

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155773	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
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NAME OF PROVIDER OR SUPPLIER  TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 MCDOWELL RD EVANSVILLE, IN 47712
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00201755.</p> <p>Complaint IN00201755-Substantiated. Federal/State deficiencies related to the allegations are cited at F-224, F-226, F-278, and F-9999.</p> <p>Survey dates: July 5, 6, 7, 11, 12, 13, &amp; 14, 2016</p> <p>Facility number: 010930 Provider number: 155773 AIM number: 201274710</p> <p>Census bed type: SNF: 31 SNF/NF: 39 Residential: 30 Total: 100</p> <p>Census payor type: Medicare: 22 Medicaid: 15 Other: 33 Total: 70</p> <p>These deficiencies reflect State findings</p>	F 0000	<p>This plan of correction is to serve as The Terrace atSolarbron's credible allegation of compliance. Submission of this plan of correction does not constitute anadmission by The Terrace at Solarbron or its management company that theallegations contained in the survey report are a true and accurate portrayal ofthe provision of nursing care and other services in this facility. Nor does this submission constitute anagreement or admission of the survey allegations.</p>	

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

TITLE

(X6) DATE

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

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F 0224 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from misappropriation of property and personal identity for 1 of 21 residents reviewed for misappropriation of property. A resident had their personal identity used to misappropriate money from their bank account by an employee. (Resident A)</p> <p>Findings include:</p> <p>During review of the State reportable incidents, obtained from the Administrator on 7/6/16 at 9:25 a.m., the reportables indicated the facility had been contacted by Resident A's bank on 6/16/16 indicating the bank had received</p>	F 0224	F 224 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility respectfully wishes to present an IDR on this citation. Resident A had no money misappropriated from her bank account. The investigation is on-going with the law enforcement agencies involved and the facility is awaiting the results of this investigation. The facility policy was followed regarding misappropriation. All residents who have alleged misappropriation have been reviewed and no misappropriation was found during the investigation. The systemic change includes all allegations of misappropriation are immediately reported to the Administrator and an investigation is immediately conducted. The facility policy is	08/05/2016

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	<p>23 (twenty-three) checks which had been written in the amount of \$30,000.00 on an account from another bank with the resident's name on the checks. Resident A's POA (Power of Attorney) was the trust officer at the resident's bank.</p> <p>The clinical record for Resident A was reviewed on 7/7/16 at 3:00 p.m. Resident A had diagnoses including, but not limited to, heart failure and age-related debility. A significant change MDS (Minimum Data Set) assessment, dated 6/13/16, indicated the resident had a BIMS (Brief Interview for Mental Status) assessment score of 3, indicating severe cognitive impairment.</p> <p>During an interview with the Administrator (Adm) on 7/12/16 at 2:45 p.m., the Adm indicated she received a call from the bank regarding misappropriation of the resident's money. The Adm indicated the bank trust officer was the POA for the resident and the resident did not have any family. She indicated the bank had informed her the funds were never given to the employee or her daughter. The Adm indicated the bank had froze the account when the checks had first started to appear. The Adm indicated an employee of the facility had obtained Resident #66's social security number and birthday from</p>		<p>followed for suspension of the staff member and a thorough investigation is conducted. An abuse checklist will be completed during the course of the investigation that outlines the facility policy and steers the completion of all aspects of the process. Education will continue to be provided to all employees upon hire, annually, and as needed on the facility policy on abuse and misappropriation of resident property. Current staff will be provided with education regarding the facility's policy on misappropriation of property. In addition, the Administrator and Director of Nursing have been provided education regarding the systemic change. The Administrator or designee, will complete the facility Abuse Checklist with all allegations of abuse, which directs all aspects of the facility policy on abuse and misappropriation. The results of these checklists will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/16</p>				

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F 0226 SS=D Bldg. 00	<p>the resident's chart and opened an online bank account through a different bank. The employee had the checks sent to a post office box in another town, in her daughter's name. The checks were then signed by the daughter of the employee and co-signed by the employee. The Adm indicated the local county police, city police, and the police in the town where the checks were sent had been notified and were investigating the incident. The Adm indicated the employee was no longer employed by the facility.</p> <p>A policy, obtained from the Nurse Consultant on 7/14/16 at 10:20 a.m., indicated the facility would not condone any form of resident abuse or neglect.</p> <p>This Federal tag relates to Complaint IN00201755.</p> <p>3.1-28(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit</p>			

