

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 16, 17, 18, 19, & 22, 2016.</p> <p>Facility number: 000572 Provider number: 155535 AIM number: 100267710</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 9 Medicaid: 42 Other: 7 Total: 58</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on February 26, 2016 by 17934.</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. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
F 0280	483.20(d)(3), 483.10(k)(2)			

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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SS=D Bldg. 00	<p>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to updated the plan of care related to resident preferences on bathing for 1 of 14 residents reviewed for care plans. (Resident #29)</p> <p>Findings include:</p> <p>During an interview on 02/19/2016 at 9:50 A.M., CNA #1 indicated Resident #29 would not go into the shower room for the first two months of her stay. The CNA indicated the resident would say she was too cold, her feet hurt, or a number of other reasons she did not want to enter the shower room. CNA #1 indicated if a resident refused it was</p>	F 0280	<p>F280 Requires the facility to update the plan of care related to resident preferences on bathing.</p> <p>1. Resident #29 was interviewed regarding her preference for bathing and care plan updated.</p> <p>2. All residents have the potential to be affected. All resident's bathing preference care plan was reviewed. No concerns were noted. See below for corrective measures. 3. The preference care plan procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure. 4. The DON or her designee will review 3 bathing</p>	02/26/2016			

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	<p>marked on the bathing form and if it was a consistent issue a form was filled out and turned in to the nurse. The CNA further indicated she thought forms had been filled out for Resident #29 refusing showers.</p> <p>During interviews on 02/19/2016 at 10:01 A.M. and 11:16 A.M., the Administrator indicated there were no concern or behavior forms for Resident #29 that indicated the resident was refusing her showers. The Administrator further indicated Resident #29's preference care plan was incorrect and should have reflected the resident's preference of bed baths.</p> <p>During an interview on 02/19/2016 at 11:32 A.M., the SSD (Social Services Director) indicated it was her responsibility to complete the preference care plan. She further indicated she had not received any concern forms and was unaware of the resident's refusal of showers. The SSD further indicated, if she had received concern forms, she would normally talk to the resident about their preference and adjust the care plan accordingly.</p> <p>Resident #29's clinical record was reviewed on 02/18/2016 at 9:58 A.M. The "Daily Preferences" care plan, dated</p>		<p>preference care plans and ensure that the resident's preference regarding bathing is being provided. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.</p> <p>5. The above corrective measures will be completed on or before February 26, 2016</p>	

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F 0371 SS=E Bldg. 00	<p>12/09/2015, indicated it was very important for the resident to receive a shower and that the resident should be bathed according to her preference.</p> <p>The "Resident Care Record" sheets for Resident #29 indicated the resident did not receive a shower between 11/09/2015 and 02/17/2016. The care records indicated the resident refused showers on 11/12/2015, 01/04/2016, and 01/14/2016.</p> <p>The CNA Assignment sheets, updated 02/04/2016, were provided by the DON (Director of Nursing) on 02/19/2016 at 12:32 A.M. The assignment sheet indicated Resident #29 was to receive showers on Monday and Thursday.</p> <p>3.1-35(d)(2)(B)</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 serve and transport food and drinks in a sanitary manner related to handwashing</p>	F 0371	F371 Requires the facility to serve and transport food and drinks in a sanitary manner related to handwashing and uncovered drinks. 1. Staff was	02/26/2016

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	<p>and uncovered drinks. This had the potential to affect 58 of 58 residents receiving food and drinks from the kitchen.</p> <p>Findings include:</p> <p>1. An observation of the Main Dining Room was conducted on 02/16/2016 at 12:15 P.M. Staff #21 washed hands for three seconds, went to room 210, knocked on the door, went on to room 207, did not touch residents, went down the 100 hall into room 116, walked into the dining room to the window into the kitchen, carried a roll of plastic wrap to the medication carts, and covered cups of applesauce with plastic wrap on all four medication carts in the building. Staff #21 returned the plastic wrap to the kitchen window, washed hands for 13 seconds, rolled a chair into the assisted dining room, and assisted Resident #23 with dining.</p> <p>Staff #7 washed hands for 10 seconds, not rubbing the backs of hands or between fingers, then walked over to Resident #60, touched his shoulder, went to the window into the kitchen, picked up a tray, and delivered the tray to Resident #41.</p> <p>During an observation of the assisted</p>		<p>immediately educated on the policy of handwashing and covering drinks with lids when transporting beverages in the hall. 2. All residents have the potential to be affected. The DON educated nursing staff on handwashing and the Dietary Manager educated dietary staff on covering beverages during transport in the hall. See below for corrective measures. 3. The Handwashing/Hand Hygeine and Room Service policy procedures were reviewed with no changes made. (See attachment C and D) The staff was inserviced on the above procedures. 4. The DON or her designee will observe 2 staff members washing their hands to ensure the staff is following proper handwashing techniques per policy. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to until 100% compliance is obtained and maintained. (See attachment B) The Dietary Manager will observe 1 meal service to ensure all beverages are covered with lids when leaving the kitchen. The Dietary Manager or her designee will utilize the dietary monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter</p>	

