

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2016
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>This visit was in conjunction with the Investigation of Compliant IN00190839.</p> <p>Survey Dates: January 4, 5, 6, 2016</p> <p>Extended Survey dates: January 7, 8, 11, 12, and 13, 2016</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Census bed type: SNF: 12 NF: 100 Total: 112</p> <p>Census payor type: Medicare: 11 Medicaid: 80 Other: 21 Total: 112</p> <p>These deficiencies reflect State findings</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending January 13, 2016. The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary, feel free to contact me. Respectfully, Steve Kassen Administrator</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 0223 SS=J Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 01/19/2015 by 29479.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident (Resident #143) with wandering and inappropriate sexual behaviors was adequately supervised to prevent the resident from attempting or engaging in non-consensual sexual interactions with 2 of 7 residents reviewed for allegations of abuse (Resident #83 and Resident #126). In addition to the residents in Immediate Jeopardy, the facility failed to ensure a resident was not threatened with harm and cursed at by another resident (Resident #55) resulting in harm or potential harm that is not Immediate</p>	F 0223	<p>Please see IDR rationale attached</p> <p>1. Resident #143, in question (in regard to inappropriate interactions with other residents/visitor) was immediately placed on one-on-one staff supervision upon notification of the alleged inappropriate interaction until such time the resident could be transferred for an in-patient psych evaluation, in an effort to ensure the safety and well-being of all residents of the facility. One should note resident #143 is cognitively intact and denied said allegations. Following in-patient psychiatric evaluation, the facility re-evaluated whether</p>	01/27/2016

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	<p>Jeopardy to 1 of 1 resident reviewed for an allegation of verbal abuse (Resident #134).</p> <p>The Immediate Jeopardy was identified on 1/07/2016 and began on 12/18/2015 when the facility identified Resident #143's wandering behaviors and failed to implement interventions to prevent the resident from wandering into other residents' rooms. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on 1/07/16 at 1:21 p.m. The Immediate Jeopardy was removed on 1/8/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy</p> <p>Findings include:</p> <p>1. During an interview on 01/06/16 at 9:56 a.m., Resident #83 indicated on "five or six" different occasions Resident #143 had been in his room at 2:00 a.m. touching himself and attempted to "grope" Resident #83. Resident #83 indicated Resident #143 had never touched him because he swung at Resident #143 to keep him away. Resident #83 was unable to provide specific dates for these incidents.</p>		<p>the facility could meet the needs of the resident on the basis of assessment and findings of the psychiatric evaluation. Upon completion of psychiatric treatment resident #143 showed no inappropriate behaviors. Upon return to the facility he was placed on one-on-one supervision until he could be relocated to another facility for long term care as a precautionary measure. Resident #143 was discharged to another facility on 01/29/2016. Resident #83 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #2 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #126 was not physically harmed and showed no signs or symptoms of mental anguish. Staff interviews noting "rumors" were referring to the consensual relationship between cognitively intact resident#143 and cognitively intact resident #36 which was previously addressed and careplanned.</p> <p>Resident #55 had a BIM score of 15 which is the highest possible score indicating she is cognitively intact. Resident #134 had a BIM score of 14 indicating he is cognitively intact. Upon resident #134 reporting the verbal abuse, the facility investigated and reported to the ISDH per facility policy. The investigation included</p>	

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	<p>During a follow up interview on 1/06/16 at 3:22 p.m., Resident #83 indicated he reported the incidents where Resident #143 entered his room to third shift nurses five times. Resident #83 was unable to recall the names of the nurses he reported the incident to.</p> <p>Resident #83's record was reviewed on 1/07/16 at 11:25 a.m. Resident #83's Resident Admission Record, dated 5/30/15, indicated diagnoses including, but not limited to, paranoid schizophrenia, chronic obstructive pulmonary disease, and below the knee left leg amputation.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/08/15, indicated Resident #83's cognitive status score was 15 indicating he was cognitively intact.</p> <p>Resident #83's nurse's notes, dated 7/02/15 through 1/06/16, were reviewed and lacked documentation of Resident #83 reporting any residents wandering into his room or observations of Resident #143 wandering into his room.</p> <p>2. During an interview on 1/7/16 at 9:31 a.m., Resident #2 indicated about three to four weeks ago, during the day, Resident #143 wandered into his room</p>		<p>interviewing other residents and staff that were in the area when said incident occurred. Resident #134 was not harmed as evident by the mental anguish assessment that was completed with no variance noted. The facility implemented an intervention to add additional chairs to the smoking area, as this was the root cause of the altercation. The subsequent events had not been reported to facility staff. Upon being made aware of the subsequent events, the facility immediately initiated an investigation and reported to ISDH per facility policy. The chairs in the smoke area not all being the same "type" of chair was noted to be the root cause of subsequent events. As a preventative measure, all chairs provided in the smoke area were changed to all be the same type of chair. No further problems have been noted or reported.</p> <p>2. In an effort to identify any other resident who could potentially be affected, interviews were conducted with all interviewable residents relative to any concerns with staff and/or residents of the facility including care, interactions, and unwanted room visitation. No concerns were noted or reported through interviews. Should concerns have been identified, immediate investigation would have been initiated and necessary actions initiated as per facility policy, in an</p>	

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	<p>and touched his roommate, Resident #126, in the private area. He stated he and Resident #126 reported the incident to Licensed Practical Nurse (LPN) #2 and that she did not report the incident to the social worker. Resident #2 indicated Resident #143 had not attempted or ever touched him. Resident #2 indicated during the weeks Resident #126 was in the hospital (after he witnessed Resident touch his roommate's private area) Resident #143 frequently asked where his roommate (Resident #126) was and sat in his wheelchair outside the door to his room and peeked into the room.</p> <p>Resident #2's record was reviewed on 1/07/16 at 9:10 a.m. Resident #2's Resident Admission Record dated 5/15/2015 indicated he had diagnoses including, but not limited to: muscle weakness, cerebral palsy, depressive disorder, and blindness to the right eye.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 8/12/15, indicated Resident #2's cognitive status score was 14, indicating he was cognitively intact.</p> <p>During an interview on 1/7/16 at 9:35 a.m., Resident #126 indicated Resident #143 came into his room and touched his private area. Resident #126 indicated he told Resident #143 to leave and he did.</p>		<p>effort to ensure the safety and well-being of all residents of the facility. Residents were re-educated of the need to immediately report any allegation of abuse or questionable conduct of a staff member or resident to ensure immediate and necessary action is taken.</p> <p>3.As a means to ensure ongoing compliance, facility staff received in-service training prior to his/her next tour of duty relative to abuse prohibition, immediate reporting of any allegation of abuse, and initiation of immediate interventions, as necessary, to supervise and prevent incidents in an effort to safeguard all residents from abuse.</p> <p>4.As a means of quality assurance, residents will be interviewed weekly for the next four weeks, then monthly thereafter in regard to personal safety and freedom from any type of abuse. Staff shall be randomly interviewed on scheduled days of work by administration in regard to response should a resident report an allegation of abuse to confirm continued compliance with facility policy. Said interviews will be conducted weekly for four weeks, and monthly thereafter. Re-education shall be provided, as warranted, on the basis of staff response. Should concerns be identified, immediate investigation shall be initiated and necessary actions initiated as per</p>	

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	<p>Resident #126 stated he reported the incident to Licensed Practical Nurse (LPN) #2. Resident #126 indicated the incident happened prior to him going to the hospital approximately four weeks ago.</p> <p>Resident #126's record was reviewed on 1/07/16 at 9:25 a.m. Resident #126's Resident Admission Record, dated 11/04/15, indicated diagnoses including, but not limited to, unspecified dementia without behavioral disturbance, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/19/15, indicated Resident #126's cognitive status score was 15, indicating he was cognitively intact.</p> <p>3. Resident #143's record was reviewed on 1/06/16 at 2:25 p.m. Resident #143's Resident Admission Record dated 7/31/2015 indicated diagnoses including, but not limited to, cerebral infraction, hemiplegia (paralysis on one side of the body), and aphasia (difficulty speaking).</p> <p>Significant change Minimum Data Set (MDS) assessment, dated 10/28/15, indicated Resident #143's cognitive status score was 14, indicating Resident #143</p>		<p>facility policy, in an effort to ensure the safety and well-being of all residents of the facility.</p> <p>Addendum</p> <p>For F223, F225, and F323-Please indicate how cognitivelyimpaired residents will be included in investigations for abuse. Please indicate if family members, visitors,and patient representatives are included in education regarding abusereporting.</p> <p>The facility follows the abuse prohibition policy for all residentsas follows;</p> <p>If resident abuse, or suspicion of abuse, is reported:</p> <ol style="list-style-type: none"> 1. Theresident(s) involved in the incident will be removed from the situation at onceor facility personnel will remain with the resident to ensure safety. 2. Theindividual who witnessed the incident or who was informed of the allegationshall immediately notify a charge nurse assigned to the unit on which theresident resides. If this is not feasible due to circumstances, the individualshall be responsible to notify any other nurse currently on duty. The nursewill examine the resident(s) involved to determine whether physical injurieshave occurred and their extent. Thisexamination shall be documented in the resident's clinical record. 3. Thecharge nurse is responsible to notify the facility 	

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	<p>was cognitively intact.</p> <p>A form titled, " Mood and Behavior Communication Memo," dated 12/17/15, indicated Resident #126 and Resident #2 reported that Resident #143 came into their room and they asked the nurse to redirect Resident #143. The memo indicated the nurse redirected Resident #143 to his room.</p> <p>A care plan for Resident #143, dated 12/18/15, indicated he was care planned for wandering and had interventions including the following: redirect resident to his room and obtain a urinalysis and urine culture.</p> <p>A care plan, dated 12/28/15, indicated Resident #143 and his roommate, Resident #36 had a need for privacy and included the following interventions: "establish a system to ensure privacy as evidenced by door sign, and staff not entering room when door is shut. "</p> <p>On 1/06/15 at 1:55 p.m., the DON provided a document titled, "Mood and Behavior Communication Memo," dated 12/26/15. The memo stated, "The husband of a visitor for Resident #96 said he was in the hallway and Resident #143 came to the doorway and asked him to come here so he said (sic) ask a question</p>		<p>Administrator and Director of Nursing immediately.</p> <p>4. Any facility personnel implicated in the alleged abuse will be immediately removed from the resident care and will remain suspended until an investigation is completed. A thorough investigation will be initiated.</p> <p>5. Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervision to prevent recurrence until investigation is completed and/or transferred for medical/psychiatric evaluation to be conducted relative to mood/behavior exhibited.</p> <p>6. The resident's attending physician will be notified as soon as feasible and any orders will be noted and initiated.</p> <p>7. Local law enforcement may be notified, as warranted.</p> <p>8. The family of the resident(s) and/or legal representative will be notified per policy.</p> <p>9. An Incident Report will be completed as per facility policy.</p> <p>10. Residents will be questioned about the nature of the incident and their statements placed in writing.</p> <p>11. Investigation will be conducted to assure other residents have not been affected by the incident or inappropriate behavior and the results documented.</p> <p>12. Statements will be taken including, but not limited to,</p>	

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	<p>when the visitor went over to see what he needed Resident #143 went to grab his private area. The visitor said he grabbed his (Resident #143) hand and told him not to do that and he should be ashamed of himself."</p> <p>A care plan, dated 12/28/15, stated Resident #143 had been, "sexually inappropriate to visitor ...attempted to grope visitor. " The care plan interventions included, but was not limited to, "Placed on 15 min. checks."</p> <p>A document titled, "Fifteen Minute Observation," indicated Resident #143 was placed on bed checks every fifteen minutes beginning 12/28/15.</p> <p>A psychological Evaluations dated 1/04/16 indicated "Patient is a [age specified] year old...mild cognitive impairment is observed...however patient appears alert, oriented, and able to make decisions for himself..Patient adamantly expressed that he is willingly participating in relationship with his roommate. He appears to understand the risks associated with sexual activity..."</p> <p>During an interview on 1/06/16 at 3:56 p.m., Resident #143 indicated he accidentally wandered into another room</p>		<ul style="list-style-type: none"> • facts and observations by involved employees • facts and observations by witnessing employees • facts and observations by witnessing non-employees • facts and observations by any others who might have pertinent information • facts and observations by the licensed nurse or individual to whom the initial report was made. <p>13. Follow-up assessments will be completed/documented during every shift until the resident(s) is stable and resident safety is maintained.</p> <p>14. The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable:</p> <ul style="list-style-type: none"> • State Department of Health • Adult Protective Services • Ombudsman • Applicable Licensing Agency <p>15. The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation, and to file a follow-up report to the State Department of Health.</p> <p>16. The Administrator is responsible to report to the State nurse aide registry or licensing authorities any knowledge of any actions by a court of law which would indicate an employee is unfit for service.</p>	

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	<p>once and was not sure when that was. He denied getting up in the middle of the night and wandering into rooms. He also denied an encounter with a visitor or attempting to touch the visitor inappropriately.</p> <p>During an interview on 1/6/15 at 4:03 p.m., Certified Nursing Assistant (CNA) #1 indicated she had never seen Resident #143 wandering at night. She indicated she had witnessed Resident #143 wander into Resident #83's room on two occasions. The first time she witnessed Resident #143 with his hand under #83's sheet. CNA #1 indicated Resident #83 was awake and did not say anything. She did not report it because Resident #83 would have told her if something inappropriate was happening. The second time the CNA #1 saw Resident #143 enter Resident #83's room she immediately had Resident #143 leave room his room. CNA #1 stated that both incidents occurred about three weeks ago in the evening after dinner.</p> <p>During an interview on 1/6/16 at 11:50 p.m., LPN #3, CNA #4, and Qualified Medication Aide (QMA) #5 all indicated they heard rumors of Resident #143 touching his roommate and indicated they did not report the rumors because they</p>		Resident/legal representatives will be informed upon admission and periodically (at least annually) thereafter of the facility's policy regarding abuse prohibition including how and to whom they may report concerns, incidents and grievances without fear of retaliation.	

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	<p>believed the managers and the Assistant Director of Nursing (ADON) already knew of the situation.</p> <p>During an interview on 1/7/16 at 12:37 a.m., LPN #6 indicated she heard "rumors last week or two weeks ago" about a resident on the D wing entering another resident's room and touching another resident sexually. The LPN indicated the resident was confused and she didn't report the allegation to anyone because she believed it had already been discussed with the Unit Manager and Assistant Director of Nursing (ADON). A typed interview statement received from the Director of Nursing (DON) on 1/7/15 at 9:05 a.m., indicated Resident #83 was interviewed on 1/06/16. He indicated Resident #143 never touched him, but made him very uncomfortable.</p> <p>During an interview on 1/07/16 at 9:05 a.m., the DON indicated Resident #143's 15 minute checks were not immediately put into place after the incident on 12/26/15 when Resident #143 attempted to touch a visitor, but initiated on 12/28/15. The DON indicated she was unaware of the incident until 12/28/15 due to the incident happening on the weekend, and staff not reporting the incident immediately.</p>			

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	<p>During an interview on 1/07/16 at 9:06 a.m., the DON indicated during the investigation of recent abuse allegations, Resident #126 reported being touched inappropriately by Resident #143. The DON also indicated that Resident #126's roommate Resident #2 indicated he witnessed the incident.</p> <p>An interview was conducted on 1/07/2016 at 10:01 a.m. with the Social Service Director (SS), Director of Nursing (DON), and Administrator. The DON indicated one behavior sheet from 12/17/15 resulted in development of a care plan to address Resident #143's wandering. The DON indicated staff should have known where care plans were located and the facility tried to include some care plan interventions or behaviors on CNA assignment sheets. The DON indicated the CNA assignment sheets were updated by the unit manager every "couple of days" after new care plans were put in place. The DON indicated no resident interviews were conducted after the 12/17/15 incident to determine if Resident #143 wandered in their rooms or abused them because she thought it was an isolated incident. The DON indicated a written report was received on 12/28/15 regarding Resident #143 grabbing a male visitor's genital</p>			

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	<p>area on 12/26/15. The DON and SSD indicated they did not receive the report until 12/28/15 due to holidays and weekend and indicated staff should have immediately reported the incident. The Social Service Director (SSD) indicated Resident #143 was placed on 15 minute checks due to his tendency towards touching males' genitals and his ability to move around the unit. The DON indicated the 15 min checks continued until 1/06/16 when the resident was placed on 1:1 supervision after receiving an allegation from Resident #83 of abuse by Resident #143. The DON indicated she wished she would have interviewed other residents when she learned of the allegation of Resident #143 grabbing a visitor.</p> <p>During an interview on 01/07/2016 at 10:33 a.m., CNA #7 indicated she completed the behavior form for Resident #143 on 12/26/15. She indicated she was at the at nurses station and Resident #96's granddaughter's husband came up to the desk and informed her that Resident #143 had stopped him in the hall and asked him to come to his room's door and then grabbed the visitor's "privates." She indicated the visitor told her he grabbed Resident #143's hands away and told him no. She indicated the visitor was concerned that he would touch someone</p>			

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	<p>else and told her to have them keep children away from the resident. She indicated she called Qualified Medication Aide (QMA) #8 and informed her and QMA #8 called LPN #2. CNA #7 indicated QMA #8 told her to complete the behavior form and went to check on Resident #143. She indicated she believed QMA #8 informed the nurse manager on call of the visitor incident. CNA #7 indicated her assignment sheet did not say anything about Resident #143 wandering as of 12/26/15. She indicated she saw Resident #143 attempt to wander into the following residents' rooms: Resident #2, Resident #126, Resident #4, Resident #96, and Resident #83. She indicated she stopped Resident #143, redirected him, and informed the nurse. CNA #7 indicated the nurses always told her to continue watching him only. She indicated she never saw Resident #143 in another resident's room, only attempting to enter.</p> <p>During an interview on 1/07/16 at 3:45 p.m., Licensed Practical Nurse (LPN) #2 indicated Resident #2 and Resident #126 informed her Resident #143 had wandered into their room, but she did not report it because Resident #2 and Resident #126 asked her to redirect Resident #143. LPN #2 indicated Resident #2 told her Resident #143 had</p>			

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	<p>been in his room, he did not like Resident #143, he was "weird", and he did not want him in his room. LPN #2 indicated she did not report the incident because it had not happened before. LPN #2 indicated Resident #83 said Resident #143 was in his room and asked her to keep him out. LPN #2 indicated she did not report the incident, but she should have. LPN #2 indicated Resident #83 had informed her he did not want Resident #143 in his room because he "wasn't like that." LPN #2 indicated there was time between the two complaints about Resident #143, so she had not noticed a behavior pattern. She indicated she had been unaware of Resident #143's care plan for wandering. She indicated she should have reported his wandering.</p> <p>The Immediate Jeopardy that began on 12/18/15 was removed on 1/8/16 when Resident #143 received 1:1 staff to resident supervision and the facility educated residents and responsible parties and in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued monitoring for abuse prevention and</p>			

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	<p>reporting.</p> <p>4. During an interview on 1/5/16 at 2:21 p.m., Resident #134 indicated Resident #55 threatened to "whip his white m----r f----g a-s" if he didn't get up from a chair in the designated smoking area and threatened to have her son "come and whoop" him. He further indicated he didn't enjoy going outside anymore "because of her." He indicated he informed the Activity Director.</p> <p>During an interview on 1/5/16 at 3:40 p.m., the Administrator indicated he was aware of the incident and it was reported and investigated.</p> <p>During an interview on 1/6/16 at 12:54 p.m., the Director of Nursing (DON) indicated the facility's system in determining whom to interview regarding abuse allegations was to interview residents with a BIMS score over 9 out of 15 and located in the area where the alleged abuse occurred.</p> <p>During an interview on 1/06/2016 at 1:56 p.m., with Activity Staff (AS) #2 and Activity Director (AD) #1, AD #1 indicated Resident #134 came to her after the 4:00 p.m. smoke break and informed her Resident #55 cursed at him and threatened him "over a chair." She indicated she informed the Administrator</p>			

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	<p>immediately. AS #2 indicated Resident #55 was "kind of a bully." She indicated she was present at the 4:00 smoke break but was not aware of the incident. She indicated she had heard Resident #55 say "smart aleck comments" to other residents during activities. She indicated Resident #55 "always" followed up the smart aleck remarks by saying she was "joking" and if staff told her she wasn't joking she would "rise to another level." She indicated residents were "scared" to respond or "talk back" or "scared to stand up to her." AS #2 indicated Resident #55 was "loud and boisterous" and looked at residents in a manner that was "intimidating." She indicated staff attempted to "appease" Resident #55 to keep her calm as much as possible in activities. AD #1 indicated after the incident where Resident #55 cursed at Resident #134, she witnessed Resident #55 "stare down" Resident #134 and indicated she immediately got another chair for Resident #55. AD #1 indicated she believed Resident #55 was "trying to intimidate" Resident #134 by starring him down. AD #1 indicated she did not report the "starring down" incident to the Administrator and indicated staff attempted to "deal with her" themselves. AD #1 and AS #2 both indicated intimidation was a form of abuse and should have been reported. AD #1</p>			

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	<p>indicated she believed administrative staff was aware of Resident #55's behavior because she "did it enough."</p> <p>During an interview on 1/6/16 at 2:30 p.m., the Administrator additional chairs were added to the smoking area and indicated he was not aware of Resident #55 intimidating or bullying other residents He further indicated staff should have reported Resident #55 bullying and/or intimidating other residents per their abuse protocol.</p> <p>During an interview on 1/07/2016 at 1:20 p.m., Resident #134 indicated Resident #55 "stares me down every time she sees me." He indicated Resident #55 was "a bully"and people were afraid of her and indicated she "always makes mean comments."</p> <p>Resident #134's record was reviewed on 1/5/16 at 3:00 p.m. A Minimum Data Set (MDS) assessment, dated 9/22/15, indicated Resident #134 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, and did not exhibit behaviors.</p> <p>Resident #55's record was reviewed on 1/5/16 at 2:30 p.m. A MDS, dated 12/4/15, indicated Resident #55 was cognitively intact with a BIMS score of</p>			