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	<p>mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement the written policy to ensure a resident was free from misappropriation of property and personal identity for 1 of 21 residents reviewed for misappropriation of property. A resident had their personal identity misappropriated and used to open an online checking account. (Resident A)</p> <p>Findings include:</p> <p>During review of the State reportable incidents, obtained from the Administrator on 7/6/16 at 9:25 a.m., the reportables indicated the facility had been contacted by Resident A's bank on 6/16/16 indicating the bank had received 23 (twenty-three) checks which had been written in the amount of \$30,000.00 on an account from another bank with the resident's name on the checks. Resident A's POA (Power of Attorney) was the trust officer at the resident's bank.</p> <p>The clinical record for Resident A was reviewed on 7/7/16 at 3:00 p.m. Resident A had diagnoses including, but not limited to, heart failure and age-related</p>	F 0226	<p>F226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility respectfully wishes to present an IDR on this citation. The facility does implement the written policy to ensure residents are free from misappropriation of property and personal identity. The law enforcement investigation is ongoing at this time. All residents who have alleged misappropriation have been reviewed and no misappropriation was found during the investigation. The systemic change includes all allegations of misappropriation are immediately reported to the Administrator and an investigation is immediately conducted. The facility policy is followed for suspension of the staff member and a thorough investigation is conducted. An abuse checklist will be completed during the course of the investigation that outlines the facility policy and steers the completion of all aspects of the process. Education will continue to be provided to all employees upon hire, annually, and as needed on the facility policy on abuse and misappropriation of resident property. Current staff will be provided with education regarding</p>	08/05/2016

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	<p>debility. A significant change MDS (Minimum Data Set) assessment, dated 6/13/16, indicated the resident had a BIMS (Brief Interview for Mental Status) assessment score of 3, indicating severe cognitive impairment.</p> <p>During an interview with the Administrator (Adm) on 7/12/16 at 2:45 p.m., the Adm indicated she received a call from the bank regarding misappropriation of the resident's money. The Adm indicated the bank trust officer was the POA for the resident and the resident did not have any family. She indicated the bank had informed her the funds were never given to the employee or her daughter. The Adm indicated the bank had froze the account when the checks had first started to appear. The Adm indicated an employee of the facility had obtained Resident #A's social security number and birthday from the resident's chart and opened an online bank account through a different bank. The employee had the checks sent to a post office box in another town, in her daughter's name. The checks were then signed by the daughter of the employee and co-signed by the employee. The Adm indicated the local county police, city police, and the police department in the town where the checks were sent, had been notified and were investigating the</p>		<p>the facility's policy on misappropriation of property. In addition, the Administrator and Director of Nursing have been provided education regarding the systemic change.</p> <p>The Administrator or designee, will complete the facility Abuse Checklist with all allegations of abuse, which directs all aspects of the facility policy on abuse and misappropriation.</p> <p>The results of these checklists will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/16</p>	

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F 0241 SS=D Bldg. 00	<p>incident. The Adm indicated the employee was no longer employed by the facility.</p> <p>A policy, obtained from the Nurse Consultant on 7/14/16 at 10:20 a.m., indicated the facility would not condone any form of resident abuse or neglect. The policy further indicated the facility would continually monitor the facility's policies and procedures to assist in preventing resident abuse.</p> <p>This Federal tag relates to Complaint IN00201755.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to provide dignity for 4 of 31 resident's</p>	F 0241	F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY Residents #1, 172, 12 and 76 are currently being provideddignity by staff knocking on the door and	08/05/2016

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	<p>reviewed. Staff failed to knock and announce themselves prior to entry and failed to provide privacy during care. (Resident #1, Resident #172, Resident #76, Resident #12.)</p> <p>Findings include:</p> <p>1. On 7/11/16 at 10:45 a.m., CNA #1 (certified nursing assistant) took Resident #1 to the bathroom in her room for a shower. CNA #1 transferred Resident #1 from her wheelchair to the bench in the shower. CNA #2 took off the resident's gown. Resident #1 took off her bra. Resident #1 was fully undressed sitting in the shower. CNA #2 did not pull the shower curtain, shut the door to the bathroom, or the door leading into the resident's room.</p> <p>2. During an observation on 7/5/16 at 2:43 p.m., CNA #4 entered the room with Resident #172. Resident #172 was observed to be sitting in a wheelchair. Resident #172's wife and brother were observed to be sitting in the resident's room. CNA #4 indicated she needed to transfer the resident to the reclining chair at that time and proceeded to call for assistance over her radio. CNA #4 applied a gait belt to Resident #172. CNA #5 and CNA #6 entered the room and assisted CNA #4 with the transfer of Resident #172 into the reclining chair.</p>		<p>announcing themselves prior to entry and privacy during care. All residents will be provided with dignity by staff knocking on the door and announcing themselves prior to entry and privacy during care. The staff involved have received education on the facility policy on dignity.</p> <p>The Systemic Change includes:</p> <ul style="list-style-type: none"> <li>The facility will continue the "Caring Hearts Program" to monitor dignity concerns with rounds and interviews with residents and families. This program has individual department managers assigned to a specific group of residents and complete rounds and interviews with both the resident and families on a routine basis. The information is immediately acted upon and presented monthly at the facility's QAPI meetings for further discussion and action plans.</li> <li>The charge nurse will complete rounds every shift to monitor for promotion of dignity through knocking on the resident's door and announcing themselves prior to entry, privacy during care and use of the pager during care. Immediate intervention will take place with any concern</li> <li>The Unit Manager or designee will complete rounds daily (Monday through Friday) to monitor for promotion of dignity through knocking on the resident's door and announcing themselves</li> </ul>		

