

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
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NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 14, 15, 16, & 17, 2014</p> <p>Facility number: 000399 Provider number: 155750 AIM number: 100289100</p> <p>Survey team: Melissa Gillis, RN-TC Cheryl Mabry, RN Diana McDonald, RN (4/15, 4/16, 4/17, 2014) Angela Patterson, RN (4/14., 4/15, 4/16, 2014)</p> <p>Census bed type: SNF/NF: 35 Total: 35</p> <p>Census payor type: Medicaid: 31 Other: 4 Total: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 25, 2014; by Kimberly Perigo, RN.</p>	F000000		
F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p>			

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

TITLE

(X6) DATE

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

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	<p>Based on observation, interview, and record review, the facility failed to ensure that a resident was free from a physical restraint in that a resident was placed in a chair with a non removable belt when exhibiting hallucinating behavior as indicated by facility policy. This had the potential to affect 1 in a sample of 4 who met criteria for review of physical restraints. (Resident # 6).</p> <p>Findings include:</p> <p>The clinical record for Resident #6 was reviewed on 4/15/14 at 2:13 p.m.</p> <p>Diagnoses included but were not limited to hyperlipidemia, gastroesophageal reflux disease (GERD), anxiety, MMR (mild mental retardation) dementia, chronic bronchitis, depression, auditory hallucinations, and schizophrenia.</p> <p>The most recent Minimum Data Set (MDS) assessment dated 3/14/14, indicated the Brief Interview for Mental Status (BIMS) was 15, 8-15 being interviewable.</p> <p>Review of physician's order dated 12/1/13 indicated, "May be in Broda chair with (c) straps due to (D/T) inability to stay safe at present related to (R/T) psychosis with (c) auditory hallucinations."</p> <p>Careplan dated 12/1/13 indicated, "Restraint use ... May be in broda chair with (c) straps due to (D/T) inability to stay safe at present, ... Requests to be placed in chair when she feels out of control., NEEDED DUE TO THE FOLLOWING MEDICAL SYMPTOM(S)."</p>	F000221	<p>1. The nursing staff and the attending physician/medical director immediately reviewed the restraint orders for Resident #6. It was decided and ordered to contact the physician each time resident #6 requests to be placed in the broda chair. Facility SS Designee has obtained a signed restraint release document from the resident guardian/POA to cooperate with the plan of care of resident #6.2. Any resident with restraint orders has the potential to be affected.3. The Facility DON in-serviced all staff regarding Facility Policy and Procedure regarding Restraints on 4/30/14. The facility reviewed the policy and has also been reviewed by QA committee members and updated with a current date of 4/30/14 These orders will be reviewed monthly as the physician signs the rewrites. The nursing staff will follow physician's orders regarding restraints.4. The DON and Charge Nurse will monitor daily x 30 days then q wcx30days then q month x 3months. The HFA will check weekly for compliance. The DON will report to the QA committee for 6 months and follow their recommendations and/or comments.5. Date Completed: 5/17/14</p>	05/17/2014			

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	<p>Review of nurse's note dated 3/22/14, indicated, "Resident agitation, crying, arguing with (c) voices that are not there..." Review of psychological services progress report, dated 4/1/14 indicated, "...Concerns discussed: Mood seems improved. Participating in activities and engaging in conversation...Still has delusions...hallucinations, but is not as disturbing to her anxiety symptom, seems to be doing better this visit."</p> <p>Review of BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD dated 2/14 indicated, "BEHAVIOR 1 auditory Hallucination, ... 2 Throwing self in floor, ...frequently without positive outcome. 3/14 indicated "BEHAVIOR 1 auditory Hallucination, ... 2 Throwing self in floor, ... 3. delusion: frequently without positive outcome."</p> <p>Interview on 4/14/14 at 12:22 p.m., with Resident #6 indicated the staff restrains her. When asked when the resident was restrained, Resident #6 indicated, "When I have a behavior of yelling or kicking. They put me in a chair and strap me down until I calm down. That makes me very angry. It p- ---- me off. I gotta know what I've done and then I'll sit in the chair. ---- [CNA #2's name] did it this morning, the DON told him to because I was screaming. I sat in the chair and --- [CNA #2's name] strapped me in. They let me out only when I had to go to the bathroom. I was hearing voices and screaming at an uncle who was outside. I told ---- [CNA #2's name] and he didn't believe me."</p> <p>Interview on 4/14/14 at 3:00 p.m., with DON indicated, "Resident #6 has been maniac</p>				

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	<p>since September or October of 2013. She's been having a lot of behaviors and hearing voices. We try to reassure her. She always thinks her family is out to take her money. We do have to sit her in a chair when she has behaviors, but sometimes she will come up to us and say that she needs to be put in the chair."</p> <p>Observation on 4/14/14 at 3:30 p.m., indicated Resident #6 approached the nursing station and indicated to the Director of Nursing (DON), "I want to tell you why I told them about the chair. I know if people yell and scream, they need to sit in the chair."</p> <p>Interview on 4/15/14 at 9:09 a.m., with DON indicated when asked where is Resident #6 placed when she is having a behavior, indicated, "In a broda chair." When asked if the staff straps the resident in, DON indicated, "Yes, sometimes it's for her safety, because she can really act up."</p> <p>Interview on 4/15/14 at 12:00 p.m., with the Administrator indicated when asked if they have a written consent from Resident #6 to be put in restraints, "Resident #6 gives verbal consent when she feels like she needs to be in the chair for a few minutes to calm down." There was no documentation of consent from resident nor resident's brother, her Power of Attorney (POA).</p> <p>Interview on 4/15/14 at 11:45 a.m., with DON indicated when asked for Resident #6's restraint log for March and April, "There is none, because she hasn't had any behaviors." When asked about the behaviors that happened on 4/14/14, the DON indicated, "Well, she was only in the chair for 20 minutes until she calmed down</p>			

