, the facility presented a form, titled "Optional/covered Items and Services" which was a form for all types of payor sources with covered and non-covered services. The form noted some of the covered items but still did not indicate what supplies were provided in the "Room and board" and "Nursing Services" and "Personal hygiene items" denotations.</p> <p>Interview with the Corporate Staff, employee #22, on 7/26/12 at 2:50 P.M., indicated one of the forms should automatically be given to residents and/or families on admission, and explained. However, the form still does not given any examples of covered personal hygiene items, or examples of nursing services provided, and what "board" includes on room and board.</p> <p>RN #9 indicated, on 07/27/12 at 2:30 P.M., the form, titled "Notice of Exclusions from Medicare Benefits" form was the form she gave residents and/or their representatives when there were questions not the untitled, "Optional/covered items and</p>		<p>It is facility practice to have a posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>It is facility practice to comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>It is facility practice to inform each resident of the name, specialty, and way of contacting the physician for his or her care.</p> <p>It is facility practice to prominently</p>				

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	<p>Services."</p> <p>During interview with the Administrator, on 07/27/12 at 2:25 P.M., the Administrator indicated a list of Resident Rights was given to each resident in the Admission packet. The Administrator indicated the charges and covered items were explained to family's by the Admission staff even though the Admission staff were unsure of the forms they utilized and unsure where to look in the forms to show family's and/or residents about the charges and covered items.</p> <p>Interview with 2 of 3 resident family's (#99 and #100), conducted on 07/24/12 at 1:30 P.M. and 2:00 P.M. respectively, indicated they were not sure of the covered and uncovered items and neither family recalled the facility staff reviewing any information about the covered and uncovered charges upon admission or at any time during their family member's stay at the facility.</p> <p>3.1-4(f)(3)</p>		<p>display in the facility written information, and provide to residents and applicants for admission oral and written information about how to receive refunds for previous payments covered by such benefits.</p> <ol style="list-style-type: none"> 1. Corrective action cannot be taken due to the alleged deficiency occurred in the past. 2. The 'Optional/Covered Items and Services' form will be updated and distributed to all current residents and POAs. 3. Marketing and Admissions staff, as well as, designees have been reinserviced on Medicare and/or Medicaid costs and benefits. 4. Administrator/designee will monitor weekly by utilizing a QA tool. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. 5. August 26, 2012. 		

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on observation, record review, and interview, the facility failed to promptly resolve the resident's grievance of missing items for 1 of 3 residents investigated for loss of personal property in a sample of 18 residents interviewed (Resident #34).</p> <p>Finding includes:</p> <p>The clinical record for Resident #34 was reviewed on 07/26/12 at 9:30 A.M. Resident #34 had diagnoses, including but not limited to, sepsis, abnormal posture, muscle weakness and multiple sclerosis (MS). The resident also required extensive assistance with his ADLs (Activities of daily living). The resident was non ambulatory and could only lie in his bed or sit in a wheelchair as a result of his disabilities.</p> <p>The resident was observed on 7/24/12 at 11:40 a.m., to have some use of his hands and with effort was able to use a laptop computer. His hands were noted to be impaired due to his MS and muscle weakness.</p>	F0166	<p><u>F-166 Right to Prompt Efforts to Resolve Grievances:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure a resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <ol style="list-style-type: none"> Resident #34 missing items have been resolved per facility policy. Missing items reported will be investigated promptly per facility policy. Staff has been reinserviced on facility missing items policy. Administrator/designee will monitor weekly by utilizing a QA tool. This will continue x 4 wk then monitored thru Q.A. monthly x2, 	08/26/2012			

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	<p>The resident was either confined to his bed, all day on 7/23, 24, 25 and 26 (by his choice) or wheelchair all morning on 7/27 and needed extensive assistance with activities of daily living.</p> <p>Interview with Resident #34, on 7/24/12 at 11:40 a.m. indicated he had 3 electric razors missing, which the facility had never found, a pair of tennis shoes and glasses. He indicated the facility finally replaced the glasses but not the razors or the shoes.</p> <p>The Social Service Director was interviewed on 7/25 at 11:30 a.m. regarding the resident's concerns of the missing glasses, razor and shoes. On 07/25/12 at 3:00 p.m. , she presented two electric razors. She indicated they both belonged to the resident and one was broken and she showed it had his name on it. She indicated the other razor had been on her desk and she did not know to whom it belonged. She indicated she now knew it belonged to resident #34 because all the cords fit the charger and plug for his razor located in his room.</p> <p>The Social Service Director was asked why the razor had been laying</p>		<p>then quarterly thereafter.</p> <p>5. August 26, 2012.</p> <p>-</p>		

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	<p>on her desk for 2 weeks without knowing to whom it belonged but she did not have an answer. There was also no reason given for why the broken razor had not been repaired or replaced. The Social Service Director also provided two pairs of glasses. She indicated one pair was an old pair and the other was the resident's glasses but the resident claimed they were not his. The Social Service Director indicated the resident received an eye exam in Nov. 2011 and received new glasses, which were the ones he had at present. The Social Service Director indicated the resident lays his glasses aside and then just can not find them most of the time. She indicated there were two more reports of missing glasses after the resident received the new glasses and these issues were resolved by finding the glasses.</p> <p>The only documentation presented for review of lost items was a "missing item report" dated 4/2/12 indicating the resident had lost his glasses on 3/30 at 9:30 p.m. The top half of this form was filled out by a CNA indicating the date, time and a description of the situation. The second half of the page was blank and there was no "follow up" documentation on the form and no</p>						

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	<p>staff signatures at the bottom of the page indicating the outcome or actions taken regarding this situation.</p> <p>During interview on 7/24/12 at 11:40 a.m., the resident indicated the lost glasses from March were found and he was satisfied with the replacement of the glasses in November but indicated he would like to have his razors and shoes returned which had been missing for several weeks.</p> <p>The facility had no documentation regarding the missing shoes or the missing razors. In the exit conference with the facility, conducted on 7/27/11 at 3:00 P.M., a comment by one facility staff member was made indicating the shoes were probably in the resident's closet. The reply did not show why the resident's concerns were not investigated promptly. It also did not explain why the resident's concern regarding his razors and shoes had not been addressed promptly. There was no documentation to show how the facility had addressed the missing tennis shoes or razor or that the facility had an adequate working system in place for addressing resident missing items or follow up.</p> <p>3.1-9(b)</p>						

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	3.1-9(c) 3.1-9(e)			

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F0167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interviews, the facility failed to ensure the survey results were prominently displayed and readily accessible for 3 of 3 residents interviewed concerning posted survey results.(Residents 38,131, and 34)</p> <p>Finding includes:</p> <p>1. On the environmental tour on 7/26 at 8:45 a.m., posted signs were observed which indicated the most recent survey results were located in the front lobby. The survey results were discovered on a large bookshelf approximately six feet high four feet wide in a white binder labeled "HIPPA privacy practices and State Survey Documents". It was located on the left end of the fourth shelf from the top, which was about two feet from the floor. Because the binder was located amongst many other books it</p>	F0167	<p><u>F-167 Right to Survey Results – Readily Accessible:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure a resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>It is facility practice to make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>1. Corrective action cannot be</p>	08/26/2012			

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	<p>was not in a prominent, easily observed location and just blended in with the many other books.</p> <p>Interview with alert and oriented Resident #34, conducted on 07/26/12 at 2:00 P.M., indicated he did not know where the State survey results were located.</p> <p>Interview with alert and oriented Resident #131, conducted on 07/26/12 at 2:15 P.M., indicated she did not know where the State survey results were located.</p> <p>During an interview with Resident #38, conducted on 07/26/12 at 11:00 A.M. , she indicated the state survey results were probably in an office but she did not know yet for sure. She indicated she did not know where they (the Indiana State Department of Health survey results) were located without asking for the results.</p> <p>3.1-3(b)(1)</p>		<p>taken due to the alleged deficiency occurred in the past.</p> <p>2. The designated shelf in front lobby has been labeled to identify location of survey book.</p> <p>3. Location of survey book will be reviewed monthly x12 in resident council. Staff has been reinserviced on survey book location.</p> <p>4. Administrator/designee will monitor weekly by utilizing a QA tool. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter.</p> <p>5. August 26, 2012.</p> <p>-</p>		

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F0223 SS=D	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record observation, record review, and interview, the facility failed to keep residents free from mental abuse/threat by staff and failed to report and thoroughly investigate 1 of 3 investigations reviewed. (Resident #34)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #34 was reviewed on 07/26/12 at 9:30 A.M. Resident #34 had diagnoses, including but not limited to, sepsis, abnormal posture, muscle weakness and multiple sclerosis (MS). The resident also required extensive assistance with his ADLs (Activities of daily living). The resident was non ambulatory and could only lie in his bed or sit in a wheelchair as a result of his disabilities. The resident was observed on 7/24/12 at 11:30 a.m., to have some use of his stiff, hands and with effort was able to use a</p>	F0223	<p><u>F-223 Free From Abuse/Voluntary Seclusion:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure a resident is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>It is facility practice to not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>-</p> <p>1. An internal investigation was initiated and ISDH notified of alleged allegation of abuse by resident #34.</p> <p>2. Staff interviewed to ensure no other allegations of abuse has been</p>	08/26/2012	