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	<p>dining room on 02/16/2016 at 12:24 P.M., a meal cart was brought to the dining room and left outside the dining room door in the hallway. Three of the four trays on the meal cart contained assistive drinking cups, three cups on each tray, that were left uncovered.</p> <p>2. An observation of the Main Dining Room was conducted on 02/22/2016 at 12:15 P.M. Staff #5 applied a clothing protector to Resident #48, moved the resident's wheelchair, touching both handles, moved two coffee cups from a tray on the second shelf to the top of the drink cart, touched her own hair putting on a hair net, took off the hair net, swiped her hand over her hair, filled two cups with tea and served them to Resident #50. Staff #5 then washed hands for 12 seconds, shut the water off with bare hands, dropped paper towels on the floor, picked them up, threw them away, and left the dining room.</p> <p>Staff #7 washed hands for seven seconds, filled two cups with ice and punch, then served them to Residents #57 and #68. Staff #7 then filled two cups with ice and tea then served them to Resident #16.</p> <p>Staff #7 washed hands for 14 seconds, served a tray to Resident #52, then used hand sanitizer.</p>		<p>to until 100% compliance is obtained and maintained. (See attachment E) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before February 26, 2016.</p>	

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	<p>Staff #7 washed hands for 12 seconds, served a tray to Resident #16, then used hand sanitizer.</p> <p>Staff #21 washed hands, backs and palms only, the entire process from beginning to end lasting 26 seconds, moved chairs, washed hands again, just washing the backs and palms, the entire process took 19 seconds.</p> <p>During an observation on 02/22/2016 at 12:27 P.M., a meal cart was left outside the assisted dining room in the hallway. Three of the four trays on the meal cart contained assistive drinking cups, three cups on each tray, that were left uncovered.</p> <p>During an interview on 02/19/2016 at 12:44 P.M., LPN #4 indicated hands were supposed to be washed for 20 seconds. The LPN further indicated hands were supposed to be washed when you entered or exited a room and after you removed gloves.</p> <p>During an interview on 02/19/2016 at 12:11 A.M., CNA #6 indicated hands were supposed to be washed for 30 to 60 seconds.</p> <p>During an interview on 02/22/2016 at</p>			

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	<p>1:56 P.M., the Dietary Manager indicated all food and drinks should be covered on residents' meal trays during transportation and delivery.</p> <p>The current, "Handwashing / Hand Hygiene", policy, dated 10/2014, was provided by the DON (Director of Nursing) on 02/22/2016 at 8:40 A.M. The policy indicated, ..."This facility shall require facility personal use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated...Apply enough soap to cover all hand surfaces...Rub hands together vigorously...for at least 20 seconds..."</p> <p>The current "Room Service" policy, dated 11/2014, was provided by the Dietary Manager on 02/22/2016 at 1:55 P.M. The policy indicated, ..."4. All food is to be covered during transportation and distribution to the residents... 6...Food is to remain covered...until delivered to resident... 9. All food/drinks are to be covered..."</p> <p>3.1-21(i)(3)</p>			

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F 0441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>			