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	<p>15 out of 15, independently ambulated, and exhibited verbal behavioral symptoms towards others, such as threats and cursing.</p> <p>A document titled, "Mood and Behavior Communication Memo," dated 12/3/15 at 4:00 p.m., indicated Resident #134 informed Activity Director (AD) #1 on 12/3/15 that Resident #55 threatened to "kick his a-s" if he didn't get up from a chair in the smoking area. The document indicated Resident #55 cursed at Resident #134.</p> <p>An incident report, dated 12/4/15, indicated the Administrator was informed of the allegation of abuse by Resident #55 to Resident #134 and indicated five residents were interviewed regarding abuse in relation to this incident. The investigation did not indicate all residents who attended activities or utilized the smoking area were interviewed to determine if there were additional residents who alleged or witnessed abuse by Resident #55. The investigation did not indicate staff were interviewed and did not indicate an intervention to prevent further verbal abuse by Resident #55.</p> <p>A facility policy, received from the Administrator on 01/05/16 at 3:41 p.m.,</p>			

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F 0225 SS=J Bldg. 00	<p>dated 10/2014 and deemed current, titled "Abuse Prohibition Reporting and Investigation," stated, "This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies...Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervisions to prevent recurrence..." The policy also stated, "This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility." The policy also stated, "All reports of abuse must be reported to the Administrator immediately and to the resident's representative."</p> <p>3.1-27(a)(1)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing,</p>			

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	<p>neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure allegations of non-consensual sexual interactions were immediately reported and investigated for 2 of 2 allegations of sexual misconduct in</p>	F 0225	<p>Please see IDR rationale attached.</p> <p>1.Resident #143, in question (in regard to inappropriate interactions with other</p>	01/27/2016

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	<p>a sample of 7 residents reviewed for allegations of abuse (Resident #83 and Resident #126). In addition to the residents in Immediate Jeopardy, the facility failed to ensure an allegation of resident to resident verbal abuse resulting in harm or potential harm that is not Immediate Jeopardy was immediately reported and thoroughly investigated for 1 of 1 resident reviewed for an allegation of verbal abuse (Resident #134).</p> <p>The Immediate Jeopardy was identified on 1/07/2016. The date the Immediate Jeopardy began was not clearly identified due to residents not providing specific dates for allegations of abuse, therefore the Immediate Jeopardy began on 1/7/16 when the facility did not have a system in place to ensure staff immediately reported and thoroughly investigated allegations of abuse. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on 1/07/16 at 1:21 p.m. The Immediate Jeopardy was removed on 1/8/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy</p> <p>Findings include:</p>		<p>residents/visitor) was immediately placed on one-on-one staff supervision upon notification of the alleged inappropriate interaction until such time the resident could be transferred for an in-patient psych evaluation, in an effort to ensure the safety and well-being of all residents of the facility. One should note resident #143 is cognitively intact and denied said allegations. Following in-patient psychiatric evaluation, the facility re-evaluated whether the facility could meet the needs of the resident on the basis of assessment and findings of the psychiatric evaluation. Upon completion of psychiatric treatment resident #143 showed no inappropriate behaviors. Upon return to the facility he was placed on one-on-one supervision as a precautionary measure until he could be relocated to another facility for long term care. Resident #143 was relocated to another facility on 01-29-2016. Resident #83 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #2 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #126 was not physically harmed and showed no signs or symptoms of mental anguish. Staff interviews noting "rumors" were referring to the consensual relationship between cognitively intact resident#143 and cognitively intact resident #36</p>	

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	<p>1. During an interview on 01/06/16 at 9:56 a.m., Resident #83 indicated on "five or six" different occasions Resident #143 had been in his room at 2:00 a.m. touching himself and attempted to "grope" Resident #83. Resident #83 indicated Resident #143 had never touched him because he swung at Resident #143 to keep him away. Resident #83 was unable to provide specific dates for these incidents.</p> <p>During a follow up interview on 1/06/16 at 3:22 p.m., Resident #83 indicated he reported the incidents where Resident #143 entered his room to third shift nurses five times. Resident #83 was unable to recall the names of the nurses he reported the incident to.</p> <p>Resident #83's record was reviewed on 1/07/16 at 11:25 a.m. Resident #83's Resident Admission Record, dated 5/30/15, indicated diagnoses including, but not limited to, paranoid schizophrenia, chronic obstructive pulmonary disease, and below the knee left leg amputation.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/08/15, indicated Resident #83's cognitive status score was 15 indicating he was cognitively intact.</p>		<p>which was previously addressed and careplanned. Resident #55 had a BIM sore of 15 which is the highest possible score indicating she is cognitively intact. Resident #134 had a BIM score of 14 indicating he is cognitively intact. Upon resident #134 reporting the verbal abuse, the facility investigated and reported to the ISDH per facility policy. The investigation included interviewing other residents and staff that were in the area when said incident occurred. Resident #134 was not harmed as evident by the mental anguish assessment that was completed with no variance noted. The facility implemented an intervention to add additional chairs to the smoking area, as this was the root cause of the altercation. The subsequent events had not been reported to facility staff. Upon being made aware of the subsequent events, the facility immediately initiated an investigation and reported to ISDH per facility policy. The chairs in the smoke area not all being the same "type" of chair was noted to be the root cause of subsequent events. As a preventative measure, all chairs provided in the smoke area were changed to all be the same type of chair. There have been no further problems noted or reported.</p> <p>2. In an effort to identify any other resident who could potentially be affected, interviews</p>				

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	<p>Resident #83's nurse's notes, dated 7/02/15 through 1/06/16, were reviewed and lacked documentation of Resident #83 reporting any residents wandering into his room or observations of Resident #143 wandering into his room.</p> <p>2. During an interview on 1/7/16 at 9:31 a.m., Resident #2 indicated about three to four weeks ago, during the day, Resident #143 wandered into his room and touched his roommate, Resident #126, in the private area. He stated he and Resident #126 reported the incident to Licensed Practical Nurse (LPN) #2 and that she did not report the incident to the social worker. Resident #2 indicated Resident #143 had not attempted or ever touched him. Resident #2 indicated during the weeks Resident #126 was in the hospital (after he witnessed Resident touch his roommate's private area) Resident #143 frequently asked where his roommate (Resident #126) was and sat in his wheelchair outside the door to his room and peeked into the room.</p> <p>Resident #2's record was reviewed on 1/07/16 at 9:10 a.m. Resident #2's Resident Admission Record dated 5/15/2015 indicated he had diagnoses including, but not limited to: muscle weakness, cerebral palsy, depressive disorder, and blindness to the right eye.</p>		<p>were conducted with all interviewable residents relative to any concerns with staff and/or residents of the facility including care, interactions, and unwanted room visitation. No concerns were noted or reported through interviews. Should concerns have been identified, immediate investigation would have been initiated and necessary actions initiated as per facility policy, in an effort to ensure the safety and well-being of all residents of the facility. Residents were re-educated of the need to immediately report any allegation of abuse or questionable conduct of a staff member or resident to ensure immediate and necessary action is taken.</p> <p>3.As a means to ensure ongoing compliance, facility staff received in-service training prior to his/her next tour of duty relative to abuse prohibition, immediate reporting of any allegation of abuse, and initiation of immediate interventions, as necessary, to supervise and prevent incidents in an effort to safeguard all residents from abuse.</p> <p>4.As a means of quality assurance, residents will be interviewed weekly for the next four weeks, then monthly thereafter in regard to personal safety and freedom from any type of abuse. Staff shall be randomly interviewed on scheduled days of work by administration in regard</p>	

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	<p>A quarterly Minimum Data Set (MDS) assessment, dated 8/12/15, indicated Resident #2's cognitive status score was 14, indicating he was cognitively intact.</p> <p>During an interview on 1/7/16 at 9:35 a.m., Resident #126 indicated Resident #143 came into his room and touched his private area. Resident #126 indicated he told Resident #143 to leave and he did. Resident #126 stated he reported the incident to Licensed Practical Nurse (LPN) #2. Resident #126 indicated the incident happened prior to him going to the hospital approximately four weeks ago.</p> <p>Resident #126's record was reviewed on 1/07/16 at 9:25 a.m. Resident #126's Resident Admission Record, dated 11/04/15, indicated diagnoses including, but not limited to, unspecified dementia without behavioral disturbance, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/19/15, indicated Resident #126's cognitive status score was 15, indicating he was cognitively intact.</p> <p>3. Resident #143's record was reviewed</p>		<p>to response should a resident report an allegation of abuse to confirm continued compliance with facility policy. Said interviews will be conducted weekly for four weeks, and monthly thereafter. Re-education shall be provided, as warranted, on the basis of staff response. Should concerns be identified, immediate investigation shall be initiated and necessary actions initiated as per facility policy, in an effort to ensure the safety and well-being of all residents of the facility.</p> <p>Addendum For F223, F225, and F323-Please indicate how cognitivelyimpaired residents will be included in investigations for abuse. Please indicate if family members, visitors,and patient representatives are included in education regarding abusereporting. The facility follows the abuse prohibition policy for all residentsas follows; If resident abuse, or suspicion of abuse, is reported: 1. Theresident(s) involved in the incident will be removed from the situation at onceor facility personnel will remain with the resident to ensure safety. 2. Theindividual who witnessed the incident or who was informed of the allegationshall immediately notify a charge nurse assigned to the unit on which theresident resides. If this is not feasible due to circumstances, the</p>	

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	<p>on 1/06/16 at 2:25 p.m. Resident #143's Resident Admission Record dated 7/31/2015 indicated diagnoses including, but not limited to, cerebral infraction, hemiplegia (paralysis on one side of the body), and aphasia (difficulty speaking).</p> <p>Significant change Minimum Data Set (MDS) assessment, dated 10/28/15, indicated Resident #143's cognitive status score was 14, indicating Resident #143 was cognitively intact.</p> <p>A form titled, "Mood and Behavior Communication Memo," dated 12/17/15, indicated Resident #126 and Resident #2 reported that Resident #143 came into their room and they asked the nurse to redirect Resident #143. The memo indicated the nurse redirected Resident #143 to his room.</p> <p>A care plan for Resident #143, dated 12/18/15, indicated he was care planned for wandering and had interventions including the following: redirect resident to his room and obtain a urinalysis and urine culture.</p> <p>A care plan, dated 12/28/15, indicated Resident #143 and his roommate, Resident #36 had a need for privacy and included the following interventions: "establish a system to ensure privacy as</p>		<p>individual shall be responsible to notify any other nurse currently on duty. The nurse will examine the resident(s) involved to determine whether physical injuries have occurred and their extent. This examination shall be documented in the resident's clinical record.</p> <p>3. The charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately.</p> <p>4. Any facility personnel implicated in the alleged abuse will be immediately removed from the resident care and will remain suspended until an investigation is completed. A thorough investigation will be initiated.</p> <p>5. Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervision to prevent recurrence until investigation is completed and/or transferred for medical/psychiatric evaluation to be conducted relative to mood/behavior exhibited.</p> <p>6. The resident's attending physician will be notified as soon as feasible and any orders will be noted and initiated.</p> <p>7. Local law enforcement may be notified, as warranted.</p> <p>8. The family of the resident(s) and/or legal representative will be notified per policy.</p> <p>9. An Incident Report will be completed as per facility policy.</p>	

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	<p>evidenced by door sign, and staff not entering room when door is shut. "</p> <p>On 1/06/15 at 1:55 p.m., the DON provided a document titled, "Mood and Behavior Communication Memo," dated 12/26/15. The memo stated, "The husband of a visitor for Resident #96 said he was in the hallway and Resident #143 came to the doorway and asked him to come here so he said (sic) ask a question when the visitor went over to see what he needed Resident #143 went to grab his private area. The visitor said he grabbed his (Resident #143) hand and told him not to do that and he should be ashamed of himself."</p> <p>A care plan, dated 12/28/15, stated Resident #143 had been, "sexually inappropriate to visitor ...attempted to grope visitor. " The care plan interventions included, but was not limited to, "Placed on 15 min. checks."</p> <p>A document titled, "Fifteen Minute Observation," indicated Resident #143 was placed on bed checks every fifteen minutes beginning 12/28/15.</p> <p>A psychological Evaluations dated 1/04/16 indicated "Patient is a [age specified] year old...mild cognitive</p>		<p>10. Residents will be questioned about the nature of the incident and their statements placed in writing.</p> <p>11. Investigation will be conducted to assure other residents have not been affected by the incident or inappropriate behavior and the results documented.</p> <p>12. Statements will be taken including, but not limited to,</p> <ul style="list-style-type: none"> • facts and observations by involved employees • facts and observations by witnessing employees • facts and observations by witnessing non-employees • facts and observations by any others who might have pertinent information • facts and observations by the licensed nurse or individual to whom the initial report was made. <p>13. Follow-up assessments will be completed/documented during every shift until the resident(s) is stable and resident safety is maintained.</p> <p>14. The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable:</p> <ul style="list-style-type: none"> • State Department of Health • Adult Protective Services • Ombudsman • Applicable Licensing Agency <p>15. The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the</p>	

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	<p>impairment is observed...however patient appears alert, oriented, and able to make decisions for himself...Patient adamantly expressed that he is willingly participating in relationship with his roommate. He appears to understand the risks associated with sexual activity..."</p> <p>During an interview on 1/06/16 at 3:56 p.m., Resident #143 indicated he accidentally wandered into another room once and was not sure when that was. He denied getting up in the middle of the night and wandering into rooms. He also denied an encounter with a visitor or attempting to touch the visitor inappropriately.</p> <p>During an interview on 1/6/15 at 4:03 p.m., Certified Nursing Assistant (CNA) #1 indicated she had never seen Resident #143 wandering at night. She indicated she had witnessed Resident #143 wander into Resident #83's room on two occasions. The first time she witnessed Resident #143 with his hand under #83's sheet. CNA #1 indicated Resident #83 was awake and did not say anything. She did not report it because Resident #83 would have told her if something inappropriate was happening. The second time the CNA #1 saw Resident #143 enter Resident #83's room she immediately had Resident #143 leave</p>		<p>incident and investigation, and tofile a follow-up report to the State Department of Health.</p> <p>16. TheAdministrator is responsible to report to the State nurse aide registry orlicensing authorities any knowledge of any actions by a court of law whichwould indicate an employee is unfit for service.</p> <p>Resident/legal representatives will be informed uponadmission and periodically (at least annually) thereafter of the facility'spolicy regarding abuse prohibition including how and to whom they may reportconcerns, incidents and grievances without fear of retaliation.</p>	

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	<p>room his room. CNA #1 stated that both incidents occurred about three weeks ago in the evening after dinner.</p> <p>During an interview on 1/6/16 at 11:50 p.m., LPN #3, CNA #4, and Qualified Medication Aide (QMA) #5 all indicated they heard rumors of Resident #143 touching his roommate and indicated they did not report the rumors because they believed the managers and the Assistant Director of Nursing (ADON) already knew of the situation.</p> <p>During an interview on 1/7/16 at 12:37 a.m., LPN #6 indicated she heard "rumors last week or two weeks ago" about a resident on the D wing entering another resident's room and touching another resident sexually. The LPN indicated the resident was confused and she didn't report the allegation to anyone because she believed it had already been discussed with the Unit Manager and Assistant Director of Nursing (ADON). A typed interview statement received from the Director of Nursing (DON) on 1/7/15 at 9:05 a.m., indicated Resident #83 was interviewed on 1/06/16. He indicated Resident #143 never touched him, but made him very uncomfortable.</p> <p>During an interview on 1/07/16 at 9:05 a.m., the DON indicated Resident #143's</p>			

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	<p>15 minute checks were not immediately put into place after the incident on 12/26/15 when Resident #143 attempted to touch a visitor, but initiated on 12/28/15. The DON indicated she was unaware of the incident until 12/28/15 due to the incident happening on the weekend, and staff not reporting the incident immediately.</p> <p>During an interview on 1/07/16 at 9:06 a.m., the DON indicated during the investigation of recent abuse allegations, Resident #126 reported being touched inappropriately by Resident #143. The DON also indicated that Resident #126's roommate Resident #2 indicated he witnessed the incident.</p> <p>An interview was conducted on 1/07/2016 at 10:01 a.m. with the Social Service Director (SS), Director of Nursing (DON), and Administrator. The DON indicated one behavior sheet from 12/17/15 resulted in development of a care plan to address Resident #143's wandering. The DON indicated staff should have known where care plans were located and the facility tried to include some care plan interventions or behaviors on CNA assignment sheets. The DON indicated the CNA assignment sheets were updated by the unit manager</p>						

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	<p>every "couple of days" after new care plans were put in place. The DON indicated no resident interviews were conducted after the 12/17/15 incident to determine if Resident #143 wandered in their rooms or abused them because she thought it was an isolated incident. The DON indicated a written report was received on 12/28/15 regarding Resident #143 grabbing a male visitor's genital area on 12/26/15. The DON and SSD indicated they did not receive the report until 12/28/15 due to holidays and weekend and indicated staff should have immediately reported the incident. The Social Service Director (SSD) indicated Resident #143 was placed on 15 minute checks due to his tendency towards touching males' genitals and his ability to move around the unit. The DON indicated the 15 min checks continued until 1/06/16 when the resident was placed on 1:1 supervision after receiving an allegation from Resident #83 of abuse by Resident #143. The DON indicated she wished she would have interviewed other residents when she learned of the allegation of Resident #143 grabbing a visitor.</p> <p>During an interview on 01/07/2016 at 10:33 a.m., CNA #7 indicated she completed the behavior form for Resident</p>			

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	<p>#143 on 12/26/15. She indicated she was at the at nurses station and Resident #96's granddaughter's husband came up to the desk and informed her that Resident #143 had stopped him in the hall and asked him to come to his room's door and then grabbed the visitor's "privates." She indicated the visitor told her he grabbed Resident #143's hands away and told him no. She indicated the visitor was concerned that he would touch someone else and told her to have them keep children away from the resident. She indicated she called Qualified Medication Aide (QMA) #8 and informed her and QMA #8 called LPN #2. CNA #7 indicated QMA #8 told her to complete the behavior form and went to check on Resident #143. She indicated she believed QMA #8 informed the nurse manager on call of the visitor incident. CNA #7 indicated her assignment sheet did not say anything about Resident #143 wandering as of 12/26/15. She indicated she saw Resident #143 attempt to wander into the following residents' rooms: Resident #2, Resident #126, Resident #4, Resident #96, and Resident #83. She indicated she stopped Resident #143, redirected him, and informed the nurse. CNA #7 indicated the nurses always told her to continue watching him only. She indicated she never saw Resident #143 in another resident's room, only attempting</p>			

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	<p>to enter.</p> <p>During an interview on 1/07/16 at 3:45 p.m., Licensed Practical Nurse (LPN) #2 indicated Resident #2 and Resident #126 informed her Resident #143 had wandered into their room, but she did not report it because Resident #2 and Resident #126 asked her to redirect Resident #143. LPN #2 indicated Resident #2 told her Resident #143 had been in his room, he did not like Resident #143, he was "weird", and he did not want him in his room. LPN #2 indicated she did not report the incident because it had not happened before. LPN #2 indicated Resident #83 said Resident #143 was in his room and asked her to keep him out. LPN #2 indicated she did not report the incident, but she should have. LPN #2 indicated Resident #83 had informed her he did not want Resident #143 in his room because he "wasn't like that." LPN #2 indicated there was time between the two complaints about Resident #143, so she had not noticed a behavior pattern. She indicated she had been unaware of Resident #143's care plan for wandering. She indicated she should have reported his wandering.</p> <p>The Immediate Jeopardy that began on 1/7/16 was removed on 1/8/16 when the</p>			
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	<p>facility educated residents and responsible parties and in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued monitoring for abuse prevention and reporting.</p> <p>4. During an interview on 1/5/16 at 2:21 p.m., Resident #134 indicated Resident #55 threatened to "whip his white m---r f----g a-s" if he didn't get up from a chair in the designated smoking area and threatened to have her son "come and whoop" him. He further indicated he didn't enjoy going outside anymore "because of her." He indicated he informed the Activity Director.</p> <p>During an interview on 1/5/16 at 3:40 p.m., the Administrator indicated he was aware of the incident and it was reported and investigated.</p> <p>During an interview on 1/6/16 at 12:54 p.m., the Director of Nursing (DON) indicated the facility's system in determining whom to interview regarding abuse allegations was to interview residents with a BIMS score over 9 out of 15 and located in the area where the</p>			

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	<p>alleged abuse occurred.</p> <p>During an interview on 1/06/2016 at 1:56 p.m., with Activity Staff (AS) #2 and Activity Director (AD) #1, AD #1 indicated Resident #134 came to her after the 4:00 p.m. smoke break and informed her Resident #55 cursed at him and threatened him "over a chair." She indicated she informed the Administrator immediately. AS #2 indicated Resident #55 was "kind of a bully." She indicated she was present at the 4:00 smoke break but was not aware of the incident. She indicated she had heard Resident #55 say "smart aleck comments" to other residents during activities. She indicated Resident #55 "always" followed up the smart aleck remarks by saying she was "joking" and if staff told her she wasn't joking she would "rise to another level." She indicated residents were "scared" to respond or "talk back" or "scared to stand up to her." AS #2 indicated Resident #55 was "loud and boisterous" and looked at residents in a manner that was "intimidating." She indicated staff attempted to "appease" Resident #55 to keep her calm as much as possible in activities. AD #1 indicated after the incident where Resident #55 cursed at Resident #134, she witnessed Resident #55 "stare down" Resident #134 and indicated she immediately got another</p>			

