

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155570	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2014
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NAME OF PROVIDER OR SUPPLIER PLEASANT VIEW LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN 46055
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 15, 16, 17, 18, and 19, 2014.</p> <p>Facility number: 000477 Provider number: 155570 AIM number: 100290860</p> <p>Survey Team: Tom Stauss, RN-TC Beth Walsh, RN Karina Gates, Generalist</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 3 Medicaid: 23 Other: 4 Total: 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 29, 2014 by Cheryl Fielden, RN.</p>	F000000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a post survey review on of after January 18, 2015	

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

TITLE

(X6) DATE

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

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F000156 SS=A	<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>				

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

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	<p>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 interview and record review, the facility failed to issue liability and appeal notices timely for 3 of 3 Medicare beneficiaries reviewed for liability and appeal notices. (Resident #33, #38, and #46)</p> <p>Findings include:</p> <p>The Notices of Exclusions from Medicare Benefits Skilled Nursing Facility (NEMB-SNF) for Residents #38, #46, and #33 were provided by the Admissions Coordinator on 12/19/14, at 2:00 p.m.</p> <p>The notice for Resident #38 indicated his Medicare covered services would end on 11/28/14. The signature date of Resident #38's authorized representative was 11/29/14.</p> <p>The notice for Resident #46 indicated her Medicare covered services would end on 7/2/14. The notice was signed by Resident #46 on 7/2/14.</p> <p>The notice for Resident #33 indicated her Medicare covered services would end on 12/10/14. The notice was signed by Resident #33 on 12/9/14.</p>	F000156	<p><u>1. Corrective action:</u> A. The business office personnel has been counseled on the requirement to ensure that all residents who are receiving Medicare benefits receive their two day notice on liability and appeal notices. <u>2. Identification of any residents affected by this event:</u> A. The business office performed an audit of the previous three months of Medicare A beneficiaries to ensure that they received their two day notice on liability and appeal notices. B. All residents that are Medicare A beneficiaries have the potential for being affected. <u>3. Measures to prevent recurrence:</u> An in-service will be conducted on 1/12/15-1/18/15 by the Administrator on two day notice requiring the Medicare beneficiaries liability and appeal. <u>4. Continued monitoring:</u> A. The business office will monitor a two day notice for Medicare beneficiaries for liability and appeal notice being timely every week for thirty days. If 100% is achieved then monitoring will be reduced to every other week for 30 days. If 100% compliancy is achieved monitoring will be reduced to monthly for four months. If 100% compliancy is achieved for six months, the monitoring will end. 1. The Quality</p>	01/18/2015

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F000226 SS=C	<p>An interview was conducted with the Admissions Coordinator on 12/19/14, at 2:28 p.m. She indicated a 2 day notice was required for issuing the above referenced notices, but she was not made aware the residents would be discharging soon enough to meet the 2 day notice requirement.</p> <p>3.1-4(f)(3)</p> <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 interview and record review, the facility failed to ensure a resident's allegation of abuse was reported immediately to the State and to ensure the facility abuse policy was updated. (Resident #19)</p> <p>Findings include:</p> <p>Resident #19's record was reviewed on 12/16/14 at 9:02 a.m. The resident's diagnoses included, but were not limited to, cerebral palsy, attention seeking behaviors, refractory major depression, anxiety, and neuropathic pain.</p>	F000226	<p>Assurance Committee will review the audits to ensure the two day notice requiring Medicare beneficiaries liability and appeal notices were issued timely quarterly for six months. If 100% compliancy is achieved in six months, the monitoring will end.</p> <p><u>1. Corrective action:</u> A. The Administrator revised our policy and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. B. The Administrator and the Assistant Director of Nursing spoke with resident #19 on 12/18/2014 and explained the importance of reporting all concerns and/or allegations immediately to the staff. Resident #19 seemed to understand the importance of reporting all concerns and/or allegations immediately. C. This allegation was <u>first</u> reported by the resident to the surveyor with the Indiana State Department of Health on 12/16/2014. The</p>	01/18/2015			

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	<p>On 12/17/14 at 1:42 p.m., Resident #19 was in a wheelchair in the hallway near the facility entrance door. She was alert, pleasant, and in no distress.</p> <p>On 12/16/14 at 9:28 a.m., during an interview, Resident #19 indicated she was verbally abused by CNA #6 while the CNA (Certified Nursing Assistant) was assisting the resident with preparations to transfer from her bed to her wheelchair. The resident indicated the CNA "yelled at me" and characterized the CNA's behavior as disrespectful. Resident #19 indicated she told another CNA about the incident "maybe a couple days" after the incident. The resident could not immediately identify the CNA she told about the incident. She also indicated she reported the incident to the Social Service Director.</p> <p>On 12/18/14 at 10:53 a.m., during a follow up interview with Resident #19, she indicated not being sure if she reported the incident regarding CNA #6 to any other staff. She indicated it was "a month or two" ago. She indicated the aide usually works in the evenings. She was being repositioned by the CNA and indicated to the aide that the repositioning assistance was "hurting" her. The aide didn't respond. She indicated the CNA raised her voice and</p>		<p>surveyor notified the Administrator of the allegation on 12/18/2014 at 1:34 p.m. D. The Administrator faxed an initial report of an allegation of verbal abuse on 12/18/2014 at 5:50 p.m.</p> <p><u>2. Identification of any residents affected by this event:</u> A. The Social Service Designee interviewed all alert residents and they denied witnessing any types of abuse or that any staff member has yelled or raised their voice at them or at any other residents. B. No other residents were affected.</p> <p><u>3. Measures to prevent recurrence:</u> A. Staff will be in-serviced on the policy and procedures of abuse during the week of 1/12/2015-1/18/2015. B. Social Service Designee will review with the residents the policy and procedures on the different types of abuse and reporting abuse, any allegations and/or concerns immediately to a staff member during the week of 1/12/2015-1/18/2015. <u>4. Continued monitoring:</u> A. SSD or their designee will interview resident #19 for any concerns or allegations of abuse and the importance of reporting it immediately on a weekly basis for 6 months. B. Social Service Designee will review monthly with all residents at the resident council meetings for reporting any concerns, allegations and/or abuse immediately to a staff member. C. The Quality Assurance Committee will review</p>				

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	<p>indicated the aide knew how to provide care for residents. She also indicated the aide has raised her voice to Resident #19 on previous occasions. She indicated she reported a previous incident to SSD or a nurse. She stated feeling like the CNA was "rough" with her during the incident a month ago. She indicated she may have reported the incident to the previous DON or the SSD. She indicated staff will not honor preferences on how to be positioned in mechanical lift. She indicated telling staff it hurts her legs. She told CNA #6 on 12/18/14 to reposition her more comfortably in the mechanical lift sling.</p> <p>On 12/18/14 at 11:18 a.m., during an interview with the SSD (Social Service Director) she indicated not having been informed of Resident #19 being mistreated or yelled at while a CNA was performing morning care for the resident. The SSD indicated if she would have been informed, she would have followed the facility abuse policy regarding investigating the allegation.</p> <p>On 12/18/14 at 1:34 p.m., the facility Administrator was informed about Resident #19's allegation of being verbally abused by CNA #6. She indicated she would immediately begin an investigation into the incident.</p>		<p>the interview notes of resident #19 and the resident council meeting notes for any concerns or allegations of abuse quarterly. If there is 100% compliancy, the monitoring will end after 6 months. <u>IDR Request</u> On the 2567 page 2 through ----- from the survey dated 12/19/14 we are requesting to delete that the "facility failed to ensure that the resident's allegation of abuse was reported immediately to the state". We are requesting this for the following reasons: A. On page 2 toward bottom resident #19 indicated that she told another CNA about the incident "<u>maybe</u>". B. On page 2 toward bottom "the resident could not immediately identify the CNA that she told about the incident". C On page 3 at the top, on a follow up interview resident #19 indicated "Not sure if she reported the incident on CNA #6 to any other staff". D. On page 3 resident indicated "The CNA raised her voice on previous occasions". This was never reported. E. Resident #19 indicated that "the CNA raised her voice and indicated that the CNA knew how to do care for residents". This was never reported to the facility. F. On page 3 resident #19 also indicated "the aid has raised her voice on previous occasions"; she indicated that "she reported a previous incident to SSD or a Nurse". The SSD denies that this was reported. No nurse has been</p>		

