

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 6, 7, 8, 9, & 10, 2014</p> <p>Facility number: 000460 Provider number: 155532 AIM number: 100290620</p> <p>Survey team: Cheryl Mabry, RN-TC Diana McDonald, RN Melissa Gillis, RN Angela Patterson, RN</p> <p>Census bed type: SNF/NF: 31 Total: 31</p> <p>Census payor type: Medicare: 2 Medicaid: 27 Other: 2 Total: 31</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 21, 2014; by Kimberly Perigo, RN.</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective May 10, 2014 to the annual licensure survey conducted on April 6, 2014 through April 10, 2014.</p>	

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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F000164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had a private place to meet with visitors as indicated by the facility</p>	F000164	F164 It is the practice of Bloomington Nursing and Rehab to assure that residents have an area to visit in private	05/10/2014

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	<p>resident's rights policy.</p> <p>Findings include:</p> <p>On 4/6/14 (Sunday) at 11:00 a.m., interview with LPN #1 when asked if there was a private place for the survey team to meet indicated, "There is no available space. No one has a key on the weekends for the Director of Nursing (DON) nor the Administrator's office."</p> <p>Resident #26's clinical record was reviewed on 4/9/14 at 1:12 p.m. Diagnosis included, but were not limited to "TBI (traumatic brain injury) and persistent vegetative state, urosepsis, aphasia, g-tube status, and hyperthermia."</p> <p>On 4/7/14 at 2:51 p.m., interview with Resident #26's mother indicated when asked; Can you meet privately with your relative/friend? "No. I work around it when her roommate is out. They [indicating staff] suggested cafeteria, but that's not private." When asked if aware of any other option, indicated, "No."</p> <p>On 4/7/14 at 10:30 a.m., interview with Resident #15 indicated he would have a private place to meet with his family if his room mate was out of the room. He indicated he doesn't have that much family that comes in, but when they do</p>		<p>in accordance with the facility resident's rights policy. The correction action taken for those residents found to be affected by the deficient practice include: Residents #15 and #26 (family) now have a designated area where private visits are allowed. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. Please see below for measures implemented to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Reinforcement of the facility policy related to identifying the area designated for residents to meet privately with visitors will occur with the facility staff. In addition, the residents and/or family members have been notified as to the designated area in the facility for private visiting. Please see below for means of monitoring through observation to assure that the policy is followed in accordance with the regulation. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents and/or families related to awareness of location where private visits may occur. The</p>				

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	<p>come to visit, he has no private place to meet.</p> <p>On 4/10/14 at 10:40 a.m., interview with the DON indicated when asked is there a private place for residents to meet with family. "Yes, my office or Administrator's office." When asked the DON if the residents and family were aware of this, the DON indicated, "Yes, Social Service director lets them know on admission and at the careplan meeting. They can always let me know that they want to meet with family member privately."</p> <p>On 4/9/14 at 3:07 p.m., the DON provided "RESIDENT RIGHTS," no date, and indicated the policy was the one currently used by the facility. The policy indicated, "... (e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meeting of family and resident groups, ... "</p> <p>On 4/9/14 at 3:13 p.m., the DON provided Review of "Visitation" policy dated August 2009 and indicated the policy was the one currently used by the</p>		<p>Social Services Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: May 10, 2014</p>				

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F000247 SS=D	<p>facility. The policy indicated, "... Our facility permits resident to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility. Policy Interpretation and Implementation 1. We recognize the resident's need to maintain contact with the community in which he or she has lived or is familiar. Therefore, the resident is permitted to have visitors as he/she permits, ...11. Space is available in the lobby/lounge for residents to receive guests in reasonable comfort and privacy."</p> <p>On 4/6/14 at 11:05 a.m., the lobby/lounge area was observed to be used as dining area, activity area, and lounge area for all residents.</p> <p>3.1-3(p)(5)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review,</p>	F000247	F247	05/10/2014			

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	<p>the facility failed to ensure the resident was notified before a room change as indicated by facility policy for 1 of 2 resident reviewed for admission, transfer, and discharge rights. (Resident # 8)</p> <p>Findings include:</p> <p>Interview on 04/08/2014 09:52 a.m., with Resident #8 indicated she was not told about a room change. Resident #8 indicated she left her assigned room to do an activity and returned to her room to discover her room had been changed, with all of her belongs moved. "My old room was 4 B, my new room is 12 A, the move happen this month."</p> <p>Clinical record review on 4/10/14 at 10:30 a.m., indicated no documentation of a room transfer notification.</p> <p>On 4/10/14 at 11:00 a.m., the Administrator provided a copy of the faculty's Room Change/Roommate Assignment policy dated December 2006, and indicated the policy was current. Review of the policy indicated, "Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives (sponsors)) will be give a 2 day advance notice of such change. ..."</p>		<p>It is the practice of this facility to assure that the resident receives notice before the resident's room or roommate in the facility is change.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Since it is not possible to correct the issue for resident#8, please see systems below to prevent reoccurrence.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Potentially all residents could be affected. Any room changes or roommate changes in the future will be addressed appropriately. Please see below for system changes to prevent reoccurrence.</p> <p>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</p>				

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	<p>Interview on 4/10/14 at 11:10 a.m., with the ADM indicated there is no documentation on a room transfer. The Social Services person could not provide any documentation of the room transfer. The resident did have a room change at the end of February or the beginning of March.</p> <p>3.1-3(v)(2)</p>		<p>An in-service has been conducted with the Department Heads related to the regulations involving room changes. In addition, a form has been initiated that will be utilized to identify proper notice to a resident or responsible party if a room change is needed.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly observes 5 residents, if applicable, that have had room changes to assure proper documentation is present. The Social Services Director, or designee, will complete this tool monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new</p>		

