STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155708		06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE MANOR NURSING HOME	1109 E NATIONAL HWY WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 1, 2, 3, 4, and 5, 2015. Facility number: 000303 Provider number: 155708 AIM number: 100287530 Census bed type: SNF:3 SNF/NF: 34 Total: 37 Census payor type: Medicare: 6 Medicaid: 26 Other: 5 Total: 37 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please accept the following POC as Hillside Manor's credible allegation of compliance. We are requesting a desk review for the validation of compliance. We believe that our supporting documentation and monitoring program of the deficiencys will validate the support of a desk review.	
F 0225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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Bldg. 00	ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure	F 0225	F225	06/26/2015

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	an allegation of abuse was thoroughly investigated, in that, other residents were not interviewed regarding an allegation of abuse for 3 of 3 allegations of abuse investigations reviewed. (Resident #3, Resident #18, Resident #27) Findings include: The following 3 investigations of allegation of abuse were provided by the Health Care Administrator on 6/3/15 at 10:11 A.M. 1. During an observation and interview on 6/2/15 at 10:16 A.M., Resident #3 indicated he had been hit on the head, slapped several times, then verbally assaulted by a female staff member. Resident #3 further indicated he had told his nurse about having been abused at that time. The report documented on 5/30/15 at 5:20 P.M. that the Charge Nurse was notified by Resident #3's family of an allegation of abuse. The facility began investigating the allegation of physical and verbal abuse immediately. The initial report was faxed to the Indiana State Department of Health (ISDH) on 5/30/15 at 6:30 P.M. The follow-up investigation report was completed and faxed to the ISDH. The follow-up report		Hillside Manor Nursing Home shall not employ or keep in employment anyone found to have violations or convictions involving mistreatment, neglect or abuse from a limited criminal Indiana State Police Repository Report or from the Indiana State Nurse Aide Registry. All rules regarding IC 16-28-13-5 guiding employment of person with certain convictions shall be followed. Any employee found guilty of misappropriation of resident's property shall be discharged. Any and all allegations of abuse reported to administration shall start an immediately investigation. This investigation, as evidenced by documentation by the state surveyor, includes immediate notification to the family, the resident's physician, and the state board of health. It also includes the immediate suspension of any staff member, if the allegation was directed to staff and not another resident. This investigation of abuse shall be thorough until the allegation is	

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	indicated staff had been interviewed, discussion with family members had taken place, and/or Resident #3's physician had been notified, but the facility did not follow its own policy by ensuring a thorough investigation by interviewing other residents residing in the facility. The clinical record for Resident #3 was reviewed on 6/2/15 at 1:29 P.M. Diagnoses included, but were not limited to, panic disorder with agoraphobia (fear of wide open places), bipolar, macular degeneration, and anxiety . The MDS (Minimum Data Set) assessment dated 4/1/15 documented that Resident #3 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated that Resident #3 was cognitively intact. 2. The report documented that during a care conference on 2/3/15 at 5:20 P.M., an employee of the facility had borrowed money from Resident #27 and had repaid the loan. On 2/17/15 the Director of Nursing (DON) had received a call from the Ombudsman stating the loan had not actually been paid back. The incident was reported to the ISDH on 2/17/15. During the investigation of the incident the facility did not interview other		substantiated or un-substantiated All residents could be effected by poor performance by the abuse policy of Hillside Manor Nursing Home. A change in administration reporting shall include the number of residents interviewed within the abuse investigation, if this is applicable. No other residents other than # 27 & #18 were effected by the current abuse investigation policy. Every resident is given the opportunity to explain and report any abuse monthly in the resident council meeting. They are **specifically** ask for information regarding any abuse. Also, as a part of Hillside Manor's policy, the quarterly QA meeting randomly selects a resident and both he/she and the family sponsor is interviewed regarding abuse, likes and	

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	residents residing in the facility. The clinical record for Resident #27 was reviewed on 6/2/15 at 1:29 P.M. Diagnoses included, but were not limited to, depression, cerebral vascular accident with left hemiplegia, traumatic brain injury and anxiety. The MDS (Minimum Data Set) assessment dated 4/10/15 documented that Resident #27 had a BIMS (Brief Interview for Mental Status) score of 15 which indicated that Resident #27 was cognitively intact. 3. On 6/1/15 at 1:59 P.M., during an interview with Resident #18, when asked if anyone at the facility had abused her the resident indicated, "Yes, abuse, don't get here on time, s--- (bowel movement) goes down your leg and then they have to clean you up. They abuse you put you up in front of the rest of them..." On 6/3/15 at 10:11 A.M., a facility Incident Report dated 6/1/15, that had been faxed to the State Department of Health was reviewed. The report indicated on 6/1/15 at 2:20 P.M., Resident #18 had stated, during an interview,'they don't get here on time and let s--- (bowel movement) roll down my leg and they put me up in front of		dislikes. Each allegation has its own merits and is investigated **thoroughly and completely** until the allegation is either substantiated or un-substantiated. This investigation involves interview of any/all staff members on duty, any/all residents in the vicinity of the alleged abuse if physical or verbal, extensive review of video tapes, and conference visits with family members or the responsible surrogate/sponsor. This tag written by the surveyor involves her interpretation of thorough and complete. Hillside Manor does always investigate any allegations of abuse **completely and thoroughly** including extensive interviews of other residents (if applicable). With no guideline to interview 20% (or more) of the facility the investigation's thoroughness has to remain with the administration.	