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	<p>and was back up. I'm not going to do a behavioral sheet and she was only in there for 20 minutes, because we have to release every 2 hours." When asked if there was an restraint implementation policy. The DON indicated "No, we only have one policy/procedure for restraints [restraint reduction]"</p> <p>Interview on 4/16/14 at 1:45 p.m., with the Medical Director indicated when asked if he was aware that Resident #6 was being restrained when she displayed a behavior, "Yes, I was made aware that Resident #6 will throw herself in the floor. I don't want to make any changes until I know the resident better. Once the disciplinary team meets, we will revisit the issue about the restraints. I think the medication has not been effective. The Medical Director indicated he was aware restraints could not be a standing order and preferred to be called whenever a restraint is used. "I will write an order clarification regarding the restraints."</p> <p>On 4/14/14 at 1:09 p.m., the Administrator provided the " RESIDENT RIGHTS " Copyright 1997, and indicated that was the one currently used by the facility. The policy indicated, " RESIDENT BEHAVIOR AND FACILITY PRACTICES (a) Restraints The resident has the right to be free from any physical or chemical restraints imposed for purpose of discipline or convenience and not required to treat the resident ' s medical symptoms."</p> <p>On 4/15/14 at 10:38 a.m., the Administrator provided the "RESTRAINT REDUCTION", no date, and indicated that was the one currently used by the facility. The policy indicated, " ... It is the policy of [Name of facility] to become</p>			

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F000242 SS=D	<p>a restraint-free environment without jeopardizing resident safety. Interventions will be put into place to prevent, reduce and/or eliminate the use of restraints whenever psychosis c auditory hallucinations. ... GOAL RESIDENT WILL BE FREE OF POTENTIAL NEGATIVE OUTCOMES AND/OR DECLINE IN FUNCTIONING SUCH AS: INCONTINENCE, DECREASED R.O.M., DECREASED AMBULATION, WITHDRAWAL, DEPRESSION, REDUCED SOCIAL CONTACT, LOSS OF BALANCE, INCREASED AGITATION, LOSS OF MUSCLE TONE, PRESSURE SORES, ...APPROACH/INTERVIEW ...7. MONITOR AND RECORD AND[ANY] CHANGES IN BEHAVIOR. ... REEVALUATE RESTRAINT FOR EFFICACY AND POTENTIAL NEED FOR REDUCTION. 10. REVIEW RESTRAINT USE QUARTERLY WITH INTERDISCIPLINARY TEAM. 11. IF RESTRAINT REDUCTION IS INDICATED, NOTIFY PHYSICIAN, FAMILY AND RESIDENT AND PROCEED ACCORDINGLY."</p> <p>PROCEDURE: Explain detrimental effects and risks associated with the use of physical restraints to staff, resident, family and/or other responsible parties."</p> <p>An updated Physician's order dated 4/16/14 indicated, "May be in broda chair with straps 2 (secondary to) treatment (Tx) ability to stay safe 2 (secondary to) psychosis with hallucinations. Order is PRN (as needed) each occurrence. Please call me to get order."</p> <p>3.1-26(o) 483.15(b) SELF-DETERMINATION - RIGHT TO</p>			

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	<p>MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure that residents were able to schedule what type of bathing preference they were allowed and what time to wake up in the morning and/or go to bed at night according to their preference. This deficient practice had the potential to affect 2 of 3 residents reviewed for choices in a sample of 8 who met the criteria for choices. (Resident #6, Resident #37)</p> <p>Findings include:</p> <p>Resident #37's clinical record was reviewed on 4/17/14 at 11:54 a.m. Diagnosis include but were not limited to, "frozen shoulder syndrome, angina, chronic pain, artery occlusion, gerd, insomnia, depression, senile dementia, cerebral palsy, sexual aggression." There was not observed any resident preference sheet in the chart. Resident # 37 was admitted on 2/28/14.</p> <p>The current MDS (minimum data set) assessment dated 3/4/14 had no BIMS (brief interview mental status) score.</p> <p>On 4/14/14 at 11:47 a.m., interview with Resident #37 indicated when asked Do you choose whether you take a shower, tub, or bed bath? "No, every Monday. I don't want to</p>	F000242	<p>1. SS Designee and Activity Director has re-assessed resident's bathing preferences, bed time choices, and getting up times on 5/1/14. In facility admission process residents are given a bathing choice, bed time choice and getting up choice during the initial assessment period. If they change their mind later the facility will honor that change, if facility is made aware of the change. Facility was unaware these choices had changed. Resident's choices are respected and to be best of the facility abilities within safety guidelines, are honored.2. Any resident has the potential to be affected.3. The HFA conducted a Resident Right's In-Service on Monday, April 30,2014. The DON In-Serviced all staff on 4/30/14 regarding the importance of resident's choices and preferences including staff being made aware of any changes. The Activity Director will review these choices quarterly with the MDS review, since these choices are primarily in the Activity Section of MDS. However, the facility wil honor resident's choices on a</p>	05/17/2014