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	<p>On 12/18/14 at 2:58 p.m., LPN #4 indicated Resident #19 asked her to give the surveyor the name of CNA #5.</p> <p>On 12/18/14 at 3:03 p.m., during an interview, the Administrator indicated she spoke with Resident #19 earlier on 12/18/14. She indicated the resident informed her that she did not tell any staff about the alleged yelling incident.</p> <p>On 12/18/14 at 3:19 p.m., during an interview with CNA #6, she indicated she was scheduled to begin work at 2:00 p.m. She indicated the facility Administrator told her "I (CNA #6) can't start yet, they have to talk to me." CNA #6 indicated some forms of verbal abuse may potentially be raising of voices or yelling at residents. She indicated not being aware of any residents at the facility being abused in "6 or 7 years" that she has been employed at the facility. She indicated she has undergone training on abuse prevention "3 times this year". She indicated she had never abused any resident. She indicated the only persons "at risk for being abused" were residents who wandered into other rooms.</p> <p>On 12/18/14 at 3:48 p.m., during an interview, the ADON indicated the facility had suspended CNA #6 for the</p>		<p>identified by the resident or the surveyor. G. Resident #19 stated "feeling like the CNA was rough with her during the incident a month ago". She indicated that "she <u>may have</u> reported the incident to the previous DON or the SSD". H. On page 3 of 38 at the bottom, the facility's Administrator was informed about resident #19's allegation of being verbally abused by CNA #6 for the first time by the Indiana State Department of Health surveyor. This was discussed in length with the surveyors. I. On page 4 of 38, 2nd paragraph, "During an interview with the Administrator, she indicated the resident informed her that she did not tell any staff about the alleged yelling incident". J. On page 5 of 38, 3rd paragraph, "During an interview with the Administrator on 12/19/14 at 5:49 p.m., she indicated resident #19 informed her "during a 12/18/14 interview" that she did not notify staff of any complaints of CNA mistreatment or "yelling at the resident". "She indicated the facility's first indication of the allegation of the incident was on 12/18/14". See attached follow up report that was sent on 12/24/14 for resident #19. K. On page 1 of follow up report, paragraph 2, it states that resident 19 has a diagnosis of attention seeking behavior. L. On page 1, paragraph 3, this allegation was first reported to the Administrator by ISDH surveyor</p>	

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	<p>investigation of Resident #19's abuse allegation. She indicated the CNA would not be allowed to return to the facility to work until the facility investigation was completed.</p> <p>On 12/18/14 at 5:58 p.m., the Administrator provided an "INCIDENT REPORT" regarding Resident #19's allegation of verbal abuse. The report had been faxed to the State, according to a fax cover sheet, on 12/18/14 at 5:51 p.m. The report indicated the facility interviewed Resident #19, interviewed "the staff member involved", notified the physician, suspended the CNA involved, and monitored Resident #19 for psychosocial complications. The report also indicated the facility notified Adult Protective Services and the State Ombudsman.</p> <p>On 12/19/14 at 9:27 a.m., during an interview, CNA #5 indicated Resident #19 had never reported a concern regarding mistreatment or being yelled at by any facility staff. She indicated also never hearing about such a complaint. She indicated having never witnessed or heard of any staff members abusing any residents. She indicated having worked for the facility for "about a year."</p> <p>During an interview with the</p>		<p>on 12/18/14. Prior to this, the alleged incident had never been reported to any employee at the facility or to anyone else. M. On page 1, paragraph 4, resident #19 alleges that the incident occurred one to two months ago between the hours of 10 a.m.-12 p.m. N. On page 2, paragraph 3, the resident stated that she had not reported it then because she thought that CNA#6 was a good CNA and that she thought that she did not have enough evidence. O. On page 2, paragraph 4, resident #19 was inconsistent with her descriptions once saying that this kind of incident had happened more than one time, before reverting to saying it had only happened one time. More significantly in a later description on 12/22/14, resident #19 alleged that incident occurred while she was being lifted with the hoier lift not while being turned in bed. P. On page 2, paragraph 6, the Administrator describes resident #19 allegations to CNA #6 and CNA responded that she was very careful with resident #19 due to her past allegations with other staff members. CNA #6 could not recall any complaints by resident #19. Q. On page 3, paragraph 4, The Administrator and the Administrative Assistant checked CNA #6 timecards beginning from 10/6/14-12/18/14. CNA #6 did not work any day between the time span of 10 a.m.-12 p.m. R. Our</p>	

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	<p>Administrator on 12/19/14 at 5:49 p.m., she indicated Resident #19 informed her (during a 12/18/14 interview) that she did not notify staff of any complaints of CNA mistreatment or "yelling" at the resident. The Administrator indicated completing an "initial notification to the State" about the incident and forwarding the notification to the State on 12/18/14. She indicated the facility's first notification of the allegation of the incident was on 12/18/14. She also indicated the investigation was not completed due to the need to contact all employees for interviews related to the potential abuse.</p> <p>A facility abuse policy, dated 5/2006, indicated "...Should an occurrence of abusive behavior be reported or witnessed, the Administrator shall be notified immediately..." and "...Should the incident be deemed an 'unusual occurrence', the state survey and certification agency shall be notified as well as the ombudsman and/or Adult Protective Services, as applicable within 24 hours..."</p> <p>The policy also indicated, under a section titled "Employee's Responsibilities" the following, "...The Administrator will provide an initial report to the Indiana State Department of Health, Adult Protection Agency, and Ombudsman within 24 hours..."</p>		<p>conclusions to the investigation were unsubstantiated with resident #19. The facility conclusions were: 1) Resident #19 changed her story on 12/22/14 from the first description on 12/18/14. On 12/18/14 resident #19 stated that the incident occurred while she was being turned side to side in bed. On 12/22/14 resident #19 stated that it happened while being transferred on the hooyer lift. 2) Resident #19 changed her description allegedly involving one staff member to two staff members. 3) No other resident or staff member reported any allegations of abuse or examples of staff members yelling or raising their voice to any resident. 4) CNA #6 has been employed at facility since April 2008. She has no disciplinary actions against her of any type since her employment with this company. This is the first time any allegation has been brought against her. 5) CNA #6 did not work during the 1-2 month time period from 10 a.m.-12 p.m. 6) Resident #19 has a past history of making allegations of abuse by staff members and not making the allegation to the facility until she is interviewed by ISDH surveyor. An example of this is her 10/26/12 allegation. 7) Resident #19 has a diagnosis of borderline personality disorder and attention seeking behavior.</p>				

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F000242 SS=D	<p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES 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. Based on interview and record review, the facility failed to honor a resident's bathing frequency preference for 1 of 3 residents reviewed for choices. (Resident #13)</p> <p>Findings include:</p> <p>The clinical record for Resident #13 was reviewed on 12/16/14, at 9:00 a.m. The diagnoses for Resident #13 included, but</p>	F000242	<p>Considering her past history of false allegations, her failure to report in a timely manner, and her changing and inconsistent descriptions we believe that is probable that resident #19 fabricated these allegations. S. Based on all of these examples of inconsistencies, we are requesting to remove that the facility failed to ensure a resident's allegation of abuse was reported immediately to the State. We are requesting a paper review of this IDR.</p> <p><u>1. Corrective action:</u> Resident #13's shower schedule has been changed to receive three showers per week to honor her preference. Resident #13 is receiving three showers per week. <u>2. Identification of any residents affected by this event:</u> A. SSD or their designee interviewed all residents or their responsible parties to verify their preference or frequency on bathing each week. B. This could have the potential to affect all</p>	01/18/2015	

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	<p>were not limited to, hemiplegia.</p> <p>The 9/5/14 Quarterly MDS (minimum data set) assessment indicated Resident #13 was a one person physical assist, requiring physical help in part of bathing.</p> <p>The 12/2/14 ADL (activities of daily living) care plan for Resident #13 indicated she was dependent with bathing.</p> <p>The assignment sheet for CNA #7 indicated Resident #13's shower days were Monday and Thursday.</p> <p>An interview was conducted with Resident #13 on 12/16/14, at 9:32 a.m. She indicated she did not choose how many times a week she bathed, she received 2 showers a week, and would like 3.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) and SSD (Social Services Director) on 12/19/14, at 3:07 p.m. The ADON indicated, "We ask the residents how many showers they'd like. We've had residents who get showers everyday. It's determined on admission. As far as nursing, I don't have any verification of how often a resident wants a shower. Her (Resident #13) getting them twice a</p>		<p>residents. <u>3. Measures to prevent recurrence:</u> The facility developed a new form to allow choices for the number of showers/baths, days of the week, and the time of day to receive showers/baths to honor the resident's preferences.</p> <p><u>4. Continued monitoring:</u> A. Director of Nursing of her designee will monitor all bathing records of the residents weekly to ensure they are receiving their preferences on frequency for number of showers/baths per week for 30 days. B. If 100% is achieved after 30 days, the DON or their designee will monitor bi-weekly for four weeks. C. If 100% is achieved after four weeks, the DON or their designee will monitor monthly for four months. D. The Quality Assurance Committee will review the audits quarterly to ensure compliance. If 100% is achieved the monitoring will end after six months.</p>				