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	everyone...' The facility investigation documentation indicated Resident #18's Power of Attorney (POA)/family member was interviewed on 6/1/15 regarding Resident #18's allegation of abuse. The facility also interviewed Resident #18 in regard to the abuse allegation on 6/1/15. The spouse of Resident #18 was also interviewed on 6/2/15 at 9:00 A.M., in regard to the abuse allegation. Documentation was lacking in the investigation of other residents in the facility being interviewed in regard to abuse. On 6/3/15 at 10:03 A.M., the facility abuse policy entitled "HILLSIDE MANOR ABUSE/NEGLECT POLICY (updated 4/25/13)" was reviewed. The policy included, but was not limited to, "...The administrator or designee shall conduct a comprehensive and complete investigation..." On 6/5/15 at 10:48 A.M., the Administrator was made aware the abuse investigation had not been a thorough and complete investigation due to the investigation lacked other resident interviews regarding abuse. The Administrator indicated at that time she had not interviewed other residents		The cited allegation case involving physical abuse was extensively investigated including three conferences with family, video tape reviews, residents were just asked (including resident making the allegation) the day before in resident council, and employee interviews. The allegation involving misappropriation **involved interviewing over 10 residents** known to have "spending money" in their possession, but the D.O.N. failed to document such. The third case cited, involved a confused lady who(she and all other residents) had ample opportunity to voice a complaint/concern on 5-28-15 (3 days earlier) about "slow response time and shi…running down her leg". The lady, now deceased, should not have been on an interview list----the abuse was investigated immediately by administration, where the resident denied the statement and reversed her alleged abuse complaint. As no other survey interview and no	

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	regarding abuse during the investigation, but that she usually does. 3.1-28(c)		complaints were filed in the resident council meeting (three days prior), regarding response time (and abuse for not getting service fast), no further interview were applicable and the claim found without merit. . Hillside Manor Nursing Home shall continue its policy of actively soliciting from all residents any acts of abuse on a monthly basis in the resident council meeting (they are specially ask this question). The QA committee shall review all abuse allegations and investigations for the next 12 months. This committee shall monitor timeliness of reporting such abuse allegation and the completeness of the investigation (including the inclusion of others interviewed in the reports). The administrator shall be responsible for the reporting, investigation, and documentation (which is to include the number of other residents interviewed if applicable).	

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F 0226 SS=E Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure the facility abuse policy was implemented, in that, allegations of abuse were not thoroughly investigated, other residents were not interviewed regarding allegation of abuse for 3 of 3 allegations of abuse reports reviewed. The facility also failed to ensure criminal background checks were completed in timely for 7 of 10 employee files reviewed. (Resident #3, Resident #18, Resident #27, RN #1, RN #2, CNA #5, CNA #6, CNA #7, CNA #8 and AA #1) Findings include: 1. During an observation on 6/2/15 at 10:16 A.M., Resident #3 indicated he had been hit on the head, slapped several times, and then verbally assaulted by a female staff member. Resident #3 further indicated he had told his nurse about having been abused at that time.	F 0226	F226 Hillside Manor Nursing Home shall not employ **or keep in employment** anyone found to have violations or convictions involving mistreatment, neglect or abuse from a limited criminal Indiana State Police Repository Report or from the Indiana State Nurse Aide Registry. All rules regarding IC 16-28-13-5 guiding employment of person with certain convictions shall be followed. Any employee found guilty of misappropriation of resident's property shall be discharged. Any and all allegations of abuse reported to administration shall start an immediate investigation. The investigation, as evidenced by documentation by the state	06/26/2015

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	The following 3 investigations of allegation of abuse were provided by the Health Care Administrator on 6/3/15 at 10:11P.M. The report documented on 5/30/15 at 5:20 P.M. that the Charge Nurse was notified by Resident #3's family of an allegation of abuse. The facility began investigating the allegation of physical and verbal abuse immediately. The initial report was faxed to the Indiana State Department of Health (ISDH) on 5/30/15 at 6:30 P.M. The follow-up investigation report was completed and faxed to the ISDH. The follow-up report indicated staff had been interviewed, discussion with family members had taken place, and/or Resident #3's physician had been notified, but the facility did not follow its own policy by ensuring a thorough investigation by interviewing other residents residing in the facility. The clinical record for Resident #3 was on reviewed on 6/2/15 at 1:29 P.M. Diagnoses included, but were not limited to, panic disorder with agoraphobia (fear of wide open places), bipolar, macular degeneration, and anxiety . The MDS (Minimum Data Set) assessment dated 4/1/15 documented that		surveyor, does include immediate notification to the family, the resident's physician, and the state board of health. It also includes the immediate suspension of any staff member, if the allegation was directed to staff and not another resident. This investigation of abuse shall be thorough until the allegation is substantiated or un-substantiated All residents could be negatively impacted by the employment of an individual with violent or abusive history. Hillside Manor Nursing Home shall change its policy regarding mailing request to the Indiana State Policy Repository for a limited background check. Hillside Manor Nursing Home administration or HR representative shall mail **within 3 business days** from employment, a request for limited background checks on all new CNA's and unlicensed employees in accordance to IC 16-28-13-5 Those employed	

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	Resident #3 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated that Resident #3 was cognitively intact. 2. The facility incident report documented that during a care conference on 2/3/15 at 5:20 P.M., that had been faxed to the State Department of Health was reviewed. The report indicated an employee of the facility had borrowed money from Resident #27 and had repaid the loan. On 2/17/15 at, the Director of Nursing (DON) had received a call from the Ombudsman stating the loan had not actually been paid back. The incident was reported to the ISDH on 2/17/15. During the investigation of the incident the facility did not interview other residents residing in the facility in regard to the allegation of abuse. The clinical record for Resident #27 was reviewed on 6/2/15 at 1:29 P.M. Diagnoses included, but were not limited to, depression, cerebral vascular accident with left hemiplegia, traumatic brain injury and anxiety. The MDS (Minimum Data Set) assessment dated 4/10/15 documented that Resident #27 had a BIMS (Brief Interview for Mental Status) score of 15 which indicated that Resident #27 was		with finding in violation with IC 16-28-13-5 guidelines shall be immediately discharged In a diligent effort to employ safe and quality employees, Hillside Manor Nursing Home implements several investigative measures ---one of which is a limited criminal background check with the Indiana State Police Repository. The Indiana Nurse Aide Registry list of un-employable is reviewed. New applicants' references of prior employment are called (2 if possible) for an employee and character reference. Drug testing at the facilities expense is a part of the agreed employment. Finally, a limited criminal background check is requested from the Indiana State Police. Hillside Manor's administrator, or HR representative, shall be responsible for the timely request for criminal/abuse background information from the Indiana State Police Repository. The QA	

