

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2014
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NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint #IN00145950.</p> <p>Complaint #IN00145950 - Substantiated. Federal/state deficiencies related to the allegations are cited at F353.</p> <p>Survey dates: April 21, 22, 23, 24, 25, &amp; 28, 2014</p> <p>Facility number: 000034 Provider number : 155086 AIM number: 100274880</p> <p>Survey Team: Debora Kammeyer, RN-TC Amber Bloss, QIDP (4/22, 4/23, 4/24, 4/25, 4/28, 2014) Lora Swanson, RN Julie Wagoner, RN</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 9 Medicaid: 42 Private: 2 Other: 5</p>	F000000	<p>Survey Event ID: WODB11 Exit date: 04.28.14 Please consider this Plan of Correction as the facility credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents, and it is submitted solely as a requirement of the provisions of Federal and State law. Woodland Manor is respectfully requesting a desk review. If there are any further questions or concerns, please feel free to contact me at 574-295-0096. Respectfully, Tara Trevino, LPN, HFA, BS</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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F000248 SS=D	<p>Total: 58</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 5, 2014, by Brenda Meredith, R.N.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide preferred structured activities for a cognitively impaired resident in 1 of 3 residents reviewed for activities in the sample of 11. (Resident J)</p> <p>Findings include:</p> <p>On 4-21-14 at 2:57 P.M., Resident J was observed in her room with eyes closed sitting in a recliner.</p> <p>On 4-22-14 at 1:21 P.M., Resident J was</p>	F000248	F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES Woodland Manor does provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	05/28/2014			
			I. A review of activity preferences, activity care plan, and attendance record will be completed for Resident J. Resident preferences will be updated, and care plan will be updated to reflect current preferences and practices.				
			II. A review of all				

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	<p>observed in her room, sitting in a padded wheelchair, with her eyes closed. Resident's television was on.</p> <p>On 4-23-14 at 2:10 P.M., the resident was observed in her room, sitting in her wheelchair with her eyes closed.</p> <p>On 4-24-14 at 10:41 A.M., a review of the clinical record for Resident J was conducted. The resident diagnoses included but were not limited to: metabolic encephalopathy, neurogenic bladder, renal failure, hearing loss, ischemic heart disease, vascular dementia, depression, history of hypoxia and hyperthyroidism.</p> <p>The care plan indicated the resident had "... a need for diversional activities in an effort to keep her socially and mentally active. Her preferences include choosing her own clothes to wear, taking a shower, having snacks, ...having reading material, listening to music, being around animals, doing things with groups of people, watching TV and bingo, going outside in nice weather, and spiritual programing..." The goal for resident was to attend 1-2 activities per week for social and mental stimulation with personal preferences honored. Interventions included, but were not limited to: offer magazines to resident,</p>		<p>resident activity preferences will be completed and compared to care plan and activity attendance records to identify any discrepancies. All identified residents will have updated preferences and care plans to reflect current preferences and practices.</p> <p>III. The radio with static will be replaced. Specific descriptions of routine activities will be created to clarify what constitutes each activity. Activity calendar will be compared to the resident preferences collected in the review of all residents and updated, if needed, to include activities of preference for current residents.</p> <p>IV. In addition to the process noted above, Activity Director or designee will audit six charts a week for eight weeks, then six charts a month until audit results are 100% compliant for one full quarter. Results will be reported in Quality Assurance Meeting monthly. (See attached audit form)</p>	

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	<p>for her to look at in her leisure time in her room, offer mental and social opportunities for resident to participate in. Provide a monthly calendar of events and one that she may keep at bed tray for easy access. Provide music in Unit 3 dining area for resident to enjoy and record daily activity participation.</p> <p>On 4-24-14 at 11:18 A.M., the resident was observed in the dining room on Unit 3 sitting in her wheelchair. A radio was playing however, it was hard to determine what kind of music was playing due to static coming thru the radio. At 11:20 A.M., the resident was taken by wheelchair to her room by the nurse to have her blood sugar checked. The resident was observed turning on the TV after the nurse left the room. The resident indicated she liked the program that was currently on her television.</p> <p>During observation on 4-25-14 from 9:00 A.M. to 11:00 A.M., the resident was in her room in front of the television.</p> <p>During an interview on 4-25-14 at 11:10 A.M., CNA #28 indicated she had last been with the resident around 7:40 A.M. when she placed the resident in her room after her shower.</p> <p>On 4-28-14 at 9:54 A.M., a review of</p>			

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	<p>form received from the Activity Director, titled "Individual Resident Daily Activities," dated April 2014, indicated the resident had participated in the following activities: one pet visit (4/5), indoor and outdoor walks (daily), attended bingo twice (4/16 &amp; 4/23), chatter club daily, dining room (social) daily, reads/reading group (4/15), and Religious/Spiritual(4/27), and views TV daily.</p> <p>During an interview on 4-28-14 at 10:00 A.M., the Activity Director indicated the chatter club was when staff talked to the resident and indoor/outdoor walks occurred when the resident was taken out of her room to go to the dining area or to an activity. The Activity Director further indicated the resident had gone to a church activity this past Sunday. She did not know why the resident had not attended the religious activity the previous weekends.</p> <p>On 4-28-14 at 10:10 A.M. a review of form titled "Activities Note-Annual MDS [Minimum Data Set assessment] Activity Note," dated 3-10-14, indicated "...confusion has increased as it pertains to her activity participation, her attention span seems shorter to falling asleep during acts. She is dependent on staff for her mobility and getting her to and from</p>						

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	<p>acts...spiritual programming remain important to her...she attends church services and comes to sensory group....in an effort to keep her socially and mentally active will attend 1-2 activities per week for social and mental stimulation...."</p> <p>On 4-28-14 at 10:15 A.M. a review of the Annual MDS dated 3-10-14 indicated the residents annual assessment for Activity Preference indicated the resident had rated religious services were very important for her to attend. Reading books/magazines and doing things with groups of people were somewhat important to the resident.</p> <p>During an interview on 4-28-14 at 10:40 A.M., the administrator indicated the facility had a religious activity on April 6 and April 20, 2014.</p> <p>Although the care plan indicated a goal for the resident to be engaged in social and religious activities, the resident was observed to spend most of her day in her room, alone, asleep or watching television.</p> <p>3.1-33(a)</p>				

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:</p> <ul style="list-style-type: none"> <li>Identification and demographic information;</li> <li>Customary routine;</li> <li>Cognitive patterns;</li> <li>Communication;</li> <li>Vision;</li> <li>Mood and behavior patterns;</li> <li>Psychosocial well-being;</li> <li>Physical functioning and structural problems;</li> <li>Continence;</li> <li>Disease diagnosis and health conditions;</li> <li>Dental and nutritional status;</li> <li>Skin conditions;</li> <li>Activity pursuit;</li> <li>Medications;</li> <li>Special treatments and procedures;</li> <li>Discharge potential;</li> <li>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set</li> </ul>			

