STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/17/2014
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561	

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F000000	This visit was for a Recertification and State Licensure Survey. Survey Dates: December 11, 12, 15, 16, and 17, 2014 Facility Number: 000517 Provider Number: 155714 AIM Number: 100266770 Survey Team: Dorothy Watts, RN-TC Terri Walters, RN (12/11, 12/12, 12/15, 12/17, 2014) Amy Wininger, RN Sylvia Scales, RN Census Bed Type: SNF/NF: 23 Total: 23 Census Payor Type: Medicare: 3 Medicaid: 14 Other: 6 Total: 23 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December	F000000		

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

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

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	23, 2014 by Jodi Meyer, RN			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and	F000157	By submitting the enclosedmaterial we are	01/09/2015

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	record review, the facility failed to ensure the physician was notified timely in regards to critical lab results, in that, a critical high lab value had not been reported for 2 days and a low hemoglobin had not reported for 22 hours after the facility received the results for 1 of 3 residents reviewed for hospitalization. (Resident #24) Finding includes: On 12/15/14 at 9:16 A.M., Resident #24 was observed sitting up in a wheel chair in the facility lounge. The clinical record for Resident #24 was reviewed on 12/15/14 at 10:28 A.M., diagnoses include, but were not limited to, congestive heart failure, end stage renal failure, and anemia. The Physician's orders included, but were not limited to, Coumadin (blood thinner) 4 mg by mouth daily starting on 10/1/14. A PT/INR (anticoagulation study) dated 10/7/14, was reviewed. It included "INR [indicator of clotting time] 7.6 (CH) [critical high]" The reference range (normal values) were listed as 0.9-1.2. A nursing note dated 10/7/14 at 11:00 A.M., included "Paged Dr [name] to		not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any proceedings and submit theseresponses pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 1-9-2015 to the state findings ofthe Recertification and State Licensure Survey conducted on December 11, 12,15, 16 and 17, 2014. F - 157 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident # 24 is in stable condition and did not have anynegative outcome related to the delayed physician response to the abnormal labvalues. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit of all recent (within the past 30days) lab results were reviewed and there were no other untimely physicianresponses to any abnormal lab values. The	

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	report Critical [sic] PT/INR...awaiting return call." A nursing note dated 10/8/14 12:30 P.M., included, "Paged Dr [name] to report lab results awaiting return call." A nursing note dated 10/9/14 at 7:30 A.M., included "Paged Dr [doctor] [name] notified of lab results. Hold Coumadin til [sic] [until] 10/12/14 then repeat PT/INR. [sic] On 10/10/14[sic]. Give Vit [sic] [Vitamin] K [antidote for Coumadin toxicity] 5 mg 1 x only. Pharmacy notified..." A PT/INR dated 10/10/14 at 6:36 P.M., included "INR 7.3 (CH)" A nursing note dated 10/10/14 at 7:20 P.M., included "Dr. [name] notified N.O. [New order] give Vitamin K 10 mg IM [intramuscular] now..." A laboratory test which was time stamped as being received at 12/9/14 at 12:10 P.M., included "HEMOGLOBIN [protein in blood that carries oxygen] 7.0 L [low], reference range 11.8-14.8." A nurse's note dated 12/9/14 at 10:00 P.M., included "Paged Dr. [name] 2 x [two times] during this shift to report labs."		measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has beenprovided for all licensed nurses on the facility policy related to theProcedure For Physician Notification to ensure that the nurses areknowledgeable on this facility policy. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance Tool has been developed and implemented to monitor the timelyreporting and timely physician response to all abnormal lab values. This tool will be completed by the Director of Nursing and/orher designee weekly for four weeks, then monthly for three months andthen quarterly for three quarters. Theoutcome of this tool will be reviewed at the regularly scheduled QualityAssurance meeting to determine if any additional action is warranted.	

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	A nurse's note dated 12/10/14 at 10:20 A.M., included "Dr. [name] notified of CBC [complete blood count] sent to [local hospital] for 2 units of packed red blood cells..." During an interview with LPN #13 on 12/17/14 at 10:30 A.M., she indicated she would immediately call any critical lab results to the resident's physician. She indicated she had been the nurse when the labs were received on 10/7/14. She further indicated after attempting to contact the resident's doctor without success, she had held the resident's Coumadin (blood thinner) for safety. She indicated she was unaware of any other doctors she could notify if the resident's physician was unattainable. The Director of Nursing was interviewed on 12/17/14 at 10:14 A.M., she indicated the nurses or herself would call any critical labs to the physician. She indicated the facility would notify the resident's physician of any concerns and if they were unreachable the facility's medical director would be called. The DON further indicated Resident #24's physician who was also the facility's Medical Director, was called several times about both labs but was unattainable at that time. She indicated			

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	at that time, they do not currently have a backup physician available if the Medical Director was unreachable. On 12/17/14 at 11:50 A.M., an undated policy titled "PROCEDURE FOR PHYSICIAN NOTIFICATION" was provided by the Director of Nursing. It included, but was not limited to, the following: 1. Nurses identifying a change in a resident's condition will notify the physician by fax or phone. 3. If the physician notified has not called back timely (according to the urgency of the resident's need). Nurse is to recall the physician. If no answer then the alternate physician will be notified. 5. If unable to notify the medical director staff will call the hospital and talk with the emergency room physician. 3.1-5(a)(2)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure medications were administered as	F000282	F – 282 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the physician forthe resident	01/09/2015