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	<p>take at all. I prefer to be washed up."</p> <p>Do you choose how many times a week you take a bath or shower? "They just give me a shower, I prefer wash up."</p> <p>Do you choose when to go to bed at night? " No, they put me in bed around 7:00 p.m. I want to go to bed around 9:00 p.m."</p> <p>Do you choose when to get up in the morning? "No, they get me up around 5:00 a.m. I want to get up around 8:00 a.m."</p> <p>2). The clinical record for Resident #6 was reviewed on 4/15/14 at 2:13 p.m. Diagnoses included, but not limited to, hyperlipidemia, gastroesophageal reflux disease (GERD), anxiety, MMR (mild mental retardation), dementia, chronic bronchitis, depression, auditory hallucinations, and schizophrenia.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/14/14, indicated the Brief Interview for Mental Status (BIMS) is 15, 8-15 being interviewable.</p> <p>On 4/14/14 at 12:17 p.m., interview with Resident #6 indicated when asked do you choose whether you take a shower, tub, or bed bath? "No, like a tub bath sometimes but tub broke. It's been broken for a while."</p> <p>On 4/17/14 at 1:55 p.m., interview with the Social Service /Activity Director indicated when asked how do you document resident preferences. "For the ones that can tell us we have a sheet on admission that gets filled out. [Name of resident #37] doesn't have clear speech so I couldn't get [gender] to give me a time preference." There was not</p>		<p>daily basis, if those changes are made known to staff.4. Activity Director, DON, HFA and all staff will monitor on a daily basis x30days then q wk x30 days then q month x3. The Activity Director will report to the QA Committee for 6 months and follow their comments and/or recommendations. 5. Date Completed 5/17/2014</p>	

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F000253 SS=E	<p>observed a preference sheet for Resident #6.</p> <p>On 4/17/14 at 2:06 p.m., the Social Service/Activity Director provided "Activity MDS 3.0 Care Plan" no date and indicated that was the current careplan used. The careplan indicated " Res. [resident] has specific activity & ADL preferences aeb [as evidenced by] resident & 1 or family interview on MDS 3.0. Goals Resident's activity & ADL preferences & patterns will be met daily thru next review. ... Intervention ...Allow res. to choose bedtime like to get up around [No answer was observed] likes to retire around [No answer was observed]."</p> <p>On 4/14 at 1:09 p.m., the Administrator provided "RESIDENT RIGHTS" undated, and indicated that was the current resident rights used by the facility. The resident rights indicated, "... (b) Self-determination and participation, The resident has the right to --- (1) Choose activities, schedules, ...plans of care;...(3) Make choices about aspects of his or her life in the facility that are significant to the resident. ...(e) Accommodation of needs, A resident has the right to--(1) ... receive services in the facility with reasonable accommodations of the individual's needs and preferences,except when the health or safety of the individual or other residents would be endangered...."</p> <p>3.1-3(u)(3) 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p>	F000253	1. The facility housekeeping staff	05/17/2014

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	<p>Based on observation and interview, the facility failed to maintain the residents' rooms in a clean and sanitary manner in that the rooms had dirty privacy curtains, window curtains, and paint chips on window ledges. This deficient practice effected 8 out of 26 rooms. (Resident's #12, #6, #16, #42, #5, #8, #11, #21)</p> <p>Findings include:</p> <p>Observation on 4/17/ 14 1:20 p.m., in room 21, indicated dirty privacy curtains and the plastic weather proofing on the window was broken.</p> <p>Observation on 4/17/ 14 1:23 p.m., in room 2, indicated dirty privacy curtains and the paint on the window ledge was chipped and peeling.</p> <p>Observation on 4/17/ 14 1:26 p.m., in room 20, indicated dirty windows and the caulking on the window had turned brown with dirt and was falling out.</p> <p>Observation on 4/17/ 14 1:29 p.m., in room 22, indicated the plastic weather proofing on window was broken, and the wood on part of the window was rotten. The curtain covered the bathroom was dirty.</p> <p>Observation on 4/17/ 14 1:32 p.m., in room 20, indicated dirty privacy curtains and the plastic weather proofing on the window was broken.</p> <p>Observation on 4/17/ 14 1:35 p.m., in room 24, indicated dirty privacy curtain, and the plastic weather proofing on window was</p>		<p>immediately removed soiled privacy curtains and hung clean curtains.2. Any resident has the potential to be affected.3. The housekeeping staff was In-Serviced on 4/30/14 and re-educated regarding prompt changing and cleaning of resident's privacy curtains. ESD and HFA re-educated maintenance personnel regarding maintaining windows in a clean condition and proper weather proofing. The facility is replacing the windows identified with broken seals.4. The ESD has instituted a monitoring log to document privacy curtain cleaning and maintaining on a daily basis. The ESD will monitor and report to QA committee quarterly for 6 months. The ESD and HFA will check windows monthly and maintenance personnel will check windows daily for needed repairs/painting. The ESD will report to the QA committee quarterly ongoing. The ESD will follow QA committee recommendations.5. Date Completed 5/17/14</p>	