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	<p>Based on observation, interview and record review, the facility failed to ensure proper infection control practices were performed according to accepted professional practice related to transportation of linens and storage of clean linens for 6 of 8 observations (Resident #6, #15, #19) and handwashing for 3 of 9 residents observed during medication administration. (Residents #17, #68, #71)</p> <p>Findings include:</p> <p>1. During an observation on 02/18/2016 at 11:44 A.M., the clean linen cart inside the 100 Hall bathing room was left open with the cover folded over the top. There were visible stacks of clean towels, washcloths, and gowns.</p> <p>During an observation on 02/18/2016 at 1:46 P.M., Housekeeper (HSK) #14 was walking down the 200 hallway with her arms full of clothing and a blanket. The clothing and blanket were resting against her uniform top and her bare arms. HSK #14 walked into Resident #15's room and left the clothing and blanket on the resident's chair.</p> <p>During an observation on 02/19/2016 at 11:32 A.M., HSK #14 was carrying a tall stack of linens against her uniform and</p>	F 0441	<p>F441 Requires the facility to ensure proper infection control practices are performed according to accepted professional practice related to transportation of linens, storage of linens and handwashing. 1. Resident #6, #15, #17, #19, #68 and #71 was not harmed. Staff was immediately educated on the policy of handwashing and proper handling of linen. 2. All residents have the potential to be affected. The DON educated nursing staff on handwashing and proper linen handling. See below for corrective measures. 3. The Handwashing/Hand Hygeine and Linen Handling policy procedures were reviewed with no changes made. (See attachment C and F) The staff was inserviced on the above procedures. 4. The DON or her designee will observe 2 staff members washing their hands to ensure the staff is following proper handwashing techniques per policy. The DON or her designee will also conduct 2 observations of staff handling linens to ensure infection control is followed correctly. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to until 100% compliance is obtained and maintained. (See attachment</p>	02/26/2016

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	<p>arm, from her hip to her shoulder. The HSK walked into Resident #6's room and left several pieces of laundry in the resident's dresser. Then HSK #14 walked out of Resident #6's room and into Resident #19's room and placed the rest of the linens in the resident's dresser.</p> <p>During an observation on 02/19/2016 at 12:25 P.M., the clean linen cart inside the 100 Hall bathing room was left open with the cover folded over the top. There was visible stacks of clean towels, and washcloths.</p> <p>During an observation on 02/22/2016 at 2:53 P.M., HSK #14 had transported an uncovered linen cart down the 200 hallway. There were several towels, washcloths, and sheets visible in the linen cart. The HSK then placed the linens inside the 200 Hall clean linen closet.</p> <p>During an interview on 02/19/2016 at 10:51 A.M., Certified Nurse Aide (CNA) #6 indicated all linen carts not being used were to be covered.</p> <p>During an interview on 02/19/2016 at 11:34 A.M., HSK #14 indicated linens should be carried away from your uniform. The HSK further indicated she was not sure about the policy of carrying linens from one resident's room to</p>		<p>B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.</p> <p>5. The above corrective measures will be completed on or before February 26, 2016.</p>	

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	<p>another resident's room.</p> <p>During an interview on 02/22/2016 at 10:18 A.M., the Director of Nursing (DON) indicated the linen cart was to be covered when transporting linens through the hallways. The staff were to only carry linens for one resident at a time. The DON further indicated staff were never to carry linens from one resident's room to another resident's room.</p> <p>The current facility policy, titled "Linen, Handling" and dated 12/2015, was provided by Corporate Nurse #10 on 02/19/2016 at 10:15 A.M. and was reviewed at that time. The policy indicated, "...Clean linen will be stored in a manner to prevent contamination...Linen will not be carried against the body..."</p> <p>2. During an observation of medication administration on 02/18/2016 at 8:27 A.M., LPN #3 prepared medications for Resident #71, donned gloves, administered one drop of medication to each eye, removed her gloves, washed her hands for 12 seconds, retrieved nasal spray from the medication cart, donned gloves, administered the nasal spray to Resident #71, removed her gloves, and washed her hands for 15 seconds.</p> <p>LPN #3 then returned the medication to</p>			

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	<p>the medication cart, retrieved a blood pressure cuff and took Resident #68's blood pressure, washed her hands for seven seconds, got the pulse oximeter from the medication cart, checked Resident #68's heart rate, prepared medications for Resident #68, administered the medications, and washed her hands for 11 seconds.</p> <p>During an observation on 02/19/2016 at 12:20 P.M., LPN #3 prepared insulin for Resident #17, washed her hands appropriately for 22 seconds, donned gloves, administered the insulin, removed her gloves, and washed her hands for 18 seconds before she disposed of the insulin needle in the sharps container.</p> <p>During an interview on 02/19/2016 at 12:44 P.M., LPN #4 indicated hands were supposed to be washed for 20 seconds. The LPN further indicated hands were supposed to be washed when you entered or exited a room and after you removed gloves.</p> <p>During an interview on 02/19/2016 at 12:11 A.M., CNA #6 indicated hands were supposed to be washed for 30 to 60 seconds.</p> <p>The current facility policy, titled "Handwashing/Hand Hygiene" and dated</p>			