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F000252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation, interview, and record review, the facility failed to maintain comfortable water temperatures in that 17 out of 18 resident's rooms water temperature did not get to a warm comfortable temperature. This deficient practice the potential to affect 31 of 31 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 4/7/14 at 1:20 p.m., interview with Resident #15 indicated when asked if he had concerns with the water, "Yes, the water doesn't get warm. I shave in here and sometimes it never gets warm."</p> <p>The water temperature was taken in Resident's room at that time. The water ran for 3.5 minutes and</p>	F000252	<p>interventions or training as needed based on the outcome of the PItool.</p> <p>The date the systemic changes will be completed: May 10, 2014</p> <p>F252</p> <p>It is the practice of this facility to assure that water temperatures are at a warm comfortable temperature. The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Water temperatures are being identified as being at warm comfortable temperatures for residents #15 and #37, as well as the Resident's bathroom, and the Resident's shower room.</p> <p>Other residents that have the potential to be affected have been</p>	05/10/2014

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	<p>reached 101 degrees Fahrenheit. The Maintenance Supervisor came into the room at that time and used his thermometer to check the water temperature. His recorded temperature was 101 degrees Fahrenheit after the water ran for 3.5 minutes. When asked if there was something that could be done to get the water temperatures up, Maintenance Supervisor indicated, "This is an old building, there really isn't much that can be done without redoing the whole pipes. A booster can be put on."</p> <p>On 4/7/14 at 1:40 p.m., interview with Resident #37 indicated when asked if he had any concerns with the water, "It doesn't get hot. You have to run the water forever to get it even warm." At that time, the water temperature was taken in Resident #37's room, the temperature reached 102 degrees Fahrenheit after running for 3.5 minutes.</p> <p>On 4/10/14 at 9:20 a.m., observation of the Maintenance Supervisor verified the water temperature was checked in Resident #15's room. His thermometer recorded a temperature of 109 degrees Fahrenheit after the water ran for 7 minutes. At that time, the Maintenance Supervisor</p>		<p>identified by: All resident rooms currently have warm comfortable watertemperatures. Please see below forsystem changes and monitoring. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: The Maintenance Director has been in-serviced related to theacceptable parameters of water temperatures. Equipment has been installed to assure that water temperatures areappropriate. The Maintenance Directorwill be checking water temperatures daily until it is assured that temperaturesare appropriate. Following this assurance, checking of water temperatures willbe part of the preventive maintenance program. The corrective action taken to monitor performance to</p>				

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	<p>indicated the appropriate temperature for water is, "110 to 120 degrees Fahrenheit."</p> <p>On 4/10/14 at 9:33 a.m., observation of the Maintenance Supervisor verified the water temperature was checked in the residents' bathroom where there was a bathtub and sink in the room. This was verified as the bathroom for all residents. The sink water temperature was recorded at 109 degrees Fahrenheit with the Maintenance Supervisor's thermometer. The water ran for 3 minutes before reaching this temperature.</p> <p>On 4/10/14 at 10:10 a.m., observation of the Maintenance Supervisor verified that the water temperature was checked in the residents' shower room. This was verified as the main shower room for all residents. There was a sink and a shower in the room. The sink water was running for 30 seconds before the water pressure became noticeably low. The temperature at that time was 99 degrees Fahrenheit, but when the water pressure decreased, the temperature dropped to 95 degrees Fahrenheit. The Maintenance Supervisor indicated, "We have everything running at this time. We</p>		<p>assure compliance through quality assurance is:</p> <p>In addition to the preventive maintenance identified above, a Performance Improvement Tool has been initiated that randomly review 5 residents rooms and/or common areas such as bathroom or shower to assure that water temperatures are warm and comfortable. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools.</p> <p>The date the systemic changes will be completed: May 10, 2014</p>		

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F000279 SS=E	<p>have the dishwasher, the washing machine and other sinks running right now." When the water pressure became normal again, the temperature in the sink rose to 124 degrees Fahrenheit and maintained that temperature. It took 1.5 minutes to get to this temperature. The shower water recorded a temperature of 119 degrees Fahrenheit and the shower water ran for 1 minute.</p> <p>The state requires water temperature at the point of use must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.</p> <p>3.1-19(f)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>			

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	<p>mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>A. Based on interview and record review, the facility failed to ensure Resident #8 had a care plan for weight loss and failed to ensure Resident #16 had a care plan for a 2 person assist when transferring. This deficient practice had the potential to effect 2 out of 28 resident reviewed for careplan's. (Resident # 8, #16)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure that a careplan had been updated with fall risk interventions for a resident with a fall history, as indicated by facility policy for 1 of 3 residents reviewed for falls in a sample of 3 who met the criteria for review of accidents. (Resident #22)</p> <p>Findings include:</p> <p>A.1. Resident #8's clinical record was reviewed on 4/9/14 at 11:15 a.m. Resident #8's medical diagnosis includes, but were not limited to tremors, partial bowel resection related to constipation, aspiration, pneumonia, osteoporosis, hypertension, multiple sclerosis, iron deficient anemia, hyperlipidemia,</p>	F000279	<p>F279</p> <p>It is the practice of this facility to assure that the residents' careplans are developed and address the needs identified by the comprehensive assessment.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Residents #8 care plan has been updated to reflect the weight loss. Resident #16 care plan has been updated to identify the need for 2 person assist with transfers. Resident #22 care plan has been updated related to fall interventions.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents have been reviewed to assure that the plan of care addresses</p>	05/10/2014