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	<p>(MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure a thorough bladder incontinence assessment was completed, an individualized care plan was followed related to incontinence care and/or toileting needs, and timely incontinence care was provided to restore as much bladder continence as possible and prevent skin issues for one of one residents reviewed for incontinence. (Resident I)</p> <p>Findings include:</p> <p>During an interview with alert and oriented, Resident I, conducted on 04/22/14 at 9:30 A.M., the resident indicated due to the lack of staff her incontinence brief was left unchanged all day, up to 8 or 9 hours. She indicated she was getting sore in her private area. She also indicated when she was assisted to the toilet, she was left on the toilet too long. Finally, she indicated there was some cream that was supposed to be put on her private area but not all staff took the time to put on the cream.</p> <p>The clinical record for Resident I was reviewed on 04/23/14 at 1:15 P.M.</p>	F000272	<p>F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS Woodland Manor does conduct initial and periodic comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity. I. A comprehensive bladder incontinence assessment which includes medication review, disease process review, presence of UTI signs and symptoms, and functional and/or cognitive barriers will be thoroughly completed following the Continence Assessment policy and the Policy and Procedure for Assessing the Resident with Incontinence (see attached) for resident I, and individualized care plan updated if needed. CNA assignment sheet will be updated to reflect the toileting care plan and followed. II. Bladder Assessments will be reviewed for all current residents to assure completion. Any residents identified as having an incomplete assessment will have a new comprehensive bladder incontinence assessment completed. CNA assignment sheets will be updated if discrepancies are identified. III. The facility's Policy and Procedure for Assessing the Resident with Incontinence was reviewed and found to be</p>	05/28/2014			

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	<p>Resident I was admitted to the facility on 01/31/14, with diagnoses, including but not limited to, paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle ligament and fascia, muscular wasting and disuse atrophy, and Parkinson's disease.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 02/12/14, indicated Resident I was always incontinent of her bowels and bladder.</p> <p>The bowel and bladder assessment, completed on 02/02/14, indicated the resident utilized a bedpan and was incontinent at times, was continent at times of her bladder and was incontinent at times of her bladder and was continent of her bowels. There was no other assessment information pertaining to the resident's bladder function on the assessment form.</p> <p>The voiding pattern record, completed on 02/08/14, 02/09/14, and 02/10/14 indicated the resident's status was only documented 4 times on 02/08/14, 3 times on 02/09/14, and 5 times on 02/10/14. In addition, the patterning form did not indicate if the resident was toileted at all during the three day voiding pattern.</p>		<p>appropriate in conjunction with the Continence Assessment. Nurses will be in-serviced on the completion of the Bowel and Bladder Monitoring Record (see attached) and specified areas of assessment. Care Plan coordinator was in-serviced on the Policy and Procedure for Assessing the Resident with Incontinence and the Continence Assessment policy including specified areas of assessment. All nursing staff will be in-serviced on how to read the CNA assignment sheets for toileting needs/ incontinence care and the necessity for providing timely care. IV. In addition to the process noted above, the DON or designee will observe incontinence care for six residents per week for 8 weeks, then six residents per month until 100% compliance has been achieved for one full quarter, to ensure individualized care plan was followed, and timely incontinence care was provided (see attached). Results will be reviewed monthly in Quality Assurance. The MDS coordinator will audit six charts per month for 6 months to monitor thorough completion of the Bowel and Bladder Monitoring Record (see attached). Results will be reviewed monthly in Quality Assurance. The DON or designee will monitor six individual resident's CNA sheets per week for 8 weeks, and then</p>				

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	<p>Interview with the MDS coordinator, RN #2, on 04/28/14 at 4:00 P.M. indicated the documentation was "scanty." The portion of the form to assess the type of urinary incontinence the resident was experiencing was left blank. The summary statement on the form, indicated the resident was always incontinent of her bladder and the resident did not wish to participate in a scheduled toileting program. It was unclear what type of scheduled toileting program was offered to the resident. The form was signed as completed on 02/11/14.</p> <p>During an interview on 4/28/14 at 1:45 P.M., the MDS coordinator, RN #2, indicated other than a patterning record, there was no other assessment form or information utilized when assessing bladder incontinence.</p> <p>The current health care plan related to incontinence for Resident I, revised on 02/18/14, indicated the resident was "functionally" incontinent. The interventions included: "Apply adult briefs when out of bed. Check and change every 2 hours and prn [as needed]. Remove adult brief when in bed...If [resident's name] is unable to stand in the bathroom then obtain the bedside commode from the shower room</p>		<p>six per month until 100% compliance has been achieved for one quarter, for accuracy when compared to bladder incontinence assessment (see attached). Results will be reviewed monthly in Quality Assurance.</p>				

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	<p>next door, allow her to use that, then clean and return the bedside commode to the shower room when finished...offer assistance for toileting upon rising, before and after meals, at hs [bedtime], and prn...."</p> <p>The facility policy and procedure, titled, "Continence Assessment, dated 05/2013, was provided as current by RN #2, on 05/28/14 at 1:45 P.M. The policy indicated the following: "Each Resident's continence will be assessed no less often than quarterly to assure proper provision of care and services to attain and/or maintain the Resident's highest practicable level of function." The policy "Interpretation and Implementation" included the following steps: "1. The Bowel and Bladder monitoring record will be initiated upon admission and during the assessment reference period for all subsequently scheduled MDS (minimum data set) assessments. 2. The Bowel and Bladder monitoring record will be completed for 72 consecutive hours. 3. The continence care plan will be based on the resident's comprehensive assessment including but not limited to the Bowel and Bladder Monitoring record. 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the</p>				

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F000282 SS=E	<p>development of and revisions to the resident's care plan. 5. The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status."</p> <p>The policy did indicated how a comprehensive bladder incontinence assessment was to be completed when the only form mentioned was the Minimum Data Set assessment and the Bowel and Bladder monitoring record. There was no facility policy to ensure the resident had been assessed thoroughly for incontinence including medications and diagnoses which could impact her continence, physical and cognitive barriers, the presence of a urinary tract infection, or any other factors including history of incontinence.</p> <p>In addition, the Bowel and Bladder monitoring record had not been completed thoroughly to ascertain any type of bladder voiding pattern.</p> <p>3.1-31(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>				