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F 0465 SS=E Bldg. 00	<p>10/2014, was provided by the DON (Director of Nursing) on 02/22/2016 at 8:40 A.M. and was reviewed at that time. The policy indicated, "Situations that require hand hygiene include, but are not limited to:...After removing gloves..." and "...Rub hands together vigorously, as follows, for at least 20 seconds..."</p> <p>The current facility policy, titled "Medication Administration" and dated 10/2014, was provided by the DON at 8:50 A.M. and was reviewed at that time. The policy indicated, "...Wash hands with soap and water...Before and after administering ophthalmic or otic meds[sic], injections..."</p> <p>3.1-18(l) 3.1-19(g)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a safe, sanitary, and homelike environment for residents related to cleaning shower rooms after use, properly disposing of soiled linens, foul odors, and</p>	F 0465	F514 Requires the facility to ensure to maintain complete clinical information related to Weekly Skin Assessment sheets documentation. 1. Linens were properly disposed and personal care items returned to resident's rooms. 2. All residents have the	02/26/2016

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	<p>floor stains. This affected 2 of 2 shower rooms observed, 100 hall, and 200 hall. Findings include:</p> <p>1. During an observation of the 200 Hall bathing room on 02/18/016 at 11:45 P.M., a pile of wet, used towels, several with brown stains on them, were lying on the floor next to the tub. There was a pile of resident clothing, including jeans, a shirt, underwear, and socks, on the floor next to the towels. On the edge of the tub there were unlabeled resident care items including deodorant, baby lotion and shampoo and body wash. On the floor of the shower there were four wet, used washrags. In the shower stall there was an unlabeled can of shave cream and an unlabeled bottle of shampoo and body wash. The bathing room door was unlocked.</p> <p>During an observation of the 100 Hall bathing room on 02/18/2016 at 11:44 A.M., a pile of wet towels were rolled up lying on the shower stall floor. The bathing room was not in use and the door was left open.</p> <p>During an observation of the 100 Hall bathing room on 02/19/2016 at 9:10 A.M., a pile of three wet, used washcloths were on the floor in the shower stall, two wet, used washcloths lying on the shower shelf, and one wet,</p>		<p>potential to be affected. Soiled linens were removed from shower rooms and resident rooms. Personal care items were returned to the resident's room. See below for corrective measures. 3. The Linen Handling, Personal Care Items and Bathroom Cleaning policy procedures were reviewed with no changes made. (See attachment F, G and H) The staff was inserviced on the above procedures. 4. The Administrator or his designee will conduct a facility round ensuring shower rooms are clean, linens are discarded properly and personal care items are placed in the resident's rooms. The Administrator or his designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to until 100% compliance is obtained and maintained. (See attachment I) The DON or her designee will also conduct 2 observations of staff handling linens and discarding them per policy. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly</p>	

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	<p>used washcloth hanging on the hand rail. The bathing room door was unlocked and the lights were turned off.</p> <p>During an observation of the 100 Hall bathing room on 02/19/2016 at 10:47 A.M., a pile of three wet, used washcloths were on the floor in the shower stall, two wet, used washcloths lying on the shower shelf, and one wet, used washcloth hanging on the hand rail. The bathing room lights were on with the door left open.</p> <p>During an interview on 02/18/2016 at 11:52 P.M., CNA #2 indicated clothing and linens were not supposed to be left on the floor. The CNA further indicated resident personal care items were not supposed to be left out and that the 200 Hall shower room had not been used since at least 10:00 P.M. and was probably left from second shift.</p> <p>During an interview on 02/19/2016 at 10:51 A.M., CNA #6 indicated the CNA's were responsible for cleaning the bathing rooms after a resident's shower. The CNA further indicated this included making sure to place all soiled linens in the soiled utility room.</p> <p>During an interview on 02/19/2016 at 12:33 A.M., CNA #6 indicated resident</p>		<p>quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.</p> <p>5. The above corrective measures will be completed on or before February 26, 2016.</p>		

