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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155738 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/26/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>MILTON HOME, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>206 E MARION ST<br>SOUTH BEND, IN 46601 |
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| F000000            | <p>This visit was for an Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit resulted in a Extended Survey - Immediate Jeopardy.</p> <p>Survey dates: August 18, 19, 20, 21 and 22, 2014<br/>Extended survey dates: August 23, 24, 25 and 26, 2014.</p> <p>Facility number: 001141<br/>Provider number: 155738<br/>AIM number: 200905640</p> <p>Survey Team:<br/>Julie Baumgartner, RN TC<br/>Shauna Carlson, RN (August 18, 22, 23, 24, 25 and 26, 2014)<br/>Sharon Ewing, RN (August 18, 19, 20, 21, 22, 25 and 26, 2014)<br/>Pamela Williams, RN (August 18, 19, 20, 24, 25 and 26, 2014)<br/>Shelly Miller-Vice, RN (August 19, 20 and 21, 2014)</p> <p>Census bed type:<br/>SNF: 11<br/>SNF/NF: 18<br/>Residential: 23</p> | F000000       |   |                      |

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

TITLE

(X6) DATE

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

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| F000223<br>SS=L    | <p>Total: 52</p> <p>Census payor type:<br/>Medicare: 6<br/>Medicaid: 23<br/>Other: 23<br/>Total: 52</p> <p>Residential Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1-5.</p> <p>Quality Review completed on September 3, 2014, by Brenda Meredith, R.N.</p> <p>483.13(b), 483.13(c)(1)(i)<br/>FREE FROM ABUSE/INVOLUNTARY SECLUSION<br/>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure that a resident was free from verbal, physical, and mental abuse when staff gave a shower against a resident's desire, sprayed the resident with cold and hot water, and</p> | F000223       | <p>1. The facility shall ensure the residents are free from abuse. No other residents other than the one mentioned in this tag were affected by this incident. An abuse investigation was immediately initiated when the surveyor informed the facility administration of the allegation.</p> | 09/19/2014           |

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|  | <p>spoke to the resident in a demeaning/intimidating manner causing the resident mental anguish for 1 of 1 residents reviewed for abuse. (Resident #22) This had the potential to affect 52 of 52 residents in the facility at risk for being verbally, physically, and mentally abused.</p> <p>This deficiency resulted in an Immediate Jeopardy. The immediate Jeopardy began on 8/12/14, when the staff gave the resident a shower against her desire. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 8/20/14 at 1:00 P.M. The Immediate Jeopardy was removed on 8/25/14, but noncompliance remained at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>On 8-20-2014 at 9:22 A.M., an interview was conducted with Resident #22 in her room with the door closed, per her request. Resident #22 indicated, "...on August 15th, I think it was [actual date 8/12/14], that girl nicknamed [name] [CNA - Certified Nursing Assistant #1] took me to take a shower...I don't like showers and I told her 'No'...she just kept</p> |   | <p>Family and physician were notified and the resident was seen by physician that date and will follow up as needed. The resident is being monitored for psycho-social changes as a precautionary measure. CNA #1 was terminated and CNA #2 and LPN #3 were provided disciplinary action and abuse prevention and reporting training. 2. The facility enhanced their staff training to now include "Bathing without a Battle" and "Hand in Hand". In order to ensure that no other resident were affected by this allegation, Social Services performed a face to face interview with all residents with no findings on 8/20/14. All staff mandatory in-service on abuse identification, prevention, and reporting was conducted on 9/15/14 and then at least quarterly thereafter. The facility will review abuse identification, prevention, and reporting monthly with CNA and nursing staff x 12 months. Social services or designee will review abuse and how to report abuse monthly for 12 months at the Resident Council Meeting. The Administrator will review abuse, abuse prevention and abuse reporting and how to file a grievance in the Family Meeting on 9/24/14 and at least annually thereafter. 3. All staff mandatory in-service on abuse identification, prevention, and reporting was conducted on 9/15/14 and then at</p> |  |  |   |  |

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|  | <p>on taking me and I kept telling her I don't want a shower, I don't like showers...." Resident #22 indicated, "I am always cold and I take bed baths, it is cold in the shower room." Resident #22 indicated, "...she told me I had to take a shower and then she sprayed me with cold water...I told her that is too cold and she turned the water all the way to hot...I told her that is burning me...." Resident #22 indicated, "I felt like she was being mean to me and that she was upset with me because I had smart words with her the day before." Resident #22 indicated, "...it burned me between my legs and I told her it hurts...I wanted CNA #2 to give me a shower cause he is nice and caring, CNA #1 has been mean to me in the past and I didn't want her to do it...CNA #2 came into the shower room and laughed at me...CNA #1 kept turning the water hotter and hotter when I was telling her I didn't want a shower and that it was hot, so I finally quit talking so she would not turn it up any more...I told her to take off my glasses so they wouldn't get broken and she said 'No, just hold your head the way I tell you and they won't get broken' and she wouldn't take them off...I told her I want someone else to take care of me...I told her that I am sick and CNA #1 said, 'That is not my fault [that you are sick]'...CNA #1 called the nurse [LPN - Licensed Practical Nurse #3] in to talk to</p> |   | <p>least quarterly thereafter. These in-services will contain outside sources like APS and the Ombudsman. The facility will review abuse identification, prevention, and reporting monthly with CNA and nursing staff x 12 months. 4. The DON or designee will randomly assess staff for ability to state types of abuse, how to identify abuse, what to do if witnessing abuse, and how to report abuse weekly for 3 months, monthly for 3 months, then every other month for 6 months. The Administrator will make daily rounds, eat lunch with the residents, etc. in efforts of making them feel comfortable to report any concerns to him. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. The QA will continue monitoring state reportables and concern reports monthly until there have been [3] consecutive months of no unreported abuse allegations. QA monitoring will be then go to quarterly and will be on-going.IDR: The Administrator and DON were not aware of the allegation. Upon hearing the allegation from the surveyor for the first time, the Administrator immediately initiated the investigation. The staff member, who the allegation was directed toward, was immediately suspended and later terminated, as well as, two staff who were believed to have some knowledge</p> |  |  |   |  |

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|  | <p>me...the nurse told me to apologize to the CNA #1 for calling her names...she [LPN #3] never asked me why I was upset...I told another CNA later that day and I told my daughter about it...CNA #2 came in my room a few days later and said, 'I thought we were friends, are you trying to get me fired?...I have a wife and kids at home to take care of...'"</p> <p>On 8-20-2014 from 9:49 A.M. to 10:15 A.M., an interview was conducted with the Administrator, DON (Director of Nursing), Social Service Designee, CNA #2, and LPN #3 in the conference room.</p> <p>The Administrator indicated, "...there are no reportables involving Resident #22...any abuse would be expected to be reported it to me immediately...."</p> <p>The DON indicated, "...I don't know anything about this [incident]...I know that Resident #22 was covered in BM [bowel movement] and needed a shower...she was not happy with her shower, she doesn't like them but it was in her best interest to take a shower...I told LPN #3 to document the behaviors...I talked to Resident #22 right before I left for the day...she [Resident #22] stated she had had a good day...she was in Bingo at that time...."</p> |   | <p>of the incident. Further, her family, all the residents and staff were interviewed, no resident indicated that they had ever been abused and all felt safe. All staff were aware of their responsibility to report an allegation of abuse and have done so routinely in the past. There was no injuryThe staff have shown a history of understanding their responsibility to report allegations od abuse (see Incident Reports); however, in this case, they did not report it to the Administrator or DON as they perceived it as her (resident) just "story telling" and not really an example of abuse. The resident family even discounted the report as story telling and did not believe anything happened and didn't report it. The follow-up training has stressed everyone's responsibility to report an allegation whether or not they believe it to be true. Training has also been provided to all the resident and families (October newsletter, Family meeting on 9/23 and at the monthly resident council meetings). While the resident does prefer bed baths she did not refuse the shower and seemed to accept the benefits of showering in this case due to the large amount of BM on her.</p> |  |  |   |  |

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|  | <p>CNA #2 indicated, "...she [Resident #22] was calling her [CNA #1] names in the shower room, she [Resident #22] had a large bowel movement and she [Resident #22] needed a shower...I was in and out of the shower [room]...there was no cussing going on...." CNA #2 had no comment related to the statements made by Resident #22 regarding their conversation a few days after the incident.</p> <p>LPN #3 indicated, "...I was called to come into the shower room...CNA #1 told me that Resident #22 was calling her names...I told her [Resident #22] to apologize to CNA #1...I did not ask Resident #22 what was wrong, I knew she [Resident #22] didn't like showers...I documented it in a nurses narrative that she was cussing at the staff...I told the DON about it...she [Resident #22] does this every day...."</p> <p>The clinical record for Resident #22 was reviewed on 8-20-2014 at 12:24 P.M. The diagnoses included, but were not limited to, depression, CVA with hemiparesis (stroke with one side paralysis), dementia.</p> <p>The MDS (Minimum Data Set) assessment, dated 6/7/14, indicated the resident was moderately cognitively</p> |   |   |  |  |   |  |

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|                    | <p>impaired.</p> <p>The behavior sheets for Resident #22 for May, June, July and August 2014, indicated no documentation related to cussing/swearing at staff.</p> <p>The care plan, dated 8/7/14, indicated, "Problem/Need...Resident exhibits inappropriate behavior of making rude comments towards other individuals...Approaches...*Do not argue with resident...*Talk with resident in a calm voice when behavior is disruptive...*Discuss resident's feelings of anger with resident...."</p> <p>The nurses notes, dated 8/12/14 at 1:30 P.M., for Resident #22 indicated, "...Pt. [patient] cussing at staff member D/T [due/to] getting shower...Had lg [large] loose BM [bowel movement] called her a 'B---- F---off' when approached resident calm-went to Bingo...." (signed) LPN #3.</p> <p>The Shower Report, dated 8/12/14, for Resident #22 indicated Behavior Problem(s): Curses(is circled)...Comments: "Called me a B---- numerous times, told her I was going to get the nurse and she said f--- you and her." Signed by CNA #1 and Charge Nurse, LPN #3.</p> |               |   |                      |

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|                    | <p>The CNA assignment sheet, received from the DON, on 8/20/14 at 5:20 P.M., and last updated on 7/18/14, indicated "BED BATH ONLY."</p> <p>During an interview on 8-20-2014 at 4:17 P.M., CNA #5 indicated, "...she [Resident #22] told her on 8-12-2014 that CNA #1 gave her a shower and put cold water on her and then really hot water...I told her [Resident #22] that they can not do that and I was going to report it to the nurse...I did tell someone but I can't remember who but it was not LPN #3 because she doesn't do anything about things I tell her about the residents..."</p> <p>During an interview on 8-20-2014 at 4:38 P.M., CNA #9 indicated, "...when I got report from her [CNA #1] she told me she gave Resident #22 a shower that day, that she had a BM [bowel movement] and it was an easier clean up to put her in the shower... I usually give her [Resident #22] a bed bath Tuesday and Friday evenings because she is too cold to take a shower...she [Resident #22] asked me, 'where were you this morning when that girl threw me in the hot shower'...she [Resident #22] told me that CNA #1 put her in the shower and CNA #2 laughed at her because she didn't want to take a shower...I told LPN #3 and LPN #3 said, 'she always is saying stuff'...she [LPN #3]</p> |               |   |                      |

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|  | <p>didn't do anything about it..."</p> <p>During an interview on 8-20-2014 at 5:00 P.M., CNA #10 indicated, "...she [Resident #22] said CNA #1 put cold water then hot water on her in the shower and it burned and CNA #2 laughed at her...I told LPN #3 and LPN #3 said to me that Resident #22 is always saying stuff like that...LPN #3 didn't do anything about it...I went to find the DON but couldn't connect with her...."</p> <p>During an interview on 8-20-2014 at 5:38 P.M., CNA #1, by phone, indicated, "...I did give her a shower on days on 8-12-2014...I did call LPN #3 in to the shower room because Resident #22 was cursing at me...LPN #3 asked Resident #22 to apologize to me and she did not...Resident #22 does not act this way on a daily basis...."</p> <p>On 8-21-2014 at 9:34 A.M., the policy titled, "Abuse Prevention and Reporting Policy," updated and revised on 7/12/14, was provided by the Human Resource staff and indicated the policy was the one currently used by the facility. The policy indicated, "...Standards...10. Any staff member who has knowledge of or reasonable cause to believe a resident has been or is being abused, or has knowledge a resident has sustained a</p> |   |   |  |  |   |  |

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|  | <p>physical injury which is not reasonable explained by the history of injuries provided in the resident's medical record, is required to make an immediate oral report to the Administrator, Director of Nursing, their supervisor and Social Service Director, if appropriate...11. Any staff member who intentionally abuses or suspected of abusing a resident or permits to exist an abusive situation which results in the abuse of a resident, is subject to immediate dismissal...22. Written reports of alleged abusive incidents are to be initiated by a licensed nurse and the individual who observed or has first-hand knowledge of an abuse incident using either a Concern/Suggestion or Accident/Incident Report Form. The Administrator, Director of Nursing and Social Service Director are responsible for reviewing the report as well as other investigative reports, interviews, etc, and developing interventions to care for the resident's medical psychological needs...."</p> <p>Review of written statement, signed by the Administrator on 8-22-2014, received on 8-22-2014 at 10:30 A.M., indicated, "...during survey interviews res. [resident] report things that have not been previously reported and this doesn't result in an IJ [Immediate Jeopardy]. This was especially true when there were no</p> |   |   |  |  |   |  |