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	cognitively intact. 3. On 6/1/15 at 1:59 P.M., during interview with Resident #18, when asked if anyone at the facility had abused her the resident indicated, "Yes, abuse, don't get here on time, s--- (bowel movement) goes down your leg and then they have to clean you up. They abuse you put you up in front of the rest of them..." On 6/3/15 at 10:11 A.M., a facility Incident Report dated 6/1/15, that had been faxed to the State Department of Health was reviewed. The report indicated on 6/1/15 at 2:20 P.M., Resident #18 had stated, during an interview, 'they don't get here on time and let s--- (bowel movement) roll down my leg and they put me up in front of everyone...' The facility investigation documentation indicated Resident #18's Power of Attorney (POA)/family member was interviewed on 6/1/15 regarding Resident #18's allegation of abuse. The facility also interviewed Resident #18 in regard to the abuse allegation on 6/1/15. The spouse of Resident #18 was also interviewed on 6/2/15 at 9:00 A.M., in regard to the abuse allegation. Documentation was lacking in the investigation of other residents in the facility being interviewed in regard to		committee shall monitory the timeliness of Criminal Background checks submitted and compliance to the new Hillside Manor Policy quarterly for the next 12 months.	

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	abuse. On 6/3/15 at 10:03 A.M., the facility abuse policy entitled "HILLSIDE MANOR ABUSE/NEGLECT POLICY (updated 4/25/13)" was reviewed. The policy included, but was not limited to, "...The administrator or designee shall conduct a comprehensive and complete investigation..." On 6/5/15 at 10:48 A.M., the Administrator was made aware the facility had not followed the facility abuse policy when investigating the allegation of abuse. The investigation lacked interviews of other residents in the facility regarding abuse. The Administrator indicated at that time she had not interviewed other residents regarding abuse during the investigation, but that she usually does. Employee records were reviewed on 6/5/15 at 10:00 A.M. The criminal background checks were completed 16 to 45 days after employment, as follows: 4. Registered Nurse (RN) #1 was hired on 2/21/15 and started working with the residents on 2/21/15. The criminal background check was requested on 3/9/15(16 days)			

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	5. RN #2 was hired on 5/20/15 and started working with the residents on 5/22/15. A criminal background check from her previous employment at the facility was used dated 1/23/14. No record of a new criminal background check being completed was provided. 6. Activities Assistant (AA) #1 was hired on 4/9/15 and started working with the residents on 4/13/15. The criminal background check was requested on 5/21/15. (42 days) 7. Certified Nursing Assistant (CNA) #5 was hired on 4/20/17 and started working with the residents on 4/23/15. The criminal background check for CNA #5 was requested on 5/20/15. (30 days) 8. CNA #6 was hired on 2/17/15 and started working with the residents on 2/23/15. The criminal background check for CNA #6 was requested on 3/9/15. (17 days) 9. CNA #7 was hired on 2/17/15 and started working with residents on 2/19/15. The criminal background check for CNA #8 was requested on 3/9/15. (17 days) 10. CNA #8 was hired on 5/19/15 and			

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	started working with residents on 5/21/15. A criminal background check from a previous term of employment at the facility was found dated 10/14/09. No record of a new criminal background check being completed was provided. A policy provided by the Administrator titled, " [facility name] Abuse/Neglect Policy " was reviewed on 6/5/15 at 1:30 P.M. it included " ... [Facility name] shall screen both perspective residents and employees for past history of abusive aggressive behavior as outlined below ... " During an interview with the Administrator on 6/5/15 at 1:40 P.M., she indicated the facility would send of the requests for criminal background checks in the mail. She indicated she understood the concerns with the timeliness of the requests and she was looking into ways of changing the way the facility completed the background checks for new employees. At this time, any further documentation of background checks was requested. The administrator indicated no further documentation could be provided at this time. An untitled and undated policy was provided by the Administrator on 6/5/15 at 2:00 P.M. It included, but was not			

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	155708		06/05/2015

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	limited to " ...In accordance with Indiana law, [facility name] will obtain from the Indiana State Police Central Repository, a limited criminal history on all persons to be employed ... " 3.1-28(a)			
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure a newly admitted resident was given a choice in regards to their shower preference and/or morning rising time for 2 of 3 residents reviewed for choices in a sample of 4. (Resident #56 and Resident #28) Findings include: 1. On 06/01/2015 at 11:04 A.M., during an interview with Resident #56 indicated he took a shower everyday at home. On 06/03/2015 at 11:39 A.M., Resident #56 indicated he would like a shower	F 0242	F242 Hillside Manor Nursing Home, one of the smallest in Indiana, prides itself in providing quality nursing service **in a home like atmosphere**. Residents have always enjoyed the choices of pharmacy, physicians, and other aspects of his/her life within the facility that effects quality of living. These choices have always been honored if they were not in direct conflict with the physician's order or sound nursing practices. Resident's choice of likes/dislikes and have always been recorded within the initial admission packet. This deficient practice of choice apparently effected only one resident regarding showers and	06/26/2015