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	ordered by the physician for Resident #18 and a follow up lab test (which was ordered by the physician after the wrong medications had been administered to Resident #18) was not completed for 1 of 1 residents reviewed for medication errors. (Resident #18) Findings include: On 12/15/14 at 9:35 A.M., Resident #18 was observed sleeping in her bed. Resident #18's clinical record was reviewed on 12/15/14 at 9:44 A.M. Resident #18 had been admitted to the facility on 9/27/14. Her current diagnoses included but were not limited to, peripheral vascular disease, diabetes mellitus, and chronic kidney disease stage 5. A nursing progress note for Resident #18 dated 11/30/14 at 11:50 A.M., indicated, "Res [resident] was given wrong medication after realizing she had she was told et [and] also told her MD would be notified; not to worry because there wasn't anything to harm her [sic]. Explained to her each medication et what it was for et affects. She was not upset or anxious. Said she was her own POA [power of attorney] so no family to notify."		identified as resident #18 was notified of the inability to drawthe Chem 8 on Tuesday 12-02-14 due to the resident being out of the facilityfor their normal dialysis appointment and did not give any additional orderssince the resident did not have any negative outcomes from receiving the wrongmedication. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* there have been no other medication errors in thefacility since the error that occurred on 11-30-14. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has beenprovided for all licensed nurses on the facility policy related to the SixRights of Medication Administration to ensure that the nurses are knowledgeableon the proper procedure for medication administration. *The corrective action taken to monitor to assure complianceis that* it is the facility's practicethat all medication errors are thoroughly investigated by nursingadministration in an attempt to determine the cause of the medication error andto provide additional education and/or disciplinary measures if warranted forany medication error. The outcome of allmedication errors will be reviewed at the facility regularly	

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	A nursing progress note dated 11/30/14 at 12:10 P.M., indicated, "Went to Res room et told her what Dr. [physician's name] said that one dose of these meds weren't enough to hurt her but would do a Chem 8 [lab test] on Tue [Tuesday] to ck [check] D/T [due to] she is a dialysis pt. [patient] She said fine..." A "PRELIMINARY INVESTIGATION REPORT" dated 11/30/14 was reviewed on 12/17/14 at 3:16 P.M. The report indicated Resident #18 had been given the wrong medication at 11:50 A.M. The report indicated, "Was going to prepare [Resident #18's name] meds [medications] when someone starting talking to me, [Resident #18's] meds had previously been in 2nd drawer but now [Resident #12's name] are. I got the meds out et popped meds out for [Resident #12's name}. But was thinking of [Resident #18's name]. So I went in there and gave them to [Resident #18's name]. I then went to pop out [Resident #12's name] meds and realized I had just done that. I immediately went back to [Resident #18's name] room and asked How many pills did you take [sic]. Actually after Res took her meds she asked what the blue pill was I said Id [sic] look and see. Its when I got [Resident #12's name] I saw her blue pill		scheduled QualityAssurance meeting to determine if any additional action is warranted.	

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	and though [sic] wait a minute and went to [Resident #18's name] room et told what happened asked How many pills she took then I told her what happened told her what she took what they're For the affects ect. told her I would notify the Dr..." On 12/17/14 at 3:16 P.M., the Director of Nursing [DON] was made aware the investigation report and the nursing progress note did not identify what medications of Resident #12's had been administered to Resident #18. She indicated she had written Resident #12's medications [11:00 A.M.] that were administered to Resident #18 on the back of the investigation report. The medications hand written on the back of the report were, dilantin (anticonvulsant) oxybutin (urinary antispasmodic), carafate (antiulcer), chlorcon (potassium supplement), tab-a-vite (vitamin) and vitamin D (supplement). The DON was made aware the documentation of the investigation report indicated LPN #5 had not checked the medications in regard to checking right medication, right resident, right time, and the other rights to check before administering medications. The DON agreed documentation was lacking that the rights of medication administration had been checked by LPN #5 before			

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	Resident #18 had been administered her 11:00 A.M., medications on 11/30/14. On 12/17/14 at 3:25 P.M., the DON provided a copy of Resident #12's physician's orders of November 2014. The DON indicated at that time the 11:00 A.M., medications of Resident #12's were the medications that had been administered to Resident #18. The orders included the following 11:00 A.M., medications, "...TAB-A-VITE 1 TABLET BY MOUTH EVERY DAY [SUPPLEMENT], VITAMIN D 1,000 UNITS 5 TABLETS [5000 I.U. BY MOUTH EVERY DAY [SUPPLEMENT], OXYBUTYNIN 5 MG TABLET 1 TABLET BY MOUTH 3 TIMES A DAY [URINARY FREQUENCY], DILANTIN 100 MG CAPSULE ONE CAPSULE BY MOUTH 3 TIMES A DAY [SEIZURES], KLOR CON M20 TABLET 1 TABLET BY MOUTH 3 TIMES A DAY [DO NOT CRUSH, MAY DISSOLVE IN H20) (SUPPLEMENT], and CARAFATE 1 GM [GRAM] TAKE 1 TABLET BY MOUTH BEFORE MEALS AND AT BEDTIME." On 12/17/14 at 3:22 P.M., the DON was made aware the clinical record lacked documentation of the chem 8 lab ordered			

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	for Resident # 18 on Tuesday (12/2/14) after the wrong medications had been administered on 11/30/14. She indicated she would contact the hospital to obtain a copy of the lab. On 12/17/14 at 3:48 P.M., the DON provided the following nurses notes Resident #18: 12/2/14 at 6:00 A.M., indicated, "Lab here unable to do chem 8 [lab test] already left for dialysis." 12/2/14 at 12:00 P.M., indicated, "Reported to Dr. [physician's name] unable to get Chem 8 this AM. No new orders." On 12/17/14 at 3:48 P.M., the DON explained the "no new orders" from the physician indicated the physician didn't want the Chem 8 lab drawn. On 12/17/14 at 3:55 P.M., the facility policy entitled "Medication and Administration Policy and Procedure" (undated) was reviewed. The policy included but was not limited to, "... g. Implement the 'Six Rights' of medication administration. Assess for: i. right patient ii. right medication iii. right dose iv. right route v. right time and frequency vi. right indication..."			