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	<p>None of the CNAs knocked on the door or announced themselves prior to entering the room and the door was left opened to the hall during the transfer.</p> <p>3. During an observation on 7/12/16 at 9:38 a.m., CNA #7 and CNA #8 were observed to be giving a partial bath to Resident #179. During the bath CNA #7 answered her pager and indicated to the caller the whereabouts of her personal items, which were located in another room. CNA #7 announced in front of the resident that the caller was needing a "female product." CNA #7 received another call on her radio from the same caller, who again was questioning the whereabouts of CNA #7's personal items. CNA #7 again directed the caller to the direction of her personal item. After disconnecting from the caller, CNA #7 announced in front of the resident the caller was needing some "Female products."</p> <p>4. On 7/11/16 at 9:13 a.m., LPN #2 failed to knock or announce themselves prior to entering Resident #172's room.</p> <p>5. On 7/12/16 at 9:32 a.m., RN #1 failed to knock or announce themselves prior to entering Resident #76's room.</p> <p>On 7/13/16 at 11:21 a.m., CNA #3 indicated that when giving a resident a</p>		<p>prior to entry, privacy during care and use of the pager during care. Immediate intervention will take place with any concern</p> <p>Education will be provided to staff regarding the facility policy on Dignity, with an emphasis on knocking on doors and announcing themselves prior to entry, privacy during care and use of the pager during care. Education will be provided to Caring Hearts representatives, charge nurses and Unit Managers regarding the systemic change.</p> <p>A quality assurance tool will be utilized by the Director of Nursing, or designee, to audit for staff knocking on the resident's door and announcing themselves prior to entry, privacy during care and use of the pager during care. This audit will be completed daily, on each unit and on random shifts for 4 weeks, then weekly for 4 weeks, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/2016</p>		

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F 0278 SS=D Bldg. 00	<p>shower dignity is maintained by pulling the shower curtain, and making sure the door to the bathroom is shut and the door to the room is shut.</p> <p>On 7/14/16 at 10:18 a.m., the Nurse Consultant provided the "Quality of Life-Dignity" policy, revised 10/2009. The policy included, but was not limited to: ....Residents' private space and property shall be respected at all times. Staff will knock and request permission before entering resident's rooms.....Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures....</p> <p>3.1-3(t)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p>						

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	<p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review, and interview, the facility failed to comprehensively complete an assessment for 2 of 31 MDS (Minimum Data Set) assessments reviewed. One (1) resident's MDS was incorrectly entered for behaviors and 1 resident's MDS was incorrectly entered for mobility. (Resident Z, Resident B)</p> <p>Findings include:</p> <p>1. During and observation on 7/6/16 at 11:02 a.m., Resident Z was observed to be sitting in his room in a wheelchair.</p> <p>During an observation on 7/11/16 at 9:10 a.m., Resident Z was observed to be</p>	F 0278	<p>F278 483.20(g) – (j)ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>Resident Z and Resident B had a corrected MDS submitted during the survey process.</p> <p>All current residents will have their most recent MDS reviewed for accuracy of mobility and behavior status and any concern will be addressed.</p> <p>The systemic change includes that the MDS coordinator will audit for accuracy of mobility status on the assessment and the Social Services Director will audit for accuracy of behavioral status on the assessment prior to any MDS being submitted. These reviews will be verified by a member of nursing administration prior to submission.</p>	08/05/2016

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	<p>propelling himself through the hall to the activity room.</p> <p>The clinical record for Resident Z was reviewed on 7/11/16 at 9:13 a.m. Resident Z had diagnoses including, but not limited to, generalized anxiety disorder, dementia with behavioral disturbances, restlessness, agitation, and COPD (chronic obstructive pulmonary disease). A quarterly MDS (Minimum Data Set) assessment, dated 6/19/16, indicated Resident Z had a BIMS (Brief Interview for Mental Status) assessment score of 6, indicating severe cognitive impairment.</p> <p>Resident Z had a physician's order, dated 9/16/15, that indicated the resident used a wheelchair for mobility.</p> <p>The MDS lacked documentation of a wheelchair as a mobility device.</p> <p>During an interview on 7/12/16 at 3:05 p.m., the MDS Coordinator indicated Resident Z used a wheelchair for mobility and she would need to speak to the person who filled out the MDS for the resident.</p> <p>2. The clinical record for Resident B was reviewed on 7/7/16 at 11:32 a.m. Resident B had diagnoses including, but</p>		<p>Education will be provided to MDS personnel, social services and nursing administration regarding correct coding of the MDS for mobility and behavioral status and the systemic change.</p> <p>-</p> <p>This audit will be ongoing at 100% for 2 months, then 10 assessments per week for 1 month, then 5 assessments per week for 1 month, then 3 assessments per week x 2 months.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/2016</p>	

