

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00127149, IN00127770, IN00127927, and IN00128370.</p> <p>This visit was in conjunction with Complaint IN00128639.</p> <p>Complaint IN00127149 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F311 and F353.</p> <p>Complaint IN00127770 - Substantiated. Federal/state deficiencies related to the allegations are cited at F353.</p> <p>Complaint IN00127927 - Substantiated. Federal/state deficiencies related to the allegations are cited at F353.</p> <p>Complaint IN00128370 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: April 30, May 1,2,3, 6, 7, 8, and 9, 2013</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p>	F000000		

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>Survey team: Diana Sidell RN TC Gordon Tyree RN</p> <p>Census bed types: SNF: 9 NF: 50 SNF/NF: 44 Total: 103</p> <p>Census payor type: Medicare: 9 Medicaid: 78 Other: 16 Total: 103</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/17/13 by Suzanne Williams, RN</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) 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 record review and interview, the facility failed to ensure residents' care plans were updated with new interventions after falls. This affected 2 of 5 sampled residents reviewed for care plan updates related to falls. (Residents #20 and #143)</p> <p>Findings included:</p> <p>1. Resident #20's record review was done on 5/7/13 at 9:24 a.m. The record indicated Resident #20 was admitted with diagnoses that included, but were not limited to, dysarthria, confusion, peripheral</p>	F000280	<p>1. Resident 143 no longer resides in the facility. Resident 20 had an appropriate intervention added to the care plan, which was reviewed and implemented by the falls committee on 5/10/13. 2. Review of all residents with a fall in the last 30 days for appropriate intervention and revision of care plan shows no other residents identified. 3. In-serviced all current nurses as to the proper procedure to follow when updating/reviewing resident care plans after resident has sustained a fall. The Administrator re-educated department managers as to facility policy with respect to care</p>	06/08/2013			

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	<p>neuropathy, chronic obstructive pulmonary disease, old stroke with residual right sided deficits, high blood fats, chronic kidney disease, anemia, osteoporosis, hypothyroidism, low blood pressure, high blood sugar, depression due to general medical condition, and probable senile dementia - vascular type.</p> <p>Physician's monthly rewrite orders dated 5/2013, indicated: "May participate in activities program per plan, activities as tolerated."</p> <p>Nurse's notes dated 4/25/13 at 1:00 p.m. indicated: "Summoned to room by ADON (Assistant Director of Nursing). Upon entering room res (resident) noted to be on floor in upright position [with] buttocks on floor. States stumbled on way out of bath room. States hit head @ some spot as previous falls. Pointing to (R) forehead just above (R) eyebrow. Noted yellowish discoloration from fading bruise. Res c/o (complained of) slight pain @ head & (R) wrist, this nurse noted red drainage sm (small) amt (amount) (R) lat[eral] wrist. Area washed [with] soap & h2o noted purplish discolored area 4X1 cm. [No] skin displacement noted [no] further drainage dry dressing applied.</p>		<p>plan procedures and/or revisions. All residents that have sustained falls will be reviewed in daily stand up meeting for appropriate interventions and care plan revision. 4. The Director of Clinical Services and/or designee will report the results of QA monitoring to the QAPI committee monthly, for continued substantial compliance. The results will also be reported during the quarterly committee meeting with the Medical Director. This is an ongoing process.5. This plan of correction constitutes or credible allegation of compliance with all regulatory requirements. Our completion date is 6/8/13.</p>		

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	<p>Res able to move all extremities well & upon command. Family & MD here @ facility & notified of above. Neuro checks initiated. B/P 147/87 HR 82 R 18 T 97.8 Pupils equal & reactive to light hand strength equal."</p> <p>Nurse's notes dated 4/27/13 at 3:00 a.m. indicated: "res. awakens easily. Alert & oriented X3. Speech approp[riate]. skin W/D (warm and dry), bruising X 3 to (R) Arm [with] small OA (open area) scabbed over. Res. states "(R) side sore but not as sore as yesterday." Noted sm area to (R) forehead 1/2" scratch. Res. able to convey events of 4/25/13...."</p> <p>A care plan with a start date of 1/26/13 indicated: "Problem/Need: of Potential for fall related to weakness/difficulty in walking/dizziness. Goal & Target Date: Remain free of injuries as evidence by no contusions, bruises, skin tears or laceration by next review. Will have no serious injury from falls by next review. Fall risk assessment. Will lock wheels chair during transfers. Will request assistance for transfers. Approaches: Monitor/anticipate/intervene for factors causing prior falls. Answer call light promptly. Encourage use of assistive devices (glasses, walkers,</p>			