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	<p>anxiety, and a fall in 2008 with a subdural hematoma (head injury).</p> <p>Resident #8's Brief Interview for Mental Status (BIMS) score dated 1/8/14 was 3, which indicated Resident #8 had severe cognitive impairment.</p> <p>Review of Supplement/ Nourishment Records, indicated Resident #8 had a 21.6 pound weight lost from October 2013 to April 2014, which represented a 13.4 % weight lost for a six month period.</p> <p>Review of laboratory data dated 3/27/14 indicated Resident #8's Albumin level was 3.9, normal range is between 3.5 and 5.5. Albumin levels are used to evaluate nutritional/protein status.</p> <p>Review of Meal Intake Records for March and April of 2014 indicated a handwritten note on top of the sheets. The note indicated, " _____ [Resident #8's name] Does not Eat Breakfast."</p> <p>Review of current diet indicated an enhanced breakfast daily, mechanical soft, thin liquids, no concentrated sweets diet, use only a Provale cup (a cup designed to deliver small swallows).</p> <p>Review of clinical record did not indicate a care plan for nutrition, nor a care plan</p>		<p>pertinent information related to the resident's current status.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been conducted for nurses related to assuring that changes in a resident status are identified/updated on the plan of care. The IDT team which meets each business morning will also be reviewing new orders, changes in the resident's condition, and incidents and will also assure that the care plan has been updated properly. This would include assuring that interventions are added to the care plan if the resident has had a fall. The IDT team will meet weekly to discuss residents at nutritional risk. If a resident is identified as having significant weight loss, or is nutritionally compromised, a care plan will be initiated.</p> <p>The corrective action</p>		

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	<p>for weight loss.</p> <p>Interview on 4/10/14 at 9:40 a.m., with DON indicated there were no care plans for weight loss for this resident.</p> <p>A.2. Resident #16's clinical record was reviewed on 4/9/14 at 2:35 p.m., Resident #16's medical diagnosis includes, but were not limited to sepsis from pneumonia, hepatitis C, previous trauma regular craniotomy, seizure disorder, hypertension, lack of coordination, dysphagia oropharyngeal phase, traumatic brain injury, and cognitive deficits due cerebrovascular disease.</p> <p>Resident #16's Brief Interview for Mental Status (BIMS) score dated 3 /18/14 was 5, which indicated Resident #16 had severe cognitive impairment.</p> <p>Review of the Minimum Data Set assessment dated 3/18/14, indicated resident #16 is an extensive assist for transfers; with resident involved in the activity. Staff is to provide weight-bearing support, with a two person physical assist.</p> <p>Review of the care plans did not indicate extensive assist with a staff of two providing weight-bearing support.</p>		<p>taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to the comprehensive assessment in correlation with the plan of care to assure that pertinent information is identified on the plan of care based on the assessment. It also assures that identified changes have been updated on the care plan. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p>The date the systemic changes will</p>		

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F000323 SS=D	<p>Interview on 4/9/14 at 3:20 p.m., with the DON indicated there are no care plans for assist of two for transfer.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on interview and record review, the facility failed to ensure the safety of Resident #16 in that the fall risk resident had been left on a bedside commode unsupervised, the resident attempted to self transfer, and fell. (Resident #16)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure proper supervision for residents identified with unsteady balance and walking, which resulted in falls, for 1 of 3 residents observed for accidents in a sample of 3 who met the criteria for review of accidents related to falls. (Resident #22)</p> <p>Findings include:</p> <p>A. Resident #16's clinical record was reviewed on 4/9/14 at 2:35 a.m., Resident #16's medical diagnosis included, but were not limited to, sepsis from</p>	F000323	<p><i>becompleted:</i> May 10, 2014</p> <p>F323 It is the practice of Bloomington Healthcare and Rehab to assure that allfall interventions are in place in accordance with the residents' plans of care <i>The correction action taken for those residents found to be affected bythe deficient practice include:</i> Residents #16 and #22 have beenreviewed and have all appropriate fall prevention interventions in place. Theplan of care has been updated accordingly. <i>Other residents that have the potential tobe affected have been identified by:</i> All residents have been reviewed toassure that if</p>	05/10/2014

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	<p>pneumonia, hepatitis C, previous trauma regular craniotomy, seizure disorder, hypertension, lack of coordination, dysphagia oropharyngeal phase, traumatic brain injury, and cognitive deficits due cerebrovascular disease.</p> <p>Resident #16's Brief Interview for Mental Status (BIMS) score dated 3 /18/14 was 5, which indicated Resident #16 had severe cognitive impairment.</p> <p>Review of the Minimum Data Set assessment dated 3/18/14 indicated resident #16 was an extensive assist for transfer care with the resident involved in the activity. Staff is to provide weight-bearing support, with a two person physical assist.</p> <p>Review of the care plans did not indicate extensive assist with a staff of two providing weight -bearing support.</p> <p>Interview on 4/9/14 at 3:20 p.m., with DON indicated there are no care plans for assist of two for transfer.</p> <p>Review of nursing notes indicated Resident #16 had a fall on 3/20/14. The notes indicated, "Resident #16 was attempting to transfer self to the bed, Resident #16 found lying on floor beside bed on coccyx [bottom], when questioned</p>		<p>they are at risk of falls that appropriate interventions are inplace. The plan of care has also beenupdated.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The interdisciplinary team will bereviewing every fall to assure that appropriate interventions are in placebased on the possible cause of the fall. The plan of care and the CNA assignment sheets will be updated asneeded. The nursing staff has beenin-serviced related to providing services to our residents in correlation withthe written plan of care. There will beroutine monitoring via rounds by nurses and nursing administration to assurethat safety devices are in place in accordance with the residents' plan ofcare.</p> <p><i>The corrective action taken to monitor performance to assure</i></p>		

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F000325 SS=D	<p>resident #16 stated he slid and landed on his bottom. Denies pain or discomfort, zero injury note, ROM [Range of Motion (mobility of joints)] within normal limits. Not sent to ER [Emergency Room]."</p> <p>Interview Resident #16 on 4/9/14 at 3:30 p.m., Asked resident #16 how he called the nurse. Resident #16 said he did not know. Asked if he yelled for the nurse, he shook his head no; asked if he used the call light, he shook his head no.</p> <p>Interview 4/9/14 at 3:10 p.m., with DON indicated call light was in reach. The call light is on window wall by the head of bed. Resident #16 was trying to transfer from bedside commode to the bed and slipped on diarrhea on floor. He always has an assist of 2. Resident #16 had been on the bedside commode, without staff present, and fell.</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p>		<p>compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents who have had falls or are at risk for falls to assure that appropriate interventions are in place to assist with the prevention of future falls. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p>The date the systemic changes will be completed: May 10, 2014</p>				

