

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/28/2012
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NAME OF PROVIDER OR SUPPLIER  SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint Number IN00109777. This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>Complaint Number IN00109777 Substantiated, Federal/State Deficiencies Related to the Allegations are cited at F323 and F456.</p> <p>Survey Dates: June 19, 20, 21, and 22, 2012 Extended Survey Dates: June 27 and 28, 2012</p> <p>Facility number: 000483 Provider number: 15E657 AIM number: 100273470</p> <p>Survey Team: Janie Faulkner, RN-TC [June 19, 20, 21, and 22, 2012]  Diana Sidell, RN [June 19, 20, 21, and 22, 2012]  Jill Ross, RN [June 20, 21, and 22, 2012] Janelyn Kulik, RN [June 27 and 28, 2012] Steve Corya, QMRP</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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	<p>[June 27 2012]</p> <p>Census bed type: NF 21 Total 21</p> <p>Census payor type: Medicaid 21 Total 21</p> <p>Sample: 10 Supplemental Sample: 8</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/3/12 Cathy Emswiller RN</p>			

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal privacy for 2 residents in that staff failed to pull privacy curtains during incontinence care (Resident #A) and spoke of a resident's dentures in a dining room with other residents present (Resident #D). This affected 2 of 9</p>	F000164	<p>F 164 Personal Privacy/Confidentiality of Records</p> <p>The facility will ensure the privacy of all residents and their personal record. On July 3, 2012, the DON and SSD conducted an in-service training for all CNA regarding privacy of resident #A and all residents in the facility and Providing AM/PM</p>	07/03/2012	

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	<p>residents reviewed in a sample of 10 reviewed for privacy.</p> <p>Findings include:</p> <p>1. Resident #A's record was reviewed on 6/22/12 at 12:01 p.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, mental retardation, high blood pressure, congestive heart failure, cerebral palsy, and paraplegia.</p> <p>An annual minimum data set assessment dated 5/20/12 indicated Resident #A had severe impairment in cognitive skills, required total assist with transfers and bed mobility, did not ambulate, was incontinent of bowels, and frequently incontinent of bladder.</p> <p>During an observation on 6/21/12 at 8:55 a.m., CNA #3 and CNA #4 were observed as they transferred Resident #A from his wheel chair to his bed and then gave incontinence care. The CNA's did not fully close the curtains around the bed, nor did they close the door. During incontinence care, the resident's buttocks were exposed, and RN #2, knocked on the open door. CNA #3 saw RN #2 and attempted to close the curtain on the open side of the bed, but a gap of 2 feet remained. The door also remained open.</p>		<p>care. The training included providing privacy by ensuring the door is closed, pulling the privacy curtains completely around the resident while providing care and the proper steps to providing AM/PM care. CQI has reviewed the facilities policy and procedure for providing resident privacy and resident AM/PM care. All nursing staff on duty is responsible to ensure that resident A and all residents receive privacy during care. All nursing staff on duty is required to ensure that proper AM/PM care is provided to resident A and all residents in the facility. The Director of Nursing is responsible to visually verify residents are provided privacy during care and proper AM/PM care by unexpectedly visualizing resident care, no less than weekly for 4 weeks then monthly. Social Service Designee is responsible to interview residents to ensure they are being provided privacy during their care, proper AM/PM care is offered to them and any reported lack of privacy or personal care to other residents, no less than weekly for 4 weeks, then monthly. The administrator will review the observations and resident interview findings weekly for 4 weeks, then monthly thereafter. CQI will review the DON and SSD observations and interviews no less than quarterly.</p>				

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	<p>The resident's roommate in bed 1 wheeled into the room in a wheelchair in view of Resident #A on his bed.</p> <p>During an interview on 6/22/12 at 7:00 p.m., the Administrator indicated staff should be pulling curtains and closing doors.</p> <p>On 6/22/12 at 6:56 p.m., the Administrator provided a section of the "Resident Care Procedures" and indicated this was what the CNA's should use as a guide to provide privacy. "The Resident Care Procedure" indicated, but was not limited to: "...8. Close curtains, drapes and doors. Keep resident covered. Expose only area of resident's body necessary to do procedure...Rationale...8. Maintains resident's right to privacy and dignity...."</p> <p>2. During observation, interview and record review on 6/21/12 at 8:00 a.m. Resident # D was sitting at the table with his breakfast sitting in front of him. Other residents were observed sitting at the tables awaiting service of their meal. Resident D had no glasses on and no dentures in his mouth. During interview at that time, the resident indicated he could not see much of anything without his glasses and he couldn't eat very much without his teeth.</p>						

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	<p>CNA #3 and #4 were asked to get this resident's glasses and teeth. They said they would but when the Administrator came in at 8:20 a.m. the resident still had no glasses or teeth. She asked CNA #3 to take this resident to his room and get his glasses and his teeth.</p> <p>In interview with the Administrator on 6/21/12 at 8:35 a.m., she indicated that getting the resident's glasses and teeth should be part of their (CNAs) A.M. care for each and every resident.</p> <p>The "A.M. Care (Early Morning Care)" received on 6/22/12 at 6:56 p.m., did not address getting the resident's glasses and teeth before breakfast.</p> <p>In interview with the Administrator on 6/22/12 at 7:00 p.m., she indicated this was the only policy they could find regarding this issue. "They should all know to do this."</p> <p>3.1-3(p)(4)</p>				