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	<p>laptop computer. His hands were noted to be impaired due to his MS and muscle weakness. The resident was either confined to his bed, all day on 7/23, 24, 25 and 26 (by his choice) or wheelchair all morning on 7/27 and needed extensive assistance with activities of daily living.</p> <p>During interview on 7/24 at 11:30 a.m., the resident indicated staff had been rude to him a few weeks ago and he had reported it.</p> <p>The resident indicated he had an argument with [gender documented] aide #20 on the night shift, about making a lot of noise while caring for his roommate. The resident indicated the staff member stated, 'if you are going to be like that I just won't clean you up if you have a BM'. The resident indicated he felt threatened but not frightened. The resident indicated he reported the interaction and the DON came to talk with him (about the incident), so he knew the information had gotten passed along. When the DON came to talk with him he felt she gave him "a stare down like you would if you had been on the play ground when you were 10." He indicated he stared at her right back. He stated she did not scold him but the look "was so immature", like she was disgusted with him. He stated he</p>		<p>verbalized by a resident. If there are any other allegations reported an internal investigation will be initiated and our abuse policy followed.</p> <p>3. Staff has been reinserviced on what is an allegation, when to notify the Administrator and the abuse policy.</p> <p>4. Administrator/designee will monitor weekly by randomly selecting three residents and interviewing them regarding their care and treatment while at Mason Health Care. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. This will also be discussed in Resident Council monthly with any concerns forwarded to the Administrator immediately.</p> <p>5. August 26, 2012.</p>		

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	<p>did not feel threatened by the DON but feels "she is not here to help the residents but is for the nurses and staff." The resident indicated he was "pretty sure" the [gender stated] aide still worked at the facility but indicated the staff member did not take care of him any more. He indicated this was the only time anyone had ever been rude to him.</p> <p>Review of the employee file for CNA #20, conducted on 07/26/12 at 2:15 P.M., indicated the CNA was still employed by the facility and had completed abuse training upon hire. There was no disciplinary action in the employee's file or counseling statements.</p> <p>The abuse investigation, regarding the allegation of abuse made by Resident #34 was requested, on 07/26/12 from the DON. The DON indicated there was no abuse investigation completed. She indicated the concern about a staff member, made by Resident #34 had been resolved.</p> <p>The concern form dated 7/2/12, indicated, "told writer he did not like the [gender stated] CNA working with him and his roommate . Does not like [gender stated] CNAs." " I think</p>				

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	<p>[gender stated] is too loud.'</p> <p>The concern resolution indicated: "Asked the writer if he felt threatened by [gender stated] and he said no. I asked if he would prefer [gender stated] didn't work with him---he said yes. Questioned roommate about [gender stated] CNA being loud. He said "I don't have any problem with [gender stated]." Writer asked [gender stated] CNA to work another hall. (resident name) had no concern with care."</p> <p>The resident was interviewed again on 7/27/12 at 10:00 a.m. The resident indicated he wanted to talk in the hallway by the shower room. He stated the DON came to his room to talk with him about the situation with CNA #20, after he had spoken with the surveyor. He indicated facility staff had been going around talking with residents after and/or before the survey staff. Facility staff were observed on all days of the survey speaking with residents before and/or after surveyors had spoken with residents. The resident nodded toward the nurse's station and indicated that the DON was watching us talk but that was alright with him. The resident was again asked if he was afraid of staff and he said "no". The resident was adamant that he</p>				

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	<p>was sure he talked with the DON about the comment from the aide the first time he talked with her, right after the incident happened. He indicated she knew exactly what the aide said. He stated he also told a day shift staff member about the comment the following morning after the incident. He stated the day shift aide gasped when he told her what the aide had said on the night shift. The resident stated several staff knew about his concern with the night shift aide. When the resident was asked who he told on the day shift he indicated the name of a staff member and then described the aide. He indicated she was not on duty on 07/27/12.</p> <p>During the facility exit conference on 7/27/12, the facility Administrator indicated she was very concerned that when the facility talked with the resident they were not getting the same story as when survey staff talked with the resident. Facility staff indicated they didn't have an employee by that name but when the aide was described the facility stated they probably knew who the staff member was.</p> <p>The Abuse Neglect and Misappropriation of Resident Property policy, revised on 01/2012, and</p>						

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	<p>presented by the Administrator as current indicated:</p> <p>" Abuse: The wilful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish..."</p> <p>"Verbal abuse:...examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident..."</p> <p>"Mental abuse: this includes but is not limited to, humiliation, harassment, threats of punishment or deprivation." The policy also indicated "possible signs of elder abuse...indicators from caregivers:</p> <ol style="list-style-type: none"> 1. verbal berating, 2. intimidation 6. indifference, 7. harassment, 8. threats of punishment 11. unwilling to cooperate with plans for care" <p>"Elder abuse is an unfortunate situation that must be reported."</p> <p>The policy further included that "all allegations of mistreatment, neglect or abuse, including injuries of unknown source are reported immediately to the Administrator of the facility...If the employee is a suspected perpetrator, the employee must be sent home (suspended)</p>			

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	<p>immediately pending outcome of final investigation...</p> <p>The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress... The facility shall analyze all occurrences of abuse, neglect, mistreatment or misappropriation of resident property to determine what changes are needed, if any, to policies and procedures to prevent further occurrences."</p> <p>Two evening shift nurses [Nurses AA & BB] interviewed on 7/25/12 at 3:25 and 3:33 p.m. respectively, indicated they would report abuse to the DON, not the Administrator, which was not in accordance with the facility policy.</p> <p>An interview with the Administrator on 7/26 at 1:28 p.m. indicated she was to be notified of all abuse allegations however she may refer some of the investigation to the DON.</p> <p>There was no documentation the Administrator knew of the abuse allegation with resident #34. The DON signed the concern form on 7/2/12, as resolved, the same day the concern form was initiated. The Administrator signed the</p>						

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	<p>resident/concern form the day after on 7/3/12.</p> <p>The investigation for the resident's allegation of mental abuse/threat by staff was not investigated as an abuse allegation and staff did not follow the facility policy. The facility did not complete a thorough investigation and did not include interviews with other staff members and interviewed only one resident. The staff member was not suspended in accordance with the policy and the staff member is a current employee of the facility.</p> <p>3.1-27(a)(1) 3.1-27(b) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F0225 SS=D	<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 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 observation, record review and interview, the facility failed to</p>	F0225	<p><u>F-225 Investigate/Report Allegations/Individuals:</u> This plan of correction is</p>	08/26/2012			

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	<p>thoroughly investigate 1 of 3 allegation of abuse reviewed. (Resident #34)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #34 was reviewed on 07/26/12 at 9:30 A.M. Resident #34 had diagnoses, including but not limited to, sepsis, abnormal posture, muscle weakness and multiple sclerosis (MS). The resident also required extensive assistance with his ADLs (Activities of daily living). The resident was non ambulatory and could only lie in his bed or sit in a wheelchair as a result of his disabilities. The resident was observed on 7/24/12 AT 11:30 A.M., to have some use of his stiff, hands and with effort was able to use a laptop computer. His hands were noted to be impaired due to his MS and muscle weakness. The resident was either confined to his bed, all day on 7/23, 24, 25 and 26 (by his choice) or wheelchair all morning on 7/27 and needed extensive assistance with activities of daily living.</p> <p>During interview on 7/24/12 at 11:30 a.m., the resident indicated staff had been rude to him a few weeks ago and he had reported it.</p>		<p>prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to 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 aid 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>It is facility practice to 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 other officials in accordance with State law through established procedures including to the State survey and certification agency).</p>				

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	<p>The resident indicated he had an argument with [gender documented] aide #20 on the night shift, about making a lot of noise while caring for his roommate. The resident indicated the staff member stated, 'if you are going to be like that I just won't clean you up if you have a BM'. The resident stated he felt threatened but not frightened. The resident indicated he reported the interaction. He indicated the DON came to talk with him (about the incident), so he knew the information had gotten passed along. When the DON came to talk with him he felt she gave him "a stare down like you would if you had been on the play ground when you were 10." He stated I stared at her right back. He stated she did not scold him but the look "was so immature", like she was disgusted with him. He stated he did not feel threatened by the DON but feels "she is not here to help the residents but is for the nurses and staff." The resident indicated he was "pretty sure" the [gender stated] aide still worked at the facility but stated the staff member did not take care of him any more. He stated this was the only time anyone had ever been rude to him.</p> <p>Review of the employee file for CNA #20, conducted on 07/26/12 at 2:15</p>		<p>It is facility practice to have evidence that all alleged violations are thoroughly investigated; and to prevent further potential abuse while the investigation is in progress. It is facility practice to ensure that the results of all investigations are 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 is taken.</p> <ol style="list-style-type: none"> 1. An internal investigation was initiated and ISDH notified of alleged allegation of abuse by resident #34. 2. Staff interviewed to ensure no other allegations of abuse has been verbalized by a resident. If there are any other allegations reported an internal investigation will be initiated and our abuse policy followed. 3. Staff has been reinserviced on what is an allegation, when to notify the Administrator and the abuse policy. 4. Administrator/designee will monitor weekly by randomly selecting three residents and interviewing them regarding their care and treatment while at Mason Health Care. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. This will also be 		