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|  | <p>known injuries and with an individual with some history of making "false [sic] statements."</p> <p>Review of Resident #22's care plans showed no indication of resident behavior of making false statements.</p> <p>The Immediate Jeopardy that began on 8/12/14 was removed 8/26/14, with an effective date of 8/25/14, when, through record review and interviews, staff had completed education regarding abuse and abuse prevention. This education included identification of abuse, how to report abuse, when to report abuse and to whom to report abuse. The administrators contact information was posted at various location for staff use. The staff were also given education related to bathing residents without a battle. Even though the facility 's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of widespread, no actual harm with potential for more than minimal harm that is no Immediate Jeopardy because of on-going monitoring to ensure residents were free of abuse.</p> <p>3.1-27(a)(1)<br/>3.1-27(b)</p> |   |   |  |  |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155738 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/26/2014 |
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| F000225<br>SS=L | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is</p> |  |  |  |
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|                    | <p>verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure a resident's allegation of verbal, physical, and mental abuse was reported immediately to the administrator after the resident had complained to other staff that she had received a shower against her desire, was sprayed with cold and hot water, and was spoken to in a demeaning/intimidating manner causing the resident to be upset for 1 of 1 residents reviewed for abuse. (Resident #22) This had the potential to affect 52 of 52 residents in the facility at risk for being verbally, physically, and mentally abused.</p> <p>This deficiency resulted in an Immediate Jeopardy. The immediate Jeopardy began on 8/12/14, when the staff gave the resident a shower against her desire. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 8/20/14 at 1:00 P.M. The Immediate Jeopardy was removed on 8/25/14, but noncompliance remained at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> | F000225       | <p>1. The facility shall ensure that allegations of abuse are properly reported and investigated. No other residents other than the one mentioned in this tag were affected by this deficient practice. An abuse investigation was immediately initiated when the surveyor informed the facility of the abuse allegation. Family and physician were notified and the resident was seen by physician that date and will follow up as needed. The resident is being monitored for psycho-social changes as a precautionary measure. CNA #1 was terminated and CNA #2 and LPN #3 were provided disciplinary action and abuse prevention and reporting training. 2. The facility enhanced staff training to now include "Bathing without a Battle" and "Hand in Hand". In order to ensure that no other resident was affected by this, Social Services performed a face to face interview with all residents with no findings on 8/20/14. All staff mandatory in-service on abuse identification, prevention, and reporting was conducted on 9/15/14 and then at least quarterly there- after. The facility will review abuse identification, prevention, and reporting monthly with CNA and nursing staff x 12 months. Social services or designee will review abuse, abuse prevention and abuse</p> | 09/19/2014           |

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|  | <p>On 8-20-2014 at 9:22 A.M., an interview was conducted with Resident #22 in her room with the door closed, per her request. Resident #22 indicated, "...on August 15th, I think it was [actual date 8/12/14], that girl nicknamed [name] [CNA - Certified Nursing Assistant #1] took me to take a shower...I don't like showers and I told her 'No'...she just kept on taking me and I kept telling her I don't want a shower, I don't like showers...." Resident #22 indicated, "I am always cold and I take bed baths, it is cold in the shower room." Resident #22 indicated, "...she told me I had to take a shower and then she sprayed me with cold water...I told her that is too cold and she turned the water all the way to hot...I told her that is burning me...." Resident #22 indicated, "I felt like she was being mean to me and that she was upset with me because I had smart words with her the day before." Resident #22 indicated, "...it burned me between my legs and I told her it hurts...I wanted CNA #2 to give me a shower cause he is nice and caring, CNA #1 has been mean to me in the past and I didn't want her to do it...CNA #2 came into the shower room and laughed at me...CNA #1 kept turning the water hotter and hotter when I was telling her I didn't want a shower and that it was hot, so I finally quit talking so she would not</p> |   | <p>reporting to monthly for 12 months with residents at the monthly Resident Council Meeting. The Administrator will review abuse, abuse prevention, abuse reporting and how to file a grievance in the Family Meeting on 9/24/14 and at least annually thereafter. 3. All staff mandatory in-service on abuse identification, prevention, and reporting was conducted on 9/15/14 and then at least quarterly there after. These in-services will contain outside sources like APS and Ombudsman. The facility will review abuse identification, prevention, and reporting monthly with CNA and nursing staff x 12 months.4. The DON or designee will randomly assess staff for ability to state types of abuse, how to identify abuse, what to do if witnessing abuse, and how to report abuse weekly for 3 months, monthly for 3 months, then every other month for 6 months. The Administrator will make daily rounds, eat lunch with the residents, etc. in efforts of making them feel comfortable to report any concerns to him. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. The QA will continue monitoring state reportables and concern reports monthly until there have been 3 consecutive months of no unreported or not immediately reported abuse allegations. QA monitoring will then go to quarterly and will be</p> |  |  |   |  |

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|  | <p>turn it up any more...I told her to take off my glasses so they wouldn't get broken and she said 'No, just hold your head the way I tell you and they won't get broken' and she wouldn't take them off...I told her I want someone else to take care of me...I told her that I am sick and CNA #1 said, 'That is not my fault [that you are sick]'...CNA #1 called the nurse [LPN - Licensed Practical Nurse #3] in to talk to me...the nurse told me to apologize to the CNA #1 for calling her names...she [LPN #3] never asked me why I was upset...I told another CNA later that day and I told my daughter about it...CNA #2 came in my room a few days later and said, 'I thought we were friends, are you trying to get me fired?...I have a wife and kids at home to take care of...."</p> <p>On 8-20-2014 from 9:49 A.M. to 10:15 A.M., an interview was conducted with the Administrator, DON (Director of Nursing), Social Service Designee, CNA #2, and LPN #3 in the conference room.</p> <p>The Administrator indicated, "...there are no reportables involving Resident #22...any abuse would be expected to be reported it to me immediately...."</p> <p>The DON indicated, "...I don't know anything about this [incident]...I know that Resident #22 was covered in BM</p> |   | <p>on-going.IDR: The Administrator and DON were not aware of the allegation. Upon hearing the allegation for the first time, the Administrator immediately initiated the investigation. The staff member, who the allegation was directed toward, was immediately suspended and later terminated, as well as, two staff who were believed to have some knowledge of the incident. Further, her family, all the residents, and staff were interviewed, no resident indicated that they had ever been abused and all felt safe. All staff were aware of their responsibility to report an allegation of abuse and have done so in the past. There was no injury. The staff have shown a history of understanding their responsibility to report an allegation of abuse [see Incident Reports]; however, in this case, they did not report it to the Administrator or DON as they perceived it as her [res] just "story telling" and not really an example of abuse. The res family even discounted the report as story telling and not really an example of abuse. The follow-up training has stressed everyone's responsibility to report an allegation whether or not they believe it is true. Training has also been provided to all the residents and families [October Newsletter, Family Meeting on 9/23 and at the monthly Res Council Mtgs]. While the resident</p> |                      |   |

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|                    | <p>[bowel movement] and needed a shower...she was not happy with her shower, she doesn't like them but it was in her best interest to take a shower...I told LPN #3 to document the behaviors...I talked to Resident #22 right before I left for the day...she [Resident #22] stated she had had a good day...she was in Bingo at that time...."</p> <p>CNA #2 indicated, "...she [Resident #22] was calling her [CNA #1] names in the shower room, she [Resident #22] had a large bowel movement and she [Resident #22] needed a shower...I was in and out of the shower [room]...there was no cussing going on...." CNA #2 had no comment related to the statements made by Resident #22 regarding their conversation a few days after the incident.</p> <p>LPN #3 indicated, "...I was called to come into the shower room...CNA #1 told me that Resident #22 was calling her names...I told her [Resident #22] to apologize to CNA #1...I did not ask Resident #22 what was wrong, I knew she [Resident #22] didn't like showers...I documented it in a nurses narrative that she was cussing at the staff...I told the DON about it...she [Resident #22] does this every day...."</p> |               | does prefer bed baths, on this occasion she did not refuse the shower and seemed to accept the benefits of showering due to the large amount of BM. |                      |

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|                    | <p>The clinical record for Resident #22 was reviewed on 8-20-2014 at 12:24 P.M. The diagnoses included, but were not limited to, depression, CVA with hemiparesis (stroke with one side paralysis), dementia.</p> <p>The MDS (Minimum Data Set) assessment, dated 6/7/14, indicated the resident was moderately cognitively impaired.</p> <p>The behavior sheets for Resident #22 for May, June, July and August 2014, indicated no documentation related to cussing/swearing at staff.</p> <p>The care plan, dated 8/7/14, indicated, "Problem/Need...Resident exhibits inappropriate behavior of making rude comments towards other individuals...Approaches...*Do not argue with resident...*Talk with resident in a calm voice when behavior is disruptive...*Discuss resident's feelings of anger with resident...."</p> <p>The nurses notes, dated 8/12/14 at 1:30 P.M., for Resident #22 indicated, "...Pt. [patient] cussing at staff member D/T [due/to] getting shower...Had lg [large] loose BM [bowel movement] called her a 'B---- F---off' when approached resident calm-went to Bingo...." (signed) LPN #3.</p> |               |   |                      |

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|                    | <p>The Shower Report, dated 8/12/14, for Resident #22 indicated Behavior Problem(s): Curses(is circled)...Comments: "Called me a B---- numerous times, told her I was going to get the nurse and she said f--- you and her." Signed by CNA #1 and Charge Nurse, LPN #3.</p> <p>The CNA assignment sheet, received from the DON, on 8/20/14 at 5:20 P.M., and last updated on 7/18/14, indicated "BED BATH ONLY."</p> <p>During an interview on 8-20-2014 at 4:17 P.M., CNA #5 indicated, "...she [Resident #22] told her on 8-12-2014 that CNA #1 gave her a shower and put cold water on her and then really hot water...I told her [Resident #22] that they can not do that and I was going to report it to the nurse...I did tell someone but I can't remember who but it was not LPN #3 because she doesn't do anything about things I tell her about the residents...."</p> <p>During an interview on 8-20-2014 at 4:38 P.M., CNA #9 indicated, "...when I got report from her [CNA #1] she told me she gave Resident #22 a shower that day, that she had a BM [bowel movement] and it was an easier clean up to put her in the shower... I usually give her [Resident</p> |               |   |                      |

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|  | <p>#22] a bed bath Tuesday and Friday evenings because she is too cold to take a shower...she [Resident #22] asked me, 'where were you this morning when that girl threw me in the hot shower'...she [Resident #22] told me that CNA #1 put her in the shower and CNA #2 laughed at her because she didn't want to take a shower...I told LPN #3 and LPN #3 said, 'she always is saying stuff'...she [LPN #3] didn't do anything about it..."</p> <p>During an interview on 8-20-2014 at 5:00 P.M., CNA #10 indicated, "...she [Resident #22] said CNA #1 put cold water then hot water on her in the shower and it burned and CNA #2 laughed at her...I told LPN #3 and LPN #3 said to me that Resident #22 is always saying stuff like that...LPN #3 didn't do anything about it...I went to find the DON but couldn't connect with her...."</p> <p>During an interview on 8-20-2014 at 5:38 P.M., CNA #1, by phone, indicated, "...I did give her a shower on days on 8-12-2014...I did call LPN #3 in to the shower room because Resident #22 was cursing at me...LPN #3 asked Resident #22 to apologize to me and she did not...Resident #22 does not act this way on a daily basis...."</p> <p>On 8-21-2014 at 9:34 A.M., the policy</p> |   |   |  |  |   |  |

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|                    | <p>titled, "Abuse Prevention and Reporting Policy," updated and revised on 7/12/14, was provided by the Human Resource staff and indicated the policy was the one currently used by the facility. The policy indicated, "...Standards...10. Any staff member who has knowledge of or reasonable cause to believe a resident has been or is being abused, or has knowledge a resident has sustained a physical injury which is not reasonable explained by the history of injuries provided in the resident's medical record, is required to make an immediate oral report to the Administrator, Director of Nursing, their supervisor and Social Service Director, if appropriate...11. Any staff member who intentionally abuses or suspected of abusing a resident or permits to exist an abusive situation which results in the abuse of a resident, is subject to immediate dismissal...22. Written reports of alleged abusive incidents are to be initiated by a licensed nurse and the individual who observed or has first-hand knowledge of an abuse incident using either a Concern/Suggestion or Accident/Incident Report Form. The Administrator, Director of Nursing and Social Service Director are responsible for reviewing the report as well as other investigative reports, interviews, etc, and developing interventions to care for the resident's medical psychological</p> |               |   |                      |

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|  | <p>needs...."</p> <p>Review of written statement, signed by the Administrator on 8-22-2014, received on 8-22-2014 at 10:30 A.M., indicated, "...during survey interviews res. [resident] report things that have not been previously reported and this doesn't result in an IJ [Immediate Jeopardy]. This was especially true when there were no known injuries and with an individual with some history of making "false [sic] statements."</p> <p>Review of Resident #22's care plans showed no indication of resident behavior of making false statements.</p> <p>The Immediate Jeopardy that began on 8/12/14 was removed 8/26/14, with an effective date of 8/25/14, when, through record review and interviews, staff had completed education regarding abuse and abuse prevention. This education included identification of abuse, how to report abuse, when to report abuse and to whom to report abuse. The administrators contact information was posted at various location for staff use. The staff were also given education related to bathing residents without a battle. Even though the facility 's corrective action removed the Immediate Jeopardy, the facility remained out of</p> |   |   |                      |   |

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| F000226<br>SS=L    | <p>compliance at a reduced scope and severity level of widespread, no actual harm with potential for more than minimal harm that is no Immediate Jeopardy because of on-going monitoring to ensure residents were free of abuse.</p> <p>3.1-28(c)<br/>3.1-28(d)<br/>3.1-28(e)</p> <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br/>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 implement policies and procedures which ensured the identification, investigation, and reporting verbal, physical, and mental abuse when a resident complained to other staff regarding a staff person giving her a shower against her desire, sprayed her with cold and hot water, and spoke to her in a demeaning/intimidating manner causing her to be upset for 1 of 1 residents reviewed for abuse. (Resident</p> | F000226       | <p>1. The facility shall ensure the policies to identify, report and investigate abuse are followed. No other residents other than the one mentioned in this tag were affected by this incident. An abuse investigation was immediately initiated when the surveyor informed the administration of the abuse allegation. Family and physician were notified and the resident was seen by physician that date and will follow up as needed. The resident is being monitored for psycho-social changes. CNA #1</p> | 09/19/2014           |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155738 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                     |  | X3) DATE SURVEY COMPLETED<br><br>08/26/2014 |  |
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|  | <p>#22) This had the potential to affect 52 of 52 residents in the facility at risk for being verbally, physically, and mentally abused.</p> <p>This deficiency resulted in an Immediate Jeopardy. The immediate Jeopardy began on 8/12/14, when the staff gave the resident a shower against her desire. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 8/20/14 at 1:00 P.M. The Immediate Jeopardy was removed on 8/25/14, but noncompliance remained at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>On 8-20-2014 at 9:22 A.M., an interview was conducted with Resident #22 in her room with the door closed, per her request. Resident #22 indicated, "...on August 15th, I think it was [actual date 8/12/14], that girl nicknamed [name] [CNA - Certified Nursing Assistant #1] took me to take a shower...I don't like showers and I told her 'No'...she just kept on taking me and I kept telling her I don't want a shower, I don't like showers...." Resident #22 indicated, "I am always cold and I take bed baths, it is cold in the</p> |   | <p>was terminated and CNA #2 and LPN #3 were provided disciplinary action and provided abuse prevention and reporting training. 2. The facility enhanced staff training to now include "Bathing without a Battle" and "Hand in Hand". In order to ensure that no other resident were affected by this, Social Services performed a face to face interview with all residents with no findings on 8/20/14. All staff mandatory in-service on abuse identification, prevention, and reporting was conducted on 9/15/14 and then at least quarterly thereafter. The facility will review abuse identification, prevention, and reporting monthly with CNA and nursing staff x 12 months. Social Services or designee will review abuse and how to report abuse monthly for 12 months at the Resident Council Meeting. The Administrator will review abuse, abuse prevention, abuse reporting and how to file a grievance in the Family Meeting on 9/25/14 and annually thereafter. The DON or designee provided training to all nurses and CNA on behaviors and behavior tracking, as well as, behavior intervention techniques by 9/15/14 and quarterly thereafter x 1 year. CNA tracking calendar logs will be implemented by Social Services in addition to Nurses behavior tracking sheets to accurately monitor resident behaviors. Social Services or</p> |  |  |   |  |