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	<p>cane, etc as clinically indicated.) Provide needed devices for locomotion, transfer wheelchair, walker. Encourage to use hand rails and assistive devices. Environment free of clutter, free of slippery floors, bed height appropriate. Keep items in reach, call system, glasses, water pitcher. Assure non-skid footing used. Fit properly, and supportive. Fall risk assessment quarterly and PRN. Observe for any injuries unexplained...."</p> <p>No care plan update was added after the fall on 4/25/13.</p> <p>A fall risk assessment, dated 4/16/13, indicated a score of 9, where a score of 10 or above indicated a high risk for falls.</p> <p>During an interview, on 5/9/13 at 4:25 p.m., LPN #1 indicated the care plan had not been updated for this resident.</p> <p>2. Resident #143's record was reviewed on 5/7/13 at 11:37 a.m. The record indicated Resident #143 had diagnoses that included, but were not limited to, abnormal gait, high blood pressure, allergies, dementia, osteoporosis, high blood fats, right upper extremity fracture, and anemia.</p>				

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	<p>A fall risk assessment dated 3/12/13 indicated a score of 16, where a score of 10 or higher indicates a high risk for falls.</p> <p>An MDS dated 3/18/13 indicated Resident #143 made self understood, usually understood others, required extensive assist of one for transfers, ambulated occasionally, required extensive assist of one for toileting, was not steady with balance while walking, turning with walking, balance moving on and off toilet and surface to surface transfer and was only able to stabilize with staff assistance.</p> <p>Nurse's notes, dated 3/27/13 at 12:25 a.m., indicated: "Resident was heard by staff when she got up out of bed & fell. Found with head against corner of dresser & 1 inch laceration Rt (right) parietal occipital (back) area of head. No LOC (loss of consciousness) noted. Appears to be thru most all layers of skin & oozing blood. Res[ident] V/S 90/73 - 91 - 20 - 98% O2 (oxygen) on R/A (room air) t. 98.8."</p> <p>Nurse's notes, dated 3/27/13 at 12:45 a.m., indicated: "Area cleansed & cold rag held to stop bleeding. Res. assisted up in w/c (wheel chair) to nsg</p>			
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	<p>(nursing) station. Nurse practitioner notified & n.o. (new order) recd (received) to send to ER (emergency room) for evaluation. DON notified. Family notified & will meet her at hospital."</p> <p>Nurse's notes, dated 3/27/13 at 3:00 a.m., indicated: "Returned from hosp [with] incision approximated [with] glue. New instructions for no ointments or creams to head wound & Bacitracin daily to (R) lower leg abrasions until healed."</p> <p>A care plan, initiated 12/31/12, and updated 2/28/13, indicated a Problem/need for "Potential for falls due to cognitive deficit/poor safety awareness /medications/multiple co-morbidities/unsteady gait/weakness. Goal & target date: [Resident #143] will be free of any injurious falls. (5/28/13) Approaches: Assist [Resident #143] with - assist for all ambulation. Assist [Resident #143] with two staff members for all ambulation. Keep walker within [Resident #143's] reach at all times. Remind [Resident #143] to ask for assist for all ambulation. Refer [Resident #143] for PT/OT as necessary. Refer [Resident #143] to restorative nursing program as appropriate. Monitor for changes in</p>						

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	<p>[Resident #143's] condition that may warrant increased supervision/assistance and notify the physician. [Resident #143] uses a wheelchair for long distance mobility. 2/18/13 - Therapy screen. UA (urinalysis) for change in cognition/confusion. 3/12/13 - Self locking brakes to w/c. 3/13/13 Therapy screen."</p> <p>No new interventions were added to care plan after the fall on 3/27/13.</p> <p>During an interview, on 5/9/13 at 4:25 p.m., LPN #1 indicated the care plan had not been updated for this resident.</p> <p>A policy and procedure for "Care Plan", with a revision date of 9/1/11, was provided by the Director of Nurses on 5/9/13 at 6:17 p.m. The policy indicated, but was not limited to, "Policy: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on as as needed basis...Goals must be measurable and objective. Procedure: 4...For event updates/reviews (such as falls or adding interventions to one problem), the Director of Clinical Services will note 'Problem' number</p>				

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	<p>and sign off. If the DON is on leave from the building (vacation/hospital, etc), the Director of Clinical Services designee can sign in their place until the Director of Clinical Services' return...23. The Care Planning Coordinator is to review the 24-Hour Report daily for significant changes or changes in resident's ADL status. The Care Planning coordinator will add minor changes in resident's status to the existing Care Plans on a daily basis. 24. Care Plans are to be maintained with the current Medical Record...."</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure residents received restorative nursing and continence tracking according to their care plans, for 2 of 26 residents whose care plans were reviewed. (Resident #A and #L)</p> <p>Findings include:</p> <p>1. Resident #A's record was reviewed on 5/6/13 at 7:58 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, urinary retention, eye dryness, constipation, anemia, overactive bladder, bladder spasms, heart disease, and wound healing.</p> <p>Physician's activity orders, dated for May 2013, indicated "Activities as tolerated." Will do therapeutic work as desired.</p> <p>A Quarterly Minimum Data Set Assessment, dated 2/28/13, indicated Resident #A had modified independence, some difficulty in new</p>	F000282	<p>1. The restorative plan for resident A will be followed: the resident will receive active ROM to bilateral upper and lower extremities; the resident will also receive restorative transfers/ambulation per care plan. Resident L's voiding diary was initiated on admission per policy. The voiding diary was located after surveyors left the building. 2. a) All residents in the restorative program have potential to be effected. b) 100% audit of all new admissions in the last 30 days to ensure the voiding diary has been initiated and completed; assessment of need for bowel and bladder training and/or toileting program. Any identified residents will have voiding diary initiated and an assessment completed.3. Director of Clinical Services and/or designee in-serviced all nursing staff to the policy and procedures for initiation of the voiding diary, continence/incontinence data collection, bowel and bladder and/or toileting program. The case mix manager educated the restorative staff on the new restorative forms/policy on 5/31/13.4. All new admissions</p>	06/08/2013	