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F000309 SS=D	<p>broken. The screen on the right side of the window was pushed out.</p> <p>Observation on 4/17/ 14 1:38 p.m., in room 6, indicated dirty privacy curtains.</p> <p>Observation on 4/17/ 14 1:41 p.m., in room 16, indicated dirty privacy curtains and dirty windows.</p> <p>Interview on 4/17/14 1:45 p.m., with the Maintenance Man indicated, "I guess I will have to go through the building and fix the plastic stuff on the window. I guess I can fix it."</p> <p>3.1-19(f) 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.</p> <p>Based on observation, interview, and record review, failed to ensure a resident received a physician prescribed medication for 1 of 14 residents reviewed for medication administration. (Resident #3)</p> <p>Findings include:</p> <p>Observation on 4/16/14 at 2:13 p.m., of the medication pass, indicated LPN #1 could not administer 30 ml of Enulose (used to prevent liver disease, causes a decrease in blood</p>	F000309	<p>1. The nursing staff immediately notified the contract pharmacy that facility needed medication delivered on new resident that had been in the facility just over 24 hours. The medical director was on-site for a regular scheduled visit and assisted facility in attending the this matter. The medication was received and administered in a corrected timely manner. No signs or symptoms was exhibited by the resident. 2. Any resident has the potential to be affected.3.</p>	05/17/2014

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F000323 SS=D	<p>ammonia concentration, increase ammonia concentrations in the blood may be toxic) (to receive by mouth three times a day for hepatic/liver encephalopathy/is the occurrence of confusion, altered level of consciousness, and coma as a result of liver failure). LPN #1 could not administer Vitamin B-1 (for thiamine deficiency) (to receive 100 mg by mouth three times a day as a supplement). Neither of the medications were in the medication cart. LPN #1 looked through all four medication carts.</p> <p>Interview 4/17/14 at 9:45 a.m., with DON indicated that the hospital did not send medications with the resident (Resident #3 had been out to the hospital from 3/28/14 to 4/15/14; and returned without being discharge from the nursing facility). "We do not throw medications out Medicaid does not pay for medications twice. The medications should be in the medication cart."</p> <p>Record review of Medication Administration Record on 4/16/14 at 2:15 p.m., indicated the resident upon return to the nursing facility on 4/15/14 through medication administration observation, had not received the Enulose and Vitamin B1 due to the medications were not available in the facility (three doses).</p> <p>Review on 4/17/14 at 10:00 a.m., of Prescription Order(s) Valid Only if Faxed to Pharmacy Below dated 4/15/14, indicate the facility failed to order Enulose 10 gm/15ml and the Vitamin B1.</p> <p>3.1-37(a) 483.25(h) FREE OF ACCIDENT</p>		<p>The DON In-Serviced licensed nursing on 4/30/14 by reviewing the Pharmacy Policy and Procedure regarding timely medication orders when are not readily available. This In-Service included reviewing with licensed nursing the steps to follow when medication is not received as ordered.4. The DON and Licensed Nursing personnel will monitor daily x30 days the q wk x1 month x3. The DON will report to the QA committee on a quarterly basis and follow their recommendatoin and/or comments.5. Date completed: 5/17/14</p>				

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	<p>HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a physically impaired resident's adaptive device (walker) to prevent accidents was keep close to resident as indicated by the careplan to prevent falls for 1 of 2 residents reviewed for accidents in a sample of 2 who met the criteria for review of accidents. (Resident #8)</p> <p>Findings include:</p> <p>Resident #8's clinical record was reviewed on 4/17/14 at 9:35 a.m. Diagnosis included but not limited to CHF (congestive heart failure), Gout, HTN (high blood pressure) , Constipation, PVD (peripheral vascular disease), morbid obesity, neuropathy, and renal failure stage 3.</p> <p>The current MDS (Minimum Data Set) assessment dated 2/25/14 indicated a BIMS (brief interview mental status) score of 14, when 8-14 was interviewable. The MDS indicated for " transfer needed extensive assist of 2 staff members, ... walk in room extensive assist of 1 staff, ... toileting use needed extensive assist of 2 staff, ... Balance during Transition and walking A. Moving from seated to standing position- not steady only able to stabilize with human assist, b. Walking- not steady only able to stabilize human assist, D. Moving on and off toilet- not steady only able to stabilize with human assist. ... Mobility b. walker, with wheelchair."</p>	F000323	<p>1. Resident #8 requests that the walker be placed near the bathroom and the resident's care plan has been updated to reflect the resident's request on 5/1/14. Resident states today that he will be on his call light and ask for walker when needed. The resident places his wheelchair near his bed. The facility has requested a physician's order to have resident evaluated by the physical therapy department for mobility. The facility will update resident plan of care per physical therapy recommendation/orders.2. Any resident has the potential to be affected.3. The DON conducted and In-Service on 4/30/14 regarding Resident's Safety for all staff. Residents' Safety Policy was reviewed and updated on 4/30/14.4. The DON, HFA and all staff will monitor daily x30 days then q wk x1 month x3. The DON will report to the QA committee on a quarterly basis and follow their comments and/or recommendations.5. Date completed 5/17/14</p>	05/17/2014