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	<p>not limited to, dementia with behavioral disturbances, depressive disorder, and anxiety disorder. Resident B had an admission MDS (Minimum Data Set) assessment, dated 5/16/16, which indicated a BIMS (Brief Interview for Mental Status) of 3, which indicated severe cognitive impairment. The MDS indicated Resident B had no behaviors exhibited.</p> <p>The clinical record, dated 2/10/16 at 10:03 p.m., indicated Resident B had been going into other resident's rooms and was redirected into the TV (television) room. The note indicated Resident B walked up to the nurse's station, indicated she was not happy and threw a cup of water at a CNA.</p> <p>During an interview on 7/12/16 at 3:05 p.m., the MDS Coordinator indicated she would need to check with SW #1 regarding the behaviors as the SW completed the behavioral section of the MDS assessment.</p> <p>On 7/13/16 at 4:05 p.m., the DON (Director of Nursing) indicated the MDS Coordinator had made the corrections for both of the residents on their MDS assessments.</p> <p>This Federal tag relates to complaint</p>			

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F 0312 SS=E Bldg. 00	<p>IN00201755.</p> <p>3.1-31(d)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide ADLs (activities of daily living) to 4 of 6 residents reviewed. Showers and oral care were not provided to the residents. (Resident #12, Resident #179, Resident #181, Resident #88)</p> <p>Findings include:</p> <p>1. During an observation on 7/6/16 at 1:55 p.m., Resident #12 was observed to have a matted left eye and thick yellow sputum in her mouth. Resident #12's hair was unkept. Resident #12 indicated she had not received a shower or oral care in quite some time.</p> <p>During an observation on 7/12/16 at 9:38</p>	F 0312	<p>F312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident #181 no longer resides at the facility. Residents #12, 179 and 88 are being provided with showers and oral care. All current residents have been reviewed for providing showers and oral care and are receiving showers and oral care per their plan of care and any concerns addressed. The systemic change includes: ·Nurses will confirm that a shower was completed by a C.N.A. by signing a "shower sheet". After confirming that a shower was given, the nurse will confirm via observation of the resident that hygiene and oral care was given. In addition, the nurse will confirm oral care on random residents during her daily rounds.</p>	08/05/2016

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	<p>a.m., CNA #7 was observed to be giving Resident #12 a partial bed bath. No oral care was offered.</p> <p>The clinical record for Resident #12 was reviewed on 7/11/16 at 10:54 a.m. Resident #12 had diagnoses including, but not limited to, generalized muscle weakness, fracture metatarsal of the right foot, major depressive disorder, anxiety disorder, and chronic ischemic heart disease. The admission MDS (Minimum Data Set) assessment indicated Resident #12 had a BIMS (Brief Interview for Mental Status) assessment score of 15, which indicated no cognitive impairment.</p> <p>The "Care Sheet Unit 1" forms for the CNAs, obtained from LPN #2 on 6/7/16 at 2:00 p.m., indicated Resident #12 was to receive a shower on the day shift every Wednesday and Saturday.</p> <p>The "Resident Care Record," obtained on 7/12/16 at 2:47 form LPN #2, indicated Resident #12 had received 2 showers during the month of May, 2016, and had not received a shower during the month of June, 2016. The resident should have received 8 showers each month.</p> <p>During an interview on 7/12/16 at 10:10 a.m., CNA #7 indicated morning care consisted of either giving the resident a</p>		<ul style="list-style-type: none"> <li>·The facility will continue the "Caring HeartsProgram" to monitor hygiene concerns with rounds and interviews with residentsand families. This program hasindividual department managers assigned to a specific group of residents andcomplete rounds and interviews with both the resident and families on a routinebasis. The information is immediatelyacted upon and presented monthly at the facility's QAPI meetings for furtherdiscussion and action plans.</li> <li>·The facility will begin documentation of showersin the electronic record. The recordwill be reviewed by the nurse prior to the C.N.A. leaving their shift.</li> <li>·The shower documentation will be reviewed in thedaily (Monday through Friday) clinical meeting for completion and the staffdevelopment coordinator will follow up with any issues with documentation inthe electronic record as needed. Education will be provided to nursing staff regarding thefacility policy for showers, oral hygiene during am and pm care anddocumentation in the electronic record of bathing. In addition, the licensed nurses will beprovided education regarding the systemic change. Caring Heart representative will be providedwith education regarding the systemic change.</li> </ul>	

