

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
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F0000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey Dates: February 8, 9, 10, 13, 14, and 15, 2012</p> <p>Facility number: 000411 Provider number:155384 AIM number: 100275100</p> <p>Survey team: Terri Walters RN TC Carole McDaniel RN Martha Saull RN</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census payor type: Medicare: 14 Medicaid: 45 Other: 16 Total: 75</p> <p>Stage 2 Sample: 38</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/21/12 Cathy Emswiller RN</p>	F0000	<p>Please accept this as our credible plan of correction for the survey event TEH511.Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and Title 19 programs.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012
FORM APPROVED
OMB NO. 0938-0391

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F0164 SS=D	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview the facility failed to ensure personal privacy in regard to isolation information posted on resident room doors for 1 of 3 residents reviewed for isolation who met the criteria in the stage 2 sample.</p> <p>Findings include:</p> <p>On 2/8/12 at 1:50 P.M., Resident #98's room door was observed to</p>	F0164	<p>How will the corrective action be accomplished for residents found affected by the alleged deficient practice cited: Corrective measures accomplished for resident #98 are as follows: The isolation sign was removed and replaced with new isolation sign that does not violate personal privacy. How will other residents having the potential to be affected by the alleged deficient practice cited be identified? The facility recognizes</p>	03/16/2012	

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	<p>have had the following respiratory droplet isolation sign posted which indicated: Droplet Isolation. Information on the sign included but was not limited to: diseases requiring droplet isolation with examples given such as meningitis, pneumonia, sepsis, etc. Special precautions listed included but were not limited to: trash container kept in room and door of room to remain closed.</p> <p>This sign was observed posted on Resident #98's room door on 2/8/12 at 1:50 P.M., 2/9/12 at 7:55 A.M., 2/13/12 at 7:55 A.M., 2/13/12 at 1:20 P.M., and 2/14/12 at 8:10 A.M.</p> <p>On 2/15/12 at 7:45 A.M., the Director of Nursing (DON) was made aware of respiratory droplet isolation information and instructions for care posted on Resident #98's room door for public viewing. During interview at that time, the DON indicated the wrong facility respiratory droplet isolation sign had been posted.</p> <p>3.1-3(o)</p>		<p>that all residents have the potential to be affected by the alleged deficient practice cited. All residents were checked and any resident with incorrect isolation signs had signs removed and correct signs posted. What measures/system changes will be made to ensure that the deficient practice does not reoccur?The measures put into place to ensure the alleged deficient practice does not recur is as follows: Education will be provided to nursing staff responsible for assuring that the correct isolation signs are used.System changes made include: The incorrect isolation signs were destroyed and replaced with the new signs.How will the facility implement, integrate, and monitor the corrective action for effectiveness: Corrective actions will be monitored by the DNS and/or designee by audits 3x weekly for 1 month, then 1x weekly for six months. Reviews will be submitted by the DNS and/or designee to the QA committee for discussion for 7 months and as needed thereafter. Interventions will be put into place as needed.</p>		

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F0248 SS=D	<p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review the facility failed to provide an individualized activity program for 1 of 3 residents in isolation who met the criteria for activities in a stage 2 sample of 38.</p> <p>Findings include:</p> <p>On 2/8/12 at 1:50 P.M. Resident #98 was observed in her room. The room door had a sign posted which indicated respiratory droplet isolation. Information listed on this isolation sign included but was not limited to: the door of the room was to be shut.</p> <p>Through out the survey from day shift of survey days 2/8/12, 2/9/12, 2/10/12, 2/13/12, and 2/14/12, Resident #98 was not observed out of her room or attending group activities.</p> <p>On 2/15/12 at 7:20 A.M., the Activity Director was interviewed regarding the activity program for Resident #98 who was in respiratory droplet</p>	F0248	<p>How will the corrective action be accomplished for residents found affected by the alleged deficient practice cited:Corrective measures were accomplished for resident #98 is as follows: The resident has been placed on one to one visits and is no longer in isolation.How will other residents having the potential to be affected by the alleged deficient practice cited by identified:The facility recognizes that all residents have the potential to be affected by the alleged deficient practice cited. All residents will be reviewed that are in isolation or do not attend activities outside their room to ensure they are receiving one to one visits and/or appropriate in room activities if wanted. What measures/system changes will be made to ensure that the deficient practice does not reoccur:The measures put into place to ensure the alleged deficient practice does not recur is as follows: Education will be provided to the activity staff relating to residents which require individualized activities due to isolation precautions and residents who do not attend activities outside their room.Systemic changes made include: Residents in isolation</p>	03/16/2012	