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	<p>P.M., indicated he was still employed by the facility and had completed abuse training upon hire. There was no disciplinary action in the employee's file or counseling statements.</p> <p>The abuse investigation, regarding the allegation of abuse made by Resident #34 was requested, on 07/26/12 from the DON who at that time indicated there was no abuse investigation completed. She indicated the concern about a staff member, made by Resident #34 had been resolved.</p> <p>The concern form dated 7/2/12, indicated, "told writer he did not like the [gender stated] CNA working with him and his roommate . Does not like [gender stated] CNAs." ' I think [gender stated] is too loud.'</p> <p>The concern resolution indicated: "Asked the writer if he felt threatened by [gender stated] and he said no. I asked if he would prefer [gender stated] didn't work with him---he said yes. Questioned roommate about [gender stated] CNA being loud. He said "I don't have any problem with [gender stated]." Writer asked [gender stated] CNA to work another hall. (resident name) had no concern with care."</p>		<p>discussed in Resident Council monthly with any concerns forwarded to the Administrator immediately.</p> <p>5. August 26, 2012.</p>		

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	<p>The resident was interviewed again on 7/27/12 at 10:00 a.m. The resident indicated he wanted to talk in the hallway by the shower room. He stated the DON came to his room to talk with him about the situation with CNA #20, after he had spoken with the surveyor. He indicated facility staff had been going around talking with residents after and/or before the survey staff. Facility staff were observed on all days of the survey speaking with residents before and/or after surveyors had spoken with residents. The resident nodded toward the nurse's station and indicated that the DON was watching us talk but that was alright with him.</p> <p>The resident was again asked if he was afraid of staff and he said "no". The resident was adamant that he was sure he talked with the DON about the comment from the aide the first time he talked with her, right after the incident happened. He indicated she knew exactly what the aide said. He stated he also told a day shift staff member about the comment the following morning after the incident. He stated the day shift aide gasped when he told her what the aide had said on the night shift. The resident stated several staff knew about his concern with the night shift aide.</p>				

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	<p>When the resident was asked who he told on the day shift he indicated the name of a staff member and then described the aide. He indicated she was not on duty on 07/27/12.</p> <p>During the facility exit conference on 7/27/12, the facility Administrator indicated she was very concerned that when the facility talked with the resident they were not getting the same story as when survey staff talked with the resident. Facility staff indicated they didn't have an employee by that name but when the aide was described the facility stated they probably knew who the staff member was.</p> <p>The Abuse Neglect and Misappropriation of Resident Property policy, revised on 01/2012, and presented by the Administrator as current indicated: " Abuse: The wilful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish..." "Verbal abuse:...examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident..." "Mental abuse: this includes but is not limited to, humiliation, harassment,</p>						

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	<p>threats of punishment or deprivation." The policy also indicated "possible signs of elder abuse...indicators from caregivers: 1. verbal berating, 2. intimidation 6. indifference, 7. harassment, 8. threats of punishment 11. unwilling to cooperate with plans for care" "Elder abuse is an unfortunate situation that must be reported."</p> <p>The policy further included that "all allegations of mistreatment, neglect or abuse, including injuries of unknown source are reported immediately to the Administrator of the facility...If the employee is a suspected perpetrator, the employee must be sent home (suspended) immediately pending outcome of final investigation... The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress... The facility shall analyze all occurrences of abuse, neglect, mistreatment or misappropriation of resident property to determine what changes are needed, if any, to policies and procedures to prevent further</p>						

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	<p>occurrences."</p> <p>Two evening shift nurses [Nurses AA & bb] interviewed on 7/25/12 at 3:25 and 3:33 p.m. respectively, indicated they would report abuse to the DON, not the administrator, which was not in accordance with the facility policy.</p> <p>An interview with the Administrator on 7/26/12 at 1:28 p.m. indicated she was to be notified of all abuse allegations however she may refer some of the investigation to the DON.</p> <p>There was no documentation the Administrator knew of the abuse allegation with resident #34. The DON signed the concern form on 7/2/12, as resolved, the same day the concern form was initiated. The Administrator signed the resident/concern form the day after on 7/3/12.</p> <p>The investigation for the resident's allegation of mental abuse/threat by staff was not investigated as an abuse allegation and staff did not follow the facility policy. The facility did not complete a thorough investigation and did not include interviews with other staff members and interviewed only one resident. The staff member was not suspended</p>						

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	<p>in accordance with the policy and the staff member is a current employee of the facility.</p> <p>3.1-27(a)(1) 3.1-27(b) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review and interview, the facility failed to follow their abuse policy and procedure regarding reporting to the administrator and protecting other residents during an investigation for 1 of 3 allegations reviewed. (Resident #34)</p> <p>Finding includes: 1. The clinical record for Resident #34 was reviewed on 07/26/12 at 9:30 A.M. Resident #34 had diagnoses, including but not limited to, sepsis, abnormal posture, muscle weakness and multiple sclerosis (MS). The resident also required extensive assistance with his ADLs (Activities of daily living). The resident was non ambulatory and could only lie in his bed or sit in a wheelchair as a result of his disabilities. The resident was observed on 7/26 to have some use of his stiff, hands and with effort was able to use a laptop computer. His hands were noted to be impaired and</p>	F0226	<p><u>F-226 Develop/Implement Abuse/Neglect, ETC Policies:</u> This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <ol style="list-style-type: none"> An internal investigation was initiated and ISDH notified of alleged allegation of abuse by resident #34. Staff interviewed to ensure no other allegations of abuse has been verbalized by a resident. If there are any other allegations reported an internal investigation will be initiated and our abuse policy followed. Staff has been reinserviced on 	08/26/2012	

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	<p>due to his MS and muscle weakness. The resident was either confined to his bed, all day on 7/23, 24, 25 and 26 (by his choice) or wheelchair all morning on 7/27 of the survey and needed extensive assistance with activities of daily living.</p> <p>On 7/24 at 11:30 a.m., the resident indicated staff had been rude to him a few weeks ago and he had reported it.</p> <p>The resident indicated he had an argument with [gender documented] aide #20 on the night shift, about making a lot of noise while caring for his roommate. The resident indicated the staff member stated, ' if you are going to be like that I just won't clean you up if you have a BM'. The resident stated he felt threatened but not frightened. The resident indicated he reported the interaction.</p> <p>He indicated the DON came to talk with him (about the incident), so he knew the information had gotten passed along. When the DON came to talk with him he felt she gave him "a stare down like you would if you had been on the play ground when you were 10." He stated I stared at her right back. He stated she did not scold him but the look "was so immature", like she was disgusted</p>		<p>what is an allegation, when to notify the Administrator and the abuse policy.</p> <p>4. Administrator/designee will monitor weekly by randomly selecting three residents and interviewing them regarding their care and treatment while at Mason Health Care. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. This will also be discussed in Resident Council monthly with any concerns forwarded to the Administrator immediately.</p> <p>5. August 26, 2012.</p>				

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	<p>with him. He stated he did not feel threatened by the DON but feels "she is not here to help the residents but is for the nurses and staff."</p> <p>The resident indicated he was "pretty sure" the [gender stated] aide still worked at the facility but stated the staff member did not take care of him any more. He stated this was the only time anyone had ever been rude to him.</p> <p>Review of the employee file for CNA #20, conducted on 07/26/12 at 2:15 P.M., indicated he was still employed by the facility and had completed abuse training upon hire. There was no disciplinary action in the employee's file or counseling statements.</p> <p>The abuse investigation, regarding the allegation of abuse made by Resident #34 was requested, on 07/26/12 but the DON indicated there was no abuse investigation completed. She indicated the concern about a staff member, made by Resident #34 had been resolved. The concern form dated 7/2/12, indicated, "told writer he did not like the [gender stated] CNA working with him and his roommate . Does not like [gender stated] CNAs." " I think</p>			

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	<p>[gender stated] is too loud.'</p> <p>The concern resolution indicated: "Asked the writer if he felt threatened by [gender stated] and he said no. I asked if he would prefer [gender stated] didn't work with him---he said yes. Questioned roommate about [gender stated] CNA being loud. He said "I don't have any problem with [gender stated]." Writer asked [gender stated] CNA to work another hall. (resident name) had no concern with care."</p> <p>The resident was interviewed again on 7/27 at 10:00 a.m. The resident indicated he wanted to talk in the hallway by the shower room. He stated the DON came to his room to talk with him about the situation with CNA #20, after he had spoken with the surveyor. He indicated facility staff had been going around talking with residents after and/or before the survey staff. Facility staff were observed on all days of the survey speaking with residents before and/or after surveyors had spoken with residents. The resident nodded toward the nurse's station and indicated that the DON was watching us talk but that was alright with him.</p> <p>The resident was again asked if he was afraid of staff and he said "no".</p>				