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	<p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to ensure Resident #8 was provided with nutritional care to maintain body weight. This deficient practice had the potential to effect 1 out of 3 residents reviewed for nutrition who met the criteria for review of nutritional status. (Resident #8)</p> <p>Findings include:</p> <p>Resident #8's clinical record was reviewed on 4/9/14 at 11:15 a.m.</p> <p>Resident #8's medical diagnosis includes, but were not limited to, tremors, partial bowel resection related to constipation, aspiration, pneumonia, osteoporosis, hypertension, multiple sclerosis, iron deficient anemia, hyperlipidemia, anxiety, and a fall in 2008 with a subdural hematoma (head injury).</p> <p>Resident #8's Brief Interview for Mental Status (BIMS) dated 1/8/14 score was 3, which indicated Resident #8 had severe cognitive impairment.</p> <p>Review of Supplement/Nourishment</p>	F000325	<p>F325</p> <p>It is the practice of this facility to assure that each resident identified as having significant weight loss have appropriate treatment and services in place to assist with preventing further weight loss.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #8 has been reviewed and is receiving nutritional support in correlation with the physician's orders.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents have been reviewed to assure that if</p>	05/10/2014			

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	<p>Records indicated Resident #8 had a 21.6 pound weight lost from October 2013 to April 2014, which represented a 13.4 % weight lost for a six month period.</p> <p>Review of Resident #8's laboratory data dated 3/27/14 indicated her Albumin level was 3.9, normal range is between 3.5 and 5.5. Albumin levels are used to evaluate nutritional/protein status.</p> <p>Review of Meal Intake Record for March and April of 2014, indicated a handwritten note on top of the sheets. The note indicated, " _____ [Resident #8's name] Does not Eat Breakfast."</p> <p>Review of the current diet indicated an enhanced breakfast daily, mechanical soft, thin liquids, no concentrated sweets diet, use only a Provale cup (a cup designed to deliver small swallows). No other interventions for additional nutritional supplement, other than at breakfast, were ordered.</p> <p>Interview on 4/10/14 at 9:40 a.m., the DON indicated Nutritional At Risk (NAR) meeting was scheduled for April 11, 2014. I will request on order from the doctor for a nutritional supplement like Ensure. We give her snacks like peanut butter and jelly, fruit, cheese and crackers, and ice cream.</p>		<p>needed,they are receiving nutritional supplements to assist with the prevention ofweight loss in accordance with the physician's orders.</p> <p>The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include:</p> <p>Nursing staff have been in-serviced related to assuring thatnutritional supplements are offered in accordance with the plan of care and/orphysician's orders. The nurses have beenin-serviced related to identifying weight loss in a timely manner and assuringthat the physician is notified and a nutritional supplement is ordered. The interdisciplinary team will be reviewingweights weekly to assure that all residents showing significant weight losshave appropriate interventions in place.</p> <p>The corrective action taken to monitor performance to</p>				

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F000364 SS=E	<p>Review of clinical record did not indicate a care plan for nutrition, nor a care plan for weight loss.</p> <p>Interview with Resident #8 on 4/10/14 at 10:00 a.m., Resident #8 indicated she enjoys her snacks of peanut butter and jelly, fruit, cheese and crackers, and ice cream. I have never eaten breakfast.</p> <p>3.1-46(a)(1)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p>		<p>assurecompliance through quality assurance is:</p> <p>A PerformanceImprovement tool has been established that randomly reviews residents forweight loss. The tool will specificallyreview for appropriate interventions as well as presence on the plan of care ifa weight loss exists. The Director ofNursing, or designee, will complete the tool weekly x3, monthly x3, thenquarterly x3. Any issues identified willbe immediately addressed. The QualityAssurance Committee will review the tool at the scheduled meeting following thecompletion of the tool with recommendations as needed based on the outcome ofthe tools.</p> <p>The date the systemic changes will be completed: May 10, 2014</p>		

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	<p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation and interview, the facility failed to ensure food was served at the proper temperature and in a palatable manner. This deficient practice had the potential to affect 31 out of 31 residents who are served meals from the kitchen. (Resident #4, #14, #15, #27, #29, #32, #37).</p> <p>Findings include:</p> <p>On 4/6/2014 at 12:00 p.m., an observation of Cook #1 indicated she was taking plates from a metal shelf located above the stove. At that time an interview with her indicated they do not have plate warmers or a hot cart to keep the food warm. She said it was the best they could do to keep the food warm for the residents.</p> <p>On 4/7/2014 at 10:27 a.m., an interview with Resident #14 indicated her coffee was cold this morning and the vegetables are mushy.</p> <p>On 4/7/2014 at 10:51 a.m., an interview with Resident #27 indicated the food is usually cold when it should be hot.</p>	F000364	<p>F364 It is the practice of this facility to assure that food is well seasoned and prepared in a manner that preserves nutritional value, is at appropriate temperature, and is acceptable to our residents. The correction action taken for those residents found to be affected by the deficient practice include: Resident #14 is receiving coffee at the appropriate temperature and properly cooked vegetables. Resident #27 is receiving food at appropriate temperature. Residents #29 and #37 are receiving food at the appropriate temperature. The facility is working with residents #32, #4, #15, and #29 to facilitate their better approval of the food served. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. Please see systematic changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All dietary staff has been in-serviced related to assuring that food is properly seasoned, preparations methods</p>	05/10/2014			