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	<p>isolation. The Activity Director was made aware of Resident #98 not observed at facility group activities during the survey. The Activity Director at this time indicated she just stops in for check in visits. She indicated she had no specific activity program planned for this resident. She indicated the resident's husband was almost daily at her bedside for a visit. She indicated she has not done room visits or 1-1 activities for this resident. She reviewed her activity documentation since the resident's admission date of 1/2012, and indicated she had assessed the resident's activity interests. The Activity Director at this time verbalized some of resident's interests as : likes country music, pets, outdoors, and children. She indicated the resident hasn't been coming out of her room for activities at the facility.</p> <p>On 2/15/12 at 7:20 A.M., the Activity Director reviewed the January 2012 and February 2012 activity documentation for this resident . She indicated none of the facilities group activities had been attended by Resident #98. She indicated the January and February 2012 documentation indicated documentation under the heading of independent activities. She indicated</p>		<p>and residents who do not attend activities outside their room will be reviewed in the morning clinical meeting. The activity director will ensure she provides individualized activities for residents who are on isolation precautions and residents who do not attend activities outside their room. How will the facility implement, integrate, and monitor the corrective action for effectiveness: Corrective actions will be monitored by the Activity Director and/or designee by audits 3x weekly for one month and 1x weekly for 6 months. Reviews will be submitted by the Activity Director and/or designee to the QA committee for discussion for 7 months and as needed thereafter. Interventions will be put into place as needed.</p>		

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	<p>she had documented the television/radio activity, the visiting activity, and the check in activity. She indicated the documentation reflected the resident having TV on in her room and the visits referred to her husband visits.</p> <p>3.1-33(a)</p>			
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F0253 SS=D	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview the facility failed to maintain an environment free of malodorous scent for the first 2 of 3 days of survey. February 9 and 10, 2012 Resident #68</p> <p>Findings include:</p> <p>On 2/9/12 at 1:20 P.M., the resident was observed in his room from the hall. He was sitting in a wheelchair at the center of the room. The resident occupied the bed farthest from the door. The bed closest to the door was occupied by another male resident. From the doorway to the room, the pungent odor of urine was detected. At this time, Resident #68 was interviewed. He indicated he eats his meals in the dining room and also goes to the therapy department. The resident was observed to have an antipressure cushion in his wheelchair base. As the antipressure cushion was approached, the pungent urine odor became more intense.</p> <p>On 2/10/12 at 9:20 A.M., the resident was observed in his room in his wheelchair. Again, the pungent odor</p>	F0253	<p>How will the corrective action be accomplished for residents found affected by the alleged deficient practice cited:Resident #68's room will be deep cleaned and will remain free of malodorous scent. Resident's wheelchair, recliner, mattress and cushion were cleaned. Bed linens will be changed routinely.How will other residents having the potential to be affected by the alleged deficient practice be identified:The facility recognizes that all residents have the potential to be affected by the alleged deficient practice cited. All resident rooms and equipment will be placed on a routine cleaning schedule.What measures/systemic changes will be made to ensure that the deficient practice does not reoccur:The measures put into place to ensure the alleged deficient practice does not recur is as follows: Education was provided to housekeeping staff and nursing staff for assuring that resident rooms remain free of malodorous scent and equipment remains clean.Systemic changes made include: the ED and/or designee will assure the following is in place: resident rooms and equipment will be on a routine cleaning schedule. How will facility implement, integrate, and monitor the corrective action for</p>	03/16/2012			