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	<p>situations only in cognitive skills for daily decision making, required extensive assist of one person for transfers, limited assist of one person with walking in the room or corridor, could not balance while moving from seated to standing position, walking, turning around and facing the opposite direction while walking, or transfer between bed and chair or wheel chair without assist, had functional limitations in range of motion in the upper extremities (shoulders, elbows, wrist, hand), and impairment on both sides of the lower extremities (hip, knee, ankle, foot), and used a wheel chair for mobility.</p> <p>A care plan for restorative indicated: "Program - AROM (Active range of motion) BUE (bilateral upper extremities)/BLE (bilateral lower extremities), /Transfers/Ambulation. Goal & Target Date: Resident will participate in restorative program. Resident will transfer safely from surface to surface w (with)/staff assist and appropriate equipment. Approaches: ROM (range of motion) to Bue/Ble 15 reps tid (three times a day), (Resident #A) to ambulate 50-100 ft w (with) rww (rolling walker) and 1 assist w leg braces on bilateral legs (Resident likes to put them on herself), Orient to task at hand. Use</p>		<p>will be reviewed/audited daily to ensure that the voiding diary and continence/incontinence data collection are initiated and completed. Continence/incontinence information will be re-evaluated quarterly and prn. MDS Coordinator/designee will complete weekly audit of restorative nursing programs to ensure all programs are completed per the care plan. These audits will be reviewed in monthly QA meetings and quarterly with the Medical Director. 5. This plan of correction constitutes or credible allegation of compliance with all regulatory requirements. Our completion date is 6/8/13.</p>				

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	<p>simple, brief statements, Call by Proper name, Use visual cues with verbal cues, Encourage use of adaptive equipment such as eye glasses, dentures, hearing etc. Do not exceed point of pain. See Restorative flow sheets for specific approaches. Check for skin break down in creases of hands, elbows, axillary, popliteal and groin areas. Do not attempt ROM when resident is agitated or resistive to care. Re-approach. Praise for all participation."</p> <p>A restorative nursing care plan indicated the resident was supposed to Ambulate 250 feet each day as tolerated, 7 days a week with rolling walker and a wheelchair following. She was also to attend a.m. exercise class for active and passive range of motion with verbal cues, and hands on as needed.</p> <p>A "Restorative Nursing Care Report" indicated the resident missed 8 days of restorative walking in April, between April 1-30, and 2 days of restorative walking in May between May 1-9, 2013.</p> <p>During an interview, on 5/9/13 at 4:26 p.m., CNA #3 indicated Resident #A didn't get to walk on Tuesday May 7,</p>						

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	<p>and Wednesday May 8. She said sometimes she doesn't get to walk quite a bit because the restorative aid is pulled to help on the halls. She also said it is a "whole days work" to walk everyone who is supposed to be walked.</p> <p>A policy and procedure for "Restorative Nursing" was provided by the Director of Nursing on 5/9/13 at 6:17 p.m. The policy indicated, but not was not limited to, "Team Members & Their Roles...Restorative Aides: The designated Restorative Aides follow the plan, developed by the team, and provide the direct care needs of the resident. The Aides will be responsible for the documentation of the care given...Restorative Staff...Designated Restorative Aides; Provide programming, document programming. Administrative Staff: Ensure back-up for Restorative Aides. Do not pull Restorative Aides to floor for general care...."</p> <p>2. Resident #L's record review was done on 5/8/13 at 2:50 p.m. The record indicated Resident #L had diagnoses that included, but were not limited to, seizure disorder, and early onset pre-senile dementia Alzheimer's type with delusions, and agitation.</p>			

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	<p>An admission assessment, dated 12/20/12, indicated Resident #L was severely impaired in cognitive skills for decision making, had long term memory problems, sometimes made himself understood, sometimes understood others, had sleep cycle issues, wandered, was continent of bowels, frequently continent of bladder, and wore briefs/pads. The section for "Potential for bowel/bladder training" was not completed that would have indicated the potential for bowel and bladder retraining.</p> <p>An admission care plan, dated 12/20/12, indicated "ADL Functional/Rehab Potential" with a goal of "Resident will achieve maximum functional mobility" and the intervention was "Toileting w/assist of 1" and a care plan for "B/B (bowel and bladder) Incontinence/Catheter Care" with a goal of "Resident will establish bowel/bladder routine" and an intervention of "Start continence tracking form."</p> <p>An Admission Minimum Data Set Assessment, dated 12/27/12, indicated Resident #L had no trial toileting program attempted, no entry for either "Yes" or "No" that the</p>				