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	<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 observation, record review, and interviews, the facility failed to provide timely incontinence care per the health care plans for 4 of 4 residents observed for incontinence care and failed to provide restorative dressing/grooming assistance as careplan for 1 of 3 residents reviewed for activities of daily living (ADL's). (Residents F, H, I, L and C)</p> <p>Findings include:</p> <p>1. During an interview with alert and oriented, Resident I, conducted on 04/22/14 at 9:30 A.M., the resident indicated due to the lack of staff her incontinence brief was left unchanged all day, up to 8 or 9 hours. She indicated she was getting sore in her private area. She also indicated when she was assisted to the toilet, she was left on the toilet too long. Finally, she indicated there was some cream that was supposed to be put on her private area but not all staff took the time to put on the cream.</p> <p>The clinical record for Resident I was reviewed on 04/23/14 at 1:15 P.M. Resident I was admitted to the facility on 01/31/14, with diagnoses, including but not limited to, paralysis agitans, diabetes,</p>	F000282	<p>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLANWoodland Manor does provide or arrange services that are provided by qualified persons in accordance with each resident's written plan of care.I. The health care plans for incontinence for Residents F, H, I, and L will be reviewed and updated as needed. CNA assignment sheets will be updated to reflect current continence needs and followed. Resident C had corrective surgery for her cataracts. Restorative care plans for Resident C will be reviewed for accuracy and updated as needed. Restorative plans will be followed.II. An audit will be done for each resident to determine current toileting plan. Observation of each unit will be done to determine the timeliness of incontinence care and toileting in comparison to the health care plan. Any discrepancies will be identified. CNA sheets will be updated and followed. All restorative programs for current residents will be reviewed for accuracy and complete charting to identify any discrepancies. Identified residents will have restorative plans updated and followedIII. All nursing staff will be in-serviced on how to read the</p>	05/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2014
NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514		
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	<p>osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle ligament and fascia, muscular wasting and disuse atrophy, and Parkinson's disease.</p> <p>The current health care plan related to incontinence for Resident I, revised on 02/18/14, indicated the resident was "functionally" incontinent. The interventions included: "Apply adult briefs when out of bed. Check and change every 2 hours and prn [as needed]. Remove adult brief when in bed...If [resident's name] is unable to stand in the bathroom then obtain the bedside commode from the shower room next door, allow her to use that, then clean and return the bedside commode to the shower room when finished...offer assistance for toileting upon rising, before and after meals, at hs [bedtime], and prn...."</p> <p>On 04/24/14, Resident I was noted at the following times: 9:00 A.M. - in the beauty shop. 9:20 A.M. - now out of beauty shop and in the activity room watching television. She indicated she was gotten up at 7:00 A.M. this morning, cleaned her up and put a clean brief on her. She indicated she was not toileted but she stated they</p>		<p>CNA assignment sheets for toileting needs/ incontinence care and the necessity for providing timely care. Additional CNAs and nurses will be in-serviced on completion of restorative programs and documentation. IV. In addition to the process noted above, the DON or designee will observe incontinence care for six residents per week for 8 weeks, then six residents per month until 100% compliance has been achieved for one full quarter, to ensure individualized care plan was followed, and timely incontinence care was provided (see attached.) Results will be reviewed monthly in Quality Assurance. The MDS coordinator will observe six resident's restorative programs being completed, and audit documentation sheets, per week for 8 weeks, and then six per month until 100% compliance has been achieved for one full quarter (see attached). Results will be reviewed monthly in Quality Assurance.</p>		

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	<p>(staff) probably would have sat her on the toilet if she had asked.</p> <p>9:50 A.M. she was noted to be in the hallway by the dining room waiting to go into the dining room for Exercises.</p> <p>10:00 A.M. - in main dining room for exercises.</p> <p>10:07 A.M. - pushed from the dining room to the end of unit 2 by the activity director. Resident and activity staff noted sitting at the end of unit 2 hallway waiting to vote.</p> <p>10:30 A.M. - back in activity room for a movie activity.</p> <p>10:45 A.M. - still in the activity room watching movies.</p> <p>11:00 A.M. - 11:35 A.M. still in activity room watching movies.</p> <p>12:00 P.M. - in the main dining room, in her wheelchair, participating in a Trivia activity. She indicated she had went straight from the activity room to the main dining room. She indicated she was not taken to her room for incontinence care.</p> <p>1:00 P.M. - resident observed in her room, in her bed still dressed. She indicated the noise in the dining room had upset her. She indicated she was assisted into her bed but was not toileted or offered a brief change.</p> <p>2:30 P.M. - was reported to have been in therapy. She was then weighed in the shower room by the therapy staff.</p>						

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	<p>During an interview on 4/24/14 at 2:30 P.M., CNA #3 indicated she had changed the resident's brief at around 10:00 A.M. She indicated CNA #4, had helped her stand the resident while she changed her.</p> <p>On 4/24/14 at 2:35 P.M., CNAs #3 and #4 were observed exiting Resident I's room. CNA #3 was carrying bags of soiled linens and trash/briefs. There was a strong urine odor noted in the room even after CNA's left the room. Resident I, who was noted to be lying in bed, indicated the CNA's had removed her wet brief but did not do any peri care.</p> <p>On 4/24/14 at 2:45 P.M., Resident I's skin was observed with the Director of Nursing. Resident I was noted to have large galded areas underneath her abdominal folds on each hip area. Her front peri area was reddened and had creases from the previous brief. There was an open blister noted on her posterior, right upper thigh. There were also two linear areas, near the open area, which had frank blood, one on the lower buttocks and the other on the upper left thigh. Resident I complained of pain in her peri area, said her brief had been on too tight. A bed pillow with wet, yellow stains, was noted in the wheelchair. There was no other cushion in her</p>			

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	<p>wheelchair. Resident I was noted to be lying in bed with a brief untaped between her legs and two cloth quilted bed pads on top of each other underneath her.</p> <p>Resident I indicated prior to having her brief changed on 04/24/14 at 2:35 P.M., she had not been checked for incontinence, had her brief changed, or been offered any type of toileting since around 7:00 A.M. when she was gotten up for the morning, assisted to dress, and assisted to her wheelchair.</p> <p>On 04/25/14 at 9:30 A.M., Resident I was noted to be in her room , in a wheelchair, sitting on a folded bed pad. She was grimacing and indicated her buttocks hurt really bad and she was going to ask to go back to bed.</p> <p>On 04/25/14 at 9:40 A.M., Resident I was assisted to transfer into her bed by two restorative CNA's #5 and 6. She was not changed before she was put into bed, her clothes and briefs were not removed, and she was placed again on two quilted bed pads. She indicated her bottom felt better after she was placed in bed.</p> <p>On 04/25/14 at 10:40 A.M., Resident I was noted to still be bed awake, had snacks in her bed, and was lying slightly crossways in bed on top of a quilted bed pad and part of her blanket was also</p>			

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	<p>rumpled up underneath the right side of her buttocks.</p> <p>On 4/25/14 from 9:40 A.M. - 11:30 A.M., Resident I was observed to remain in her bed without any care. She indicated her brief had not been changed nor had she been offered any toileting assistance since 7:00 A.M., when she was assisted to dress and transfer to her wheelchair for the day.</p> <p>2. On 04/27/14 at 5:15 P.M. Resident F was observed in the main dining room in her wheelchair. The evening meal had not yet been served. She remained in the dining room until 6:52 P.M. when she was pushed from the dining room to the hallway across from the nurse's station. At 6:56 P.M., she was pushed in her wheelchair into her room and left seated in her wheelchair at the bedside. She remain in her wheelchair by her bed from 6:56 P.M. until 8:27 P.M., when she was transferred, by CNA #1 and #7, utilizing a two person lift technique into her bed. She was placed in her bed, her pants were left on, and she did not receive incontinence care at the time. CNA #1 and #7 proceeded to transfer Resident F's roommate with a mechanical lift and then left the room. Resident F had not received incontinence care and was last observed, lying in her bed with a hospital</p>			
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	<p>gown on her top and her regular outside pants on her bottom at 8:45 P.M. CNA's #1 and #7 were noted to be on Unit 1 assisting another resident who required a two person lift transfer.</p> <p>The clinical record for Resident F was reviewed on 04/28/14 at 3:00 P.M. Resident F was readmitted to the facility on 03/01/14 with diagnoses, including but not limited to muscular wasting and disuse atrophy, abnormality of gait, recent extraction of teeth, and early Alzheimer's dementia.</p> <p>The current health care plans, initiated on 03/07/14, for Resident F indicated she required staff assistance of two to change her brief, was always incontinent of both her bowels and bladder, and was to be turned and repositioned at least every 2 hours. There were no specific instructions regarding how often Resident F was to have her brief checked for incontinence and/or changed.</p> <p>3. Resident L was observed on 04/28/14 at 5:15 P.M. in her room, seated in her wheelchair. At 5:20 P.M., LPN #8 cued Resident L to go to the dining room for the evening meal. Resident L remained in her wheelchair from 5:15 P.M. - 8:18 P.M. At 8:18 P.M., CNA #7 was noted to assist Resident L to remove her T-shirt</p>			