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	<p>of urine was detected from the doorway to the resident's room. A visitor was also observed sitting in the room at this time.</p> <p>On 2/14/12 at 1 P.M., the resident's clinical record was reviewed. A plan of care addressing the problem of urinary tract infection, was dated 2/8/12 and indicated the following: "... Monitor urine color, odor, check q (every) 2 hrs (hours) for incont (incontinence) and provide peri (perineal) care..." An MDS (minimum data set assessment, dated 10/28/11 indicated the following for the resident: moderately impaired cognition; resident was frequently incontinent; was currently on a toileting program; extensive assistance required (resident involved in activity but staff provide weight bearing support) for toileting and personal hygiene.</p> <p>On 2/15/12 at 1 P.M. CNA #8 was interviewed. She indicated Resident #68 is incontinent and is also taken to the toilet by the use of a lift.</p> <p>3.1-19(f)</p>		<p>effectiveness: Corrective actions will be monitored by the ED and/or designee by audits 5x weekly for one month and then 3x weekly for six months. Reviews will be submitted by the Ed and/or designee to the QA committee for discussion for seven months and as needed thereafter. Interventions will be put into place as needed.</p>		

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F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control policies and</p>	F0441	How will the corrective action be accomplished for residents found affected by the alleged deficient practice cited:Corrective measures were accomplished as	03/16/2012	

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	<p>procedures were maintained to prevent the potential spread of infection for 2 of 3 residents in isolation who met the stage 2 criteria for infection. This had the potential to affect 75 of 75 residents in the facility due to the lack of infection control practices by the 4 staff. LPN #7, RN #6, CNAS #5 and #2. Resident #98, Resident #97, Resident #13, Resident #76</p> <p>Findings include:</p> <p>1. On 2/9/12 at 11 A.M., Resident #97 was interviewed in his room. Resident #97 was in the last room in the hall, on the left side. The door was observed opened and positioned to the left side of the doorway. When entering the room, the sign, which was printed on a white piece of paper, was not positioned as to catch one's attention. To read the sign, staff/visitors would have to look to the left side of the room. The sign on the door was titled "Contact Precautions."</p> <p>The resident was observed to be sitting in his room with a disposable mask on, which covered his nose and mouth. The resident indicated he had a knee replaced and had something on his nostril so they (facility) told him</p>		<p>follows: A bright colored isolation sign was placed on the wall to the left of the resident #97's door to catch one's attention. Care plan was updated to reflect date initiated. Resident # 97's isolation sign was changed and is located on the outside of the wall. The sign is a bright colored isolation sign which does not indicate the type of isolation the resident(s) is in. Resident 98's incorrect sign was removed from door and correct sign posted on the wall to the left of the door. CNAs #5 and #2 and LPN #7, RN #6 were educated to contact vs. droplet isolation including correct infection control practices. How will other residents having the potential to be affected by the alleged deficient practice be identified: The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. All residents in isolation were checked for proper signs on wall to catch one's eye before entering. All residents in isolation had care plans updated to reflect date initiated. What measures/system changes will be made to ensure that the deficient practice does not reoccur: The measures put into place to ensure he alleged deficient practice does not recur is as follows: Education was provided to staff members responsible for assuring that the infection control protocol is followed, including</p>		