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	3.1-35(g)(2)			
F000309 SS=D	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 psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure care was provided to a resident receiving dialysis services, in that, the resident was not monitored for post-dialysis complications, the bruit/thrill was not checked every shift, and/or the graft/fistula site was not monitored for bleeding for 1 of 2 residents who met the criteria for review of dialysis services. (Resident #23) Findings include: During an observation on 12/11/14 at 11:13 A.M., Resident #23 was observed sitting in his wheelchair in the hall. The clinical record of Resident #23 was reviewed on 12/16/14 at 10:00 A.M. The record indicated Resident #23 was	F000309	F – 309 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident #23 now has the documentation to reflect the need fordialysis and is being monitored every shift for post dialysis complicationsincluding the monitoring of bruits/thrills, bleeding and for any signs andsymptoms of infection. In addition theresident's care plan has been up-dated to include post dialysis monitoring forcomplications. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit has been completed for allresidents currently receiving dialysis. All residents currently receiving dialysis are being monitored everyshift for complication of post dialysis, including the monitoring	01/09/2015

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	admitted on 7/1/14 and the diagnoses of Resident #23 included, but were not limited to, chronic kidney disease (stage 3-4), renal failure. The Admission MDS (Minimum Data Set) assessment dated 10/07/14 indicated Resident #23 experienced no cognitive impairment. The admission Physician's Order dated 7/1/14 lacked documentation that Resident #23 needed dialysis. The most recent Physician's Order Recap dated 12/1/14 lacked documentation that Resident #23 needed dialysis. The Treatment Administration Records from 11/01/14 through 12/16/14, provided by the DON on 12/16/14 at 2:30 P.M., lacked documentation the bruit or thrill had been checked every shift. A Care Plan for RENAL FAILURE/INSUFFICIENCY dated 09/26/14 indicated, "...Dialysis 3 times per week. Mon.(Monday) Wed. (Wednesday) Fri (Friday)." The Care Plan lacked any interventions to monitor for any complications from the hemodialysis, check for a bruit and thrill every shift and to check Resident #23's graft/fistula site for bleeding.		forbruits/thrills, needle site bleeding and for signs and symptoms of infection.All residents receiving dialysis have had their care plans up-dated to includethe interventions for monitoring for post dialysis complications. The facilityhas also obtained a written agreement/contract with all providers of dialysisservices that are currently serving any dialysis resident in the facility. The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has reviewed andup-dated their policy on bruits and thrills to include post dialysis monitoringfor bruits/thrills, bleeding at the needle insertion site and for signs andsymptoms of infection every shift. Amandatory in-service has been provided for all licensed nurses on the revisedpolicy and procedure related to post dialysis care. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance Tool has been developed and implemented to ensure that all residentsreceiving dialysis are being monitored every shift for complications related topost dialysis care. This tool will be completed by the Director of Nursing and/orher designee weekly for four weeks, then monthly for three months andthen quarterly for three quarters. Theoutcome of this tool will be reviewed at the regularly	

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	The Nursing notes from 12/1/14 through 12/16/14 lacked any documentation related to monitoring Resident #23 for complications from hemodialysis, the presence of bruit/thrill, and/or the monitoring of the graft/fistula site for bleeding. During an interview on 12/16/14 at 10:40 A.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate Resident #23 had been monitored for complications from hemodialysis, that the bruit/thrill had been checked every shift, or that the graft/fistula site had been monitored for bleeding. The DON further indicated, at that time, the facility did not have a contract with the Dialysis provider and/or a policy related to monitoring residents after dialysis treatment. An undated Policy and Procedure was provided by the DON on 12/16/14 at 2:00 P.M. for "BRUITS AND THRILLS. It stated, "...Procedure: 1. Check daily the fistula/graft site for any signs and symptoms of Infection...2...place stethoscope over the fistula/graft site. Listen to ensure good blood flow is present...3....place fingers over fistula/graft site to feel vibration of the blood flowing through the artery to the		scheduled QualityAssurance meeting to determine if any additional action is warranted.	

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	vein..." During an interview 12/16/14 at 3:31 P. M. the DON indicated Resident #23 had a previous history of complication with his fistula. At that time, the DON further indicated the admission Physician's Orders dated 7/1/14 lacked an order for dialysis and an order for monitoring the fistula every shift. A Medical Surgical Nursing 5th edition as provided by the DON on 12/17/14 at 3:00 P.M., page 1754, read as follows: "BEST PRACTICE for Caring for the client with an arteriovenous, fistula, Arteriovenous Graft, or Arteriovenous Shunt... Palpate for thrills and auscultate (listen) for bruits every 4 hours while the client is awake. Assess ...distal pulses and circulation...Check for bleeding at needle insertion site...Assess for ...infections..." The DON indicated, at that time, that the best practices outlined in the above referenced text would have been the basis for the care, monitoring and treatment of Resident #23. 3.1-37(a)			
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out			

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	activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure a resident who needed assistance was toileted, in that, a resident who experienced decreased episodes of incontinence while on a toileting program, did not receive assistance to prevent incontinence for 1 of 1 who met the criteria for review of urinary incontinence. (Resident #21) Findings include: During a random observation on 12/11/14 at 10:52 A.M., Resident #21 was noted to have a strong urine odor. A dark wet stain was observed, at that time, on the front of the Resident #21's pants. During a confidential interview on 12/11/2014 at 1:54 P.M., the FR (Family Representative) #1 indicated the resident was frequently incontinent of urine to the point of saturation and did not believe their family member was receiving the necessary toileting assistance from staff. The clinical record of Resident #21 was reviewed on 12/12/2014 at 1:41 P.M. The record indicated the diagnoses of	F000312	F – 312 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident #21 has had a new bowel and bladder assessmentcompleted. Based on the results of thenew assessment the resident has been placed on a scheduled toiletingprogram. The resident's care plan hasbeen updated to reflect his current bowel and bladder needs along with theidentified appropriate interventions for this resident. The resident's care plan has also beenup-dated to reflect the resident's currently bowel/bladder needs andinterventions. The CNA assignment sheethas been also up-dated to reflect the resident's current bowel/bladder needs. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit has been completed on all residentswho are incontinent of bowel and bladder. Each resident's plan of care has been reviewed and up-dated as indicatedto meet the residents' bowel and bladder needs. The CNA assignment sheets have also been up-dated to reflect theresidents' current bowel and bladder needs. The measures	01/09/2015