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	and put on a hospital gown. Her white outside capri pants were not changed or removed and the resident remained in the wheelchair. CNA #7 indicated she was waiting on CNA #1 to assist her to transfer residents to their beds. At 8:30 P.M., Resident L was in her room in a wheelchair eating a sandwich. CNA #1 and #7 then brought the mechanical lift into the room and prepared to transfer Resident L to her bed. When CNA #1 pulled the lift pad into position behind the resident, Resident L exclaimed, "oh, that's wet." CNA #1 and #7 proceeded to transfer Resident L to her bed. The CNA's left her outside white capris pants and the wet hoyer pad under the resident and did not perform any incontinence care or assist the resident to finish dressing for bed. The resident exclaimed as she was being transferred "I smell a strong ammonia smell. Like baby diapers that have not been changed." There was a strong urine odor noted in the resident's room. CNA #1 and #7 left the room and LPN #8 entered the room to administer medication. LPN #8 was queried as to why Resident L had been placed in bed without any incontinence care and she indicated CNA #7 would be back later to provide care. It was uncertain how much later it would be before the CNA returned. The resident had not received incontinence care or dressing assistance			

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	<p>at 8:45 P.M. and both CNAs #1 and #7 were noted to be in a resident room on unit 1 providing transferring assistance.</p> <p>The clinical record for Resident L was reviewed on 04/23/14 at 2:43 P.M. Resident L was admitted to the facility on 09/24/13, with diagnosis, including but not limited to, diabetes, stage iv pressure ulcers, abdominal/pelvic swelling/mass, muscular disuse and wasting atrophy, symbolic dysfunction, left below the knee amputation, chronic schizophrenia, gerd, anemia, depression, cad, arthritis, hyperlipidemia, cardiovascular disease, obesity, seizures, congestive heart failure.</p> <p>The health care plans for Resident L, current through 07/16/14, indicated the resident required mechanical lift for transfers and was totally dependent upon staff for toileting needs. The plan indicated the resident was to be checked every 2 - 3 hours and as required for incontinence. "Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes." was also included. Resident L also currently had a stage 4 pressure ulcer on her upper right buttocks.</p> <p>4. Resident H was observed, on 04/27/14 at 5:15 P.M. seated in a geri chair type wheelchair in the main dining room. He</p>			

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	<p>remained in the dining room until 7:03 P.M. when he was pushed by CNA #7 from the dining room into the hallway.</p> <p>He remained in his geri chair until 8:40 P.M. when he was transferred from his geri chair into his bed by CNA #1 and #7 utilizing a mechanical lift. At 8:45 P.M., Resident H was noted to be lying in his bed awake. His outside shorts were noted to be visibly soiled and wet. There was a very malodorous smell of urine in the resident's room. The resident was wearing a hospital gown but still had on his plaid shorts. His T-shirt and a towel were noted on the floor beside his bed. CNA #1 and #7 had left the room and were on unit 1 providing transferring care to another resident.</p> <p>The clinical record for Resident H was reviewed on 04/28/14 at 11:00 A.M. Resident H was admitted to the facility on 06/15/06, with diagnoses, including but not limited to, toxic encephalopathy, abnormal posture, senile dementia, diabetes, and major depressive disorder. The health care plans, current through 07/07/14, indicated the resident required two person staff assistance and mechanical lift for transfers, and was to be checked and changed every 2 hours and as needed.</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interviews, the facility failed to implement interventions for pressure relief and provide incontinence care to prevent impaired skin for 1 of 3 residents reviewed for ADL's. (Resident I) and 1 of 3 residents reviewed for positioning needs. (Resident J)</p> <p>Finding includes:</p> <p>1. During an interview with alert and oriented, Resident I, conducted on 04/22/14 at 9:30 A.M., the resident indicated due to the lack of staff her incontinence brief was left unchanged all day, up to 8 or 9 hours. She indicated she was getting sore in her private area. She also indicated when she was assisted to the toilet, she was left on the toilet too long. Finally, she indicated there was some cream that was supposed to be put on her private area but not all staff took</p>	F000314	F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Woodland Manor does assure based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident I is receiving skin care according to care plan and skin is improving. The health care plans for incontinence for Resident I will be reviewed and updated as needed. CNA assignment sheets will be updated to reflect current continence needs and followed. Resident J is receiving skin care according to care plan and skin is	05/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2014	
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	<p>the time to put on the cream.</p> <p>The clinical record for Resident I was reviewed on 04/23/14 at 1:15 P.M. Resident I was admitted to the facility on 01/31/14, with diagnoses, including but not limited to, paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle ligament and fascia, muscular wasting and disuse atrophy, and Parkinson's disease.</p> <p>The initial MDS (minimum data set) assessment, completed on 02/12/14, indicated Resident I was always incontinent of her bowels and bladder, was at risk for pressure ulcer development, did not have any pressure ulcers or any other skin impairments.</p> <p>The Pressure Ulcer Risk assessment, completed on 02/02/14, indicated the resident was assessed to be a mild risk for pressure ulcer development.</p> <p>The current health care plan related to incontinence for Resident I, revised on 02/18/14, indicated the resident was "functionally" incontinent. The interventions included: "Apply adult briefs when out of bed. Check and change every 2 hours and prn [as</p>		<p>improving. The health care plans for positioning for Resident J will be reviewed and updated as needed. CNA assignment sheets will be updated to reflect current positioning needs and followed.II. A skin sweep will be conducted to identify all current areas of skin breakdown. Braden risk assessments will be reviewed for all Residents to identify those at high risk. Care plan interventions will be reviewed and updated if needed, and CNA sheets will be updated.III. The Prevention of Pressure Ulcer policy (see attached) was reviewed and determined to remain appropriate. All nursing staff will be educated on the policy as well as the prevention, identification, treatment, and documentation of pressure ulcers as well the proper use of incontinence briefs and cloth bed pads. IV. In addition to the process noted above, the DON or designee will visualize all wounds weekly and review weekly wound assessment documentation, and would care plans weekly at Nutrition at Risk meetings. Results will be presented in Quality Assurance Meeting monthly. The DON or designee will observe incontinence care for six residents per week for 8 weeks, then six residents per month until 100% compliance has been achieved for one full quarter, to ensure individualized care plan was followed, and timely</p>				