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F000248 SS=D	<p>week, probably would have been determined on admission." The ADON indicated the facility had no system in place for determining if a resident's preference for shower frequency changed after admission, if the resident didn't inform them. The SSD indicated, "If they are alert enough, they can tell us how often they want a shower. A resident would have to tell us if they wanted more showers. Then, we would change the CNA assignment sheet. We have no system in place to periodically determine if a resident is okay with their shower schedule."</p> <p>An interview was conducted with Resident #13 and the SSD on 12/19/14, at 3:15 p.m. Resident #13 informed the SSD she'd like 3 showers a week, but only received 2. Resident #13 stated, "You (SSD) said you'd come back, and give me a shower yesterday, and you never came." The SSD indicated, "I'm sorry." The SSD later stated, "It wasn't yesterday. It was the other day."</p> <p>3.1-3(u)(3)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in</p>			

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	<p>accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to provide an activity program to meet a resident's activities of choice for 1 of 3 residents reviewed for activities. (Resident #13)</p> <p>Findings include:</p> <p>The clinical record for Resident #13 was reviewed on 12/16/14, at 9:00 a.m. The diagnoses for Resident #13 included, but were not limited to, hemiplegia.</p> <p>An interview was conducted with Resident #13 on 12/16/14, at 9:34 a.m. She indicated facility staff did not provide items she could do on her own in her room, like puzzles. She stated, "I'd like for them to provide puzzles."</p> <p>The 12/2/14 activity care plan for Resident #13 indicated her need was to attend activities of choice daily. It indicated the goal was to remain actively participating in activities of choice.</p> <p>An interview was conducted with Resident #13 on 12/19/14, at 2:41 p.m. She indicated, "I'd still like puzzles....I have to ask for puzzles, but they don't seem to bring them. They don't care."</p>	F000248	<p><u>1. Corrective action:</u> Resident #13 has been given puzzles to honor her activity of choice weekly by the Activity Director. <u>2. Identification of any residents affected by this event:</u> A. All resident activity assessments were reviewed to ensure that their activity choices are being honored. B. All residents have the potential for being affected. <u>3. Measures to prevent recurrence:</u> A. The activity assessment will be reviewed weekly with the resident and updated to reflect the resident's activity preferences. B. The Activity Director was ins-serviced on: Identifying activity preference, calendar development with attention to residents interests and preference, providing individual activities for residents to do independently, and F-0248 activity regulation review. <u>4. Continued monitoring:</u> A. The Activity Director or their designee will review the activity participation records weekly to assure activity preferences are being honored. B. The Quality Assurance Committee will review that the residents activity choices are being honored quarterly for six months. If 100% compliancy is achieved, the monitoring will end.</p>	01/18/2015

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F000279 SS=D	<p>An interview was provided with the AD (Activity Director) on 12/19/14, at 12:44 p.m. She indicated the facility provided activities for residents to do on their own in their room for people who ask. She indicated the facility had puzzles, but did not go around the facility to offer them.</p> <p>3.1-33(a) 3.1-33(b)</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, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F000279	<p><u>1. Corrective action:</u> A. Resident #16's care plan was updated on proper positioning during meal</p>	01/18/2015

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	<p>a resident had a care plan to address her need to be properly positioned to eat for 1 of 2 residents reviewed for positioning. (Resident #16) The facility failed to develop a limited range of motion care plan for 1 of 15 residents reviewed for care plans. (Resident #30)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #16 was reviewed on 12/16/14, at 12:00 p.m. The diagnoses for Resident #16, included, but were not limited to, dementia.</p> <p>The 9/12/14 Quarterly MDS (minimum data set) assessment for Resident #16 indicated she required limited assistance of 1 person for eating.</p> <p>An interview was conducted with Family Member #9, Resident #16's son, on 12/16/14, at 12:15 p.m. He indicated Resident #16 did not receive the assistance with meals that she needed. He stated, "She's not always positioned correctly, when they give her her food. I've come here once or twice, and seen her positioned too low, with her feet by the edge of the bed, so she has a hard time reaching her food."</p> <p>An interview was conducted with CNA</p>		<p>times. B. Resident #30's care plan was updated on limited range of motion. <u>2. Identification of any residents affected by this event:</u> A. All residents were assessed by the DON or ADON for proper positioning during meal times. B. All residents were screened by the therapy department for range of motion. C. No other residents were affected. <u>3. Measures to prevent recurrence:</u> A. In-service training will be provided for the nursing department during the week of 1/12/15-1/18/15 on proper positioning during meal times. B. All residents will be screened by the therapy department for range of motion quarterly and as needed. <u>4. Continued monitoring:</u> A. The DON or their designee will monitor all residents for proper positioning one time a week for four weeks. B. If 100% compliancy is achieved after four weeks, the DON or their designee will monitor all residents for proper positioning bi-weekly for four weeks. C. If 100% compliancy is achieved, the DON or their designee will monitor one time a month for four months. D. If 100% compliancy is achieved after six months, the monitoring will end. E. The DON or their designee will monitor the therapy department screenings for all residents' range of motion quarterly for six months. If 100% compliancy is achieved, the monitoring will end after six</p>				

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	<p>#10 on 12/17/14, at 3:03 p.m. She indicated, "She does eat in her room, sometimes. I've brought her her tray in her room before. For breakfast, she's usually already dressed, and in her recliner when I bring her her breakfast tray. I make sure she's sitting upright, not reclined, with her feet on the floor, because sometimes, she'll just lean back, and fall asleep if she's reclined. If she's sitting up, she's more aware it's time to eat."</p> <p>An observation was made on 12/17/14, at 9:01 a.m. Resident #16 was in her recliner chair with her breakfast tray in front of her on the bedside table. Her head was down, and she was sleeping. On her tray, was a full bowl of cornflakes, a whole slice of french toast, chopped up sausage, a full bowl of grits, and several drinks. None of her food was eaten. Her chair was fully reclined, with her legs stretched out in front of her. She was not in an upright position.</p> <p>On 12/17/14, at 9:06 a.m., the SSD (Social Services Director) came down the hall, and stated, "I was just going in there to help her eat. I came to get her tray, and saw she did not eat anything." The SSD came in the room, and began to assist Resident #16 to eat. Resident #16 was still reclined, and sitting back in her</p>		<p>months.</p> <p>F. The Quality Assurance Committee will review the audits on proper positioning during meal times and the therapy screens for range of motion quarterly for six months. F. If 100% compliancy is achieved after six months, the monitoring will end.</p>	

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	<p>chair. Resident #16 was observed to scoot herself up in the chair with her elbows, while still reclined. She had to lift her arm up and over the bedside table to reach her fork. The SSD asked Resident #16 if she'd like her feet down, but did not put her feet down.</p> <p>An interview was conducted with CNA #11 on 12/18/14, at 10:30 a.m. She indicated, "I work with her (Resident #16) 4 out of 5 days a week. I've never seen her recline her actual chair herself....I usually recline her chair for her. I have given her her meal tray in her room, usually breakfast. The person who trained me, (name of CNA #7), said she eats breakfast meals in her room. Today, I was told to bring her to the dining room, because she fell asleep at breakfast in her room yesterday....I normally set her up in her recliner, put her tray up to her, give her her first bite to get her going. I put her feet down in the recliner when she eats. She never refuses to put her feet down....She's never been combative or aggressive. She's never refused to have her feet down in the recliner while eating."</p> <p>An interview was conducted with Therapist #12 and Therapist #13 on 12/18/14, at 9:02 a.m. Therapist #13 indicated, "If the resident is able to sit</p>			

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	<p>upright, they should probably sit in a regular chair or their wheel chair....Ideally, if they have no impairments, they should be sitting up, feet on the floor. That would be the safest."</p> <p>An interview was conducted with Family Member #9 on 12/17/14, at 2:04 p.m. He indicated, "As long as she's up far enough, so she can swallow, it's okay. She eats fine in her chair, if she's sitting up where she can eat, with her feet not reclined...."</p> <p>An observation of Resident #16 was made on 12/18/14, at 12:45 p.m. She was laying in bed with her hands on her stomach. Her lunch tray was at the side of her bed.</p> <p>Neither Resident #16's 12/13/14 nutrition care plan, nor her 12/3/14 ADL (activities of daily living) care plan, indicated her need to be properly positioned for meals. No care plan in Resident #16's clinical record indicated her need to be properly positioned for meals.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) on 12/19/14, at 4:53 p.m. She indicated she was unsure if Resident #16 should have a care plan to address proper</p>			