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	<p>On 4/7/2014 at 11:02 a.m., an interview with Resident #32 indicated she doesn't like the food here.</p> <p>On 4/7/2014 at 12:06 p.m., an interview with Resident #4 indicated she doesn't think the food smells good nor tastes good. Looks okay.</p> <p>On 4/7/14 at 1:24 p.m., Resident #15 indicated he would rather eat nothing than the food they served here.</p> <p>On 4/7/14 at 1:45 p.m., Resident #37 indicated he eats in his room and the food is cold.</p> <p>On 4/7/14 at 1:55 p.m., Resident #29 indicated the food is edible at times, they could change up the menu. It 's the same thing all the time. The food could be hotter too.</p> <p>On 04/09/2014 at 12:25, an observation of a hall tray food temperature being taken indicated the macaroni and cheese temperature measured 117 degrees Fahrenheit. The tomato and zucchini measured 151 degrees Fahrenheit. At that time an interview with the Dietary Manager indicated the food was not at proper temperature.</p>		<p>preserve nutritional values, and food is served at the appropriate temperature. In the interim as we review additional options, we are preparing only a few trays for delivery at one time. This allows for faster serving of the trays immediately after preparation. This has worked at keeping temperatures within the acceptable range.</p> <p>Additionally, the Dietary Manager will be responsible for monitoring to assure that food is cooked and seasoned appropriately and that it is served at the appropriate temperature. In addition, the facility will be working with the residents to involve them in food items that they would like to see on the menu. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 meals per week to assure that they were prepared and seasoned appropriately and are served at the appropriate temperature. This tool will randomly include all meals in a 7 day period. In addition, this tool interviews residents related to their opinions of the meals served. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee</p>				

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F000371 SS=F	<p>On 4/9/2014 at 12:30 p.m., an observation of a hall test tray indicated the ham slice was cold, macaroni and cheese was cold, and tomato stew was warm.</p> <p>On 4/10/2014 at 11:30 a.m., requested policy for proper serving food temperatures. At the time of survey exit a policy on proper food temperatures was not provided.</p> <p>3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper handwashing was completed in the kitchen and during dining and the facility failed to ensure food was stored</p>	F000371	<p>will review the tools at the scheduled meetings with recommendations as needed for additional interventions. The date the systemic changes will be completed: May 10, 2014</p> <p>F371 It is the practice of Bloomington Healthcare and Rehab to assure that food is prepared, stored, and served in a manner that is within acceptable sanitation guidelines. It is also the facility practice that handwashing</p>	05/10/2014			

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	<p>properly in 1 of 1 refrigerators in that expired food had not been discarded as indicated by the facility policy. This deficient practice had the potential to affect 31 out of 31 residents who were served meals from the kitchen. (CNA #1, Dietary Manager, Cook #1, Dietary Aide #1).</p> <p>Findings include:</p> <p>1. On 4/6/2014 at 11:25 a.m., an observation of Cook #1 indicated she left the kitchen with a cup for a resident and returned to the kitchen and poured coffee without hand sanitizing or hand washing.</p> <p>On 4/6/2014 at 11:28 a.m., an observation of DA (Dietary Aide) #1 indicated he left the kitchen and returned with ice in two pitchers, he preceded to the sink where he filled them with water. No observation of hand sanitizing or washing.</p> <p>On 4/6/2013 at 11:29 a.m., an interview with DA #1 indicated you should wash your hands when entering the kitchen. At that time, he indicated the proper time for hand washing was 5-10 seconds.</p> <p>On 4/6/2014 at 11:33 a.m., an observation of DA #1 indicated he lifted the trash container lid bare handed, and</p>		<p>occurs within the parameters of infection control standards in the kitchen and when food is served. The correction action taken for those residents found to be affected by the deficient practice include: There are no specific residents identified. The staff that was identified in the 2567 has received additional training on handwashing and proper storage and disposal of food items. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. Please see systematic changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nursing staff has been in-serviced related to proper handwashing and the protocol related to handwashing during meal service. All dietary staff has been in-serviced related to handwashing and proper storage/disposal of foods. The Dietary Manager will be responsible for assuring that the kitchen is maintained properly and that staff is following proper handwashing procedures as well as proper storage/disposal of foods. In addition, administration will make rounds in the kitchen at least weekly to assure that the dietary is clean, proper storage and disposal of foods are in</p>				

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	<p>then placed an item in the can. No observation of hand sanitizing or hand washing. He then began pouring coffee into coffee pots for residents.</p> <p>On 4/6/2014 at 11:40 a.m., an observation of DA (Dietary Aide) #1 indicated he washed his hands for 10 seconds. Then donned gloves.</p> <p>On 4/6/2014 at 11:49 a.m., an observation of Cook #1 indicated she washed her hands for 15 seconds.</p> <p>On 4/9/2014 at 12:15 p.m., an observation of CNA (Certified Nursing Assistant) #1 indicated she was in the dining room serving food trays to residents. After serving a resident their tray she removed the trash from the tray lid and placed the trash into the trash receptacle, retrieved a tray from the the cart and gave it to a resident. No observation of hand washing or hand sanitizing.</p> <p>On 4/09/2014 at 12:20 p.m., an observation of CNA #1 passing trays to residents on the hall. CNA #1 gave Resident #14 her tray and washed her hands for 10 seconds.</p> <p>On 4/9/2014 at 1:00 p.m., an interview with CNA #1 indicated the proper</p>		<p>place, and observation of handwashing is in place. The corrective action taken to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes the dietary department and meal service 5 times in a weekly period to assure that the areas is identified as clean, food is stored/disposed of properly, and handwashing is occurring in accordance with the guidelines by both dietary and nursing. This random observation will include all 3 meals 7 days per week. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed for additional interventions as necessary. The date the systemic changes will be completed: May 10, 2014</p>		