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	<p>personal care items were supposed to be labeled and were supposed to go in the residents' rooms, not left out in the shower room. The CNA further indicated after the shower room was used, linens were to be bagged and taken to the dirty linen room and the shower room was to be cleaned after each resident.</p> <p>The current facility policy, titled "Personal Care Items/Medications Maintained by the Resident" and dated 10/2014, was provided by the ADON (Assistant Director of Nursing) on 02/22/2016 at 3:00 P.M. and was reviewed at that time. The policy indicated, "...Facility personnel will monitor individual rooms to ensure that personal care items are maintained in a manner so as not to cause potential hazards to resident or other residents of the facility...Facility assistance shall be offered to maintain personal care items/medications in a manner...to ensure the health and safety of confused residents of the facility who could have potential access to those items..."</p> <p>The current, undated facility policy, titled "Bathroom Cleaning", was provided by the DON (Director of Nursing) on 02/19/2016 at 9:57 A.M. and was reviewed at that time. The policy indicated, "...To prevent the spread of</p>			

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	<p>infection, use proper cleaning techniques..."2. During the initial tour on 02/16/2016 at 10:22 A.M., there was a pillow case lying on the floor and a wash cloth hanging on the edge of a chair in Resident #19's room. There were no staff or residents present in the room.</p> <p>During an observation of the 100 Hall on 02/19/2016 at 9:11 A.M., a large black garbage can, located next to the linen closet, had several towels hanging on the rim and two inches of cloudy gray water in the bottom of the can with no plastic liner. No staff members were observed in the area of the garbage can.</p> <p>During an interview on 02/19/2016 at 4:45 A.M., Certified Nurse Aide (CNA) #2 indicated linens should not be placed on the floor or left in the resident's room after use. The CNA further indicated all soiled linens were to be placed in a plastic bag.</p> <p>During an interview on 02/22/2016 at 2:53 P.M., the Directory of Nursing (DON) indicated no linens were to be placed on the floor and all soiled linens were to be placed into plastic bags then transported to the soiled linens closet or to laundry.</p> <p>The current facility policy, titled "Linen,</p>			

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	<p>Handling" and dated 12/2015, was provided by Corporate Nurse #10 on 02/19/2016 at 10:15 A.M. and was reviewed at that time. The policy indicated, "...The facility shall ensure that soiled linen is securely contained at the source where it is generated...soiled linen will not be placed on the floor..."3.</p> <p>During an observation of the 200 hall, on 02/16/2016 at 2:18 P.M., a strong urine odor was noted in the hall outside room #208.</p> <p>During an observation of the 200 hall, on 02/17/2016 at 8:44 A.M., a strong urine odor was noted in the hall outside room #208.</p> <p>During an observation of the 200 hall, on 02/17/2016 at 9:33 A.M., a strong urine odor was noted in the hall outside room #208 after the room was cleaned.</p> <p>During an observation of the 200 hall, on 02/19/2016 at 1:30 A.M., a strong foul odor was noted in the hall outside room #208.</p> <p>During an observation of the 200 hall, on 02/19/2016 at 9:05 A.M., a strong foul odor was noted in the hall outside room #208.</p> <p>During an observation on 02/22/2016 at</p>			

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	<p>9:44 A.M., a strong urine odor was noted in room #208 near a large recliner.</p> <p>During an observation on 02/22/2016 at 4:00 P.M., a strong urine odor was noted in room #208 and noticeable just inside the doorway..</p> <p>During an interview on 02/17/2016 at 10:32 A.M., Housekeeper #8 indicated the odor emitted from Resident #15's chair and the odor had been "bad" for a month.</p> <p>During an interview on 02/17/2016 at 10:35 A.M., Corporate Nurse #10 indicated Resident #15's chair in room #208 would be removed that day and a new one brought in.</p> <p>During an interview on 02/17/2016 at 1:44 P.M., a family member of Resident #76, the roommate of Resident #15, indicated there had been a strong odor in the room and used incontinence product in the sink when she had visited earlier in the week. She further indicated there had been foul odors in the resident's room on occasion in the past.</p> <p>During an interview on 02/22/2016 at 2:40 P.M., CNA (Certified Nurse's Aide) #11 indicated Resident #15 was incontinent at times and would not allow</p>			

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	<p>staff to assist her with changing her clothes. CNA #11 further indicated at times the resident's pants had a wet stain and smelled like urine and the resident continued to refuse care.</p> <p>4. During an observation on 2/15/16 at 10: 38 A.M., a brown stain, 3"x 6" was noted on the floor outside room #211.</p> <p>During an observation on 2/17/16 at 10: 30 A.M., a brown stain, 3"x 6" was still noted on the floor outside room #211 along with two reddish-brown, quarter size spots nearby.</p> <p>During an interview on 02/17/2016 at 10:35 A.M., Housekeeper #9 indicated the spots were removed with no difficulties.</p> <p>The "Deep Clean Calendar" for the month of January was provided by Corporate Nurse #10 on 02/19/2016 at 10:00 A.M. The calendar indicated room #208 was deep cleaned on 01/29/2016.</p> <p>The current, undated "Room Cleaning" policy, provided by the DON on 02/19/2016 at 9:57 A.M., indicated "...A Room Cleaning must be completed at least once a month..."</p> <p>3.1-19(f)</p>			