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|  | shower room." Resident #22 indicated, "...she told me I had to take a shower and then she sprayed me with cold water...I told her that is too cold and she turned the water all the way to hot...I told her that is burning me...." Resident #22 indicated, "I felt like she was being mean to me and that she was upset with me because I had smart words with her the day before." Resident #22 indicated, "...it burned me between my legs and I told her it hurts...I wanted CNA #2 to give me a shower cause he is nice and caring, CNA #1 has been mean to me in the past and I didn't want her to do it...CNA #2 came into the shower room and laughed at me...CNA #1 kept turning the water hotter and hotter when I was telling her I didn't want a shower and that it was hot, so I finally quit talking so she would not turn it up any more...I told her to take off my glasses so they wouldn't get broken and she said 'No, just hold your head the way I tell you and they won't get broken' and she wouldn't take them off...I told her I want someone else to take care of me...I told her that I am sick and CNA #1 said, 'That is not my fault [that you are sick]'...CNA #1 called the nurse [LPN - Licensed Practical Nurse #3] in to talk to me...the nurse told me to apologize to the CNA #1 for calling her names...she [LPN #3] never asked me why I was upset...I told another CNA later that day and I told |   | designee will audit behavior tracking forms for accurate documentation daily x 1 month, weekly x 3 months, and monthly thereafter. An assessment of all resident's with history of false allegations were reviewed to ensure that these behaviors are accurately care planned by 9/15/14. 3. All staff mandatory in-service on abuse identification, prevention, and reporting were conducted by 9/15/14 and then at least quarterly thereafter. These in-services will involve outside sources like APS and Ombudsman. The facility will review abuse identification, prevention, and reporting monthly with CNA and nursing staff x 12 months. The facility provided training to all nurses and CNA on behaviors and behavior tracking, as well as, behavior intervention techniques by 9/15/14 and quarterly thereafter x 1 year. Social Services or designee will audit behavior tracking forms for accurate documentation daily x 1 month, weekly x 3 months, and monthly thereafter. 4. The DON or designee will randomly assess staff for ability to state types of abuse, how to identify abuse, what to do if witnessing abuse, and how to report abuse weekly for 3 months, monthly for 3 months, then bi-monthly for 6 months. Social services will audit behavior tracking forms for accurate documentation daily x 1 month, weekly x 3 months, and |  |  |   |  |

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|                    | <p>my daughter about it...CNA #2 came in my room a few days later and said, 'I thought we were friends, are you trying to get me fired?...I have a wife and kids at home to take care of...'</p> <p>On 8-20-2014 from 9:49 A.M. to 10:15 A.M., an interview was conducted with the Administrator, DON (Director of Nursing), Social Service Designee, CNA #2, and LPN #3 in the conference room.</p> <p>The Administrator indicated, "...there are no reportables involving Resident #22...any abuse would be expected to be reported it to me immediately...."</p> <p>The DON indicated, "...I don't know anything about this [incident]...I know that Resident #22 was covered in BM [bowel movement] and needed a shower...she was not happy with her shower, she doesn't like them but it was in her best interest to take a shower...I told LPN #3 to document the behaviors...I talked to Resident #22 right before I left for the day...she [Resident #22] stated she had had a good day...she was in Bingo at that time...."</p> <p>CNA #2 indicated, "...she [Resident #22] was calling her [CNA #1] names in the shower room, she [Resident #22] had a large bowel movement and she [Resident</p> |               | <p>monthly thereafter. The Administrator will make daily rounds, eat lunch with the residents, etc. in efforts of making them feel comfortable to report any concerns. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. The QA will continue to monitor any Abuse Policy violations, state reportables and concern reports until there have been [3] consecutive months of no unreported abuse allegations. QA monitoring will then go to quarterly and will be on-going.IDR: The Administrator and DON were not aware of the allegation. Upon hearing the allegation from the surveyor for the first time, the Administrator immediately initiated the investigation. The staff member, who the allegation was directed toward, was immediately suspended and later terminated, as well as, two staff who were believed to have some knowledge of the incident. Further, her family, all the residents and staff were interviewed, no resident indicated that they had ever been abused and all felt safe. All staff were aware of their responsibility to report an allegation of abuse and have done so routinely in the past. There was no injuryThe staff have shown a history of understanding their responsibility to report allegations od abuse (see Incident Reports); however, in this case, they did not report it</p> |                      |

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|  | <p>#22] needed a shower...I was in and out of the shower [room]...there was no cussing going on...." CNA #2 had no comment related to the statements made by Resident #22 regarding their conversation a few days after the incident.</p> <p>LPN #3 indicated, "...I was called to come into the shower room...CNA #1 told me that Resident #22 was calling her names...I told her [Resident #22] to apologize to CNA #1...I did not ask Resident #22 what was wrong, I knew she [Resident #22] didn't like showers...I documented it in a nurses narrative that she was cussing at the staff...I told the DON about it...she [Resident #22] does this every day...."</p> <p>The clinical record for Resident #22 was reviewed on 8-20-2014 at 12:24 P.M. The diagnoses included, but were not limited to, depression, CVA with hemiparesis (stroke with one side paralysis), dementia.</p> <p>The MDS (Minimum Data Set) assessment, dated 6/7/14, indicated the resident was moderately cognitively impaired.</p> <p>The behavior sheets for Resident #22 for May, June, July and August 2014,</p> |   | <p>to the Administrator or DON as they perceived it as her (resident) just "story telling" and not really an example of abuse. The resident family discounted the report as story telling and did not believe anything happened and didn't report it. The follow-up training has stressed everyone's responsibility to report an allegation whether or not they believe it to be true. Training has also been provided to all the resident and families (October newsletter, Family meeting on 9/23 and at the monthly resident council meetings). While the resident does prefer bed baths on this occasion she did not refuse the shower and seemed to accept the benefits of showering due to the large amount of BM on her.</p> |  |  |   |  |

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|  | <p>indicated no documentation related to cussing/swearing at staff.</p> <p>The care plan, dated 8/7/14, indicated, "Problem/Need...Resident exhibits inappropriate behavior of making rude comments towards other individuals...Approaches...*Do not argue with resident...*Talk with resident in a calm voice when behavior is disruptive...*Discuss resident's feelings of anger with resident...."</p> <p>The nurses notes, dated 8/12/14 at 1:30 P.M., for Resident #22 indicated, "...Pt. [patient] cussing at staff member D/T [due/to] getting shower...Had lg [large] loose BM [bowel movement] called her a 'B---- F---off' when approached resident calm-went to Bingo...." (signed) LPN #3.</p> <p>The Shower Report, dated 8/12/14, for Resident #22 indicated Behavior Problem(s): Curses(is circled)...Comments: "Called me a B---- numerous times, told her I was going to get the nurse and she said f-- you and her." Signed by CNA #1 and Charge Nurse, LPN #3.</p> <p>The CNA assignment sheet, received from the DON, on 8/20/14 at 5:20 P.M., and last updated on 7/18/14, indicated "BED BATH ONLY."</p> |   |   |  |  |   |  |

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|                    | <p>During an interview on 8-20-2014 at 4:17 P.M., CNA #5 indicated, "...she [Resident #22] told her on 8-12-2014 that CNA #1 gave her a shower and put cold water on her and then really hot water...I told her [Resident #22] that they can not do that and I was going to report it to the nurse...I did tell someone but I can't remember who but it was not LPN #3 because she doesn't do anything about things I tell her about the residents...."</p> <p>During an interview on 8-20-2014 at 4:38 P.M., CNA #9 indicated, "...when I got report from her [CNA #1] she told me she gave Resident #22 a shower that day, that she had a BM [bowel movement] and it was an easier clean up to put her in the shower... I usually give her [Resident #22] a bed bath Tuesday and Friday evenings because she is too cold to take a shower...she [Resident #22] asked me, 'where were you this morning when that girl threw me in the hot shower'...she [Resident #22] told me that CNA #1 put her in the shower and CNA #2 laughed at her because she didn't want to take a shower...I told LPN #3 and LPN #3 said, 'she always is saying stuff'...she [LPN #3] didn't do anything about it...."</p> <p>During an interview on 8-20-2014 at 5:00 P.M., CNA #10 indicated, "...she</p> |               |   |                      |

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|  | <p>[Resident #22] said CNA #1 put cold water then hot water on her in the shower and it burned and CNA #2 laughed at her...I told LPN #3 and LPN #3 said to me that Resident #22 is always saying stuff like that...LPN #3 didn't do anything about it...I went to find the DON but couldn't connect with her...."</p> <p>During an interview on 8-20-2014 at 5:38 P.M., CNA #1, by phone, indicated, "...I did give her a shower on days on 8-12-2014...I did call LPN #3 in to the shower room because Resident #22 was cursing at me...LPN #3 asked Resident #22 to apologize to me and she did not...Resident #22 does not act this way on a daily basis...."</p> <p>On 8-21-2014 at 9:34 A.M., the policy titled, "Abuse Prevention and Reporting Policy," updated and revised on 7/12/14, was provided by the Human Resource staff and indicated the policy was the one currently used by the facility. The policy indicated, "...Standards...10. Any staff member who has knowledge of or reasonable cause to believe a resident has been or is being abused, or has knowledge a resident has sustained a physical injury which is not reasonable explained by the history of injuries provided in the resident's medical record, is required to make an immediate oral</p> |   |   |  |  |   |  |

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|  | <p>report to the Administrator, Director of Nursing, their supervisor and Social Service Director, if appropriate...11. Any staff member who intentionally abuses or suspected of abusing a resident or permits to exist an abusive situation which results in the abuse of a resident, is subject to immediate dismissal...22. Written reports of alleged abusive incidents are to be initiated by a licensed nurse and the individual who observed or has first-hand knowledge of an abuse incident using either a Concern/Suggestion or Accident/Incident Report Form. The Administrator, Director of Nursing and Social Service Director are responsible for reviewing the report as well as other investigative reports, interviews, etc, and developing interventions to care for the resident's medical psychological needs...."</p> <p>Review of written statement, signed by the Administrator on 8-22-2014, received on 8-22-2014 at 10:30 A.M., indicated, "...during survey interviews res. [resident] report things that have not been previously reported and this doesn't result in an IJ [Immediate Jeopardy]. This was especially true when there were no known injuries and with an individual with some history of making "false [sic] statements."</p> |   |   |  |  |   |  |

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| F000241<br>SS=D    | <p>Review of Resident #22's care plans showed no indication of resident behavior of making false statements.</p> <p>The Immediate Jeopardy that began on 8/12/14 was removed 8/26/14, with an effective date of 8/25/14, when, through record review and interviews, staff had completed education regarding abuse and abuse prevention. This education included identification of abuse, how to report abuse, when to report abuse and to whom to report abuse. The administrators contact information was posted at various location for staff use. The staff were also given education related to bathing residents without a battle. Even though the facility 's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of widespread, no actual harm with potential for more than minimal harm that is no Immediate Jeopardy because of on-going monitoring to ensure residents were free of abuse.</p> <p>3.1-28(a)</p> <p>483.15(a)<br/>DIGNITY AND RESPECT OF INDIVIDUALITY</p> |               |   |                      |

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|  | <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure privacy and dignity was provided to two residents during two observations. (Resident #22 and #25)</p> <p>Finding includes:</p> <p>On 8/18/14 at 12:40 P.M., an observation was made of CNA #13 knocking and entering Resident #22 and #25 without waiting for invitation into the room by Resident #22 or #25.</p> <p>On 8/18/14 at 1:02 P.M., an observation was made of Employee #12 opening the door to the residents room and walking in without knocking, announcing herself or waiting for a invitation into the room by Resident #22 or #25. An interview at this time with housekeeping at this time indicated "...yes sometimes I should knock...I knock sometimes...."</p> <p>An interview with LPN #3, on 8/20/14 at 10:40 A.M., indicated, "... you should knock, identify yourself, wait to be asked in, you should not just walk in...."</p> | F000241   | <p>1. The facility shall ensure that resident rights to privacy and dignity are maintained. The residents mentioned in this tag had no adverse reactions from this incident. Employees #12, #13 were counseled related to their actions. All staff are to be educated regarding resident rights and dignity. 2. A policy was created related to resident rights and dignity. All employees were in-serviced related to the new policy on 9/15/14 and at least quarterly thereafter for 12 months. 3. DON or designee with randomly monitor staff knocking prior to entering resident rooms, as well as, for other potential privacy violations twice daily x 2 months, daily x 3 months, weekly x 3 months and continue weekly thereafter or until 100% compliance is achieved for 30 days. 4. DON or designee with randomly monitor staff knocking prior to entering resident rooms as well as for other potential privacy violations twice daily x 2 months, daily x 3 months, weekly x 3 months and continue weekly thereafter or until 100% compliance is achieved for 30 days. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months.</p> | 09/19/2014           |   |

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| F000257<br>SS=D    | <p>An interview with the ADON (Assistant Director of Nursing), on 8/26/14 at 8:30 A.M., indicated the facility did not have a policy regarding dignity.</p> <p>3.1-3(t)</p> <p>483.15(h)(6)<br/>COMFORTABLE &amp; SAFE TEMPERATURE LEVELS<br/>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F<br/>Based on observation and interview, the facility failed to ensure a comfortable temperature was maintained in Room 110. This deficient practice affected the one of two residents who resided in this room. (Resident #22)</p> <p>Finding includes:</p> <p>On 8/18/14 at 12:31 P.M., an interview was conducted with Resident # 22. Resident #22 indicated it was cold in her room.</p> <p>On 8/26/14 at 11:23 A.M., an environmental tour was conducted with</p> | F000257       | <p>1. The facility will provide comfortable and safe temperatures between 71 and 81 degrees with a mean temperature of 74-75 degrees. There were no known adverse reactions related to this incident. The Maintenance Director has added wall thermometers in varied locations in the facility in order to monitor the desired temperature. He will adjust the thermostats daily if needed. Temperatures will be logged daily. 2. The temperature in Rm 110 will be maintained at 74-75 degrees. Resident #22 who maintains she is always cold no matter how warm the room is will be asked daily if she is as comfortable as possible. 3. Daily</p> | 09/19/2014           |