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	<p>amount of time for handwashing was 2 minutes.</p> <p>On 4/8/2014 at 9:38 a.m., the Administrator provided the facilities current, undated "HANDWASHING" policy. The policy indicated....In general as personal hygiene after using the toilet, before preparing food, before and after smoking, and after gloves are removed. PROCEDURE:6. Lather all areas of the hands and wrists rubbing vigorously for 20 seconds.</p> <p>2. On 4/06/2014 at 11:00 a.m., an observation of the refrigerator indicated the following:</p> <p>On the top shelf was sausage in a plastic sleeve Under the sausage contained undated jello covered with aluminum foil, 2 containers of cottage cheese, a cut green pepper in a plastic bag,a cucumber wrapped in plastic wrap.</p> <p>On 4/06/2014 at 11:20 a.m., an interview with Cook #1 indicated she didn't put the sausage on the top shelf, she then indicated the meat should be stored on the bottom shelf.</p> <p>On 4/8/2014 at 11:12 a.m., an</p>				

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	<p>observation of tomato soup in a sealed plastic container dated 4/3/2014. At that time an interview with the Dietary Manager indicated she thought she could keep it for 48 hours. She then disposed of the tomato soup.</p> <p>On 04/08/2014 at 10:40 a.m., the Administrator provided the facilities current "Food labeling and dating" policy dated 04/03. The policy indicated ... 2. Leftover foods and all opened, perishable items are dated with the current date and discarded after 48 hours. If an item is not readily identifiable, the name of the item is also written on the label."</p> <p>On 4/9/2014 at 2:35 p.m., the DoN provided the facilities current, undated policy titled "FROZEN & REFRIGERATED FOOD STORAGE", the policy indicatedPROCEDURE: 1. Label and date, with time, all leftovers and refrigerate or freeze immediately...3. Food may be stored in the refrigerator for 3 days... 5. Food that is not used in the designated amount of time, as stated above, shall be discarded. On 4/9/2014 at 2:35 p.m., the DoN (Director of Nursing) provided the facilities current, undated policy titled "SAFE FOOD PREPARATION", the policy indicated2. ...Raw foods will be placed on the lower shelves of the refrigerator...7.</p>			

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F000441 SS=D	<p>Prepare foods on surfaces that have been cleaned, rinsed and sanitized. ...8. Wash hands before handling food, after handling raw food and after any interruptions they may contaminate hands.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the 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</p>			

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	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing and glove use during resident care. This deficient practice had to potential to affect 1 of 1 randomly observed resident during personal care. (Resident #26) (CNA #2, CNA #3) (MDS coordinator)</p> <p>Findings include:</p> <p>1). On 4/10/14 at 9:05 a.m., observed CNA #3 (Certified Nursing Assistant) providing morning care for Resident #26. LPN #1 (Licensed Practical Nurse) was present. CNA #3 was observed to hand wash, put on gloves, walk over and crank down Resident #26's bed. No change of gloves was observed.</p> <p>CNA #3 removed the brief from Resident #26, rolled resident on her left side, wiped the buttock and rectum with a</p>	F000441	<p>F441 It is the practice of this facility to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines. The correction action taken for those residents found to be affected by the deficient practice include: Resident #26 is receiving care in a manner that is within acceptable parameters of infection control Other residents that have the potential to be affected have been identified by: All residents could potentially be affected. All residents are receiving services in a manner which promotes acceptable infection control. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for nursing staff related to proper infection control practices. The in-service addresses proper hand washing and proper changing of gloves.</p>	05/10/2014

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	<p>moist cloth, placed a clean brief under the right side of the resident, rolled resident on right side, and wiped buttock with moist cloth.</p> <p>CNA #3 was observed to discard the dirty moist cloth in a plastic bag on the bed, retrieved a clean moist cloth, and wiped Resident #26's vaginal area. No handwashing nor change of gloves was observed.</p> <p>CNA #3 sealed the brief on the resident, pushed trash in a plastic bag on the bed, and removed a dirty blouse off of resident. CNA #3 then covered the resident with a sheet. CNA #3 was then observed to place the dirty blouse in a different plastic bag on the bed and removed the wet sheet from underneath the resident and placed the sheet in the plastic bag on the bed.</p> <p>CNA #3 removed the soiled gloves, placed the gloves in the plastic bag on the bed, tied the plastic bag, walked over to sink and washed her hands, returned to the bedside, and washed Resident #26's face.</p> <p>CNA # 3 when asked when should hand washing be done, indicated, "Before and after care and in between as needed." When asked if that was done; CNA #3</p>		<p>The facility nursing administration will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents related to following of proper infection control procedures during the provision of services. The observations will include handwashing and changing of gloves. The random observations will include all shifts 7 days per week. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. The date the systemic changes will be completed: May 10, 2014</p>	

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	<p>indicated, "Yes, I did. I took gloves off as soon as I was done." When asked if she changed gloves and handwashed after cleaning Resident #26's buttock and rectum and before cleaning vaginal area or touching trash in bag, "No, I did not." When asked what could happen if handwashing was not done. CNA #3 indicated "Infection."</p> <p>2). On 4/10/14 at 11:00 a.m., observed MDS coordinator (Minimum Data Set) enter Resident #26's room, placed gloves on, walked over to Resident #26, and attempted to open the resident's mouth. No hand washing observed.</p> <p>The MDS coordinator was observed to walk out of the room, re-enter room with mouth swabs, get gloves from box, walk over to the resident, and began to put on gloves. The MDS coordinator indicated when asked what should she have done before putting on gloves, " Wash hands." The MDS coordinator was observed to hand wash at that time.</p> <p>On 4/8/14 at 9:38 a.m., the Administrator provided the "Handwashing" policy, no date, and indicated the policy was the one currently used by the facility. The policy indicated, " ... Handwashing should be performed: As promptly as possible after contact with blood, body fluids,</p>			