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F000176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on record review, interview and observation, the facility failed to ensure a resident received a breathing treatment as ordered with staff supervision for Resident #A in that the nurse set up and started the breathing treatment and then left the room.</p> <p>Findings include:</p> <p>Review of Resident #A's clinical record on 6/22/12 at 5:00 p.m., indicated this resident had diagnoses that included, but were not limited to: cerebral palsy, profound MR (mental retardation), and CHF (congestive heart failure). There was no self-medication administration assessment available for this resident in the clinical record.</p> <p>During the medication pass observation on 6/21/12 at 9:10 a.m., with RN #2, the breathing treatment was set up for Resident #A. Resident was sitting up in bed with siderails up. Treatment was started and the nurse left the room. At 9:30 a.m., the nurse returned to find CNA #3 holding the mask on the resident's</p>	F000176	<p>F 176 Resident Self-Administering Drugs</p> <p>The Director of Nursing reviewed the current policy and procedure for resident self-administration of medication and Nebulizer treatments. On June 28, 2012, the Director of Nursing conducted an in-service training for all licensed nurses on medication administration, including nebulizer treatments and adequate documentation. The Director of Nursing will evaluate residents who may qualify for self-administration of medication assessments. The Director of Nursing or her delegate will monitor the administration of nebulizer treatments on Resident A and other residents with an order to receive nebulizer treatments to ensure facility policy and procedure for Nebulizer Treatments are followed and residents receive sufficient medication as ordered for inhalation medication weekly times 4 weeks, then monthly thereafter. The administrator will review the findings of the observation weekly for 4 weeks then monthly thereafter. CQI will monitor the observation of medication administration, no less than</p>	06/28/2012			

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	<p>face.</p> <p>During interview at that time, CNA # 3 indicated on 6/21/12 at 9:30 a.m., he had gone into the room and found the resident with his head against the siderail. He repositioned the resident and decided he should hold the mask on resident's face to ensure the resident received his full treatment. RN #2 thanked the CNA and said, "Come get me when it is finished."</p> <p>CNA #3 came to RN #2 at 9:49 a.m., and said the treatment was done. The nurse went back to the room and finished up the treatment.</p> <p>In interview with RN #2 on 6/21/12 at 9:14 a.m., she indicated it was "OK to leave him while he is taking his treatment."</p> <p>In interview with the DON (Director of Nursing) on 6/22/12 at 1:20 p.m., she indicated the nurse was to stay with the resident for the entire treatment. "This resident does not have a self - medicate assessment."</p> <p>In review of the facility policy regarding nebulizer treatments received on 6/22/12 at 4:45 p.m., there was only an indication the nurse should stay with the resident during his treatment. This "Policy and</p>		quarterly.		

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	<p>Procedure for Nebulizers and Maintenance" with an effective date of July 29, 2009 and a review date of May 5, 2012 states: "...15. If the resident becomes dizzy or feels jittery, stop the treatment and let the resident rest for about 5 minutes. Then continue the treatment, but try to have the resident breathe more slowly...."</p> <p>3.1-11(a)</p>			

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F000252 SS=C	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment for the residents, staff, and visitors in the facility in 4 resident rooms, also the shower room and the dining room utilized by 21 of 21 residents currently residing in the facility.</p> <p>Findings included:</p> <p>During the environmental tour with the Maintenance Director on 6/21/2012 from 10:20 A.M. to 11:50 A.M., in Room # 4 observed brown sticky substance on floor under call light, floor grate rusty with dust over openings, dust and peeling paint on wall in room and in the bathroom windowsill, the caulking around the tub had 1/4 inch space between the tub and wall. The closet floor was dusty with items sitting on the floor.</p> <p>Room # 5 was observed to have moderate dust on heater register, dust on windowsill, and peeling paint on wall under the windows. The bathroom call light was not working.</p>	F000252	<p>F252 Safe/Clean/Comfortable/Homelike Environments The following corrective actions have been taken to correct the findings noted in F 252: Room 4 - Brown sticky substance on the floor under the call light in room 4 was removed and the entire room thoroughly mopped. The floor grate was removed and replaced with a new cold air return grate. The room was cleaned to remove all dust, including the closet. The items on the floor were removed off of the floor. Room 5 – The dust on the heater register and window sill was removed. The entire room was cleaned and painted. The call light continues to communicate to the nurses' station alarming and indicating the location. New bulbs to replace the light bulb outside the room have been ordered. Room 6 – The room was cleaned to ensure free from dust. The floor grate was removed and replaced with a new cold air return grate. The bathroom was caulked to eliminate the space around the tub. Room 7 – The floor register vent and broken tile was removed and then replaced with new tile and register. The dead bug was</p>	07/18/2012			

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	<p>Observation in room # 6 of two floor grates rusted with dust over openings, dust in the windowsill, and on an oxygen concentrator. The bathroom caulking around the tub and sink had 1/4 inch space between the tub/sink and wall.</p> <p>Room # 7 was observed to have floor register vent broken with chips out of the tile in several places around rusty floor grate. A dead bug was noted on the floor, the Maintenance Director indicated was a "June Bug".</p> <p>The shower room observation had two wall registers with covers off, dusty, and the register by the sink was rusty. The shower room was observed to have broken tiles, black and rust color residue on the walls and floor of the shower. A musty odor was noted in the shower room. A spider was observed crawling up wall in the shower stall. The Maintenance Director stated, "Iv'e been on them a long time about the shower needing replaced."</p> <p>During the dining room environmental tour at 11:40 A.M. on 6/21/2012, the dining room wall registers both had dust and dead bugs, the window sills in the dining room had cracked peeling paint, and dead bugs on the windowsills. Strip</p>		<p>removed from the floor and the facility contracted pest control was notified of the dead bug. Shower room- The shower room was completely cleaned. The covers to the heat registers were put back on. The shower stalls were completely cleaned to remove residue from the walls and floor. The facility will replace the ceramic tile on the shower stall walls with new ceramic tile. The spider was removed from the shower room and the facilities' contracted pest control company was notified of the spider. Dining room – The dining room was completely cleaned to remove all dust and dead bugs. The window sill was replaced and painted. Carpet – A metal strip was secured to the area where the hall carpet and dining room tile meet. The loose carpet was secured with tape until flooring can be replaced with new flooring. Housekeeping is responsible to clean all rooms thoroughly as indicated on the cleaning schedule. On June 28, 2012, housekeeping was in-serviced on the facilities policy and procedure for cleaning residents' rooms and the facilities cleaning schedule. Housekeeping is responsible to complete a Maintenance Report sheet for all repairs needed. The maintenance director or his delegate is responsible to conduct a visual walk through assessment in the facility no less than weekly to</p>		