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	every other day. He also indicated staff did not ask him upon admission how often he would like to take a shower. On 06/04/2015 at 9:12 A.M., during an interview the ADON (Assistant Director of Nursing) indicated the floor nurses do the admission, and she was unaware if residents were asked about choices pertaining to shower frequency. On 06/04/2015 at 09:19 A.M., during an interview LPN #2 indicated preferences were asked using the "ADMISSION NURSING ASSESSMENT" form. She indicated with this form preferences were asked in relation to their sleep patterns, food likes/dislikes, and type of bathing (tub, shower and/or bed bath). On 06/04/2015 at 9:59 A.M., during an interview the Social Service Director indicated staff review all policies and procedures with residents and families. She indicated residents were asked if they have any special request, but she did not ask specifically about shower frequencies upon admission. On 06/05/2015 at 9:55 A.M. Resident #56 clinical record was reviewed. The resident's diagnoses included, but were not limited to, pneumonia, abdominal aneurysm, hypertension, and hypoxia.		shower times. A facility wide, all resident interview took place on 6-23-15 and no changes or corrections were requested. Changes/corrective action: While the admission package and interview always includes likes/dislikes and special requests, it doesn't currently include a request for # of showers each week or the time of the shower. **A new form including shower times, number of showers, bedtime, rise time, and normal eating times was initiated on 6-23-15 for all current residents and placed in new admission packets.** Corrective action attempt: All residents were interview by ADON and Social Services on 6-23-15 regarding likes/dislikes and # of showers and time of shower. Each was so recorded within their admission file.Resident 28's compliant to interviewing surveyor regarding "she is made to get up at 7:30 to eat breakfast" seems without merit. Further investigation would show that to accommodate her request to "sleep in" the physician had previously changed all of her 8AM meds to 11:00AM. Additionally, her breakfast was at the time of the interview, being held in the kitchen, as usual, to be re-heated when she awoke. The complaint voiced to the surveyor regarding risetime was made on 6-2-15 and on 6-3-15 another surveyor walked to	

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	The resident was admitted on 5/22/15. The resident's "ADMISSION NURSING ASSESSMENT" indicated the resident was alert and oriented and required assistance of 2 persons for transfers and assist with bathing. 2. On 6/02/2015 at 8:41 A.M., during an interview Resident #28 indicated she would like to wake up naturally. On 06/03/2015 at 9:45 A.M., resident indicated she would like to sleep until 10:30 A.M., but the staff would wake her up at 7:30 A.M. for breakfast. Resident #28 indicated once she was awake she would stay up. Resident indicated she did get tired of asking staff not to wake her up early in the morning. On 6/03/2015 at 11:21 A.M., CNA # 3 indicated when staff would take her breakfast in to her, they would ask Resident # 28 if she would need anything. CNA #3 indicated sometimes the resident would get up to eat breakfast and sometimes she would stay in bed. On 6/05/2015 at 8:34 A.M., Resident # 28 clinical record was reviewed. The resident's diagnosis included, but were not limited to, major depression disorder, diabetes, hypertension, left below knee amputation, anxiety disorder, paranoid		resident room at approximately 8am to find her sleeping and surveyor inquired about whereabouts of breakfast tray. Surveyor was notified that the kitchen holds her breakfast until she awakes for the day. All attempts to accommodate resident 28 have been made without any voice of dissention at the 5-28-15 resident council meeting. The QA committee shall review quarterly for the next year, all new admission packet for “right of choices” including showers/shower time. Also they shall review the randomly selected resident interview for likes/dislikes and showers and shower times.	

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	schizophrenia, and chronic insomnia. The resident was admitted on 04/05/2015. The resident's " ADMISSION NURSING ASSESSMENT" indicated the resident was alert and oriented with an independent functional status. An Minimum Data Set assessment (MDS) dated 5/4/15 indicated Resident #28 had a Brief interview for Mental Status (BIMS) score of 13 indicating she was cognitively intact. The MDS further indicated Resident #28 was assessed as requiring extensive assist of two persons for transfers and toileting and extensive assist of one person with bed mobility. On 6/04/2015 at 9:04 A.M., the Admission packet was provided by the ADON and indicated no information regarding a resident's choice for getting up in the A.M. 3.1-3(u)(1)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate			

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	monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observations, interviews and record review, the facility failed to assess and evaluate a resident for the use of non-pharmacological interventions prior to an increase in his medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #14) Findings include: On 6/3/15 10:23 A.M., Resident # 14 was observed at activities with his eyes closed, at 11:14 A.M., Resident # 14 was observed in wheelchair (w/c) with his eyes open, at 1:43 P.M., Resident # 14 was observed in bed sleeping. On 6/4/15 at 8:39 A.M., Resident # 14	F 0329	F 329 Hillside Manor Nursing Home shall provide an environment for all residents being free of unnecessary drugs. Specifically, residents are to be free of unnecessary antipsychotic drugs. Any use of antipsychotic drugs shall have documented specific conditions, non drug intervention attempts, and an effort to a gradual reduction Failure to apply the long standing policy and practice could adversely effect any and all residents with behavior issues being	06/26/2015

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	was observed awake in the hallway in w/c. On 6/5/15 at 9:17 A.M., during an interview the ADON (Assistant Director of Nursing) indicated Resident #14 had increased agitation, "such as hitting himself with fist in the chest" on 5/13/15. She indicated when the family physician was called, he changed his order to Ativan 2 mg (milligrams) at noon and 1 mg at bedtime. She further indicated on 5/20/15 the Psychiatrist came in and changed the order to Ativan 1 mg three times daily. The ADON indicated the non-pharmacological intervention of re-assurance was attempted. The ADON indicated communication with staff was initiated with behavioral formal care plans, which Resident #14 did not have. On 6/4/15 at 11:27 A.M., during an interview the Social Service Director (SSD) indicated non-pharmacological interventions should be used, for examples, redirection, take outside, and/or take to activities. The SSD indicated the physician should be made aware of behaviors or excessive sleeping. A morning meeting would be held to discuss resident behaviors, and the nurses should be monitoring the behaviors with updates to the doctor daily as needed.		prescribed an antipsychotic. Only one resident was effected by this errorant practice of an increase in dosage of an antipsychotic drug by a visiting family physician. Corrective action: All licensed nurses shall be in serviced on proper and complete documentation of any and all behavior issues and non drug interventions attempted before the physician writes an order to increase such antipsychotic medication. Resident 14 had documentation of increased agitation up to two days prior to the family physician's rounds. The documentation was errorantly missing from nursing notes leading one to conclude that resident 14 had no re-occurring behavior issues within the last two days. The physician's personal observation along with the nurse on duty's verbal report resulting in an increase the Ativan by 1mg.	