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	<p>secretions, excretions, and equipment or article contaminated by them. Whether or not gloves are worn. After gloves are removed, After situations during which microbial contamination of hands is likely to occur, ... When otherwise indicated to avoid transfer of microorganisms to other residents and environments, When indicated between tasks and procedures on the same resident to prevent cross contamination, In general as personal hygiene after using the toilet, ...and after gloves are removed. Handwashing with soap and water is the best approach to hand hygiene however alcohol-based handrub may be used in certain circumstances unless hands are visibly soiled. Examples include contact with a resident's intact skin, taking blood pressure or pulse, performing non-invasive physical assessment, lifting the resident in bed, ..."</p> <p>On 4/8/14 at 9:38 a.m., received Policy " Infection Control" , no date, from the ADM (Administrator) who indicated that was the one currently used by the facility. The policy indicated, " ... 1. This facility's infection control policies and practice apply equally to all personnel, consultants, ...2. The objectives of our infection control policies and practices are to: a. Prevent detect, investigate, and control infections in the facility: b.</p>			

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F000465 SS=F	<p>Maintain a safe, sanitary and comfortable environment for personnel, residents, visitors, and the general public; ...4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures, ... "</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary and comfortable environment for 17 out of 18 resident rooms in that the cubicle curtains were dirty or stained and dining room vents were not cleaned of dust or debris. This deficient practice had the potential to affect 31 out of 31 residents.</p> <p>Findings include:</p> <p>1). Observation on 4/7/14 at 9:00 a.m., indicated room 16 with 3 cubicle/privacy curtains with dirt or stains on all three curtains.</p> <p>Observation on 4/7/14 at 11:00 a.m., indicated rooms 3, 5, 6, 10, 11, and 14 with 3 cubicle/privacy curtains in</p>	F000465	<p>F441 It is the practice of this facility to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines. <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> Resident #26 is receiving care in a manner that is within acceptable parameters of infection control <i>Other residents that have the potential to be affected have been</i></p>	05/10/2014

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	<p>each room with dirt or stains on them.</p> <p>Observation on 4/9/14 at 10:00 a.m., indicated rooms 1, 2, 4, 7, 9, 12, 13, 14, 16, 17, and 18 with 3 cubicle/privacy curtains in each room with dirt or stains on them.</p> <p>Interview on 4/9/14 at 10:30 a.m., with Resident #29 indicated, "Oh, they just put those curtains up." When showed the resident the dirt and stains on all the curtains, Resident #29 indicated, "Oh my, I didn't realize they were that dirty." When asked how many times the curtains were cleaned, Resident #29 indicated, "I thought they did it often, but I'm not sure now."</p> <p>On 4/9/14 at 12:15 p.m., the Maintenance Supervisor was shown the condition of the curtains in rooms 5, 11, 16 and 18. When told of the condition of the curtains in all of the rooms observed, Maintenance Supervisor indicated, "I didn't know they were that stained. I'll have to go through the rooms and clean them."</p> <p>Interview on 4/9/14 at 4:00 p.m., with the Maintenance Supervisor indicated, "We deep clean a room daily. We clean from top to bottom."</p>		<p>identified by: All residents could potentially be affected. All residents are receiving services in a manner which promotes acceptable infection control. The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include: An in-service has been conducted for nursing staff related to proper infection control practices. The in-service addresses proper hand washing and proper changing of gloves. The facility nursing administration will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy The corrective action taken to monitor performance to assure compliance through quality assurance is:</p>				

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	<p>On 4/9/14 at 4:04 p.m., the Maintenance Supervisor provided the "Housekeeping Quality Assurance Checklist." The checklist indicated, "Cubicle curtains are clean. Met. Not Met. Comments. Follow up needed." At the same time, the Maintenance Supervisor provided the "Deep Cleaning List". The list indicated, "...Check all privacy curtains, take down if dirty..."</p> <p>On 4/9/14 at 4:04 p.m., the Maintenance Supervisor provided the "Bloomington Nursing and Rehabilitation Center Housekeeping Manual", no date. The manual indicated, "Cubicle Curtains...Have spare curtains to replace dirty or torn curtains immediately. 1. Treat soiled area with presoak...Housekeeping Care Plan...Cubicle Curtains: Cubicle curtains are clean and free from spots...Change curtains immediately if any of the above problems are noted...Cubicle Curtains-Check and report any soil or damage to Housekeeping Supervisor..."</p> <p>2). On 4/6/2014 at 12:10 p.m., an observation of the 3 vents in the dining area by the television indicated there was</p>		<p>A Performance Improvement Tool has been initiated that randomly observes 5 residents related to following of proper infection control procedures during the provision of services. The observations will include handwashing and changing of gloves. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><i>The date the systemic changes will be completed: May 10, 2014</i></p>	

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	<p>a brown dried substance webbing over all three vents. The vent facing the dining room had brown dried substance on the wall above the vent.</p> <p>On 4/7/2014 at 10:00 a.m., an observation of the 3 vents in the dining area by the television indicated there was brown dust webbing over all 3 vents. The vent facing toward the dining area had brown dried substance running up the wall above the vent.</p> <p>On 4/8/2014 at 2:00 p.m., an observation of the 3 vents in the dining area with the Maintenance Supervisor indicated the 3 vents in the dining area were covered with a brownish dried substance covering the vents. The vent facing the dining area had brownish dried substance on the wall above the vent. At that time an interview with the Maintenance Supervisor indicated he would have housekeeping clean the vents.</p> <p>On 4/9/2014 at 2:00 p.m., an interview with Maintenance Supervisor indicated the housekeeper cleaned the 3 vents in the dining room.</p> <p>On 4/9/2014 at 3:00 p.m., an observation of the 3 vents in the dining area with the Maintenance Supervisor indicated there is still brown dried substance above the</p>			