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	<p>where the carpet and tile meet tiles are cracked and carpet raised creating a trip hazard. The Maintenance Director indicated they have plans to replace the flooring throughout the building.</p> <p>During an interview with the Administrator on 6/22/2012 at 7:00 P.M., she indicated they will replace the shower in the shower room. The Administrator stated, "the black in shower around the floor and wall is caulking."</p> <p>3.1-19(f)(5)</p>		<p>ensure that residents are provided a safe, clean, comfortable and homelike environment that allows the resident to use his or her personal belongings to the extent possible. The administrator will review the visual walk through assessment and repair of the findings during the weekly observation. The administrator will review the weekly observation sheets along with the repair weekly. CQI will review the visual walk through assessment and repair of the findings no less than quarterly.</p>		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan that met the needs of the resident in that Resident #11 had his voice box removed and there were no interventions in a care plan to help with communication for this resident.</p> <p>Findings include:</p> <p>Resident #11's clinical record was reviewed on 6/20/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to: Stage IV head and neck cancer, post laryngectomy (surgical</p>	F000279	<p>F 279 Develop Comprehensive Care Plans The facility will develop, review, and revise care plans for each resident based on the results of their assessments. All resident care plans were reviewed to ensure triggered areas were care planned. Resident #11's care plans were reviewed and revised as needed by the Director of Nursing and Social Service Designee. The director of nursing reviewed and revised as needed the facility policy and procedure for Care Planning. The Director of Nursing or her delegate is responsible to ensure that all resident care plans are</p>	07/18/2012	

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	<p>removal of the voice box). The current MDS (minimum data set) report system triggered for a care plan to be developed for communication. There was no care plan that addressed the communication problem for this resident.</p> <p>In interview with the DON (Director of Nursing) on 6/22/12 at 1:20 p.m., the DON indicated there should have been a care plan for communication but none was found.</p> <p>In interview with the DON on 6/22/12 at 6:30 p.m., she stated, "If it triggers on the CAA (care area assessment) then I am supposed to write a care plan for any triggered areas." She indicated she followed the MDS RAI manual and no policy was available.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>		<p>developed reviewed and revised based on the triggered areas from their assessments. Resident care plans are reviewed and revised as needed weekly with their weekly summary by the charge nurse scheduled. The Director of Nursing is responsible to review every resident care plans no less than quarterly. CQI will randomly review that care plans are developed based on their assessment triggers, no less than quarterly.</p>		

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F000323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, record review and interview, the facility failed to ensure a resident who needed assistance to keep his head off of his bedrail while receiving a nebulizer treatment (breathing treatment) and who had bed rails which did not meet the required spacing [were larger] between bars and bed rails for 1 of 1 residents in a sample of 10 [Resident A] and failed to ensure the spacing between the bed rails and the spacing between the bars of the bed rails met the requirement for 13 or 21 beds used in the facility.</p> <p>This immediate jeopardy began on 6/21/12 when CNA #3 was holding Resident #A's breathing mask on his face after finding the resident with his head against the siderail. Resident #A was observed on 6/27/12 in his bed with half siderails up times four. The resident's bed rails did not meet the required spacing [were larger] between the bed rails and the bars of the bed rails. The Administrator of the facility was notified of the immediate jeopardy at 1:25 p.m. on 6/27/12. The immediate jeopardy was</p>	F000323	F 323 Free of Accidents A.) The facility will ensure that the residents receive adequate assistive devices to prevent accidents. On June 27, 2012, after the administrator was made aware of the side rails on some of the beds did not meet the required spacing bars and bed rails for resident A and 13 other beds, side rail assessments were completed on all residents. The administrator instructed maintenance to remove all side rails from the residents' bed. On June 27, 2012 at 7 pm, all side rails were removed from beds, except one of 29 beds. Resident A side rails were removed and an extra wide mattress was provided. Following notification of Immediate Jeopardy @ 1:27 PM, the administrator and director of nursing assessed all beds in the facility. The following actions were completed and submitted as an abatement: O Administration requested a new side rail assessment to be completed on every resident. O A resident meeting was arranged to notify the residents the requirement to remove their current side rail if it did not meet FDA requirements	06/29/2012			