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	<p>chair for Resident #55. AD #1 indicated she believed Resident #55 was "trying to intimidate" Resident #134 by starring him down. AD #1 indicated she did not report the "starring down" incident to the Administrator and indicated staff attempted to "deal with her" themselves. AD #1 and AS #2 both indicated intimidation was a form of abuse and should have been reported. AD #1 indicated she believed administrative staff was aware of Resident #55's behavior because she "did it enough."</p> <p>During an interview on 1/6/16 at 2:30 p.m., the Administrator additional chairs were added to the smoking area and indicated he was not aware of Resident #55 intimidating or bullying other residents He further indicated staff should have reported Resident #55 bullying and/or intimidating other residents per their abuse protocol.</p> <p>During an interview on 1/07/2016 at 1:20 p.m., Resident #134 indicated Resident #55 "stares me down every time she sees me." He indicated Resident #55 was "a bully"and people were afraid of her and indicated she "always makes mean comments."</p> <p>Resident #134's record was reviewed on 1/5/16 at 3:00 p.m. A Minimum Data Set</p>			

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	<p>(MDS) assessment, dated 9/22/15, indicated Resident #134 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, and did not exhibit behaviors.</p> <p>Resident #55's record was reviewed on 1/5/16 at 2:30 p.m. A MDS, dated 12/4/15, indicated Resident #55 was cognitively intact with a BIMS score of 15 out of 15, independently ambulated, and exhibited verbal behavioral symptoms towards others, such as threats and cursing.</p> <p>A document titled, "Mood and Behavior Communication Memo," dated 12/3/15 at 4:00 p.m., indicated Resident #134 informed Activity Director (AD) #1 on 12/3/15 that Resident #55 threatened to "kick his a-s" if he didn't get up from a chair in the smoking area. The document indicated Resident #55 cursed at Resident #134.</p> <p>An incident report, dated 12/4/15, indicated the Administrator was informed of the allegation of abuse by Resident #55 to Resident #134 and indicated five residents were interviewed regarding abuse in relation to this incident. The investigation did not indicate all residents who attended activities or utilized the smoking area were interviewed to</p>			

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	<p>determine if there were additional residents who alleged or witnessed abuse by Resident #55. The investigation did not indicate staff were interviewed and did not indicate an intervention to prevent further verbal abuse by Resident #55.</p> <p>A facility policy, received from the Administrator on 01/05/16 at 3:41 p.m., dated 10/2014 and deemed current, titled "Abuse Prohibition Reporting and Investigation," stated, "This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies...Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervisions to prevent recurrence..." The policy also stated, "This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility." The policy also stated, "All reports of abuse must be reported to the Administrator immediately and to the resident's representative."</p> <p>3.1-28(c) 3.1-28(d)</p>			

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F 0226 SS=J Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</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 its policies and procedures were implemented to prevent a resident (Resident #143) with wandering and inappropriate sexual behaviors from attempting or engaging in non-consensual sexual interactions with other residents and failed to ensure allegations of abuse were reported and thoroughly investigated for 2 of 7 residents reviewed for allegations of abuse (Resident #83 and Resident #126). In addition to the residents in Immediate Jeopardy, the facility failed to ensure its policis and procedures were implemented to prevent verbal abuse and an allegation of resident to resident verbal abuse resulting in harm or potential harm that is not Immediate Jeopardy was immediately reported and thoroughly investigated for 1 of 1 resident reviewed for an allegation</p>	F 0226	<p>Please see IDR rationale attached Past noncompliance: No POC required.</p> <p>1. Resident #143, in question (in regard to inappropriate interactions with other residents/visitor) was immediately placed on one-on-one staff supervision upon notification of the alleged inappropriate interaction until such time the resident could be transferred for an in-patient psych evaluation, in an effort to ensure the safety and well-being of all residents of the facility. One should note resident #143 is cognitively intact and denied said allegations. Following in-patient psychiatric evaluation, the facility re-evaluated whether the facility could meet the needs of the resident on the basis of assessment and findings of the psychiatric evaluation. Upon completion of psychiatric treatment resident #143 showed no inappropriate behaviors. Upon</p>	01/25/2016

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	<p>of verbal abuse (Resident #134).</p> <p>The Immediate Jeopardy was identified on 1/07/2016 and began on 12/18/15 when the facility failed to ensure interventions to prevent Resident #143 from wandering into other residents' room. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on 1/07/16 at 1:21 p.m. The Immediate Jeopardy was removed on 1/8/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy</p> <p>Findings include:</p> <p>1. During an interview on 01/06/16 at 9:56 a.m., Resident #83 indicated on "five or six" different occasions Resident #143 had been in his room at 2:00 a.m. touching himself and attempted to "grope" Resident #83. Resident #83 indicated Resident #143 had never touched him because he swung at Resident #143 to keep him away. Resident #83 was unable to provide specific dates for these incidents.</p> <p>During a follow up interview on 1/06/16 at 3:22 p.m., Resident #83 indicated he reported the incidents where Resident #143 entered his room to third shift</p>		<p>return to the facility he was placed on one-on-one supervision as a precautionary measure until he could be relocated to another facility for long term care. Resident #143 was relocated to another facility on 01-29-2016. Resident #83 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #2 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #126 was not physically harmed and showed no signs or symptoms of mental anguish. Staff interviews noting "rumors" were referring to the consensual relationship between cognitively intact resident#143 and cognitively intact resident #36 which was previously addressed and careplanned. Resident #55 had a BIM score of 15 which is the highest possible score indicating she is cognitively intact. Resident #134 had a BIM score of 14 indicating he is cognitively intact. Upon resident #134 reporting the verbal abuse, the facility investigated and reported to the ISDH per facility policy. The investigation included interviewing other residents and staff that were in the area when said incident occurred. Resident #134 was not harmed as evident by the mental anguish assessment that was completed with no variance noted. The facility implemented an intervention to add additional chairs to the smoking area, as</p>	

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	<p>nurses five times. Resident #83 was unable to recall the names of the nurses he reported the incident to.</p> <p>Resident #83's record was reviewed on 1/07/16 at 11:25 a.m. Resident #83's Resident Admission Record, dated 5/30/15, indicated diagnoses including, but not limited to, paranoid schizophrenia, chronic obstructive pulmonary disease, and below the knee left leg amputation.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/08/15, indicated Resident #83's cognitive status score was 15 indicating he was cognitively intact.</p> <p>Resident #83's nurse's notes, dated 7/02/15 through 1/06/16, were reviewed and lacked documentation of Resident #83 reporting any residents wandering into his room or observations of Resident #143 wandering into his room.</p> <p>2. During an interview on 1/7/16 at 9:31 a.m., Resident #2 indicated about three to four weeks ago, during the day, Resident #143 wandered into his room and touched his roommate, Resident #126, in the private area. He stated he and Resident #126 reported the incident to Licensed Practical Nurse (LPN) #2 and that she did not report the incident to the</p>		<p>this was the root cause of the altercation. The subsequent events had not been reported to facility staff. Upon being made aware of the subsequent events, the facility immediately initiated an investigation and reported to ISDH per facility policy. The chairs in the smoke area not all being the same "type" of chair was noted to be the root cause of subsequent events. As a preventative measure, all chairs provided in the smoke area were changed to all be the same type of chair. There have been no further problems noted or reported.</p> <p>2. In an effort to identify any other resident who could potentially be affected, interviews were conducted with all interviewable residents relative to any concerns with staff and/or residents of the facility including care, interactions, and unwanted room visitation. No concerns were noted or reported through interviews. Should concerns have been identified, immediate investigation would have been initiated and necessary actions initiated as per facility policy, in an effort to ensure the safety and well-being of all residents of the facility. Residents were re-educated of the need to immediately report any allegation of abuse or questionable conduct of a staff member or resident to ensure immediate and necessary action is taken.</p>		

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	<p>social worker. Resident #2 indicated Resident #143 had not attempted or ever touched him. Resident #2 indicated during the weeks Resident #126 was in the hospital (after he witnessed Resident touch his roommate's private area) Resident #143 frequently asked where his roommate (Resident #126) was and sat in his wheelchair outside the door to his room and peeked into the room.</p> <p>Resident #2's record was reviewed on 1/07/16 at 9:10 a.m. Resident #2's Resident Admission Record dated 5/15/2015 indicated he had diagnoses including, but not limited to: muscle weakness, cerebral palsy, depressive disorder, and blindness to the right eye.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 8/12/15, indicated Resident #2's cognitive status score was 14, indicating he was cognitively intact.</p> <p>During an interview on 1/7/16 at 9:35 a.m., Resident #126 indicated Resident #143 came into his room and touched his private area. Resident #126 indicated he told Resident #143 to leave and he did. Resident #126 stated he reported the incident to Licensed Practical Nurse (LPN) #2. Resident #126 indicated the incident happened prior to him going to the hospital approximately four weeks</p>		<p>3.As a means to ensure ongoing compliance, facility staff received in-service training prior to his/her next tour of duty relative to abuse prohibition, immediate reporting of any allegation of abuse, and initiation of immediate interventions, as necessary, to supervise and prevent incidents in an effort to safeguard all residents from abuse.</p> <p>4.As a means of quality assurance, residents will be interviewed weekly for the next four weeks, then monthly thereafter in regard to personal safety and freedom from any type of abuse. Staff shall be randomly interviewed on scheduled days of work by administration in regard to response should a resident report an allegation of abuse to confirm continued compliance with facility policy. Said interviews will be conducted weekly for four weeks, and monthly thereafter. Re-education shall be provided, as warranted, on the basis of staff response. Should concerns be identified, immediate investigation shall be initiated and necessary actions initiated as per facility policy, in an effort to ensure the safety and well-being of all residents of the facility.</p> <p>AddendumFor F223, F225, and F323-Please indicate how cognitively impaired residents will be included in investigations for abuse. Please indicate if family members, visitors, and patient</p>	

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	<p>ago.</p> <p>Resident #126's record was reviewed on 1/07/16 at 9:25 a.m. Resident #126's Resident Admission Record, dated 11/04/15, indicated diagnoses including, but not limited to, unspecified dementia without behavioral disturbance, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/19/15, indicated Resident #126's cognitive status score was 15, indicating he was cognitively intact.</p> <p>3. Resident #143's record was reviewed on 1/06/16 at 2:25 p.m. Resident #143's Resident Admission Record dated 7/31/2015 indicated diagnoses including, but not limited to, cerebral infraction, hemiplegia (paralysis on one side of the body), and aphasia (difficulty speaking).</p> <p>Significant change Minimum Data Set (MDS) assessment, dated 10/28/15, indicated Resident #143's cognitive status score was 14, indicating Resident #143 was cognitively intact.</p> <p>A form titled, " Mood and Behavior Communication Memo," dated 12/17/15, indicated Resident #126 and Resident #2</p>		<p>representatives are included in education regarding abuse reporting. The facility follows the abuse prohibition policy for all residents as follows; If resident abuse, or suspicion of abuse, is reported: 1. The resident(s) involved in the incident will be removed from the situation at once or facility personnel will remain with the resident to ensure safety. 2. The individual who witnessed the incident or who was informed of the allegation shall immediately notify a charge nurse assigned to the unit on which the resident resides. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty. The nurse will examine the resident(s) involved to determine whether physical injuries have occurred and their extent. This examination shall be documented in the resident's clinical record. 3. The charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately. 4. Any facility personnel implicated in the alleged abuse will be immediately removed from the resident care and will remain suspended until an investigation is completed. A thorough investigation will be initiated. 5. Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervision to prevent recurrence until investigation is</p>	

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	<p>reported that Resident #143 came into their room and they asked the nurse to redirect Resident #143. The memo indicated the nurse redirected Resident #143 to his room.</p> <p>A care plan for Resident #143, dated 12/18/15, indicated he was care planned for wandering and had interventions including the following: redirect resident to his room and obtain a urinalysis and urine culture.</p> <p>A care plan, dated 12/28/15, indicated Resident #143 and his roommate, Resident #36 had a need for privacy and included the following interventions: "establish a system to ensure privacy as evidenced by door sign, and staff not entering room when door is shut. "</p> <p>On 1/06/15 at 1:55 p.m., the DON provided a document titled, "Mood and Behavior Communication Memo," dated 12/26/15. The memo stated, "The husband of a visitor for Resident #96 said he was in the hallway and Resident #143 came to the doorway and asked him to come here so he said (sic) ask a question when the visitor went over to see what he needed Resident #143 went to grab his private area. The visitor said he grabbed his (Resident #143) hand and told him not to do that and he should be ashamed</p>		<p>completed and/or transferred for medical/psychiatric evaluation to be conducted relative to mood/behavior exhibited.6. The resident's attending physician will be notified as soon as feasible and any orders will be noted and initiated.7. Local law enforcement may be notified, as warranted.8. The family of the resident(s) and/or legal representative will be notified per policy.9. An Incident Report will be completed as per facility policy. 10. Residents will be questioned about the nature of the incident and their statements placed in writing.11. Investigation will be conducted to assure other residents have not been affected by the incident or inappropriate behavior and the results documented.12. Statements will be taken including, but not limited to,• facts and observations by involved employees• facts and observations by witnessing employees• facts and observations by witnessing non-employees• facts and observations by any others who might have pertinent information• facts and observations by the licensed nurse or individual to whom the initial report was made.13. Follow-up assessments will be completed/documented during every shift until the resident(s) is stable and resident safety is maintained.14. The Administrator, Director of</p>	

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	<p>of himself."</p> <p>A care plan, dated 12/28/15, stated Resident #143 had been, "sexually inappropriate to visitor ...attempted to grope visitor. " The care plan interventions included, but was not limited to, "Placed on 15 min. checks."</p> <p>A document titled, "Fifteen Minute Observation," indicated Resident #143 was placed on bed checks every fifteen minutes beginning 12/28/15.</p> <p>A psychological Evaluations dated 1/04/16 indicated "Patient is a [age specified] year old...mild cognitive impairment is observed...however patient appears alert, oriented, and able to make decisions for himself...Patient adamantly expressed that he is willingly participating in relationship with his roommate. He appears to understand the risks associated with sexual activity..."</p> <p>During an interview on 1/06/16 at 3:56 p.m., Resident #143 indicated he accidentally wandered into another room once and was not sure when that was. He denied getting up in the middle of the night and wandering into rooms. He also denied an encounter with a visitor or attempting to touch the visitor</p>		<p>Nursing, or designee, is responsible to notify the following agencies, as applicable:• State Department of Health• Adult Protective Services• Ombudsman• Applicable Licensing Agency15. The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation, and to file a follow-up report to the State Department of Health.16. The Administrator is responsible to report to the State nurse aide registry or licensing authorities any knowledge of any actions by a court of law which would indicate an employee is unfit for service. Resident/legal representatives will be informed upon admission and periodically (at least annually) thereafter of the facility's policy regarding abuse prohibition including how and to whom they may report concerns, incidents and grievances without fear of retaliation.</p>	

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	<p>inappropriately.</p> <p>During an interview on 1/6/15 at 4:03 p.m., Certified Nursing Assistant (CNA) #1 indicated she had never seen Resident #143 wandering at night. She indicated she had witnessed Resident #143 wander into Resident #83's room on two occasions. The first time she witnessed Resident #143 with his hand under #83's sheet. CNA #1 indicated Resident #83 was awake and did not say anything. She did not report it because Resident #83 would have told her if something inappropriate was happening. The second time the CNA #1 saw Resident #143 enter Resident #83's room she immediately had Resident #143 leave room his room. CNA #1 stated that both incidents occurred about three weeks ago in the evening after dinner.</p> <p>During an interview on 1/6/16 at 11:50 p.m., LPN #3, CNA #4, and Qualified Medication Aide (QMA) #5 all indicated they heard rumors of Resident #143 touching his roommate and indicated they did not report the rumors because they believed the managers and the Assistant Director of Nursing (ADON) already knew of the situation.</p> <p>During an interview on 1/7/16 at 12:37 a.m., LPN #6 indicated she heard</p>			

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	<p>"rumors last week or two weeks ago" about a resident on the D wing entering another resident's room and touching another resident sexually. The LPN indicated the resident was confused and she didn't report the allegation to anyone because she believed it had already been discussed with the Unit Manager and Assistant Director of Nursing (ADON). A typed interview statement received from the Director of Nursing (DON) on 1/7/15 at 9:05 a.m., indicated Resident #83 was interviewed on 1/06/16. He indicated Resident #143 never touched him, but made him very uncomfortable.</p> <p>During an interview on 1/07/16 at 9:05 a.m., the DON indicated Resident #143's 15 minute checks were not immediately put into place after the incident on 12/26/15 when Resident #143 attempted to touch a visitor, but initiated on 12/28/15. The DON indicated she was unaware of the incident until 12/28/15 due to the incident happening on the weekend, and staff not reporting the incident immediately.</p> <p>During an interview on 1/07/16 at 9:06 a.m., the DON indicated during the investigation of recent abuse allegations, Resident #126 reported being touched inappropriately by Resident #143. The</p>			

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	<p>DON also indicated that Resident #126's roommate Resident #2 indicated he witnessed the incident.</p> <p>An interview was conducted on 1/07/2016 at 10:01 a.m. with the Social Service Director (SS), Director of Nursing (DON), and Administrator. The DON indicated one behavior sheet from 12/17/15 resulted in development of a care plan to address Resident #143's wandering. The DON indicated staff should have known where care plans were located and the facility tried to include some care plan interventions or behaviors on CNA assignment sheets. The DON indicated the CNA assignment sheets were updated by the unit manager every "couple of days" after new care plans were put in place. The DON indicated no resident interviews were conducted after the 12/17/15 incident to determine if Resident #143 wandered in their rooms or abused them because she thought it was an isolated incident. The DON indicated a written report was received on 12/28/15 regarding Resident #143 grabbing a male visitor's genital area on 12/26/15. The DON and SSD indicated they did not receive the report until 12/28/15 due to holidays and weekend and indicated staff should have</p>			

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	<p>immediately reported the incident. The Social Service Director (SSD) indicated Resident #143 was placed on 15 minute checks due to his tendency towards touching males' genitals and his ability to move around the unit. The DON indicated the 15 min checks continued until 1/06/16 when the resident was placed on 1:1 supervision after receiving an allegation from Resident #83 of abuse by Resident #143. The DON indicated she wished she would have interviewed other residents when she learned of the allegation of Resident #143 grabbing a visitor.</p> <p>During an interview on 01/07/2016 at 10:33 a.m., CNA #7 indicated she completed the behavior form for Resident #143 on 12/26/15. She indicated she was at the at nurses station and Resident #96's granddaughter's husband came up to the desk and informed her that Resident #143 had stopped him in the hall and asked him to come to his room's door and then grabbed the visitor's "privates." She indicated the visitor told her he grabbed Resident #143's hands away and told him no. She indicated the visitor was concerned that he would touch someone else and told her to have them keep children away from the resident. She indicated she called Qualified Medication Aide (QMA) #8 and informed her and</p>			

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	<p>QMA #8 called LPN #2. CNA #7 indicated QMA #8 told her to complete the behavior form and went to check on Resident #143. She indicated she believed QMA #8 informed the nurse manager on call of the visitor incident. CNA #7 indicated her assignment sheet did not say anything about Resident #143 wandering as of 12/26/15. She indicated she saw Resident #143 attempt to wander into the following residents' rooms: Resident #2, Resident #126, Resident #4, Resident #96, and Resident #83. She indicated she stopped Resident #143, redirected him, and informed the nurse. CNA #7 indicated the nurses always told her to continue watching him only. She indicated she never saw Resident #143 in another resident's room, only attempting to enter.</p> <p>During an interview on 1/07/16 at 3:45 p.m., Licensed Practical Nurse (LPN) #2 indicated Resident #2 and Resident #126 informed her Resident #143 had wandered into their room, but she did not report it because Resident #2 and Resident #126 asked her to redirect Resident #143. LPN #2 indicated Resident #2 told her Resident #143 had been in his room, he did not like Resident #143, he was "weird", and he did not want him in his room. LPN #2 indicated she did not report the incident because it</p>						

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	<p>had not happened before. LPN #2 indicated Resident #83 said Resident #143 was in his room and asked her to keep him out. LPN #2 indicated she did not report the incident, but she should have. LPN #2 indicated Resident #83 had informed her he did not want Resident #143 in his room because he "wasn't like that." LPN #2 indicated there was time between the two complaints about Resident #143, so she had not noticed a behavior pattern. She indicated she had been unaware of Resident #143's care plan for wandering. She indicated she should have reported his wandering.</p> <p>A facility policy, received from the Administrator on 01/05/16 at 3:41 p.m., dated 10/2014 and deemed current, titled "Abuse Prohibition Reporting and Investigation," stated, "This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies...Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervisions to prevent recurrence..." The policy also stated, "This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of</p>			

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	<p>resident property are reported immediately to the administrator of the facility." The policy also stated, "All reports of abuse must be reported to the Administrator immediately and to the resident's representative."</p> <p>The Immediate Jeopardy that began on 12/18/15 was removed on 1/8/16 when Resident #143 received 1:1 staff to resident supervision and the facility educated residents and responsible parties and in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued monitoring for abuse prevention and reporting.</p> <p>4. During an interview on 1/5/16 at 2:21 p.m., Resident #134 indicated Resident #55 threatened to "whip his white m----r f----g a-s" if he didn't get up from a chair in the designated smoking area and threatened to have her son "come and whoop" him. He further indicated he didn't enjoy going outside anymore "because of her." He indicated he informed the Activity Director.</p> <p>During an interview on 1/5/16 at 3:40 p.m., the Administrator indicated he was</p>			