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	<p>needed]. Remove adult brief when in bed...If [resident's name] is unable to stand in the bathroom then obtain the bedside commode from the shower room next door, allow her to use that, then clean and return the bedside commode to the shower room when finished...offer assistance for toileting upon rising, before and after meals, at hs [bedtime], and prn...."</p> <p>The care plan related to the potential for impaired skin indicated the resident required a Pressure reducing device on the bed, medications and treatments to be administered, and to "follow facility policies/protocols for the prevention/treatment of skin breakdown."</p> <p>On 04/24/14, Resident I was noted at the following times: 9:00 A.M. - in the beauty shop. 9:20 A.M. - now out of beauty shop and in the activity room watching television. She indicated she was gotten up at 7:00 A.M. this morning, cleaned her up and put a clean brief on her. She indicated she was not toileted but she stated they (staff) probably would have sat her on the toilet if she had asked. 9:50 A.M. she was noted to be in the hallway by the dining room waiting to go into the dining room for Exercises. 10:00 A.M. - in main dining room for</p>		<p>incontinence care was provided (see attached). Results will be reviewed monthly in Quality Assurance Meeting. The DON or designee will observe repositioning for six residents per week for 8 weeks, then six residents per month until 100% compliance has been achieved for one full quarter, to ensure individualized care plan was followed, and timely repositioning was provided (see attached). Results will be reviewed monthly in Quality Assurance Meeting. The DON or designee will monitor 6 individual resident CNA assignment sheets for accuracy on pressure reduction interventions per week for 8 weeks, then 6 sheets per month until 100% compliance is achieved for one full quarter (see attached). Results of the audits will be reviewed in Quality Assurance Meeting monthly.</p>				

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	<p>exercises.</p> <p>10:07 A.M. - pushed from the dining room to the end of unit 2 by the activity director. Resident and activity staff noted sitting at the end of unit 2 hallway waiting to vote.</p> <p>10:30 A.M. - back in activity room for a movie activity.</p> <p>10:45 A.M. - still in the activity room watching movies.</p> <p>11:00 A.M. - 11:35 A.M. still in activity room watching movies.</p> <p>12:00 P.M. - in the main dining room, in her wheelchair, participating in a Trivia activity. She indicated she had went straight from the activity room to the main dining room. She indicated she was not taken to her room for incontinence care.</p> <p>1:00 P.M. - resident observed in her room, in her bed still dressed. She indicated the noise in the dining room had upset her. She indicated she was assisted into her bed but was not toileted or offered a brief change.</p> <p>2:30 P.M. - was reported to have been in therapy. She was then weighed in the shower room by the therapy staff.</p> <p>During an interview on 4/24/14 at 2:30 P.M., CNA #3 indicated she had changed the resident's brief at around 10:00 A.M. She indicated CNA #4, had helped her stand the resident while she changed her.</p>			
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	<p>On 4/24/14 at 2:35 P.M., CNAs #3 and 4 were observed exiting Resident I's room. CNA #3 was carrying bags of soiled linens and trash/briefs. There was a strong urine odor noted in the room even after CNA's left the room. Resident I, who was noted to be lying in bed, indicated the CNA's had removed her wet brief but did not do any peri care.</p> <p>On 4/24/14 at 2:45 P.M., Resident I's skin was observed with the Director of Nursing. Resident I was noted to have large galded areas underneath her abdominal folds on each hip area. Her front peri area was reddened and had creases from the previous brief. There was an open blister noted on her posterior, right upper thigh. There were also two linear areas, near the open area, which had frank blood, one on the lower buttocks and the other on the upper left thigh. Resident I complained of pain in her peri area, said her brief had been on too tight. A bed pillow with wet, yellow stains, was noted in the wheelchair. There was no other cushion in her wheelchair. Resident I was noted to be lying in bed with a brief untaped between her legs and two cloth quilted bed pads on top of each other underneath her. Resident I indicated prior to having her brief changed on 04/24/14 at 2:35 P.M.,</p>			

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	<p>she had not been checked for incontinence, had her brief changed, or been offered any type of toileting since around 7:00 A.M. when she was gotten up for the morning, assisted to dress, and assisted to her wheelchair.</p> <p>On 04/25/14 at 9:30 A.M., Resident I was noted to be in her room , in a wheelchair, sitting on a folded bed pad. She was grimacing and indicated her buttocks hurt really bad and she was going to ask to go back to bed.</p> <p>On 04/25/14 at 9:40 A.M., Resident I was assisted to transfer into her bed by two restorative CNA's #5 and 6. She was not changed before she was put into bed, her clothes and briefs were not removed, and she was placed again on two quilted bed pads. She indicated her bottom felt better after she was placed in bed.</p> <p>On 04/25/14 at 10:40 A.M., Resident I was noted to still be bed awake, had snacks in her bed, and was lying slightly crossways in bed on top of a quilted bed pad and part of her blanked was also rumbled up underneath the right side of her buttocks.</p> <p>Resident I was observed to remain in her bed without any care on 04/25/14 from 9:40 A.M. - 11:30 A.M. She indicated</p>						

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	<p>her brief had not been changed nor had she been offered any toileting assistance since 7:00 A.M., when she was assisted to dress and transfer to her wheelchair for the day.</p> <p>Review of the facility policy and procedure, titled, "Prevention of Pressure Ulcers," dated 10/2010, and indicated as current by the ADON (Assistant director of Nursing) on 04/24/14 at 3:00 P.M. included the following instructions: "...3. For a person in a chair: a. Change position at least every hour; b. Use foam, gel or air cushion as indicated to relieve pressure. c. All residents identified to be at risk for pressure ulcer development should have a pressure reduction chair cushion... 1. Risk Factor - Moisture a. Use a moisture barrier. b. Use absorbent pad or adult briefs c. Provide clean, unwrinkled sheets d. Place resident on a minimum of a q 2 hours check and change program...."</p> <p>During an interview on 4/24/14 at 3:00 P.M., the ADON indicated the resident recently been readmitted to the facility. During her previous admission, over 8 months previous, the resident had refused to utilize a wheelchair cushion and had preferred to sit on a bed pillow in the wheelchair. The wheelchair cushion had been transferred with the resident to the</p>				

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F000315 SS=D	<p>other facility and had not returned with the resident when she was readmitted to the facility on 01/31/14. The ADON did not remember what type of cushion the resident had and indicated there had been no pressure relief cushion attempted with this resident on this admission. She indicated the resident was working with therapy but not on wheelchair positioning.</p> <p>Review of an incident/accident report for Resident I, completed on 4/24/14 at 4:00 P.M., indicated a 5.5 x .5 centimeter linear red open area was noted on the upper inner thigh.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a thorough bladder incontinence assessment was completed, an individualized care plan was followed related to incontinence care and/or</p>	F000315	F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Woodland Manor ensures based on a comprehensive assessment, that a resident who enters the facility without an indwelling catheter is	05/28/2014			

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	<p>toileting needs, and timely incontinence care was provided to restore as much bladder contingency as possible and prevent skin issues for 1 of 3 residents reviewed (Resident I).</p> <p>Finding includes:</p> <p>During an interview with alert and oriented, Resident I, conducted on 04/22/14 at 9:30 A.M., the resident indicated due to the lack of staff her incontinence brief was left unchanged all day, up to 8 or 9 hours. She indicated she was getting sore in her private area. She also indicated when she was assisted to the toilet, she was left on the toilet too long. Finally, she indicated there was some cream that was supposed to be put on her private area but not all staff took the time to put on the cream.</p> <p>The clinical record for Resident I was reviewed on 04/23/14 at 1:15 P.M. Resident I was admitted to the facility on 01/31/14, with diagnoses, including but not limited to, paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle ligament and fascia, muscular wasting and disuse atrophy, and Parkinson's disease.</p>		<p>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. I. A comprehensive bladder incontinence assessment which includes medication review, disease process review, presence of UTI signs and symptoms, and functional and/or cognitive barriers will be thoroughly completed following the Continence Assessment policy and the Policy and Procedure for Assessing the Resident with Incontinence (see attached) for resident I, and individualized care plan updated if needed. CNA assignment sheet will be updated to reflect the toileting care plan and followed. II. Bladder Assessments will be reviewed for all current residents to assure completion. Any residents identified as having an incomplete assessment will have a new comprehensive bladder incontinence assessment completed. CNA assignment sheets will be updated if discrepancies are identified. An audit will be done for each resident to determine current toileting plan. Observation of each unit will be done to determine the timeliness of incontinence care and toileting in</p>	