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	<p>Nurses notes dated 4/5/14 indicated, "Res [resident] states that [gender] slipped on [gender] own bowel movement because [gender] had the diarrhea all over the floor, in the bathroom. Res safely on toilet when call light answered but bruise noted to (L) thoracic side (rib) Res assisted to cleanliness & safety. ... 4/6/14 ... Res educated about need to use call light for assistance. ..."</p> <p>Careplan Falls initiated 1/3/13 and signature sheet updated 3/6/14 indicated, "Resident has multiple risk factors for falls such as: peripheral neuropathy, generalized weakness, hx of falls, osteoarthritis, strength: Uses walker. Goal Resident will sustain no injuries due to falls thru next review. Approach ... 3. Instruct resident in correct use of adaptive equipment, as indicated. Keep assistive equipment within easy reach. ... 4/5/14 Remind res [resident] prn [as needed] not to be up s [without] walker."</p> <p>On 4/14/14 at 3:25 p.m., observed Resident #8 in room sitting in a wheelchair and his walker was away from the bed over by the bathroom.</p> <p>On 4/17/14 at 10:30 a.m., observed Resident #8 in room in wheelchair and the walker was away from the bed by the bathroom.</p> <p>On 4/14/14 at 12:58 p.m., interview with the DON indicated, "On 4/5/14 [gender] was ambulating to the bathroom slipped in bm [bowel movement] because of diarrhea. He ambulates with a walker." When asked what interventions were put in place after the fall. The DON indicated "Remind resident not to get up without walker. He said that he was in a hurry."</p>			

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	<p>On 4/17/14 at 10:20 a.m., interview with the DON indicated When asked why Resident #8 was up by [gender] for toileting when the MDS indicated extensive assist of 2 for transferring. The DON indicated, "Well once [gender] gets up and has walker [gender] can stabilize, but [gender] didn't use the walker at that time because [gender] felt like [gender] didn't have time."</p> <p>On 4/17/14 at 1:45 p.m., interview with Resident #8 indicated "during the day I use my wheelchair and sometimes the walker. I didn't use my walker because the bathroom was close, it was in my room. I think it was the diarrhea on the floor why I slipped. I hurt my ribs, but it is better. I slipped out of the wheelchair before while trying to put my shoes on, but other than that I haven't had a fall."</p> <p>On 4/15/14 at 2:22 p.m., the Administrator provided "Accident and Incident Reports" undated and indicated the policy was the one currently used by the facility. The policy indicated, " Purpose ... 3. To study and evaluate accidents/incidents to prevent reoccurrence. ...10. Corrective action taken. ..."</p> <p>On 4/17/14 at 11:59 a.m., the Administrator provided " RESIDENT SAFETY" undated and indicated the policy was the one currently used by the facility. The policy indicated, " ... The resident has the right to expect reasonable safety insofar as the practices of _____ Facility and the environment are concerned.... Ambulatory Residents: ... The following guidelines must prevail: ... Residents must wear regular shoes or non-skid slippers. Walking areas</p>			
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F000332 SS=D	<p>must be dry and free of obstacles and slipping hazards. Hand rails must be provided. ..."</p> <p>3.1-45(a)(2) 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an adequate supply of medication for Resident #3. The deficient practice resulted in a medication administration error rate of 7.41% for 2 out of 27 observations. (Resident #3, LPN #1)</p> <p>Findings include:</p> <p>Observation on 4/16/14 at 2:13 p.m., of medication pass for Resident #3. The MAR (Medication Administration Record) indicated Resident #3 should receive 30 ml of Enulose (20 gm) (used to prevent liver disease / causes a decrease in blood ammonia concentration, increase ammonia concentrations in the blood may be toxic) orally three times a day for hepatic encephalopathy (is the occurrence of confusion, altered level of consciousness, and coma as a result of liver failure). The Enulose was not administrated, because the medication was not in the medication cart. LPN #1 proceeded to look through all four medication carts and could not find Resident #3's Enulose.</p> <p>Observation on 4/16/14 at 2:15 p.m., of</p>	F000332	<p>1. Please refer to tag #F0309 for 1,2 and 3.4. The DON and all licensed nursing will monitor daily x30 days then q wk x1 month then 1 month x3. The DON will report to the QA committee on a quarterly basis and will follow their recommendation and/or comments.5. Date completed: 5/17/14</p>	05/17/2014

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F000371 SS=F	<p>medication pass for Resident #3. The MAR indicated Resident #3 should receive Vitamin B-1 (for thiamine deficiency) 100 mg by mouth three times a day as a supplement. The Vitamin B-1 medication was not administrated, because the medication was not in the medication cart. LPN #1 proceed to look through all four medication carts.</p> <p>Interview 4/17/14 at 9:45 a.m., with the DON indicated the hospital did not send medications with the resident (Resident #3 had been sent to the hospital on and returned 4/15/14, without being discharged from the nursing facility). We do not throw medications out Medicaid does not pay for medications twice. The medications should be in the medication cart.</p> <p>Review on 4/17/14 at 10:00 a.m., of Prescription Order(s) Valid Only if Faxed to Pharmacy Below dated 4/15/14, indicate the facility failure to order Enulose 10 gm/15ml and Vitamin B1.</p> <p>3.1-48(c)(1) 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</p> <p>A). Based on observation, interview, and record review, the facility failed to ensure food was discarded from 1 of 1 dry storage room, 1 of 1 refrigerator, and 1 of 1 walk in freezer when the expiration date had passed,</p>	F000371	F-371 – 1. A. The expired food as identified was immediately discarded. B. This employee was immediately counseled and reminded to wash hands per facility policy. A.1. DM discarded all identified opened foods. A.2.	05/17/2014