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	<p>resident was on a toileting program, and this resident was frequently incontinent of urine - 7 or more incontinent episodes, but at least 1 episode of continent voiding.</p> <p>During an interview on 5/9/13 at 3:18 p.m., LPN #1 indicated there was no continence tracking form completed upon admission.</p> <p>This Federal tag relates to Complaint IN00127149.</p> <p>3.1-35(g)(2)</p>			

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F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure a resident received restorative nursing to maintain or improve her abilities for 1 of 3 residents reviewed for restorative nursing programs. (Resident #A)</p> <p>Findings include:</p> <p>1. Resident #A's record was reviewed on 5/6/13 at 7:58 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, urinary retention, eye dryness, constipation, anemia, overactive bladder, bladder spasms, heart disease, and wound healing.</p> <p>Physician's activity orders, dated for May 2013, indicated "Activities as tolerated." Will do therapeutic work as desired.</p> <p>A Quarterly Minimum Data Set Assessment, dated 2/28/13, indicated Resident #A had modified independence, some difficulty in new</p>	F000311	<p>1. The restorative plan for resident A will be followed: the resident will receive active ROM to bilateral upper and lower extremities; the resident will also receive restorative transfers/ambulation per care plan.2. All residents in the restorative program have potential to be effected. 3. The case mix manager educated the restorative staff on the new restorative forms/policy on 5/31/13.4. The MDS Coordinator/designee will complete weekly audit of restorative nursing programs to ensure all programs are completed per the care plan. These audits will be reviewed in monthly QA meetings and quarterly with the Medical Director.5. This plan of correction constitutes or credible allegation of compliance with all regulatory requirements. Our completion date is 6/8/13.</p>	06/08/2013	

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	<p>situations only in cognitive skills for daily decision making, required extensive assist of one person for transfers, limited assist of one person with walking in the room or corridor, could not balance while moving from seated to standing position, walking, turning around and facing the opposite direction while walking, or transfer between bed and chair or wheel chair without assist, had functional limitations in range of motion in the upper extremities (shoulders, elbows, wrist, hand), and impairment on both sides of the lower extremities (hip, knee, ankle, foot), and used a wheel chair for mobility.</p> <p>A care plan for restorative indicated: "Program - AROM (Active range of motion) BUE (bilateral upper extremities)/BLE (bilateral lower extremities), /Transfers/Ambulation. Goal & Target Date: Resident will participate in restorative program. Resident will transfer safely from surface to surface w (with)/staff assist and appropriate equipment. Approaches: ROM (range of motion) to Bue/Ble 15 reps tid (three times a day), (Resident #A) to ambulate 50-100 ft w (with) rww (rolling walker) and 1 assist w leg braces on bilateral legs (Resident likes to put them on herself), Orient to task at hand. Use</p>			

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	<p>simple, brief statements, Call by Proper name, Use visual cues with verbal cues, Encourage use of adaptive equipment such as eye glasses, dentures, hearing etc. Do not exceed point of pain. See Restorative flow sheets for specific approaches. Check for skin break down in creases of hands, elbows, axillary, popliteal and groin areas. Do not attempt ROM when resident is agitated or resistive to care. Re-approach. Praise for all participation."</p> <p>A restorative nursing care plan indicated the resident was supposed to Ambulate 250 feet each day as tolerated, 7 days a week with rolling walker and a w/c following. She was also to attend a.m. exercise class for active and passive range of motion with verbal cues, and hands on as needed.</p> <p>A "Restorative Nursing Care Report" indicated the resident missed 8 days of restorative walking in April, between April 1-30, and 2 days of restorative walking in May between May 1-9, 2013.</p> <p>During an interview, on 5/9/13 at 4:26 p.m., CNA #3 indicated Resident #A didn't get to walk on Tuesday May 7,</p>						