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	Resident # 14's clinical record was reviewed on 6/3/15 at 10:59 a.m. The resident's diagnoses included, but were not limited to, debility, anxiety, dementia with behavior disturbances, depressive disorder, psychosis, Bipolar with psychotic fixations, chronic pain. The quarterly Minimum Data Set assessment (MDS), dated 4/20/15, indicated Resident #14 cognition was moderately impaired, had long term and short term memory problems. The resident was indicated to exhibit inattention and disorganized thinking with no other behaviors identified. The physician's order, dated 1/21/15, was Lorazepam (Ativan) 0.5 mg (milligrams) (anti-anxiety) 1 tablet by mouth every day. The physician's order dated 1/21/15 was Brintellix 10 mg 1 tablet daily.(mood stabilizer). The physician's order, dated 5/15/15 was to discontinue current Ativan order and change to Ativan 2 mg at noon and Ativan 1 mg at hour of sleep. The physician's order, dated 5/20/15, was change Ativan 1 mg to three times a day. The physician's order dated 5/20/15 was Zyprexa 7.5mg at noon daily. (antipsychotic). The April, 2015 and May, 2015 and June		The ADON shall review all new or changed orders for antipsychotic medications for the next 6 months to assure there is proper documentation that warrants an increase or change. The ADON shall report any issues immediately to the DON and administrator. The D.O.N. shall be responsible for proper compliance.	

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	1 to 4, 2015's "PSYCHOACTIVE MEDICATION MONTHLY FLOW RECORD" indicated Resident #14 had no behaviors. The Nurse's notes were reviewed for May, 2015 and June 1 to 4, 2015 and indicated the following: On 5/13/15 the resident was indicated as having increased agitation, "such as hitting himself with fist in the chest." The nurse indicated he was scared and reassured him. On 5/22/15 the resident was hollering out and complaining of back discomfort. The resident was administered pain medication which was effective. No other information was indicated related to any behaviors. The care plan indicated the problem was "Mood State Issues." The interventions included, but were not limited to, to assess/record for changes in mood state pattern , support resident's strengths and coping skills, provide regular opportunities for physical activity, daily decision making, stimulation, socialization and leisure activities of resident's interests, and reduce stressors that may be contributing to the resident's anxiety. 3.1-48(a)(3)			

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F 0371 SS=F Bldg. 00	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 ensure refrigerator temperatures were maintained at 40 degrees (Fahrenheit), foods were thawed to prevent contamination of other foods and/or food items opened were dated and expired food items were discarded. The facility also failed to ensure food storage room floors were clean and free of soil. This had the potential to affect 37 of 37 residents who resided in the building. Findings include: The following was observed on 6/1/15: 1. On 6/1/15 at 9:37 A.M., the initial tour of the kitchen began with the Food Service Manager (FSM). A freezer in the kitchen contained an open undated plastic container of orange sherbet with a label hand written of a resident's last name. The FSM indicated a family member had	F 0371	F 371 Hillside Manor Nursing Home shall store, prepare, and distribute foods under sanitary conditions. Hillside Manor shall maintain all refrigerators at 41 degrees or lower. Newly opened items stored in the refrigerators/freezers shall have an opened date attached. All frozen foods in a lower refrigerator bin or shelf thawing shall have no other items below or in contact with said item. Items with unlimited shelf life shall be monitored for “use by date” and discarded when expired. Dry food storage room basement floors shall be maintained via a cleaning schedule so as to afford a clean and sanitary environment. Food transported to a different hall shall be done so in a sanitary method to prevent contamination. Failure to apply safe-serve and sanitary methods of food transportation, thawing procedures, cleanliness of environment and timely discarded of expired food items could be potentially dangerous to	06/26/2015

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	brought the sherbet into the facility. The reach in refrigerator in the kitchen had a thermometer that indicated a temperature of 50 degrees F(Fahrenheit). Dietary staff #1 indicated she had been stocking in the refrigerator and earlier the temperature had been 34 degrees F which she had documented. The partician between the 2 doors of the reach in refrigerator was loose and caused the doors to be difficult to close. The FSM indicated at that time a "piece" had been ordered 3 weeks ago to replace the loose partician and it still had not arrived. 2. The initial tour continued downstairs in a room that contained 3 freezers and 2 refrigerators. The 2nd freezer contained a large opened undated plastic bag with breadsticks. The FSM indicated the the open date of the breadsticks was lacking. One of the refrigerators also contained in a bottom drawer a 2 lb (pounds) roll of ground beef in a plastic bag with red juice observed in the bag. The ground beef was thawing in the drawer which also contained a plastic bag of bologna slices, a bag of taco shells, a bag of shredded cheese and a bag of cheese slices. The FSM moved all of the food		all resident. All refrigerators and freezer temps were checked and so recorded in the AM before the surveyor made inspection. All refrigerators were 41degrees or lower. The cited refrigerator was opened to re-stock immediately before inspection. Said refrigerator had a recorded temp of 34 in early AM and by surveyor's observation 36 degrees at 6:00PM. No repairs were made although a new thermometer was added to assure the refrigerator was ok. Refrigerator checked 3 consecutive days and temp held at 34-36 degrees. All expired "use by date" foods were discarded which included the three items so cited. An inservice on 6-25-15 was held for all dietary staff addressing labeling and dating open items placed in refrigerators and freezers (found was one small bag of bread sticks undated). The inservice also addressed thawing procedures of meats (nothing below items) and proper observation of self-life use by dates and proper/timely disposal. All basement floors for dry food storage was re-painted and will be maintained by the dietary staff on their weekly cleaning schedule. An finally, a change in policy shall alter a many times approved sanitary mode of food transport in an enclosed insulated food cart to include a food tray cover while inside the cart.The	