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	<p>partial bath or a shower, getting the resident dressed, applying deodorant, combing the hair, and providing oral care.</p> <p>2. During an observation on 7/5/16 at 3:27 p.m., Resident #179 was observed to be sitting in a reclining chair in her room. Resident #179 indicated she had only received 1 (one) shower since being admitted to the facility on 6/16/16.</p> <p>The "Care Sheets Unit 1", obtained from LPN #2 on 6/7/16 at 2:00 p.m., indicated Resident #179 was to receive a shower on Monday and Thursday evening every week.</p> <p>The "Resident Care Records", obtained from LPN #2 on 7/12/16 at 2:27 p.m., indicated the resident had not received a shower for the month of June, 2016. The resident should have received a total of 4 showers for the month of June, 2016.</p> <p>3. On 7/5/16 at 2:29 p.m., during an interview, Resident #181 indicated that he had not receive a shower for over a week.</p> <p>On 7/12/16 at 9:30 a.m., Resident #181's clinical records were reviewed. The resident care record for June 2016 indicated Resident #181 received 4</p>		<p>A quality assurance tool will be utilized by the Director of Nursing, or designee, to audit for completion of showers, oral care and completion of documentation in the electronic record. This audit will be completed daily, on each unit and on random shifts for 4 weeks, then weekly for 4 weeks, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/2016</p>	

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	<p>showers for the month of June 2016. July showers were not documented. Resident #181 was admitted to the facility on 6/10/16, and discharged from the facility on July 6, 2016.</p> <p>4. On 7/5/16 at 2:28 p.m., Resident #88 indicated he sometimes only received one shower a week.</p> <p>On 7/11/16 at 9:41 a.m., Resident #88's clinical record was reviewed. Resident #88 was admitted on 4/25/16. The Quarterly MDS (Minimum Data Set) assessment, dated 6/7/16, indicated Resident #88 BIMS (Brief Interview Mental Status) indicated Resident #88 was cognitively intact. The MDS further indicated Resident #88 required physical help in part of the bathing activity.</p> <p>The Care Plans included, but were not limited to: Resident is limited in ability to maintain grooming, dressing, and personal hygiene independently....the interventions included, but were not limited to, assist resident in full body bathing per resident preference.</p> <p>The May Resident Care Record indicated Resident #88 had only received a shower on 5/28/16. The Shower/Bath Sheets indicated Resident #88 had also received</p>			

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F 0441 SS=D Bldg. 00	<p>a shower on 5/18/16.</p> <p>On 7/11/16 at 1:40 p.m., the DON indicated a resident should receive two showers a week unless the resident requested more.</p> <p>On 7/14/16 at 10:18 a.m., the Nurse Consultant Provided the "Shower/Tub Bath" policy, revised 10/2009. The policy included, but was not limited to: The following information should be recorded on the resident's ADSL record, the electronic record and/or in the resident's medical record: The date the shower/tub bath was performed....</p> <p>3.1-38(a)(3) 3.1-38(a)(3)(B)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>			

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	<p>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 procedures were followed for 1 of 5 residents observed for personal care and 2 of 6 residents observed for medication administration.</p>	F 0441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Infection control procedures are being followed for personalcare and medication administration for Residents #189, 178 and 172. LPN #1 is no longer employed at thefacility. C.N.A. #4, 5, and 6 havereceived education regarding	08/05/2016

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	<p>Hand hygiene was not performed prior to and after resident care. (Resident #189, Resident #178, Resident #172)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 7/12/16 at 8:46 a.m., LPN #1 entered Resident #189 to administer medications. LPN #1 hand washed for 9 seconds, administered the medications, and hand washed for 7 seconds.</li> <li>On 7/12/16 at 8:37 a.m., LPN #1 entered Resident #178's room to administer medications. LPN #1 gave Resident #178 oral medications, hand washed, applied gloves, administered an injection, removed the gloves, and hand washed for 10 seconds.</li> <li>During an observation on 7/5/16 at 2:43 p.m., CNA #4 entered the room with Resident #172. Resident #172 was observed to be sitting in a wheelchair. CNA #4 indicated she needed to transfer the resident to the reclining chair at that time and proceeded to call for help over her radio. CNA #5 and CNA #6 entered the room and assisted CNA #4 with the transfer of Resident #172 into the reclining chair. No hand hygiene was performed and no gloves were applied prior to transferring the resident.</li> </ol>		<p>infection control and hand washing for personalcare.</p> <p>Infection control procedures are being followed for personalcare and medication administration for all residents per visual auditing and monitoring.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> <li>Nursing staff will complete a skills validation for hand-washing upon hire, annually and as needed.</li> </ul> <p>Education will be provided to nursing staff regarding the facility policy on hand hygiene, with emphasis on medication administration and washing prior to and after resident care.</p> <p>A quality assurance audit will be completed by the Staff Development Coordinator or designee to review for hand hygiene per the facility policy during one medication pass on a unit, on random shifts, daily (including weekends). In addition, a review will be completed on each unit, on random shifts for proper hand washing prior to and after resident care on random units and random shifts daily (including weekends). This audit will be completed daily (including weekends) for 4 weeks, then weekly for 4 weeks, then monthly for a duration of twelve months of monitoring.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months</p>	