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	<p>removed on 6/28/12 at 6:40 p.m., but non compliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>B. Based on observation and interview, the facility failed to ensure a mechanical lift was safe to use during resident transfers in that the lift was unsteady and made popping noises when used. This affected 2 of 4 residents reviewed who used the mechanical lift in a sample of 10. (Residents #A and B) This had the potential to affect all 5 residents in the facility who utilize the mechanical lift.</p> <p>C. Based on observation, interview, and record review, the facility failed to ensure a shower chair was safe for resident use in that the shower chair had a metal plate exposed with sharp edges on the arm. This had the potential to affect 19 of 21 residents in the facility who utilized the shower chair.</p> <p>Findings include:</p> <p>A. During the medication pass observation on 6/21/12 at 9:10 a.m., with RN #2, the breathing treatment was set up for Resident #A. Resident was sitting up in bed with side rails up. Treatment was</p>		<p>O Maintenance was notified of the need to remove all side rails from residents' beds that did not meet FDA approval. Removal of the side rails began immediately.</p> <p>O Dr. Willage was notified of the requirement to remove the side rails from all residents' beds that did not meet the FDA approval, along with the results of the new side rail assessment. O All residents side rail care plans were reviewed and revised as needed. O The following is a list of residents according to resident identifier list provided during all annual recertification survey that completed on June 27, 2012: O Resident families / responsible parties were notified of the change with side rail use. O Nursing staff will be in serviced individually, prior to the start of their shift on the removal of side rails, policy and procedure for proper positioning of residents O An in-service with evaluation of resident response to removal of side rails scheduled O Social service to discuss, observe and assess residents' individual response to removal of their side rails June 28, 2012 O Resident Identifier # SR removed / action</p> <p>1 Removed / positioning &amp; transfer bar place on left side of bed</p> <p>2 No / side rail X 1</p> <p>3 Removed</p> <p>4 Removed</p> <p>5 Removed</p>		

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	<p>started and the nurse left the room. At 9:30 a.m., the nurse returned to find CNA #3 holding the mask on the resident's face.</p> <p>CNA stated on 6/21/12 at 9:30 a.m., that he had gone into the room and found the resident with his head against the side rail. He repositioned the resident and decided he should hold the mask on the resident's face to ensure the resident received his full treatment. RN #2 thanked the CNA and said, "Come get me when it is finished."</p> <p>On 6/27/12 at 1:10 p.m. the resident was observed laying in his bed with the head of his bed elevated. He had half bed rails times four up on this bed. The bed rail on upper right and the lower left had been covered in fabric.</p> <p>On 6/27/12 at 1:00 p.m. during a tour of the facility Resident #A's bed was observed with 4 half bed rails being used on the bed. The bed rails at the head of the bed had a 14 inch space between bed rail and the head of the bed, a 7 inch space between the two half bed rails and an 8 inch space between the bed rail and the foot of the bed and the foot of the bed. There was a 7 inch by 9 inch space between the bars on the bedrail.</p>		<p>6 Replace with full rails d/t specialty mattress</p> <p>7 2 side rails removed at foot of the bed</p> <p>8 Removed</p> <p>9 No / side rail X 1</p> <p>10 No side rails</p> <p>11 No side rails</p> <p>12 No side rails</p> <p>13 Removed</p> <p>14 Removed</p> <p>15 No side rails</p> <p>16 No side rails</p> <p>17 Removed</p> <p>18 Removed / positioning &amp; transfer bar place on left side of bed</p> <p>19 No side rails</p> <p>20 Removed</p> <p>21 Removed</p> <p>O Resident families / responsible parties were notified of the change with side rail use. O Nursing staff will be in serviced individually, prior to the start of their shift on the removal of side rails, policy and procedure for proper positioning of residents O An in-service with evaluation of resident response to removal of side rails scheduled O Social service to discuss, observe and assess residents' individual response to removal of their side rails June 28, 2012 B.) The facility has a new Hoyer mechanical lift to transfer resident A, resident B and all other residents requiring the use of a mechanical lift. Staff has been in-serviced on the new lift and the need to report all device concerns</p>				

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	<p>Review of the Resident #A's diagnoses and medications on 6/22/12 at 5:00 p.m., indicated this resident had diagnoses that included, but were not limited to: cerebral palsy, profound MR (mental retardation), and CHF (congestive heart failure), severe agitation, anxiety, and seizure disorder.</p> <p>A side rail assessment dated 4/14/12 indicated the resident was not able to transfer from the bed when holding onto the rail, was not comatose, semi-comatose or has fluctuations in level of consciousness, he did receive medications which could alter his mental status and potentially increase safety risks, he used the side rails as an enabler for turning and positioning, he did demonstrate poor bed mobility, he requested side rail to be raised when in bed, he did have a diagnosis which has symptoms of involuntary movement or seizures, an alteration in safety awareness due to cognitive impairment, there was no history of falls with injury, he had difficulty with balance control or poor trunk control and no postural hypotension.</p> <p>An annual MDS(Minimum Data Set) Assessment dated 5/20/12, indicated the resident was sometimes understood and sometimes understands, he had a BIMS</p>		<p>to their supervisor immediately and a maintenance repair sheet to be completed before ending their shift. C.) The shower chair arm was repaired. A new shower chair has been ordered. All staff has been in-serviced on the requirement to report all devices that are in need of repair immediately when noted. Findings included section: A.) Resident A's bed rails were removed and a wider mattress put in place. Staff was in-service on proper positioning of resident in bed. Licensed nurses were in-serviced on administration of nebulizer treatments. Side rails were removed on all beds except 2. Room 2, res B has one bed with full side rails with a opening of 4 inches between the bars. This resident requires a specialty low air mattress d/t a stage 3 decubitus that was present on admission and S/P catheter which would be on the floor if a low bed were used. Room 3 bed A has half rails on the bed. This bed has specialty mattress topper which covers the side rails except 2 inches. B.) CNA 3 &amp; 4 were trained along with all other cna's to report all concerns immediately to their supervisor and to complete a maintenance repair sheet to report concerns with all devices which is given to the maintenance director after coping to give also to the administrator. A new mechanical lift and lift pad are available to use for resident</p>				