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F 0514 SS=D Bldg. 00	<p>3.1-19(g)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to maintain complete clinical information related to Weekly Skin Assessment sheets documentation for 1 of 14 residents reviewed for complete documentation. (Resident #39)</p> <p>Findings include:</p> <p>The clinical record for Resident #39 was reviewed on 02/18/2016 at 10:05 A.M. The diagnoses included, but were not limited to, peripheral vascular disease,</p>	F 0514	<p>F514 Requires the facility to ensure to maintain complete clinical information related to weekly skin assessment sheets</p> <p>1. All weekly skin assessment s were completed per schedule 2. All residents have the potential to be affected. A weekly skin assessment schedule was placed to ensure the nurse's completed a skin assessment per policy. See below for corrective measures.</p> <p>3. The Skin Management Program policy procedure was reviewed with no changes made. (See attachment</p>	02/26/2016

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	<p>hemiplegia, wound infection, malnutrition, heart failure, and diabetes.</p> <p>Resident #39's Alteration In Skin Care Plan, which was initiated on 12/14/2015, indicated the resident had an alteration in skin as evidence by bilateral lower extremity edema. The interventions included, but were not limited to, "monitor site with weekly skin rounds."</p> <p>Resident #39's Pressure Ulcer Risk Care Plan, which was initiated on 3/13/2015, indicated the resident was at risk for the development of pressure ulcers due to "L heel II [sic]" (left heel stage two pressure ulcer). There were no risks or diagnoses listed. The interventions included, but were not limited to, "Head to toe skin assessment weekly".</p> <p>Resident #39's "Weekly Skin Assessment" sheet was blank with no assessment findings or nurse signature for 12/25/2015, 01/08/2016, and 01/15/2016.</p> <p>Review of the "Skin Binder" indicated no initial assessment/ongoing monitoring forms were found concerning Resident #39's left heel or lower extremities.</p> <p>The "Nursing Summary", dated 12/24/2015, under skin condition</p>		<p>J) The staff was inserviced on the above procedures. 4. The DON or her designee will review the weekly skin assessment documentation to ensure that assessments are completed timely. If the assessment is not completed by end of the day, the DON will complete herself. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before February 26, 2016.</p>	

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	<p>indicated "see skin sheet for any alteration in skin integrity" and was signed by Licensed Practical Nurse (LPN) #12.</p> <p>The "Nursing Summary", dated 01/15/2016 under skin condition indicated "see skin sheets" was signed by LPN #12.</p> <p>The Nurses Notes, dated 12/25/2015, 01/08/2016, and 01/15/2016 were reviewed with only a specific wound assessment noted. There were no head to toe skin assessment notes found for Resident #39.</p> <p>During an interview on 02/19/2016 at 1:08 A.M., the Assistant Directory of Nursing (ADON) indicated the nursing staff were suppose to complete and sign off on the Weekly Skin Assessment sheets.</p> <p>During an interview on 02/19/2016 at 1:22 A.M., LPN #13 indicated the "Weekly Skin Assessment" sheet for Resident #39 was to be completed weekly. LPN #13 further indicated the "Weekly Skin Assessment" sheet was to be completed and signed by the nurse.</p> <p>During an interview on 02/19/2016 at 1:28 A.M., LPN #14 indicated the weekly</p>			

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	<p>skin assessment was documented on the "Weekly Skin Assessment" sheet and was to be signed by the nurse completing the documentation.</p> <p>The current facility policy titled, "Skin Management Program" and dated 10/2013, was provided by the ADON on 02/22/2016 at 10:02 A.M. and was reviewed at that time. The policy indicated, "...A comprehensive head to toe assessment will be completed by a licensed nurse ...at least weekly...should a skin condition be identified, the licensed nurse will begin the completion of the appropriate initial assessment/ongoing monitoring form which is then placed in the Skin Binder in lieu of the weekly skin assessments..."</p> <p>3.1-50(a)(1)</p>			