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| F000279<br>SS=D    | <p>the maintenance director. During the environmental tour the Maintenance Director indicated the temperature in Resident #22's room was 68 degrees. An interview was conducted at this time. Maintenance Director indicated he thought 68 degrees to 72 degrees was acceptable temperature for resident rooms for this time of year.</p> <p>3.1-19(h)</p> <p>483.20(d), 483.20(k)(1)<br/>DEVELOP COMPREHENSIVE CARE PLANS<br/>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>random resident interviews will be conducted by the Maintenance Director regarding whether they are comfortable. Temperatures will be adjusted accordingly. After adjusting the thermostat, the Maintenance Director will revisit any resident that expressed being too warm or too cold to ensure they are comfortable. 4. The Maintenance Director will continue to monitor the facility temperatures on a daily basis and will review his findings at least weekly with the Administrator. The QA Committee will review audits monthly x [6] months, as well as, concern reports from residents or families related to facility temperature. The QA Committee shall continue monitoring monthly until [3] consecutive months of no temperature problems are noted. QA Committee will then review temperature comfort and satisfaction quarterly, on-going.</p> |                      |

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|                    | <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 record review and interview, the facility failed to ensure that a care plan was developed related to the use of antidepressant medication for 1 of 17 residents reviewed for care plans. (Resident #43)</p> <p>Finding includes:</p> <p>On 8/19/14 at 12:53 P.M., the clinical record review was conducted for Resident #43. Resident #43 was admitted to the facility on May 6, 2014. Diagnosis included, but was not limited to, depression. Review of Resident #43 physician order indicated " ... Zoloft [antidepressant] QHS [every bedtime] 50 mg [milligrams]."</p> <p>Review of care plans for Resident #43 showed no documentation that a care plan was developed for the use of antidepressants.</p> | F000279       | <p>1. The facility shall ensure that each resident is provided a comprehensive care plan designed to meet their needs and promote their independence. A comprehensive audit was completed on all skilled residents with a diagnosis of depression and all residents on psych medications to ensure that all had appropriate care plans on 9/10/14. Resident #43 had care plan modifications made. 2. On 9/10/14 a comprehensive audit was completed on all residents with a diagnosis of depression and all residents on psych medications to ensure that all had appropriate care plans and modifications were made a necessary. ADON will complete a comprehensive review of all resident care plans ensuring individualized and appropriate interventions are in place as well as that all diagnosis, medication, treatments, and interventions are care planned by 9/25/14. ADON will check all new orders daily throughout the week and ensure that they are transcribed correctly</p> | 09/19/2014           |

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| F000282<br>SS=D                                      | <p>An interview with Social Services, on 8/19/14 at 2:30 P.M., indicated that "...a care plan should be developed within 3-4 days after a condition is diagnosed... resident does not have care plan for depression in the care plan book...."</p> <p>On 8/26/14 at 8:30 A.M., review of the current and undated policy titled, " Resident Care Plan Policy," provided by the ADON (Assistant Director of Nursing), indicated " ...a comprehensive plan of care will be provided for each resident that includes measurable objectives and time frames to meet the medical, nursing, mental and psychosocial needs... revised at any time the condition of the resident changes...where change has occurred which would alter the plan of care...."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br/>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's</p> |   | <p>and care planned starting 9/15/14. 3. ADON will complete a comprehensive review of all residents care plans ensuring individualized and appropriate interventions in place as well as that all diagnosis, medication, treatments, and interventions are care planned by 9/25/14. Beginning no later than 9/15/14, the ADON will check all new orders daily to ensure they are transcribed correctly and care planned starting 9/15/14 all nursing staff were educated on this. 4. Social services or designee will complete an audit all resident with a diagnosis of depression and all residents on psych medications to ensure that all had appropriate care plans. Weekly x 2 months, every other week x 2 months, monthly x 6 months, every other month x 4 months. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. QA monitoring will continue monthly until there are [3] consecutive months of no problems related to missing care plans for psychotropic medications.</p> |                      |   |

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|  | <p>written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure the plan of care was followed related to a gel cushion to the wheelchair and to obtain a urinalysis (Resident #24). The facility further failed to provide care according to the plan of care related to incontinence care (Resident #43). This deficient practice affected 2 of 17 residents reviewed for care plans.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #24 was reviewed on 8-19-14 at 1:12 P.M. Resident #24 was admitted to the facility on 10-23-14. Diagnoses included but were not limited to: COPD (chronic obstructive pulmonary disease), neuropathy, acid reflux, HTN (hypertension), anemia and hypothyroidism.</p> <p>A quarterly MDS (Minimum Data Set) assessment, completed on 6-28-14, indicated Resident #24 had no pressure ulcers but was at mild risk for pressure ulcers.</p> <p>On 8-18-14 at 2:05 P.M., review of the MAR for Resident #24 indicated "...Gel cushion in w/c [wheelchair]. Document</p> | F000282   | <p>1. The facility shall ensure the services are provided in accordance with their plan of care. On 9/15/14 comprehensive audit was completed on all skilled residents ensuring all residents with orders for wheelchair cushions had them in place. All residents will be assessed for need for wheelchair cushion and initiated as appropriated by 9/15/14 and monthly thereafter x 12 months. 2. All nursing staff was trained on following resident care plans for wheelchair cushions by 9/15/14 and monthly thereafter x 12 months. This training will also include reviewing the procedures related to obtaining UA's within 24 hours and the procedures to follow if it was unobtainable. The ADON will check all physician orders daily and monitor to ensure they are completed within 24 hours or per procedure. 3. All residents will be monitored for wheelchair cushion placement daily x 1 month, weekly x 2 months, every other week x 2 month, monthly x 3 months and then monthly until 100% compliance for 2 months. ADON will check all new orders daily and ensure that they are transcribed correctly, initiated, care planed, as well as updating CNA assignment sheets as needed starting 9/15/14. ADON will check all new orders daily and ensure that they are transcribed correctly, initiated, care planned,</p> | 09/19/2014   |  |   |  |

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|  | <p>every shift in MAR...."</p> <p>On 8-19-14 at 12:30 P.M. Resident #24 was observed sitting in her wheelchair in her room. No wheelchair cushion was observed on her chair.</p> <p>On 8-19-14 at 2:00 P.M., Resident #24 was observed sitting in her wheelchair in her room. No wheelchair cushion was observed on her chair.</p> <p>On 8-21-14 at 9:22 A.M., Resident #24 was observed lying in her bed. Observation of her wheelchair showed no gel cushion in the seat of her chair.</p> <p>On 8-25-14 at 10:05 A.M., an observation was made of Resident #24's wheelchair. The wheelchair showed no gel cushion in the seat. Interview with CNA (Certified Nursing Assistant) #18 was conducted at this time. CNA #18 indicated "...she usually has a cushion in her chair...someone must have removed it to clean it and did not return it to her wheelchair...."</p> <p>The clinical record for Resident #24 was reviewed again on 8-25-14 at 10:30 A.M. A nurses note, dated 8-24-14 at 5:00 A.M., indicated "...Pressure areas noted Rt [right] buttock, Rt hip, et [and] Rt ankle...."</p> |   | <p>as well as updating CNA assignment sheets as needed starting 9/15/14. 4. All residents will be monitored for wheelchair cushion placement daily x 1 month, weekly x 2 months, every other week x 2 month, monthly x 3 months and then monthly until 100% compliance for 2 months. ADON will check all new orders daily and ensure that they are transcribed correctly, initiated, care planned, as well as updating CNA assignment sheets as needed starting 9/15/14. ADON will check all new orders daily and ensure that they are transcribed correctly, initiated, care planed, as well as updating CNA assignment sheets as needed starting 9/15/14. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. QA monitoring will continue until there are [3] consecutive months of full compliance.</p> |  |  |   |  |

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|                    | <p>Review of the "Weekly Pressure Ulcer Record" dated 8-24-14 indicated "...Date of onset: 8-24-14...Site/Location: R buttock pinpoint...Stage: St [stage] II [two]...size in CM [centimeters] (length x width): .2 x [by] .2...Depth: &lt; [less than] .1...." (Signed by ADON).</p> <p>Review of the "Weekly Pressure Ulcer Record" dated 8-24-14 indicated "...Date of onset: 8-24-14...Site/Location: R buttock [Actual area R hip]...Stage: St II...size in CM (length x width): 1.5 x .4...Depth: &lt; .1...." (Signed by ADON)</p> <p>Review of the Skin Breakdown Care Plan indicated "...Problem Onset: 4-24-14 The resident is at risk for skin breakdown r/t [related to] immobility...Goal &amp; Target Date: The resident will be free from skin breakdown through the next period 10-17-14...Approaches: Assist with toileting as needed, Check skin weekly during shower, Encourage 100% of meals, Notify MD as needed, Treatments as ordered...."</p> <p>On 8-26-14 at 11:00 A.M., Resident #24's wounds on her buttocks were observed. Area #1 was observed to be dime sized, without defined edges, just below the right hip area. Area #2 was observed to be just below Area #1, on the</p> |               |   |                      |

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|  | <p>right buttock, and was pinpoint in size. No redness or drainage was noted to either of the wounds.</p> <p>2. The clinical record for Resident #24 was reviewed on 8-19-14 at 1:12 P.M. Resident #24 was admitted to the facility on 10-23-14. Diagnoses included but were not limited to: COPD (chronic obstructive pulmonary disease), neuropathy, acid reflux, HTN (hypertension), anemia and hypothyroidism.</p> <p>On 8-25-14 at 10:20 A.M., a nurses note, dated 8-19-14 at 2:30 P.M., was reviewed. The nurses note indicated "...MD [Medical Director] ordered UA C&amp;S [urinalysis with culture and sensitivity] d/t [due to] confusion...."</p> <p>On 8-25-14 at 11:08 A.M., a fax notification sent to the physician on 8-19-14 at 1:48 P.M., was reviewed. The fax indicated "...Resident acting a bit confused this shift. Claims to see things that aren't there...Can we have order for US C&amp;S?... [reply from MD] Yes, Please place her on my list to see tomorrow...."</p> <p>On 8-25-14 at 11:08 A.M., an interview with LPN #26 was conducted. LPN #26 indicated the UA C&amp;S ordered for Resident #24 had not been completed yet,</p> |   |   |                      |   |

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|  | <p>"...We place her on the bedpan and she poops in it and it [the urine specimen] gets contaminated. If we can't obtain it we will notify the doctor and do a straight cath [a method of obtaining a urine specimen].</p> <p>On 8-25-14 at 11:12 A.M., an interview with the DON was conducted. The DON indicated "...if the UA was done it would be checked as done on the MAR. If the staff were unable to get it [urinalysis] they could straight cath, it is our standing order...."</p> <p>On 8-25-14 at 11:30 A.M., the MAR for Resident #24 was reviewed. The MAR indicated the following: "...UA c [with] C&amp;S if indicated...." 8-19-14, 8-20-14, 8-21-14, 8-23-14, 8-24-14 and 8-25-14 had no initials noted on the MAR indicating the UA was not attempted. 8-22-14 on the MAR indicated a set of initials with a circle with a line through it, indicating the UA had been attempted but not obtained.</p> <p>On 8-25-14 at 11:35 A.M., the nurses notes from 8-20-14 at 10:00 A.M. to 8-25-14 at 5:00 A.M. were reviewed. The nurses notes showed no indication that the UA C&amp;S had been completed or that the physician had been notified that it was not completed.</p> |   |   |  |  |   |  |

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|                    | <p>On 8-25-14 at 11:40 A.M., review of the Urinalysis Protocol, received from the DON, indicated "...Urinalysis with culture and sensitivity as indicated, may straight cath if unable to obtain clean catch in 24 hours...if unable to straight cath per resident refusal MD to be notified..."</p> <p>3. On 8/26/14 at 8:50 A.M., during an observation of pressure ulcer assessment with the DON( Director of Nursing) Resident #43 was observed to be wet with urine. The DON indicated at this time "... the resident is usually wet..."</p> <p>On 8/26/14 at 11:30 A.M., a review or residents' #43 care plan, provided on 8/19/14 at 10:00 A.M., by the ADON ( Assistant Director of Nursing) indicated "...Keep resident clean and dry...."</p> <p>An interview with CNA #24 on 8/26/14 at 11:40 A.M., indicated ".... I know what care to provide the residents because of what is on the CNA assignment sheet... I get a new sheet from behind the nurses station every day I work... CNA #43 produced her assignment sheet and Resident #43 was not on the sheet.<br/>"...I would not know of any changes since she is not on the sheet...."</p> |               |   |                      |

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|                    | <p>An interview with the DON (Director of Nursing) on 8/26/14 11:50 A.M., indicated "CNA assignment sheet should be updated at least weekly, more often if changes occur i.e. new pressure mattress... Resident #43 is not on the assignment sheet..."</p> <p>On 8/26/14 at 11:55 A.M., a review of the current, undated policy "CNA Care Givers Assignment" indicated "...3. The CNA Assignment Form will be up dated according to changes in resident care needs not less than quarterly... 10. When a change is identified... it is the responsibility of the licensed nurse to update the Assignment Form to reflect the change in the resident care...."</p> <p>An interview with the ADON on 8/26/14 at 12:00 P.M., indicated " the date on the current CNA assignment sheet was 4/17/14... the CNA's make copies from old ones that is why the date is cut off.. I update the CNA sheet weekly and more if a change occurs...."</p> <p>On 8/26/14 at 12:10 P.M., the ADON provided a copy of the CNA assessment sheet dated 7/28/14 indicating this was the current assignment sheet that should be being used by the CNA's...."</p> |               |   |                      |