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	Resident #21 included, but was not limited to, dementia, weakness, and/or urinary frequency. The most recent annual MDS (Minimum Data Set) assessment dated 09/30/14 indicated Resident #21 experienced severe cognitive impairment, was on a toileting program, experienced decreased wetness with a toileting program, experienced urinary incontinence daily, and required the limited assistance of one staff member for toileting. A Bowel and Bladder Progress Note dated 09/30/14 indicated, "...Dx [diagnosis] with urinary urgency, dribbles urine without control wears incont. briefs...Supervision needed to make sure changes...wet clothes..." A Care Plan for "...Incontinence...due to dribbles urine before making it to the bathroom..." dated 09/2014 included the following interventions: "...Provide urinal/bedpan/bedside commode, Provide pericare after each incontinent episode, Keep call light within reach, and remind resident to call for assistance, monitor for signs and symptoms of urinary tract infection. Provide loose fitting, easy to remove clothing, meds [medicine] as ordered..."		that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has beenprovided for all nursing staff on the facility's policy and procedures relatedto meeting the needs of each resident related to their individualized bowel andbladder needs. The staff was re-educatedon ensuring that each resident receives the proper assistance needed fortoileting in an attempt to prevent episodes of incontinence. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance Tool has been developed and implemented to monitor residents whoexperience incontinency, to ensure they are receiving the amount of assistancewith toileting that they need in an attempt to prevent episodes ofincontinence. This tool will be completed by the Director of Nursing and/or herdesignee weekly for four weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of this tool will be reviewed at the regularly scheduled QualityAssurance meeting to determine if any additional action is warranted.	

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	The plan lacked any intervention related to a toileting program. A Nursing note dated 12/11/14 at 2200 indicated, "... Res. is alert to self...Incont [Incontinent] of urine wears briefs or adult diapers...will change self, sometimes needs assist..." A Nursing note dated 12/13/14 at 1000 indicated, "...toilets self et has incont episodes..." A Nursing note dated 12/14/14 at 2130 indicated, "Cont [continent] of B/B [bowel and bladder]..." A Nursing note dated 12/16/14 at 0800 indicated, "...toilets self does have incont episodes of B +B [bowel and bladder]..." A December 2014 Resident Care Flow Record indicated Resident #21 experienced incontinence daily and included a handwritten notation of, "...FYI [for your information] Check resident-toilet, check and change every 2 [two] hrs [hours]..." During an interview on 12/16/14 at 11:30 A.M., CNA #1 indicated she was new staff member at the facility, was the CNA for Resident #21, but, did not know the toileting habits of Resident #21.			

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	During an interview on 12/16/14 at 11:35 A.M., CNA #2 indicated Resident #21 was checked for incontinence every two hours, but was not toileted unless the need was expressed. CNA #2 further indicated, at that time, Resident #21 experienced frequent episodes of incontinence. The CNA Assignment Sheet provided by CNA #2 on 12/16/14 at 10:40 A.M. indicated, "...toileting prog [program] Check every 2 hrs for incont. dribbles..." During an interview on 12/16/14 at 12:00 P.M., the DON (Director of Nursing) indicated Resident #21 should have been on scheduled toileting to prevent episodes of incontinence. 3.1-38(a)(3)			
F000323 SS=G	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 observation, interview, and record review, the facility failed to ensure effective safety interventions and/or	F000323	F – 323 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident # 14	01/09/2015

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	supervision were provided, in that, effective interventions were not implemented to prevent further falls for a Resident identified as having cognitive impairment and assessed to be at risk for falls for 1 of 3 residents that were reviewed for falls. This deficient practice resulted in Resident #14 experiencing 6 falls and experiencing 3 fractures. (Resident #14) Findings include: On 12/15/14 at 10:32 A.M., Resident #14 was observed on the bed in her room. The clinical record of Resident #14 was reviewed on 12/16/14 at 2:00 P.M. The record indicated Resident #14 was admitted on 3/21/14 with diagnoses including, but not limited to, psychosis and dementia with behaviors. The Quarterly MDS (Minimum Data Set) assessment dated 09/31/14 indicated Resident #14 experienced severe cognitive impairment, required the assistance of 2 staff with transfers, and was always incontinent and required the assistance of 2 staff for toileting. A Care Plan for falls dated 08/29/14 through 12/8/14 read as follows: "...Interventions...10/26/14 Fall		has not had a fall since 12-07-14. The resident has been reassessed by theInterdisciplinary Team. Her previousfalls have once again been reviewed. Hercare plan has been up-dated to ensure that all appropriate safety interventionshave been put in place in an attempt to prevent future falls includingincreased supervision. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit has been completed on all residentsat high fall risk to ensure that all appropriate safety interventions are inplace and are effective. The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has reviewed its fallinvestigation report form to ensure it includes assesses the interventions foreffectiveness. A mandatory in-servicehas been provided for all licensed nurses on the completion of the fallinvestigation report form to ensure their knowledge on the importance ofaccurate completion of this document in an effort to provide the most effectivefall safety interventions. *The corrective action taken to monitor to assurecompliance is that* the facility hasadopted the practice that all fall investigation report forms are to bereviewed by nursing administration to ensure	