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	<p>aware of the incident and it was reported and investigated.</p> <p>During an interview on 1/6/16 at 12:54 p.m., the Director of Nursing (DON) indicated the facility's system in determining whom to interview regarding abuse allegations was to interview residents with a BIMS score over 9 out of 15 and located in the area where the alleged abuse occurred.</p> <p>During an interview on 1/06/2016 at 1:56 p.m., with Activity Staff (AS) #2 and Activity Director (AD) #1, AD #1 indicated Resident #134 came to her after the 4:00 p.m. smoke break and informed her Resident #55 cursed at him and threatened him "over a chair." She indicated she informed the Administrator immediately. AS #2 indicated Resident #55 was "kind of a bully." She indicated she was present at the 4:00 smoke break but was not aware of the incident. She indicated she had heard Resident #55 say "smart aleck comments" to other residents during activities. She indicated Resident #55 "always" followed up the smart aleck remarks by saying she was "joking" and if staff told her she wasn't joking she would "rise to another level." She indicated residents were "scared" to respond or "talk back" or "scared to stand up to her." AS #2 indicated Resident #55</p>			

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	<p>was "loud and boisterous" and looked at residents in a manner that was "intimidating." She indicated staff attempted to "appease" Resident #55 to keep her calm as much as possible in activities. AD #1 indicated after the incident where Resident #55 cursed at Resident #134, she witnessed Resident #55 "stare down" Resident #134 and indicated she immediately got another chair for Resident #55. AD #1 indicated she believed Resident #55 was "trying to intimidate" Resident #134 by starring him down. AD #1 indicated she did not report the "starring down" incident to the Administrator and indicated staff attempted to "deal with her" themselves. AD #1 and AS #2 both indicated intimidation was a form of abuse and should have been reported. AD #1 indicated she believed administrative staff was aware of Resident #55's behavior because she "did it enough."</p> <p>During an interview on 1/6/16 at 2:30 p.m., the Administrator additional chairs were added to the smoking area and indicated he was not aware of Resident #55 intimidating or bullying other residents He further indicated staff should have reported Resident #55 bullying and/or intimidating other residents per their abuse protocol.</p>			

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	<p>During an interview on 1/07/2016 at 1:20 p.m., Resident #134 indicated Resident #55 "stares me down every time she sees me." He indicated Resident #55 was "a bully"and people were afraid of her and indicated she "always makes mean comments."</p> <p>Resident #134's record was reviewed on 1/5/16 at 3:00 p.m. A Minimum Data Set (MDS) assessment, dated 9/22/15, indicated Resident #134 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, and did not exhibit behaviors.</p> <p>Resident #55's record was reviewed on 1/5/16 at 2:30 p.m. A MDS, dated 12/4/15, indicated Resident #55 was cognitively intact with a BIMS score of 15 out of 15, independently ambulated, and exhibited verbal behavioral symptoms towards others, such as threats and cursing.</p> <p>A document titled, "Mood and Behavior Communication Memo," dated 12/3/15 at 4:00 p.m., indicated Resident #134 informed Activity Director (AD) #1 on 12/3/15 that Resident #55 threatened to "kick his a-s" if he didn't get up from a chair in the smoking area. The document indicated Resident #55 cursed at Resident #134.</p>			

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	<p>An incident report, dated 12/4/15, indicated the Administrator was informed of the allegation of abuse by Resident #55 to Resident #134 and indicated five residents where interviewed regarding abuse in relation to this incident. The investigation did not indicate all residents who attended activities or utilized the smoking area were interviewed to determine if there were additional residents who alleged or witnessed abuse by Resident #55. The investigation did not indicate staff were interviewed and did not indicate an intervention to prevent further verbal abuse by Resident #55.</p> <p>A facility policy, received from the Administrator on 01/05/16 at 3:41 p.m., dated 10/2014 and deemed current, titled "Abuse Prohibition Reporting and Investigation," stated, "This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies...Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervisions to prevent recurrence..." The policy also stated, "This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of</p>			

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F 0241 SS=E Bldg. 00	<p>unknown source and misappropriation of resident property are reported immediately to the administrator of the facility." The policy also stated, "All reports of abuse must be reported to the Administrator immediately and to the resident's representative."</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. Based on observation, interview, and record review, the facility failed to ensure residents' dignity was maintained by posting signs with resident care needs on a bulletin board visible to visitors, residents, and employees at 3 of 4 nursing stations and failed to ensure a resident's catheter bag was covered to prevent view of collected urine for 27 of 44 residents reviewed for dignity (Residents #1, #2, #7, #9, #11, #27, #28, #29, #32, #39, #43, #50, #53, #54, #65, #84, #93, #95, #105, #110, #112, #117,</p>	F 0241	<p>1.Residents #1, #2, #7, #9, #11, #27, #28, #29, #32, #39,#43, #50, #53, #54, #65, #84, #93, #95, #105, #110, #112, #117, #130, #133,#160, C, and D) were affected. The residents were not harmed. The postings were immediately relocated to a location accessible to caregivers, but not visible to public. The catheter bag was covered with a dignity bag. 2.All residents have the potential to be affected. Facility rounds were conducted to ensure resident specific information was</p>	01/27/2016

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	<p>#130, #133, #160, C, and D).</p> <p>Findings include:</p> <p>1. During observations on 1/6/16 at 10:12 a.m., 1/7/16 at 1:40 p.m., 1/8/16 at 10:10 a.m., and 1/11/16 at 12:52 p.m., the following information was posted on bulletin boards visible from the hallway at the A, B, and D nurses' stations:</p> <p>a. A sign indicated residents required a stretcher for transportation if they required a bari-bed (oversized bed), and if they had a tracheostomy. The following residents' were indicated on the sign: Residents #1, #2, #7, #9, #27, #28, #29, #32, #39, #43, #53, #54, #65, #84, #93, #95, #110, #117, #130, #133, C, and D.</p> <p>b. A sign indicated residents who required special diets and their specific dietary aids: Residents #50, #105, and #112.</p> <p>c. A sign indicated residents who were an elopement risk: Residents #11 and #160.</p> <p>d. A sign indicated residents who required dialysis and their dialysis schedules: Residents #53, #93, and #117.</p> <p>A Resident's Rights policy identified as</p>		<p>placed in a private area. All catheter bags were checked to ensure dignity bags were in place. All staff will be in-serviced on privacy and dignity.</p> <p>3.As a measure to ensure ongoing compliance the DON or designee will complete an audit to ensure the residents are provided with dignity and privacy in regards to informational postings and covered catheter bags five times weekly for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing.</p> <p>4.As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised, as warranted.</p>	

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	<p>current by the Administrator on 1/12/16 at 4:00 p.m., indicated, "...The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications. personal care, visits, meetings of family and resident groups...."</p> <p>2. On 1/4/16 at 10:15 a.m., Resident #28 was observed sitting in the activities room in his wheelchair with a urinary catheter bag hanging uncovered off the bottom of his wheelchair. The urinary catheter bag had yellow urine visible in the bag.</p> <p>On 1/4/16 at 11:38 a.m., Resident #28 was observed in the main dining room sitting in his wheelchair. His urinary catheter bag was hanging uncovered off his wheelchair, the tubing was resting on floor, and Resident #28's foot was on the urinary catheter tubing. The urinary catheter bag had yellow urine visible in the bag and tubing.</p> <p>On 1/11/16 at 10:30 a.m., Resident #28's record was reviewed. The care plan titled, "Foley Catheter," initiated on 1/26/15, stated, "Resident requires the use of indwelling S/P (subrapubic) Foley Catheter due to urinary obstruction and is</p>			

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	<p>at risk for infection." The care plan interventions included, but were not limited to the following: "...keep cath (catheter) drainage bag covered as to maintain resident dignity/privacy."</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 10/29/15, indicated Resident #28 had catheter and had a Brief Interview for Mental Status score of 14 of 15, indicating he was cognitively intact.</p> <p>On 1/8/16 at 12:55 p.m. Licensed Practical Nurse (LPN) #20 indicated in an interview Resident #28's urinary catheter bag should have been covered and should not touch the floor.</p> <p>On 1/12/16 at 9:10 a.m., the Director of Nursing provided the current policy titled, "Catheter Care, Suprapubic." The policy did not address the covering of catheter bag.</p> <p>A Resident's Rights policy identified as current by the Administrator on 1/12/16 at 4:00 p.m., indicated, "...Privacy and confidentiality, The resident has the right to personal privacy...Personal privacy includes accommodations, medical treatment, written and telephone communications. personal care, visits, meetings of family and resident groups."</p>			

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F 0278 SS=D Bldg. 00	<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> <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. Based on observation, interview, and record review, the facility failed to ensure</p>	F 0278	1.MDS modifications were completed on identified residents (#143, #81, #28, #48,).	01/27/2016

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	<p>medical, functional and psychosocial assessments were coded correctly for 4 of 23 residents reviewed for accuracy of Minimum Data Set (MDS) assessments (Residents #143, Resident #81, Resident #28, and Resident #48).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #143 was reviewed on 1/08/16 at 10:20 a.m. Diagnoses included, but were not limited to, cerebral infraction, hemiplegia non dominate side, aphasia, ataxia, and expressive language disorder</p> <p>The admission MDS assessment, dated 8/07/15, indicated the resident was continent.</p> <p>A Bowel and Bladder assessment, dated 8/10/15, indicated perception of need to void was present, urinary urgency, checks for incontinence during night, continent during the day.</p> <p>An Interdisciplinary Care Plan, dated 8/17/15, indicated the resident was incontinent of bladder at times and continent of bowel.</p> <p>A significant change MDS assessment, dated 10/28/15, indicated the resident was frequently incontinent.</p> <p>An Interdisciplinary Care Plan Conference Record, dated 11/17/15 indicated, "Continent B&B (Bowel and Bladder) with episodes of incontinence. "</p>		<p>2.All residents have the potential to be affected. All active residents' most recent OBRA assessments were reviewed to ensure accurate coding. Modifications were completed as indicated. MDS coordinators were re-educated per RAI guidelines on accurate coding of affected areas by MDS consultants (Urinary Continence, ADL Coding- eating, catheters, Height). Coordinators were also educated on importance of careful data entry.</p> <p>3.As a measure to ensure ongoing compliance, all OBRA MDS's will be audited by a peer MDS coordinator to ensure accuracy (ADL coding-eating, Urinary incontinence, height, and catheters) for 30 days. The MDS consultant or designee will complete audits on at least 5 records weekly X 60 days then at least 2 records monthly ongoing to ensure MDS coding is accurate. Should a discrepancy be noted, a modification to provide correction will be completed.</p> <p>4.As a measure of quality assurance the MDS consultant or designee will review any findings and subsequent corrective actions in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>	

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	<p>A care plan, dated 12/31/15, indicated " provide peri-care each shift and after each incontinent episode. A care plan titled " Urinary Incontinence," dated 12/31/15, indicated the resident was incontinent of bladder due to history of CVA (cerebrovascular accident) and TIA (transient ischemic attack) and required extensive assistance with toilet use. During an interview on 1/08/16 at 10:49 a.m., LPN #11 indicated Resident #143 was continent during the day and told staff when he needed to go to the restroom and was incontinent at night. During an interview on 1/12/16 at 9:53 a.m., the MDS Coordinator indicated the admission MDS, dated 8/07/15, was a "data error" in regard to Resident #143 being continent.</p> <p>2. Resident #81's record was reviewed on 1/8/16 at 3:22 p.m. An admission Minimum Data Set (MDS) assessment, dated 9/22/15, indicated Resident #81 was incontinent due to absent perception of a need to void related to cognitive and/or physical functioning. The assessment indicated the resident needed extensive assistance for eating.</p> <p>A MDS assessment, dated 10/25/15, indicated Resident #81 declined from being occasionally incontinent to always incontinent and declined from requiring</p>			

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	<p>limited assistance to eat to requiring extensive assistance from staff for eating.</p> <p>During an interview on 1/11/16 at 4:17 p.m., Minimum Data Set (MDS) employee #5 indicated she incorrectly coded Resident #81 as always continent and limited assistance for eating on her admission MDS assessment, dated 9/29/15. She indicated she should have coded the resident as always incontinent and requiring extensive assistance with eating.</p> <p>3. On 1/4/16 at 10:15 a.m., Resident #28 was observed sitting in the activities room in his wheelchair with a urinary catheter bag hanging uncovered off the bottom of his wheelchair. The urinary catheter bag had yellow urine visible in the bag.</p> <p>Resident #28's record was reviewed on 1/11/16 at 10:30 a.m. "Section H: Bladder and Bowel," of Resident #28's quarterly Minimum Data Set (MDS) assessment, dated 11/17/15, indicated the resident did not have appliances including, but not limited to, a suprapubic catheter.</p> <p>The form titled, "Bowel and Bladder Assessment," dated 11/17/15, indicated Resident #28 had a subrapubic catheter due to the inability to void.</p>			

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	<p>The form titled, "Catheter Assessment," dated 12/8/15, indicated Resident #28's urinary catheter was inserted due to urinary obstruction. The assessment stated the resident had, "Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible."</p> <p>The Physician's order summary, dated 12/30/15, indicated Resident #28 had a diagnosis of urinary obstruction. The physician order summary indicated Resident #28 had a physician order for a subrapubic urinary catheter.</p> <p>During an interview on 1/12/16 at 9:33 a.m., Minimum Data Set (MDS) Assistant #14 indicated Resident #28 had a suprapubic catheter and it was a clerical error on her part that she marked no bladder appliances for the MDS dated 11/12/15 and 11/17/15.</p> <p>4. On 1/5/16 at 11:00 a.m. Resident #48's record was reviewed. Resident #48's weight log indicated the resident weighed 142 pounds on 6/9/15, 133 pounds on 9/3/15, 130 pounds on 11/10/15, and 126 on 12/10/15.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 8/21/15, indicated</p>			

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F 0309 SS=G Bldg. 00	<p>Resident #48 was 60 inches, and had not had a significant weight loss or gain.</p> <p>Resident #48's quarterly Minimum Data Set (MDS) assessment, dated 11/21/15, her height was 66 inches and her weight was 126 pounds.</p> <p>During an interview on 1/12/16 at 12:34 p.m., Minimum Data Set (MDS) Assistant #22 indicated Resident #48's height was actually 62 inches according to her 2015 weight record and indicated she made a mistake on the MDS, dated 8/21/15, and rounded Resident #48's height of 62 inches down to 60 inches. She indicated the dietician's note, dated 11/20/15, indicated Resident #48's height was 66 inches and she used the height recorded in dietician's note to complete the MDS, dated 11/21/15.</p> <p>3.1-31 (i)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and</p>			

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>A. Based on observation, record review, and interview the facility failed to ensure medication was administered to manage pain resulting in acute pain and the resident yelling out during wound treatments for 1 of 3 residents reviewed for pain management (Resident B).</p> <p>B. Based on record review and interview, the facility failed to ensure communication between the facility and the dialysis provider for 1 of 1 resident reviewed for dialysis (Resident #117).</p> <p>Findings include:</p> <p>A. On 1/12/16 at 11:29 a.m., with Qualified Medication Aide (QMA) # 98, Certified Nursing Assistant (CNA) #97, CNA #86, Licensed Practical Nurse (LPN) #96, and LPN #99 present, Resident B's wound care was observed. Resident B was positioned on his right side. During the procedure at:11:46 a.m., Resident B screamed out three times. LPN # 96 indicated the resident was feeling pain. LPN #99 was heard telling Resident B she was trying to get the dressing change completed as fast as she could and indicated she did not know how often Resident B received pain</p>	F 0309	<p>1.Resident #B was affected. Resident #B received pain medication as ordered 30 minutes prior to the dressing change. When resident #B complained of pain during the dressing change the skin area being dressed was secured and pain medication was immediately provided to the resident. Resident B was not observed to have verbal or non-verbal signs/symptoms of pain after the pain medication was administered. Resident#117 was affected. The resident was not harmed. The dialysis center had been contacted on multiple occasions to provide the facility with resident dialysis care documentation. The dialysis center provided such information to the facility.</p> <p>2.All residents requiring dressing changes or receiving dialysis have the potential to be affected. All residents receiving dressing changes had a pain assessment completed to ensure pain was controlled with dressing changes. Should the resident require additional intervention to control pain, the physician will be notified and orders followed. All nursing staff will be in-serviced on pain control, to include stopping care immediately should resident exhibit pain symptoms during care and implement</p>	01/27/2016

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	<p>medication. At 11:48 a.m., Resident B screamed out again and LPN #99 was heard telling LPN #96 the resident had PRN (as needed) pain medication and indicated to Resident B pain medication would be given as soon as she finished the "big" dressing change. LPN #99 continued with the wound care and at 11:50 a.m., stated, "This is going to be a bad part," and continued the wound care. At 11:52 a.m., Resident B screamed out "I hurt." LPN #99 indicated the resident would "probably get some medication" after the dressing change was completed. LPN #99 continued with wound care while Resident B yelled out again. At 12:00 p.m., LPN #99 indicated Resident B was administered scheduled pain medication prior to the procedure and indicated she "tried" to do wound care around his "scheduled" or "PRN" medication. Resident B cursed and asked, "How would you feel?" when asked about his pain level. At 12:03 p.m. LPN #99 asked Resident B if he wanted pain medication and the resident indicated "yes." LPN #96 administered sublingual (under the tongue) pain medication 37 minutes after wound care began at 12:06 p.m., and without delays, wound care continued until 12:26 p.m. Resident B was not observed to have verbal or non-verbal signs/symptoms of pain after the pain medication was administered.</p>		<p>interventionsfor pain control before continuing with said care. All residents receiving dialysis care have a specified binder for dialysis center communication which is transported with them to and from the dialysis center. The dialysis center is to provide communication to the facility in the binder. All nurses will be in-serviced on the dialysis binder use and necessary communication with the dialysis center.</p> <p>3.As a measure to ensure ongoing compliance the DON or designee will complete treatment change observations daily on regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing to ensure pain is controlled with dressing changes. Should the resident require additional intervention to control pain,the physician will be notified and orders followed.</p> <p>Additionally, the DON or designee will complete an audit on all residents receiving dialysis to ensure the dialysis center has provided communication to the facility weekly ongoing. Should the facility note that the dialysis binder is lacking communication documentation from the dialysis center, the dialysis center will be contacted to provide such documentation. The facility will document requests made to the dialysis center and monitor to ensure the requested records are</p>	

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	<p>Resident B's record was reviewed on 1/12/16 at 10:05 a.m. Resident B had diagnoses which included, but were not limited to, multiple sclerosis, urinary retention, chronic back pain, weakness, contracture, pressure ulcers.</p> <p>A pain care plan originally dated 5/13/15, and last updated on 1/11/16, indicated Resident B had the potential for pain in the following areas: general discomfort, buttocks, feet, back, and hands due to a diagnosis of multiple sclerosis, depression, pressure ulcers, chronic back pain, contracture, and complaints of "pain all over." A goal indicated he would have pain rated less than a 7 on a scale from 0-10, Interventions indicated staff would monitor for non-verbal signs of pain, asses his level of pain, and administer pain medication as ordered and monitor for efficacy.</p> <p>A physician's order, dated 12/14/15, indicated orders for Roxanol (narcotic pain medication/Morphine Sulfate 100 milligrams/5 milliliters solution, give 1 milliliters (20 milligrams) every hour as needed for pain/shortness of breath.</p> <p>A physician's order, dated 1/11/16, indicated orders for Roxanol (narcotic pain medication) 20</p>		<p>provided to the facility timely.</p> <p>4. As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>	

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	<p>milligrams/milliliters, give 1.25 milliliters sublingual every 2 hours for pain.</p> <p>Resident B's medication administration record (MAR), dated January 2016, and Resident B's PRN flow sheet were reviewed on 1/12/16 at 12:30 p.m., with LPN #95 present. The MAR indicated Resident B was administered routine Roxanol pain medication at 6:00 a.m., 8:00 a.m., 10:00 a.m., and 12:00 p.m. There was no indication the resident had received additional pain medication until 37 minutes after the treatment began.</p> <p>A pressure ulcer assessment record, dated 1/11/16, indicated the wound measured 2.7 x 3.2 x 1.5, had moderate amount of serous drainage, 5.4 cm (centimeters) tunneling at 12:00. Wound associated pain was 8 out of 10 and the wound bed was red with red/dark edges.</p> <p>A pressure ulcer assessment record, dated 1/11/16, indicated the wound measured 4 x 3.3 x 1.5, had a moderate amount of serous exudates, with 2 cm tunneling/undermining at 11:00-12:00 locations of a clock face. The wound associated pain was rated a 5 out of 10, with a red wound bed and red wound edges.</p>			

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	<p>A pressure ulcer assessment record, dated 1/11/16, indicated the wound measured 5.7 x 3.7 x 3, had a moderate amount of serous exudates, 4 cm of tunneling/undermining located at 3:00-4:00 on a clock face, wound associated pain was rated 5 out of 10, with a red wound bed with red wound edges.</p> <p>During an interview on 1/12/16 at 12:30 p.m., LPN #95 indicated she administered Resident B's routine Roxanol pain medication at 10:00 a.m. and had not administered additional "as needed" pain medication.</p> <p>During an interview on 1/12/15 at 12:40 p.m., with the Director of Nursing, Administrator, and corporate nurse consultant present, the corporate nurse consultant indicated, if ordered, pain medication should have been administered prior to wound care.</p> <p>During an interview on 1/13/16 at 11:08, Physician #90 indicated he recently observed staff reposition Resident B and indicated he experienced pain and could not tolerate the repositioning. He went on to indicate he believed the most important thing was to keep him comfortable.</p>			