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| F000314<br>SS=D | <p>3.1-35(b)(1)</p> <p>483.25(c)<br/>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to consistently implement a preventative measure for the development of a pressure ulcer and ensure treatment for a newly developed pressure ulcer was obtained timely for 1 of 2 residents reviewed for pressure ulcers. (Resident #24)</p> <p>Finding includes:</p> <p>The clinical record for Resident #24 was reviewed on 8-19-14 at 1:12 P.M. Resident #24 was admitted to the facility on 10-23-14. Diagnoses included but were not limited to: COPD (Chronic Obstructive Pulmonary Disease), neuropathy, acid reflux, HTN (hypertension- high blood pressure), anemia and hypothyroidism.</p> | F000314 | <p>1. The facility shall ensure that residents entering the facility do not develop pressure sores unless they are unavoidable, and that they have appropriate treatment services to promote healing and to prevent new sores. A comprehensive audit was completed on all skilled residents ensuring all residents with orders for wheelchair cushions had them in place. All residents were assessed for need for wheelchair cushion and initiated as appropriated by 9/15/14 and monthly thereafter x 12 months. DON or designee completed a BRADEN assessment on all residents and insured interventions were implemented by 9/15/15. All new admissions will have a BRADEN assessment completed at admission and then weekly x 4 effective 9/15/14. 2. A policy was created on incontinence care and</p> | 09/19/2014 |
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|  | <p>A quarterly MDS (Minimum Data Set) assessment was completed on 6-28-14. The assessment indicated Resident #24 had no pressure ulcers but was at mild risk for pressure ulcers.</p> <p>On 8-18-14 at 2:05 P.M. review of the Medication Administration Record (MAR) for Resident #24 indicated "...Gel cushion in w/c [wheelchair]. Document every shift in MAR...."</p> <p>On 8-19-14 at 12:30 P.M., Resident #24 was observed sitting in her wheelchair in her room. No wheelchair cushion was observed on her chair.</p> <p>On 8-19-14 at 2:00 P.M., Resident #24 was observed sitting in her wheelchair in her room. No wheelchair cushion was observed on her chair.</p> <p>On 8-21-14 at 9:22 A.M., Resident #24 was observed lying in her bed. Observation of her wheelchair showed no gel cushion in the seat of her chair.</p> <p>On 8-25-14 at 10:05 A.M., an observation was made of Resident #24's wheelchair. The wheelchair did not contain a cushion. Interview with CNA (Certified Nursing Assistant) #18 was conducted at this time. CNA #18</p> |   | <p>all staff in-serviced on 9/15/14. All nursing staff will be trained on following resident plan of care, incontinence care, and facility protocols by 9/15/14. All staff was trained on preventative skin care and pressure sore prevention on 9/15/14. All residents were assessed for need for wheelchair cushion and initiated as appropriated by 9/15/14 and monthly thereafter x 12 months. All staff was trained on preventative skin care and pressure sore prevention on 9/15/14. All new admissions will have a BRADEN assessment completed at admission and then weekly x 4 effective 9/15/14. As a comprehensive and multidisciplinary review, all residents with breaks in skin integrity will be reviewed by the skin and weight committee at each meeting [meets at least every two weeks] until healed effective 9/11/14. ADON will utilize a skin / QI log weekly to track all skin integrity issues when completing skin rounds effective 9/11/14 (MD notification tracking is located on this form). An audit of skin and wounds will be completed weekly x 3 months, every other week x 3 months, monthly x 6 months. 3. All residents will be monitored for wheelchair cushion placement daily x 1 month, weekly x 2 months, every other week x 2 month, monthly x 3 months and then monthly until 100%</p> |  |  |   |  |

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|  | <p>indicated "...she usually has a cushion in her chair...someone must have removed it to clean it and did not return it to her wheelchair...."</p> <p>The clinical record for Resident #24 was reviewed again on 8-25-14 at 10:30 A.M. A nurses note, dated 8-20-14 10:00 A.M., indicated "...Called to pt's [patients] room by CNA, noted unst [unstageable, full thickness tissue loss in which the base of the ulcer is covered by slough and/or rschar in the ulcer bed] area over R [right] ankle...." (Signed by ADON - Assistant Director of Nursing).</p> <p>A nurses note, dated 8-24-14 at 5:00 A.M., indicated "...Pressure areas noted Rt [right] buttock, Rt hip, et [and] Rt ankle. MD [Medical Doctor] notified...."</p> <p>Review of the "Weekly Pressure Ulcer Record," dated 8-24-14, indicated "...Date of onset: 8-24-14...Site/Location: R buttock pinpoint...Stage: St [stage, partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough.] II [two]...size in CM [centimeters] (length x width): .2 x [by] .2...Depth: &lt; [less than] .1...." (Signed by ADON).</p> <p>Review of the "Weekly Pressure Ulcer Record," dated 8-24-14, indicated</p> |   | <p>compliance for 2 months. ADON will check all new orders daily and ensure that they are transcribed correctly, initiated, care planed, as well as updating CNA assignment sheets as needed starting 9/15/14 this practice will continue indefinitely. ADON will check all new orders daily and ensure that they are transcribed correctly, initiated, care planed, as well as updating CNA assignment sheets as needed starting 9/15/14 this p[practice will continue indefinitely. All residents with skin integrity issues will be reviewed by the skin and weight committee at each meeting until healed as a comprehensive multidisciplinary review effective 9/11/14. ADON will utilize a skin / QI log weekly to track all skin integrity issues when completing skin rounds effective 9/11/14 (MD notification tracking is located on this form). An audit of skin and wounds will be completed weekly x 3 months, every other week x 3 months, monthly x 6 months. 4. All residents will be monitored for wheelchair cushion placement daily x 1 month, weekly x 2 months, every other week x 2 month, monthly x 3 months and then monthly until 100% compliance for 2 months. An audit of skin and wounds will be completed weekly x 3 months, every other week x 3 months, monthly x 6 months. ADON will check all new orders daily and ensure that they are transcribed</p> |  |  |   |  |

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|                    | <p>"...Date of onset: 8-24-14...Site/Location: R buttock [Actual area R hip]...Stage: St II...size in CM (length x width): 1.5 x .4...Depth: &lt; .1...." (Signed by ADON)</p> <p>Review of the "Weekly Pressure Ulcer Record" dated 8-24-14 indicated "...Date of onset: 8-24-14 [Actual date of onset 8-20-14]...Site/Location: R outer ankle...Stage: II...Size in CM (length x width): 1. x 1.5...Depth: &lt; .1...." (Signed by ADON)</p> <p>Review of the Skin Breakdown Care Plan indicated "...Problem Onset: 4-24-14 The resident is at risk for skin breakdown r/t [related to] immobility...Goal &amp; Target Date: The resident will be free from skin breakdown through the next period 10-17-14...Approaches: Assist with toileting as needed, Check skin weekly during shower, Encourage 100% of meals, Notify MD as needed, Treatments as ordered...."</p> <p>On 8-25-14 at 11:00 A.M., an interview with the ADON was conducted. The ADON indicated that on 8-20-14, "...I was walking by and the CNA called me into the patients room. I noted an unstageable area on her right ankle...." The ADON further indicated she did not notify the physician at this time, "...I passed that on to the nurse on duty who</p> |               | <p>correctly, initiated, care planned, as well as updating CNA assignment sheets as needed starting 9/15/14 this practice will continue indefinitely. The ADON will check all new orders daily and ensure that they are transcribed correctly, initiated, care planned, as well as updating CNA assignment sheets as needed starting 9/15/14 this practice will continue indefinitely. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. QA monitoring will continue monthly until there are [3] consecutive months full compliance.</p> |                      |

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|  | <p>was to report it to the physician...."</p> <p>On 8-25-14 at 1:00 P.M., review of Resident #24's physician orders indicated an order to clean and dress the wounds was obtained on 8-24-14.</p> <p>On 8-26-14 at 11:00 A.M., Resident #24's wounds were observed. Area #1 was observed to be dime sized, without defined edges, just below the right hip area. Area #2 was observed to be just below Area #1, on the right buttock, and was pinpoint in size. Area #3 was observed to be nickel sized, without defined edges, on the outside of the right ankle. No redness or drainage was noted to any of the wounds.</p> <p>On 8-26-14 at 2:00 P.M., review of the the current policy titled "Licensed Nurse Procedure, Change in Condition Assessment and Documentation Guidelines", indicated "...Standards: Physicians and family...will be notified of each change in clinical condition, accident/incident or unusual occurrence...."</p> <p>3.1-40 (1)(2)(3)</p> |   |   |                      |   |

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| F000323<br>SS=E | <p>483.25(h)<br/>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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>Based on observation, interview and record review, the facility failed to ensure doors to rooms or cabinets, that contained potentially hazardous materials and unlabeled chemical spray bottles, were kept locked for 49 of 52 residents who had the ability to be mobile.</p> <p>Finding includes:</p> <p>On 8-18-2014 from 7:55 A.M. to 8:40 A.M., an initial tour was conducted on the first floor with the following observed:</p> <p>The first floor Biohazard room was closed but unlocked. The Biohazard door had a sign stating, "Keep door locked." Inside the Biohazard room was an unlocked cabinet with 3 bottles containing chemicals, a gallon-sized container of Quat (a cleaning solution) and two spray bottles labeled with permanent marker indicated "Quat" and "Acid D-lime." Review of the label for the Quat indicated, "...Irreversible eye damage can occur...." A biohazard box</p> | F000323 | <p>1. The facility shall ensure that the facility is free of hazards. On 9/15/12 all staff was in-serviced on hazards related to proper storage, securing doors/cabinets/tools, and treatment/medication carts. This training will identify hazards and potential hazards and the responsibility to keep them supervised or secured in order to ensure residents are protected. No residents were affected by this incident. 2. Shower room cabinets were locked or removed by 9/16, keyless locks were installed on the utility, biohazard and janitors closet, maintenance tools will be kept in visual proximity or behind a secured door, and a lock was added to the Activity Closet. All chemicals are kept secured. 3. The Maintenance Director or designee will monitor utility rooms, biohazard storage, closets/cabinets to ensure they are secured. DON or designee will randomly monitor for medication and treatment carts being secured three times daily x 3 months, twice daily x 3 months, daily x 3 months and daily</p> | 09/19/2014 |
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|  | <p>was observed to be overflowing with full sharps containers (a container that is used for the disposal of used needles). A 5 drawer treatment cart was observed to be unlocked with medicated ointments and powders inside.</p> <p>The first floor Men's shower room was observed with an unlocked cabinet over the toilet with shaving cream and hand sanitizer inside.</p> <p>On 8-18-2014 at 8:50 A.M., an open shelved cart with tools, including a battery-powered screw driver, was observed inside the open administrator's office unattended. Interview with the ADON (Assistant Director of Nursing) on 8-18-2014 at 8:53 A.M., indicated "...this [the tool cart] should not be unattended...."</p> <p>On 8-18-2014 at 8:55 A.M., an unlocked Activity Closet located inside the main entrance doors was observed to have 2 bags of Miracle Gro inside on a shelf.</p> <p>On 8-18-2014 at 8:58 A.M., the door marked "Roof" was unlocked and contained a ladder leading to a hatch in the ceiling, a free standing ladder and black cable wires on all walls.</p> <p>On 8-18-2014 at 8:59 A.M., the door to</p> |   | <p>thereafter until 100% compliance has been reached x 7 days. 4. Compliance will be reviewed monthly by the Quality Assurance Committee for 6 months. QA monitoring will continue monthly for [3] consecutive months of full compliance.</p> |                      |   |

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|                    | <p>the Janitors Closet on the second floor was observed to be unlocked and the closet contained 3 containers of Quat.</p> <p>On 8-18-2014 from 9 A.M. to 9:45 A.M., an initial tour of the second floor was conducted with the following observed:</p> <p>The second floor Biohazard room door was propped open with a large gray trash can. The sign on the Biohazard room door indicated, "Keep door locked."</p> <p>The second floor Clean Utility Room was observed to have a key in the lock of the door knob. One unlocked cabinet contained personal care items used for resident care included: Derma Vera Skin Cleanser, Get Fresh Lotion, Spa Deodorant, Aero Disinfectant, Microkill and PDI Saniclothes.</p> <p>The second floor unlocked Women's shower room was observed to have 3 bottles of Derma Vera Skin Cleanser, 4 bottles of Get Fresh Lotion and 4 Med Spa Deodorant in an unlocked cabinet over the toilet, some of which were partially used.</p> <p>The second floor unlocked Men's shower room was observed to have 2 bottles of Derma Vera Skin Cleanser and a bottle of Peri Fresh Perineal Cleaner sitting on the</p> |               |   |                      |

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|                    | <p>grab bar in the shower. Also observed in an unlocked cabinet located over the toilet, 2 bottles of Periwash, an Arrid XX Dry Deodorant, a bottle of Get Fresh Lotion, 2 bottles of Fresh Scent Shaving Cream and a bottle of Pert Plus Shampoo.</p> <p>On 8-18-2014 at 9:50 A.M., an interview with the Maintenance Director indicated, "...I unlock any locked doors when I get here, for easier access...."</p> <p>On 8-19-2014 at 1:44 P.M., an observation of the unlocked second floor Men's shower room was observed to have 2 bottles of Derma Vera Skin Cleanser and a bottle of Peri Fresh Perineal Cleaner sitting on the grab bar in the shower. Also observed in an unlocked cabinet located over the toilet, 2 bottles of Periwash, an Arrid XX Dry Anti-persperant, a bottle of Get Fresh Lotion, 2 bottles of Fresh Scent Shaving Cream and a bottle of Pert Plus Shampoo.</p> <p>On 8-23-2014 at 12:59 P.M., the unlocked second floor Men's shower room was observed to have 2 bottles of Derma Vera Skin Cleanser and a bottle of Peri Fresh Perineal Cleaner sitting on the grab bar in the shower. Also observed in an unlocked cabinet located over the</p> |               |   |                      |

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|                    | <p>toilet, 2 bottles of Periwash, an Arrid XX Dry Anti-persperant, a bottle of Get Fresh Lotion, 2 bottles of Fresh Scent Shaving Cream and a bottle of Pert Plus Shampoo.</p> <p>On 8-24-2014 at 12:31 P.M., the unlocked first floor Men's shower room was observed to have 2 bottles of Fresh Scent Shaving Cream and a bottle of hand sanitizer in an unlocked cabinet located over the toilet.</p> <p>On 8-24-2014 at 12:41 P.M., the unlocked second floor Women's shower room was observed to have 3 bottles of Derma Vera Skin Cleanser, 4 bottles of Get Fresh Lotion and 4 bottles of Med Spa Anti-persperant in an unlocked cabinet located over the toilet. Also observed was a Dry Idea Anti-persperant on the sink.</p> <p>On 8-24-2014 at 12:43 P.M., the unlocked second floor Men's shower room was observed to have 2 bottles of Derma Vera Skin Cleanser and a bottle of Peri Fresh Perineal Cleaner sitting on the grab bar in the shower. Also observed, 2 bottles of Peri Wash, 1 Arrid XX Dry Deodorant, 1 bottle of Get Fresh Lotion, 2 bottles of Fresh Scent Shaving Cream and 1 Pert Plus Shampoo in an unlocked cabinet located over the toilet.</p> |               |   |                      |

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|                    | <p>On 8-25-2014 at 6:37 A.M., the unlocked first floor Men's shower room was observed to have 2 bottles of Fresh Scent Shaving Cream and a bottle of hand sanitizer in an unlocked cabinet located over the toilet.</p> <p>On 8-26-2014 at 8:46 A.M., the unlocked first floor Men's shower room was observed to have 2 bottles of Fresh Scent Shaving Cream and a bottle of hand sanitizer in an unlocked cabinet located over the toilet.</p> <p>On 8-26-2014 at 8:50 A.M., an interview, in the first floor Women's shower room, with the ADON (Assistant Director of Nursing) indicated, "...these [resident care items] should not be left in here...the cabinets should be locked...."</p> <p>On 8-26-2014 at 9:30 A.M., an interview with the ADON indicated, "...we have no policy related to resident care items left out in common areas...."</p> <p>On 8-26-2014 at 11:12 A.M., record review of the Housekeeping Services Policy, received from the Maintenance Director on 8-26-2014 at 10:45 A.M. as the current policy, indicated<br/>"...Standards:...7. Cleaning supplies and equipment shall be stored in a safe and</p> |               |   |                      |