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	<p>The resident was adamant that he was sure he talked with the DON about the comment from the aide the first time he talked with her, right after the incident happened. He indicated she knew exactly what the aide said. He stated he also told a day shift staff member about the comment the following morning after the incident. He stated the day shift aide gasped when he told her what the aide had said on the night shift. The resident stated several staff knew about his concern with the night shift aide. When the resident was asked who he told on the day shift he indicated the name of a staff member and then described the aide. He indicated she was not on duty on 07/27/12.</p> <p>During the facility exit conference on 7/27/12, the facility administrator indicated she was very concerned that when the facility talked with the resident they were not getting the same story as when survey staff talked with the resident. Facility staff indicated they didn't have an employee by that name but when the aide was described the facility stated they probably knew who the staff member was.</p> <p>The Abuse Neglect and Misappropriation of Resident Property</p>				

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	<p>policy, revised on 01/2012, and presented by the Administrator as current indicated:</p> <p>" Abuse: The wilful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish..."</p> <p>"Verbal abuse:...examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident..."</p> <p>"Mental abuse: this includes but is not limited to, humiliation, harassment, threats of punishment or deprivation." The policy also indicated "possible signs of elder abuse...indicators from caregivers:</p> <ol style="list-style-type: none"> 1. verbal berating, 2. intimidation 6. indifference, 7. harassment, 8. threats of punishment 11. unwilling to cooperate with plans for care" <p>"Elder abuse is an unfortunate situation that must be reported."</p> <p>The policy further included that "all allegations of mistreatment, neglect or abuse, including injuries of unknown source are reported immediately to the Administrator of the facility...If the employee is a suspected perpetrator, the employee</p>						

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	<p>must be sent home (suspended) immediately pending outcome of final investigation...</p> <p>The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress... The facility shall analyze all occurrences of abuse, neglect, mistreatment or misappropriation of resident property to determine what changes are needed, if any, to policies and procedures to prevent further occurrences."</p> <p>Two evening shift nurses [Nurses AA & BB] interviewed on 7/25/12 at 3:25 and 3:33 p.m. respectively, indicated they would report abuse to the DON, not the administrator, which was not in accordance with the facility policy.</p> <p>An interview with the Administrator on 7/26 at 1:28 p.m. indicated she was to be notified of all abuse allegations however she may refer some of the investigation to the DON.</p> <p>There was no documentation the Administrator knew of the abuse allegation with resident #34. The DON signed the concern form on 7/2/12, as resolved, the same day the concern form was initiated. The Administrator signed the</p>						

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	<p>resident/concern form the day after on 7/3/12.</p> <p>The investigation for the resident's allegation of mental abuse/threat by staff was not investigated as an abuse allegation and staff did not follow the facility policy. The facility did not complete a thorough investigation and did not include interviews with other staff members and interviewed only one resident. The staff member was not suspended in accordance with the policy and the staff member is a current employee of the facility.</p> <p>3.1-27(a)(1) 3.1-27(b) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure personal care was delivered in a dignified manner for 1 of 40 residents observed. (Resident #170) In addition, the facility failed to promote dignity for 10 of 10 residents who were waiting to eat in the assisted dining room. (Residents # 13, 37, 19, 62, 45, 69, 94, 126, 163, and 174)</p> <p>Findings include:</p> <p>1. Resident #170 was observed on 07/23/12 at 2:00 P.M., seated in her room in her wheelchair with her call light activated. There was a strong odor of bowel movement in the room. During interview at that time, the resident indicated she thought she might have been incontinent of stool. She indicated she felt a "pile" of what she thought was "poop" and it felt terrible.</p> <p>Interview with Resident #170 on 07/26/12 at 12:57 P.M., regarding her</p>	F0241	<p><u>F 241 Dignity and Respect of Individuality:</u> This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <ol style="list-style-type: none"> Corrective action cannot be taken due to the alleged deficiencies occurred in the past. Additional toileting slings have been ordered for the facility. Resident #170 will be assessed to ensure she can safely be placed on toilet. Common areas being used by residents will not be over crowded and will have space available for 	08/26/2012

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	<p>care needs indicated since she had been admitted, the staff would offer her a bed pan for BM's (bowel movements) or just clean her up and throw away the incontinent brief after she had been incontinent of her bowels. She indicated she did not care for the bedpan because it hurt the sore spots on her bottom. She also indicated at home she was able to pull herself to the toilet and could usually make it, though at times she made "messes" on the bathroom floor. She indicated she was given showers at the facility, sat in the shower chair, but was not offered to toilet because she thought the hoyer pad was in the way. She indicated she sure wished there was a way to toilet her for bm's because she did not like the bedpan or having to get into the bed to have a bm.</p> <p>Review of the clinical record for Resident #170, on 07/26/12 at 2:00 P.M., indicated the Minimum Data Set (MDS) assessment had not been completed yet and the care plans in place did not address specific toileting needs.</p> <p>Interview on 07/27/12 at 9:00 A.M. with CNA #16, assigned to 400 hall, indicated she had never seen any hoyer slings with toileting capabilities.</p>		<p>residents to move freely.</p> <p>3. Nursing staff has been reinserviced on using toileting slings. All staff has been reinserviced on resident dignity.</p> <p>4. DON/designee will monitor weekly by utilizing a QA tool to ensure common areas are utilized appropriately, as well as, toileting plan through POC is being followed for resident #170. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter.</p> <p>5. August 26, 2012.</p>				

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	<p>She indicated all the hoyer slings had straps that criss-crossed between the resident's legs. CNA #16 checked with the laundry aide, Employee #19, indicated she had never noticed any hoyer slings with a toileting capability.</p> <p>Interview on 07/27/12 at 9:05 A.M. with the Housekeeping/Laundry Supervisor indicated the facility had two hoyer toileting slings and she would go find them. Subsequent interview, on 07/27/12 at 10:45 A.M., indicated a previously admitted resident had utilized the specific Hoyer pads with toileting capabilities but she was still unsure where the slings were located.</p> <p>2. On 7/23 at 11:35 a.m., 10 residents, # 13, 37, 19, 62, 45, 69, 94, 126, 163, and 174 most in reclined Broda-chairs, were crowded into the small lounge across from the SNF nurses station before lunch. This narrow room had furniture all the way around the perimeter of the room such as chairs, tables, a computer desk and a TV in the corner at one end of the room.</p> <p>The Broda chairs were placed in the lounge and staggered so almost all the floor space was taken by Broda chairs. Broda chairs were positioned</p>				

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	<p>so that the backs of the chairs were toward the nurse's station. From the nurse's station you could tell there were resident's in the chairs but their bodies and faces could not be observed.</p> <p>The lounge was so full that chairs toward the back of the lounge, by the TV, could not be gotten out unless several chairs in the front of the lounge were removed.</p> <p>At approximately 12 noon, the Broda chairs were moved into the assisted feeding dining room. During Interview with nursing staff #3 at that time, they put residents in the lounge so they could watch TV before lunch. She further indicated if they were put the residents into the assisted DR room staff could not observe them very well.</p> <p>During the observation the TV was not turned on and there were no activities or other stimulation in the lounge. The TV was not observed to be turned on until after residents were moved into the assisted DR and one resident was left in the lounge in a wheelchair.</p> <p>3.1-3(t)</p>				

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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 2 residents reviewed for choices in a sample of 18 residents interviewed was given food choices. (Resident #65)</p> <p>Finding includes:</p> <p>During observation on 7/23/12 at 12:10 p.m., meal trays were delivered to the 300-400 unit and to the assisted dining room. Resident #65 had pureed food and during interview at that time indicated she did not like it. She indicated it looked like oatmeal and she said she had that for breakfast. The food was identified by dietary employee #29, as pureed creamed vegetable soup and a ham salad sandwich. Dietary employee # 29 indicated they would get her something else. Dietary employee #30, brought the resident 3 different kinds of cream soups and she ate a little bit of each kind but did</p>	F0242	<p><u>F-242 Self-Determination – Right To Make Choices:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure the resident has the right to choose activities, schedules, and health care consistent with his other interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of her or her life in the facility that are significant to the resident.</p> <p>1. Corrective action cannot be taken due to the alleged deficiency occurred in the past.</p>	08/26/2012			

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	<p>not eat the pureed sandwich. The soups did not appear to be thickened. The resident's tablemate's indicated she was a picky eater.</p> <p>Interview with Resident #65, on 07/24/12 at 9:00 A.M., indicated she was not given preference for meals like other alert and oriented residents. She indicated the facility had a "set" menu for all residents receiving a pureed diet.</p> <p>Interview with cook, Employee #12, on 07/25/12 at 11:30 A.M. indicated if a resident receiving pureed was "with it" then they could order whatever they wanted but if she did not get a menu for them or they were unable to choose, then she would just serve them the regular first choice menu. She said if they order something else and they are the only one ordering the item she would and has prepared the separate item for them.</p> <p>Interview with the Food Service Supervisor, on 07/27/12 at 9:45 A.M. indicated the facility had asked the resident if she wanted to be given food choices at meal times and the resident had declined. She indicated she was going to change the documentation so the resident would be asked for her preferences for</p>		<ol style="list-style-type: none"> 2. Residents have been offered menu choices. 3. Staff has been reinserviced on menu options. 4. DM/designee will monitor weekly by utilizing a QA tool to ensure residents are being given food choices. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. 5. August 26, 2012. 		