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	<p>A policy titled, "Pain Assessment," dated 10/2014, was provided by the DON on 1/12/2016 at 3:05 p.m., and indicated the following, "...Purpose: To identify those residents who utilize routine medications for pain or who utilize frequent PRN (as needed) pain medications in an effort to ensure adequate pain control is achieved...1. Upon admission, each resident shall be assessed for the presence of acute or chronic pain per the admission assessment. 2. If resident verbalizes pain, unaffected by the currently ordered pain medication, and/or exhibits non-verbal communication that pain is present, resident shall be identified through completion of regularly scheduled MDS' to ensure pain symptoms are evaluated and communicated to the physician...6. The care plan for the individual resident shall be reviewed to ensure pain management is addressed..."B. Resident #117's record was reviewed on 1/7/2016 at 12:17 p.m. The resident's diagnosis included, but was not limited to, end stage renal disease and the record indicated the resident received hemodialysis three days a week.</p> <p>A "Dialysis Center Communication Record Form" indicated Resident #117 received dialysis on 12/2/2015 and did not indicate the dialysis center provided</p>			

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	<p>complete pre-vital and post-vital signs.</p> <p>A "Dialysis Center Communication Record Form" indicated Resident #117 received dialysis on 12/7/2015 and did not indicate the dialysis center provided complete pre-vital and post-vital signs.</p> <p>A "Dialysis Center Communication Record Form" indicated Resident #117 received dialysis on 12/11/2015 and did not indicate the dialysis center provided complete pre-vital and post-vital signs.</p> <p>A "Transfer to Appointments Form" indicated Resident #117 received dialysis on 1/4/2016. The record lacked documentation the dialysis center provided a returned "Dialysis Communication Record Form" upon Resident #117's return to the facility. The record lacked documentation a "Transfer to Appointments Form" had been completed by the facility for his other dialysis appointments attended in January 2016.</p> <p>During an interview on 1/7/2016 at 9:41 a.m., Unit Manager #60 indicated Resident #117 received dialysis three times a week. A dialysis communication binder contained a "Dialysis Communication Record Form" for the dialysis center to complete and return to</p>			

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	<p>the facility with Resident #117. The binder also contained a "Transfer to Appointments Form" completed by the facility and sent with the resident to dialysis. The Unit Manager indicated the binder was not always returned to the facility with completed information and she could not provide communication documentation for all of Resident #117's dialysis appointments.</p> <p>During an interview on 1/11/2016 at 3:54 p.m., the Director of Nursing (DON) indicated the facility was responsible for sending the completed "Transfer to Appointments Form" to the dialysis center and ensuring the retrieval of the completed "Dialysis Communication Record Form" information from the dialysis center upon Resident #117's return to the facility. She indicated Resident #117 had attended all of his scheduled dialysis appointments for the month of January 2016.</p> <p>A policy titled, "Dialysis Coordination/Facility Services," dated 10/2014, was provided by the DON on 1/11/2016 at 9:00 a.m., and indicated the following, "...Purpose: to ensure effective communication between the facility and dialysis center providing service to the facility...facility personnel will communicate with the outpatient dialysis</p>						

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F 0314 SS=G Bldg. 00	<p>center in an effort to ensure the resident is rendered necessary care and services for the provision and maintenance of dialysis services...2. Facility personnel shall ensure that all appropriate medical and administrative information accompanies resident at the time of transfer or referral to the dialysis center...4. Unit manager/licensed nurse shall monitor the needs of the dialysis resident and review any notes/orders accompanying resident from the dialysis center upon arrival to the facility...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to identify changes in skin condition and</p>	F 0314	1. Resident #B, C, and D were affected. Resident # B was only sitting up in the Broda chair for	01/27/2016	

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	<p>ensure effective pressure reducing interventions for 3 of 3 residents reviewed for pressure ulcers. This deficient practice resulted in a resident's existing pressure ulcers deteriorating to stage IV (full thickness tissue loss with exposed bone, tendon or muscle) or unstageable pressure ulcers and development of additional pressure ulcers on the buttocks and bilateral, medial knees. This deficient practice also resulted in a resident with a stage III pressure ulcer (full thickness tissue loss where bone, tendon or muscle is not exposed) on the right great toe worsening to an unstageable pressure ulcer and resulted in lack of wound healing for a resident with a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying tissue) to the right heel (Residents B, C and D).</p> <p>Findings include:</p> <p>1. During an observation on 1/11/15 at 4:00 p.m., Resident B was seated in a reclined broda chair by the C wing nursing station without a pressure reducing cushion in place. The resident had bilateral heel protectors on and his right and left knees had wound dressings in place. The knees were positioned against one another.</p>		<p>approximately an hour. The Broda chair's built in seat cushion has pressure redistribution and air flow properties. Resident B's cushioned knee dressings were in place. The blue foam knee protector was ordered and received on 1/12/16 and put into place that day. Resident B did not tolerate being positioned completely over on his side, thus pillows were used to redistribute pressure from side to side. The care plan did include that resident B was non-adherent with turning and repositioning and treatment changes. Staff encouraged Resident B to allow turning and repositioning and dressing changes as well as make him aware of risk for non-adherence as needed. A mirror was placed on the wall so that Resident B could still see his television when he is turned away from it. Resident B was receiving hospice care due to end stage Multiple Sclerosis and interventions were in place as care planned. Resident B's open areas were unavoidable due to his terminal illness per his physician. Resident B has since past away.</p> <p>Resident C has an area to his right great toe that has continued due to peripheral vascular disease. The area was listed as unstageable due to it being a scabbed area. The care plan was revised to note the</p>	

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	<p>During an observation on 1/12/16 at 11:29 a.m., with Qualified Medication Aide (QMA) # 98, Licensed Practical Nurse (LPN) #96, and LPN #99 present, Resident B's wounds were observed during a dressing change. QMA #98 and LPN #99 positioned Resident B on his left side. There was a stage IV pressure ulcer on the coccyx with a yellow and dark brown wound bed. The wound edges were reddened and yellow crusted. No drainage was observed. The left buttock wound was a stage IV pressure ulcer with a yellow wound bed with a moderate amount of continuous brownish colored drainage. The wound edges were reddened. The right buttock wound was observed as a stage IV pressure ulcer with a yellow wound bed with some red tissue. No drainage was observed and the wound edges were intact. The right lower buttock wound was observed as an unstageable pressure ulcer with a dark brown center and yellow tissue surrounding the dark center.</p> <p>During an observation on 1/12/16 at 10:00 a.m., Resident B was positioned on his back on a low air loss mattress.</p> <p>During observations on 1/12/16 at 12:33 p.m., 12:50 p.m., and 1:00 p.m., Resident B was lying in bed on his back. His legs were covered with a thin sheet and a blue</p>		<p>wound is vascular in nature. Staff were immediately re-educated on resident C's interventions. Interventions are in place as ordered and care planned. Resident D was admitted from the hospital with the pressure area with interventions in place. Interventions were clarified and care planned accordingly. 2. All residents at risk for pressure areas have the potential to be affected. Braden scores were updated on all residents. All residents' at high risk for pressure ulcers care plans and assignment sheets were reviewed and revised as indicated to include appropriate interventions. Nurses were in-serviced on skin management including pressure ulcer prevention and treatment, care planning, and assessment. All CNA's were in-serviced on proper positioning and prevention of pressure ulcers. 3. As a measure to ensure ongoing compliance each resident will have a head to toe skin assessment completed weekly and as needed. If any new areas are noted the physician will be notified and a treatment order requested. The noted problem skin areas will be measured on a weekly basis. The status of all pressure ulcers will be reviewed weekly in SWAT meeting and if no improvement is noted after 2 weeks or the area had worsened, a change in the treatment regimen will be requested and</p>	

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	<p>foam knee protector pad was at the end of the bed.</p> <p>During an observation on 1/12/16 at 1:08 p.m., with LPN #96 present, Resident B was observed on his back, foam knee protector was at the end of the bed. Resident B had a stage two pressure ulcer with yellow wound bed and reddened wound edges on his right inner knee and a stage two pressure ulcer with a yellow wound bed and reddened wound edges on his left inner knee.</p> <p>During an observation on 1/13/16 at 10:14 a.m., with Certified Nursing Assistant (CNA) #92 present, Resident B was lying in bed on his back with a regular bed pillow positioned under his left hip. The pillow was compressed flat and did not position the Resident to reduce pressure to his coccyx and buttock wounds.</p> <p>Resident B's record was reviewed on 1/12/16 at 10:05 a.m. and indicated diagnoses which included, but were not limited to, multiple sclerosis, urinary retention, chronic back pain, weakness, and contractures.</p> <p>An admission assessment, dated 9/26/14, indicated Resident B was admitted to the facility without pressure ulcers.</p>		<p>implemented. Care plans and assignment sheets will be updated accordingly. Braden scale scores will be completed upon admission and weekly for four weeks, then quarterly, annually, and with any significant changes. All residents with pressure areas and residents at high risk for pressure areas will be observed by the DON or designee to ensure proper positioning with pressure reducing devices and that treatments are in place as ordered which will include varied times five times weekly for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly. 4. As a quality measure, the DON or designee will review any finding and subsequent corrective action in the quarterly Quality Assurance meeting. The plan will be revised, as warranted.</p>	

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	<p>Laboratory tests results, dated 1/5/15, indicated Resident B had a total protein level of 6.8 gm/dL (reference range 6.0-8.2) and an albumin (helps tissue growth ad healing) of 3.7g/dl (reference range 3.2-5.7). The record lacked indication levels were monitored after this date.</p> <p>A hospice certification note, dated 1/12/15, indicated Resident B qualified for hospice due to his diagnosis of multiple sclerosis.</p> <p>A pressure ulcer assessment record, dated 3/25/15, indicated Resident B developed a stage III (full thickness loss) pressure ulcer which measured 5.0 x 5.0 x 0.1 (length X width X depth in centimeters) on his left buttock. The record indicated the wound was measured weekly and indicated the wound became unstageable and measured 6.0 x 6.0 with an undetermined depth on 5/1/15. The wound bed was "100 percent necrotic" and the wound edges were "red." On 5/28/15, the wound stage was documented as stage 3 and the wound measured 5.0 X 5.0 with 0.1 depths. The wound bed was "10 percent slough and 90 percent beefy red." On 6/12/15, the wound stage was documented as unstageable and measured 2.6 x 2.4 with</p>			

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	<p>the depth undetermined. The wound bed was "100 percent slough" and the wound edges were red. On 1/8/15, the wound stage was documented as stage IV and measured 3 x 3.2 x 5.2 with a moderate amount of serosanguineous drainage with no tunneling. Wound associated pain was rated 7 out of 10, the wound bed was red, and the wound edges were red. On 1/11/16, the wound measured 2.7 x 3.2 x 1.5, had moderate amount of serous drainage, 5.4 cm (centimeters) tunneling at 12:00. Wound associated pain was 8 out of 10 and the wound bed was red with red/dark edges.</p> <p>A pressure ulcer assessment record, dated 4/23/15, indicated Resident B developed an "unstageable" pressure ulcer which measured 4 x 2 x undetermined depth to his right buttock. The wound bed was 100 percent necrotic with red wound edges. The record indicated weekly wound measurements and indicated on 6/8/15 the wound stage was documented as stage III and measured 1.6 x 1.2 x undermined depth. The wound bed was 100 percent slough with red wound edges. On 6/12/15 the wound stage was documented as unstageable and measured 1.4 x 1.0 x undetermined depth. The wound bed was 100 percent slough with red wound edges. On 1/8/15, the wound stage was documented as stage IV and</p>						

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	<p>measured 5 x 3 x 3.6 with no tunneling. Wound associated pain was a 7/10 and the wound bed was red with red wound edges. On 1/11/16 the wound measured 4 x 3.3 x 1.5, had a moderate amount of serous exudates, with 2 cm tunneling/undermining at 11:00-12:00 locations of a clock face. The wound associated pain was rated a 5/10, with a red wound bed and red wound edges.</p> <p>A pressure ulcer assessment record, dated 10/16/15, indicated Resident B developed a stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a res-pink wound bed without slough) on his sacrum which measured 1.2 x 0.4 x less than 0.1. The wound had no tunneling and no pain. The wound bed was red and the wound edges had "redness." The record indicated wounds were measured weekly and on 12/18/15 the wound stage declined to a stage III and measured 2.5 x 2 x 0.2. Wound associated pain was rated at a 4/10. The wound bed was red and the edges were red. On 1/8/16, the wound stage declined to a stage IV and measured 3.9 x 3.6 x 2.8, had a moderate amount of serosanguinous drainage, no tunneling, wound associated pain rated 7/10, wound bed was red, and the wound edges were red. On 1/11/16 the wound measured 5.7 x 3.7 x 3, had a moderate</p>			

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	<p>amount of serous exudates, 4 cm of tunneling/undermining located at 3:00-4:00 on a clock face, wound associated pain was rated 5/10, with a red wound bed with red wound edges.</p> <p>A Minimum Data Set (MDS) assessment, dated 8/5/15, indicated Resident B was at risk for developing pressure ulcers and had one stage II pressure ulcer, 2 stage III pressure ulcers, and no stage IV pressure ulcers. The assessment indicated the resident was totally dependent on staff for bed mobility.</p> <p>A pressure sore care plan, initiated on 3/29/15, and last updated 10/30/15, indicated Resident B had a pressure ulcer. A goal indicated the pressure ulcer would decrease in size or heal by the next review. Interventions to meet this goal included: apply treatment as ordered, monitor per skin management program, monitor for signs/symptoms of infection, monitor for treatment efficacy and consult the physician if the ulcer did not improve. Additional interventions included pressure reducing devices to the bed and chair, low air loss mattress, encourage consumption of meals, fluids, and supplements, assist/encourage to turn and reposition at least every two hours and as needed, educate the resident and responsible party on factors of skin</p>			

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	<p>breakdown and interventions as needed, use the bed pad/sheets for bed mobility and positioning, and refer to incontinence, dietary, and pressure risk care plans. The record lacked indication Resident B refused interventions to prevent or promote healing of pressure ulcers.</p> <p>A pressure ulcer risk care plan, originally dated 5/13/15, and last updated 12/12/15, indicated Resident B was at risk for the development of pressure ulcers due to: dependence on staff for bed mobility, functional limitation in range of motion to bilateral upper extremities and bilateral lower extremities, bedfast, frequently slides down in bed, bowel incontinence, use of s/p (suprapubic) catheter, impaired cognition, use of psychotropic and narcotic pain medications, pain, increased pain with repositioning, use of oxygen, significant weight loss, current pressure ulcers, diagnosis of multiple sclerosis, chronic back pain, urinary retention, spinal cord lesions, depression, anxiety, weakness, coronary pulmonary disease, history of non adherence with turning and repositioning and treatment changes. A goal indicated he would be free from pressure ulcers by the next review. Interventions included: weekly head to toe skin assessments, observation of skin condition during care, notification of skin</p>			

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	<p>problems to the charge nurse for further assessment and possible physician notification, pressure redirecting cushion to chair, pressure reducing mattress to be, low air loss mattress, encourage and assist with turning and repositioning at least every two hours and as needed, application of preventative topical medication as ordered, monitor labs as ordered, encourage food and fluid intake, refer to dietician as indicated, dietary supplements as ordered, hospice visits as scheduled, educate him on the risks of non adherence as needed and encourage him to comply. The record lacked indication Resident B refused interventions to prevent or promote healing of pressure ulcers</p> <p>A physician's order, dated 10/23/15 at 2:30 p.m., indicated orders to position Resident B on his left and right side only. The order indicated, "not on his back."</p> <p>A physician's order, dated 10/30/15 at 2:30 p.m., indicated, "Reposition on side except meals (from side to side).</p> <p>A Minimum Data Set (MDS), dated 11/5/15, indicated Resident B was totally dependent on two staff for bed mobility, had range of motion limitations in upper and lower extremities, had unhealed pressure ulcers, was at risk for</p>			

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	<p>developing additional pressure ulcers, and did not exhibit behaviors of rejecting care.</p> <p>A Certified Nursing Assistant assignment sheet, dated 1/4/16, indicated Resident B was dependent for activities of daily living, confused at times, needed encouraged to lay on his side, turned every two hours, and checked every 30 minutes.</p> <p>An initial pressure ulcer assessment, dated 1/5/16, indicated Resident B developed a stage 2 pressure ulcer which measured 2 x 2.5 x less than 0.1 on his right knee and a stage 2 pressure ulcer which measured 1 x 0.9 x 0.1 on his left knee.</p> <p>An initial pressure ulcer assessment, dated 1/11/16, indicated Resident B developed a stage III pressure ulcer to his right lower buttock which measured 2 x 1.9 x 0.1, with a dark brown wound bed and red edges.</p> <p>An initial pressure ulcer assessment, dated 1/11/16, indicated Resident B developed a stage 1 pressure ulcer on his left heel which measured 2.5 x 5.5, had a dark red wound bed with red wound edges.</p>			

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	<p>A physician's order, dated 1/12/16, indicated an order for a knee abductor pillow to be placed on Resident B at all times with the exception of when care or/bathing was provided.</p> <p>A care plan, dated 1/11/16, and updated on 1/12/16, indicated Resident B had pressure ulcers located on his left and right buttocks, coccyx, left and right knees, lower right buttock, and his left heel. A goal indicated the pressure ulcers would decrease in size/heal without complications by the next review. Interventions to meet this goal included: administer treatments as ordered, monitor skin management program, monitor for signs and symptoms of infection, monitor for treatment efficacy and notify physician if not improving, pressure reducing devices to bed and the chair, encourage consumption of meals, fluids and supplements, assist/encourage to turn and reposition at least every two hours and as needed, turn on his left and right only, turn every two hours, dressing changes as ordered, notify hospice nurse as needed, bunny boots to bilateral feet, abductor pillow (knee) at all times "may remove for bathing and care."</p> <p>During an interview, on 1/11/2016 at 4:00 p.m., Licensed Practical Nurse #96 indicated the chair in which Resident B</p>			

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	<p>was seated did not have a pressure reducing cushion.</p> <p>During an interview, on 1/12/16 at 1:08 p.m., LPN #96 pointed to a foam cushion at the end of Resident B's bed and indicated she did not know when the resident got the foam cushion and indicated it was to prevent his skin from breaking down between his knees.</p> <p>During an interview on 1/13/16 at 10:14 a.m., CNA #92 indicated she was assigned to Resident B and indicated she repositioned Resident B every two hours. The CNA indicated Resident B wasn't supposed to be on his back "too much" and indicated she didn't want to position him on his side because he "wouldn't have anything to look at but the wall." She indicated she placed a pillow under his left hip to help relieve the pressure. She indicated she should "probably get more pillows" to help relieve the pressure and indicated Resident B complained of pain when she moved him, but he did not refuse repositioning.</p> <p>During an interview on 1/13/16 at 9:15 a.m., with the Director of Nursing and Corporate Nurse Consultant present, the Director of Nursing indicated preventative measures were in place prior to him developing pressure ulcers. The</p>			

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	<p>Corporate Nurse Consultant indicated the interventions in place to prevent Resident B from developing pressure ulcers did not prevent the Resident from developing pressure ulcers. She indicated she believed the facility had done everything they could to prevent the skin breakdown and indicated the pressure ulcers were "unavoidable." The Corporate Nurse Consultant indicated Resident B refused to be turned from side to side and indicated the facility documented times when the refused repositioning and indicated he had been provided with education regarding the risks of refusing repositioning. Documentation of the refusals was requested, but not provided before the survey was exited.</p> <p>During an interview on 1/13/16 at 11:08, Physician #90 indicated the only intervention that would have prevented pressure ulcers on Resident B's back side was to keep him off his back. He indicated in the past, when Resident B was obese, the facility staff had difficulty keeping him positioned off his back. The physician indicated Resident B declined nutritionally and had muscle wasting. He indicated the wound treatments ordered were appropriate and the only other possible intervention would be surgical repairs of the wounds. The physician indicated Resident B was on hospice and</p>			

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	<p>not a candidate for surgery. He indicated he recently observed staff reposition Resident B and indicated he experienced pain and could not tolerate the repositioning. He went on to indicate he believed the most important thing was to keep him comfortable. The physician indicated he believed pressure ulcers were unavoidable for residents who had end stage multiple sclerosis.</p> <p>During an interview, on 1/13/15 at 11:30 a.m., the Administrator indicated documentation which indicated Resident B had refused interventions to heal/prevent pressure ulcers was not available.</p> <p>2. During an interview on 1/5/2016 at 10:38 a.m., Licensed Practical Nurse (LPN) #61 indicated Resident C had an unstageable (full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed) pressure ulcer to his right great toe.</p> <p>During an observation on 1/7/2016 from 2:05 p.m. to 2:17 p.m., Resident C was observed with his right great toe pressure ulcer positioned flat against his composure mattress before his dressing change. LPN #61 changed a dressing to Resident C's unstageable pressure ulcer to his right great toe. She measured the</p>			

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	<p>wound as 1.0 centimeter (cm) x 0.1 cm with depth unable to be determined. The wound was a pink scabbed area, with white slough visible at the edges encompassing the scab. Resident C was observed positioned on his left side with his bilateral legs contracted upward, as both legs laid on top of one another. The area of pressure to his right great toe was placed flat against the composure mattress upon completion of his dressing change. Resident C was not observed to have bunny boots applied to both feet before or after the dressing change. The resident's heels were not observed to be floated before or after the dressing change.</p> <p>During a continuous observation on 1/8/2016 from 9:29 a.m. to 10:53 a.m., Resident C was observed sitting up in his broda chair. Orthotic braces were applied to both legs without the abductor bar of the orthotics present. The area of pressure to his right great toe was observed lying against the brace to his left leg.</p> <p>During a dining observation on 1/08/2016 at 1:11 p.m., Resident C was sitting up in his broda chair with his brace orthotics placed on both legs. The abductor bar of the orthotics was not observed. The area of pressure to his right great toe was observed lying against</p>			