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	items out of the drawer except the ground beef. 3. On 6/1/15 at 3:55 P.M., the reach in refrigerator thermometer was rechecked with the FSM. The thermometer observed in the A.M. (morning) had a temperature of 54 degrees F. A new thermometer had been added in the refrigerator and had a measurement of 44 degrees F. The Administrator was made aware of the temperatures of 54 degrees F and 44 degrees F in the reach in refrigerator. On 6/1/15 at 4:40 P.M., the reach-in refrigerator's temperature was rechecked and the new thermometer indicated a temperature of 36 degrees F. The following were observed on 6/3/15: 4. On 6/3/15 at 10:45 A.M., the downstairs dry food storage room was toured with the FSM. One of the refrigerators contained a gallon container of open barbeque sauce with the product label date of 11/24/14 and the lid had an open date of 12/24/14. A large plastic jar (one-half full) contained 4 bean salad. An open date written on the lid of the 4 bean salad was 2/20/15, and the 4 bean salad had a use by date of 4/5/15. An open 8 lb bottle of salsa had an open		registered dietician shall by monthly visit check on compliance to her inserviced items of concern over the next 6 months. She shall visually check refrigerator temps and recorded logs. She shall conduct a mini exam of the kitchen and food storage area for cleanliness and cross check it with the recorded cleaning schedule. The administrator or designee will perform a kitchen audit of refrigerator/freezer temperatures, food storage cleanliness, food storage labeling, transport, and food thawing procedures for 2 times per week for the next 6 weeks. The QA Committee shall review the 16 audits performed by the Admin. or designee during the August QA Meeting to determine whether additional monitoring shall be continued. If the 16 audits completed show proper compliance then no additional monitoring is necessary. If the audits show a pattern or lack of compliance then additional monitoring shall occur for the next 6 months. The FSS shall be responsible for complete compliance.	

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	date of 11/30/13 and a use date of 7/2/2014. The FSM indicated at that time she was discarding all 3 items. 5. On 6/3/15 at 10:58 A.M., in the food storage room, the FSM was made aware when a paper towel was swept across the floor by the food storage shelves and around the corners of the room black soil particles were observed. The FSM agreed to the soiling and indicated she was responsible for the cleaning of the room . The downstairs room floor (concrete) containing freezers and refrigerators had missing paint in areas and heavy soiling of dust and black soil through out and in corners of the room and the doorway. 6. On 6/3/15 at 11:38 A.M., during meal preparation of the noon meal the back hall trays were observed to be prepared and placed in the cart for hall delivery. The beef stew entry was place on the plate with a biscuit and a lettuce salad. No plate cover or plastic wrap was placed over the plates. At that time Dietary Staff #2 asked Dietary Staff #1 about covering the plate of food before placing the trays in the cart for hall delivery. Dietary Staff #1 indicated using a plate cover would make the salad hot. 7. On 6/3/15 at 3:55 P.M., during			

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	interview with the FSM, she indicated she was behind in cleaning the food storage room floor due to working upstairs in the kitchen. The FSM indicated she was not sure who cleaned the floor in the downstairs room that contained the freezers and refrigerators. The Housekeeping Supervisor was present, at that time, and indicated housekeeping staff were to clean that floor. 8. During interview with the Administrator on 6/4/15 at 1:30 P.M., the Administrator was made aware of the problem of open food items undated. The Administrator indicated, at that time, it was standard to date food items when opened. On 6/4/15 at 2:05 P.M., the Administrator was made aware of problems of refrigerator temps over 40 F, ground meat thawing in a drawer with other food items, storage room floors soiled, and uncovered food hall trays. The Administrator, at that time, provided the following information: Page 163 from an Inservice Manual (date 2010). The documentation included but was not limited to, "...Care of Storeroom...4. Keep floors, walls, shelves and equipment clean...5. floors must be swept clean at all times and mopped at			

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	least weekly... Refrigerator: 1. Refrigerator temperatures should be thermostatically controlled to maintain food temperatures at or below 41 Degrees F..." Nutritional Services Practice Manual (last revision January 2007) " PROCEDURE Serving: Serve food safely in order to prevent contamination and foodborne illness... 7. Transport food in a sanitary method to prevent contamination..." Nutrition Services Practice Manual (last revision July 2005) PROCEDURE Thawing: Foods will be thawed properly to prevent foodborne illness... 4. Place frozen meat in pans on the lowest shelves in the refrigerator/cooler to prevent juices dripping onto other foods and causing cross contamination..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt			

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	and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to ensure, medications were stored securely, in that, medications located on the front hall in the medication storage room and/or the medication cart were observed unsecured and unsupervised by a licensed staff member for 1 of 2 medication storage rooms and/or medication carts	F 0431	F431 Hillside Manor Nursing Home shall maintain a safe and secure system for dispensing all drugs in an accepted professional manor. All records of drug receipts and dispersal shall be maintained	06/26/2015

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	reviewed. Findings include: 1. During a continuous observation on 6/1/15 at 10:54 A.M., an unlocked medication storage cart was observed sitting next to the front hall nurses desk. A drawer on the cart was observed to be open with a set of keys in the lid. No staff or residents were observed in the immediate area. At 10:57 A.M., LPN #1 was observed coming out of a room adjacent the nursing desk. She indicated she had been distracted and forgot her keys in the cart. She further indicated the cart should be closed prior to leaving it and the keys should not be left in the cart. 2. On 6/2/15, from 9:13 A.M. through 9:17 A.M., the door to the medication storage room located on the front hall was observed to be open. At that time, no nurses were observed to be within sight of the medication room. LPN #14 returned from the hall and closed and locked the medication room door, indicating that someone must have left the door open. During an interview at that time, LPN #14 indicated the medication storage room door should always be closed and locked when no staff was present.		in a recordable record. All controlled drugs shall be dispensed with enough recorded detail to enable an accurate reconciliation on each nursing shift. All drugs and biologicals used must be labeled and secured in locked compartments and permit only authorized personnel to have access to the keys. Schedule ll drugs shall have an additional separate locked storage system. Deviation from this accepted safe practice of drug control could lead to minimal to serious harm to a resident or residents that gained un-lawful access to un prescribed drugs. No resident was harmed and the schedule ll drug count was accurate when recon ciliated. Corrective action: An in service was conducted on 6-18-15 and 6-25-15 by the D.O.N. and A.D.O.N. to all licensed personnel on safe and proper drug storage. This included keeping all med room doors closed and locked when not in use; all	