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	Intervention to take to BR [bathroom] before putting in bed..." The Fall Risk Evaluation dated 6/10/14, provided by the Director of Nursing on 12/17/14, indicated Resident #14 was at risk for falls. The Incident Reports, provided by the Director of Nursing on 12/17/14 at 3:15 P.M., indicated Resident #14 fell on the following days: Fall # 1 occurred on 9/04/14 at 1445 (2:45 P.M.). "Resident #14 slid from the bed to the floor... Alarm batteries were replaced..." Fall # 2 occurred on 9/15/14 at 2245 (10:45 P.M.). "Resident's alarm sounded but she was on the floor when CNA and I arrived. Bed alarm was all the way on edge of bed..." Fall # 3 occurred on 10/26/14 at 11:30 A.M. "Resident was in bed...staff heard pressure pad alarm...resident was sitting on mat beside bed...said she had to go to BR [bathroom]...Staff took resident to the BR and she voided and was put back up in chair...Interventions take resident to BR before putting to bed." Fall # 4 occurred on 11/21/14 at 1310		that based on the informationprovided that effective safety interventions have been implemented in anattempt to prevent future falls. The Director of Nursing and/orher designee are to sign the investigation report upon review tovalidate that appropriate and effective interventions are in place. The Director of Nursing is responsible formaintaining these records for further Quality Assurance Review as warranted.	

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	(1:10 P.M.). "Res [Resident] found on mat beside bed with head facing floor. She had tried to get up without assist [assistance]...alarm was sounding...Has bed bolster et [and] a wedge which had come loose when she crawled over it..." A Nurse's Note dated 11/21/14 at 1420 (2:20 P.M.) read as follows: "Called Dr. [Doctor] et [and] reported NO [new orders] received to send to ER [Emergency Room] for CT [Cat Scan]...forehead Eval hip to see if she needs x-ray..." Fall # 5 occurred on 11/22/14 at 1745 (5:45 P.M.). "Resident was in another residents room alarm was sounding found her sitting in front of her W/C [wheelchair] states she was trying to get in bed..." Fall # 6 A Nurse's note dated 12/07/14 at 1820 (6:20 P.M.) read as follows: "Resident was in the hallway in her w/c alarm was sounding found resident laying on the floor on her L [left] side in front of her wheelchair...cut...bridge of nose...nose swollen and bleeding out R [right] nostril. upper lip swollen...eyes closed and would not respond to me for 30-45 seconds...called the ambulance..."			

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	The ED (Emergency Department) Report dated 12/7/14 was provided by the Director of Nursing and read as follows: "...Chief complaint: Fall...History of falls...Closed fracture of malar and/or maxillary bones; Closed fracture of nasal bones; Closed fracture of rib..." During an interview on 12/15/14 at 11:15 A.M., CNA #1 indicated Resident #14 recently fell out of her wheelchair and experienced a fractured rib and nose. CNA #1 said, "when Resident #14 gets in her wheelchair she takes off fast." On 12/17/14 at 3:57 P.M., the Health Care Administrator provided a copy of the Policy and Procedure "FALL RISK/FALL POLICY AND PROCEDURE" and it read as follows: "...5. Residents who have fallen will be reviewed by the Fall Committee to evaluate the effectiveness of the interventions..." During an interview on 12/17/14 at 3:15 P.M., the MDS nurse indicated Resident #14 should have been toileted before lying down in bed, but she failed to add toileting before bed to the care plan. During an interview with the DON on 12/17/14 at 4:00 P.M., the DON indicated more supervision was needed			

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	to prevent the falls and fractures Resident #14 experienced. During an interview on 12/17/14 at 4:15 P.M., the Health Care Administrator indicated more supervision was needed to prevent the problems Resident #14 with her falls. 3.1-45(a)(2)			
F000371 SS=F	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 was prepared in a sanitary manner, in that, dietary staff did not perform proper hand hygiene and/or the hand washing facilities did not contain a waste receptacle that was easily accessible. This had the potential to affect 23 of 23 residents residing in the facility. Findings include: 1. During initial tour of the kitchen on	F000371	F – 371 The corrective action takenfor those residents found to have been affected by the deficient practice isthat no specificresident was identified however all residents have the potential to be effectedby this deficient practice. The dietarystaff is now preparing food in a sanitary manner. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* all resident have the potential to be effected by thisdeficient practice. The dietary staffhave been	01/09/2015

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	12/11/14 at 10:10 A.M., with the Dietary Manager, the hand washing facility was observed, there was no waste receptacles located near the sink. The Dietary Manager indicated the staff used the trash can across the room. A large black trash can with a dome lid and swinging door was observed across the kitchen. 2. During observation of meal preparation on 12/16/14 at 11:00 A.M., Dietary Cook #1 was observed while preparing the residents puree meals. She indicated she needed to gather the supplies, after donning gloves she walked to the dishwasher and grasped the handle with her right hand and opened it. Dietary Cook #1 removed the food processor container and placed it on the machines base. She then was observed while wearing the same gloves to open foil covered container and remove 5 corn muffins with her right gloved hand and place them in a pan. The Dietary Manager was made aware of the observation and indicated hand hygiene should be performed in-between touching a dirty surface (handle of the dishwasher) and handling food. At 11:15 A.M., the Dietary Manager was observed to instruct Dietary Cook #1 to wash her hands and get new muffins. Dietary Cook #1 was observed performing hand hygiene for 11 seconds		assessed and educated and is now preparing food in a sanitary manner. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has beenprovided for all dietary staff on the facility's policy and procedure on handwashing and proper glove usage in the preparation and serving of food. In addition a waste receptacle is now easilyaccessible to the dietary staff at the hand washing station. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance Tool has been developed and implemented to monitor the proper handwashing and glove usage in the preparation and serving of food. This tool will be completed by the Food Service Manager and/or herdesignee weekly for four weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of this tool will be reviewed at the regularly scheduled QualityAssurance meeting to determine if additional action is warranted.	