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	<p>and Wednesday May 8. She said sometimes she doesn't get to walk quite a bit because the restorative aid is pulled to help on the halls. She also said it is a "whole days work" to walk everyone who is supposed to be walked.</p> <p>A policy and procedure for "Restorative Nursing" was provided by the Director of Nursing on 5/9/13 at 6:17 p.m. The policy indicated, but not was not limited to, "Team Members & Their Roles...Restorative Aides: The designated Restorative Aides follow the plan, developed by the team, and provide the direct care needs of the resident. The Aides will be responsible for the documentation of the care given...Restorative Staff...Designated Restorative Aides; Provide programming, document programming. Administrative Staff: Ensure back-up for Restorative Aides. Do not pull Restorative Aides to floor for general care...."</p> <p>This Federal tag relates to Complaint IN00127149.</p> <p>3.1-38(a)(2)(B)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review, interview, and observation, the facility failed to initiate their toileting program in that one resident did not receive services to maintain or restore bladder function. This affected 1 of 3 residents reviewed for urinary incontinence of 3 who met the criteria for urinary incontinence. (Resident #L)</p> <p>Findings include:</p> <p>Resident #L's record review was done on 5/8/13 at 2:50 p.m. The record indicated Resident #L had diagnoses that included, but were not limited to, seizure disorder, and early onset pre-senile dementia Alzheimer's type with delusions, and agitation.</p> <p>An admission assessment, dated 12/20/12, indicated Resident #L was</p>	F000315	<p>1. Resident L's voiding diary was initiated on admission per policy. The voiding diary was located after surveyors left the building.</p> <p>2. 100% audit of all new admissions in the last 30 days to ensure the voiding diary has been initiated and completed; assessment of need for bowel and bladder training and/or toileting program. Any identified residents will have voiding diary initiated and an assessment completed.</p> <p>3. Director of Clinical Services and/or designee in-serviced all nursing staff to the policy and procedures for initiation of the voiding diary, continence/incontinence data collection, bowel and bladder and/or toileting program.</p> <p>4. All new admissions will be reviewed/audited daily to ensure that the voiding diary and continence/incontinence data collection are initiated and completed.</p> <p>Continence/incontinence</p>	06/08/2013			

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	<p>severely impaired in cognitive skills for decision making, had long term memory problems, sometimes made himself understood, sometimes understood others, had sleep cycle issues, wandered, was continent of bowels, frequently continent of bladder, and wore briefs/pads. The section for "Potential for bowel/bladder training" was not completed that would have indicated the potential for bowel and bladder retraining.</p> <p>An Admission Minimum Data Set Assessment, dated 12/27/12, indicated Resident #L had no trial toileting program attempted, no entry for either "Yes" or "No" that the resident was on a toileting program, and this resident was frequently incontinent of urine - 7 or more incontinent episodes, but at least 1 episode of continent voiding.</p> <p>An admission care plan, dated 12/20/12, indicated "ADL Functional/Rehab Potential" with a goal of "Resident will achieve maximum functional mobility" and the intervention was "Toileting w/assist of 1" and a care plan for "B/B (bowel and bladder) Incontinence/Catheter Care" with a goal of "Resident will establish bowel/bladder routine" and</p>		<p>information will be re-evaluated quarterly and prn. 5. This plan of correction constitutes or credible allegation of compliance with all regulatory requirements. Our completion date is 6/8/13.</p>	

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	<p>an intervention of "Start continence tracking form."</p> <p>During an interview on 5/9/13 at 3:18 p.m., LPN #1 indicated there was no continence tracking form completed upon admission.</p> <p>During an observation, on 5/8/13 at 3:10 p.m., Resident #L was ambulating around the activity/dining room on the "B" hall when CNA #2 assisted him to the bathroom. CNA #2 had approached the resident and said "Let's go to the bathroom", then the resident walked with him to the bathroom.</p> <p>During an interview, on 5/8/13 at 3:34 p.m., CNA #2 said the resident was "incontinent all of the time."</p> <p>A policy and procedure for "Bladder Independence/Retraining" was provided by the Director of Nursing on 5/9/13 at 7:22 p.m. The policy indicated, but was not limited to, "Policy: Residents will be assessed for bladder independence/ retraining after determining the type of bladder incontinence. Those residents identified as potential candidates for bladder independence/ retraining program will be evaluated by the interdisciplinary team to determine</p>						

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	<p>the implementation of a bladder independence-retraining program. Procedure: 1. A Potential for Bowel/Bladder Retraining form will be completed. A resident that receives a score of 0 - 6 is not considered a candidate for retraining. Residents that score 7 - 14 are to be considered candidates and residents that score 15 - 21 are considered good candidates for retraining. 2. Information will also be gathered by completing the Incontinence Data Collection Tool. 3. An observation of resident voiding times will determine, residents who have potential for improved bladder function. These potential candidates include residents who: a. Have the ability and willingness to understand and cooperate in the program AND...c. Have recently (within last 3 to 4 months) developed a loss of bladder control AND/OR d. Have potential for improvement of bladder function...."</p> <p>3.1-41(a)(2)</p>				

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F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review, and interview, the facility failed to provide sufficient nursing staffing to meet the needs of the residents. This affected Residents #F, E, A, and had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Dressing change observations were done on 5/8/13 at 10:39 a.m., with LPN #6, for Resident #F. The dressing that was removed from the</p>	F000353	<p>1. a) Resident F: wound on lower buttock was cleansed and a clean dressing applied; tracheostomy area was cleansed and a clean dressing applied.b) Resident E: G tube site cleansed and dressing applied.c) Resident A: restorative plan for active range of motion to bilateral upper and lower extremities and restorative plan for transfers and ambulation will be followed as written per care plan.The restorative aide will only be involved in restorative programming. d) The facility will advertise with newspapers in the surrounding counties to recruit</p>	06/08/2013			