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	Located in the medication room were sixty nine 10 ml syringes of Heparin, 1 drawer filled with 22 and 24 gauge half inch needles, 4 boxes of Duoneb 2.5-0.5/3 ml and two boxes of Proventil 2.5 mg/3ml. During an interview on 6/2/15 at 9:44 A.M., the Assistant Director of Nursing (ADON) indicated the medication room door should have been closed and locked when no nursing staff was present in the immediate area. The policy and procedure "MEDICATION STORAGE IN THE FACILITY" was provided by the Assistant Director of Nursing (ADON) on 6/2/15 at 9:55 A.M., and the policy read as follows: "...Medication rooms, carts and medication supplies are locked or attended by persons with authorized access." 3. On 6/4/2015 at 11:00 A.M., the front hall medication room was observed with the Assistant Director of Nursing (ADON). No cover was observed over the ceiling sprinkler leaving an opening around it. The suction machine, stored as clean, was uncovered. The open freezer was observed with ice build up. A one liter, unlabeled opened Diet Coke		medication carts are to be secured and locked when not being attended. The in service included the proper and accepted method of dispensing all drugs and the proper timely recording of each that is given. Reconciliation of all controlled drugs and proper procedure to follow if the "count" of scheduled II drugs is off. The in service included acceptable nursing principals of sanitary and safe storage of "clean" items such as the suction machine, the med refrigerator and allowable items that may be stored in it. **All drug room doors have been fitted with self closing closures on 6-19-15. These doors will latch and lock without reminders each time accessed.** The ADON, shall randomly monitor 5 different nurses at least one time a week for observation for the next 3 months, monitor the process of drug security by watching the med cart being locked when not being attended (or within	

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	and a Pepsi can were observed at that same time. The ADON indicated the Diet Coke was a resident's, and the Pepsi was a staff member's drink, which should not be kept in the medication room. She also indicated the suction machine should be covered. 4. On 6/4/15 at 1:40 P.M., the narcotic count was observed. RN #1 was observed during that time to sign out two narcotics. At that same time, during an interview she indicated one medication was scheduled at 11:00 A.M., and the second at 12:00 noon. She also indicated she should sign the medication out when given. 3.1-25 (e)(3) 3.1-25(m) 3.1-25(n)		plain view) during med passes. She shall also monitor the effectiveness of the "door closures" on the med room doors. Any breech in acceptable safe and proper practices in drug security shall be reported directly to the administrator who shall be responsible for proper performance. The QA committee shall review quarterly the effectiveness of the door closures on the med rooms and request reports of nursing performance regarding securing the med pass cart when not being attended or in plain sight. This review shall continue for the next 12 months.	
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection			

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	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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure handwashing was completed at appropriate times and correctly after incontinence care and/or blood sugar monitoring for 4 of 4 residents reviewed for infection control. (Resident #19, Resident #33, Resident #18, Resident #52) Findings include:	F 0441	F441 Hillside Manor shall implement a professional infection control program to prevent the spread of infection. Within this program isolation procedures for those resident that warrant such shall be employed, employees with communicable disease or	06/26/2015

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	1. During observations of blood sugar monitoring on 6/3/15 at 11:06 A.M. Licensed Practical Nurse (LPN) #3 was observed to don gloves and perform the check on Resident #18. After completing the test she was observed to dispose of gloves and observed to wash her hands for 12 seconds. On 6/3/15 at 11:10 A.M., LPN #3 was observed performing an blood sugar monitoring on Resident #52. During that observation no hand hygiene was performed prior to donning gloves. LPN #3 performed the test disposed of gloves and was observed to wash hands for 10 seconds. 2. On 6/3/15 at 11:25 a.m., Resident #33's personal care was observed.. CNA #1 and CNA #2 were both observed to don a pair of gloves. After foot wear was applied, both CNA's with same gloves, ambulated resident to the bathroom. After peri care was completed, with same gloves CNA # 1 and #2 redressed resident, and ambulated resident back to her room. At that time, CNA #1 and CNA #2 were observed to remove gloves and perform hand hygiene. 3. On 6/4/15 at 9:50 A.M., CNA #1 and CNA #4 indicated Resident #19 was to		infections shall not be in direct contact with residents or their food, and proper and accepted hand washing practices/techniques shall be performed. Any and all residents could be negatively effected by the spread of infection from staff not employing proper and accepted hand washing techniques. All employees were in serviced on 6-18-15 by the ADON on approved and proper techniques in hand washing. Included was information regarding when to “glove” and when to sanitize and wash hands. A weekly check-off is/has been performed x 5 days per week by the D.O.N or her designee on gloving and hand washing. This shall continue for the next 4 weeks. A “hand washing” in service shall be scheduled again in 6 months as a refresher. The D.O.N., or ADON shall	

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	be assisted to toilet. Both CNAs applied gloves and assisted Resident #19 to walk to her bathroom from her bed with a rolling walker. After Resident #19 had been seated on the commode, her urine soiled disposable brief was removed by the CNAs. Resident #19 voided and had a bm (bowel movement) while on the commode. Resident #19 was provided a sponge bath by the CNAs while on the commode after toileting. After bathing the upper body, the CNAs had the resident stand from the commode holding on to her walker. Then CNA #4 cleaned the buttock/ rectal area and CNA #1 cleaned the peri area both using wash cloths. CNA # 2 then removed her gloves and without handwashing and applied new gloves. CNA #4 then combed Resident #19's hair before collecting the bagged soiled clothing and bathroom trash. CNA #4 then exited the resident room without handwashing. After bathing of the peri area, CNA #1 continued to wear her gloves and then proceeded to hand Resident #19 her eye glasses without first removing her gloves and handwashing after peri cleansing had been provided. 5. On 6/4/15 at 10:00 a.m., LPN #2 was observed to handwash for 11 seconds. She then returned to the desk and resumed her charting.		assume responsibility for complete compliance in performance and technique in hand washing. The QA committee shall review quarterly for the next 12 months reports from the D.O.N on the proper habits/practice/performance of complete and timely hand washing.	