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	<p>to wear the mask. He indicated the facility told him he was to keep the mask on when he is out of his room for sure. The resident indicated he had been here since the end of January 2012. He indicated he also attended out of room activities and therapy out of his room.</p> <p>On 2/10/12 at 8 A.M., Resident #97 was observed wheeling himself throughout the facility in his wheelchair. The resident was observed with a disposable mask on, covering his nose and mouth. The resident's room was located at the far end of a long hall by the emergency exit. The resident was observed wheeling himself from his room down the long hall and to another unit where he was observed to participate in therapy in the therapy department.</p> <p>On 2/10/12 at 8:05 A.M., LPN #10 was interviewed. She indicated she was the nurse caring for Resident #97 today. She indicated the reason the resident had a mask on because he had MRSA (methicillin resistant staphylococcus aureus) in his nares (nose).</p> <p>On 2/10/12 at 8:20 A.M., the Unit Manager #6 was interviewed. She indicated Resident #97 was in</p>		<p>isolation precautions and correct isolation signs to use. The systemic changes made include: Return demonstrations will be conducted with staff responsible for assuring correct infection control practices are followed, including following isolation precautions. How will the facility implement, integrate, and monitor the corrective action for effectiveness: Corrective actions will be monitored by the Director of Clinical Education and/or designee by audits 5x weekly for one month and 3x weekly for 6 months. Reviews will be submitted by the Director of Clinical Educaiton and/or designee to the QA committee for discussion for 7 months and as needed thereafter. Interventions will be puinto place as needed.</p>		

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	<p>currently respiratory isolation.</p> <p>On 2/10/12 at 9:30 A.M., the DON provided a copy of the facility policy and procedure for "Multidrug - Resistant Organisms." This policy had a revision date of October 2009. This policy included, but was not limited to, the following: "Should a resident be placed on contact precautions, implement the following:...place a box of gloves in the room..." Documentation does not indicate to wear a mask for contact precautions.</p> <p>On 2/10/12 at 9:40 A.M. the Medical Record staff provided a current copy of the facility policy and procedure for "Isolation - Categories of Transmission Based Precautions." This policy and procedure was undated. This policy and procedure included but was not limited to, the following information: "After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room..."</p> <p>On 2/10/12 at 10 A.M., the clinical record of Resident #97 was reviewed. A care plan (CP) had an initial date of 1/30/12 and addressed the problem of "MRSA infection nares."</p>			
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	<p>Interventions included, but were not limited to, the following: "Droplet isolation due to MRSA to nares." Interventions included, but were not limited to, the following: "Droplet isolation due to MRSA to nares."</p> <p>On 2/10/12 at 10:20 A.M., the DON (Director of Nursing) was interviewed. Stated indicated the resident was admitted to the facility with a diagnosis of MRSA in his nares. She indicated Resident #97 is in droplet isolation and the resident wears a mask covering his nose and mouth when he is outside his room. The DON indicated anyone within 3 - 6 feet of Resident #97 would wear a mask if Resident #97 wasn't. At this time, the DON was made aware the resident's isolation sign indicated he was on "contact precautions." The DON indicated the staff was following protocol for droplet isolation but the sign needed to be changed to indicate "droplet isolation." The DON indicated they were changing the signs on the door now.</p> <p>On 2/10/12 at 11:20 A.M. a "Droplet Isolation" sign was observed on the resident's opened door. This sign included but was not limited to, the following: "Handwashing...after contact with articles contaminated</p>			
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	<p>with infective material...masks all persons entering the room...discard disposable articles, bag disposable articles contaminated with infective material..."</p> <p>On 2/13/12 at 7:48 A.M., LPN #7 was interviewed. She was passing medications to Resident # 97. She indicated Resident #97 was "in contact isolation so we need to use the mask for him." At 7:55 A.M., Resident #97's door was observed opened and the resident was in the room with no mask on. LPN #7 put a mask on herself before entering the room to give the resident his medication. A sign on the door titled "Droplet Isolation" was observed on the opened door. After LPN #7 gave the resident his medications, she removed her gloves and washed her hands in the resident's room. As she was exiting the room, with clean hands, LPN #7 removed her mask and wadded it up. LPN #7 then walked down the hall, took the mask and threw it away in the open trash receptacle on the side of her medication cart, which was located in the hall.</p> <p>On 2/13/12 at 10 A.M., the DON was interviewed. She was made aware the resident was observed in the</p>			
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	<p>therapy department with his mask down underneath his nose, with other resident's and staff within proximity of Resident #97. The DON indicated the resident had been educated on correct policy and procedures for droplet isolation as well as the CNAs (certified nursing assistants) and other nursing staff.</p> <p>On 2/14/12 at 11:50 A.M., the resident was observed in his room, with his mask off. The door to the room is open. When door was in the opened position, the isolation sign was not in such a position as to easily alert staff/visitors as to precautions to be observed when entering this room.</p> <p>On 2/14/12 at 12:40 P.M., Resident #97 was observed sitting in his room in his wheelchair. The resident did not have a mask on. At this time, RN #6 was observed to take Resident #97's meal tray into his room. RN #6 walked into the room without a mask on. She put the meal tray on the resident's table, which was located within a foot of the resident. She then exited the room. At this time, RN #6 indicated that sometimes the resident takes his mask off in his room and sometimes he doesn't. RN #6 stated "I can't always say that he has it on in the room.</p>			
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	<p>On 2/14/12 at 2:45 P.M. the Infection Control Nurse (ICN) was being interviewed. During the interview, CNA #5 was observed to enter Resident #97's opened door, without a mask on. The resident was observed sitting in his room, at the end of his bed, without a mask on. CNA #5 walked within 3 feet of the resident, retrieved an article from the closet and walked out the door. The ICN informed CNA #5 that she should have had a mask on to enter the room.</p> <p>2. On 2/8/12 at 1:50 P.M., Resident # 98's room door had a sign posted which indicated : Droplet Isolation. Information on the sign included but was not limited to: diseases requiring droplet isolation with examples given such as meningitis, pneumonia, sepsis, etc. Special precautions listed included but were not limited to: trash container kept in room and door of room to remain closed.</p> <p>On 2/8/12 at 1:50 P.M., the Assistant Director of Nursing (ADON) and LPN#1 were interviewed regarding Resident #98's isolation. The ADON indicated Resident #98 was in respiratory /droplet isolation. She</p>			
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	<p>indicated the isolation was due to respiratory MRSA (Methicillin Resistant Staphylococcus Aureus) . LPN#1 indicated staff were to wear gown, gloves, and mask when entering the resident's room for this type of isolation. She indicated when Resident #98 goes to therapy she was to wear a mask (when out of her room). The ADON indicated Resident #98's roommate (Resident #13) whose bed was by the window (2nd bed in the room) was not in isolation. She indicated the roommate (Resident #13) had previously had MRSA . LPN#1 indicated facility kept the privacy curtain pulled between Resident #98 and her roommate.</p> <p>On 2/9/12 at 7:55 A.M., LPN #1 applied paper gown, gloves, and mask, before entering Resident #98's room (room door had been open before LPN #1 prepared to enter). Droplet isolation sign with isolation instructions remained on room door as observed on 2/8/12. LPN #1 assisted Resident #98 to ambulate to the bathroom and toilet. After care provided LPN#1 removed, gown, gloves and mask, washed hands and disposed of these items in red trash container in the resident's room.</p> <p>On 2/9/12 at 12:20 P.M., CNA #1 and</p>						