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	<p>his left foot.</p> <p>During an observation on 1/8/2016 from 2:38 p.m. to 3:11 p.m., Resident C was observed in bed positioned on his right side with his knees bent and legs contracted upward. His right foot was lying flat on the composure mattress with his left foot placed directly on top of his right foot. His left great toe was observed rubbing against the area of pressure to his right great toe. Resident C's pants were pulled down around his ankles. Resident C was not observed with soft boots to his feet or his heels floated. A pillow was not observed in between his contracted legs.</p> <p>During an observation on 1/8/2016 at 4:09 p.m., Resident C was observed lying in bed and positioned on his right side. His legs were bent with his knees toward the ceiling. His left foot was lying on top of his right foot flat on the composure mattress. His heels were not observed to be floated and soft boots were not observed on his feet.</p> <p>Resident C's record was reviewed on 1/7/2016 at 3:00 p.m. Resident C's diagnoses included, but were not limited to, dementia, aphasia, Chronic Obstructive Pulmonary Disease, seizure disorder, and history of Metachromic Leukodystrophy (accumulation of fats in</p>			

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	<p>nervous system cells).</p> <p>A Certified Nursing Assistant (CNA) Assignment sheet, dated 1/4/2015, indicated Resident C should be turned and repositioned every hour, laid down after meals, wear Bunny Boots while in bed, and wear orthotics to bilateral lower extremities.</p> <p>A Minimum Data Set assessment (MDS), dated 9/25/2015, indicated Resident C was totally dependent with assistance of 1 staff person with bed mobility, dressing, and locomotion on the unit. The resident was totally dependent and required assistance of 2 staff members for transfers. The record indicated Resident C was at risk of developing pressure ulcers, had an unstageable pressure ulcer with measurements of 0.2 cm x 0.2 cm, and did not have a venous or arterial ulcer present. The record indicated Resident C's skin and ulcer treatments included: pressure reducing device for chair, pressure reducing device for bed, pressure ulcer care, and applications of ointments/medications other than to feet. The record lacked indication Resident C received a turning and repositioning program or applications of dressings to feet (with or without topical medications).</p>			

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	<p>A Pressure Ulcer Risk care plan, dated 10/13/2015, indicated Resident C was at risk for the development of pressure ulcers due to: dependent on staff for bed mobility and all activities of daily living (ADL's) and transfers, current pressure ulcer to his right medial great toe, decreased mobility, impaired ROM (range of motion) in lower extremities and his history of healed pressure ulcers. The care plan goal indicated Resident C would be free from pressure ulcers by next review. Current interventions included: head to toe skin assessment at least weekly by a licensed nurse, staff to observe skin condition while providing care, pressure redirecting mattress to bed, treatment to pressure ulcers as ordered, Z-flow cushion to elevate heels and check each shift while in bed, encourage and assist resident with turning and repositioning at least every two hours and as needed, monitor labs as ordered, and avoid lying on right side.</p> <p>A Pressure Area care plan, dated 10/13/2015, indicated Resident C has a pressure area located on his right medial foot and right medial great toe. The care plan goal indicated Resident C's pressure areas will decrease in size or heal without complications through the next review. Interventions included: daily skin inspection by nursing assistants, head to</p>			

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	<p>toe skin assessments by licensed nurse weekly and as needed, provide pressure redistribution mattress to bed, monitor for treatment efficacy if area is not improving and consult with the physician for further instruction, and assist with turning and repositioning at least every two hours and as needed.</p> <p>A physician's telephone order, dated 12/9/2015, indicated, "PT (physical therapy) to evaluate right great toe medial likely venous stasis ulcer."</p> <p>A Nurse Practitioner (NP) progress note, dated 12/9/2015, indicated, "Chief Complaint: Venous stasis ulcer...This is a new problem, is acute...Resident is a highly contracted male, bed bound, concern that ulcer is 2/2 (secondary) to PVD (peripheral vascular disease). Will request therapy to evaluate and monitor. Will observe but given patient's chronic condition, unlikely to improve. Interested in therapy's evaluation and care plan, problem unlikely to resolve quickly if at all, patient unlikely surgical candidate unless toe becomes necrotic...Diagnosis: Venous insufficiency (chronic) (peripheral) (PT to evaluate right great toe for possible venous stasis ulcer)...."</p> <p>A physician's telephone order, dated 12/11/2015, indicated, "Order</p>			

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	<p>clarification: 1. PT wound care eval [evaluation] completed. 2. PT skilled intervention not recommended at this time via electrical stimulation due to wound stage and status. 3. Nursing to perform saline flush, xeroform (wound dressing) application, cover with gauze daily and as needed for soilage. 4. Unit staff to strictly adhere with orthotic application as scheduled."</p> <p>A Physical Therapy Plan of Care (Evaluation Only), dated 12/11/2015 and signed by the physician on 12/18/2015, indicated, "...Reason for Referral: non healing pressure ulcer to right dorsal [back] aspect of 1st DIP [distal interphalangeal joint] of foot...Therapy Necessity: Wound care skilled intervention via electrical stimulation is not recommended at this time d/t (due to) current wound stage and status however wound care treatment to be performed by nursing is recommended...2. Strict adherence to orthotic application and schedule to alleviate progression of contractures and pressure wound and prevent new onset of contractures and pressure wound...Discharge Plans: RNP (Restorative Nursing Program) will be in place to delay progression and new onset contractures and pressure sores...Underlying Impairments Other: Pt (patient) presents with stage 2 pressure</p>			

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	<p>wound to dorsal 1st DIP of R [right] foot with 100% granular tissue [new connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process] measuring 1 cm x 0.9 cm x no depth with minimal exudate, no odor and intact periwound [tissue surrounding the wound]...."</p> <p>A physician's order, dated 12/18/2015, indicated, "...cleanse R (right) great toe medial with NS [normal saline], pat dry, Xeroform [dressing] application and cover with gauze and secure QD [daily] and PRN [as needed] for soilage."</p> <p>A Braden Scale for Predicting Pressure Ulcer Risk, dated 12/23/15, indicated Resident C had a score of 11, indicating he was at a high risk for skin breakdown.</p> <p>The Certified Nursing Assistant (CNA) Shower Book, dated January 2016, indicated Resident C was to receive showers on Wednesday and Saturday evenings. The record lacked documentation the CNAs had performed a skin assessment for Resident C during his assigned showers for 1/2/2016 and 1/6/2016.</p> <p>Resident C's Medication Administration Record (MAR), dated 1/1/2016 through 1/31/2016, was reviewed on 1/8/2016 at</p>			

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	<p>9:39 a.m. The record lacked indication Resident C had received his dressing change to his right great toe on 1/1/2016, 1/3/2016, and 1/6/2016. The record lacked indication Resident C had worn his orthotics to his legs on 1/2/2016 from 4 p.m. to 8 p.m., 1/3/2016 from 12 a.m. to 4 a.m., 1/5/2016 from 4 p.m. to 8 p.m., 1/5/2016 from 12 a.m. to 4 a.m., 1/6/2016 from 7 a.m. to 11 a.m., 4 p.m. to 8 p.m., or 12 a.m. to 4 a.m., and 1/7/2016 from 4 p.m. to 8 p.m. The record lacked indication Resident C had used a Z-flow cushion to elevate his bilateral heels while in bed on 1/2/2016 from 3 p.m. to 11 p.m., 1/5/2016 from 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m., 1/6/2016 from 3 p.m. to 11 p.m., 11 p.m. to 7 a.m., and 1/7/2016 from 3 p.m. to 11 p.m. The record lacked indicated Resident C had been turned every 2 hours on 1/2/2016 from 4 p.m. to 10 p.m., 1/3/2016 from 12 a.m. to 6 a.m., 1/5/2016 from 12 a.m. to 6 a.m. and 4 p.m. to 10 p.m., 1/6/2016 from 12 a.m. to 6 a.m. and 4 p.m. to 10 p.m. The record lacked indicated Resident C had a weekly skin assessment performed on Wednesday, 1/6/2016, and a skin sheet had been charted. The record did not indicate a reason Resident C had not received the nursing measures or dressing change.</p>			

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	<p>An undated Weekly Skin Assessment, reviewed in the January 2016 Treatment Administration Record (TAR), indicated, "Directions: A head-to-toe assessment of each resident is to be completed. Should a new skin alteration be identified, the appropriate assessment and ongoing monitoring tool shall be initiated and noted below. Weekly assessment shall continue in an effort to identify any additional areas thereafter...." The record lacked documentation a weekly skin assessment had been performed by a nurse for Resident C during the month of January 2016.</p> <p>A Physician's Order sheet, dated 1/1/2016 through 1/31/2016, indicated the following Nursing Measures for Resident C: Z-flow cushion to elevate bilateral heels and check each shift while in bed, turn every 2 hours, weekly skin assessment every Wednesday and chart on skin sheet, patient to wear bilateral lower extremity (BLE) orthotics daily for four hours each shift, from 7 a.m. to 11 a.m., 4 p.m. to 8 p.m. and 12 a.m. to 4 a.m., for his diagnosis of contractures. The record lacked documentation of an order for Bunny Boots (soft boots) to be applied to Resident C's feet while in bed.</p> <p>A Podiatry Exam progress report, dated 1/6/2016, did not indicate Resident C had</p>			

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	<p>vascular conditions, cyanosis (poor circulation or inadequate oxygenatio of the blood), or claudication (condition in which cramping pain the the leg can be caused by obstruction of arteries).</p> <p>A Pressure Ulcer care plan, dated 1/7/2016, indicated Resident C had a pressure ulcer to his right great toe. The care plan indicated a goal for Resident C's ulcer to decrease in size/heal without complications by next review. The care plan included undated interventions of: treatment as ordered, monitor per Skin Management Program and SWAT (facility's wound monitoring) protocol, monitor for treatment efficacy, pressure reducing devices to bed and chair, assist/encourage to turn and reposition at least every two hours and as needed, Xeroform (dressing change) per order, boots on bilateral feet when braces are off.</p> <p>A Contracture care plan, dated 1/7/2016, indicated Resident C suffers with contractures to bilateral knees and is at risk for further contractures. The goal indicated Resident C will be free from further contractures. Undated care plan interventions include: ensure that splints are placed as per orders and patient to wear BLE Bilateral lower extremities) daily for four hours each shift for his</p>			

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	<p>contractures.</p> <p>An undated Restorative Program document was provided by the Physical Therapist (PT) #66 on 1/8/2016 at 1:55 p.m. This document indicated, "...Program #1 Special Instructions: Apply RLE (right lower extremity) and LLE (left lower extremity) splint daily. Leave on for 5 hours each shift then remove. The record indicated a picture with instructions that an abductor bar is to be placed medial (inside) the orthotics.</p> <p>A Wound Care Evaluation, dated 12/21/15, indicated Resident C had a stage 3 (full thickness skin loss) wound to his right greater toe, measuring 0.4 cm x 0.4 cm with depth of 0.1 cm. The date of the wound's onset was 8/8/2014 and had been facility acquired.</p> <p>SWAT program documentation titled, "Ongoing Assessment of Pressure Ulcer," measurements indicated Resident C's pressure ulcer to his right medial great toe had been identified as a Stage 3 pressure ulcer on 12/31/2014 with measurements of 0.7 cm x 0.4 cm and depth of 0.1 cm. The wound continued as a stage 3 pressure ulcer with increase in length and width until it progressed to an unstageable wound on 7/16/2015 with measurements of 2.6 cm x 2.8 cm and</p>			

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	<p>depth of 0.1 cm. The wound was then classified down as a stage 3 pressure ulcer on 7/24/2015 with measurements of 3 cm x 3 cm and depth 0.1 cm. Resident C's wound was classified down as a stage 2 (partial thickness loss of dermis) pressure ulcer on 8/14/2015 with measurements of 3 cm x 3 cm and depth less than 0.1 cm. The wound progressed to an unstageable pressure ulcer with measurements of 0.3 cm x 0.3 cm and depth unable to be determined on 9/3/15. Resident C's wound was classified on 10/8/2015 as a stage 2 pressure ulcer with measurements of 1.7 cm x 1.6 cm and depth less than 0.1 cm. From 10/16/2015 to 11/6/2015, measurements indicated Resident C's pressure ulcer to his right great toe was classified as a stage 2 pressure ulcer with depth unable to be determined. On 11/13/2015, the wound continued as a stage 2 pressure ulcer with measurements less than 0.1 cm x less than 0.1 cm and no depth. The wound progressed to a stage 3 pressure ulcer on 12/18/2015 with measurements of 2.5 cm x 2.0 cm and depth of 0.2 cm. The wound progressed to an unstageable pressure ulcer on 12/22/2015 with measurements of 1 cm x 1 cm and depth unable to be determined. Resident C's pressure ulcer to his right great toe remained at an unstageable pressure ulcer on 12/30/2015 with measurements of 1</p>			

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	<p>cm x 1 cm and depth unable to be determined.</p> <p>During an interview on 1/7/2016 at 2:17 p.m., LPN #61 indicated Resident C currently had a composure (therapeutic) mattress and used to have a low air loss mattress. She indicated he wore orthotic braces to his legs from 8 a.m. to 2 p.m. She indicated the staff experience difficulty floating his heels due to his contracted legs.</p> <p>During an interview on 1/8/2016 at 9:34 a.m., CNA #65 indicated Resident C had orders to wear his orthotic braces to his lower legs for 4 hours each shift. She indicated she did not float his heels with a Z-flow cushion while in bed and indicated his room did not contain a cushion to float his heels with. She indicated he is repositioned in bed every 2 hours and she did not always float his heels with a pillow while in bed. She indicated he had a pair of Bunny Boots in his closet and he did not wear them during the day shift. She indicated the CNAs monitor the residents' skin conditions during each shower day by filling out a skin sheet and placing it in the shower binder. She indicated the nurses monitor the skin sheets each shift.</p> <p>During an interview on 1/8/2016 at 10:33</p>						

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	<p>a.m., Unit Manager (UM) #67 indicated she had not performed Resident C's wound measurements for the week. She indicated she had been unaware if that was a task assigned to her.</p> <p>During an interview on 1/8/2016 at 10:35 a.m., the Director of Nursing (DON) indicated she expected the UM to take measurements of Resident C's wound. She indicated there was not an assigned date during the week, as long as the measurements were taken by Friday each week. She indicated Resident C's pressure ulcer developed within the facility. She indicated the efficacy of the resident's current wound interventions were measured by the wound measurements and visual site of the wound and this would determine if the resident required new interventions to be put in place. She indicated Resident C's current interventions were turning and repositioning every 2 hours, a low air loss mattress, heels floated while in bed, pillow between his contracted knees while in bed, and Bunny Boots applied to both of his feet when his leg orthotics are off. She indicated the Bunny Boots are padded and protect Resident C's pressure area due to him rubbing his feet together and causing pressure to his right great toe. She indicated the NP had questioned circulation issues in December 2015, but</p>			

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	<p>Resident C had not received any diagnostic testing to address if circulation issues had been present. She indicated the pressure area to his right great toe had been a result of his feet rubbing together.</p> <p>During an interview on 1/8/2016 at 1:26 p.m., CNA #65 indicated Resident C's orthotics had been applied incorrectly without the abductor bar present. She indicated the abductor bar for his orthotics remained in his closet as he had worn his orthotics for the day shift.</p> <p>During an interview on 1/8/2016 at 1:36 p.m., RNA #86 indicated she had placed Resident C's orthotics to his legs without the abductor bar between 6 a.m. to 7 a.m. She indicated she had not placed the abductor bar to his orthotics because he had been lying in bed when she applied the orthotics.</p> <p>During an interview on 1/8/2016 at 1:53 p.m., PT #66 indicated Resident C's orthotics had been applied incorrectly without the abductor bar present. She indicated the orthotics required the abductor bar to ensure abduction (to draw away from the axis of the body) of his leg contractures and keep his legs from rubbing together.</p> <p>During an interview on 1/8/2016 at 2:38</p>			

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	<p>p.m. CNA #65 indicated Resident C had his orthotics applied to his legs between 6 a.m. to 7 a.m. by Restorative Nursing Assistant (RNA) #68 and she had removed his orthotics at 2:18 p.m.</p> <p>During an interview on 1/11/2016 at 11:30 a.m., the DON indicated the UM who had performed Resident C's wound measurements to his right great toe had incorrectly staged the pressure ulcer from 10/16/2015 to 11/6/2015 and the wound measurements had not been updated with correct information. She indicated Resident C's pressure ulcer should have been classified as an unstageable pressure ulcer to his great toe, with depth unable to be determined.</p> <p>During an interview on 1/11/2016 at 11:23 a.m., the Nurse Consultant indicated Resident C's wound to his right great toe began from pressure. She indicated it was being considered a possible venous stasis ulcer due to the facility being unable to heal the pressure area.</p> <p>During an interview on 1/11/16 at 11:25 a.m., the DON indicated the staff had not provided Resident C with correct pressure reducing interventions with his orthotics applied incorrectly, heels not floated, and staff were unaware when</p>			

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	<p>Bunny Boots were to be placed on the resident. She indicated she expected her nursing staff to correctly document nursing measurements and dressing treatments in the MAR and TAR.</p> <p>During an interview on 1/11/16 at 4:09 p.m., the DON indicated Resident C's Z-flow cushion had ruptured and was unavailable for an uncertain amount of time. She indicated the Bunny Boots had been ordered for the resident to wear while in bed until his new Z-flow cushion arrived. She indicated there should have been an order for the nursing measure of the Bunny Boots in the MAR for nursing staff to have awareness of when Resident C was to wear the Bunny Boots and the Z-flow cushion order should have been removed. She could not provide a date when the Bunny Boots were implemented.</p> <p>During an interview on 1/11/2016 at 4:11 p.m., the NP indicated he and the facility had considered Resident C's wound to his right great toe as a pressure ulcer since August 2014. He indicated since Resident C's pressure ulcer had not been able to heal with the interventions of Bunny Boots, orthotic braces applied to his legs, heels off-loaded, and treatment changes the facility had attempted, he had considered the pressure ulcer a possible</p>			

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	<p>venous stasis ulcer that could be a result of PVD (peripheral vascular disease) or PAD (peripheral artery disease) in December 2015. He indicated he had referred Resident C to a podiatrist and wound care via the facility's therapy department to evaluate possible venous insufficiency to the open area. He indicated Resident C did not have a history of circulatory or venous insufficiency diagnoses and had not received a diagnostic evaluation of PVD or PAD. He indicated Resident C had not received wound care from the outpatient wound care facility that he utilized for residents with pressure ulcers in the facility.</p> <p>During an interview on 1/12/2016 at 11:56 a.m., PT #66 indicated the facility's therapy department was able to provide consultation and observation in determining whether an open area was the result of pressure or venous insufficiency. She indicated an open area that occurs in an area of muscle, such as the calf, would indicate venous insufficiency. She indicated an open area on a bony prominence that receives pressure, such as the heel or toe, would indicate a pressure ulcer.</p> <p>3. On 1/11/2016 at 10:30 a.m., Resident D was observed lying in bed on a regular mattress tilted on his right side with the</p>			

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	<p>head of the bed elevated approximately 45 degrees and he was slouched down in the bed with his head at the fold of the mattress. He had a cloth boot on his right foot covering his right ankle and his pants were pulled down around his ankles and covered his heels. Resident D was observed rubbing his legs together to kick his pants down.</p> <p>On 1/11/16 at 11:53 a.m., Resident D was sitting up in his wheelchair with a foam boot on his left foot and socks on his bilateral feet. Resident D wore only a sock on the right foot. Licensed Practical Nurse (LPN) #23 indicated the foam boot was a heel protector.</p> <p>On 1/11/16 from 1:09 p.m. to 1:12 p.m., Resident D was sitting in his wheelchair in front of his room. Resident D had socks on bilateral feet and a foam boot on the left foot. The right foot only had a sock on it. Resident D was observed to have both feet on the foot pedals, then he lifted both feet off of the pedals and placed them on floor behind the foot pedals. Resident D placed both feet back on the foot pedals before he lifted his right leg and placed it on top of his left knee.</p> <p>On 1/11/16 at 3:37 p.m., Resident D was laying on his back on his mattress with a</p>			

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	<p>protective boot on his right foot. His feet were lying against the mattress.</p> <p>On 1/12/16 at 9:56 a.m., Resident D's right heel wound was observed with Unit Manager (UM) #63. Resident D was lying on his left side on his mattress with his pants down to his knees. Both of his heels were lying against the mattress. A black protective boot was on his right heel, and blue foam boot was on his left heel. Resident D had socks on both feet under the boots. Unit Manager #63 removed the black boot and sock from his right foot. An area approximately the size of a quarter was noted on his right heel with a pink center. Black eschar (dead tissue) surrounded the sides of the open area and around the top. The black eschar on the top of the wound was approximately the size of a dime, and the eschar on the sides were approximately a quarter of an inch wide and half an inch in length. UM #63 applied skin prep to the wound, and placed his sock and protective boot back onto his foot.</p> <p>On 1/12/16 at 10:05 a.m., Resident D was lying on his left side on his mattress with protective boots on both feet and his boots lying against the mattress.</p> <p>On 1/12/16 at 11:21 a.m., Resident D was lying on his back on his mattress with</p>			

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	<p>protective boots on both feet and his feet flat against the mattress.</p> <p>On 1/12/16 at 12:53 a.m., Resident D was propelling his wheelchair down the hall with his feet. He had a black protective boot on his right heel and a blue foam boot on his left heel.</p> <p>On 1/12/16 at 2:35 p.m., Resident D was lying on his back on his mattress with protective boots on both feet and his feet lying against the mattress.</p> <p>On 1/13/16 at 11:20 a.m., Resident D was lying on his back with both feet in foam boots lying flat against the mattress.</p> <p>On 1/11/16 at 10:02 a.m., Resident D's record was reviewed. The form titled, "Admission/Re-admission Resident Assessment," dated 8/17/15, indicated Resident D had a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying tissue) on his right heel. The form indicated "bunny" boots and skin prep were to be applied to both heels. The form indicated the resident required total assistance, was non-weight bearing, and needed a Hoyer lift.</p> <p>The form titled, "Non-Pressure related skin condition," initiated on 8/17/15,</p>				