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F 9999  Bldg. 00	<p>On 7/13/16 at 1:50 p.m., LPN #1 and CNA #1 indicated hands should be washed for 40-60 seconds before and after each resident contact.</p> <p>On 7/14/16 at 10:18 a.m., the Nurse Consultant provided the "Hand Washing/Hand Hygiene Policy, dated 3/24/16. The policy included, but was not limited to: ....Employees must wash their hands for at least twenty (40-60) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions....before and after direct resident contact.....</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia</p>	F 9999	<p>andthen quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will beincreased as needed, if compliance is below 100%. Compliance date 08/05/2016</p> <p>F9999 3.1 – 13 ADMINISTRATION AND MANAGEMENT The facility will have a Registered Nurse overseeing thecurrent Memory Care Unit Manager of the dementia special care unit and both theRegistered</p>	08/05/2016			

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	<p>special care unit. The director shall have an earned degree from an educational institution in health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special unit and six (6) hours annually thereafter to:</p> <p>This State rule is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure the Memory Care Director had an earned degree and twelve hours of dementia training for 1 of 1 special units observed. (Program Director)</p> <p>Findings include:</p> <p>On 7/6/16 at 10:01 a.m., the ADON</p>		<p>Nurse and the current Unit Manager will complete 12 hours of dementia training. The systemic change includes that the facility will have a Registered Nurse overseeing the current Memory Care Unit Manager of the dementia special care unit and both the Registered Nurse and the current Memory Care Unit Manager will complete 12 hours of dementia training. In the event of a change in the Memory Care Unit Manager or Registered Nurse overseer, there will be 12 hours of dementia training completed prior to starting the new position. Education for the Memory Care Unit Manager and "overseer" will be completed to include twelve hours of dementia specific training. The Administrator or designee will report the change in the program oversight to the facility's quality assurance committee. The Staff Development Coordinator will monitor for completion of 12 hours of Dementia Training for the current Memory Care Unit Manager and the Register Nurse designated to oversee the unit, as well as completion of 12 hours of Dementia Training for any changes in the Unit Manager or Registered Nurse designated to oversee the unit. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months</p>				

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	<p>indicated LPN #3 was the Memory Care Program Director.</p> <p>On 7/6/16 at 10:55 a.m., AS (Activity Staff) #1 indicated LPN #3 was the Memory Care Program Director.</p> <p>On 7/6/16 at 11:44 a.m., LPN #3 indicated she was the Memory Care Program Director.</p> <p>On 7/12/16 at 10:15 a.m., the employee files were reviewed. LPN #3's employee file indicated she was the Memory Care Program Director, hired on 1/13/16. The employee file further indicated LPN #3 had only obtained 4.75 hours of dementia specific training.</p> <p>On 7/12/16 at 11:30 a.m., the Administrator indicated the LPN #3 oversaw the memory care unit and acted as the Memory Care Program Director independently.</p> <p>On 7/12/16 at 1:01 p.m., the Administrator indicated the LPN #3 lacked an earned degree.</p> <p>On 7/13/16 at 10:50 a.m., the Administrator indicated LPN #3 had not received twelve hours of dementia specific training.</p>		<p>and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/2016</p>	

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R 0000 Bldg. 00	<p>On 7/14/16 at 9:22 a.m., the Administrator provided the "Memory Care Unit Manager" job description. The Administrator indicated, at that time, the job description was incorrect in indicating a LPN could function as the Memory Care Program Director.</p> <p>This State tag relates to Complaint IN00201755.</p>	R 0000	<p>This plan of correction is to serve as The Terrace atSolarbron's credible allegation of compliance. Submission of this plan of correction does not constitute anadmission by The Terrace at Solarbron or its management company that theallegations contained in the survey report are a true and accurate portrayal ofthe provision of nursing care and other services in this facility. Nor does this submission constitute anagreement or admission of the survey allegations.</p>	
R 0026 Bldg. 00	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and</p>			

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	<p>responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on interview and record review, the facility failed to have the Resident Rights Acknowledgement signed on admission for 1 of 7 resident's reviewed. (Resident #222)</p> <p>Findings include:</p> <p>On 7/13/16 at 10:30 a.m., Resident #222's clinical record was reviewed. The clinical record did not contain a signed Resident Rights Acknowledgement.</p> <p>On 7/13 /16 at 1:30 p.m., the Administrator provided a signed Resident Rights document, dated 7/13/16. Resident #222 was admitted on 2/4/16 to the facility. The Administrator</p>	R 0026	<p>R026 410 IAC 16.2-5.1.2(a) Residents' Rights – Noncompliance Resident #222 had the acknowledgement signed for residentrights during the survey process. All current resident files were reviewed for a signedacknowledgment for resident rights and any concerns were addressed. The systemic change includes that the Administrator or designee will confirm that the resident rights acknowledgement is signed by theresident or designated family member upon admission upon the next business dayafter admission. Education will be provided to the Admissions personnelregarding the facility policy regarding signing of resident rights uponadmission and the systemic change.</p>	08/05/2016