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	<p>positioning for her while eating in her room."</p> <p>2. The clinical record for Resident #30 was reviewed on 12/19/14 at 11:15 a.m. The diagnoses for Resident #30 included, but were not limited to, advanced Huntington's disease, facial dyskinesia (involuntary muscle movements), and vitamin D deficiency. Resident #30 was on hospice services.</p> <p>During an observation of Resident #30, on 12/16/14 at 11:15 a.m., Resident #30 appeared to have limited movement of their left arm/hand.</p> <p>During a staff interview with the Director of Nursing (DON), on 12/16/14 at 11:21 a.m., the DON indicated Resident #30 had a contracture of her left arm/hand.</p> <p>A Limited Range of Motion (ROM) care plan was not located in the clinical record.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 12/19/14 at 4:16 p.m., the ADON indicated she was not able to locate a Limited Range of Motion care plan for Resident #30 in the clinical record.</p> <p>During an ROM assessment with the ADON, on Resident #30, on 12/19/14 at</p>						

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F000280 SS=D	<p>4:20 p.m., Resident #30 was unable to open her left hand completely and would not let the ADON open her left hand any further. The ADON indicated Resident #30 should have a Limited Range of Motion care plan, at this time.</p> <p>On 12/19/14 at 6:46 p.m., during an interview with Hospice Manager #15, she indicated hospice staff performs passive range of motion exercises during their visits with Resident #30 because Resident #30 was not a candidate for therapy or splinting.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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</p>						

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	<p>and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to timely invite a resident's POA (power of attorney) to care plan meetings, and to update a resident's activity care plan for 1 of 3 residents reviewed for care plan meeting invitation and 1 of 3 residents reviewed for activities (Resident #37) and the facility failed to revise an activity care plan and an ADL (Activities of Daily Living) care plan for 1 of 15 residents reviewed for care plans. (Resident #9)</p> <p>Findings include:</p> <p>1 a.) The clinical record for Resident #37 was reviewed on 12/16/14, at 3:00 p.m. The diagnoses for Resident #37 included, but were not limited to, dementia.</p> <p>An interview was conducted with Family Member #8, Resident #37's daughter and POA, on 12/16/14, at 3:11 p.m. She indicated she was Resident #37's POA, and did not recall being invited to participate in Resident #37's care planning conferences.</p> <p>An interview was conducted with the Admissions Coordinator on 12/18/14, at 9:36 a.m. She indicated she was responsible for scheduling residents' care</p>	F000280	<p><u>1. Corrective action:</u> A. Resident #37's daughter and the resident's husband was invited to a care plan conference by telephone on 1/5/15. B. The daughter chose to attend the care plan conference on 1/7/15. Due to the weather, the daughter and the resident's husband have requested to reschedule the care plan conference for 1/13/15. C. Resident #37's activity care plan has been updated to include small group and in short duration outing with an invitation to the resident's family to participate in the outing. D. Resident #9's activity care plan has been updated to include interventions for 1 on 1 activities. E. Resident #9's nursing care plan for assistance with activities of daily living has been updated. <u>2. Identification of any residents affected by this event:</u> A. The ADON audited all residents care plans for assistive activities of daily living care plans. B. The Activity Director will audit all residents activity care plans for all interventions or approaches for activity outings and 1 on 1 activities. C. The business office audited all care plan invitation notices for timeliness. D. All residents may have the potential for being affected. <u>3. Measures to prevent recurrence:</u> A. The facility created a formal care plan meeting invitation to be mailed to</p>	01/18/2015

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	<p>plan meetings. She stated, "I send the notices out. I get a list of residents who's MDS (minimum data set assessments) are coming up. I schedule the meeting for a Tuesday. The resident's POA or responsible person gets the statements each month, and the reminder notice about the care plan meeting is at the bottom of the statement. Sometimes it's on the bottom of the previous 2 statements. Sometimes, just 1 statement." She indicated Resident #37's husband received the notices, not Family Member #8.</p> <p>The Admissions Coordinator provided Resident #37's 10/31/14 and 7/31/14 financial statements, addressed to Resident #37's husband, on 12/18/14, at 10:00 a.m. The 10/31/14 one page statement included a disclaimer in the middle of the page that stated, "Invitation to Care Plan Meeting 11/04/14 @ 11:00 AM". The 7/31/14 one page statement included the disclaimer in the middle of the page that stated, "Invitation to Care Plan Meeting 8/05/14 @ 11:00 AM".</p> <p>An interview was conducted with the Admissions Coordinator on 12/18/14, at 10:00 a.m. She stated, "The notices would be mailed on the notice date. It's just our process to inform responsible parties at the end of the month. We</p>		<p>families/responsible parties. These individuals have the option to attend the meeting, reschedule the meeting, or to request a telephone conference at a more convenient time. These notices will be mailed with a 14-21 day advance notice. B. The nursing department has created a log sheet to monitor all the residents care plans to ensure that all care plans are updated with the residents current MDS to include their assistive activity of daily living level. C. The activity department has created a log sheet to monitor that all residents' activity care plans are correct to include all interventions or approaches for activity outings and 1 on 1 activities. 4. <u>Continued monitoring</u>: A. The business office will monitor that the formal care plan meeting invitation has been mailed to the families/responsible parties with a 14-21 day notice every two weeks for six months. 1. The Quality Assurance Committee will review the care plan invitations quarterly to ensure they are giving families advance notice to attend the care plan conference for six months. 2. If there is 100% compliancy, the monitoring will end after six months. B. The DON or ADON will monitor the nursing care plan one time a week for four weeks to ensure that the nursing care plans are updated to match the MDS for the assistive activities of daily living. This will be done with</p>	

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	<p>could change it. It's not set in stone. I see how they would have a short amount of time from the time they receive the notice, before the actual meeting."</p> <p>A telephone interview was conducted with Family Member #8 on 12/18/14, at 11:21 a.m. She indicated, "I don't always catch the mail. I'm only at Dad's house Tuesday through Friday. That's when I pick up the mail. Dad can't get the mail himself. I never noticed that sentence before. It's not in a location to draw my attention. Ideally, I'd need 1 week's notice before the meeting. Neither myself, nor my dad, have gone to any meetings. I'd like to start going. Now that I know about them, I'll start going. My dad probably won't go, because he's hard of hearing. If they don't mind, I'd like to start receiving notices, too."</p> <p>An interview was conducted with the Administrator and Admissions Coordinator on 12/18/14, at 12:21 p.m. The Administrator indicated, "Well, to be honest, a lot of families don't come, or we can do them over the phone, or reschedule. The time frame could be close to being a conflict. I haven't allowed more time, but it would be possible to allow more time."</p> <p>1b) A bruise was observed on the back</p>		<p>new admission MDS, quarterly MDS or significant change MDS within 7 days of the MDS completion. If 100% is achieved then DON or ADON will monitor for every other week for four weeks. If 100% is achieved we will then monitor one time a month for four months. If 100% is achieved then monitoring will end. 1. The Quality Assurance Committee will review the audits of the MDS to ensure that the care plan matches the residents current MDS quarterly. 2. If there is 100% compliancy, the monitoring will end after six months. C. The activity director or their designee will monitor the activity care plans for interventions, approaches and 1 on 1 activities to ensure they are updated and match the residents participation monthly for six months. If 100% compliancy is achieved after six months then monitoring will end. 1. The Quality Assurance Committee will review the activity care plan and activity 1 on 1 participation records to ensure they are current to the residents' care quarterly for six months. If 100% compliancy is achieved after six months monitoring will end.</p>				

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	<p>of Resident #37's right hand, on 12/16/14, at 2:55 p.m.</p> <p>An interview was conducted with the SSD (Social Services Director) on 12/18/14, at 11:39 a.m. She indicated, "We went on an outing. She (Resident #37) thought she was at home. I was right behind her. She started to get up. I asked her what she needed. She said she was going to bed. I told her where we were, and we'd be done soon. She sat back down, and got up again. The third time she got up, she said she needed to use the bathroom. I was going to help her, and she didn't want my help, because she said 'I know where I'm going. I'm just going to the bathroom.' When she walked passed me, I walked behind her. She said, 'Don't follow me,' and I told her I had to for safety. Other staff were not in distance for someone else to help her. The exit way from the theater had 2 or 3 steps to go up. When she started to make the first step, she became unsteady, steadied herself, then I opened the door. One of the workers at the (name of theater), could hear (Name of Resident #37) yelling at me. The lady stepped towards us. (Name of Resident #37) was yelling help. I asked the worker to bring the wheel chair. (Name of Resident #37) was yelling, carrying on, and she almost fell. I reached out, and caught her so she</p>			