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| F000328<br>SS=D                                      | <p>secure manner. Hazardous cleaning solutions, compounds and substances shall be labeled, stored in a safe place, and kept in an enclosed or locked section separate from other materials...."</p> <p>On 8-26-2014 at 2:37 P.M., record review of the Spray Bottle Use/Labeling Policy, received at this time from the DON as the current policy, indicated, "...Purpose: To provide identification of chemicals placed in spray bottles...Policy: It is the policy of this facility that all containers will be labeled with contents...Standards: 1. In the event chemical agents are missed by the housekeeping personnel, the container will be labeled and dated on the date of preparation. 2. The label shall contain at a minimum the name of the chemical agent, the mix ratio and any precautions...5. Hazardous chemicals shall be maintained in a locked area, such as a Janitor's Closet...."</p> <p>3.1-45(a)(1)</p> <p>483.25(k)<br/>TREATMENT/CARE FOR SPECIAL NEEDS<br/>The facility must ensure that residents receive proper treatment and care for the following special services:<br/>Injections;<br/>Parenteral and enteral fluids;<br/>Colostomy, ureterostomy, or ileostomy care;<br/>Tracheostomy care;</p> |   |   |                      |   |

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|  | <p>Tracheal suctioning;<br/>Respiratory care;<br/>Foot care; and<br/>Prostheses.</p> <p>Based on record review and interview, the facility failed to follow the plan of care related to changing of nebulizer mask and tubing for one of one residents reviewed who required inhaled nebulizer treatments. (Resident #27)</p> <p>Finding includes:</p> <p>On 8-22-14 at 11:00 A.M., the clinical record for Resident #27 was reviewed. Resident #27 was admitted to the facility on 1-21-12. Diagnoses included but were not limited to: COPD (chronic obstructive pulmonary disease), dementia, coronary artery disease and congestive heart failure.</p> <p>On 8-25-14 at 1:00 P.M., Resident #27's room was observed to have a nebulizer machine sitting on the bedside table. The nebulizer inhalation mask was resting upright on the bedside table. The nebulizer tubing was dated 7-29-14.</p> <p>On 8-25-14 at 2:53 P.M., an interview was conducted with LPN #16. LPN #16 indicated the mask should be stored in a bag and the tubing should be changed weekly.</p> | F000328   | <p>1. The facility shall ensure residents receive proper care and treatment. No other residents were affected by this incident. The staff responsible for changing the tubing was given disciplinary action and any disciplinary actions will be provided for any known variances moving forward. 2. All nursing staff were re-educated on care of residents with special services on 9/15/14. 3. Policy regarding respiratory equipment stargaze will be re-evaluated for appropriateness and staff were trained of changes by 9-15-14. Re-education of nursing and staff of residents with special services: injections, parenteral and enteral nutrition, colostomy / urostomy / ileostomy care, respiratory care, foot care was conducted by 9/15/14 and will be monthly thereafter x 12 months. The DON or designee will monitor respiratory equipment daily x 3 months, weekly x 3 months, every other week x 3 month, monthly x 3 months for appropriate storage. 4. All nursing and general staff will be re-educated of residents with special services: injections, parenteral and enteral nutrition, colostomy / urostomy / ileostomy care, respiratory care, foot care by 9/15/14 and monthly thereafter x 12 months. The DON or</p> | 09/19/2014   |  |   |  |

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| F000356<br>SS=C                                      | <p>On 8-25-14 at 2:55 P.M., the MAR (Medication Administration Record) for Resident #27 was reviewed. The MAR indicated "...Change Neb [nebulizer] Mask &amp; Tubing Weekly on Tues. [Tuesday]...." Dates the nebulizer mask and tubing was to be changed were outlined as 8-5-14, 8-12-14, and 8-19-14. The MAR indicated no documentation of the mask and tubing being changed.</p> <p>On 8-26-14 at 8:30 A.M., review of the current policy "Licensed Nurse or Respiratory Therapist Procedure", received by the ADON (Assistant Director of Nursing) at this time, did not indicate how the mask was to be stored or how often the tubing should be changed.</p> <p>On 8-26-14 at 2:00 P.M., an interview was conducted with the DON (Director of Nursing). The DON indicated nebulizer inhalation masks and tubing should be changed weekly.</p> <p>3.1-47(a)(6)</p> <p>483.30(e)<br/>POSTED NURSE STAFFING INFORMATION<br/>The facility must post the following information on a daily basis:<br/>o Facility name.</p> |   | designee will monitor respiratory equipment daily x 3 months, weekly x 3 months, every other week x 3 month, monthly x 3 months for appropriate storage and labeling. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. QA monitoring will continue monthly until [3] consecutive months of full compliance are obtained. |  |  |   |  |

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|  | <p>o The current date.</p> <p>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to post the facility name, potential number and actual hours worked by licensed and unlicensed staff, resident census for 1 or 9 days (August 18,2014) or maintain records for 18 months.</p> <p>Findings include:</p> <p>On 8/18/14 at 9:00 A.M., an observation</p> | F000356   | <p>1. The facility shall maintain a daily posting of all direct nursing scheduled hours each day. The posting shall include: the facility name, the current date and the total number hours per shift of RN, LPN and CNA. 2. The DON or designee shall post the daily schedule. The charge nurse shall update the posting if different than scheduled at the beginning of each shift. 3. The DON shall ensure the nursing schedule is</p> | 09/19/2014   |  |   |  |

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|  | <p>of staffing hours was noted on the wall in the 1st floor hallway. The posting had hours written on it for all departments of the facility but did not contain a date or how many hours were worked by the nursing department.</p> <p>On 8/18/14 at 9:02 A.m., an interview was conducted with the Director of Nurses. The Director of Nurses indicated the nursing department staffing was posted on the nursing units on a dry erase board.</p> <p>On 8/18/14 at 11:35 A.M., an observation was made of a dry erase board on the 2nd floor. The dry erase board did not contain any nursing staffing information.</p> <p>On 8/18/14 at 2:30 P.M., an observation was made of a dry erase board on the 1st floor that contained staffing information for LPN's and CNA's. The dry erase board did not contain the facility name, total number and actual hours worked by licensed and unlicensed staff per shift or resident census.</p> <p>On 8/22/14 at 2:40 P.M., a second interview was conducted with the Director of Nurses. The Director of Nurses indicated the receptionist puts out a report regarding staffing hours budgeted and overtime but it is not</p> |   | <p>maintained for at least 18 months and is available to the public. 4. The Administrator shall monitor daily for 30 days or until compliance is established. Compliance will be reviewed monthly by the Quality Assurance Committee. QA monitoring will continue monthly until there have been [3] consecutive months of full compliance.</p> |  |  |   |  |

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| F000364<br>SS=D    | <p>posted. She further indicated she has never posted nurse staffing hours and she does not have copies of 18 months worth of staffing reports.</p> <p>483.35(d)(1)-(2)<br/>NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br/>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. Based on observation, interview and record review, the facility failed to ensure food that was prepared conserved the nutritive value related to pureed food preparation related to 3 of 3 meals prepared.</p> <p>Finding includes:</p> <p>On 8/20/14 at 10:45 A.M., during puree meal preparation the following was observed: Employee #21 added chunks of 3 chicken breasts into puree machine, mixed it then added 3 ladles of gravy on top of the chicken, mixed it again then while mixing the chicken added 1 additional ladle of gravy, then using a spatula scrapped it out of container, dividing it between three plates.</p> | F000364       | <p>1. The facility shall ensure food is prepared following the recipe. No residents were affected by this incident. 2. The DSM provided in-service training to all dietary staff on 9/5/14 requiring that recipes be followed for pureed diets. The DSM will monitor to ensure recipes are followed at least two meals daily. 3. Monitoring shall continue daily x 2 meals for 30 days, daily for 30 days and 2 x weekly for 4 months. 4. The DSM shall monitor. Audits shall be reviewed monthly by the Quality Assurance Committee for 6 months. QA committee will continue to monitor monthly until there have been [3] consecutive months of full compliance.</p> | 09/19/2014           |

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| F000371<br>SS=F                                      | <p>Employee # 21 indicated at this time "... Yes we have a recipe book... I have been here for 7 years I don't need recipes anymore... I just scoop out portions and put on plate, I don't measure them...."</p> <p>An interview with CDM (Certified Dietary Manager), on 8/25/14 at 1:15 P.M., indicated "...honey mustard chicken and baked chicken were on the menu for Wednesday 8/20/14...cooks are expected to follow the puree recipes...."</p> <p>On 8/25/14 at 1:20 P.M., the CDM provided the current recipe for pureed chicken that indicated "... Serving size : #8 scoop of 4 oz... Ingredients: prepared chicken [off bone] 2 cups, Bread, slice 3-4, chicken broth 1/2-3/4 cup...."</p> <p>On 8/25/14 at 1:30 P.M., review of the current undated policy, provided by the CDM on 8/20/14 at 11:00 A.M., titled "Puree Food," indicated "... 2. Follow Puree recipes...."</p> <p>3.1-21(a)(1)</p> |   |   |                      |   |
|  | 483.35(i)<br>FOOD PROCURE,<br>STORE/PREPARE/SERVE - SANITARY  |   |   |                      |   |

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|  | <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(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 storage, preparation and distribution of food under sanitary conditions in the kitchen in 1 of 1 kitchens. This had the potential to affect 52 of 52 residents.</p> <p>Findings include:</p> <p>1. On 8/18/14 between 7:50 A.M. and 8:45 A.M., during initial kitchen tour, the following was observed:</p> <p>In front refrigerator: 1 open and undated box containing 5 heads of lettuce.</p> <p>In the main cooler: 1 open and undated 5 pound container of scrambled egg blend, 1 open and undated bottle of caramel dessert sauce, 1 open and undated jar of brown mustard, 1 open and undated container of beef base, 1 open and undated container of chicken base, 1 gallon of open and undated thousand island dressing, 2-open and undated half gallon bottles of "True Moo" chocolate milk, 1 open and undated quart of soy milk, 2 &amp; 1/2 pounds of pasteurized</p> | F000371   | <p>1. The facility shall ensure meals are prepared under sanitary conditions. No residents were identified as affected by this incident. 2. The DSM provided an all dietary staff in-service on 9/5/14. The in-service covered: covering, dating and labeling opened food, storing bowls and pitchers upside down, hairnets with all hair covered, completing temperature logs, non-dietary staff in the kitchen food preparation area and proper hand washing. 3. On 9/5/14 the DON provided hand washing with return demonstration. Prohibiting personal cell phone use policy was implemented by the Administrator. CNA # 13 was disciplined. 4. The DSM will monitor compliance daily x 2 meals for 30 days, daily for 30 days and 2 x weekly for 4 months. Audits shall be reviewed monthly by the Quality Assurance Committee for 6 months. QA monitoring will continue monthly until there have been [3] consecutive months of full compliance.</p> | 09/19/2014           |   |

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|                    | <p>American cheese open to air and undated, 15 slices of open and undated Swiss cheese, 1 open and undated bag of Parmesan cheese, 1 open and undated bag of sliced Italian ham, 1 open and undated bag of sliced ham, 1 open and undated bag of hard salami, 1 open bag of diced ham dated 8/9/14, a plastic container containing sausage gravy dated 6/12/14. An interview at this time with the CDM (Certified Dietary Manager) indicated that "...food should only be kept in the cooler for 3 days after use... all food that is opened should have a date on it...."</p> <p>In the freezer: 1 open undated bag of diced pork.</p> <p>In the milk cooler: 1 gallon of fat free milk open and undated, 1 gallon of 2% milk open and undated, 1 open and undated container of thickened cranberry juice. The CDM indicated at this time that " ...we don't date the milk when we open it...."</p> <p>On the shelf below the coffee cup cupboard, 16 dessert bowls were observed stored upright, 25 plate covers, 23 plates, and 28 bowls were observed stored upright in the china cupboard, 50 bread plates were observed stored upright in the coffee cup cupboard. An interview</p> |               |   |                      |

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|                    | <p>with the CDM at this time indicated "... did not know how plates, bowls and plate covers should be stored....."</p> <p>On the clean pan storage rack a clear plastic pitcher was observed upright and a stock pot was observed on its side.</p> <p>On the prep table next to the stove a open undated half bag of noodles was observed . The CDM indicted at this time "... yes it should have a date...."</p> <p>On the prep table 1 container of chocolate frosting was observed uncovered and undated on bottom shelf of prep table and 1 container of vanilla frosting was observed opened and undated. The CDM indicated at this time "...yes these should be covered and dated...."</p> <p>The shelf under the prep table had the following containers of spices opened and undated: pepper, Italian seasoning, nutmeg, basil, and Tuscan rub.</p> <p>The Maintenance supervisor was observed in the kitchen next to the dishwasher, while breakfast was being served, without a hairnet.</p> <p>The ADON (Assistant Director of Nursing) was observed walking in</p> |               |   |                      |

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|                    | <p>kitchen with no hairnet on pickup a pot of coffee and returned to dining room. The CDM indicated at this time " the ADON and the Maintenance Supervisor do not need hairnets on because they are not near the food. We don't use the lines on the floor for hairnet rules...."</p> <p>Employee #21 was observed with her bangs hanging out of hairnet. An interview with the CDM at this time indicate that "...all hair should be covered when cooking.... "</p> <p>In the bakery freezer #3 four loaves of sliced sandwich bread was observed to have a date of April 2014. The CDM indicated at this time "... we keep it until we use it or until it dries out...."</p> <p>The temperature logs on the bakery freezer was observed to have missing temperatures for the P.M. on August 8th, 9th, 10th, 13th, 14th, 15th, 16th, 17th, 2014 and A.M. on August 12th, 16th, and 17th, 2014.</p> <p>The temperature log on the downstairs meat freezer was observed to have missing temperatures for PM on August 13th and AM on August 16th and 17th, 2014. The CDM indicated at this time that "...the day shift and the evening shift cooks are responsible for logging the</p> |               |   |                      |