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	<p>indicated Resident D had a suspected deep tissue injury (DTI) on his right heel that measured 2 centimeters (cm) by 3 cm.</p> <p>The form titled, "Initial Pressure Ulcer Assessment," dated 8/17/15 to 1/8/16, indicated Resident D's had a deep tissue injury (DTI) to his right heel. On 8/17/15, Resident D's DTI measured 2 centimeters (cm) in length by 3 cm in width, and the depth could not be visualized. On 9/3/15, Resident D's DTI measured 10 cm in length by 4 cm in width, and the depth could not be visualized. On 9/9/15, the DTI measured 9 cm in length by 3 cm in width, and the depth could not be visualized. On 9/17/15, Resident D's DTI measured 8 cm in length by 2 cm in width, and the depth could not be visualized. On 10/2/15, the DTI measured 6 cm in length by 5 cm in width, and the depth could not be visualized. On 10/8/15, the DTI measured 3 cm in length by 3 cm in width, and the depth could not be visualized. On 10/23/15, the DTI measured 1.5 cm in length by 1.5 cm in width, and the depth could not be visualized. On 10/29/15, Resident D's DTI measured 1 cm in length by 1 cm in width, and the depth could not be visualized. On 11/25/15, Resident D's DTI measured 1.5 cm in length by 2 cm</p>				

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	<p>in width, and the depth could not be visualized. On 12/8/15, the DTI measured 1.5 cm in length by 1.8 cm in width, and the depth could not be visualized. On 12/18/15, the DTI measured 2 cm in length by 3 cm in width, and the depth could not be visualized. On 12/25/15, Resident D's DTI measured 2 cm in length by 3 cm in width, and the depth could not be visualized. On 1/1/16, the DTI measured 2 cm in length by 3 cm in width, and the depth could not be visualized. On 1/8/16, Resident D's DTI measured 1.8 cm in length by 2.8 cm in width, and the depth could not be visualized.</p> <p>The lab results, dated 8/21/15, indicated Resident D had a low albumin level, and a normal protein level.</p> <p>The pressure ulcer risk care plan, initiated on 9/4/15, stated Resident D was "...at risk for the development of pressure ulcers due to:...Extensive assist with bed mobility...impaired cognition (sic)...Diabetes, HX (history) CVA (cerebrovascular accident), confined to bed and chair...Limited ROM (range of motion), left side weakness." Interventions did not include pressure reducing boots or to float his heels while in bed.</p>			

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	<p>The form titled, "Care Plan Conference Record," dated 9/8/15, indicated Resident D had a deep tissue injury to his left heel and he was dependent on staff for all activities of daily living and transfers.</p> <p>The dietary notifications form, dated 9/23/15, indicated Resident D had a deep tissue injury on his right heel. The form indicated Resident D was on a regular pureed diet, his weight was stable, and the physician had been notified of his low albumin level.</p> <p>The physician order, dated 10/2/15, ordered skin prep to the resident's right heel.</p> <p>The form titled, "Braden Scale for Predicting Pressure Ulcer Risk," dated 11/23/15 and 12/15/15, indicated Resident D had a score of 14 out of 18, and was at a moderate risk for developing pressure ulcers.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 11/24/15, indicated Resident D had a Brief Interview for Mental Status score of 9 out of 15, and had moderate cognitive impairment. The MDS indicated Resident D required extensive assistance of one person for bed mobility, locomotion, dressing, personal hygiene, and bathing. The MDS indicated</p>			

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	<p>Resident D required extensive assistance of two people for transfers. The MDS indicated Resident D had one unstageable pressure ulcer that was a suspected deep tissue injury.</p> <p>The form titled, "Care Plan Conference Record," dated 12/15/15, indicated Resident D's deep tissue injury to his left heel was healing and he was dependent on staff for all activities of daily living and transfers.</p> <p>The activities of daily living (ADL) care plan, revised on 12/15/15, stated Resident D required, "...up to total/2 assist in performing ADL's due to : Dementia (sic), weakness, risk for falls, Delirium, Cognitive loss, Moderately impaired vision, Abnormal lab level, use of psychotropic medications, limited ROM (range of motion), incontinence." The care plan indicated Resident #30 had diagnoses including, but not limited to: diabetes, history of cerebrovascular accident, altered mental status, and congestive heart failure.</p> <p>The physician order, dated 12/18/15, discontinued the dressing to Resident D's right heel due to the area being "closed/intact."</p> <p>The physician order summary, dated</p>						

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	<p>12/28/15, discontinued the foam boot and sterile dressing to Resident D's right heel.</p> <p>The physician order summary, dated 12/28/15, indicated the following was ordered on 10/29/15, "float both heels while in bed."</p> <p>The form titled, "C.N.A. Assignment Sheets," dated 1/4/16, indicated Resident D required a Hoyer lift, had a concave mattress, and was to have his heels floated.</p> <p>During an interview on 1/11/16 at 1:24 p.m., Unit Manager #63 indicated Resident D had a deep tissue injury (DTI) to his right heel and it was acquired in the facility on 8/2/15. UM #63 indicated she was unsure how he had obtained the DTI because he was able to reposition himself. She indicated she thought the DTI was not found during his most recent readmission assessment, so the facility had to claim the wound as a facility acquired wound. She indicated the wound presented as a colored area of skin with a hard disc in the center and no open area. She indicated Resident D was to have padded boots on both heels in bed, and socks on bilateral feet and a boot on the right heel when he was up in the wheelchair.</p>			

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	<p>During an interview on 1/12/16 at 9:56 a.m., Unit Manager (UM) #63 indicated Resident D had a black protective boot for his right heel to relieve pressure from the wound. She indicated the blue foam boot on Resident D's left foot was only for preventative measures. UM #63 indicated Resident D was not wearing the black boot on his right foot on 1/11/16 afternoon while he was in his wheelchair, and she had to track him down to put it on him.</p> <p>During an interview on 1/12/16 at 3:15 p.m., the Director of Nursing (DON) and the Nurse Consultant indicated they believed Resident D was admitted with the wound on his right heel from the hospital.</p> <p>During an interview on 1/12/16 at 3:28 p.m., Licensed Practical Nurse (LPN) #24 indicated the order for the heel dressing was discontinued not the protective boot. She indicated the order for the heel protector was in treatment administration record (TAR). LPN #24 indicated Resident D had an order to float his heels in bed.</p> <p>During an interview on 1/13/16 at 11:21 a.m., Certified Nursing Assistant (CNA) #25 indicated she was the CNA for Resident D and she was unaware</p>			

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	<p>Resident D had a wound on his foot or any interventions in place related to his wound.</p> <p>A Skin Management Program policy, dated 10/2013, and identified by the DON as current on 1/12/2016 at 3:05 p.m., indicated the following, "Policy: This facility will assess/identify the presence of risk factors that may contribute to the development of pressure ulcers and other skin alterations in an effort to prevent skin breakdown and/or further deterioration limited by the individuals' recognized pathology and pre-existing co-morbid conditions.</p> <p>Assessment/Documentation/Monitoring: A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, readmission and at least weekly thereafter...See Weekly Skin Assessment (to be used for weekly skin assessments for all residents...Residents who receive assistance with bathing and/or peri-care will be observed daily by nursing staff and any observance of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations in skin will be reported to the licensed nurse for further assessment...See Shower Observation Sheet: to be completed by the direct caregiver and given to licensed nurse on charge when a resident is assisted to</p>			

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F 0315 SS=D Bldg. 00	<p>bathe/shower...Residents who wear a device such as a splint, brace, immobilizer, etc. will have his/her affected limb(s) assessed daily by a licensed nurse due to greater risk of skin breakdown....</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's subrapubic urinary catheter bag and tubing were positioned to avoid contact with the floor during 5 of 6 observations for 1 of 1 resident reviewed for urinary catheters (Resident #28).</p> <p>Finding includes: On 1/4/16 at 10:15 a.m., Resident #28</p>	F 0315	<p>1.Resident #28 was affected. The resident was not harmed.The tubing and bag were immediately positioned appropriately.</p> <p>2.All residents utilizing a catheter bag have the potential to be affected. All nursing staff will be in-serviced on appropriate placement of the catheter bag and tubing.</p> <p>3.As a measure to ensure ongoing compliance the DON or designee will complete an audit to ensure all catheter bags and</p>	01/27/2016

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	<p>was observed sitting in the activities room in his wheelchair with a urinary catheter bag hanging uncovered off the bottom of his wheelchair. The urinary catheter bag had yellow urine visible in the bag. The urinary catheter tubing was observed resting on the floor under the resident's wheelchair. No urine was visible in the urinary catheter tubing.</p> <p>On 1/4/16 at 11:38 a.m., Resident #28 was observed in the main dining room sitting in his wheelchair. His urinary catheter bag was hanging uncovered off his wheelchair, the tubing was resting on floor, and Resident #28's foot was on the urinary catheter tubing. The urinary catheter bag had yellow urine visible in the bag and tubing.</p> <p>On 1/8/16 from 12:08 p.m. to 12:25 p.m., Resident #28 was observed in the main dining room in his wheelchair. His urinary catheter tubing was observed touching floor under the wheelchair. The urinary catheter bag was observed covered and hanging from the wheelchair. Clear urine was observed in the urinary catheter tubing.</p> <p>On 1/8/16 at 12:17 p.m., the Director of Nursing (DON) and Unit Manager (UM) #67 were observed to walk past Resident #28 while the urinary catheter tubing was</p>		<p>tubing are positioned appropriately five times weekly for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing.</p> <p>4.As a measure for ongoing compliance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised, as warranted.</p>	

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	<p>touching the floor.</p> <p>On 1/8/16 at 12:55 p.m., Resident #28 was observed in main dining room with his urinary catheter tubing and bag on the floor under his wheelchair. Clear urine was observed in the catheter bag and tubing.</p> <p>On 1/11/16 at 10:30 a.m., Resident #28's record was reviewed. The care plan titled, "Foley Catheter," initiated on 1/26/15, stated, "Resident requires the use of indwelling S/P (subrapubic) Foley Catheter due to urinary obstruction and is at risk for infection." The care plan interventions included, but were not limited to the following: "...Position tubing/drainage bag below level of bladder to minimize risk of influx, position cath tubing/drainage bag in such away to avoid contact with the floor...keep cath (catheter) drainage bag covered as to maintain resident dignity/privacy."</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 10/29/15, indicated Resident #28 had catheter.</p> <p>The quarterly MDS, dated 11/17/15, indicated Resident #28's urinary continence was not rated due to the presence of a urinary catheter.</p>			

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	<p>The form titled, "Bowel and Bladder Assessment," dated 11/17/15, indicated Resident #28 had a subrapubic catheter due to the inability to void.</p> <p>The form titled, "Catheter Assessment," dated 12/8/15, indicated Resident #28's urinary catheter was inserted due to urinary obstruction. The assessment stated the resident had, "Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible."</p> <p>The form titled, "Temporary Problem List," dated 12/13/15, indicated Resident #28's suprapubic catheter was to be changed due to the inability to flush the current urinary catheter. The form indicated the staff was to obtain a urinalysis and urine culture.</p> <p>The form titled, "Temporary Problem List," dated 12/15/15, indicated Resident #28 had a urinary tract infection and was started on an oral antibiotic for 14 days.</p> <p>The lab results, dated 12/17/15, indicated Resident #28's urine had an abnormal presence of blood and protein, the clarity was cloudy, was amber in color, had bacteria, and had an abnormal amount of red and white blood cells.</p>			

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	<p>The form titled, "Temporary Problem List," dated 12/18/15, indicated Resident #28 had a urinary tract infection and had an order for a daily dose of an intramuscular antibiotic for 14 days.</p> <p>The Physician's order summary, dated 12/30/15, indicated Resident #28 had a diagnosis of urinary obstruction. The physician order summary indicated Resident #28 had a physician order for a subrapubic urinary catheter.</p> <p>On 1/8/16 at 12:55 p.m. Licensed Practical Nurse (LPN) #20 indicated Resident #28's urinary catheter bag should have been covered and the catheter bag and tubing should not touch the floor.</p> <p>On 1/11/16 at 4:15 p.m., the Director of Nursing indicated Resident #28's urinary catheter tubing and bag should not have been on the floor.</p> <p>On 1/12/16 at 9:10 a.m., the Director of Nursing provided the current policy titled, "Catheter Care, Suprapubic." The policy did not address the covering of catheter bag or the need to keep the catheter bag and tubing off the floor.</p> <p>3.1-41(a)(2)</p>			

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F 0323 SS=J Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to adequately monitor and supervise a resident (Resident #143) who wandered to prevent the resident from entering other residents' rooms and attempting or engaging in non-consensual sexual interactions with 2 of 7 residents reviewed for safe living environment (Resident #83 and Resident #126).</p> <p>The Immediate Jeopardy was identified on 1/07/2016 and began on 12/18/2015 when the facility identified Resident #143's wandering behaviors and failed to implement interventions to prevent the resident from wandering into other residents' rooms. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on 1/07/16 at 1:21 p.m. The Immediate Jeopardy was removed on 1/8/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than</p>	F 0323	<p>Please see IDR rationale attached.</p> <p>1. Resident #143, in question (in regard to inappropriate interactions with other residents/visitor) was immediately placed on one-on-one staff supervision upon notification of the alleged inappropriate interaction until such time the resident could be transferred for an in-patient psych evaluation, in an effort to ensure the safety and well-being of all residents of the facility. One should note resident #143 is cognitively intact and denied said allegations. Following in-patient psychiatric evaluation, the facility re-evaluated whether the facility could meet the needs of the resident on the basis of assessment and findings of the psychiatric evaluation. Upon completion of psychiatric treatment resident #143 showed no inappropriate behaviors. Upon return to the facility he was placed on one-on-one supervision until he could be relocated to another facility for long term care as a</p>	01/27/2016

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	<p>minimal harm that is not Immediate Jeopardy</p> <p>Findings include:</p> <p>1. During an interview on 01/06/16 at 9:56 a.m., Resident #83 indicated on "five or six" different occasions Resident #143 had been in his room at 2:00 a.m. touching himself and attempted to "grope" Resident #83. Resident #83 indicated Resident #143 had never touched him because he swung at Resident #143 to keep him away. Resident #83 was unable to provide specific dates for these incidents.</p> <p>During a follow up interview on 1/06/16 at 3:22 p.m., Resident #83 indicated he reported the incidents where Resident #143 entered his room to third shift nurses five times. Resident #83 was unable to recall the names of the nurses he reported the incident to.</p> <p>Resident #83's record was reviewed on 1/07/16 at 11:25 a.m. Resident #83's Resident Admission Record, dated 5/30/15, indicated diagnoses including, but not limited to, paranoid schizophrenia, chronic obstructive pulmonary disease, and below the knee left leg amputation.</p> <p>A quarterly Minimum Data Set (MDS)</p>		<p>precautionary measure. Resident #143 was relocated to another facility on 01-29-2016. Resident #83 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #2 was not physically harmed and showed no signs or symptoms of mental anguish. Resident #126 was not physically harmed and showed no signs or symptoms of mental anguish. Staff interviews noting "rumors" were referring to the consensual relationship between cognitively intact resident #143 and cognitively intact resident #36 which was previously addressed and careplanned.</p> <p>2. In an effort to identify any other resident who could potentially be affected, interviews were conducted with all interviewable residents relative to any concerns with staff and/or residents of the facility including care, interactions, and unwanted room visitation. No concerns were noted or reported through interviews. Should concerns have been identified, immediate investigation would have been initiated and necessary actions initiated as per facility policy, in an effort to ensure the safety and well-being of all residents of the facility. Residents were re-educated of the need to immediately report any allegation of abuse or questionable conduct of a staff member or resident to ensure immediate and necessary</p>	

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	<p>assessment, dated 11/08/15, indicated Resident #83's cognitive status score was 15 indicating he was cognitively intact.</p> <p>Resident #83's nurse's notes, dated 7/02/15 through 1/06/16, were reviewed and lacked documentation of Resident #83 reporting any residents wandering into his room or observations of Resident #143 wandering into his room.</p> <p>2. During an interview on 1/7/16 at 9:31 a.m., Resident #2 indicated about three to four weeks ago, during the day, Resident #143 wandered into his room and touched his roommate, Resident #126, in the private area. He stated he and Resident #126 reported the incident to Licensed Practical Nurse (LPN) #2 and that she did not report the incident to the social worker. Resident #2 indicated Resident #143 had not attempted or ever touched him. Resident #2 indicated during the weeks Resident #126 was in the hospital (after he witnessed Resident touch his roommate's private area) Resident #143 frequently asked where his roommate (Resident #126) was and sat in his wheelchair outside the door to his room and peeked into the room.</p> <p>Resident #2's record was reviewed on 1/07/16 at 9:10 a.m. Resident #2's Resident Admission Record dated</p>		<p>action is taken.</p> <p>3.As a means to ensure ongoing compliance, facility staff received in-service training prior to his/her next tour of duty relative to abuse prohibition, immediate reporting of any allegation of abuse, and initiation of immediate interventions,as necessary, to supervise and prevent incidents in an effort to safeguard all residents from abuse.</p> <p>4.As a means of quality assurance, residents will be interviewed weekly for the next four weeks, then monthly thereafter in regard to personal safety and freedom from any type of abuse. Staff shall be randomly interviewed on scheduled days of work by administration in regard to response should a resident report an allegation of abuse to confirm continued compliance with facility policy. Said interviews will be conducted weekly for four weeks, and monthly thereafter. Re-education shall be provided, as warranted, on the basis of staff response. Should concerns be identified, immediate investigation shall be initiated and necessary actions initiated as per facility policy, in an effort to ensure the safety and well-being of all residents of the facility. Addendum For F223, F225, and F323-Please indicate how cognitivelyimpaired residents will be included in investigations for abuse. Please indicate if family</p>	

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	<p>5/15/2015 indicated he had diagnoses including, but not limited to: muscle weakness, cerebral palsy, depressive disorder, and blindness to the right eye.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 8/12/15, indicated Resident #2's cognitive status score was 14, indicating he was cognitively intact.</p> <p>During an interview on 1/7/16 at 9:35 a.m., Resident #126 indicated Resident #143 came into his room and touched his private area. Resident #126 indicated he told Resident #143 to leave and he did. Resident #126 stated he reported the incident to Licensed Practical Nurse (LPN) #2. Resident #126 indicated the incident happened prior to him going to the hospital approximately four weeks ago.</p> <p>Resident #126's record was reviewed on 1/07/16 at 9:25 a.m. Resident #126's Resident Admission Record, dated 11/04/15, indicated diagnoses including, but not limited to, unspecified dementia without behavioral disturbance, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/19/15, indicated Resident #126's cognitive status score</p>		<p>members, visitors, and patient representatives are included in education regarding abusereporting. The facility follows the abuse prohibition policy for all residents as follows; If resident abuse, or suspicion of abuse, is reported: 1. The resident(s) involved in the incident will be removed from the situation at once or facility personnel will remain with the resident to ensure safety. 2. The individual who witnessed the incident or who was informed of the allegations shall immediately notify a charge nurse assigned to the unit on which the resident resides. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty. The nurse will examine the resident(s) involved to determine whether physical injuries have occurred and their extent. This examination shall be documented in the resident's clinical record. 3. The charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately. 4. Any facility personnel implicated in the alleged abuse will be immediately removed from the resident care and will remain suspended until an investigation is completed. A thorough investigation will be initiated. 5. Any resident implicated in the alleged abuse will be placed under</p>	

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	<p>was 15, indicating he was cognitively intact.</p> <p>3. Resident #143's record was reviewed on 1/06/16 at 2:25 p.m. Resident #143's Resident Admission Record dated 7/31/2015 indicated diagnoses including, but not limited to, cerebral infraction, hemiplegia (paralysis on one side of the body), and aphasia (difficulty speaking).</p> <p>Significant change Minimum Data Set (MDS) assessment, dated 10/28/15, indicated Resident #143's cognitive status score was 14, indicating Resident #143 was cognitively intact.</p> <p>A form titled, "Mood and Behavior Communication Memo," dated 12/17/15, indicated Resident #126 and Resident #2 reported that Resident #143 came into their room and they asked the nurse to redirect Resident #143. The memo indicated the nurse redirected Resident #143 to his room.</p> <p>A care plan for Resident #143, dated 12/18/15, indicated he was care planned for wandering and had interventions including the following: redirect resident to his room and obtain a urinalysis and urine culture.</p> <p>A care plan, dated 12/28/15, indicated</p>		<p>appropriatemonitoring/supervision to prevent recurrence until investigation is completedand/or transferred for medical/psychiatric evaluation to be conducted relativeto mood/behavior exhibited. 6. Theresident's attending physician will be notified as soon as feasible and anyorders will be noted and initiated. 7. Local lawenforcement may be notified, as warranted. 8. Thefamily of the resident(s) and/or legal representative will be notified perpolicy. 9. AnIncident Report will be completed as per facility policy. 10. Residentswill be questioned about the nature of the incident and their statements placedin writing. 11. Investigationwill be conducted to assure other residents have not been affected by theincident or inappropriate behavior and the results documented. 12. Statementswill be taken including, but not limited to, • facts andobservations by involved employees • facts andobservations by witnessing employees • facts andobservations by witnessing non-employees • facts andobservations by any others who might have pertinent information • facts andobservations by the licensed nurse or individual to whom the initial report wasmade. 13. Follow-upassessments will be completed/documented during</p>	