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	<p>(Brief Interview of Mental Status) score of 3, which indicated the resident had severe cognitive impairment. He was total dependence with full staff performance with a two person physical assist for bed mobility.</p> <p>On 6/21/12 at 11:52 a.m., a tour was done to measure the spaces in the side rails of the beds. The Food and Drug Administration (FDA) recommends no more than 4 and 3/4 inches spacing between the bars to ensure resident safety. In 1995, the FDA issued a safety alert entitled "Entrapment hazards with hospital bed side rails", with those recommendations. The following side rails were observed that did not meet those standards:</p> <ul style="list-style-type: none"> <li>- In room #1, beds #2 had 4 side rails with openings that measured 7 1/2" by 9" by 7 1/2" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening.</li> <li>- In room #2, all 3 beds had 4 side rails with openings that measured 7 1/2" by 9" by 7 1/2" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening.</li> <li>- In room #9, all 3 beds had 4 side rails with three openings. The side rail openings measured 7 1/2" by 9" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening. The Maintenance Supervisor indicated the openings in the rails were larger than the 4 3/4" when</li> </ul>		<p>B. C.) The shower chair was repaired and a new shower chair ordered. Staff was trained to ensure they report all devices of concern or broken. All staff is responsible to report any concerns with assistive devices immediately to their supervisor. A maintenance repair sheet is to be completed for all devices with concerns or need of repair. The maintenance supervisor is responsible to respond to all maintenance slips in a timely manner, report to the administrator for purchase of devices unable to repair. Department Supervisors will assess for concerns of assistive devices as reported and with their scheduled weekly floor tour. CQI will review supervisor findings and corrective actions taken to fix or repair the concerns in a timely manner, no less than quarterly.</p>		

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	<p>measured.</p> <ul style="list-style-type: none"> <li>- In room #7, Bed 2 had 4 side rails with 3 openings on each one that measured 7 1/2" by 9" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening.</li> <li>- In room #6, the bed by the door had 4 side rails with measurements of 7 1/2" by 9" for the two outer openings, and 7 1/2" by 7 1/2" for the middle opening.</li> <li>- In room #10, bed 2 had 4 side rails with 3 openings on each one that measured 7 1/2" by 9" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening.</li> <li>- In room #3, the bed by the window had 4 side rails; the 2 side rails at the head of the bed had openings that measured 6 1/2" by 5" and the side rails at the foot of the bed measured 5" by 5" on the outer openings and 7 1/4" by 5" in the middle opening. The second bed had 4 side rails that measured 7 1/2" by 9" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening.</li> <li>- In room #1, beds #2 and 3 had 4 side rails with openings that measured 7 1/2" by 9" by 7 1/2" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening.</li> <li>- In room #2, all 3 beds had 4 side rails with openings that measured 7 1/2" by 9" by 7 1/2" for the two outer openings, and 7 1/2" by 7 1/2" in the middle opening.</li> </ul> <p>A policy for "Side Rails" was provided by</p>			

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	<p>the administrator on 6/22/12 at 12:37 p.m. The policy indicated, but was not limited to, "Purpose: To prevent resident from injury. Equipment: Side rails attached to bed, of adequate height and length for safety...Entrapment Hazards: The FDA has issued a safety alert identifying how entrapment deaths have occurred and preventive measures. All reported entrapments occurred in one of the following ways (numbered 1-4 in the diagram below): 1. Through the bars of an individual side rail. 2. Through the space between split side rails..."</p> <p>The immediate jeopardy that began on 6/21/12 was removed on 6/28/12 when the facility had completed an assessment of side rails in the facility and side rail assessments on residents, side rails were removed for those residents who did not demonstrate mental and physical capabilities to utilize the side rails. Staff was educated one on one prior to their next shift. The educations included the proper positioning of residents of residents and the side rail policy. A resident council meeting was conducted to inform residents. The facility notified resident's family and physician. Resident's side rail care plans were reviewed and revised as needed. The facility assessed the resident's needs for side rails and one resident continued to</p>			

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	<p>need side rails due to a specialty mattress and increased risk of the mattress to slide off of the bed, one resident was given a wider mattress, one resident's side rails remained due to the bed controls were attached to the side rails, and three residents had enabler bars placed on their bed. The immediate jeopardy was removed on 6/28/12 at 6:40 p.m., but non compliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>B. 1. Resident #A's record was reviewed on 6/22/12 at 12:01 p.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, mental retardation, high blood pressure, congestive heart failure, cerebral palsy, and paraplegia.</p> <p>An annual minimum data set assessment dated 5/20/12 indicated Resident #A had severe impairment in cognitive skills, required total assist with transfers and bed mobility, did not ambulate, was incontinent of bowels, and frequently incontinent of bladder.</p> <p>During an observation on 6/21/12 at 8:55 a.m., CNA #3 and CNA #4 transferred Resident #A from his wheel chair to his</p>				