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	<p>The initial MDS (minimum data set) assessment, completed on 02/12/14, indicated Resident I was always incontinent of her bowels and bladder.</p> <p>The bowel and bladder assessment, completed on 02/02/14, indicated the resident utilized a bedpan, was incontinent at times of her bladder and was continent of her bowels.</p> <p>The voiding pattern record, completed on 02/08/14, 02/09/14, and 02/10/14 indicated the resident's status was only documented 4 times on 02/08/14, 3 times on 02/09/14, and 5 times on 02/10/14. In addition, the patterning form did not indicate if the resident was toileted at all during the three day voiding pattern. Interview with the MDS coordinator, RN #2, on 04/28/14 at 4:00 P.M. indicated the documentation was "scanty." The portion of the form to assess the type of urinary incontinence the resident was experiencing was left blank. The summary statement on the form, indicated the resident was always incontinent of her bladder and the resident did not wish to participate in a scheduled toileting program. It was unclear what type of scheduled toileting program was offered to the resident. The form was signed as completed on 02/11/14.</p>		<p>comparison to the health care plan. Any discrepancies will be identified. CNA sheets will be updated and followed.III. The facility's Policy and Procedure for Assessing the Resident with Incontinence was reviewed and found to be appropriate in conjunction with the Continence Assessment. Nurses will be in-serviced on the completion of the Bowel and Bladder Monitoring Record (see attached) and specified areas of assessment. Care Plan coordinator was in-serviced on the Policy and Procedure for Assessing the Resident with Incontinence and the Continence Assessment policy which includes all specified areas of assessment. All nursing staff will be in-serviced on how to read the CNA assignment sheets for toileting needs/ incontinence care and the necessity for providing timely care. IV. In addition to the process noted above, the DON or designee will observe incontinence care for six residents per week for 8 weeks, then six residents per month until 100% compliance has been achieved for one full quarter, to ensure individualized care plan was followed, and timely incontinence care was provided (see attached). Results will be reviewed monthly in Quality Assurance. The MDS coordinator will audit six charts per month for 6 months to monitor thorough completion of</p>				

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	<p>The current health care plan related to incontinence for Resident I, revised on 02/18/14, indicated the resident was "functionally" incontinent. The interventions included: "Apply adult briefs when out of bed. Check and change every 2 hours and prn (as needed). Remove adult brief when in bed...If (resident's name) is unable to stand in the bathroom then obtain the bedside commode from the shower room next door, allow her to use that, then clean and return the bedside commode to the shower room when finished...offer assistance for toileting upon rising, before and after meals, at hs (bedtime), and prn...."</p> <p>On 04/24/14, Resident I was noted at the following times: 9:00 A.M. - in the beauty shop. 9:20 A.M. - now out of beauty shop and in the activity room watching television. She indicated she was gotten up at 7:00 A.M. this morning, cleaned her up and put a clean brief on her. She indicated she was not toileted but she stated they (staff) probably would have sat her on the toilet if she had asked. 9:50 A.M. she was noted to be in the hallway by the dining room waiting to go into the dining room for Exercises. 10:00 A.M. - in main dining room for</p>		<p>the Bowel and Bladder Monitoring Record (see attached). Results will be reviewed monthly in Quality Assurance. The DON or designee will monitor six individual resident's CNA sheets per week for 8 weeks, and then six per month until 100% compliance has been achieved for one quarter, for accuracy when compared to bladder incontinence assessment (see attached). Results will be reviewed monthly in Quality Assurance.</p>	

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	<p>exercises.</p> <p>10:07 A.M. - pushed from the dining room to the end of unit 2 by the activity director. Resident and activity staff noted sitting at the end of unit 2 hallway waiting to vote.</p> <p>10:30 A.M. - back in activity room for a movie activity.</p> <p>10:45 A.M. - still in the activity room watching movies.</p> <p>11:00 A.M. - 11:35 A.M. still in activity room watching movies.</p> <p>12:00 P.M. - in the main dining room, in her wheelchair, participating in a Trivia activity. She indicated she had went straight from the activity room to the main dining room. She indicated she was not taken to her room for incontinence care.</p> <p>1:00 P.M. - resident observed in her room, in her bed still dressed. She indicated the noise in the dining room had upset her. She indicated she was assisted into her bed but was not toileted or offered a brief change.</p> <p>2:30 P.M. - was reported to have been in therapy. She was then weighed in the shower room by the therapy staff.</p> <p>During an interview on 04/24/14 at 2:30 P.M., CNA #3 indicated she had changed the resident's brief at around 10:00 A.M. She indicated CNA #4, had helped her stand the resident while she changed her.</p>			
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	<p>On 4/24/14 at 2:35 P.M., CNAs #3 and 4 were observed exiting Resident I's room. CNA #3 was carrying bags of soiled linens and trash/briefs. There was a strong urine odor noted in the room even after CNA's left the room. Resident I, who was noted to be lying in bed, indicated the CNAs had removed her wet brief but did not do any peri care.</p> <p>On 4/24/14 at 2:45 P.M., Resident I's skin was observed with the Director of Nursing. Resident I was noted to have large galded areas underneath her abdominal folds on each hip area. Her front peri area was reddened and had creases from the previous brief. There was an open blister noted on her posterior, right upper thigh. There were also two linear areas, near the open area, which had frank blood, one on the lower buttocks and the other on the upper left thigh. Resident I complained of pain in her peri area, said her brief had been on too tight. A bed pillow with wet, yellow stains, was noted in the wheelchair. There was no other cushion in her wheelchair. Resident I was noted to be lying in bed with a brief untaped between her legs and two cloth quilted bed pads on top of each other underneath her. Resident I indicated prior to having her brief changed on 04/24/14 at 2:35 P.M.,</p>			

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	<p>she had not been checked for incontinence, had her brief changed, or been offered any type of toileting since around 7:00 A.M. when she was gotten up for the morning, assisted to dress, and assisted to her wheelchair.</p> <p>On 04/25/14 at 9:30 A.M., Resident I was noted to be in her room , in a wheelchair, sitting on a folded bed pad. She was grimacing and indicated her buttocks hurt really bad and she was going to ask to go back to bed.</p> <p>On 04/25/14 at 9:40 A.M., Resident I was assisted to transfer into her bed by two restorative CNA's #5 and 6. She was not changed before she was put into bed, her clothes and briefs were not removed, and she was placed again on two quilted bed pads. She indicated her bottom felt better after she was placed in bed.</p> <p>On 04/25/14 at 10:40 A.M., Resident I was noted to still be in bed awake, had snacks in her bed, and was lying slightly crossways in bed on top of a quilted bed pad and part of her blanked was also rumped up underneath the right side of her buttocks.</p> <p>Resident I was observed to remain in her bed without any care on 04/25/14 from 9:40 A.M. - 11:30 A.M. She indicated</p>						