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	<p>the labeling of unidentifiable foods, open date and expiration dates, trash can properly maintained, proper storage of cooking equipment, proper working thermometer, maintaining adequate freezer temperatures and infection control practices were followed in the kitchen by facility staff as indicated by facility policy and The Retail Food Establishment Sanitation Requirements Manual. This deficient practice had the potential to affect 35 of 35 residents being served out of the kitchen. (Cook #1), Dietary Manager (DM)</p> <p>B). Based on observation, interview, and record review the facility failed to ensure that proper handwashing was completed in the dining room as indicated by the facility policy. This deficient practice had the potential to affect 16 out of 16 resident who ate in the main dining room. (Social Services Director).</p> <p>Findings include:</p> <p>A. 1). On 4/14/14 at 10:15 a.m., with the DM (dietary manager) present, observed in the dry storage the following:</p> <p>vanilla health shake powder open 4/19 with no expiration date. The DM indicated " It was probably opened 2-3 days ago if that."</p> <p>cream of wheat with no open date,</p> <p>brown sugar with open date 2/20/14 no expiration date. The DM indicated when asked what is the expiration date, " They don't have it on here. Well I usually keep things 3-6 months."</p> <p>2 packs of chocolate cake mix with use by</p>		<p>Per DM these cupcakes were just removed from oven at the timesurveyor commented. Cupcakes finished cooling. Frosting was put on cupcakes and they were served for lunch as on menu. A.3. Pans were removed from steam table, Cook #1 realized her mistake (her first time to be surveyed) and removed pan to the stove for complete drying before putting on storage shelf. A.4. DM immediately discarded all identified items. 1.5. DM immediately discarded the identified items of food that needed to be dated. Regarding the freezer temperatures. The outside thermostat reads 10 degrees and has been rendered out of order. Two inside freezer thermostats read zero. Food was frozen solid and remains frozen solid. A.6. Trash was immediately taken out of dietary. Trash can will no longer be placed by the sink. A.7. DM and HFA immediately contacted facility's chemical company and the dish machine leased company. The DM immediately implemented the temperature logs to be documented three times daily. Facility staff instructed to follow cold dish machine procedures. A.8. HFA immediately counseled DM and reviewed facility handwashing policy with her. DM ordered a supply of thermometers immediately and have been received. B. The SSD was</p>				

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	<p>date of 3/2014, 1 pack with used by date 11/2013</p> <p>unidentified packs in a baggie [DM indicated tea bags] dated 2/2014. Observed the DM to label at that time.</p> <p>A. 2). On 4/16/14 at 10:26 a..am., observed 3 pans of cup cakes in the dry storage area uncovered. Cook #1 indicated, when asked should they be covered, "They should be." The DM indicated " I am letting them cool before I put anything over it."</p> <p>A. 3). On 4/17/14 at 12:28 p.m., Cook #1 was observed to remove 2 wet pans from underneath the cabinet. When asked was water in those pans. Cook #1 indicated "Yes, I just put them there from the steam table." When asked if those pans can be stored wet Cook #1 indicated "No." There was no policy provided.</p> <p>On 4/15/14 at 10:26 a.m., interview with the Administrator indicated when asked for policy of how to store items in the dry storage or freezers, "There is no policy for that other than the states policy of so many feet off the floor."</p> <p>A. 4). On 4/14/14 at 10:35 a.m., with the DM present observed the following in the refrigerator:</p> <p>margarine tub with no open date nor expiration date</p> <p>3 bowls of apple cobbler with no cooked date nor expiration date. The DM indicated when asked when was this pie made " I believe over the weekend. It was made on Sunday."</p>		<p>counseled and corrected regarding the facility hand washing policy.</p> <p>2. Any resident has the potential to be affected</p> <p>3. DM and HFA in-serviced dietary and SSD on 4-30-14 covering all the cited concerns. Cook #1 was given written counseling and one on one instruction.</p> <p>A new dish machine and 2 new water heaters have been installed, also a new chemical company has been contracted to supply chemicals for dish machine. The facility policy and procedure for hand washing was been reviewed, changed and updated to comply with recommended guidelines. DM has made certain that expiration dates are on all food in storage area and will check daily. DM has implemented a temperature log sheet and in-serviced staff to maintain dish machine operations</p> <p>4 – DM or designee will monitor daily for 30 days. DM, HFA and RD will monitor weekly for 60 days. DM and HFA will monitor for 6 months. DM will report to the QA committee quarterly in regular scheduled meetings and will follow the recommendations and comments.</p> <p>5. – Date Completed 5:17/14</p>				

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	<p>2 trays with spilled milk on them and several cups filled with milk no dates. The DM indicated when asked if those drinks were for today. "No, that was from yesterday and I have to clean up his mess. I will throw that out."</p> <p>A. 5). On 4/14/14 at 10:43 a.m., with the DM present observed the freezer to have 2 packs of unidentifiable meat [DM indicated chicken patties] no received date, no expiration date nor identity label, 4 pack of bologna with no expiration date and 2 boxes of bread on the freezer floor. The DM indicated when asked can those boxes be on the floor, " In the freezer. It shouldn't be I guess."</p> <p>On 4/16/14 at 10:24 a.m., observed the outside refrigerator freezer to have a temperature of 19 degrees Fahrenheit, standup freezer had temperature of 2 degrees. The DM indicated when asked what should the temperatures read. "It should be -10." Observed 2 packs [what the DM had indicate prior to be chicken patties] unlabeled and no expiration date. The outside refrigerator freezer had temperature of 19 degrees, standup freezer had temperature of 2 degrees. The DM indicated when asked what should the temperatures be. "It should be -10."</p> <p>On 4/17/14 at 8:35 a.m., with Cook #1 present observed the outdoor stand up freezer had a temperature of 10 degrees Fahrenheit, the outdoor refrigerator freezer had a temperature of 10 degrees Fahrenheit. When asked what should the temperature be for the freezer. Cook #1 indicated, "I was taught 10 degrees."</p> <p>On 4/17/14 at 9:00 a.m., interview with the</p>			