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R 0246  Bldg. 00	<p>acknowledged that the document should have been signed on admission to the facility and that she was aware that the document had been signed by the resident on 7/13/16.</p> <p>On 7/14/16 at 10:40 a.m., the Nurse Consultant provided a policy that indicated the facility will review with the resident, and/or his/her representative, the facility's policies and procedures relating to resident rights.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	R 0246	<p>The Administrator or designee will audit all new admissions for signature by the resident or designated family member for acknowledgement of resident rights. This audit will be completed daily (on the next business day after admission) for new admissions. This audit will continue for a duration of twelve months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/2016</p> <p>R246 410 IAC 16.2-5-4(e)(6) Health Services - Deficiency A licensed nurse has reviewed the as</p>	08/05/2016	

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	<p>a licensed nurse authorized as needed medications administered by a QMA (Qualified Medication Aide) for 5 of 7 resident records reviewed. (Resident #215, Resident #220, Resident #190, Resident #203, Resident #222)</p> <p>Findings include:</p> <p>1. On 7/13/16 at 8:45 a.m., Resident #203's clinical record was reviewed. The most recent signed physician's recapitulation orders, signed 6/2/16, included, but was not limited to: Loperamide (a medication used to treat diarrhea) cap (capsule), 2 mg (milligrams), take 1 capsule, by mouth, after each loose stool, as needed, for up to eight capsule in 24 hours.</p> <p>The May MAR (Medication Administration Record), indicated the resident received the as needed loperamide on 5/25/16 and 5/27/16-5/28/16. The MAR further indicated the medication was administered by a QMA (Qualified Medication Aide) and lacked a licensed nurse's authorization.</p> <p>2. On 7/13/16 at 9:30 a.m., Resident #220's clinical record was reviewed. The most recent signed physician's recapitulation orders, signed 6/2/16,</p>		<p>needed medications given by a QMA to Resident #215, 220, 190, 203 and 222.</p> <p>A licensed nurse will authorize as needed medications administered by a QMA for all residents receiving medication as needed by a QMA.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> <li>-In the event that a QMA is administering medications, the QMA will notify a licensed nurse of any request for an as needed medication by a resident.</li> <li>-A log will be utilized to record all as needed medications given by a QMA with a line for the licensed nurse to sign as acknowledgment of authorization for administration.</li> </ul> <p>Education will be provided to licensed nurses and QMAs regarding the systemic change.</p> <p>A quality assurance audit tool will be utilized by the Director of Nursing or designee daily to review for completion of the log with signatures of the licensed nurse authorizing the administration of as needed medications. Any concerns will be addressed. This audit will be completed daily for 4 weeks, then weekly for 4 weeks, then monthly for a duration of 12 months of monitoring.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will</p>	

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	<p>included, but were not limited to: Polyethylene glycol (a medication used to treat constipation), mix 17 grams, in 8 ounces of liquid of choice, and take by mouth, once daily, as needed for constipation Omeprazole (a medication used to treat heartburn) cap (capsule), 20 mg (milligrams), take one capsule by mouth, once daily, as needed for heartburn</p> <p>The June MAR (Medication Administration Record) indicated the resident received the as needed Omeprazole on: 6/1/16-6/5/16, 6/14/16, and 6/17/16. The Omeprazole was administered by a QMA (Qualified Medication Aide). The MAR lacked a licensed nurse's authorization.</p> <p>The May MAR indicated the resident received the as needed Omeprazole on 5/23/16-5/26/16. The MAR further indicated the resident received the Polyethylene Glycol on 5/7/16. Both as needed medications were administered by a QMA and lacked a licensed nurse's authorization.</p> <p>The March MAR indicated the resident received the as needed Polyethylene Glycol on 3/12/16. The MAR further indicated the medication was administered by a QMA and lacked a</p>		<p>beincreased as needed, if compliance is below 100%.</p>	

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R 0356  Bldg. 00	<p>licensed nurse's authorization.</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure emergency files were complete for 2 of 7 resident records reviewed. The emergency files lacked a picture of the resident. (Resident #220, Resident #214)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 7/13/16 at 9:30 a.m., Resident #220's clinical record was reviewed. The Emergency file lacked a picture of Resident #220.</li> <li>The clinical record for Resident #214</li> </ol>			R 0356	<p>F356 410 IAC 16.2-5.8.1(i)(1-8) Clinical Records –Noncompliance The emergency files for Resident #220 and #214 were completed with a picture of the resident attached during the survey process. All emergency files of current residents have been auditedfor completion with a picture of the resident and no other issues were found. The systemic change includes that the Medical Record Managerwill review all new admissions on the next business day for a completed pictureof a resident, and if the picture has not been completed by the</p>		08/05/2016