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F000469 SS=D	<p>vent that's facing the dining area, the lower vent facing north was covered in a brown dried webbing over the vent. At that time an interview with the Maintenance Supervisor indicated the vents were not adequately clean, and he would fix it.</p> <p>On 4/8/2014 at 2:30 p.m., the Maintenance Supervisor provided the current undated facilities "Housekeeping Quality Assurance Checklist", the checklist indicated Vents & Vent screens are free of dust...". At that time an interview with him indicated the Housekeepers are to do the tasks on the checklist daily.</p> <p>On 4/9/14 at 4:04 p.m., the Maintenance Supervisor provided "Bloomington Nursing and Rehabilitation Center Housekeeping Manual", no date. The manual indicated, "...Vents: Vents are done quarterly...2. Vents should be cleaned daily as part of the high dusting guideline..."</p> <p>3.1-19(f)(5)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p>						

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	<p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for 1 of 1 resident room in that live activity of ants were observed in Resident #14 and Resident #28's room and by the exit door in the dining room.</p> <p>Findings include:</p> <p>Interview on 4/8/14 at 10:33 a.m., with Resident # 28 indicated, "There are ants in the center of the room once in awhile. The last time I noticed ants was about a week ago."</p> <p>Observation on 4/9/14 at 10:00 a.m. in Resident #14 and #28's room indicated there was a piece of food on the floor by Resident #14's chair and bedside tray. There were dozens of live ants crawling on and around the food. Interview at that time with Resident #28 indicated, "The ants usually show up on her side of the room and it happens weekly."</p> <p>Observations on 4/9/14 at 12:10 p.m., indicated the piece of food was still present on the floor with live ants</p>	F000469	<p>F469</p> <p>It is the practice of this facility to maintain an effective pest control program.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #14 and #28 room is free of ants. There have been no additional ants identified by the exitdoor keypad.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All resident rooms and common areas have been reviewed and there have been no additional occurrence of ants.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>An in-service has been scheduled for all staff</p>	05/10/2014			

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	<p>crawling on and around the food. At that time, the Maintenance Supervisor was brought into the room and the ants were brought to his attention. "We just had the pest control company in here to spray. I will call them in here and get this taken care of."</p> <p>Observation on 4/9/14 at 12:30 p.m., indicated the piece of food and the ants were gone from the floor in Resident #14 and 28's room.</p> <p>On 4/10/14 at 3:00 p.m., an observation of the keypad next to the exit door in the dining room indicated an ant was crawling across the keypad. At that time, an interview with CNA #1 indicated it was an ant crawling on the keypad.</p> <p>On 4/9/14 at 12:25 p.m., the Administrator provided the last 6 months of pest control program customer receipts. The last visit from the pest control company indicated the company came into the facility on 3/18/14. The visits were monthly.</p> <p>On 4/10/14 at 11:25 p.m., the Administrator provided the "Pest Control" policy, dated 8/2011. The policy indicated, "Policy Statement: This facility shall provide a clean,</p>		<p>related to the protocol to follow if ants or other insects are observed. The protocol alerts administration so that appropriate interventions can be implemented. The Pest Control company routinely visits on a monthly basis but will visit more frequently if alerted by facility that additional services are needed.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been initiated that randomly reviews 5 resident rooms or common areas for the presence of pest. The Maintenance Director, or designee, will complete this tool weekly x 3, monthly x 3, then quarterly x 3. Any findings will be immediately addressed. The Quality Assurance Committee will review the tools at the scheduled meetings</p>	

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F000514 SS=A	<p>sanitary environment free from pests. Policy Interpretation and Implementation: 1. The following routine actions will be taken to minimize the risk of pest infestation...b. Spillage should be promptly removed...2. This facility will ensure that an appropriate pest control contract is in operation. Pest control services will be provided (usually on a weekly basis except for special circumstances) and as needed..."</p> <p>3.1-19(f)(4)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted</p>		<p>with recommendations for new interventions as needed based on the outcomes of the tools. The date the systemic changes will be completed: May 10, 2014</p>	

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	<p>professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure that a resident's records were accurate in that a medication was not linked with the correct clinical diagnosis for 1 of 28 residents reviewed for accurate clinical record. (Resident #14).</p> <p>Findings include:</p> <p>On 4/9/2014 at 1:38 p.m., the clinical record was reviewed for Resident #14. Diagnosis include but are not limited to coronary artery disease.</p> <p>Medications include but were are not limited to, Plavix 75 mg daily for dyslipidemia</p> <p>Review of Medication Administration Record from January 2014-April 2014 indicated Resident #14 had been receiving Plavix 75 mg daily for a</p>	F000514	<p>F154</p> <p>It is the practice of Bloomington Nursing and Rehab to assure that clinical records are maintained on each resident in accordance with accepted professional standards. The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident #14 has had a correct clinical diagnosis added to the medication usage.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents have been reviewed related to assuring that medications</p>	05/10/2014

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	<p>diagnosis of dyslipidemia.</p> <p>On 4/10/2014 at 9:00 a.m., an interview with the DoN (Director of Nursing) indicated she would follow up with the physician and pharmacy.</p> <p>On 4/10/2014 at 9:20 a.m., an interview with the DoN indicated she contacted the physician and had the order changed for Plavix 75 mg daily for dyslipidemia to Plavix 75 mg daily for coronary artery disease, and contacted the consulting pharmacist to review diagnosis for residents.</p> <p>On 4/10/2014 a physicians order was written to change diagnosis for Plavix 75 mg daily for coronary artery disease.</p> <p>3.1-50(a)(2)</p>		<p>have proper diagnosis. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>The nurses have been in-serviced related to assuring that when there is a new medication order that a proper diagnosis is obtained for the use of the medication. Please see below for systems to monitor.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents to assure that there is proper diagnosis related to the medication use.</p> <p>The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be</p>		

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			<p>immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.</p> <p><i>The date the systemic changes will be completed:</i> May 10, 2014</p>	