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	<p>left lower buttock was dated 5/7/13 on the 6 a.m. - 2 p.m. shift. The dressing that was removed from the tracheostomy was dated 5/7/13 on the 6 a.m.-2 p.m. shift. When queried about dressing change times, LPN #6 indicated the dressing should have been changed on the second shift the night before.</p> <p>Resident #F's record was reviewed on 5/3/13 at 12:40 p.m. The record indicated Resident #F was admitted with diagnoses that included, but were not limited to, respiratory failure and pneumonia.</p> <p>Current physician's orders dated 5/1/2013 through 5/31/2013, indicated Resident #F's dressing to the left lower back was to be changed twice a day once on the 6 a.m. to 2 p.m. shift and once on the 2 p.m. to 10 p.m. shift.</p> <p>2. A dressing change observation was done with LPN #6 on 5/8/13 at 11:47 a.m., on Resident #E, and the dressing removed from the gastrostomy tube site was dated 5/7/13 on the 6 a.m. - 2 p.m. shift. LPN #6 indicated the dressing was supposed to be changed twice a day</p> <p>Resident #E's record was reviewed</p>		<p>nursing staff. 2. a) All residents have the potential to be effected by the alleged staffing concerns. b) The facility completed an audit on 5/22/13 of all resident dressing changes, and any concerns of dressing changes were immediately addressed. c) A 100% audit of resident files completed for residents receiving restorative programming to ensure that restorative programming is completed as indicated in resident care plans. 3. a) All nursing staff were in-serviced on 5/17/13 that physicians orders must be followed as to cleansing and changing all resident dressings. b) Nursing staff was in-serviced on facility policy and procedure for restorative programming and to the facility policy that the restorative aide will be designated to perform only restorative programming. 4. a) Director of Clinical Services and/or designee will perform an audit daily on each unit to ensure that all dressing changes are completed per M.D. orders for a period of 2 weeks; then 3 times per week on each unit for 2 weeks; then weekly on each unit for 2 weeks, then weekly on a random unit for one month, then randomly on different units for 1 month, until it has been determined by the QA committee that the issue has been resolved. b) The MDS coordinator/designee will audit weekly to ensure that restorative</p>		

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	<p>on 5/9/13 at 4:15 p.m. The record indicated Resident #E was admitted with diagnoses that included, but were not limited to, stroke, locked in state, quadriplegia, difficulty swallowing, chronic pain, anxiety, and did not speak.</p> <p>Current physician's orders dated May 1 through May 31, 2013 indicated Resident #E's gastrostomy tube site was to be monitored twice a day, and Zinc oxide cream applied around the site and change the dressing twice a day on the 6 a.m. to 2 p.m. shift and on the 2 p.m. to 10 p.m. shift.</p> <p>3. Resident #A's record was reviewed on 5/6/13 at 7:58 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, urinary retention, eye dryness, constipation, anemia, overactive bladder, bladder spasms, heart disease, and wound healing.</p> <p>Physician's activity orders, dated for May 2013, indicated "Activities as tolerated." Will do therapeutic work as desired.</p> <p>A care plan for restorative indicated: "Program - AROM (Active range of motion) BUE (bilateral upper</p>		<p>programs are completed on a daily basis. The results of the audits will be reviewed in the Monthly QA meeting, and Quarterly with the Medical Director. c)The staffing ratio will be reviewed daily in the a.m. meeting to ensure that adequate staff is available.5. This plan of correction constitutes or credible allegation of compliance with all regulatory requirements. Our completion date is 6/8/13.</p>		

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	<p>extremities)/BLE (bilateral lower extremities), /Transfers/Ambulation. Goal & Target Date: Resident will participate in restorative program. Resident will transfer safely from surface to surface w (with)/staff assist and appropriate equipment. Approaches: ROM (range of motion) to Bue/Ble 15 reps tid (three times a day), (Resident #A) to ambulate 50-100 ft w (with) rww (rolling walker) and 1 assist w leg braces on bilateral legs (Resident likes to put them on herself), Orient to task at hand. Use simple, brief statements, Call by Proper name, Use visual cues with verbal cues, Encourage use of adaptive equipment such as eye glasses, dentures, hearing etc. Do not exceed point of pain. See Restorative flow sheets for specific approaches. Check for skin break down in creases of hands, elbows, axillary, popliteal and groin areas. Do not attempt ROM when resident is agitated or resistive to care. Re-approach. Praise for al participation.</p> <p>A restorative nursing care plan indicated the resident was supposed to Ambulate 250 feet each day as tolerated, 7 days a week with rolling walker and a w/c following. She is also to attend a.m. exercise class for</p>			

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	<p>active and passive range of motion with verbal cues, and hands on as needed.</p> <p>A "Restorative Nursing Care Report" indicated the resident missed 8 days of restorative walking in April, between April 1-30, and 2 days of restorative walking in May between May 1-9, 2013.</p> <p>During an interview, on 5/9/13 at 4:26 p.m., CNA #3 indicated Resident #A didn't get to walk on Tuesday May 7, and Wednesday May 8. She said sometimes she doesn't get to walk quite a bit because the restorative aide is pulled to help on the halls. She also said it is a "whole days work" to walk everyone who is supposed to be walked.</p> <p>A policy and procedure for "Restorative Nursing" was provided by the Director of Nursing on 5/9/13 at 6:17 p.m. The policy indicated, but not was not limited to, "Team Members & Their Roles...Restorative Aides: The designated Restorative Aides follow the plan, developed by the team, and provide the direct care needs of the resident. The Aides will be responsible for the documentation of the care given...Restorative Staff...Designated Restorative Aides;</p>						