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R 0414 Bldg. 00	<p>was reviewed on 7/13/16 at 9:25 a.m. Resident #214 had diagnoses including, but no limited to, congestive heart failure and chronic obstructive pulmonary disease.</p> <p>The emergency file for Resident #214 lacked a picture of the resident.</p> <p>During an interview with the MR (Medical Records) Coordinator on 7/13/16 at 10:00 a.m., the MR Coordinator indicated she was lacking photographs of some of the residents on the Assisted Living section. She indicated she had given a list to the Admissions Coordinator to obtain, but he had not been able to obtain them yet.</p> <p>On 7/14/16 at 10:20 a.m., the Nurse Consultant provided the "Medical Records Disaster Binder" policy, dated 7/1/14. On 7/14/16 at 11:07 a.m., the Nurse Consultant indicated the policy did not include the necessity of a photo for the emergency binder.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and</p>	R 0414	<p>admissions coordinator, the Medical Record Manager will complete the picture and attach the picture to the emergency files. Education will be provided to the Medical Record Manager regarding the systemic change and a review of the policy for emergency files for residents. The Medical Record Manager will complete a quality assurance audit tool for all new admissions, on the next business day after admission, for a picture of the resident attached to the emergency file. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 08/05/2016</p>	08/05/2016

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	<p>record review, the facility failed to ensure infection control procedures were followed for 1 of 1 residents observed for personal care and 4 of 5 residents observed for medication administration. Hand hygiene was not performed. (Resident #190, Resident #194, Resident #209, Resident #214)</p> <p>Findings include:</p> <p>1. On 7/13/16 at 7: 57 a.m., LPN #1 was observed to enter Resident #190's room. LPN #1 was observed to hand wash for 10 seconds. LPN #1 administered Resident #190's medications and hand washed for 16 seconds. LPN #1 prepared medications for Resident #194. LPN #1 provided the medications to Resident #194 in the dining room. LPN #1 prepared Resident #209's medications. LPN #1 entered Resident #209's room and hand washed for 12 seconds.</p> <p>2. During an observation on 7/13/16 at 1:24 p.m., LPN #1 was observed to enter Resident #214's room to change a dressing to the back of the resident's right leg. LPN #1 was observed to wash her hands for 10 (ten) seconds and removed the old bandage and placed it in the bathroom wastebasket. LPN #1 washed her hands for 15 seconds, applied gloves, and washed the back of the right leg with a washcloth. LPN #1 changed her</p>		<p>Infection control procedures are being followed for personalcare and medication administration for Residents #190,194, 209 n 214. LPN #1 is no longer employed at thefacility.</p> <p>Infection control procedures are being followed for personalcare and medication administration for all residents per visual auditing andmonitoring.</p> <p>The systemic change includes: ·Nursing staff will complete a skills validationfor hand-washing upon hire, annually and as needed.</p> <p>Education will be provided to nursing staff regarding thefacility policy on hand hygiene, with emphasis on medication administration andwashing prior to and after resident care.</p> <p>A quality assurance audit will be completed by the StaffDevelopment Coordinator or designee to review for hand hygiene per the facilitypolicy during one medication pass on a unit, on random shifts, daily (includingweekends). In addition, a review will becompleted on each unit, on random shifts for proper hand washing prior to andafter resident care on random units and random shifts daily (includingweekends). This audit will be completeddaily (including weekends) for 4 weeks, then weekly for 4 weeks, then monthlyfor a duration of twelve months of monitoring.</p>	

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	<p>gloves, applied an ointment using a Q-tip to the wound, and placed a Telfa over the wound. LPN #1 removed her gloves and applied Kerlix to the area. LPN #1 indicated she had forgotten to bring tape into the room. LPN #1 washed her hands and obtained the tape for the dressing.</p> <p>On 7/13/16 at 1:50 p.m., LPN #1 and CNA #1 indicated hands should be washed for 40-60 seconds before and after each resident contact.</p> <p>On 7/14/16 at 10:18 a.m., the Nurse Consultant provided the "Hand Washing/Hand Hygiene Policy, dated 3/24/16. The policy included, but was not limited to: ....Employees must wash their hands for at least twenty (40-60) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions....before and after direct resident contact.....</p>		<p>The results of these reviews will be discussed at themonthly facility Quality Assurance Committee meeting monthly for 3 months andthen quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will beincreased as needed, if compliance is below 100%. Compliance date 08/05/2016</p>	