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|                    | <p>bakery and meat freezer temps and yes, they should be completed twice daily...."</p> <p>On 8/18/14 at 11:55 A.M., the CDM provided the current, undated polices "... Food Storage and Frozen, Refrigerated Food Storage, and Personal Hygiene" that indicated "...4. Foods will be kept in clean, undamaged wrappers or packages... 11. Cover, Label and date all leftovers... 14. Do not keep potentially hazardous foods in the refrigerator for longer than 3 days... 1. Label and date all leftovers and refrigerate or freeze immediately... 3. Food may be stored in the refrigerator for 3 days... 4. Food may be stored in the freezer for a maximum of 3 months... 5. Food that is not used in the designated amount of time... shall be discarded... 7. Hairnets or bonnets must be worn at all times in the kitchen. The hairnet/bonnet must completely cover the hair...."</p> <p>On 8/19/14 at 3:00 P.M., review of the current, undated policy "Personal Hygiene and the Sanitation Orientation" provided by the CDM indicated "... 7. Hairnets or bonnets must be worn at all times in the kitchen. The hairnet/bonnet must completely cover the hair.... 1. Hair covers, covering all hair, must be worn at all times by all employees while preparing or serving food or drinks...."</p> |               |   |                      |

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|                    | <p>On 8/20/14 at 10:45 A.M., Employee #21 was observed to wash her hands for 10 seconds, dry her hands then open trash can with her bare hand, throw paper towel away then fill 3 plates with pureed food. At this time Employee #21 was also observed wearing her hairnet back off her right ear leaving hair above right ear uncovered and loose.</p> <p>On 8/20/14 at 10:45 A.M., observed open undated jar of peanut butter on prep table next to stove.</p> <p>On 8 /25/14 at 12:40 P.M., the CDM and Maintenance Supervisor were observed in kitchen without hairnets on.</p> <p>On 8/25/14 at 3:38 P.M., Employee # 23 was observed exiting the kitchen through a door that said "dietary employees only" with her son and his girlfriend. Employee #23 was the only one wearing a hairnet. Employee #23 further indicated that her son nor his girlfriend work here.</p> <p>An interview with the CDM on 8/26/14 at 10:02 A.M., indicated that "... hands should be washed before and after using gloves. Sanitize after every 3 plates served, wash after 6 plates served. Hands should be washed for 30 seconds or to</p> |               |   |                      |

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|                    | <p>sing happy birthday twice. Hairnets should be worn when preparing and handing food. Hairnets should cover all hair when worn. Dietary employees only should be in the kitchen and should have a hairnets on...."</p> <p>On 8/26/14 at 11:30 A.M., the CDM provided the current undated policy " Dietary Management" that indicated "...10. Employees assigned to other duties in the facility shall not be allowed in the food preparation area during normal operating hours...."</p> <p>On 8/26/14 at 8:30 A.M., review of the current undated policy "Hand washing" provided by the ADON indicated " 1. Hand washing will be practiced as follows: ... I. Before handling food or food trays and after feeding a resident..."</p> <p>On 8/26/14 at 2:37 P.M., the DON (Director of Nursing) provided the current, undated policy " Traffic of Non Dietary Personnel" that indicated "... 2. Maintenance employees are to be away from food serving and preparation and are to work, if possible, when food is not being prepared or served...."</p> <p>2. On 8-26-2014 at 10:00 A.M., an observation of CNA #13 in the second</p> |               |   |                      |

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| F000431  | <p>floor dining room on her cell phone. CNA #13 then placed her cell phone into her pocket and picked up a danish, with her bare hand, and handed it to a resident. CNA #13 then picked up a cloth napkin and wiped her hands on it before handing the napkin to the resident. Interview at this time with ADON (Assistant Director of Nursing) indicated, "...they (staff) are not to be on their cell phones while working and that is why...she should have washed her hands and she should not touch resident food with bare hands...."</p> <p>On 8-26-2014 at 10:15 A.M., the Hand Washing Policy was reviewed, received from the ADON on 8-26-2014 at 8:30 A.M., indicated "Policy: All facility staff will practice hand washing activities with an antimicrobial agent...Standards: 1. Hand washing will be practiced as follows:...i. Before handling food...."</p> <p>On 8-26-2014 at 2:37 P.M., review of the Glove Use-Dietary policy, received from the DON (Director of Nursing) at this time, indicated "...Standards...Disposable...2. Gloves may be worn at other times, during food preparation and serving...."</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e)</p> |   |   |  |  |   |  |

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| SS=F   | <p><b>DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>A. Based on record review and interview, the facility failed to ensure the narcotic reconciliation record was maintained according to their policy for 2 of 2 medication carts and 2 of 2 nursing unit</p> | F000431   | 1. The facility shall ensure that drug records are complete and accurate. Due to the time frames of this incident the documentation cannot be amended. However, effective immediately all | 09/19/2014   |  |   |  |

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|  | <p>medication refrigerators. (1st floor and 2nd floor)</p> <p>B. Based on observation and interview, the facility failed to ensure that treatment carts were locked when unattended for 2 of 2 treatment carts. (1st and 2nd Floor Treatment Carts)</p> <p>Findings include:</p> <p>A.1. On 8-26-14 at 9:15 A.M., review of the narcotic reconciliation record for the 1st and 2nd floor medication carts, and the 1st and 2nd floor medication refrigerators indicated the "Nurse Signature" space was blank for multiple dates and times.</p> <p>The 1st floor medication refrigerator narcotic reconciliation record was reviewed from 7-25-14 to 8-26-14 and indicated 43 missing signatures of a possible 195 signatures.</p> <p>The 2nd floor medication refrigerator narcotic reconciliation record was reviewed from 7-21-14 to 8-23-14 and indicated 56 missing signatures of a possible 199 signatures.</p> <p>The 1st floor medication cart narcotic reconciliation record was reviewed from 7-1-14 to 8-26-14 and indicated 35</p> |   | <p>oncoming staff will be required to check for missing documentation missed by the off-going shift. Corrective action will follow any variances. All nursing staff was trained on appropriate documentation on 9/15/14. Keyless locks were installed to all utility room doors by 9/15/14 2. Effective immediately, all oncoming staff much check for missing documentation by the off-going shift. Corrective action will follow any variances. DON or designee will monitor narcotic reconciliation records for holes daily x 3 months, weekly x 3 months, bi-weekly x 3 months, and monthly x 3. All nursing staff was re-trained on appropriate documentation on 9/15/14. Appropriate documentation will be covered in nursing staff monthly meetings x 12 months. Maintenance or designee will monitor all doors ensuring that they are secured each shift x 3 months, twice daily x 3 months, and daily x 3 months. Maintenance or designee will monitor soiled utility rooms, biohazard boxes, sharps containers for potential replacement issues daily x 3 months, weekly x 3 months, every other week x 6 months. DON or designee will randomly monitor for medication and treatment carts being secured three times daily x 3 months, twice daily x 3 months, daily x 3 months and daily thereafter until 100%</p> |  |  |   |  |

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|  | <p>missing signatures of a possible 336 signatures.</p> <p>The 2nd floor medication cart narcotic reconciliation record was reviewed from 7-21-14 to 8-23-14 and indicated 12 missing signatures of a possible 200 signatures.</p> <p>On 8-23-14 at 12:55 P.M., an interview with the DON (Director of Nursing) was conducted. The DON indicated the narcotic count was completed every shift and the narcotic reconciliation record should be completely filled in.</p> <p>On 8-23-14 at 1:20 P.M., review of the "Controlled Substance Policy", received from the ADON (Assistant Director of Nursing) at this time, indicated "...9. Change of shift counts (audits) will be conducted by authorized nursing personnel to reconcile drug availability...."</p> <p>B.1. On 8-18-2014 at 8:05 A.M., the first floor treatment cart was observed, in the first floor unlocked Biohazard room, unlocked and unattended.</p> <p>On 8-23-2014 at 12:47 P.M., a treatment cart was observed in the second floor nurses station, unlocked and unattended. Interview at this time with LPN #20</p> |   | <p>compliance has been reached x 7 days. Staff was trained on proper storage of personal hygiene items, cleaning supplies, handling of biohazard waste and sharps boxes, locking doors and medication/treatment carts by 9/15/14 and monthly thereafter x 12 months. 3. DON or designee will monitor narcotic reconciliation records for holes daily x 3 months, weekly x 3 months, biweekly x 3 months, and monthly x 3. All nursing staff was re-trained on appropriate documentation on 9/15/14. Appropriate documentation will be covered in nursing staff monthly meetings x 12 months. Maintenance or designee will monitor all doors ensuring that they are secured each shift x 3 months, twice daily x 3 months, and daily x 3 months. Maintenance or designee will monitor soiled utility rooms, biohazard boxes, and sharps containers for potential replacement daily x 3 months, weekly x 3 months, and every other week x 6 months. DON or designee will randomly monitor for medication and treatment carts being secured three times daily x 3 months, twice daily x 3 months, daily x 3 months and daily thereafter until 100% compliance has been reached x 7 days. Staff was trained on proper storage of personal hygiene items, cleaning supplies, handling of biohazard waste and sharps</p> |  |  |   |  |

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|                    | <p>(Licensed Practical Nurse) indicated "...that is supposed to be locked, I haven't used it yet today...my shift started at 6:30 A.M...."</p> <p>During an interview, on 8-23-2014 at 12:55 P.M., the DON (Director of Nursing) indicated, "Yes, that should be locked."</p> <p>On 8-25-2014 at 6:23 A.M., a treatment cart in the second floor nurses station was observed, unlocked and unattended. Interview at this time with LPN #22 indicated, "...it [the treatment cart] is supposed to be locked...there are medications in there...."</p> <p>3.1-25(e)(3)<br/>3.1-25(m)</p> |               | <p>boxes, locking doors and medication/treatment carts by 9/15/14 and monthly thereafter x 12 months. 4. DON or designee will monitor narcotic reconciliation records for holes daily x 3 months, weekly x 3 months, biweekly x 3 months, and monthly x 3. All nursing staff was re-trained on appropriate documentation on 9/15/14. Appropriate documentation will be covered in nursing staff monthly meetings x 12 months. Maintenance or designee will monitor all doors ensuring that they are secured each shift x 3 months, twice daily x 3 months, and daily x 3 months. Maintenance or designee will monitor soiled utility rooms, biohazard boxes, and sharps containers for potential replacement daily x 3 months, weekly x 3 months, and every other week x 6 months. DON or designee will randomly monitor for medication and treatment carts being secured three times daily x 3 months, twice daily x 3 months, daily x 3 months and daily thereafter until 100% compliance has been reached x 7 days. Staff was trained on proper storage of personal hygiene items, cleaning supplies, handling of biohazard waste and sharps boxes, locking doors and medication/treatment carts by 9/15/14 and monthly thereafter x 12 months. Audits will be reviewed by the Quality</p> |                      |

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| F000441<br>SS=F    | <p>483.65<br/>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(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.<br/>(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> |               | Assurance Committee monthly for 6 months. The QA Committee will continue monitoring monthly until there are [3] consecutive months of full compliance. |                      |

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|  | <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure linens were transported, stored, and distributed in a sanitary manner. This deficient practice had the potential to affect 52 of 52 residents who reside in the facility.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure a sanitary environment and to help prevent the development and transmission of disease and infection in relation to peri care in 1 of 1 residents observed for peri care. (Resident #43)</p> <p>Findings include:</p> <p>A.1. On 8/18/14 at 7:58 A.M., during an initial tour of the facility, a metal linen cart, containing bed linen was observed. The bed linen was partially covered with a sheet.</p> <p>On 8/18/14 at 12:47 P.M., Employee #12 was observed on the 2nd floor distributing clean laundry to resident's rooms. The laundry was hanging on a large rolling cart that was partially covered with a sheet.</p> | F000441   | <p>1. The facility shall ensure the infection control program provides a safe, sanitary and comfortable environment. No residents were negatively affected by this incident. On 9/16/14, the Housekeeping/Laundry Supervisor completed a departmental in-service which included infection control, hand washing and linen handling. On 9/15/14 a Peri-care policy was developed and training was provided to all staff. On 9/15/14 an all staff in-service was conducted by the DON reviewing infection control, peri-care, hand washing. The hand washing training required passing a return demonstration. 2. The Housekeeping/Laundry Supervisor will monitor her laundry staff completing laundry handling 2 x daily [am/pm shifts] for 30 days, and daily [alternating am/pm] for 30 days. The ADON or designee will monitor peri-care randomly daily x 30 days, 2 x per week for 3 months and then weekly for 3 months. 3. Corrective action will follow any examples of non-compliance related to infection control procedures. 4. Audits will be reviewed in the Quarterly Quality Assurance Committee meeting for 6 months. The QA monitoring</p> | 09/19/2014           |   |

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|  | <p>On 8/19/14 at 12:16 P.M., Employee #12 was observed on the 1st floor distributing clean laundry to resident's rooms. The laundry was hanging on a large rolling cart that was partially covered with a sheet.</p> <p>On 8/19/14 at 12:17 P.M., Employee #12 was observed transporting laundry to a resident's room by holding the clean laundry up against her body.</p> <p>On 8/19/14 at 12:18 P.M., an interview was conducted with Employee #12. Employee #12 indicated she held the clothing up to her body but she was not supposed to.</p> <p>On 8/26/14 at 9:15 A.M., an interview with Employee # 15 indicated the clean laundry should be transported completely covered and should not be carried up against the body.</p> <p>On 8/26/14 at 2:37 P.M., a current policy, provided by the Director of Nurses was reviewed. The policy indicated the following: "...19. Clean linen and personal laundry items are transported to the resident's room or appropriate location on covered carts...."</p> <p>B.1. On 8/26/14 at 8:50 A.M., during an observation of the DON (Director of</p> |   | wil continue until there have been 3 consecutive of full compliance.  |                      |   |

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|                    | <p>Nursing) providing peri care to Resident #43 who was wet with urine, the following was observed: RN #7 rolled resident onto her left side, using a towel wet with soap and water, washed buttocks of Resident #43, she then, using the same towel washed over the coccyx area which had a open, uncovered, stage 2 pressure ulcer. She then used the same towel to dry Resident #43 buttocks and coccyx area. She then rolled up wet Chux's (absorbent pad), replaced them with 3 dry Chux's, rolled Resident #43 onto her right side removed the wet Chux and the Duoderm (wound dressing) from her left hip and then rolled Resident #43 onto her back and covered her up with sheet and blanket without providing care to her front peri area.</p> <p>An interview with CNA #19 and LPN #18 on 8/26/14 at 10:00 A.M., indicated " when doing peri care use one cloth washing the tops of legs, then wash buttocks, using a new clean cloth wash the front peri area... do not wash a open wound with a cloth you used to do peri care with..."</p> <p>On 8/26/14 at 2:37 P.M., a policy for " Peri Care" was requested from the ADON (Assistant Director of Nursing) and no copy was received.</p> |               |   |                      |