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	<p>wouldn't fall, but her hands flew back, and the right one hit the edge of the door. It started getting discolored...(Name of Resident #37) wanted to talk to her family. I called and left a message. The worker offered me a place to sit with her, in the downstairs coat room. I continued to try to call the daughter...I called (name of Activity Assistant) to come down to see if (name of Resident #37) would calm down for her. We went outside. She calmed down, and apologized to me, and said she was really sorry. When we got down to the coat room, I realized how purplish her hand was....We've never been to the (name of theater) before. We have gone to (name of department store) and (name of restaurant), and she went to that, and was fine. My opinion is, because at the (name of theater), they turn the lights down. She thought she was at home, and wanted to go to bed. The plan in the future is to only take her out, if family is with her. If family can't come, we'll try to do something shorter, like going to get a milkshake."</p> <p>Resident #37's activity care plan was reviewed. It did not indicate any interventions or approaches to include family in activity outings outside of the facility.</p> <p>An interview was conducted with the</p>						

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	<p>ADON (Assistant Director of Nursing) on 12/19/14, at 12:30 p.m. She indicated, "Having a family member go with her should be on the care plan."</p> <p>2. The clinical record for Resident #9 was reviewed on 12/19/14 at 10:15 a.m. The diagnoses for Resident #9 included, but were not limited to, diabetes mellitus, anxiety, bipolar disorder, and schizoaffective disorder.</p> <p>During an interview with the Social Services Director/Activity Director (SSD), on 12/19/14 at 10:48 a.m., the SSD indicated Resident #9 does participate in group activities and has had also been added to the one to one (1:1) activities provided by the facility.</p> <p>A review of the November and December Activity Logs/1:1 Activity Logs indicated Resident #9 participated in both sets of activities provided by the facility.</p> <p>Resident #9's Activity care plan, dated 11/29/14, did not indicate an intervention of 1:1 activities.</p> <p>During an interview with the SSD, on 12/19/14 at 5:29 p.m., she indicated she was in charge of developing and revising the Activity care plans. The SSD further indicated she did indicate earlier in the day that Resident #9 was part of the 1:1</p>			

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F000309 SS=D	<p>activities provided by the facility.. The SSD indicated she did not see an intervention for 1:1 activities on the Activity care plan, so she must've forgot to update the care plan. The SSD indicated she will revise the care plan now.</p> <p>2 b) A review of Resident #9's Assistive ADL (Activities of Daily Living) care plan, dated 11/29/14, indicated Resident #9 was limited assist with bed mobility, transfers, dressing, toilet use, and personal hygiene.</p> <p>A 9/10/14 Quarterly MDS (minimum data set) assessment indicated Resident #9 only needed supervision and set up help with bed mobility, transfers, dressing, toilet use, and personal hygiene.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 12/19/14 at 6:21 p.m., the ADON indicated the Assistive ADL care plan was not reflective of Resident #9's MDS status and should be revised.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p>			

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	<p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was properly positioned to eat in her room for 1 of 2 residents reviewed for positioning (Resident #16), and to recognize a bruise on the back of a resident's hand, that had been there for days, for 1 of 3 residents reviewed for skin conditions (Resident #7) and the facility failed to perform a skin assessment as indicated by facility policy and failed to initially identify a skin issue for 1 of 2 residents reviewed for positioning. (Resident #11)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #16 was reviewed on 12/16/14, at 12:00 p.m. The diagnoses for Resident #16, included, but were not limited to, dementia.</p> <p>The 9/12/14 Quarterly MDS (minimum data set) assessment for Resident #16 indicated she required limited assistance of 1 person for eating.</p> <p>An interview was conducted with Family Member #9, Resident #16's son, on</p>	F000309	<p><u>1. Corrective action:</u> A. Resident #16's nursing care plan was updated for proper positioning during meals. B. Resident #17's bruise located on the back of her right hand has been updated on her skin assessment sheet and her nursing care plan. C. The DON reviewed the policy and the procedures with the ADON on performing proper skin assessments. D. Resident #11's skin assessment has been updated. <u>2. Identification of any residents affected by this event:</u> A. All residents were assessed for proper positioning during meal times by the DON or the ADON. B. All residents skins were assessed for bruising. C. The DON and the ADON completed skin assessments on all residents. D. No other residents were affected. <u>3. Measures to prevent recurrence:</u> A. In-service training will be conducted the week of 1/12/15-1/18/15 on proper positioning during meal times, documentation on reporting bruising and review of the policy on skin assessments and proper identification of skin issues. <u>4. Continued monitoring:</u> A. The DON or their designee will monitor all residents for proper positioning during meal times one time a week for four weeks. 1. If</p>	01/18/2015

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	<p>12/16/14, at 12:15 p.m. He indicated Resident #16 did not receive the assistance with meals that she needed. He stated, "She's not always positioned correctly, when they give her her food. I've come here once or twice, and seen her positioned too low, with her feet by the edge of the bed, so she has a hard time reaching her food."</p> <p>An interview was conducted with CNA #10 on 12/17/14, at 3:03 p.m. She indicated, "She does eat in her room, sometimes. I've brought her her tray in her room before. For breakfast, she's usually already dressed, and in her recliner when I bring her her breakfast tray. I make sure she's sitting upright, not reclined, with her feet on the floor, because sometimes, she'll just lean back, and fall asleep if she's reclined. If she's sitting up, she's more aware it's time to eat."</p> <p>An observation was made on 12/17/14, at 9:01 a.m. Resident #16 was in her recliner chair with her breakfast tray in front of her on the bedside table. Her head was down, and she sleeping. On her tray, was a full bowl of cornflakes, a whole slice of french toast, chopped up sausage, a full bowl of grits, and several drinks. None of her food was eaten. Her chair was fully reclined, with her legs</p>		<p>100% compliancy is achieved after four weeks, the DON or their designee will monitor all residents for proper positioning bi-weekly for four weeks. If 100% compliancy is achieved, the DON or their designee will monitor all residents for proper positioning one time a month for four months 2. If 100% compliancy is achieved after six months, the monitoring will end. 3. The Quality Assurance Committee will review the audits on proper positioning during meal times quarterly for six months. If 100% compliancy is achieved after six months, the monitoring will end.</p> <p>B. Nursing staff will monitor for bruises and any skin issues daily for 30 days. 1. If 100% compliancy is achieved after 30 days, we will monitor three times a week for 30 days. 2. If 100% compliancy is achieved after 30 days, we will monitor one time a week for four months. If 100% compliancy is achieved after six months then monitoring will end.</p> <p>C. The DON, ADON or their designee will perform skin assessments weekly. 1. The Quality Assurance Committee will review the audits on proper documentation for bruises quarterly for indefinitely. D. The DON, ADON or their designee will monitor all residents for skin issues weekly. 1. The Quality Assurance Committee will review the audits on proper documentation for bruises</p>				

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	<p>stretched out in front of her. She was not in an upright position.</p> <p>On 12/17/14, at 9:06 a.m., the SSD (Social Services Director) came down the hall, and stated, "I was just going in there to help her eat. I came to get her tray, and saw she did not eat anything." The SSD came in the room, and began to assist Resident #16 to eat. Resident #16 was still reclined, and sitting back in her chair. Resident #16 was observed to scoot herself up in the chair with her elbows, so she could reach her food better. She had to lift her arm up and over the bedside table to reach her fork. The SSD asked Resident #16 if she'd like her feet down, but did not put her feet down.</p> <p>An interview was conducted with CNA #11 on 12/18/14, at 10:30 a.m. She indicated, "I work with her (Resident #16) 4 out of 5 days a week. I've never seen her recline her actual chair herself....I usually recline her chair for her. I have given her her meal tray in her room, usually breakfast. The person who trained me, (name of CNA #7), said she eats breakfast meals in her room. Today, I was told to bring her to the dining room, because she fell asleep at breakfast in her room yesterday....I normally set her up in her recliner, put her tray up to her, give</p>		quarterly for indefinitely.				