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	<p>Resident #143 and his roommate, Resident #36 had a need for privacy and included the following interventions: "establish a system to ensure privacy as evidenced by door sign, and staff not entering room when door is shut."</p> <p>On 1/06/15 at 1:55 p.m., the DON provided a document titled, "Mood and Behavior Communication Memo," dated 12/26/15. The memo stated, "The husband of a visitor for Resident #96 said he was in the hallway and Resident #143 came to the doorway and asked him to come here so he said (sic) ask a question when the visitor went over to see what he needed Resident #143 went to grab his private area. The visitor said he grabbed his (Resident #143) hand and told him not to do that and he should be ashamed of himself."</p> <p>A care plan, dated 12/28/15, stated Resident #143 had been, "sexually inappropriate to visitor ...attempted to grope visitor. " The care plan interventions included, but was not limited to, "...Placed on 15 min. checks."</p> <p>A document titled, "Fifteen Minute Observation," indicated Resident #143 was placed on bed checks every fifteen minutes beginning 12/28/15.</p>		<p>every shift until the resident(s) is stable and resident safety is maintained. 14.</p> <p>The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable: • State Department of Health • Adult Protective Services • Ombudsman • Applicable Licensing Agency 15.</p> <p>The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation, and to file a follow-up report to the State Department of Health. 16.</p> <p>The Administrator is responsible to report to the State nurse aide registry or licensing authorities any knowledge of any actions by a court of law which would indicate an employee is unfit for service.</p> <p>Resident/legal representatives will be informed upon admission and periodically (at least annually) thereafter of the facility's policy regarding abuse prohibition including how and to whom they may report concerns, incidents and grievances without fear of retaliation.</p>	

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	<p>A psychological Evaluations dated 1/04/16 indicated "Patient is a [age specified] year old...mild cognitive impairment is observed...however patient appears alert, oriented, and able to make decisions for himself...Patient adamantly expressed that he is willingly participating in relationship with his roommate. He appears to understand the risks associated with sexual activity..."</p> <p>During an interview on 1/06/16 at 3:56 p.m., Resident #143 indicated he accidentally wandered into another room once and was not sure when that was. He denied getting up in the middle of the night and wandering into rooms. He also denied an encounter with a visitor or attempting to touch the visitor inappropriately.</p> <p>During an interview on 1/6/15 at 4:03 p.m., Certified Nursing Assistant (CNA) #1 indicated she had never seen Resident #143 wandering at night. She indicated she had witnessed Resident #143 wander into Resident #83's room on two occasions. The first time she witnessed Resident #143 with his hand under #83's sheet. CNA #1 indicated Resident #83 was awake and did not say anything. She did not report it because Resident #83 would have told her if something inappropriate was happening. The second</p>			

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	<p>time the CNA #1 saw Resident #143 enter Resident #83's room she immediately had Resident #143 leave room his room. CNA #1 stated that both incidents occurred about three weeks ago in the evening after dinner.</p> <p>During an interview on 1/6/16 at 11:50 p.m., LPN #3, CNA #4, and Qualified Medication Aide (QMA) #5 all indicated they heard rumors of Resident #143 touching his roommate and indicated they did not report the rumors because they believed the managers and the Assistant Director of Nursing (ADON) already knew of the situation.</p> <p>During an interview on 1/7/16 at 12:37 a.m., LPN #6 indicated she heard "rumors last week or two weeks ago" about a resident on the D wing entering another resident's room and touching another resident sexually. The LPN indicated the resident was confused and she didn't report the allegation to anyone because she believed it had already been discussed with the Unit Manager and Assistant Director of Nursing (ADON). A typed interview statement received from the Director of Nursing (DON) on 1/7/15 at 9:05 a.m., indicated Resident #83 was interviewed on 1/06/16. He indicated Resident #143 never touched him, but made him very uncomfortable.</p>				

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	<p>During an interview on 1/07/16 at 9:05 a.m., the DON indicated Resident #143's 15 minute checks were not immediately put into place after the incident on 12/26/15 when Resident #143 attempted to touch a visitor, but initiated on 12/28/15. The DON indicated she was unaware of the incident until 12/28/15 due to the incident happening on the weekend, and staff not reporting the incident immediately.</p> <p>During an interview on 1/07/16 at 9:06 a.m., the DON indicated during the investigation of recent abuse allegations, Resident #126 reported being touched inappropriately by Resident #143. The DON also indicated that Resident #126's roommate Resident #2 indicated he witnessed the incident.</p> <p>An interview was conducted on 1/07/2016 at 10:01 a.m. with the Social Service Director (SS), Director of Nursing (DON), and Administrator. The DON indicated one behavior sheet from 12/17/15 resulted in development of a care plan to address Resident #143's wandering. The DON indicated staff should have known where care plans were located and the facility tried to include some care plan interventions or</p>			

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	<p>behaviors on CNA assignment sheets. The DON indicated the CNA assignment sheets were updated by the unit manager every "couple of days" after new care plans were put in place. The DON indicated no resident interviews were conducted after the 12/17/15 incident to determine if Resident #143 wandered in their rooms or abused them because she thought it was an isolated incident. The DON indicated a written report was received on 12/28/15 regarding Resident #143 grabbing a male visitor's genital area on 12/26/15. The DON and SSD indicated they did not receive the report until 12/28/15 due to holidays and weekend and indicated staff should have immediately reported the incident. The Social Service Director (SSD) indicated Resident #143 was placed on 15 minute checks due to his tendency towards touching males' genitals and his ability to move around the unit. The DON indicated the 15 min checks continued until 1/06/16 when the resident was placed on 1:1 supervision after receiving an allegation from Resident #83 of abuse by Resident #143. The DON indicated she wished she would have interviewed other residents when she learned of the allegation of Resident #143 grabbing a visitor.</p>			

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	<p>During an interview on 01/07/2016 at 10:33 a.m., CNA #7 indicated she completed the behavior form for Resident #143 on 12/26/15. She indicated she was at the at nurses station and Resident #96's granddaughter's husband came up to the desk and informed her that Resident #143 had stopped him in the hall and asked him to come to his room's door and then grabbed the visitor's "privates." She indicated the visitor told her he grabbed Resident #143's hands away and told him no. She indicated the visitor was concerned that he would touch someone else and told her to have them keep children away from the resident. She indicated she called Qualified Medication Aide (QMA) #8 and informed her and QMA #8 called LPN #2. CNA #7 indicated QMA #8 told her to complete the behavior form and went to check on Resident #143. She indicated she believed QMA #8 informed the nurse manager on call of the visitor incident. CNA #7 indicated her assignment sheet did not say anything about Resident #143 wandering as of 12/26/15. She indicated she saw Resident #143 attempt to wander into the following residents' rooms: Resident #2, Resident #126, Resident #4, Resident #96, and Resident #83. She indicated she stopped Resident #143, redirected him, and informed the nurse. CNA #7 indicated the nurses always told</p>			

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	<p>her to continue watching him only. She indicated she never saw Resident #143 in another resident's room, only attempting to enter.</p> <p>During an interview on 1/07/16 at 3:45 p.m., Licensed Practical Nurse (LPN) #2 indicated Resident #2 and Resident #126 informed her Resident #143 had wandered into their room, but she did not report it because Resident #2 and Resident #126 asked her to redirect Resident #143. LPN #2 indicated Resident #2 told her Resident #143 had been in his room, he did not like Resident #143, he was "weird", and he did not want him in his room. LPN #2 indicated she did not report the incident because it had not happened before. LPN #2 indicated Resident #83 said Resident #143 was in his room and asked her to keep him out. LPN #2 indicated she did not report the incident, but she should have. LPN #2 indicated Resident #83 had informed her he did not want Resident #143 in his room because he "wasn't like that." LPN #2 indicated there was time between the two complaints about Resident #143, so she had not noticed a behavior pattern. She indicated she had been unaware of Resident #143's care plan for wandering. She indicated she should have reported his wandering.</p>			

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	<p>A facility policy, received from the Administrator on 01/05/16 at 3:41 p.m., dated 10/2014 and deemed current, titled "Abuse Prohibition Reporting and Investigation," stated, "This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies...Any resident implicated in the alleged abuse will be placed under appropriate monitoring/supervisions to prevent recurrence..." The policy also stated, "Supervisory personnel shall be responsible to monitor deployment of personnel on each shift in sufficient numbers to meet the needs of the residents, and to identify inappropriate behaviors which may lead to conflict or neglect." The policy stated, "Supervisory personnel shall be responsible to monitor...occurrences, patterns and trends that may constitute abuse, in an effort necessary investigation be initiated should potential concern be identified."</p> <p>The Immediate Jeopardy that began on 12/18/15 was removed on 1/8/16 when Resident #143 received 1:1 staff to resident supervision and the facility educated residents and responsible parties and in-serviced all staff regarding abuse and abuse reporting requirements. The</p>						

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F 0371 SS=D Bldg. 00	<p>noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued supervision and monitoring for abuse prevention and reporting.</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food stored in the walk in refrigerator was disposed of by the use by date for 1 of 2 kitchen observations and failed to ensure residents were assisted with dining in a sanitary manor for 1 of 2 assisted dining observations (Residents #27, #9, #52 and C).</p> <p>Findings include:</p>	F 0371	<p>1.No residents were harmed. The mandarin oranges were disposed of from the walk-in-cooler. Staff involved were immediately re-educated on proper handwashing/hand hygiene.</p> <p>2.All residents have the potential to be affected. Dietary staff were re-educated and in serviced (January 27, 2016) about the importance of labeling and dating and disposing of food by the use by date. All staff were in-serviced on the facility's Handwashing policy.</p>	01/27/2016			

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	<p>1. During the initial kitchen tour on 1/4/2016 at 10:36 a.m., 1 tub of prepared mandarin oranges with a prepared dated of 12/23/2015 and use by dated of 12/26/2015 was observed in the walk-in refrigerator.</p> <p>During an interview on 1/4/2016 at 10:36 a.m., the Dietary Manager indicated the tub of mandarin oranges should have been discarded by the use by date of 12/26/2015.</p> <p>A policy titled, "Storage of Foods under Sanitary Conditions, dated 11/2014 and identified by the Director of Nursing (DON) as current on 1/12/2016 at 3:05 p.m., indicated, "...Leftover foods should be placed in an approved storage container and should be discarded after three days...."</p> <p>2. On 1/4/2016 from 12:38 p.m. to 12:47 p.m., during the lunch dining observation, the Assistant Director of Nursing (ADON) propelled Resident #27's wheelchair to the table. She then removed a blanket from Resident #27's chest and began feeding the resident with her right hand. The ADON was then observed to provide feeding assistance with her left hand holding the fork to Resident C. She was then observed to touch her hair with both hands and</p>		<p>3. As a measure of ongoing compliance with food storage the Dietary Manager will complete an audit of stored food daily (Monday through Friday) for 4 weeks then twice weekly for 4 weeks then weekly for two months then monthly to ensure continued compliance ongoing. As a measure to ensure ongoing compliance with sanitation, the DON or designee will complete handwashing observations at varied times (including meal times) on five staff members five times weekly for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing.</p> <p>4. As a measure of quality assurance the findings for the above audits and subsequent corrective actions will be reviewed by the Dietary Manager/designee and DON/designee during the facilities quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	

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	<p>provide a spoonful of food to Resident #27 with her right hand. She was then observed to wipe her nose with her right hand and provide a spoonful of food to Resident C with her left hand. She then provided Resident #27 a spoonful of food with her right hand. The ADON was not observed to perform hand sanitation in between feeding assistance and resident care.</p> <p>On 1/04/2016 at 12:59 p.m., Unit Manager (UM) #63 was observed to adjust Resident #52's glasses with both hands while providing feeding assistance. She was then observed to provide Resident #9 a spoonful of Jello with her right hand. She then provided Resident #52 two spoonfuls of applesauce with her right hand. UM #63 was not observed to perform hand sanitation in between feeding assistance and resident care.</p> <p>During an interview on 1/12/2016 at 2:44 p.m., Certified Nursing Assistant (CNA) #69 indicated while providing feeding assistance to multiple residents in the dining room, staff are expected not to touch soilage, their hair, or the resident, and should hand sanitize in between feeding each resident. She indicated staff should handwash for at least 20 seconds.</p> <p>During an interview on 1/12/2016 at 3:25</p>			

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	<p>p.m., the ADON indicated staff should have provided feeding assistance to one resident at a time. She indicated if multiple residents had been provided feeding assistance by the same staff member, the staff member should have perform hand gel sanitation in between feeding each resident.</p> <p>A policy titled, "Handwashing Hygiene," dated 10/2014, and identified as current by the Director of Nursing (DON) on 1/12/2016 at 3:05 p.m., indicated, "Purpose: Hand hygiene is the single most important measure for preventing the spread of infection...Situations that require hand hygiene include, but are not limited to:...before and after direct resident contact...before and after assisting a resident with meals...before an after assisting a resident with personal care...before and after changing a dressing...upon and after coming in contact with a resident's intact skin...after blowing or wiping nose...after handling soiled or used linens, dressings, bedpans, catheters and urinals...Handwashing Procedure (Duration 40-60 seconds):...rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers...How to Use Handrub (Duration 20- 30 seconds): Apply a palmful of the product in a cupped hand and</p>						

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F 0431 SS=D Bldg. 00	<p>cover all surfaces...rub hands palm to palm...allow hands to dry...."</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976</p>			

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	<p>and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired medications were removed from the medication storage refrigerator or carts and failed to ensure a date opened was recorded on an insulin vial for 2 of 7 medication carts and 1 of 4 medication storage rooms. This deficient practice had the potential to affect 3 of 29 residents whose medications were stored in the medication carts or refrigerator (Residents #1, #69, #165).</p> <p>Findings include:</p> <p>During an observation on 01/11/16 at 1:00 p.m. of the C hall medication storage area with Licensed Practical Nurse (LPN) #9 present, 3 influenza vaccines were stored in the medication refrigerator with expiration dates of 5/2015.</p> <p>During an observation on 01/11/16 at 1:12 p.m. of the C hall medication cart with LPN #9 present, 14 Tolterodine Tartrate 4 milligram (mg) capsules with an expiration date of 12/2015 were stored in the medication cart for administration to Resident # 1.</p> <p>During an interview on 01/11/16 at 1:00</p>	F 0431	<p>1. Resident #1, #69, and #165 were affected. The residents were not harmed. The expired medications were immediately destroyed and new medications were ordered from the pharmacy.</p> <p>2. All residents have the potential to be affected. All medication carts, refrigerators and rooms were checked to ensure there were no expired medications and the date open indicated on medications as warranted. All nurses and QMA's were in-serviced on expired medications and date open labeling.</p> <p>3. As a measure to ensure ongoing compliance the DON or designee will audit medication carts, refrigerators and rooms to ensure there are no expired medications and medications are labeled with the date open as indicated three times weekly for 30 days, then weekly for 30 days, then monthly ongoing.</p> <p>4. As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action will be reviewed in the facility's quality assurance meeting. The plan will be revised as warranted.</p>	01/27/2016

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	<p>p.m., LPN #9 indicated any nurse could remove expired medications from medication storage carts and indicated a specific staff was not designated to remove expired medications from the medication storage areas.</p> <p>During an observation on 1/11/16 at 3:55 p.m. of the B hall medication cart with LPN #10 present, 1 bottle of Chlorhexidine Gluconate 12% oral rinse with an expiration date of 12/2015 was observed to be stored on the cart for administration to Resident #69. One opened container of Humalog (insulin) was stored in the cart for administration to Resident #165 without a date the insulin was opened. The Humalog bottle had a received date of 11/25/15.</p> <p>During an interview on 1/11/16 at 4:00 p.m., LPN #10 indicated the bottle of insulin was supposed to be dated when opened. LPN #10 turned to a sheet in the medication book titled, "Medications with Shortened Expiration Dates," and indicated Humalog was good for 28 days after opened and removed from the refrigerator. LPN #10 indicated she did not know when the bottle of insulin was opened.</p> <p>A policy titled, "Storing Drugs," dated 01/2015, and received on 1/12/16 at 9:10 a.m. from the DON (Director of Nursing)</p>			

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F 0441 SS=E Bldg. 00	<p>and deemed current indicated, "Any outdated, contaminated, or deteriorated drugs, or those drugs that have containers that are cracked, soiled or without closure must be removed from stock and destroyed according to policy. "</p> <p>A policy titled, "Medication Expiration," dated 01/2015 and received on 1/12/16 at 9:10 a.m. from the DON and deemed current indicated, "...d. Multiple dose injections, such as insulin will expire 28 days after opening unless otherwise noted by manufacturer. 2. Any product whose expiration date depends on the date opened must be labeled with the date the product was opened. "</p> <p>3.1-25(o)</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 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</p>			

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	<p>isolation, should be applied to an individual resident; and</p> <p>(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. Based on observation, interview, and record review, the facility failed to ensure adequate hand sanitation or infection prevention procedures when providing wound care to 1 of 3 residents observed for infection prevention during wound care (Resident B).</p> <p>Findings include:</p> <p>1. On 1/12/16 at 11:29 a.m., with Qualified Medication Aide (QMA) # 98, Certified Nursing Assistant (CNA) #97, CNA #86, Licensed Practical Nurse (LPN) #96, and LPN #99 present,</p>	F 0441	<p>1.Resident # B was affected. The resident was not harmed. Staff involved were re-educated on the facility's Handwashing and clean dressing change policies.</p> <p>2.All residents have the potential to be affected. All staff were in-serviced on the facility's Handwashing policy. All nurses were in-serviced on the facility's clean dressing change policy.</p> <p>3.As a measure to ensure ongoing compliance the DON or designee will complete handwashing/infection control principle observations at varied times (including during dressing changes) on five staff members</p>	01/27/2016

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	Resident B's wound care was observed. Resident B was positioned on his right side on a disposable pad. The pad was observed to have a brownish reddish drainage on it. LPN # 99 was observed positioned with her bare left arm up to and including the short sleeve on her scrub top having direct contact with the soiled pad. Her hair was pulled back in a pony tail but when she tilted her head to the left her hair came in contact with the soiled pad. After cleaning Resident B's wound LPN #99 removed her soiled gloves and washed her hands for 16 seconds. She applied clean gloves and proceeded to irrigate Resident B's right buttock wound. After irrigating the wound, she removed the soiled gloves and washed her hands for 10 seconds. The LPN dried her hands and donned clean gloves and cleansed Resident B's left buttock wound. After cleansing the wound, she removed the soiled gloves and washed her hands for 13 seconds. LPN #99 washed her hands multiple times during the wound treatments, but did not perform adequate hand sanitation during any of the handwashing procedures. LPN # 96 assisted with wound care and also did not perform adequate hand sanitation. LPN #96 washed her hands for 9 seconds after assisting with wound care, left the resident's room, then re-entered with		five times weekly for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing. 4.As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.	

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	<p>liquid pain medication in a syringe, washed her hands for 11 seconds and administered the medication to Resident B. Additional observations were made during the remainder of the wound treatments of LPN #96 and LPN #99 not performing adequate hand sanitation. When wound care was completed, LPN #99 leaned across Resident B's mattress and her exposed left arm, front of her uniform, and her hair came in contact with Resident B's bed and soiled disposable pad. At 12:19 p.m., CNA #86 held Resident B on his side facing towards her with the resident in contact with her clothing. At 12:23 p.m., without removing her soiled gloves, LPN #96 touched the bathroom door knob, opened Resident B's closet, and removed clean linens. The linens were placed on Resident B's bed.</p> <p>During an interview on 1/12/16 at 12:27 p.m., LPN #99 indicated hands should be washed between treatments to each wound and any time the gloves were contaminated. She indicated hands should be washed for the duration of time it takes to "sing happy birthday twice." LPN #96 indicated hands should be washed for two minutes.</p> <p>During an interview on 1/12/15 at 12:40 p.m., with the Director of Nursing,</p>			

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Administrator present, the Corporate Nurse Consultant indicated hands should be washed for two minutes and clothing protectors were available for staff to use.</p> <p>During an interview on 1/12/16 at 2:00 p.m., CNA #86 indicated she should have worn her scrub jacket to protect her clothing from coming in contact with Resident B.</p> <p>A policy titled, "Handwashing Hygiene," dated 10/2014, and identified as current by the Director of Nursing (DON) on 1/12/2016 at 3:05 p.m., indicated, "Purpose: Hand hygiene is the single most important measure for preventing the spread of infection...Situations that require hand hygiene include, but are not limited to:...before and after direct resident contact...before and after assisting a resident with meals...before an after assisting a resident with personal care...before and after changing a dressing...upon and after coming in contact with a resident's intact skin...after blowing or wiping nose...after handling soiled or used linens, dressings, bedpans, catheters and urinals...Handwashing Procedure (Duration 40-60 seconds):...rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers...How to Use Handrub (Duration</p>			

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	<p>20- 30 seconds): Apply a palmful of the product in a cupped hand and cover all surfaces...rub hands palm to palm...allow hands to dry...."</p> <p>A policy titled, "Dressing- Clean Technique," dated 10/2014, and identified as current by the DON on 1/12/2016 at 3:05 p.m., indicated, "Purpose: A clean dressing technique is used to provide an appropriate environment conducive to wound healing. Policy: All dressings are performed by licensed personnel per physician's order using clean technique, unless another technique is specified by the physician...Procedure:...2. Remove soiled dressing and discard into designated waste receptacle. 3. Remove gloves, wash hands, and put on a pair of clean gloves. 4. Cleanse wound with solution as specified by physician. 5. Apply dressing as specified by the physician, touching only the outer part of the dressing. Remove gloves. Apply tape sparingly, if necessary...."</p> <p>3.1-18(a) 3.1-18(l)</p>			