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	<p>her brief had not been changed nor had she been offered any toileting assistance since 7:00 A.M., when she was assisted to dress and transfer to her wheelchair for the day.</p> <p>The facility policy and procedure, titled, "Continence Assessment," dated 05/2013, was provided as current by RN #2, on 05/28/14 at 1:45 P.M. The policy indicated the following: "Each Resident's continence will be assessed no less often than quarterly to assure proper provision of care and services to attain and/or maintain the Resident's highest practicable level of function." The policy "Interpretation and Implementation" included the following steps: "1. The Bowel and Bladder monitoring record will be initiated upon admission and during the assessment reference period for all subsequently scheduled MDS (minimum data set) assessments. 2. The Bowel and Bladder monitoring record will be completed for 72 consecutive hours. 3. The continence care plan will be based on the resident's comprehensive assessment including but not limited to the Bowel and Bladder Monitoring record. 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the</p>				

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F000323 SS=D	<p>resident's care plan. 5. The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status."</p> <p>The policy did indicate how a comprehensive bladder incontinence assessment was to be completed when the only form mentioned was the Minimum Data Set assessment and the Bowel and Bladder monitoring record. There was no facility policy to ensure the resident had been assessed thoroughly for incontinence including medications and diagnoses which could impact her continence, physical and cognitive barriers, the presence of a urinary tract infection, or any other factors including history of incontinence.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident</p>						

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	<p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the resident environment was free of hazards and hazardous chemicals, related to disposable razor blades and shaving cream left at the resident's handwashing sink. (Resident #6 and Resident #13) In addition, the facility failed to ensure fall interventions were followed to reduce the risk of an accident for 1 of 3 residents reviewed for falls. (Resident #59)</p> <p>Findings include:</p> <p>1. On 4/22/14 at 10:12 A.M., an observation of Room 123 indicated Resident #13 had 2 disposable razors at the handwashing sink in a shared bathroom.</p> <p>On 4/24/14 at 3:08 P.M., an interview with the Director of Nursing (DON), indicated personal razors were not suppose to be stored in the bathroom. The DON further indicated the facility normally doesn't keep them in the room, the razors are usually put in a sharps container after use.</p> <p>On 4/25/14 from 10:00 A.M. to 11:30 A.M., an environmental tour was</p>	F000323	<p>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES Woodland Manor ensures that the resident environment remains as free of accidents hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>I. All razor blades and shaving cream were removed from the resident's hand washing sink for residents #6 and #13. Fall intervention care plan will be reviewed and updated for Resident #59. CNA assignment sheet will be updated to reflect current fall interventions and followed.</p> <p>II. An audit of all resident rooms will be completed to assess for the proper storage of personal hygiene/grooming items. Any items improperly stored will be relocated to the proper storage area. Fall risk assessment score will be reviewed for all residents to assure risk is identified. All fall risk care plans will be reviewed and compared to the CNA assignment sheets. Any identified discrepancies will be corrected.</p> <p>III. A Proper Storage of Personal Hygiene Equipment policy was reviewed and approved for use through QA (see attached). All staff will be in-serviced on the new policy. The Fall Prevention and</p>	05/28/2014

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	<p>conducted of the facility with the Maintenance Director and the Housekeeping Supervisor, during which the following was observed:</p> <p>At 11:05 A.M., an observation of Resident #6's room, on the dementia unit was observed with a disposable razor on the counter at the handwashing sink. A small can of shaving cream was also noted on the counter at the sink. The warning label on the can of shaving cream indicated "keep out of reach of children."</p> <p>On 4/25/14 at 11:30 A.M., an interview with RN#14 indicated the resident's on the dementia unit should not have personal grooming items, including disposable razors, at the sink. She further indicated personal grooming items should be locked in a cabinet located in the shower room.</p> <p>On 4/25/14 at 11:35 A.M., an interview with the Assistant Director of Nursing indicated some resident's do keep items, like toothpaste and combs, at the handwashing sink, but no grooming items were allowed to be left at the sink in the dementia unit. The ADON further indicated the facility did not have a policy regarding the storage of personal grooming items.</p>		<p>Assessment Policy (see attached) was reviewed and determined to remain appropriate. All nursing personnel will be in-serviced on the Fall Prevention and Assessment Policy.</p> <p>IV. In addition to the process noted above, the DON or designee will audit 6 rooms per week for 8 weeks, then 6 rooms per month until 100% compliance for one full quarter, for proper storage of hygiene items (see attached). Results of the audits will be reviewed in Quality Assurance Meeting monthly. The DON or designee will monitor 6 individual resident CNA assignment sheets for accuracy on fall prevention interventions per week for 8 weeks, then 6 sheets per month until 100% compliance is achieved for one full quarter (see attached). Results of the audits will be reviewed in Quality Assurance Meeting monthly.</p>	

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	<p>2. On 4/24/14 at 3:00 P.M., record review indicated Resident #59's diagnoses included but were not limited to "...status post cerebral vascular accident, foot drop, depression, anxiety and end stage macular degeneration...."</p> <p>An annual MDS (Minimum Data Set) assessment, dated 1/2/14, indicated the resident was independent for toilet use, and was independent to walk in the room.</p> <p>A fall risk assessment, dated 4/6/14, indicated a score of 13. A score of 10 or more represents a high risk for falls. A fall risk assessment, dated 4/13/14, indicated a score of 18.</p> <p>A care plan, dated 1/7/14, indicated "...a potential for injuries from falls related recent fall, need for use of walker when transferring, toileting, and ambulating...Interventions:...Ensure that resident is wearing appropriate footwear such as non skid shoes or slippers and shoes without heels...."</p> <p>A "Fall Scene Investigation Report", dated 4/13/14, indicated "...attempting to ambulate from bathroom to bedside...found on the floor in resident room beside bed...footwear at time of fall: barefoot...root cause of fall:</p>			

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	<p>improper foot wear...interventions to prevent further falls: wear proper foot wear when ambulation...."</p> <p>An interdisciplinary team progress note, dated 4/14/14, indicated "...On 4/13/14 at 8:45 P.M. resident was attempting to transfer self without assistance from bathroom back to bed...Resident was not wearing any shoes or gripper socks...Resident was not wearing appropriate footwear, no shoes or gripper socks...."</p> <p>On 4/22/14 at 10:15 A.M., an observation of Resident #59 indicated resident was resting in bed with her pajamas on uncovered, no socks on, and her bare feet were hanging over the edge of the bed. The resident's walker was observed at the end of her bed.</p> <p>During an interview on 4/28/14 at 2:07 P.M., CNA #15 indicated "...the resident had her days when she would walk with assistance to the bathroom, other days the resident had to be taken into the bathroom by a wheelchair due to the pain she had in her legs. The CNA further indicated the resident had slippers she liked to wear but they were slick and do not have any treads on the bottom of them. The CNA indicated she was not aware that the resident should have non</p>			

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F000329 SS=D	<p>skid shoes or gripper socks on before walking.</p> <p>On 4/28/14 at 3:20 P.M., review of the current policy titled "Using the Care Plan," received from the MDS Coordinator, indicated "...2. The nurse supervisor uses the care plan to complete the CNA's daily work assignment sheet and/or flow sheets. CNA's are aware of the need to follow the care instructions as indicated...."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless</p>						