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	<p>CNA #2 answered the call light of Resident #98's room. Resident #98's room door had been open before the call light had been answered. Both CNAs applied gowns, gloves, and masks before entering Resident #98's room. CNA #2 exited the Resident #98's room carrying her gown, gloves, and mask and disposing of items outside of the resident's room.</p> <p>On 2/9/12 at 1:20 P.M., the room door was open Resident #98's room with Resident #98 in room.</p> <p>On 2/10/12 at 8:25 A.M., Resident #98's door was open with the resident in bed by the room door.</p> <p>On 2/10/12 at 8:29 A.M., during interview with Resident #98's nurse, LPN #2, she indicated all staff to were wear gowns, gloves, and mask, when entering Resident #98's room even if they were going to care for the roommate who was not in isolation.</p> <p>On 2/10/12 at 8:30 A.M., during interview with the ADON, she indicated Resident #98 had been admitted to the facility on 1/20/12, and had placed in isolation (due to MRSA noted at hospital). The ADON indicated Resident #13 was Resident</p>			
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	<p>#98's roommate on 1/20/12 and had continued to be her roommate at the present time. On 2/10/12 at 8:33 A.M. during interview with the Director of Nursing (DON) and the Infection Control Nurse, they indicated Resident #98 had been on droplet isolation from admission. They indicated Resident #98 had been on Levaquin (an antibiotic) from the admission date of 1/20/12, for 5 days. The facility had received a physician's order on 1/26/12 for collection of sputum specimen, 48 hrs after post antibiotic. They indicated on 1/29/12, Resident #98 had been admitted back to the hospital. They indicated Resident #98 was then readmitted to the facility from the hospital on 2/5/12 (same facility room). They indicated on readmission on 2/5/12, Resident #98 had been on Levaquin (an antibiotic) x 3 days(2/6, 2/7, 2/8/ 2012). The Infection Control Nurse at this time indicated the facility policy was to reculture 48 hours after an antibiotic had been completed. The facility had then needed 3 negative cultures before the resident could be taken out of isolation (each culture- 1 week apart). If a positive culture had been obtained the physician would be notified for a restart of antibiotics. The Infection Control Nurse indicated,</p>				