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| F000465<br>SS=D                                      | <p>3.1-18(b)(5)<br/>3.1-19(g)</p> <p>483.70(h)<br/>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br/>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a sanitary and comfortable environment was maintained related to loose and frayed carpeting on 2 of 2 floors.</p> <p>Finding includes:</p> <p>On 8/18/14 at 7:45 A.M., an observation of the carpeting in hallway on the first floor, near the entryway, indicated 4 areas of unraveling, frayed seams and one area of carpeting, in front of the Administrators office that was loose from the floor. Observation of the second floor hallway carpeting indicated 3 areas of unraveling, frayed seams.</p> <p>A daily observation from 8/19/14 to</p> | F000465   | <p>1. The facility shall ensure the residents, staff and public are provided a safe environment. No residents were adversely affected by this condition. 2. The carpeting areas where it is loose, frayed or unraveling will be repaired or replaced. A flooring consultant will be contacted by 9/19/14 to arrange for the repair and/or replacement of flooring issues. Services will be arranged as soon as possible. The repairs/replacement will be completed or scheduled by 9/25/14, the Administrator responsible. 3. The Maintenance Director will make daily rounds to ensure any flooring needs are noted and corrective steps taken. This will continue for 6 months. 4. Audits will be reviewed monthly by the Quality Assurance Committee for six months. QA monitoring will continue monthly until there are [3] consecutive</p> | 09/19/2014           |   |

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| F000502<br>SS=D                                      | <p>8/25/14, of the first floor and second floor carpeting indicated, carpeting in the hallway on the first floor, near the entryway, indicated 4 areas of unraveling, frayed seams and one area of carpeting, in front of the Administrators office that was loose from the floor. Observation of the second floor hallway carpeting indicated 3 areas of unraveling, frayed seams.</p> <p>An interview with with the Maintenance Supervisor, during the environmental tour, on 8/26/14 at 11:23 A.M. indicated that 'there is a proposal to the owner to replace the carpeting ... we glue the edges down.. yes that is a fall hazard...."</p> <p>3.1-19(f)</p> <p>483.75(j)(1)<br/>ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure a urinalysis with culture and sensitivity was obtained for a resident who had a change in condition. (Resident #24).</p> <p>Finding includes:</p> | F000502   | <p>months of full compliance.</p> <p>1. The facility shall ensure laboratory services are provided to meet the needs of the resident. The doctor saw res #24 on 8/20/14 and ordered an antibiotic. On 8/26/14 the doctor again follow-up and did not order a UA because res # 24 had already been started on an antibiotic. No other residents were affected. 2. ADON will</p> | 09/19/2014   |  |   |  |

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|                    | <p>The clinical record for Resident # 24 was reviewed on 8/19/14 at 1:12 P.M.</p> <p>Resident #24 was admitted to facility on 10/23/14. Diagnoses included but were not limited to the following: COPD [chronic obstructive pulmonary disease], neuropathy, acid reflux, HTN [hypertension], anemia and hypothyroidism.</p> <p>On 8/25/14 at 10:20 A.M., a nurses note dated 8/19/14 at 2:30 P.M., was reviewed. The nurses note indicated "... MD [medical doctor] ordered UA C&amp;S [urinalysis, with culture and sensitivity, d/t [due to] confusion...."</p> <p>On 8/25/14 at 10:30 A.M., a notification sent to physician via fax was reviewed. The fax indicated the following: "... Resident acting a bit confused this shift see things that aren't there. Can we have order for UA C&amp;S.... Yes Please put her on my list to see tomorrow...."</p> <p>On 8/25/14 at 11: 08 A.M., an interview with LPN # 25 was conducted. LPN # 25 indicated the UA C&amp;S ordered for Resident #24 had not been completed yet. LPN # further indicated "... We place her on the bedpan and she poops in it and it [specimen] gets contaminated. If we can't obtain it [the urine specimen] we will notify the doctor and do a straight cath.[a</p> |               | <p>check all new orders daily and ensure that they are transcribed correctly, initiated, care planed, as well as updating CNA assignment sheets as needed starting 9/15/14. 3. All nursing staff was trained on following resident plan of care and facility protocols by 9/15/14, DON responsible. 4. Audits will be reviewed by the Quality Assurance Committee on a monthly basis for 6 months. QA monitoring will continue monthly until there is [3] consecutive months of full compliance.</p> |                      |

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|  | <p>method of obtaining a urine specimen].</p> <p>On 8/25/14 at 11:12 A.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated "... if the UA was done it would be checked as done on the Medication Administration Record. If the staff were unable to get it [Urinalysis] they could straight cath, it is our standing order...."</p> <p>On 8/25/14 at 11:30 A.M., the Medication Administration Record for Resident #24 was reviewed. The Medication Administration Record indicated the following: "... UA with C&amp;S if indicated...Hour: 6-2, 2-10, 10-6. 8/19/14...." 8/19/14, 8/20/14 and 8/21/14 no initials are noted on the Medication Administration Record to indicate the UA was done. 8/23/14, 8/24/14 and 8/25/14 no initials are noted on the Medication Administration Record.</p> <p>On 8/25/14 at 11:35 A.M., a review of the nurses notes, from 8/20/14 at 10:00 A.M. to 8/25/14 at 5:00 A.M., was conducted. The nurses notes lacked documentation to indicate the UA C&amp; S had been completed or that the physician had been notified that it was not completed.</p> <p>On 8/26/14 at 11:40 A.M., a current</p> |   |   |  |  |   |  |

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| F000514<br>SS=D    | <p>protocol, titled Urinalysis Protocol, provided by the Director of Nurses was reviewed. The Urinalysis Protocol indicated the following: "... Urinalysis with culture and sensitivity as indicated may straight cath if unable to obtain clean catch in 24 hours...if unable to straight cath per resident refusal MD to be notified. Follow up urinalysis 72 hours post antibiotic treatment for UTI..."</p> <p>3.1-49(a)</p> <p>483.75(l)(1)<br/>RES<br/>RECORDS-COMplete/ACCURATE/ACCESSIBLE<br/>The facility must maintain clinical records on each resident in accordance with accepted 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 observation, record review and interview, the facility failed to ensure the</p> | F000514       | 1. The facility shall ensure the clinical record is complete and accurate. There were no known negative affects to resident #43. | 09/19/2014           |

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|  | <p>nutritional intake was documented for 1 of 17 residents reviewed for care plans. (Resident #43)</p> <p>Finding includes:</p> <p>On 8/24/14 at 12:15 P.M., review of the Meal and Hydration Consumption log and the Supplement/ HS Snack Consumption log for Resident #43 indicated missing documentation for meal and fluid intake on multiple shifts for multiple days. The Meal and Hydration Consumption log was missing 98 entries of a possible 294 entries. The Supplement/HS Snack Consumption logs were missing 8 entries of a possible 48 entries.</p> <p>An interview with CDM (Certified Dietary Manager), on 8/25/14 at 12:45 P.M., indicated that "meal and hydration logs along with supplement / HS snack consumption logs should be completed each shift, with out these being completed I am unable to determine residents intake and be able to make recommendations related to supplement or protein protein needs without them being filled in. The staff has been told to make sure they are filling in the consumption logs...."</p> <p>On 8/26/14 at 8:30 A.M., the ADON</p> |   | <p>Nursing staff was trained on appropriate documentation by 9/15/14. Appropriate documentation will be covered in each nursing staff monthly meetings x 12 months. 2. There were no residents affected by this incident. 3. DON or designee will monitor CNA documentation records for holes daily x 3 months, 2 x weekly x 3 months, weekly x 3 months, and monthly x 3. DON to follow-up with corrective action if information is not documented properly. 4. Audits will be reviewed by the Quality Assurance Committee for 6 months. QA monitoring will continue monthly until there is [3] consecutive months of full compliance.</p> |  |  |   |  |

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| F009999            | <p>(Assistant Director of Nursing) provided the the current, undated policy " Nutritional Monitoring and Resident Care Plan" which indicated "... 3... Monitor each meal to assess the nutrition and hydration consumption.... Record the food intake as follows on the Nutritional Monitoring Worksheets... 20... the resident care plan is available for use by all individuals caring for the resident...."</p> <p>3.1-50(a)(1)</p> <p>3.1.51 DISASTER AND EMERGENCY PREPAREDNESS</p> <p>(c) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions except that the movement of infirm or bedridden residents to safe areas or to the exterior of the building is not required. Drills shall be conducted at least four (4) times a year at regular intervals throughout the year, on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least</p> | F009999       | <p>1. The facility shall ensure monthly fire drills are conducted with each shift being completed at least quarterly. No residents were affected by this incident. Since April, 2014 the facility has completed the monthly drills. According to the previous Maintenance Supervisor, monthly drills had been conducted each month in 2013 and 2014; however, due to a change in the maintenance director position, the records could not be located. The fire alarm monitoring company evidenced this as their records did show monthly occurrences where the facility had informed them of a test. No residents were</p> | 09/19/2014           |

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|                    | <p>twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(d) At least annually , a facility shall attempt to hold a fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personal present.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to perform fire drills on all three shifts per quarter, perform annually a fire drill and disaster drill in conjunction with the local fire department. This has the potential to affect 52 out of 52 residents that reside in the facility.</p> <p>Finding includes:</p> <p>A record review of the facilities fire and disaster drill documentation indicated that no fire and disaster drill was conducted in conjunction with the local fire department. Record review further indicated that no fire drills were conducted for the 1st, 2nd, or 3rd shifts</p> |               | <p>affected. 2. On 9/23/14, the Fire Dept. is scheduled to participate with the facility for a Fire/ Disaster Drill. The Maintenance Supervisor shall continue completing monthly drills. 3. The Administrator will monitor monthly to ensure these drills are conducted. Drills will be monthly with one per shift each quarter. 4. Audits will be reviewed monthly by the Quality Assurance Committee for 6 months. The QA committee will continue to monitor monthly until there have been 3 consecutive months of full compliance</p> |                      |

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|  | <p>of the 3rd and 4th quarter of 2013.</p> <p>An interview with the Administrator on 8/19/14 at 12:20 P.M., indicated "... I only have fire drills for the months of February, April, May, June, and July 2014. I don't know what happened before that..."</p> <p>An interview with the Maintenance Supervisor on 8/14/14 at 1:50 P.M., indicated that "...fire drills are to be conducted quarterly on all shifts...I have not conducted a joint fire drill with the local fire department..."</p> <p>On 8/15/14 at 11:32 A.M., a review of the current , undated policy " Fire and Disaster Preparedness " provided by the Administrator indicated "... It is also the policy of this facility that the plan be practiced regularly... 7. The facility will conduct unannounced fire drills a minimum of one time per shift, four times a year, with at least twelve (12) drills held per year... 8... will maintain documentation including names, signatures, and location of all personnel present ... 9. At least annually the facility will conduct a fire drill in conjunction with the local fire department ... 14. In addition to fire drills, tornado drills will be conducted annually...."</p> |   |   |  |  |   |  |



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| R000148            | <p>A daily observation from 8/19/14 to 8/25/14 of the door for Room 212 indicated a 2 inch gap between the top of the door and the door frame when the door was closed.</p> <p>On 8/26/14 at 11:23 A.M., during the environmental tour the Maintenance Supervisor indicated that "... yes the door does not fit the frame and it is a fire hazard for the resident in that room...."</p> <p>410 IAC 16.2-5-1.5(e)(1-4)<br/>Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:<br/>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.<br/>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.<br/>(3) All plumbing shall function properly and comply with state plumbing codes.<br/>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview, the facility failed to maintain plumbing in working order for one of six shower rooms.</p> | R000148       | <p>1. The facility shall maintain a safe and sanitary environment. The toilet in the shower room across from room 205 was flushed and cleaned. 2. This</p> | 09/19/2014           |

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| R000414  | <p>Findings include:</p> <p>On 8-18-2014 at 9:37 A.M., an observation of the second floor shower room across from Room 205 was conducted. The toilet in the shower room clogged with fecal matter. A strong odor was noted in the room and outside the closed shower room door.</p> <p>Daily tours indicated the toilet in the same state of disrepair.</p> <p>On 8-26-2014 at 8:27 A.M., an observation of the second floor was conducted. A strong odor was noted in the hall way, 4 rooms away from the shower room, and became stronger outside the shower room with the strongest odor inside the shower room. The toilet was noted to still be clogged.</p> <p>On 8-26-2014 at 11:23 A.M., interview with Maintenance Director indicated, "...this shower room is no longer in use and the water is shut off...I need to turn the water on so the toilet can be flushed...."</p> <p>410 IAC 16.2-5-12(k)<br/>Infection Control - Deficiency<br/>(k) The facility must require staff to wash their hands after each direct resident contact</p> |   | <p>room shall remain secured and out of service to the staff, residents and public. 3. The Maintenance Supervisor shall complete monthly facility wide reviews of all bathrooms to ensure they are properly maintained. 4. These audits shall be reported to the Quality Assurance Committee monthly for 6 months. QA monitoring will continue for 3 months until full compliance is obtained.</p> |  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155738 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                     |  | X3) DATE SURVEY COMPLETED<br><br>08/26/2014 |  |
|--|---|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MILTON HOME, THE |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>206 E MARION ST<br>SOUTH BEND, IN 46601 |  |   |  |
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|  | <p>for which hand washing is indicated by accepted professional practice.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper hand sanitizing was completed between medication passing for 5 of 5 residents observed. (Resident #1, Resident #7, Resident #8, Resident #9 and Resident #10)</p> <p>Findings include:</p> <p>On 8-25-14 between 7:07 A.M. and 7:50 A.M. LPN #26 was observed passing morning medications for Resident #1, Resident #7, Resident #8, Resident #9, and Resident #10. LPN #26 was observed to not wash her hands or use hand sanitizer gel between any of the medication passes.</p> <p>On 8-25-14 at 7:51 A.M., an interview was conducted with LPN #26. LPN #26 indicated "...I normally use hand sanitizer in between medication pass and wash hands after every couple of residents...."</p> <p>On 8-25-14 at 10:00 A.M., an interview was conducted with the DON (Director of Nursing). The DON indicated "...wash hands after 3 medication passes, use hand sanitizer between every pass...."</p> <p>On 8-25-14 at 11:40 A.M., review of the</p> | R000414   | <p>1. The facility shall ensure proper hand washing/sanitizing between medication passes. 2. No residents were affected. The DON provided all nurses with in-service training on 9/15/14. This training included return demonstrations on hand washing techniques as well as their responsibility to hand wash or sanitize between direct resident contact. 3. The DON or designee shall complete monitoring of nurses during medication passes at least daily for 30 days, 2x weekly for 30 days and weekly for 30 days. 4. Audits shall be reviewed by Quality Assurance Committee monthly for 6 months. QA monitoring will continue monthly until there have been [3] consecutive months of full compliance.</p> | 09/19/2014   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155738 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>08/26/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>MILTON HOME, THE |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>206 E MARION ST<br>SOUTH BEND, IN 46601                                |                      |   |
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|  | "Licensed Nurse and QMA Procedure, Administration of Medications - Oral" policy, received by the DON at this time, indicated "...2. Handwashing is to be performed before beginning and after each resident contact unless antibacterial agent is used...." |   |   |                      |   |