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	<p>ADM when asked if they had a policy and procedure for refrigerator and freezer temperatures indicated, "No, only what the state says."</p> <p>On 4/15/14 at 9:17 a.m., the ADM provided "Stock Storage Guidelines" dated 2004 and indicated that the policy was the one used by the facility. The policy indicated, "... Leftovers maximum temperature 40 degrees ... maximum storage 2 days (covered container)."</p> <p>A. 6). On 4/16/14 at 10:27 a.m., observed the trash can by the handwashing sink to have trash overflowing out the top of the can. The DM indicated when asked if the trash should be hanging out of the can. "No." Observed the DM to remove the trash bag at that time.</p> <p>A. 7). On 4/16/14 at 10:27 a.m., with the DM and Cook #1 present observed a tray of silverware being washed in the dishwasher. The dishwasher temperature was observed to be 110 degrees Fahrenheit and the rinse temperature 118 degrees Fahrenheit. A third wash temperature was observed to be 104 degrees Fahrenheit and rinse 108 degrees Fahrenheit. The DM indicated when asked what do you do if the temperature is not reaching required temperature. " We get maintenance. He ain't here today." When asked what is the temperature usually. " I don't know. Maintenance always checks the temperature." When asked to see the daily temperature log for the dishwasher. The DM indicated " Maintenance checks the temperatures. I guess he has the logs." When maintenance is not here who does the dishwasher temperatures. The DM indicated "[Name of housekeeping supervisor]." When asked how do you know the required</p>			

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	<p>temperature is reached. "I don't."</p> <p>On 4/16/14 at 10:50 a.m., interview with the Administrator indicated when asked who keeps track of daily dishwasher temperatures." The kitchen does their own temperature."</p> <p>On 4/16/14 at 11:00 a.m., interview with the DM, Housekeeping supervisor and ADM present the DM indicated that she doesn't keep a log of daily dishwasher temperature. When asked how do you know if water reaching the proper temperature to clean dishes if you don't check the temperature. " I don't." The ADM indicated to the DM "You should have a log. You are suppose to keep track of the dishwasher temperatures not maintenance."</p> <p>On 4/17/14 at 8:20 a.m., interview with the DM indicated when asked if water temperature were fixed. "No the plumber is suppose to be here early this morning." No chemical log was observed. When asked how did you do the dishes if water temperature not fixed. "Well last night it got hot." There was not observed any temperature documentation.</p> <p>On 4/17/14 at 8:30 a.m., the ADM indicated, "The plumber is putting in 2 water heaters."</p> <p>On 4/16/14 at 11:22 a.m., the Administrator provided Review of "DISHWASHER CHEMICAL CONTROL SHEET dated March/April 2014, indicated last day dishwasher chemical was checked was 4/8/14. The PPM (parts per million) range was 50-100 or 75-100. The DM indicated when asked had water chemical levels been checked since April 8th. "No." How do you</p>			

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	<p>know if chemical was at required level. No reply was given.</p> <p>On 4/17/14 at 8:39 a.m., the ADM provided "American Dish Service ... Model AF-3DS, AFC-3DS, AFB" manual dated 6/7/13 and indicated that was the one currently used by the facility. The manual indicated " ...#3 WATER HEATERS--or boilers must provide the minimum temperature of 120 degrees Fahrenheit required by the machine listed above ... The recommended temperature and for optimal performance is 130-140 degrees Fahrenheit. These specifications are for the dishmachine only, ... TYPE OF CHEMICALS-- ... Do not exceed 50 parts-per-million (PPM) ... Using higher than 50 ppm will be dependent on local health requirements ... "</p> <p>A. 8). On 4/17/14 at 8:30 a.m., observed the DM walk over to the dietary office, retrieve 2 pans from the ADM, place pans on the sink, walk over and open the kitchen door, retrieve a cart from the hall, enter the kitchen, open the refrigerator door, walk over to a cart in the kitchen, retrieve a tray for residents breakfast. No handwashing observed. When asked what did she forget to do. The DM indicated " When I walked out of the kitchen, cause I opened the door." Did you forget to handwash. "Yea." Observed the DM to handwash at that time.</p> <p>On 4/15/14 at 2:23 p.m., the ADM provided " Handwashing" no dated and indicated that was the one currently used by the facility. The policy indicated, Purpose: "To provide guidelines to employees for proper and appropriate handwashing techniques that will aid in the prevention of the transmission of infections. ... When to Wash Hands Appropriate thirty (30) -second handwashing</p>			