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	meals. 3.1-3(u)(1)				

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interviews, the facility failed to assess 1 of 1 resident's ability to perform self trach care. (Resident #114)</p> <p>Findings include:</p>	F0272	<p><u>F-272 Comprehensive Assessments:</u> This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged</p>	08/26/2012

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	<p>During the initial tour of the facility, conducted on 07/23/12 between 10:15 A.M. - 11:00 A.M., RN #4 indicated Resident #114 had a tracheostomy tube and completed all of his own care regarding the tracheostomy tube.</p> <p>Resident #114 was observed on 07/25/12 at 3:00 P.M. The resident had no trach ties or dressing around his trach stoma During interview at that time, the resident indicated he did his own trach care. The following supplies were noted placed on an over bed table in his room: a bottle of hydrogen peroxide, a bottle of sterile water, paper towels, a pipe type cleaner, and packages of lube, and a cup with sterile swab, and a box of cotton swabs. The resident said he removed his canula, holds it in his hand, cleans it with peroxide and water and then puts it back in.</p> <p>Resident #114 was observed completing his own laryngeal tube care, on 07/27/12 at 11:15 a.m. as follows:</p> <ol style="list-style-type: none"> 1. Without washing his hands, the resident removed the soft plastic inner canula, took a bottle of hydrogen peroxide and washed the 		<p>deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>It is facility practice to make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: identification and demographic information, customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnosis and health conditions, dental and nutritional status, skin conditions, activity pursuit, medications, special treatments and procedures, discharge potential, documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS and documentation of participation in assessment.</p> <ol style="list-style-type: none"> 1. Resident #114 has had his assessment updated. Resident has doctor visits scheduled for additional 				

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	<p>inner canula with water first - twice running a twisted paper towel through the inside of the inner canula. Next he ran hydrogen peroxide down the tube.</p> <p>2. After exiting the bathroom he placed the inner canula on a piece of paper towel. Then he proceeded to take a q-tip out of box, dipped it in sterile water and wipe around the exterior of the opening in his throat. Next he took a sterile q-tip, put bacitracin ointment from a package on the q-tip and wiped around his stoma.</p> <p>3. Next he put on a regular disposable glove, took the wooden end of the sterile swab and repeatedly ran the end around a plastic prosthesis in his throat. The resident held a pen flashlight so he could view the area. He wiped the end of the swab off on a kleenex tissue but did not change swabs.</p> <p>4. Next the resident explained he had trouble with the apparatus leaking so he showed me how he takes a sip of liquid and views the apparatus to ensure it was sealing correctly.</p> <p>5. Finally, he changed gloves, picked up the inner canula shook it a bit to</p>		<p>self care training.</p> <p>2. No other resident has a trach.</p> <p>3. Licensed staff has been reinserviced on trach care..</p> <p>4. DON/designee will monitor weekly by utilizing a QA tool to ensure resident is being assessed as needed. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter.</p> <p>5. August 26, 2012.</p>		

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	<p>help air dry it, then put lube ointment from an opened package on it with his gloved hand and placed the inner canula tube back into his stoma.</p> <p>The clinical record for Resident #114 was reviewed on 07/27/12 at 10:50 A.M. The current physician's orders for Resident #114 included the following order: "Assist resident with cleaning laryngeal tube and prosthetic. He cannot do this himself. IT MUST BE DONE DAILY!!!"</p> <p>The current health care plans for Resident #114, current through 09/12/12, included a plan which indicated the resident was independent for activities of daily living except for "trach" care. The interventions included, but were not limited to: "assist of nursing staff for trach care."</p> <p>The Director of Nursing presented documentation, on 07/27/12 at 2:00 P.M. of nursing documentation for "assist resident with cleaning laryngeal tube and prosthetic. He cannot do this himself. IT MUST BE DONE DAILY!!!" documental as completed for June and July 2012. However, interview with the DON, indicated the nursing staff were documenting the assistance but were</p>						

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	<p>not actually observing the resident perform his own laryngeal tube care or assisting him in any way. She indicated the nursing staff were available to assist the resident if he needed the help. It was unclear how nursing staff were to know whether the resident required assistance since they were not directly observing or assessing the resident's self care.</p> <p>The Director of Nursing presented a Speech Therapy discharge plan of treatment, completed on 12/26/2011, which indicated the resident "exhibits safety awareness for cleaning of stoma 80% of the time. Decreased cleaning of the voice prostheses d/t (due to) anatomical difficulties related to size of stoma...." In addition, the form indicated the resident was having difficulty with "new voice prosthesis leaking and may require a new voice prosthesis from (acute care center's name) with higher resistance....."</p> <p>There was no assessment completed by nursing staff to ensure the resident could always safely perform his own tracheostomy care and maintain infection control standards.</p> <p>3.1-31(c)(6)</p>			

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F0280 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 observation, record review, and interviews, the facility failed to ensure care plans were revised for 2 of 20 residents reviewed for care plans. (Resident #33 and 114)</p> <p>Finding includes:</p> <p>1. During the initial tour of the facility, conducted on 07/23/12 between 10:15 A.M. - 11:00 A.M., LPN #25 indicated Resident #114 was alert and oriented and completed his own tracheostomy care. During observation at that time, the resident was noted to be very hard of hearing,</p>	F0280	<p><u>F-280 Right To Participate Planning Care:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure a resident has the right, unless adjudged incompetent or otherwise found to be</p>	08/26/2012			

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	<p>attempted to read lips, and spoke in a barely audible whisper or utilized a dry erase board to communicate.</p> <p>The resident was observed on 07/25/12 at 3:00 P.M., seated in his room in a chair watching television. The resident had no trach ties or dressing around his stoma. Resident # 114 indicated he does his own trach care. There were medical supplies, including hydrogen peroxide, sterile water, paper towels, a pipe type cleaner, a box of q-tips, and packages of lubricating ointment on an over bed table. The resident indicated he removed his canula, held it in his hand, cleaned it with peroxide and water and then put it back in to his stoma opening.</p> <p>The clinical record for Resident #114 was reviewed on 07/27/12 at 10:50 A.M. The current physician's orders for Resident #114 included the following order: "Assist resident with cleaning laryngeal tube and prosthetic. He cannot do this himself. IT MUST BE DONE DAILY!!!"</p> <p>The Director of Nursing presented a Speech Therapy discharge plan of treatment, completed on 12/26/2011, which indicated the resident "exhibits safety awareness for cleaning of</p>		<p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. It is facility practice to develop a comprehensive care plan 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 legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <ol style="list-style-type: none"> Care plans for residents #33 and #114 have been revised. No other residents were affected. Designated staff has been reinserviced on care planning. DON/designee will monitor weekly by utilizing a QA tool to ensure resident care plans are accurate. SSD/designee will monitor weekly by utilizing a QA tool to ensure behavior care plans are accurate. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. August 26, 2012. 		

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	<p>stoma 80% of the time. Decreased cleaning of the voice prostheses d/t (due to) anatomical difficulties related to size of stoma...." The form indicated the resident was having difficulty with "new voice prosthesis leaking and may require a new voice prosthesis from (acute care center's name) with higher resistance....."</p> <p>The current health care plans for Resident #114, current through 09/12/12, included a plan which indicated the resident was independent for activities of daily living except for "trach" care. The interventions included, but were not limited to: "assist of nursing staff for trach care."</p> <p>Interview with the Director of Nursing, on 07/27/12 at 2:00 P.M. indicated the physician had been contacted and the care plan revised related to the resident's independent status on completing his tracheostomy care.</p> <p>2. Resident #33's clinical record was reviewed on 7/25/12 at 9:30 A.M. The record indicated the resident was admitted to the facility on 4/23/12 with diagnoses including, but not limited to, dementia with behavioral disturbances and anxiety disorder. The physician's orders indicated the resident had an order from 4/12/12 for Lorazepam 1.0</p>			

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	<p>milligrams (mg) by mouth as needed (PRN) twice daily for anxiety/agitation along with an order from 5/22/12 for Risperdal 0.25 mg by mouth daily for dementia with behavioral disturbances.</p> <p>Review of the medication administration records (MAR's) for June and July 2012 indicated the resident received Lorazepam 1.0 mg PRN on 21 occasions. The MAR for June 2012 indicated the resident received Lorazepam 1.0 mg PRN on: 6/1 at 4:48 P.M. and 7:32 P.M.; 6/4 at 3:06 P.M. and 7:21 P.M.; 6/5 at 4:45 P.M.; 6/6 at 4:26 P.M.; 6/11 at 3:09 P.M.; 6/12 at 3:56 P.M.; 6/15 at 4:51 P.M.; 6/16 at 7:38 P.M.; 6/21 at 4:39 P.M.; 6/22 at 3:06 P.M. and 7:25 P.M. 6/28 at 4:14 P.M. and 7:17 P.M.. The July 2012 MAR indicated the resident received Lorazepam 1.0 mg PRN on 7/3/12 at 3:08 P.M.; 7/4 at 3:09 P.M. and 7:44 P.M.; 7/11 at 3:12 P.M.; 7/23 at 4:27 P.M..</p> <p>Review of the behavior management record for June and July 2012 indicated the resident had 5 separate behavior codes: 1. refusing care; 2. spitting on floor/furniture; 3. cursing, name calling; 4. exit seeking; 5. undirectable restlessness. The behavior management record had 9 separate intervention codes: 1. change position; 2. re-approach; 3. take to bathroom/give bed pan; 4. one-to-one with resident; 5. offer drink; 6. offer snack; 7. offer activity or TV; 8. call family; 9. PRN medication. For all 13 of the behavior incidents in June 2012 the resident had behavior code #5, undirectable restlessness. For 9 of the 13 incidents the same interventions of 1, 2, 4, and 5 were attempted and the behavior was unchanged. Then intervention #9 was tried, PRN Lorazepam, and the behavior improved. For none of the 9</p>			