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	<p>if 2 residents had the same organism they can be in same room together with 6 feet apart with the privacy curtain between them.</p> <p>On 2/10/12 at 10:15 A.M., the door of Resident #98 remained open.</p> <p>On 2/13/12 at 7:28 A.M., Resident #98's room door was open and the resident was in bed. Observed respiratory droplet isolation sign with instructions as was posted last week on the room door.</p> <p>On 2/13/12 at 9 A.M., the resident was observed in the therapy department. He was wearing a respiratory mask, which was pulled down, exposing his nose while he was using exercise equipment. The resident was facing in a direction away from other residents. There were 4 therapists in the room with the resident at this time.</p> <p>On 2/13/12 at 10:25 A.M., Resident #98's door was observed open and the resident was sitting up in bed.</p> <p>On 2/13/12 at 1:20 P.M., the door of Resident #98 had not closed. The droplet sign remained on door as it had all day.</p>						

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	<p>On 2/14/12 at 8:10 A.M., the door of Resident #98's room was open and had the same respiratory droplet sign on the door with instructions for care.</p> <p>On 2/14/12 at 12:18 P.M., CNA #2 had put a mask on and had entered Resident #98's room. The CNA then exited the room at 12:20 P.M. She had exited the room holding her mask in her hands. She had then entered the visitor's restroom by the nursing station and disposed of her mask in the visitor's rest room. She then gelled her hands. After this care had been provided, the door of Resident #98's room was open and Resident #98 was observed in bed.</p> <p>On 2/14/12 at 12:25 P.M., CNA #2 entered Resident #98's room again, applied a mask only before entering the room. She exited the room and had disposed of her mask in Resident's #76's bathroom which was across the hall from Resident #98's room.</p> <p>On 2/14/ at 12:40 P.M., CNA #2 applied mask and entered Resident #98's room with Resident #98's lunch tray. CNA #2, when exiting the room had wore her mask out unto the hall and disposed of mask in Resident #76's bathroom(across the hall from</p>			
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	<p>Resident #98's room). Resident #98's room door had remained open at lunch with respiratory isolation droplet sign still posted on the room door. Resident #98 was observed sitting on edge of bed feeding self with the room door open.</p> <p>On 2/14/12 at 1:50 P.M., CNA #2 applied mask and entered Resident #98's room. When she exited the room she took the mask with her and entered Resident #76's bathroom (across the hall) and disposed of the mask.</p> <p>On 2/15/12 at 7:45 A.M., the DON was interviewed regarding respiratory droplet isolation for Resident #98. The DON was made aware of the staff wearing gowns, gloves, and masks during the survey on 2/9/12 at 7:55 A.M., and 2/9/12 at 12:20 P.M. Then on 2/14/12 at 12:18 P.M., 12:25 P.M., 12:40 P.M., and 1:50 P.M., only a mask had been worn when entering Resident #98's room. The DON was made aware of staff on 2/14/12 ,exiting the isolation room and disposing of the mask in another resident bathroom across the hall from Resident #98's room. The DON had also been made aware of Resident #98's room door frequently open thru out the survey, 2/9/12 -</p>			
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	<p>2/14/12, with instructions of respiratory droplet isolation posted on the door. These instructions had indicated to keep the room door shut.</p> <p>On 2/15/12 at 7:45 A.M., during interview with the DON, she indicated the wrong respiratory droplet isolation sign had been posted. She indicated staff needed to wear a mask to protect them from respiratory MRSA. She indicated a gown was needed if resident had been coughing or if there was a potential of spraying of respiratory secretions. She indicated gloves were needed for care such as peri-care, bathing, brushing teeth, or evasive treatments. She indicated staff should dispose of mask in Resident #98's room in the designated trash container. The DON indicated staff should not dispose of mask in another resident's bathroom.</p> <p>3.1-18(b)(1)</p>			