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	at that time. Dietary Cook #1 was observed to use hands to turn off the water. She used a paper towel to dry them and walked across the room to the trash can and using her right hand to open the swinging door, she threw away the paper. At that time Dietary Cook #1 indicated she would have to wash her hands again since she touched the trash can lid. 3. On 12/16/14 at 11:45 A.M., Dietary Cook #1 was observed to perform hand washing for 15 second, she then donned gloves and set up for service of noon meal. She was observed to use her gloved right hand to adjust her glasses. She was observed while wearing the same gloves to start and serve lunch. She indicated she needed to get some bowls for the soup. She was observed while wearing gloves to open a cabinet below the counter. Dietary Cook #1 was observed to use her gloved right hand to brace herself on the floor as she bent down to retrieve the bowls. She was then observed to return to service of meal using the same pair of gloves. The Dietary Manager instructed Dietary Cook #1 to perform hand hygiene. 4. A policy dated December 2001 and titled "Handwashing/Hand Hygiene" was provided on 12/16/14 at 2:08 P.M., by the Dietary Manager.			

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	It included: "1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene. 3. Hand hygiene products and supplies (sink, soup, towels, alcohol-based hand rub, ect.) shall be readily accessible and convenient for staff to use to encourage compliance with hand hygiene policies. 5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions, before and after eating or handling food (hand washing with soap and water) and after handling soiled equipment or utensils. 8. The use of gloves does not replace hand washing." 3.1-21(i)(2) 3.1-21(i)(3)			
F000385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on observation, interview and	F000385	F – 385 The corrective action	01/09/2015

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	record review, the facility failed to ensure a resident's care was supervised by a physician, in that, a resident's primary physician was not reachable for long periods of time when the resident's condition needed intervention and no back up or alternate physician had been notified for 1 of 3 residents reviewed for hospitalization. (Resident #24) Findings include: On 12/15/14 at 9:16 A.M., Resident #24 was observed sitting up in a wheel chair in the facility lounge. The clinical record for Resident #24 was reviewed on 12/15/14 at 10:28 A.M., diagnoses include, but were not limited to, congestive heart failure, end stage renal failure, and anemia. The Physician's orders included, but were not limited to, Coumadin (blood thinner) 4 mg by mouth daily starting on 10/1/14. A PT/INR (anticoagulation study) dated 10/7/14, was reviewed. It included "INR [indicator of clotting time] 7.6(CH) [critical high] " The reference range (normal values) were listed as 0.9-1.2. A nursing note dated 10/7/14 at 11:00		takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident # 24 is in stable condition and did not have anynegative outcome related to the delayed physician response to the abnormal labvalues. The resident's care is currentlybeing supervised by a physician. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit of all recent (within the past 30days) lab results were reviewed and there were no other untimely physician responsesto any abnormal lab values and to ensure that each residents' care issupervised by a physician. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has beenprovided for all licensed nurses on the facility policy related to theProcedure For Physician Notification to ensure that the nurses areknowledgeable on this facility policy and that all resident care is beingsupervised by a physician. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance Tool has been developed and implemented to monitor the timelyreporting and timely physician response to all abnormal lab values and that allresident care is being	

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	A.M., included "Paged Dr [name] to report Critical [sic] PT/INR...awaiting return call." A nursing note dated 10/8/14 12:30 P.M., included, "Paged Dr [name] to report lab results awaiting return call." A nursing note dated 10/9/14 at 7:30 A.M., included "Paged Dr [doctor] [name] notified of lab results. Hold Coumadin til [sic] [until] 10/12/14 then repeat PT/INR. [sic] On 10/10/14[sic]. Give Vit [sic] [Vitamin] K [antidote for Coumadin toxicity] 5 mg 1 x only. Pharmacy notified..." A PT/INR dated 10/10/14 at 6:36 P.M., included "INR 7.3 (CH)" A nursing note dated 10/10/14 at 7:20 P.M., included "Dr. [name] notified N.O. [New order] give Vitamin K 10 mg IM [intramuscular] now..." A laboratory test was time stamped as being received at 12/9/14 at 12:10 P.M., included "HEMOGLOBIN [protein in blood that carries oxygen] 7.0 L [low], reference range 11.8-14.8." A nurse's note dated 12/9/14 at 10:00 P.M., included "Paged Dr. [name] 2 x [two times] during this shift to report		supervised by a physician. This tool will be completed by the Director of Nursing and/or herdesignee weekly for four weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of this tool will be reviewed at the regularly scheduled QualityAssurance meeting to determine if any additional action is warranted.	

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	labs." "A nurse's note dated 12/10/14 at 10:20 A.M., included "Dr. [name] notified of CBC [complete blood count] sent to [local hospital] for 2 units of packed red blood cells..." During an interview with LPN #13 on 12/17/14 at 10:30 A.M., she indicated she would immediately call any critical lab results to the resident's physician. She indicated she had been the nurse when the labs were received on 10/7/14. She further indicated after attempting to contact the resident's doctor without success, she held the resident's Coumadin (blood thinner) for safety. She indicated she was unaware of any other doctors she could notify if the resident's physician was unattainable. The Director of Nursing was interviewed on 12/17/14 at 10:14 A.M., she indicated the nurses or herself would call any critical labs to the physician. She indicated the facility would notify the resident's physician of any concerns and if they were unreachable the facility's medical director would be called. The DON further indicated Resident #24's physician who was also the facility's Medical Director, was called several times about both labs but unattainable at			