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
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	<p>must be performed under the following conditions: 1. Upon reporting for work; 2. Whenever hands are obviously soiled; ... 10. Before and after eating; 11. Whenever in doubt; and 12. Upon completion of duty."</p> <p>Review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24" dated November 13, 2004 on 3/25/14 at 3:00 p.m., indicated ..."Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately before engaging in food preparation. ... and the following... (6) After handling soiled surfaces, equipment, or utensils ... after engaging in other activities that contaminate the hands."</p> <p>On 4/17/14 at 12:28 p.m., observed food thermometers not to work properly. Cook #1 was observed to take temperature of pureed bologna with a thermometer which had current temperature of 58 degrees Fahrenheit before it was inserted in the bologna and never changed. Cook #1 with the DM present was unable to get the thermometer temperature to zero degrees Fahrenheit. Cook #1 was observed to take the thermometer outside to the outdoor freezer. [to see if temperature would drop to zero degrees] Cook #1 entered the kitchen and the thermometer was observed not to be</p>			

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F000441 SS=F	<p>at zero degrees. The DM was observed to leave the kitchen and go get another thermometer. The new thermometer was observed to have a temperature of 30 degrees Fahrenheit before it was used. The DM was observed to put the thermometer in a pitcher of ice to see if the temperature would drop to zero degrees.</p> <p>B). On 4/14/2014 at 12:40 p.m., an observation of meal service in the main dining room of the SSD (Social Services Director) indicated she washed her hands for 15 seconds. At that time an interview with her indicated the proper amount of time for handwashing was 30 seconds.</p> <p>On 4/15/2014 at 2:23 p.m., the Administrator provided the facilities current "Handwashing" policy. The policy indicated"When to Wash Hands appropriate 30 second handwashing must be performed under the following conditions...11. Whenever in doubt; and..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3) 3.1-21(i)(5) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents</p>						

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	<p>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure infection control practices were followed related to handwashing while assisting residents with their lunch and passing of ice in the hall as indicated by facility policy. This deficient practice had the potential to affect 35 of 35 residents. (CNA #1) (Helping Aid #1).</p> <p>Findings include:</p> <p>1. On 4/15/2014 at 11:01 a.m., an observation of Helping Aide #1 indicated she was passing ice to the residents. The lid to</p>	F000441	1. (1)The Helping Aide #1 was immediately reminded regarding correct procedure for passing ice water and using proper equipment. (2) The DON conducted mini In-Service circles for all C.N.A. regarding proper use of gloves.2. Any resident has the potential to be affected. 3. The DON In-Serviced all staff on Universal Precautions and Infection Control Policy and Procedure. Policy and Procedure was reviewed, updated and dated on 4/30/14. The DON and charge nurse will monitor the nursing	05/17/2014

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	<p>the cooler containing the ice was left open with the uncovered scoop handle hanging outside of the cooler. The Helping Aide #1 left room #3 and reached into the cooler to obtain the scoop. No handwashing or use of gloves was observed.</p> <p>On 4/16/2014 at 11:20 a.m., an observation of Helping Aide #1 passing ice to the residents indicated she went into room #5. No handwashing or use of gloves was observed. The cooler containing the ice was observed to be open with the uncovered scoop hanging out of it. She then pushed the cart down the hall with the cooler lid open and the uncovered scoop handle hanging out of the cooler. She then went into room #13, obtained their cup and began to place ice in the cup. No handwashing or use of gloves was observed.</p> <p>On 4/16/2014 at 11:23 a.m., an interview with the DoN (Director of Nursing) indicated the Helping Aide #1 should be wearing gloves and hand sanitizing. She then informed Helping Aide #1 that the cooler needs to be kept closed and the scoop needs to be kept in a separate closed container.</p> <p>2). Observation on 4/14/14 at 12:00 p.m., indicated CNA #1 was assisting Resident #36 with her tray. CNA #1 took the plastic covering off of the resident's drink and dessert with her ungloved hands and threw the plastic away in the trash can located in the hall. The trash can CNA #1 used had a lid on it that had to be pushed in to open so debris could be put in it. She then went back into the dining room and started to assist the resident with her lunch. When Resident #36 was finished eating, CNA #1 took the resident into her room and let her sit in the chair. Resident #11, which is the room mate</p>		<p>department on a daily basis x30 days then q wk x1 month then 1 month x3 to assure compliance.4. The DON will report to the QA committee on a quarterly basis for 6 months and will follow their comments or recommendations.5. Date completed 5/17/14.</p>	

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	<p>of Resident #36, wanted assistance from CNA #1. CNA #1 went to Resident #11's side of the room and started helping Resident #11 with her items. CNA #1 then put gloves on and took the trash out of Resident #11's wastebasket. CNA #1 walked out of the room with the trash with her gloves still on. CNA #1 was observed not to wash her hands during care between resident.</p> <p>On 4/15/14 at 2:23 p.m., the Administrator provided the "Handwashing" policy, no date, and indicated the policy was the one currently used by the facility. The policy indicated, "Handwashing. Purpose: To provide guidelines to employees for proper and appropriate handwashing techniques that will aid in the prevention of the transmission of infections...When to wash hands: Appropriate thirty (30)-second handwashing must be performed under the following conditions: 5. After having prolonged contact with a resident; 6. After handling...contaminated tissues, linen, etc.;...8. After handling items or work surfaces potentially contaminated with a resident's...secretions...11. When in doubt...12. Upon completion of duty..."</p> <p>3.1-18(l)</p>						