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	<p>bed with the mechanical lift. The lift was unsteady, swayed during the transfer, and made popping and creaking sounds. CNA #4 indicated the lift has "turned over five times in the past 2 years, and "you have to kick the legs open". The CNAs attached the hooks on the arms of the lift and attached them to the lift pad, then used the hand crank on the lift to raise the resident up out of his chair. Then they turned the lift around to the bed and lowered the resident onto the bed.</p> <p>B. 2. Resident #B's record was reviewed on 6/21/12 at 12:45 p.m. The record indicated Resident #B had diagnoses that included, but were not limited to, obesity, osteoporosis, chronic anxiety, and immobility syndrome.</p> <p>A quarterly minimum data set assessment dated 6/11/12 indicated Resident #B was severely impaired in cognitive skills for daily decision making, required extensive assist of 2 for transfers, and used a wheel chair for mobility.</p> <p>On 6/21/12 at 10:10 a.m., Resident #B was observed as she was transferred from her wheel chair to her bed with CNA #3 and CNA #4. The CNAs attached the hooks to the lift pad under the resident and lifted the resident onto the bed. The lift made popping and cracking sounds</p>			

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	<p>and swayed slightly during the transfer. CNA #3 held the left shoulder part of the sling, where it was attached to the hook so it wouldn't slide off during the transfer. CNA #3 said: "I'm afraid it will slip off." As the resident was placed on the bed, the CNAs had to manually lift her up onto the mattress due to the height of the specialty mattress on her bed. The resident stated: "This thing scares the h--- out of me." The lift pad was removed from under the resident and placed on her wheel chair. When the edge of the lift pad was raised to inspect it, the metal bar with the hole in the center where the hooks attach, fell out of a hole in the fabric where it was supposed to have been securely stitched.</p> <p>On 6/21/12 at 12:12 p.m., Resident #B was observed as she was transferred from her bed to her wheel chair with CNAs #3 and 4. The lift pad was placed under the resident and the hooks placed in the swivel bar hooks. When the resident was lifted up, she did not clear the bed, and the bed rolled with the resident. Staff were able to clear the bed and placed the resident into the wheel chair. The lift made creaking sounds as the resident was transferred.</p> <p>On 6/21/12 at 10:55 a.m., the Administrator indicated she has a call out to a local pharmacy to replace the lift pad</p>			

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	<p>and had spoken to them about replacing the actual lift.</p> <p>On 6/21/12 at 6:25 p.m., the Director of Nurses indicated she did not know the lift wasn't working right until 5/21/12.</p> <p>A policy for use of the hydraulic lift was provided by the Administrator on 6/22/12 at 5:55 p.m. The policy indicated, but was not limited to, general instructions for transferring the resident, and "...7. Attach the ends of the chains to the swivel bar hooks. 8. Attach "S" hooks of the back rest if seat has a back rest. Note: At this point, check to be sure that all hooks are secure and evenly placed so resident is balanced. Position seat close to the knees for safety...."</p> <p>C. During the environmental tour with the Maintenance Director on 6/21/2012 at 10:20 A.M. to 11:50 A.M., an observation of the shower room, noted a shower chair with the left black rubber arm rest broken exposing the metal arm plate containing sharp edges. During interview at that time, the Maintenance Director indicated he was not aware of the broken arm rest on the shower chair, but he would fix it or request a new one.</p> <p>During interview at that time, CNAs # 6 and # 7, indicated the shower chair arm</p>						

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	rest with exposed sharp metal edges, had been this way for awhile and we just cover a towel over the arm rest during showers for residents. They both indicated all but two residents use this shower chair, CNA # 6 stated, "no I did not tell the maintenance man that the arm rest was broken".  3.1-19(c)			

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NAME OF PROVIDER OR SUPPLIER  SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to store prepare, distribute and serve food under sanitary conditions in that a 3 compartment sink failed to register parts per million (ppm's) for the sanitizer, the inside of a metal range hood was rusty, the bottom of a freezer was rusty, and non food boxes were stored in the dry food storage area for 2 of 2 dietary observation. This had the potential to affect all 21 residents who resided in the facility.</p> <p>Findings include:</p> <p>During a dietary observation on 6/21/12 at 9:20 a.m., with the Dietary Manager, the following was observed: - In the 3 compartment sink, the sanitation compartment of the sink did not register any parts per million (PPMs) that would have indicated it was effectively sanitizing dishes. Dietary staff #5 had just finished washing the breakfast dishes, and these were draining on the left side of the sink. During interview at that time, Dietary staff #5 said she would re-wash</p>	F000371	<p>F 371 Food Procure, Store/Prepare/Serve – Sanitary The facility will store, prepare, distribute and serve food under sanitary conditions. The dietary supervisor conducted an in-service training on dish washing with the use of the three compartment sink for all dietary staff. The metal range hood was cleaned thoroughly and painted. The vent fan was removed and cleaned. The freezer with noted rust has been defrosted, cleaned and the bottom drawer area with the noted rust will not be used. The freezer will be replaced by August 15, 2012. The following has been removed from the food storage area: 1 box of tile, 2 boxes of liquid feeding, 2 boxes of enteral feeding syringes, 2 boxes of florescent lights. The policy and procedure for dish washing has been reviewed by the dietary supervisor, administrator and the contracted dietician. The maintenance main has been trained to not allow non-food items, including florescent bulbs to be stored in the food supply room. The dietary supervisor will be responsible to visual assess the</p>	07/18/2012			