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	<p>Provide programming, document programming. Administrative Staff: Ensure back-up for Restorative Aides. Do not pull Restorative Aides to floor for general care...."</p> <p>4. During an interview on 5/6/13 at 5:15 a.m., CNA #7 indicated on her hall she has 28 residents with one CNA during the night. She said she stays busy and is usually here a half hour to an hour past her shift because she has so many people to get up and get dressed, and has to get help with the two person assists. She said the charge person on her hall helps her when she needs help.</p> <p>During an interview on 5/6/13 at 5:55 a.m., LPN #8 indicated they have been short nurses and aides, but "they just got agency in here and it's been better."</p> <p>A family member who wished to be anonymous, indicated that sometimes they have to wait two hours for staff to change their family member who was wet and soiled. Also, there is one aide on the floor for each hall during the evening at times, and wonders how one person can turn residents when they need two to be turned. The aide has to go to another hall to get help.</p>				

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	<p>During an interview on 5/9/13 at 1:50 p.m., Corporate Nurse #1 and Corporate Nurse #2 indicated they have been given permission to give a wage increase. They are working on the "per patient day" staffing ratio which is 3.10 staffing hours per patient per day, this includes nursing, QMAs, CNAs, and restorative aides. They indicated they are putting ads in newspapers in the surrounding counties to recruit nurses.</p> <p>This Federal tag relates to Complaints IN00127149, IN00127770, IN00127927.</p> <p>3.1-17(a)</p>				

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as 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> <p>Based on observation, interview, and record review, the facility failed to</p>	F000441	1. a) LPN #4 was educated/in-serviced that hand	06/08/2013			

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	<p>ensure their infection control policies related to hand hygiene and glove use were followed during 3 care observations, failed to ensure their infection tracking logs were completed in order to monitor and track infections in the facility, and failed to ensure an employee had a first step Tuberculin test read, and a second step Tuberculin administered for 1 of 10 employees reviewed for Tuberculin testing. This affected Residents #9, #F, LPN #4, Speech Therapist #1, Employee #5, and had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 5/7/13 at 8:56 a.m., during a medication pass observation, LPN #4 did not wash her hands before pouring meds for Resident #9, and touched the pills with her bare hands. <p>During an interview on 5/7/13 at 12:29 p.m., LPN #4 indicated she had washed her hands before she went to get Resident #9 in the dining room, checked Resident #9's blood pressure, then wheeled her back to her room and did not wash her hands before setting up her meds.</p> <ol style="list-style-type: none"> During an observation on 5/8/13 at 		<p>washing must occur prior to, during, and after the administration of resident medication. b) The Speech Therapist was in-serviced that gloves should not be worn in the hallway, and that gloves should be changed and hands washed when moving from resident to resident to assist with face and hand washing. The Therapist was also in-serviced as to the proper protocol to follow when entering and exiting an isolation room, including proper hand washing and glove use. c) Housekeeper #5 was administered a Tuberculin Skin Test (TST) on the date that the concern was identified. The test was read within the appropriate timeframe and the results were 0 mm (negative). The 2nd step TST will be administered and read as required. 2. All residents have the potential to be effected.3. The facility in-serviced all nursing/therapy staff as to facility policy for infection control, hand washing, glove use, changing of gloves, prohibition of gloves worn in the hallways, and to the importance of hand washing when changing and removing gloves. The staff were also in-serviced as to the proper procedure to follow when caring for residents in isolation, including hand washing, changing and removing gloves prior to leaving an isolation room. Nurses also in-serviced on proper hand</p>		

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	<p>8:15 a.m., Speech Therapist #1 wore gloves as she pushed a resident in a wheelchair into the dining room off the 'D' hall. She then moved some chairs around, and washed the face and hands of another resident who sat at the same table as the first resident she had brought in. She was then observed to change the gloves, but did not wash her hands after she removed the first pair of gloves.</p> <p>On 5/8/13 at 10:39 a.m., Speech Therapist #1 was observed in Resident #F's room, an isolation room for Methicillin Resistant Staphylococcus Aureus (MRSA) in a tracheostomy. Speech Therapist #1 wore gloves, had a mask on while she worked with the resident. She was observed as she removed her gloves, put clean gloves on, but did not wash her hands before or after, and then left the room without removing the gloves.</p> <p>During an interview on 5/9/13 at 3:58 p.m., the Therapy Supervisor indicated Speech Therapist #1 was a contracted employee and she does receive facility inservices here which includes handwashing.</p> <p>A policy and procedure for "Introduction to Isolation Precautions"</p>		<p>hygiene and glove use with medication administration.a)Facility completed audit of all staff for completion of TST. 4. a) The IDT will monitor during the daily QA rounds for adherence to the infection control policy/procedure. The IDT will further monitor as to appropriate hand washing, glove changes as needed and for glove use as necessary during medication pass. b) DON/Designee will complete a medication pass observation as to appropriate hand washing and glove use daily on a random units for one month; then weekly on units for one month; then monthly on random units for one quarter. Quarterly random audits will continue until the QA committee determines that compliance has been achieved. c) The Therapy Director will perform random weekly audits of the Therapy staff to ensure that appropriate hand washing and glove use is occurring. d) The Monthly Line List Report (Monthly Infection Control Log) will be completed in its entirety, including the organism if a culture is completed. e) No employee will begin employment until the TST (Tuberculin Skin Test) has been given and read. e) All audits will be reviewed weekly on Fridays in the morning meeting; in the monthly QA meetings; and quarterly with the Medical</p>				