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	<p>incidents were interventions 3, 6, 7, 8 attempted before the administration of the PRN Lorazepam. For the other 4 incidents requiring PRN Lorazepam administration in June 2012, the interventions were 1, 2, 4, and 6. On each of those 4 incidents intervention #9 was tried and the behavior improved. For those 4 incidents, the other interventions, 3, 5, 7, 8 were not attempted before the PRN Lorazepam was given. For the 5 incidents in July 2012 when Lorazepam PRN was given, the behavior codes were 1, 2, and 3 for 4 of the incidents and 1 and 4 for the other incident. On all 5 occasions, the interventions of 1, 2, 4, and 5 were attempted with the behavior unchanged and then intervention #9 was attempted and the behavior improved. On none of the 5 incidents in July 2012 were the other interventions of 3, 6, 7 and 8 attempted before the administration of Lorazepam PRN.</p> <p>Review of the resident's health care plan initiated on 4/18/12 indicated problematic manner in which the resident acts characterized by ineffective coping; verbal aggression (cursing, yelling) repeated wheeling in wheelchair; exit seeking, constant up and down; history of throwing things. The interventions were: observe for behaviors and intervene/redirect with identified interventions. Report to nursing for recording and any PRN medication use; elicit family input for best approaches to resident; give medication as prescribed by MD; five resident item or task in an attempt to distract; praise resident for demonstrating consistent desired/acceptable behavior; remove resident from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity. For the 18</p>			

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	<p>incidents in June and July 2012 requiring PRN Lorazepam, the health care plan interventions of give resident item or task in an attempt to distract, remove resident from public area when behavior is disruptive/unacceptable, talk with resident in a low pitch, calm voice.</p> <p>An interview with the Social Service Director (SSD) on 7/26/12 at 10:20 A.M. indicated she did not know why the other behavioral interventions on the behavior management record or the health care plan were not attempted before administering PRN Lorazepam for the 18 episodes in June and July 2012. The SSD also indicated she did not know why the health care plan was not updated when the interventions used were repeatedly ineffective.</p> <p>3.1-35(d)(2)(B)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a physician's order regarding providing tracheostomy care was followed for 1 of 1 residents reviewed for tracheostomy care. (Resident #114)</p> <p>Findings include:</p> <p>During the initial tour of the facility, conducted on 07/23/12 between 10:15 A.M. - 11:00 A.M., RN #1 indicated Resident #114 had a tracheostomy tube and completed all of his own care regarding the tracheostomy tube.</p> <p>Resident #114 was observed on 07/25/12 at 3:00 P.M. The resident had no trach ties or dressing around his trach stoma. During interview at that time, the resident indicated he did his own trach care. The following supplies were noted placed on an over bed table in his room: a bottle of hydrogen peroxide, a bottle of sterile water, paper towels, a pipe type cleaner, and packages of lube, and a</p>	F0282	<p><u>F 282-Services by Qualified Persons/Per Care Plan:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.</p> <ol style="list-style-type: none"> Physician orders for resident #114 are being followed. No other residents were affected.. Licensed nursing staff has been reinserviced on following physician's orders. DON/designee will monitor weekly by utilizing a QA tool to ensure resident orders are being followed. This will continue x 4 wk 	08/26/2012			

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	<p>cup with sterile swab, and a box of cotton swabs. The resident said he removed his canula, holds it in his hand, cleans it with peroxide and water and then puts it back in.</p> <p>Resident #114 was observed completing his own laryngeal tube care, on 07/27/12 at 11:15 A.M. as follows:</p> <ol style="list-style-type: none"> 1. Without washing his hands, the resident removed the soft plastic inner canula, took a bottle of hydrogen peroxide and washed the inner canula with water first - twice running a twisted paper towel through the inside of the inner canula. Next he ran hydrogen peroxide down the tube. 2. After exiting the bathroom he placed the inner canula on a piece of paper towel. Then he proceeded to take a q-tip type out of box, dipped it in sterile water and wipe around the exterior of the opening in his throat. Next he took a sterile q-tip, put bacitracin ointment from a package on the q-tip and wiped around his stoma. 3. Next he put on a regular disposable glove, took the wooden 		<p>then monitored thru Q.A. monthly x2, then quarterly thereafter.</p> <p>5. August 26, 2012.</p>		

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	<p>end of the sterile swab and repeatedly ran the end around a plastic prosthesis in his throat. The resident held a pen flashlight so he could view the area. He wiped the end of the swab off on a kleenex tissue but did not change swabs.</p> <p>4. Next the resident explained he had trouble with the apparatus leaking so he showed me how he takes a sip of liquid and views the apparatus to ensure it was sealing correctly.</p> <p>5. He changed gloves, picked up the inner canula shook it a bit to help air dry it, then put lube ointment from an opened package on it with his gloved hand and placed the inner canula tube back into his stoma.</p> <p>The clinical record for Resident #114 was reviewed on 07/27/12 at 10:50 A.M. The current physician's orders for Resident #114 included the following order: "Assist resident with cleaning laryngeal tube and prosthetic. He cannot do this himself. IT MUST BE DONE DAILY!!!"</p> <p>The current health care plans for Resident #114, current through 09/12/12, included a plan which indicated the resident was independent for activities of daily</p>				

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	<p>living except for "trach" care. The interventions included, but were not limited to: "assist of nursing staff for trach care."</p> <p>The Director of Nursing presented documentation, on 07/27/12 at 2:00 P.M. of nursing documentation for "assist resident with cleaning laryngeal tube and prosthetic. He cannot do this himself. IT MUST BE DONE DAILY!!!" During Interview with the DON, at this time, indicated the nursing staff were documenting the assistance but were not actually observing the resident perform his own laryngeal tube care or assisting him in any way. She indicated the nursing staff were available to assist the resident if he needed the help. It was unclear how nursing staff were to know whether the resident required assistance since they were not directly observing the resident's self care.</p> <p>3.1-35(g)(2)</p>				

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure 1 of 1 residents observed performing self tracheostomy cleaning performed the care properly. (Resident #114)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 07/23/12 between 10:15 A.M. - 11:00 A.M., RN #1 indicated Resident #114 had a tracheostomy tube and completed all of his own care regarding the tracheostomy tube.</p> <p>Resident #114 was observed on 07/25/12 at 3:00 P.M. The resident had no trach ties or dressing around his trach stoma The resident indicated he did his own trach care. The following supplies were noted neatly placed on an over bed table in</p>	F0328	<p><u>F 328 Treatment/Care For Special Need:</u> This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. It is facility practice to ensure that residents receive proper treatment and care for the following special services: injections, parenteral and enteral fluids, colostomy, ureterostomy, or ileostaomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care and prostheses.</p> <p>1. Resident #114 has received order for staff to monitor proper self</p>	08/26/2012			

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	<p>his room: a bottle of hydrogen peroxide, a bottle of sterile water, paper towels, a pipe type cleaner, and packages of lube, and a cup with sterile swab, and a box of cotton swabs. The resident said he removed his canula, holds it in his hand, cleans it with peroxide and water and then puts it back in. No suction machine was noted in the room.</p> <p>Interview with RN #14, on 07/25/12 at 3:10 P.M. indicated a suction machine was in the medication room. A clean, covered suction machine was noted, however, there was no tubing noted to connect machine and utilize the machine. The correct tubing was located in a medical storage closet located at the other end of the building.</p> <p>Resident #114 was observed completing his own laryngeal tube care, on 07/27/12 at 11:15 A.M. as follows:</p> <p>1. Without washing his hands, the resident removed the soft plastic inner canula, took a bottle of hydrogen peroxide and washed the inner canula with water first - twice running a twisted paper towel through</p>		<p>trach care. Resident has doctor visits scheduled for additional self care training.</p> <p>2. No other resident has a trach.</p> <p>3. Licensed staff has been reinserviced on trach care..</p> <p>4. DON/designee will monitor weekly by utilizing a QA tool to ensure resident is performing proper self care. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter.</p> <p>5. August 26, 2012.</p>				

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	<p>the inside of the inner canula. Next he ran hydrogen peroxide down the tube.</p> <p>2. After exiting the bathroom he placed the inner canula on a piece of paper towel. Then he proceeded to take a q-tip type out of box, dipped it in sterile water and wipe around the exterior of the opening in his throat. Next he took a sterile q-tip, put bacitracin ointment from a package on the q-tip and wiped around his stoma.</p> <p>3. Next he put on a regular disposable glove, took the wooden end of the sterile swab and repeatedly ran the end around a plastic prosthesis in his throat. The resident held a pen flashlight so he could view the area. He wiped the end of the swab off on a kleenex tissue but did not change swabs.</p> <p>4. Next the resident explained he had trouble with the apparatus leaking so he showed me how he takes a sip of liquid and views the apparatus to ensure it was sealing correctly.</p> <p>5. He changed gloves, picked up the inner canula shook it a bit to help air dry it, then put lube ointment from an opened package on it with his gloved</p>			