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	During an interview with the Assistant Director of Nursing (ADON) on 6/5/15 at 10:15 A.M., she indicated the facility policy was to perform handwashing for a minimum of 30 seconds. She further indicated staff was in-serviced on this practice yearly and as needed. On 6/5/15 at 11:50 A.M., the Assistant Director of Nursing (ADON) provided the facility handwashing policy, entitled "Handwashing (undated)." The policy included but was not limited to, appropriate handwashing techniques, "...7. After contact with blood, body fluids, secretions, excretions, mucous membranes, or broken skin. 8. After handling items potentially contaminated with a resident's blood, body fluids, excretions, or secretions. 9. after removing gloves..." The ADON On 6/5/15 at 12:35 P.M., was interviewed regarding handwashing. The ADON was made aware of CNA #4 not handwashing after gloves removed and incontinent care and bathing of Resident #19 had been provided. The ADON was also made aware of CNA #1 not removing gloves and handwashing after incontinent cleaning was provided and before assisting the resident with her eye glasses. The ADON agreed handwashing			

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	had been lacking. 3.1-18(b)(2) 3.1-18(l)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the environment was sanitary and in good repair, in that, walls, chairs, commodes, and/or floors were soiled and/or in disrepair for 5 of 6 survey days on 2 of 2 units. (Room 12, Room 16, Room 21, Room 6, Front Unit and the Back Unit) Findings include: On the Front Unit: 1. On 6/1/15 at 10:30 A.M., and on 6/5/15 at 8:34 A.M., debris and black soiling were observed on the hall floor edges and the door jams of the front hall. 2. On 6/1/15 at 11:37 A.M., and on 6/5/15 at 8:40 A.M., the bathroom floor of room 12 was soiled and a dried, black and unidentified substance was observed on the bathroom floor around the base of	F 0465	F465 Hillside Manor shall provide a safe, functional, and sanitary environment for all residents. No direct or indirect harm was evidenced by dust on the weight scale or soiling along the edges of baseboard or door casing. All resident deserve to live in a comfortable, clean, environment in good repair. The housekeeping supervisor conducted an in-service on 6-25-15 regarding complete and comprehensive cleaning which shall include door jams and acceptable hall and room floor edges. Duties and schedules on cleaning such items as weight scales and reporting of marred or scratched furniture or wall repair shall be covered within the in service. An additional contractor has been employed to catch up on needed and necessary repairs. Any and all paint peeled has been re-painted. All soiling on room and hall edges have been cleaned. All door jam were	06/26/2015

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	the commode. The floor edges of the residents' rooms and the doorway floor edges had soiling along the edges of the baseboard. Located on the bathroom wall behind the commode was an unfinished area of drywall, and a 6 inch diameter area of peeling paint was observed on the wall below the light switch. 3. On 6/2/15 at 8:53 P.M., and on 6/5/15 at 8:34 A.M., dust and debris were observed on the weight scale located in the hallway of the front unit. On the Back unit: 4. On 6/1/15 at 11:30 A.M., and on 6/5/15 at 8:34 A.M., the clothing dresser located in room 21 was marred and scraped. 5. On 6/2/15 at 9:38 A.M., and on 6/5/15 at 8:34 A.M., a recliner located in room 16 was soiled with food and crumbs. The material covering for the arm of the recliner was torn and worn away. 6. On 6/2/15 at 8:53 P.M., and on 6/5/15 at 8:34 A.M., a build-up of dust was observed on the protection grill of the fan which was located in the commons area. During an interview with Housekeeper #1 (HK #1), she indicated she cleaned		cleaned on the front hall. Clothing dresser in room 21 was re-stained for marring. The weight scale was dusted and cleaned and placed on the housekeepers weekly schedule. Any/all floor fans have had the grills cleaned and are to be on the housekeeper's monthly schedule. Any un-finished drywall has been finished and painted. The recliner in room 16 was cleaned, however it belongs to the resident who is not interested in replacing it at this time. We will assist in any temporary repairs to the arm(s) Environment cleanliness and repair shall be the responsibility of the housekeeping supervisor who shall solicit mechanical help or construction service through the administration. Issue or conditions shall be reported to the administrator within the daily staff meeting. This responsibility shall be on-going and not time-limited. The Enviornmental supervisor shall conduct an audit 2 x per week for the next 6 weeks. The QA Committee shall review the 16 audits performed during the August meeting and then determine whether additional monitoring is necessary. If the 16 audits show proper compliance then additional monitoring will not be necessary but if there is a trend of non compliance (3 or more failed audits) then additional monitoring shall take place for the next 6 months.	

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	and mopped the rooms daily. HK #1 indicated that the recliners were supposed to be wiped daily with a damp cloth. The HK #1 further indicated the House Keeping Supervisor scheduled the room for deep cleaning and would then notify the staff which rooms to deep clean. On 6/5/15 at 8:34 A.M., a random environmental tour was completed with the Administrator. The Administrator agreed the areas were soiled. On 6/5/15 at 2:24 P.M., the Housekeeping Supervisor provided a policy "HOUSE KEEPING STANDARDS" and it read as follows: "...Floors are clean - including baseboards and corners and behind furniture. Furniture is damp wiped at least weekly... 3.1-19(f)			