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	<p>her her first bite to get her going. I put her feet down in the recliner when she eats. She never refuses to put her feet down....She's never been combative or aggressive. She's never refused to have her feet down in the recliner while eating."</p> <p>An interview was conducted with Therapist #12 and Therapist #13 on 12/18/14, at 9:02 a.m. Therapist #13 indicated, "If the resident is able to sit upright, they should probably sit in a regular chair or their wheel chair....Ideally, if they have no impairments, they should be sitting up, feet on the floor. That would be the safest."</p> <p>An interview was conducted with Family Member #9 on 12/17/14, at 2:04 p.m. He indicated, "As long as she's up far enough, so she can swallow, it's okay. She eats fine in her chair, if she's sitting up where she can eat, with her feet not reclined...."</p> <p>An observation of Resident #16 was made on 12/18/14, at 12:45 p.m. She was laying in bed with her hands on her stomach. Her lunch tray was at the side of her bed.</p> <p>2. The clinical record for Resident #7</p>			

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	<p>was reviewed on 12/16/14, at 10:00 a.m. The diagnoses for Resident #7 included, but were not limited to, dementia with behaviors.</p> <p>An observation of a bruise on the back of Resident #7's right hand was made on 12/16/14, at 10:09 a.m. It was dime sized, dark purple, and at the ring finer knuckle area. Resident #7 indicated, "I don't know how I got it or when. I bruise easily."</p> <p>The 12/16/14 skin assessment for Resident #7 indicated, "Skin intact. No redness."</p> <p>The assignment sheet for Resident #7 indicated, "Extensive assist with a.m. & p.m. care, turn and reposition every 2 hours, toilet as needed & after meals & before bedtime..."</p> <p>An observation of the bruise on the back of Resident #7's right hand was made on 12/19/14, at 4:05 p.m. It was still there.</p> <p>An observation of the bruise was made with LPN #14 on 12/19/14, at 4:10 p.m. LPN #14 observed the bruise and asked Resident #7 if it hurt. Resident #7 indicated it did not hurt, had been there a while, wasn't sure how she got it, and "probably bumped into something."</p>			

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	<p>An interview was conducted with the ADON (Assistant Director of Nursing) on 12/19/14, at 4:15 p.m. She indicated she performed Resident #7's skin assessment the morning of 12/16/14, and the bruise was not there. She indicated Resident #7 required assistance with bathing, as well as morning and evening care, and the bruise could have been noticed.</p> <p>An observation of the bruise was made with the ADON on 12/19/14, at 4:27 p.m. She stated, "Yeah, it's pretty noticeable. It wasn't there on 12/16 (12/16/14). She's 1 to 2 person (assist) for transfer. She's at least limited assist for dressing, hygiene, bathing."</p> <p>3. The clinical record for Resident #11 was reviewed on 12/17/14 at 11:15 a.m. The diagnoses for Resident #11 included, but were not limited to, hydrocephaleus (buildup of fluid inside the brain), severe mental retardation, contractures of all extremities, and severe osteoporosis.</p> <p>A review of a Skin Assessment sheet, indicated a skin assessment was performed on Resident #11, on 12/16/14, by the Assistant Director of Nursing (ADON). The assessment indicated the skin was intact with no areas of redness.</p>			
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	<p>A skin assessment was performed with the ADON and the Director of Nursing (DON), on 12/17/14 at 2:07 p.m. An over bed light was turned on, with only the top of the light turning on, creating a dim environment. Resident #11 was turned with his right side up by the ADON and the DON. An area of red excoriation was observed between Resident #11 legs/thighs. A quarter sized area with a purple border at 1 o'clock and 4 o'clock was observed on Resident #11's upper right thigh. The ADON indicated the area was old scar tissue. A flashlight was requested at 2:11 p.m., to observe the area in brighter light. The ADON left the room to retrieve a flashlight at this time. The DON indicated at 2:17 p.m., there was not a specific flashlight to use for skin assessments and a flashlight should be kept in the treatment cart for easy access. The ADON returned at 2:21 p.m. with a flashlight. The flashlight appeared to be missing a bulb or a bulb was dimming, which created a darker area in the center of the light casted by the flashlight. On Resident #11's upper thigh, the quarter-sized area appeared to be open in certain spots that were pink. The ADON indicated again the quarter-sized area was old scar tissue and not a new area. Resident #11 was returned to his back and was covered with blankets.</p>			

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	<p>A skin assessment with performed with the Nurse Practioncer (NP), on 12/17/14 at 2:30 p.m. The NP indicated the facility wanted her to look at Resident #11's skin since there might be a new skin issue. The NP pulled out her own light source to observe Resident #11's skin. The area, on Resident #11's upper right thigh, appeared to be mottled (areas of pink and white) but was closed. The NP indicated at this time, the area was fungal in nature and was not open or a pressure ulcer at any stage. The NP also indicated since the observed area was in a pressure area, the NP would like to have skin assessments performed every shift.</p> <p>A Physician Order, dated 12/17/14, indicated to, "Cleanse perineal area with soap and water q [each] shift, pat dry then apply Nizoral 2% [anti-fungal] cream to reddened groin and thighs q shift."</p> <p>A NP Visit Note, dated 12/17/14, indicated, "Very debilitated 64 yo [description of Resident #11] [symbol for with] severe chronic contractures, seen today for groin rash....1. fungal groin rash-cleansing, fungal cream, nurse to [symbol for check] area q shift."</p> <p>During an interview with the ADON, on 12/17/14 at 3:50 p.m., the ADON</p>			
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	<p>indicated she did not see the quarter-sized area the previous day during her skin assessment of Resident #11. The ADON also indicated she did not have a flashlight when she performed Resident #11's skin assessment the previous day. The ADON further indicated she never used a flashlight when she performed Resident #11's skin assessments. The ADON also indicated it took awhile to retrieve the flashlight for the skin assessment because she retrieved the flashlight from her personal belongings. The ADON indicated she chose that specific flashlight to perform the skin assessment that day, because it was lighter weight. The ADON also indicated the facility does have a designated flashlight for skin assessments, but she did not routinely use it for skin assessments.</p> <p>A policy titled, Resident Examination and Assessment, dated 12/11, was received from the DON on 12/19/14 at 1:45 p.m. The policy indicated, "The purpose of this procedure is to examine and assess the resident for any abnormalities in the health status, which provides a basis for the care plan....2. Assemble equipment and supplies needed. The following equipment and supplies will be necessary when performing this procedure....2. Pen</p>			

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F000323 SS=E	<p>Light...4. Examine and note the following....h. Skin...(5) presence of bruises, pressure sores, redness, edema, rashes...."</p> <p>A Risk for Skin Breakdown care plan, dated 11/19/14, indicated the intervention, "...3. Assess skin per policy...."</p> <p>3.1-37(a) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a soiled utility room, containing biohazards, was locked. This had the potential to affect 5 cognitively impaired, mobile residents on the unit. (Residents #6, #16, #20, #37, and #39) and the facility failed to ensure a clean utility closet, with disposable razors in it, had a door that remained closed and locked. This had the potential to affect 5 of 30 residents residing in the facility. (Residents #6, #16, #20, #37, and #39) The facility also failed to ensure a resident with the diagnosis of Huntington's disease had a</p>	F000323	<p><u>1. Corrective action:</u> A. The soiled utility room lock was repaired by the Maintenance department on 12/15/14. B. The clean utility door was repaired by the Maintenance department on 12/15/14. C. The disposable razors were removed from the clean utility room and they are being stored in a separate cabinet in the medicine room. D. Resident #41's nursing care plan and CNA assignment sheet have been updated to instruct the nursing staff that all four wheels must be locked. <u>2. Identification of any residents affected by this event:</u> A. Housekeeping supervisor reviewed that all doors that need to be secured and locked are</p>	01/18/2015			