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	that time. She indicated at that time, they do not currently have a backup physician available if the Medical Director was unreachable. On 12/17/14 at 11:50 A.M., an undated policy titled "PROCEDURE FOR PHYSICIAN NOTIFICATION" was provided by the Director of Nursing. It included, but was not limited to, the following: 1. Nurses identifying a change in a resident's condition will notify the physician by fax or phone. 3. If the physician notified has not called back timely (according to the urgency of the resident's need). Nurse is to recall the physician. If no answer then the alternate physician will be notified. 5. If unable to notify the medical director staff will call the hospital and talk with the emergency room physician. 3.1-5(a)(2)			
F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program			

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	The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on observation, interview, and record review, the facility failed to follow its policy and procedure for hand washing between contact with residents, in that, the handwasing was not performed for at least 20 seconds, and/or handwashing was not performed prior to the initiation of a dressing change during 2 of 2 medication administrations and 1 dressing change.	F000441	F – 441 A1. The corrective action taken for those residents foundto have been affected by the deficient practice is that the resident identified as resident# 5 is receiving their medications and eye drops by the nurse identified as LPN#13 who has washed her hands for at least 20 seconds in accordance withfacility policy. A2. The corrective action taken for those residents foundto have been affected by the deficient	01/09/2015

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	(Resident #5, Resident #12, Resident #26, Resident #9) B. Based on interview and record review, the facility failed to ensure employees were screened and/or evaluated for communicable disease upon employment for 9 of 10 employees reviewed. (DON [Director of Nursing], LPN #1, LPN #2, CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8) Findings include: A. During an observation of the medication pass on 12/15/14 at 10:30 A.M. the following hand washing by LPN #13 was observed: A. 1. At 10:34 A.M., LPN #13 completed administering medication and eye drops to Resident #5. LPN #13 then entered the Resident's bathroom and washed her hands in the sink for 7 seconds. A. 2. At 10:36 A.M., LPN #13 prepared Resident #24's medication and administered the medication to Resident #24. LPN #13 then proceeded to the Resident #24's bathroom and washed her hands for 8 seconds. A. 3. At 11:08 A.M., LPN #13		practice is that the resident identified as resident# 24 is receiving their medications by the nurse identified as LPN #13 who haswashed her hands for at least 20 seconds in accordance with facility policy. A3. The corrective action taken for those residents foundto have been affected by the deficient practice is that the resident identified as resident#26 is receiving their eye drops by the nurse identified as LPN #13 who haswashed her hands for at least 20 seconds in accordance with facility policy. A4. The corrective action taken for those residents foundto have been affected by the deficient practice is that the resident identified as resident#14 is receiving their insulin by the nurse identified as LPN #13 who has washedher hands for at least 20 seconds in accordance with facility policy and beforereturning the insulin pen to the med cart. A5. The corrective action taken for those residents foundto have been affected by the deficient practice is that the resident identified as resident#35 is now receiving their eye drops by the nurse identified as LPN #13 who haswashed her hands for at least 20 seconds in accordance with facility policy. A6. The corrective action taken for those residents foundto have been affected by the deficient practice is that the resident identified as resident#26 is now receiving their skin treatment by the nurse identified	

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	administered eye drops to Resident #26 and proceeded to the Resident's bathroom and washed her hands for 8 seconds. A. 4. At 11:51 A.M., LPN #13 administered an injection of insulin to Resident #9, then proceeded to the medication cart (without washing her hands) where she returned the insulin pen to its packaging. During an observation of the medication pass on 12/17/14 at 10:30 A.M. the following hand washing by LPN #13 was observed: A 5. At 10:10 A.M., LPN #13 entered Resident #35's bathroom and washed her hands in the sink for 12 seconds and then proceeded to administer Resident 35's eye drops. During an interview on 12/17/14 at 10:13 A.M., LPN #13 indicated the facility's policy was to wash hands for 3 to 5 seconds. During an interview on 12/17/14 at 10:25 A.M., the Director of Nursing indicated hands must be washed for 20 seconds. The facility's policy for Hand washing/Hand Hygiene was made available by the Dietary Manager and		as the MDSassessment nurse who has washed her hands for at least 20 seconds in accordancewith facility policy prior to downing gloves to complete the dressing change. B1. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The DONhas now been reassessed by a physician and determined to be free ofcommunicable disease. This informationis documented in the employee's health file. B2. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as LPN #1 has now been reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. B3. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as LPN #2 has now been reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. B4. The corrective action taken for those	

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	reviewed on 12/16/14 at 2:08 P.M. The policy read as follows:..."This facility considers hand hygiene the primary means to prevent the spread of infections...5. Employees must wash their hands for at least 20 seconds..." A. 6. On 12/12/14 at 9:20 A.M., the MDS (Minimum Data Set) assessment nurse indicated she was going to administer the treatment to Resident #26's right hip skin area. She entered the resident's room with supplies of hydrogel silver ointment and a foam dressing. She applied gloves without handwashing. She assisted Resident #26 who was in bed to adjust his clothing and position in bed to expose his right hip area for the treatment. After viewing the right hip skin area the MDS nurse did not apply the treatment but determined the physician needed to be contacted regarding a change of treatment. She removed her gloves and stepped into the resident's bathroom and proceeded to wash her hands for a total of 12 seconds. On 12/17/14 at 12:45 P.M., the MDS nurse was interviewed regarding handwashing in regard to Resident #26's treatment on 12/12/14. She was made aware she had not washed her hands before applying gloves to do a skin treatment and after gloves were removed hand washing had been timed at 12		residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as CNA #3 has now been reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. B5. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as CNA #4 has now been reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. B6. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as CNA #5 has now been reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. B7. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as CNA #6 has now been	