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	<p>hand and placed the inner canula tube back into his stoma.</p> <p>Interview with the resident at that time, indicated he had not needed suctioned since he was in the hospital in September 2011 when he had a locking device he could not remove. He indicated he was able to expel any leakage issues out of his stoma. He indicated when it really leaked it was like being "water boarded" but he had not felt that way since he was in the hospital and could not remove the inner canula himself and cough out the leakage.</p> <p>The clinical record for Resident #114 was reviewed on 07/27/12 at 10:50 A.M. The current physician's orders for Resident #114 included the following order: "Assist resident with cleaning laryngeal tube and prosthetic. He cannot do this himself. IT MUST BE DONE DAILY!!!"</p> <p>The current health care plans for Resident #114, current through 09/12/12, included a plan which indicated the resident was independent for activities of daily living except for "trach" care. The interventions included, but were not limited to: "assist of nursing staff for trach care."</p>				

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	<p>The Director of Nursing presented documentation, on 07/27/12 at 2:00 P.M. of nursing documentation for "assist resident with cleaning laryngeal tube and prosthetic. He cannot do this himself. IT MUST BE DONE DAILY!!!" Interview with the DON, at that time, indicated the nursing staff were documenting the assistance but were not actually observing the resident perform his own laryngeal tube care or assisting him in any way. She indicated the nursing staff were available to assist the resident if he needed the help. It was unclear how nursing staff were to know whether the resident required assistance since they were not directly observing the resident's self care.</p> <p>The Director of Nursing presented a Speech Therapy discharge plan of treatment, completed on 12/26/2011, which indicated the resident "exhibits safety awareness for cleaning of stoma 80% of the time. Decreased cleaning of the voice prostheses d/t (due to) anatomical difficulties related to size of stoma...." In addition, the form indicated the resident was having difficulty with "new voice prosthesis leaking and may require a new voice prosthesis from (acute care center's name) with higher</p>						

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	<p>resistance....."</p> <p>There were no specific instructions, change in the physician's orders, or the health care plans related to the resident's discharge status from speech therapy. In addition, there was no assessment completed by nursing staff to ensure the resident could always safely perform his own tracheostomy care and maintain infection control standards.</p> <p>There was no emergency suction equipment located immediately in the vicinity of the resident's room where he preferred to spend most of his time, ate his meals, and performed his own tracheostomy care up to 5 -6 times per day.</p> <p>3.1-47(a)(4)</p>				

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 6 residents reviewed for psychoactive medications had non-pharmacological interventions attempted prior to administering anxiety medication. (Resident #33).</p> <p>Findings include:</p> <p>Resident #33's clinical record was reviewed on 7/25/12 at 9:30 A.M. The record indicated the resident was</p>	F0329	<p><u>F 329 Drug Regimen Is Free From Unnecessary Drugs:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p>	08/26/2012

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	<p>admitted to the facility on 4/23/12 with diagnoses including, but not limited to, dementia with behavioral disturbances and anxiety disorder. The physician's orders indicated the resident had an order from 4/12/12 for Lorazepam 1.0 milligrams (mg) by mouth as needed (PRN) twice daily for anxiety/agitation along with an order from 5/22/12 for Risperdal 0.25 mg by mouth daily for dementia with behavioral disturbances.</p> <p>Review of the medication administration records (MAR's) for June and July 2012 indicated the resident received Lorazepam 1.0 mg PRN on 21 occasions. The MAR for June 2012 indicated the resident received Lorazepam 1.0 mg PRN on: 6/1 at 4:48 P.M. and 7:32 P.M.; 6/4 at 3:06 P.M. and 7:21 P.M.; 6/5 at 4:45 P.M.; 6/6 at 4:26 P.M.; 6/11 at 3:09 P.M.; 6/12 at 3:56 P.M.; 6/15 at 4:51 P.M.; 6/16 at 7:38 P.M.; 6/21 at 4:39 P.M.; 6/22 at 3:06 P.M. and 7:25 P.M. 6/28 at 4:14 P.M. and 7:17 P.M.. The July 2012 MAR indicated the resident received Lorazepam 1.0 mg PRN on 7/3/12 at 3:08 P.M.; 7/4 at 3:09 P.M. and 7:44 P.M.; 7/11 at 3:12 P.M.; 7/23 at 4:27 P.M..</p> <p>Review of the behavior management record for June and July 2012 indicated the resident had 5 separate</p>		<p>It is facility practice to ensure that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>It is facility practice to ensure, based on a comprehensive assessment of a resident, that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual does reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <ol style="list-style-type: none"> Corrective action cannot be taken due to the alleged deficiencies occurred in the past. All behavior sheets will be reviewed and revised as needed. Licensed nursing staff has been reinserviced on using proper interventions prior to administering antipsychotic. SSD/designee will monitor 				

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	behavior codes: 1. refusing care; 2. spitting on floor/furniture; 3. cursing, name calling; 4. exit seeking; 5. undirectable restlessness. The behavior management record had 9 separate intervention codes: 1. change position; 2. re-approach; 3. take to bathroom/give bed pan; 4. one-to-one with resident; 5. offer drink; 6. offer snack; 7. offer activity or TV; 8. call family; 9. PRN medication. For all 13 of the behavior incidents in June 2012 the resident had behavior code #5, undirectable restlessness. For 9 of the 13 incidents the same interventions of 1, 2, 4, and 5 were attempted and the behavior was unchanged. Then intervention #9 was tried, PRN Lorazepam, and the behavior improved. For none of the 9 incidents were interventions 3, 6, 7, 8 attempted before the administration of the PRN Lorazepam. For the other 4 incidents requiring PRN Lorazepam administration in June 2012, the interventions were 1, 2, 4, and 6. On each of those 4 incidents intervention #9 was tried and the behavior improved. For those 4 incidents, the other interventions, 3, 5, 7, 8 were not attempted before the PRN Lorazepam was given. For the 5 incidents in July 2012 when Lorazepam PRN was given, the behavior codes were 1, 2, and 3 for 4		weekly by utilizing a QA tool to ensure interventions are used appropriately. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. 5. August 26, 2012.				

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	<p>of the incidents and 1 and 4 for the other incident. On all 5 occasions, the interventions of 1, 2, 4, and 5 were attempted with the behavior unchanged and then intervention #9 was attempted and the behavior improved. On none of the 5 incidents in July 2012 were the other interventions of 3, 6, 7 and 8 attempted before the administration of Lorazepam PRN.</p> <p>Review of the resident's health care plan initiated on 4/18/12 indicated problematic manner in which the resident acts characterized by ineffective coping; verbal aggression (cursing, yelling) repeated wheeling in wheelchair; exit seeking, constant up and down; history of throwing things. The interventions were: observe for behaviors and intervene/redirect with identified interventions. Report to nursing for recording and any PRN medication use; elicit family input for best approaches to resident; give medication as prescribed by MD; five resident item or task in an attempt to distract; praise resident for demonstrating consistent desired/acceptable behavior; remove resident from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional</p>			

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	<p>activity. For the 18 incidents in June and July 2012 requiring PRN Lorazepam, the health care plan interventions of give resident item or task in an attempt to distract, remove resident from public area when behavior is disruptive/unacceptable, talk with resident in a low pitch, calm voice. An interview with the Social Service Director (SSD) on 7/26/12 at 10:20 A.M. indicated she did not know why the other behavioral interventions on the behavior management record or the health care plan were not attempted before administering PRN Lorazepam for the 18 episodes in June and July 2012. The SSD also indicated she did not know why the health care plan was not updated when the interventions used were repeatedly ineffective.</p> <p>3.1-48(b)(1)</p>			

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the posted nurse staffing hours were accurate on 2 of 5 days of the survey. [7/23/12 & 7/26/12]</p>	F0356	<p><u>F 356 Posted Nurse Staffing Information:</u></p> <p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care</p>	08/26/2012

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	<p>Finding includes:</p> <p>During observation on 7/23/12 at 11:00 a.m., the documentation of the nursing staffing was posted at the nurse's stations but was noted to be inaccurate. The sign listed RN (Registered Nurse) hours, for the day shift, as six nurses for 48 hours. Interview on 07/23/12 at 11:00 A.M., with Employee #18, the staff member responsible for completing the staff posting sign indicated the six nurses included RNs that were not responsible for direct resident care, such as the DON and MDS (Minimum Data Set) nurses.</p> <p>On 7/26/12 at 11:00 a.m., the posting hours still indicated six RNs for a total of 48 hours for Registered Nurse hours. By observation on 7/26 day shift, only three RNs were assigned to direct resident care duties on the day shift. Six LPNs were listed for a total of 48 hours for LPNs on the day shift. Evening hours indicated no RNs and 32 hours of LPNs. The posting still reflected the same inaccuracy as noted on the first day of survey, 07/23/12.</p> <p>3.1-13(i)(4)</p>		<p>agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure that the following information is posted on a daily basis: facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift – RNs, LPNs, LVNs, CNAs – and resident census.</p> <ol style="list-style-type: none"> Corrective action cannot be taken due to the alleged deficiencies occurred in the past. Postings reflect accurate hours. Facility scheduler has been reinserviced on the proper way to post direct care nursing hours. Administrator/designee will monitor weekly by utilizing a QA tool to ensure posted hours are accurate. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. August 26, 2012. 				