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	<p>locked wheelchair during random observations. (Resident #41) The facility also failed to ensure fall care plan interventions, during a fall, were in place for 1 of 3 residents reviewed for accidents. (Resident #25)</p> <p>Findings include:</p> <p>1. An observation of an unlocked soiled utility room door was made on 12/15/14, at 6:55 p.m. The door had a key pad, but the door would not lock. The inside of the closet was observed with the SSD (Social Services Director) on 12/15/14, at 6:55 p.m. There were 5 barrels labeled soiled linen, 1 unlabelled barrel, 3 trash barrels, 2 biohazard containers labeled soiled bed pans and linens, urinals soaking in a sink, and a little, brown refrigerator labeled specimens and biohazard.</p> <p>An interview and observation of the closet was made with RN #15 on 12/15/14, at 7:00 p.m. RN #15 opened the little, brown refrigerator labeled specimens and biohazard. No specimens were observed inside. RN #15 indicated, "The door should be locked. The problem with it not being locked is a resident could come in here, and think one of the urine specimens is apple juice and drink it." Also observed was 1</p>		<p>locked. 1. Five residents have the potential to be affected. B. The ADON performed random audits of observation on residents in wheelchairs. No other dependent residents were observed in wheelchairs that were unlocked <u>3. Measures to prevent recurrence:</u> A. The facility created a form to monitor and ensure that the soiled utility door and clean utility door are locked. B. The facility created a form to monitor that resident #41's wheelchair is locked when in use. <u>4. Continued monitoring:</u> A. The maintenance department, housekeeping department or their designee will monitor the soiled utility door and clean utility door daily to ensure the doors are locked for four weeks. If 100% compliancy is achieved then monitoring will be reduced to three times a week for four weeks. If 100% compliance is achieved then monitoring will be reduced to one time a week for four months. If 100% is achieved after 6 months, monitoring will end. 1. The Quality Assurance Committee will review the soiled utility door form and the clean utility form to ensure the door is locked quarterly for six months. B. The DON, ADON or nursing department will monitor daily for four weeks that resident #41's wheelchair is locked when in use. If 100% compliancy is achieved then reduce monitoring to three times a week for four weeks. If</p>				

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	<p>container labeled goggles with used goggles inside, 1 container labeled soiled gloves with hand towels observed inside. RN #15 stated, "I think a company comes to collect those."</p> <p>On 12/19/14, at 5:30 p.m., the SSD provided a list of cognitively impaired, mobile residents. It included Residents #6, #16, #20, #37, and #39.</p> <p>2. During initial tour of the facility, on 12/15/14 at 6:17 p.m., a clean utility closet/room across from Room #2, was observed to be open. Seven (7) disposable razors were observed in a drawer in the room. The drawer was at wheelchair height and easily accessible. No staff members were located in the area of the clean utility closet/room at the time.</p> <p>During an interview with the Assistant Director of Nursing, on 12/15/14 at 6:20 p.m., she indicated the door should be closed and locked.</p> <p>A list of cognitively impaired, independently mobile residents was provided on 12/19/14 at 6:35 p.m. by the Social Service Director. The list indicated 5 residents were cognitively impaired and independently mobile. The residents were #6, #16, #20, #37, and #39.</p>		<p>100% is achieved then monitor one time a month for four months. If 100% is achieved after six months, monitoring will end. 1. The Quality Assurance Committee will review the audits for resident #41's wheelchair being locked when in use quarterly for six months. If 100% compliancy is achieved after six months then monitoring will end. <u>IDR Request</u> On page 28 of 38 from 2567 with the survey date of 12/19/14, an error was noted to be in the 2nd paragraph under findings include. The paragraph is referring to RN#15 on 12/15/14 at 7:00 a.m. This is an error due to the survey did not begin until 12/15/14 at approximately 6:10 p.m. We are requesting that this be deleted from the 2567 due to this never occurred on this date and time.</p> <p>We are requesting a paper review for this IDR.</p>		

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	<p>3. The clinical record for Resident #41 was reviewed on 12/19/14 at 2:15 p.m. The diagnoses for Resident #41 included, but were not limited to, Huntington's disease, hypothyroidism, and EPS (extrapyramidal symptoms-muscle spasms/contractures and motor restlessness).</p> <p>During a random observation, on 12/16/14 at 11:50 a.m., Resident #41 was observed in her wheelchair in the dining room. Resident #41 was kicking her left leg out of the wheelchair and the wheelchair moved to the side, closer to the wall. The front wheelchair brakes did not appear to be locked.</p> <p>On 12/18/14, at 12:39 p.m., Resident #41 was observed in her wheelchair in the center of the dining room. Resident #41's left leg was aggressively jerking out of the wheelchair. The wheelchair moved to left. The back right brake was locked on the wheelchair, but no other brake on the wheelchair was observed to be locked. Resident #41's left leg continued to jerk out of her wheelchair and the wheelchair continued to move from the center of the room. The Assistant Director of Nursing (ADON) then wheeled Resident #41 back to the center of the room. The wheelchair appeared to</p>			

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	<p>move freely without any resistance when the ADON moved the wheelchair.</p> <p>At 12:35 p.m., on 12/19/14, Resident #41 was observed in her wheelchair in the dining room. Resident #41's left leg jerked abruptly and the wheelchair moved closer to the dining room table. None of Resident #41's wheelchair brakes appeared to be locked.</p> <p>During an interview with the Director of Nursing (DON), on 12/19/14 at 2:11 p.m., the DON indicated Resident #41's wheelchair should be locked when Resident #41 was in her wheelchair due to her medical diagnosis and safety for Resident #41.</p> <p>A policy titled, Safety and Supervision of Residents, dated 12/07, was received from the DON on 12/19/14 at 2:45 p.m. The policy indicated, "...Resident -Oriented Approach to Safety....2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS (minimum data set)...."</p> <p>On 12/19/14 at 2:58 p.m., the ADON indicated Resident #41's wheelchair should be locked when Resident #41 was</p>			

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	<p>in the wheelchair due to the muscle spasms Resident #41 has and safety concerns.</p> <p>4. During an staff interview, with the Director of Nursing (DON), on 12/16/14 at 2:01 p.m., the DON indicated Resident #25 had a fall on 11/23/14.</p> <p>The clinical record for Resident #25 was reviewed on 12/19/14 at 3:35 p.m. The diagnoses for Resident #25 included, but were not limited to, history of cerebral vascular accident, osteoarthritis, and dementia with delusions.</p> <p>A Fall Risk Assessment, dated 8/20/14, indicated a score of 15, which was indicative of High Risk for Falls.</p> <p>A Fall care plan, dated 11/26/14, indicated an intervention, dated 10/10/14, of low bed with mat.</p> <p>A Nurse's Note, dated 11/23/14 at 2:30 p.m., indicated, "Called to Resident's room of [sic] report that he was sitting on floor, on entering room [sic] observed Resident in sitting position covered [symbol for with] his wet sheet, when asked what happened [sic] stated that he fell out of bed [sic] 'I was going to the bathroom' [sic] denies hitting his head...."</p>			

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F000371 SS=D	<p>A Fall Follow-Up, dated 11/24/14, indicated, "...DON [Director of Nursing]/Administrator investigation of incident or comments relating to incident: Resident noted to be in bed, went to get up without assistance to the restroom + slid out of bed. Bed not in low position + bed mat not in place. Will do one on one inservice [symbol for with] staff member....Action taken to prevent reoccurrence: Staff counseled on putting mat in place next to bed and to keep bed is [sic] low safe position for Resident...."</p> <p>A policy titled, Safety and Supervision of Residents, dated 12/07, was received from the DON on 12/19/14 at 2:45 p.m. The policy indicated, "...Implementing interventions to reduce accident risks and hazards shall include the following...d. ensuring that interventions are implemented...."</p> <p>3.1-45(a)(1) 3.1-45(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</p>			

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	<p>under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure a nutritional supplement was properly labeled and dated in the kitchen. This had the potential to affect 1 resident in the facility. (Resident #22)</p> <p>Findings include:</p> <p>An observation of the kitchen was made on 12/15/14, at 6:45 p.m. A cream colored, powdery substance was observed inside of a small, paper pill cup in a cabinet, with plastic wrap around it, unlabelled and undated. The DM (Dietary Manager) indicated it was a nutritional supplement for Resident #22, and it should be on her tray.</p> <p>An interview was conducted with the DM on 12/19/14, at 1:42 p.m. She indicated, (Name of Resident #22) got her (name of nutritional supplement) that day. We just made up an extra one. It should have been labeled and dated.</p> <p>The Food & Nutrition Services Storage policy was provided by the Administrative Assistant on 12/19/14, at 5:56 p.m. It indicated, "Dry Storage: All opens (sic) foods will be kept in containers that prevent contamination and absorption of humidity. Such containers</p>	F000371	<p><u>1. Corrective action:</u> The nutritional supplement for resident #22 was not used and discarded.</p> <p><u>2. Identification of any residents affected by this event:</u> A. The food service supervisor inspected the dietary department and found no item not dated or not labeled properly. B. One resident had the potential for being affected.</p> <p><u>3. Measure to prevent recurrence:</u></p> <p>A. The dietician has created a new policy titled "Kitchen dry food storage". B. The dietician has created a new form for the dietary department to monitor the kitchen dry storage.</p> <p><u>4. Continued monitoring:</u> A. The food service supervisor or her designee will monitor the kitchen storage of dry food products daily. B. The Quality Assurance Committee will review the kitchen's storage dry food products quarterly for six months. If 100% compliancy is achieved after six months the monitoring will end</p>	01/18/2015			