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	<p>the dishes, then drained the sink and re-washed the dishes. The PPMs tested 50 -100 as checked when Dietary staff #5 re-washed the dishes.</p> <p>- The metal range hood which was approximately 4' by 4' had scattered rusted areas that covered half the inside surface. The back inside of the range hood had a vent with dust on the vent pipe cover and spider webs on the back of the vent, in front of a fan. During interview at that time, the Dietary Manager indicated those were spider webs in front of the fan.</p> <p>- In the dry food storage area, the floor of the upright freezer had multiple rusty scratches that covered half the surface of the freezer floor and ice covering most of the surface. Under the ice, an object the Dietary Manage identified as an apple stem had been frozen.</p> <p>- On the right side of freezer #4, under a metal shelf, and sitting on the floor, the following was stored: 1 box of floor tile, 1 large box that contained 2 boxes of "liquid feeding", 24 cans in each box, and 2 boxes of syringes. The dietary Manager indicated at that time the boxes of syringes were put in there by nursing to be taken to the storage shed and "they were going to send them back."</p> <p>- Under the window, 2 tall boxes of fluorescent lights, one opened, and both approximately 4' tall were stored.</p>		<p>policy and procedure for washing dishes in a 3 compartment sheet is followed and to randomly check the chlorine ppm in the final rinse sink to ensure adequate chlorine ppms are recorded. The cleaning schedule for the dietary department has been reviewed by the dietary supervisor and administrator to ensure all areas with finding are included on the schedule. The dietary supervisor is responsible to ensure that the cleaning is performed adequately and thoroughly as scheduled. CQI will monitor dietary cleaning as scheduled, non-food items are not stored in food storage area and the chlorine ppm are maintained in the third compartment of the 3 compartment sink.</p>				

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	<p>A policy for "Manual Washing in a Three Compartment Sink" was provided by the administrator on 6/22/12 at 12:37 p.m. The policy indicated, but was not limited to, "Policy: a stainless steel three-compartment sink with two drain boards is used to manually wash pots, pans, and other production utensils...Procedure...5. Washing method...c. Sink # - Items are sanitized in an appropriate amount of sanitizing solution as specified by the manufacturer (i.e., 50-100 ppm chlorine) at 75 [degrees Fahrenheit] for at least one minute...."</p> <p>3.1-21(i)(3)</p>			

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F000441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review, interview and observation, the facility failed to ensure</p>	F000441	F 441 Infection Control, prevent the spread, linens	06/28/2012			

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	<p>medications were given under sanitary conditions in that gloves were not worn to do blood sugar testing, give insulin injections, nebulizer canister was not cleaned after use, and paper medication cups that fell on floor were picked up and placed back on the clean stack of cups on the medication cart. This affected 3 out of 21 residents in the facility with the potential to affect 21 out of 21 residents. (Residents #1, A, and #10)</p> <p>Findings include:</p> <p>During the medication pass on 6/20/12 beginning at 11:10 a.m. to 12:30 p.m., RN #1 did not wear gloves when doing a blood sugar or giving an insulin injection for Resident #1. At 11:43 a.m., a breathing treatment was done and there was no cleaning of the canister. At 12:16 p.m., 4 paper medication cups stacked on a medication cart were knocked off onto the floor. RN#1 picked them up off the floor and placed them back on the stack. She moved on to another task. She was asked to remove those cups from the stack and put them in the trash. At the time of this she was preparing medications for Res #10.</p> <p>During interview on 6/22/12 at 1:20 p.m., with the DON (Director of Nursing), she indicated that gloves were to be worn</p>		<p>The director of Nursing reviewed the policy and procedure for infection control, obtaining blood sugars and administration of nebulizer. The Director of nursing conducted an in-service training of Infection Control for all licensed nurses. The facility pharmacy has conducted evaluations on 3 of 6 nurses, including RN# 1, RN # 2 and a LPN. RN#1 and all other licensed nurses was trained on the importance of using gloves when obtaining blood sugars, giving insulin and the rinsing of nebulizer canister after every use for all residents, including services to resident #1. RN#1 and all other licensed nurses were trained on discarding medication cups which fall on the floor to the trash. The Director of Nursing is responsible to visually observe that the facilities policy and procedure of infection control is maintained randomly while in the facility. CQI committee members are responsible to observe the facilities infection control policy is maintained at all times while in the facility. CQI members will report all concerns to the administrator as noted. CQI will review infection control maintenance no less than Quarterly.</p>				

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	<p>during blood sugar testing and insulin injections. There was to be cleaning of the nebulizer canister after each use and the medication cups should have gone in the trash.</p> <p>A policy received on 6/21/12 at 3:35 p.m., from the Administrator, titled: "AA. In administering injectable medications, the following guidelines apply:...6. Gloves shall be worn when administering injectable medications..."</p> <p>A policy received on 6/22/12 at 4:30 p.m., titled; "Universal Precautions" indicated: "...Body fluids to which universal precautions apply 1. Blood...Protective Barriers...1. Gloves - if contact with visible blood is probable...b. Gloves are to be used for Glucometer or Accucheck testing. (blood sugar testing)</p> <p>A policy and procedure titled, "Policy and Procedure for Nebulizers and Maintenance" was received from the Administrator on 6/22/12 at 4:45 p.m., with an effective date of July 29, 2009 and a review date of May 5, 2012. In the section titled; "Maintenance: 1...Cleaning should be done after each treatment,..."</p> <p>Potter and Perry's "Fundamentals of Nursing", third edition, indicated:</p>			

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	"...Medical asepsis, or clean technique, includes procedures used to reduce the number of microorganisms and prevent their spread...using clean medication cups are examples of medical asepsis..."  3.1-18(a) 3.1-18(b)(1)			