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interviews, the facility failed to promote a system to accurately account for liquid narcotic</p>	F0431	<p><u>F 431 Drug Records, Label/Store Drugs & Biologicals:</u> This plan of correction is prepared and executed because the provisions of State and</p>	08/26/2012			

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	<p>medications for 1 of 2 residents reviewed for liquid narcotic (Resident #171) and failed to label all drugs with the appropriate/required labeling.</p> <p>Findings include:</p> <p>1. On 7/26/12 at 3:00 p.m., medication storage was reviewed on 100 and 200 hall. The 100 hall medication cart was observed and a bottle of liquid Morphine Sulfate for resident #171 was in the locked portion of the medication cart. During interview at that time, RN #10 indicated the measurement on the outside of the bottle appeared to be 24 ml. [milliliters] left. During observation and interview on 7/26/12 at 3:10 p.m., LPN #17 thought the bottle appeared to be just a little over 24 ml. Review of the medication reconciliation sheet indicated the amount in the narcotic count book showed 21.9 ml of Morphine Sulfate was supposed to be left. LPN #17 indicated the bottles always appear to be a little overfilled when they arrive. The bottle from the pharmacy indicated the starting amount was 30 ml. which was recorded on the narcotic sheet. The bottle had a syringe-type stopper and a syringe had to be used to withdraw the medication. The medication could not</p>		<p>Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure that 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 are obtained.</p> <p>It is facility practice to ensure that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>It is facility practice to ensure that all drugs and biologicals are stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys, in accordance with State and Federal laws.</p> <p>It is facility practice to provide separately locked, permanently</p>				

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	<p>be dumped into another container to be measured unless it was withdrawn with a syringe or the plastic stopper taken out. LPN #17 indicated she was reluctant to take out the plastic stopper as it appeared to be part of the packaging. The reconciliation of the narcotic count could not be verified to be accurate and the measuring device on the side of the bottle, sent from the pharmacy, caused the two nurses to view two different amounts of medication left in the bottle.</p> <p>LPN #17 indicated they subtract what they give and that is what is recorded on the record sheet. Thus an accurate accounting of narcotics was not done and the documentation did not match the amount that appeared to be in the bottle.</p> <p>2. On 7/23/12 at 11:00 a.m. in a cupboard in the 300 hall medication room, a partial bottle of aspirin, Aleve, and B 12 tablets with the manufacturer's label only, were located in the cupboard. The medications and vitamins were not labeled with a resident's name or room-number. RN #4 indicated she assumed this belonged to a resident and perhaps the family had brought in the medication but also agreed it could belong to staff.</p>		<p>affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other rugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity store is minimal and a missing dose can be readily detected.</p> <ol style="list-style-type: none"> Corrective action cannot be taken due to the alleged deficiencies occurred in the past. Medication containers have been reviewed to ensure proper labeling. Liquid narcotics have been changed out by the pharmacy with more visually accurate containers. Licensed nursing has been reinserviced on proper labeling and proper measuring of liquid narcotics. DON/designee will monitor weekly by utilizing a QA tool to ensure proper labeling and accurate liquid narcotic counts. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. August 26, 2012. 		

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	<p>3.1-25(e)(2) 3.1-25(j)</p>				

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F0441 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 transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interviews, the facility failed to</p>	F0441	F-441 Infection Control, Prevent Spread, Linens:	08/26/2012			

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	<p>ensure 1 of 6 staff observed providing care followed acceptable infection control parameters. (Resident #33) In addition, the facility failed to ensure 1 of 1 residents observed performing self trach care followed infection control procedures. (Resident #114)</p> <p>Findings include:</p> <p>1. On 07/26/12 at 1:35 pm, Resident #33 was observed propelling himself up and down the hallway on the skilled nursing unit. The resident's outside pants were noted to be wet in the crotch area. Facility CNA #15 assisted Resident #33 to his room, provided privacy, put on gloves, and placed the resident on stand up lift. After transferring the resident from his wheelchair to the bathroom, CNA #15 proceeded to remove the resident's soiled brief and outside pants. CNA #16 joined to assist and both CNAs donned new gloves, CNA #15 and 16 bagged wet outside pants and the soiled brief in separate bags and CNA #16 removed her gloves, washed her hands, and left the room with the soiled linens and trash. CNA #15 hooked the resident back up to the stand up lift, put the new brief on and the outside pants and shoes back on, then lifted the resident, took a small square of toilet tissue, quickly swiped</p>		<p>This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>It is facility practice to establish and Infection Control Program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation, should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>It is facility practice that when the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility isolates the resident; prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit</p>		

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	<p>the tissue around the resident's penis and once up the resident's buttocks, removed her gloves, and then pulled up his briefs and outside pants. CNA #15 then with her bare hands adjusted the resident's polo shirt, touching a wet spot she did not realize was wet on the center front bottom edge of his shirt. She then proceeded to pull the resident on the lift out of the bathroom and assist him back into his wheelchair touching the lift and belt with her bare hands.</p> <p>Review of the undated facility policy, titled, "Perineal Care" provided by the Director of Nursing on 07/26/12 at 2:55 P.M. indicated it included the following instructions for male perineal care not soiled with feces:</p> <p>"g. Ask resident to separate his legs and flex knees. If he is unable to spread his legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed.</p> <p>h. Gently wash tip of penis using circular motion beginning at urethra. If uncircumcised, pull back foreskin and wash as above. Continue washing down the penis to the scrotum and inner thighs.</p> <p>i. Change water, with clean washcloth rinse area thoroughly in same directions as washing...."</p>		<p>the disease; and requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>It is facility practice that personnel must handle, store, process and transport lines so as to prevent the spread of infection.</p> <ol style="list-style-type: none"> Corrective action cannot be taken due to the alleged deficiencies occurred in the past. All incontinent residents have the potential of being affected, however, no other residents were identified. No other residents have trachs. Nursing staff has been reinserviced on proper peri care. Licensed nursing staff has been reinserviced on trach care. DON/designee will monitor weekly by utilizing a QA tool to ensure peri care is being performed properly and to ensure proper trach care is performed. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. August 26, 2012. - - - 				

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	<p>2. Resident #114 was observed completing his own laryngeal tube care, on 07/27/12 at 11:15 A.M. The resident utilized the following procedure:</p> <p>1. Without washing his hands, the resident removed the soft plastic inner canula, took a bottle of hydrogen peroxide and washed the inner canula with water first - twice running a twisted paper towel through the inside of the inner canula. Next he ran hydrogen peroxide down the tube.</p> <p>2. After exiting the bathroom he placed the inner canula on a piece of paper towel. Then he proceeded to take a q-tip (over the counter type) out of box, dipped it in sterile water and wipe around the exterior of the opening in his throat. Next he took a sterile q-tip, put bacitracin ointment from a package on the q-tip and wiped around his stoma.</p> <p>3. Next he put on a regular disposable glove, took the wooden end of the sterile swab and repeatedly ran the end around a plastic prosthesis in his throat. The resident held a pen flashlight so he</p>			

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	<p>could view the area. He wiped the end of the swab off on a kleenex tissue but did not change swabs.</p> <p>4. Next the resident explained he had trouble with the apparatus leaking so he showed me how he takes a sip of liquid and views the apparatus to ensure it was sealing correctly.</p> <p>5. Finally, he changed gloves, picked up the inner canula shook it a bit to help air dry it, then put lube ointment from an opened package on it with his gloved hand and placed the inner canula tube back into his stoma.</p> <p>3.1-18(j)</p>				

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F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure bathroom tiles were kept clean and in good repair on 2 of 4 nursing units, for rooms 110, 208, 214, 300, 301 and 312.</p> <p>Finding includes:</p> <p>On 7/23/12 at 9:00 a.m. during the initial tour, bathroom floor tiles were observed to be yellow-stained around the toilets and smelled of urine in rooms 300, 301 and 312.</p> <p>On 7/27/12 at 9:15 a.m. during the environmental tour bathroom floor tiles were observed to be yellow-stained around the toilets in rooms 110, 208, and 214.</p> <p>During interview on 07/27/12 at 9:15 A.M., the Maintenance Director indicated housekeeping had a special tool to clean around the toilets but agreed these tiles were yellow-stained and may have to be replaced.</p> <p>3.1-19(f)</p>	F0465	<p><u>F 465</u> <u>Safe/Functional/Sanitary/Comfortable Environment:</u> This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Mason Health Care agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</p> <p>It is facility practice to ensure that a safe, functional, sanitary, and comfortable environment for residents, staff and the public is provided.</p> <ol style="list-style-type: none"> 1. Rooms identified have been evaluated and tiles cleaned or replaced as needed. 2. All resident bathrooms have the potential of being affected, however, no other bathrooms were identified. 3. Maintenance and housekeeping staff have been reinserviced on floor care. 4. Administrator/designee will monitor weekly by utilizing a QA tool 	08/26/2012			

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			to ensure bathroom floors are clean and in good repair. This will continue x 4 wk then monitored thru Q.A. monthly x2, then quarterly thereafter. 5. August 26, 2012.	