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F000441 SS=D	<p>will be clearly labeled with the common name of the food."</p> <p>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 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>			
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	<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 discard soiled/contaminated gloves before touching items in a resident's room. This had the potential to affect 1 of 1 residents reviewed for skin assessments. (Resident #11) and the facility failed to ensure a nurse washed her hands prior to administering medication to a resident. (Resident #27)</p> <p>Findings include:</p> <p>1. A skin assessment was performed on Resident #11, with the ADON and the Director of Nursing (DON), on 12/17/14 at 2:07 p.m. Resident #11 was turned with his right side up by the ADON and the DON. The ADON/DON proceeded to examine/touch Resident #11's skin, which included Resident #11's backside and perineal area with gloves. A flashlight was requested at 2:11 p.m. to observe the skin in brighter light. The ADON proceeded to touch the left siderail on Resident #11's bed and then move the privacy curtain aside with her "contaminated" gloves still on. At the conclusion of the skin assessment at 2:25 p.m., the DON replaced the blankets over</p>	F000441	<p><u>1. Corrective action:</u> A. The ADON and DON have been counseled by the Administrator on discarding soiled contaminated gloves before touching items in a resident's room. B. LPN #4 was counseled on washing her hands prior to administering medication by the DON. <u>2. Identification of any residents affected by this event:</u> A. The Administrator monitored the ADON and DON on random observations of residents while care was provided to ensure proper discarding of soiled/contaminated gloves before touching items in a resident's room. 1. No other residents were affected. B. The DON and/or ADON monitored LPN #4's medication pass on her assigned residents to ensure that she washed her hands prior to administering medication to those residents 1 No other residents were affected <u>3. Measures to prevent recurrence:</u> A. In-service training for all RN, LPN & QMA on proper hand washing prior to administering medications during the week of 1/12/15-1/18/15. B. In-service training for all staff on discarding soiled/contaminated gloves before touching other items during the week of 1/12/15-1/18/15. <u>4. Continued</u></p>	01/18/2015

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NAME OF PROVIDER OR SUPPLIER PLEASANT VIEW LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN 46055
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	<p>Resident #11, touched the left siderail, and move the privacy curtain aside with her "contaminated" gloves still on.</p> <p>During an interview with the DON, on 12/19/14 at 9:23 a.m., the DON indicated she should have discarded her gloves prior to touching Resident #11's blankets, siderail and privacy curtain.</p> <p>The ADON indicated, on 12/19/14 at 3:36 p.m., she should have discarded her gloves prior to touching Resident #11's siderail and privacy curtain.</p> <p>A policy titled, Infection Control Guidelines for All Nursing Procedures, dated 4/13, was received from the Administrator, on 12/17/14 at 2:50 p.m. The policy indicated, "...1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease...3. Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents...."</p> <p>2. On 12/17/14 at 9:58 a.m., during an observation, LPN #4 picked up a button off of the main dining room floor on her way to deliver oral medications to</p>		<p><u>monitoring:</u> A. The DON or her designee will monitor licensed nurses and QMAs on proper hand washing prior to administration of medications to residents one time a week for four weeks. If 100% compliancy is achieved monitoring will reduce to bi-weekly for four weeks. If 100% compliancy is achieved monitoring will be reduced to one time a month for four months. If 100% compliancy is achieved after six months then monitoring will end. 1. The Quality Assurance Committee will review the audits to ensure proper hand washing prior to administering medications quarterly for six months. If 100% compliancy is achieved after six months, monitoring will end. B. The DON or their designee will monitor the nursing staff to ensure they are removing their gloves prior to touching a resident's items daily for four weeks. If 100% compliancy is achieved monitoring will be reduced to two times a week for four weeks. If 100% is achieved monitoring will be reduced to one time a week for four months. If 100% compliancy is achieved monitoring will end. 1. The Quality Assurance Committee will review the audits to ensure proper removal of gloves prior to touching a resident's items quarterly for six months. If 100% compliancy is achieved after six months then the monitoring will end.</p>	

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F000463	<p>Resident #27. She continued to deliver the medications to the resident without washing her hands prior to the medication administration.</p> <p>On 12/17/14 at 10:02 a.m., during an interview, LPN #4 indicated she should have washed her hands after picking up the button off the floor and prior to administering oral medications to Resident #27. She indicated it "just slipped my mind."</p> <p>On 12/19/14 at 5:19 p.m., during an interview, the ADON indicated staff should wash their hands before administering any medications to residents after picking something up off of the floor.</p> <p>A facility policy, dated April of 2013 and titled "Infection Control Guidelines for All Nursing Procedures" indicated "...Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents..."</p> <p>3.1-18(a) 3.1-18(l)</p> <p>483.70(f)</p>						

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SS=D	<p>RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's call light system functioned properly for 1 of 27 residents whose call light systems were checked. (Resident #35)</p> <p>Findings Include:</p> <p>1) On 12/19/14 at 11:40 a.m., during an observation, Resident #35's call light next to her bed was not functioning. When the call light was activated, no alarm sounded nor did a light in the hallway light up.</p> <p>On 12/19/14 at 11:51 a.m., during an observation and interview with the Maintenance Director, he indicated he was not aware of any residents call light's not functioning. He indicated the call light next to Resident #35's bed was not functioning properly and he would fix it.</p> <p>On 12/19/14 at 11:52 a.m., during an interview, the Housekeeping Supervisor indicated she checks all facility call lights once a week on Mondays. She indicated she checked Resident #35's call light on</p>	F000463	<p><u>1. Corrective action:</u> A. Resident #35's call light was repaired on 12/19/14 by the maintenance department. Resident #35's call light cord had been designed by the resident as her "preference", this has been added to her nursing care plan. B. Resident #28's call light cord was replaced on 12/19/14 by the housekeeping supervisor. C. We are currently in the process of installing a new type of call light cord. <u>2. Identification of any residents affected by this event:</u> A. All call lights were check and working properly on 12/19/14. B. All call light cords were checked and they were in good condition on 12/19/14. C. No other residents were affected. <u>3. Measures to prevent recurrence:</u> The facility created a new form to audit call lights and call light cords. In-service training will be held on 1/12/15-1/18/15 for the housekeeping and maintenance department. <u>4. Continued monitoring:</u> A. The maintenance department or housekeeping department will monitor the call light cords weekly for six months to ensure they are in good working condition. If 100% compliancy is achieved, monitoring will end after six</p>	01/18/2015			

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	<p>Monday 12/15/14. She indicated the call light was functioning properly at the time.</p> <p>A facility "MAINTENANCE LOG" indicated "ROOM CALL BELL LIGHTS" were checked on 12/15/14. The Housekeeping Supervisor indicated, on 12/19/14 at 11:52 a.m., she initialed the call bell light area on the maintenance log for 12/15/14 which, she indicated, identified the call light for Resident #35 was working as of that date.</p> <p>On 12/16/14 at 2:27 p.m., during an observation, Resident #28's call light in his room was observed to be extremely frayed.</p> <p>On 12/16/14 at 2:43 p.m., during an observation, Resident #30's call light was observed to be extremely frayed.</p> <p>On 12/19/14 at 2:00 p.m., during an observation, the cord attached to the call light in Resident #30's room was frayed. After pulling on the cord, the call light system functioned properly.</p> <p>On 12/19/14 at 2:02 p.m., during an interview, the Housekeeping Supervisor indicated the cord attached to the call light system in Resident #30's room, next to her bed, was "frayed." She indicated</p>		<p>months. 1. The Quality Assurance Committee will review the call light cords to ensure they are in good working condition quarterly for six months. If 100% compliancy is achieved after six months monitoring will end. B. The maintenance department or housekeeping department will monitor that the call lights are working properly two times a week for four weeks. If 100% is achieved monitoring will reduce to weekly for indefinitely. 1. The Quality Assurance Committee will review that the call lights are working properly quarterly for six months. If 100% is achieved monitoring will end.</p>		

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	<p>the cord may potentially break. She indicated the cord "should be replaced."</p> <p>On 12/19/14 at 4:29 p.m., during an observation of Resident #'s 28 and 30's call light cords, they were observed to be new and intact. The call lights were tested and they functioned appropriately.</p> <p>2. An observation of Resident #35's room was made on 12/16/14, at 11:05 a.m. The call light next to her bed was not functioning, nor was there a string attached for ease of use.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>				