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	seconds. She indicated she should have washed her hands before applying gloves to do a treatment. She indicated handwashing should be performed longer than 12 seconds not sure of the exact time needed but indicated 2 minutes. B. The Employee Files were reviewed on 12/16/14 at 1:00 P.M., and the following was noted: B. 1. DON: The Employee Health Examination completed on 06/30/14 lacked any documentation the employee was free of communicable disease. B. 2. LPN #1: The Employee Health Examination completed on 10/06/14 lacked any documentation the employee was free of communicable disease. B. 3. LPN #2: The Employee Health Examination completed on 10/30/14 lacked any documentation the employee was free of communicable disease. B. 4. CNA #3: The Employee Health Examination completed on 06/05/14 lacked any documentation the employee was free of communicable disease. B. 5. CNA #4: The Employee Health Examination completed on 10/16/14 lacked any documentation the employee		reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. B8. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as CNA #7 has now been reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. B9. The corrective action taken for those residents foundto have been affected by the deficient practice is that no specific residents wereidentified during the survey. The staffmember identified as CNA #8 has now been reassessed by a physician anddetermined to be free of communicable disease. This information is documented in the employee's health file. A. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* potentiallyall residents could be effected by the deficient practice of the nurseidentified as LPN #13 and the nurse identified as the MDS assessmentnurse. Each nurse has been provided withone-on-one in-service on the facility hand washing policy and procedure. They have also been	

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	was free of communicable disease. B. 6. CNA #5: The Employee Health Examination completed on 10/24/14 lacked any documentation the employee was free of communicable disease. B. 7. CNA #6: The Employee Health Examination completed on 10/22/14 lacked any documentation the employee was free of communicable disease. B. 8. CNA #7: The Employee Health Examination completed on 11/25/14 lacked any documentation the employee was free of communicable disease. B. 9. CNA #8: The Employee Health Examination completed on 11/25/14 lacked any documentation the employee was free of communicable disease. A policy and procedure from the Employee Handbook provided by the BOM (Business Office Manager) on 12/17/14 at 10:06 A.M. indicated, "...13.1.1 Medical Examination...The employee must be deemed free of any communicable disease..." During an interview on 12/17/14 10:30 A.M., the BOM indicated the Employee Health Examination would be updated to include the screening for communicable		instructed on proper handwashing related to glove usage. B. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* potentiallyall residents could be affected by the deficient practice. A house wide audit of all employee files wascompleted to ensure that all employees have documentation to ensure that theyhave been screened and/or evaluated for communicable disease. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has beenprovided for all nursing staff on the facility policy and procedure as itrelates to hand washing and glove usage. In addition the facility has reviewed and revised their employeephysical form to include screening and/or evaluation of communicable disease,which must be completed by the physician prior to employment. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance Tool has been developed and implemented to monitor proper handwashing and glove usage in accordance with facility policy. The tool also include the monitoring ofemployee physicals to ensure there is documentation to support that theemployee has been screened and/or evaluated for communicable disease prior	

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	disease. 3.1-18(l) 3.1-18(b)		toemployment. This tool will be completedby the Director of Nursingand/or her designee andBOM or DESIGNEE weekly for four weeks, then monthly for three months andthen quarterly for three quarters. Theoutcome of this tool will be reviewed at the regularly scheduled QualityAssurance meeting to determine if any additional action is warranted.	
F000500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. Based on interview, and record review, the facility failed to obtain a written agreement between the renal dialysis provider and the facility which outlined services that would be provided for residents by the facility and/or the	F000500	F – 500 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident #23 is now receiving dialysis care and services inaccordance with the dialysis provider agreement. *The*	01/09/2015

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	dialysis service-provider, and which designated responsibilities that would be assumed by the dialysis service-provider and/or the facility. (Resident #23) Findings include: During an observation on 12/11/14 at 11:13 A.M., Resident #23 was observed sitting in his wheelchair in the hall. The clinical record of Resident #23 was reviewed on 12/16/14 at 10:00 A.M. The record indicated Resident #23 was admitted on 7/1/14 and the diagnoses of Resident #23 included, but were not limited to, chronic kidney disease (stage 3-4), renal failure. The Admission MDS (Minimum Data Set) assessment dated 7/01/14 indicated Resident #23 was receiving dialysis treatments. The Care Plan for RENAL FAILURE/INSUFFICIENCY dated 09/26/14 read as follows: "...Dialysis 3 times per week. Mon. (Monday) Wed. (Wednesday) Fri (Friday)..." During an interview on 12/16/14 at 10:40 A.M., the DON (Director of Nursing) indicated the facility did not have a contract/agreement with the dialysis		*corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* the facility has now obtained an agreement/contractwith any dialysis provider that is providing services for any residentcurrently residing in the facility that is receiving dialysis treatments. The residents are receiving appropriate careand services in accordance with their dialysis providers of services and thefacility's agreement/contract. The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has adopted thepractice that prior to admitting a resident who is in need of dialysis servicesthat the facility will ensure that an agreement/contract is in place with thatresidents' dialysis provider and the facility. *The corrective action taken to monitor to assurecompliance is that* the Administratorwill conduct an annual review of the facility agreement/contract binder toensure that a current agreement/contract is in place with each provider ofdialysis services that is currently providing services to the resident of thefacility. ADM or DESIGNEE	

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NAME OF PROVIDER OR SUPPLIER OAK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561	

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	provider and was unaware of the services to be provided by the renal dialysis provider. The DON further indicated Resident #23 should have been monitored for post-dialysis complications, the bruit/thrill should have been checked every shift, and the fistula site should have been monitored for bleeding. During an interview on 12/17/14 at 2:30 P.M., the Health Care Administrator indicated the facility did not have a written agreement between the facility and the renal dialysis provider, but would obtain one right away. 3.1-13(m)(1) 3.1-13(m)(2)			