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F0464 SS=E	<p>The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation and interview, the facility failed to provide adequate space for rehabilitative therapy services for 9 of 9 residents observed receiving services in the space on 2 of 2 days observed. Resident 20 Resident 95 Resident 60 Resident 97 Resident 100 Resident 82 Resident 68 Resident 19 Resident 14</p> <p>Findings include:</p> <p>1. On 2/08/12 at 10:00 A.M., the rehabilitation therapy space was observed. The space consisted of a section of building at the end of a hall of Unit 1. The space was approximately 20 feet by 25 feet and included the hallway portion merged with what had been a double resident room on the right. On the left side of the hall there was an occupied resident room with the doorway of the room inside the therapy space. The hallway portion of the space was visible at the end of the hall thru an opening between 2 short walls on either side which gave the</p>	F0464	<p>How will the corrective action be accomplished for residents found affected by the alleged deficient practice cited:Corrective measures accomplished were as follows: The residents will be receiving therapy services in a different location with smaller groups.How will other residents having the potential to be affected by the alleged deficient practice cited by identified:The facility recognizes that all residents have the potential to be affected by the alleged deficient practice cited. All residents receiving therapy services were reviewed to ensure they are receiving therapy services in an area with adequate space and in small groups during construction services. What measures/system changes will be made to ensure that the deficient practices does not reoccur:The measures put into place are as follows: Education on adequate spacing and group size for rehabilitative services will be provided to the therapy staff.Systemic changes made include: (1) the residents receiving therapy will be located to a different location during the construction period (2) the residents receiving therapy</p>	03/16/2012			

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	<p>appearance of a removed double wide door. Inside the space there was a bathroom, 2 tables put together (suitable for 6-8 places), an ice machine an exercise bike. There were 9 residents and 8 staff involved in therapy.</p> <p>There were 4 residents positioned in the hallway area in front of the resident room on the left of the space which was occupied by Resident 43. The 4 residents were seated in a wide wheel chair and three dining chairs and a walker. There were 3 therapists in the space, 2 colored cone activity units in use and an Electrical Stimulation (ES) unit.</p> <p>At the time of the above observation, Resident #43 had a call light on. In order to respond to the call light, CNA #22 entered the hallway portion of the therapy space, walking sideways in and around resident equipment, interrupting the resident therapies, bumping a wheel chair, replacing the ES unit and causing one therapist to stand aside in order to get to the door of Resident #43. She stated excuse 2x, sorry, and oops 1 x.</p> <p>On 2/08/12 at 10:30 A.M., during interview, CNA 22 indicated there was "always a nice crowd" in therapy in the morning and "you can work</p>		<p>services will be smaller groups during the construction period to allow for space.How will facility implement, integrate, and monitor the corrective action for effectiveness:The therapy team leader and/or designee will conduct audits 3x weekly for one month, then 1 time weekly for 6 months to ensure residents are receiving therapy services in an adequate space in small groups. Reviews will be submitted by the therapy team leader and/or designee to the QA committee for discussion for seven months and as needed thereafter. Interventions will be put into place as needed.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	<p>around it since they are all so nice."</p> <p>2. On 2/13/12 at 9:00 A.M., the same Therapy space was observed to have 9 residents receiving treatment. In the hallway entry portion of space Resident 95 was seated in a double wide wheel chair. Progressing into the hallway there were 4 therapy staff and Resident 60, Resident 19 and 14 (sitting side by side with elbows touching) Resident 20 being attended by Speech Therapist (ST) 6. Progressing into the rest of the space were Resident 100, Resident 82, Resident 97, Resident, Resident 68 and 3 additional therapy staff.</p> <p>ST 6 was observed at that time to be coming thru the hallway area pushing the wheel chair of Resident 20, with urgency. Residents 19, Resident 14, and Resident 95 had to moved from their spaces to allow Resident 20 and ST 6 to exit the space. ST 6 explained Resident 20 was experiencing chest pain and she needed to get the resident back to his unit to the nurse. Resident 95 remarked " we are kinda tight in here as she was assisted to move her wheel chair forward 1/2 foot and angled to the side with assist of 2.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2012
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	<p>At 10:00 A.M. ST 6 was observed to be verifying with the Unit 4 nurse sat the desk that Resident 20 was "fine" and the resident was sitting un distressed at the nurses station.</p> <p>3.1-19(v)</p>				