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F000456 SS=E	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review, and interview, the facility failed to ensure resident care equipment was in safe operating condition in that 1 of 1 mechanical lifts was unsteady and made popping and creaking sounds when used. This affected 2 of 4 residents (Residents #A and B) reviewed for utilizing the mechanical lift, and had the potential to affect 5 residents in the facility who utilized the mechanical lift.</p> <p>Findings include:</p> <p>1. During an observation on 6/21/12 at 8:55 a.m., CNA #3 and CNA #4 transferred Resident #A from his wheel chair to his bed with the mechanical lift. The lift was unsteady, swayed during use, and made popping and creaking sounds. CNA #4 indicated the lift has "turned over five times in the past 2 years, and "you have to kick the legs open". The CNAs attached the hooks on the arms of the lift to the lift pad, then used the hand crank on the lift to raise the resident up out of his chair. Then they turned the lift around to the bed and lowered the resident onto the bed.</p>	F000456	<p>F 456 Essential equipment, safe operating Condition</p> <p>The facility has a new Hoyer mechanical lift to transfer resident A, resident B and all other residents requiring the use of a mechanical lift. Staff has been in-serviced on the new lift and the need to report all device concerns to their supervisor immediately and a maintenance repair sheet to be completed before ending their shift.</p> <p>1.) CNA 3 &amp; 4 were trained along with all other cna's to report all concerns immediately to their supervisor and to complete a maintenance repair sheet to report concerns with all devices which is given to the maintenance director after coping to give also to the administrator. A new mechanical lift and lift pad are available to use for residents. CNA 3 &amp; 4 was trained along with all other cna's on the proper use of the mechanical lift and new lift pad.</p> <p>2.) The lift pad which staff had cut to easily remove bars was discarded. CNA 3 &amp; 4 were trained along with all other cna's to report all concerns immediately to their supervisor and to complete a maintenance repair sheet to report concerns with all</p>	07/18/2012			

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	<p>2. On 6/21/12 at 10:10 a.m., Resident #B was observed as she was transferred from her wheel chair to her bed with CNA #3 and CNA #4. The CNAs attached the hooks to the lift pad under the resident and lifted the resident onto the bed. The lift made popping and cracking sounds and swayed slightly during use. CNA #3 held the left shoulder part of the sling, where it was attached to the hook so it wouldn't slide off during the transfer. CNA #3 said: "I'm afraid it will slip off." As the resident was placed on the bed, the CNAs had to manually lift her up onto the mattress due to the height of the specialty mattress on her bed. The resident stated: "This thing scares the h--- out of me." The lift pad was removed from under the resident and placed on her wheel chair. When the edge of the lift pad was raised to inspect it, the metal bar with the hole in the center, where the hooks attach, fell out of a hole in the fabric of the lift pad.</p> <p>On 6/21/12 at 12:12 p.m., Resident #B was observed as she was transferred from her bed to her wheel chair with CNAs #3 and 4. The lift pad was placed under the resident and the hooks placed in the lift pad bars. When the resident was lifted up, she did not clear the bed, and the bed rolled with the resident. Staff were able to clear the bed and placed the resident</p>		<p>devices which is given to the maintenance director after coping to give also to the administrator. A new mechanical lift and lift pad are available to use for residents. CNA 3 &amp; 4 was trained along with all other cna's on the proper use of the mechanical lift and new lift pad. The new mechanical lift raises resident # B above the mattress to ensure she clears the mattress. The Director of Nursing reviewed the policy and procedure of use of the hydraulic lift. All CNA's were trained on the use of manual lift and reporting defective assistive devices immediately. The director of nursing is responsible to visually observe the transfer of residents weekly for 4 weeks then randomly monthly. The maintenance supervisor will monitor assistive devices including the mechanical lift is working properly during his weekly rounds. CQI will monitor maintenance round reports and the mechanical lift no less than quarterly.</p>				

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	<p>into the wheel chair. The lift made creaking sounds as the resident was transferred.</p> <p>On 6/21/12 at 10:55 a.m., the Administrator indicated she has a call out to a local pharmacy to replace the lift pad and had spoken to them about replacing the actual lift.</p> <p>On 6/21/12 at 6:25 p.m., the Director of Nurses indicated she did not know the lift wasn't working right until 5/21/12.</p> <p>A policy for use of the hydraulic lift was provided by the Administrator on 6/22/12 at 5:55 p.m. The policy indicated, but was not limited to, general instructions for transferring the resident, and "...7. Attach the ends of the chains to the swivel bar hooks. 8. Attach "S" hooks of the back rest if seat has a back rest. Note: At this point, check to be sure that all hooks are secure and evenly placed so resident is balanced. Position seat close to the knees for safety...."</p> <p>This federal tag relates to complaint IN00109777.</p> <p>3.1-19(bb)</p>				

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F000465 SS=A	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment in 1 of 1 wash room.</p> <p>Findings included:</p> <p>During the environmental tour with the Maintenance Director on 6/21/2012 from 10:20 A.M. to 11:50 A.M., the wash room, had a dust-filled register grate rusted with corner broken.</p> <p>During interview at that time, the Maintenance Director indicated this room was used by CNA's and nurses to wash out soiled clothing before sending it to the laundry.</p> <p>3.1-19(f)</p>	F000465	<p>F 465The grate in the soiled Utility Room (wash room) was removed and the register was cleaned. A new cold air duct vent cover was replaced. The maintenace supervisor is responsible to check all floor register for dust during weekly floor tour. Housekeeping is responsible to clean all floor registers during the routinely scheduled major cleaning. The housekeeping cleaning schedule was reviewed by the housekeeping supervisor. Housekeeping department was in-serviced on maintaining a clean environment for residents, staff and vistitors. Department supervisors will observe floor registers for dust no less than weekly. CQI will monitor floor tour findings no less than quarterly.</p>	07/18/2012			