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	<p>was provided by the Director of Nursing on 5/1/13 at 11:42 a.m. The policy included, but was not limited to: "Policy: The facility will adhere to isolation practices as recommended by the Center for Disease Control and Hospital Infection Control Advisory Committee publication, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007, to prevent the spread of communicable diseases. Procedure: 1. The facility will use two tiers of precautions. a. Standard Precautions is the first tier (and most important) and are designed for the care of all residents in the facility regardless of their diagnoses or presumed infection status. Implementation of these Standard Precautions is the primary strategy for successful infection control. b. The second tier of precautions includes: i. Airborne Precautions ii. Droplet Precautions iii. Contact Precautions...."</p> <p>A policy and procedure for "Preventing Spread of Methicillin-Resistant Staphylococcus Aureus (MRSA)" was provided by the Director of Nursing on 5/1/13 at 11:42 a.m. The policy included, but was not limited to: "...1. Wear clean, non-sterile gloves when caring for the</p>		Director.5. This plan of correction constitutes or credible allegation of compliance with all regulatory requirements. Our completion date is 6/8/13.	

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	<p>MRSA infected or colonized resident. During the course of caring for the resident, gloves shall be changed after contact with material that may contain high concentrations of MRSA (e.g., sputum)...4. Gloves and gowns shall be removed before leaving the resident's room and placed in a plastic bag. Wash hands immediately with an antimicrobial soap...."</p> <p>3. The "Monthly Line Listing Report" for infections, for January 2013, indicated 29 total infections, but failed to include the date of onset, the date of the culture and results, the start date of the antibiotic, whether the infection was community acquired or facility acquired, and the date resolved.</p> <p>The February 2013 "Infection Control Surveillance Report - Monthly Report of Infections" indicated 40 total infections, but failed to include the organism cultured.</p> <p>During an interview on 5/9/13 at 9:50 a.m., the Director of Nursing indicated they had no infection control log for March, and the April list was started with residents who had currently been on an antibiotic. She said there were 19 infections in April and this included a good portion of the infections that</p>				

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	<p>had started in March.</p> <p>A policy and procedure for "Infection Control Resident Information", with an effective date of 3/2012, was provided by the Director of Nursing on 5/9/13 at 6:17 p.m. The policy included, but was not limited to, "Policy: Infection Control-Resident Information will be collected. It will be used as a surveillance data collection tool for recording information related to infections. The Infection Control Nurse will utilize the data collection tool to gather information for monitoring, evaluation and analysis as directed by the Infection Control Committee...Procedure: 1. Utilize the Infection Report Form to assist in collecting resident information to make a determination regarding infection."</p> <p>4. During the employee record review, on 5/9/13 at 3:00 p.m., Housekeeper #5's Tuberculosis Screening & Testing Record was reviewed. The record indicated Housekeeper #5's start date was 4/9/13, and a first step Mantoux skin test (for tuberculosis screening) was administered on 3/28/13. There was no documentation that the Mantoux skin test had been read 48 to 72 hours after it was given.</p>						

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	<p>During an interview on 5/9/13 at 7:57 p.m., the Social Service Designee indicated the Mantoux skin test had not been read, that they could not find where it had been read.</p> <p>A policy and procedure for "Administering Tuberculin Skin Testing", with a revision date of 1/1/2009, was provided by the Social Service Designee on 5/9/13 at 8:03 p.m. The policy indicated, but was not limited to: "Policy: Tuberculin skin testing is the standard method of identifying persons infected with tuberculosis...All new employees will receive a tuberculin skin test by a RN/LPN unless a physician's statement is obtained stating that the employee has a positive reaction to the tuberculin skin test. The 2-step method is required on any resident/employee in accordance with regulation and CDC guidelines...15. Advise the resident/employee that they must be seen by the trained RN/LPN for measurement of the injection site within 48-72 hours. 16. Resident/Employees requiring the 2-Step Method will have the tuberculin skin test repeated within seven to ten days. 17. When the 2-Step Method is required, document the same information as in the first</p>						

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	test...19. Tests on employees are documented on the Employee TB Screening Form." 3.1-18(b)(1)(A) 3.1-18(b)(2) 3.1-18(l)				