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F0465 SS=F	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide sanitary conditions in regard to clean flooring in the food preparation areas and kitchen areas during 2 of 2 days of kitchen tours. This deficiency had the potential to affect all 75 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 2/8/12 at 8:10 A.M., the kitchen area was observed. The floor in the kitchen area was observed. The floor in the kitchen area was soiled with debris and dust especially around the edges of the room and underneath the steam table, equipment, and shelving units of the kitchen. On 2/14/12 at 9:00 A.M., the kitchen area was again toured. The floor of the kitchen area thru out and especially around the edges of the room and under the steam table, in front of the walk in refrigerator and freezer, and behind the ice cream freezer had brown debris and dust when the hand was swept across the floor. A section of the floor between the dishwashing area and the food preparation equipment had a metal 	F0465	<p>How will the corrective action be accomplished for residents found affected by the alleged deficient practice cited: Corrective measures will be accomplished as follows: The flooring, food preparation areas and kitchen area will be deep cleaned. How will other residents having the potential to be affected by the alleged deficient practice be identified: The facility recognizes that all residents have the potential to be affected by the alleged deficient practice cited. The floor in the food preparation area and kitchen area will be monitored and cleaned routinely. What measures/system changes will be made to ensure that the deficient practice does not reoccur: The measures put into place to ensure the alleged deficient practice does not recur is as follow: Education will be provided to the dietary staff on floor cleaning in the food preparation areas and kitchen areas. System changes include: The floor in the food preparation area and kitchen area will be placed on a regular cleaning schedule. How will facility implement, integrate and monitor the corrective action for effectiveness: Corrective actions will be monitored by the Dietary Services Manager and/or designee by audits 3x a week</p>	03/16/2012			

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	<p>strip (approximately 1 inch wide) missing (for approximately 4 feet) with an accumulation of brown particle matter noted. The painted floor in the furnace section of the kitchen area in front of the walk in freezer had missing paint areas with soilage. Dietary staff #1 and #2 were made aware of floor soilage at this time.</p> <p>On 2/14/12 at 10:00 A.M., the dietician was made aware of floors in the kitchen area were soiled thru out and especially around edges of floors and under kitchen equipment and shelving units. The dietician at this time indicated kitchen equipment needs to be pulled out from the wall for cleaning. She indicated at this time the kitchen floor receives a deep cleaning twice a year. She indicated the deep cleaning was due but had not been done due to construction in the facility. She indicated the cleaning of the floor is a contracted facility service.</p> <p>3.1-19(f)</p>		for 1 month, then 1x weekly for 6 months. Reviews will be submitted by the DNS and/or designee to the QA committee for discussion for 7 months and as needed thereafter. Interventions will be put into place as needed.		

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