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	<p>antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs in regards to adequate monitoring for a prescribed hypnotic for 1 of 5 residents reviewed for unnecessary drugs. (Resident E)</p> <p>Findings include: Resident E's clinical record was reviewed on 4/28/14 at 9:42 A.M. and indicated Resident E's diagnoses included, but were not limited to, depression, CAD (coronary artery disease), HTN (high blood pressure), Dementia with delusional features, anxiety state, panic disorder with agoraphobia (anxiety caused by fear of certain environments usually large, open areas), chronic pain syndrome, insomnia with sleep apnea, obstructive sleep apnea (repeated episodes of complete or partial blockage of the upper airway during sleep which causes the diaphragm and chest muscles to work harder to pull air into the lungs), hypoxemia (abnormally low oxygen level</p>	F000329	<p>F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Woodland Manor does ensure that each resident's drug regimen is free from unnecessary drugs. I. Resident E's Lunesta was reviewed by the consultant pharmacist. Order was received from the physician to reduce the medication to PRN only. II. All residents receiving hypnotic medications will be identified through a review of physician's orders. Monitoring for side effects and effectiveness will be added to each resident MAR for residents on hypnotic medications. Care Plans will be reviewed and updated to reflect current needs. III. The policy for Unnecessary Drug-Monitoring was reviewed and found to be appropriate (see attached). All nursing and social services staff will be in-serviced on this policy. All nursing staff will be in-serviced on the new side effect and effectiveness monitoring on the MAR for hypnotic medications. IV. In addition to the process noted above, Social services or designee will audit all residents on hypnotic medication to identify diagnosis for use, date of most</p>	05/28/2014

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	<p>in the blood), periodic limb movement disorder, osteoporosis, and CHF (congestive heart failure). Resident E's care plan dated 12/4/13 for hypnotic medication indicated Resident E was "taking hypnotic medication (Lunesta) &amp; has the potential for adverse side effects from taking the hypnotic medication." Resident E's care plan indicated the goal as resident will be free from any adverse side effects. The care plan indicated the following Interventions: administer medication as ordered while observing for the effectiveness and side effects, complete AIMS (abnormal involuntary movement scale) and fall risk assessments per facility protocol, encourage to participate in activities of her interest during the day to promote tiredness for the night, evaluate for dose reduction per regulations and prn (as needed), and observe for changes in mental or physical functioning.</p> <p>A review of Resident E's current physician's order, dated 04/1/14 to 4/30/14, indicated Lunesta 1 mg (milligram), one tablet by mouth every night at bedtime for insomnia."</p> <p>Monthly psychiatric progress notes from 6/13/14 thru 9/13/13 indicated the Lunista medication was prescribed "as needed for sleep".</p> <p>A Progress note, dated 10/23/13,</p>		<p>recent gradual dose reduction, and effectiveness of use monthly during behavior management meeting (see attached). Results will be presented in Quality Assurance Meeting monthly.</p>				

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	<p>indicated no mention of Resident E's sleep disturbances and/or complaints or review of effectiveness of prescribed hypnotic. The note indicated Resident E was prescribed Lunesta 1 mg "as needed for sleep." The note indicated "Unsuccessful GDR (gradual dose reduction) of Lunesta." The note did not indicate any further information regarding dates of GDR, schedule for reduction, or any other indication to document a reduction of Lunesta was attempted.</p> <p>A Progress Note, dated 4/17/14, indicated "staff report behavior is fine -- calm, cooperative, pleasant." The note indicated Resident E was prescribed Lunesta 1 mg "as needed for sleep." No further documentation was available for review which indicated the psychiatric physician had monitored the prescribed hypnotic (Lunesta) as a scheduled, daily dose. All behavior medication/progress notes reviewed indicated the hypnotic medication was reviewed as a PRN for sleep.</p> <p>Social service behavior and progress notes from 12/4/13 to 4/18/14 indicated no mention of complaints of sleep disturbances.</p> <p>Record review indicated "Behavior/Mood Symptom Tracking Tool" for Resident E from 6-2013 to 4-2014 indicated there were no documented episodes of</p>			

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F000353 SS=E	<p>insomnia.</p> <p>On 4/28/14 at 3:25 PM, the ADON (Assistant Director of Nursing) indicated the psychiatric physician's group assessed behaviors at least monthly. The ADON indicated Resident E's prescribed Lunesta was a scheduled medication given nightly and indicated she was unsure why the psychiatric physician behavior/progress notes indicated Lunesta as a PRN medication. The ADON indicated there was no further documentation available to indicate Resident E was experiencing sleep disturbances. The ADON indicated no further documentation was available to review which indicated a GDR for Lunesta was attempted in the last year. The ADON indicated she agreed the psychiatric physician's group may not have monitored the Lunesta correctly as a scheduled medication. The ADON indicated Resident E's use of Lunesta may need to be reevaluated for its use.</p> <p>3.1-48(a)(6)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff</p>			

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	<p>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>A. Based on observation, interview and record review, the facility failed to provide adequate staffing to meet the toileting needs of 4 of 4 incontinent residents reviewed for toileting on Unit 1 and 2. (Residents F, H, L, and I)</p> <p>B. Based on observation and interview, the facility failed to ensure there was adequate nursing staffing to meet the eating needs of 1 resident in the main dining room. (Resident 27)</p> <p>C. Based on observation and interview, the facility failed to ensure there was adequate nursing staff to ensure positioning was provided for 1 of 2</p>	F000353	F353 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANSWoodland Manor has 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.I. Staffing levels needed to meet the toileting needs of Residents F, H, L, and I; the eating needs of Resident 27; the positioning needs of Resident J, and the acute health issues for Resident M will be determined based on review of the care plans, and additional staff added as necessary to meet those	05/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2014	
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	<p>residents on the Skill unit who required extensive staff assistance for positioning. (Resident J). This has the potential to affect 17 of 37 residents residing on Unit 1 and Unit 2, 12 of 25 residents who required feeding assistance in the main dining room, 2 residents who required extensive staff assistance for positioning on the Skilled unit.</p> <p>D. Based on observation and interview, the facility failed to ensure there was sufficient staff to respond timely to a resident with acute health issues nausea, vomiting and pain, for one of one resident reviewed. (Resident M)</p> <p>Findings include:</p> <p>A1. During the initial tour of the facility, conducted on 04/21/14 between 10:30 - 10:45 A.M., two licensed nurses and two certified nursing assistants were observed working on units 1 and 2. There was one nurse and one certified nursing assistant (CNA) observed working on unit 3. The unit 3 nurse indicated she was also covering nursing duties on Unit 4, the Memory care unit. There was one nursing assistant assigned to Unit 4 but she was not observed on the unit during the tour. There was a staff member, later identified as the unit manager, and several residents in the dining room at the</p>		<p>needs.II. Care plan review of all residents will be done to identify the level of assistance required on each unit to meet the individual needs. Additional staff will be added as necessary to meet those needs.III. Staffing patterns will be determined taking acuity into account as well as the actual number of residents. Nursing management staff will be in-serviced on adjusting the hours of staffing as well as the assignments. Additional staff will be hired as needed to cover any additional positions with two full time CNAs already hired and finished with orientation. Both Medical Records and Human Resources who have a CNA certificate have also added shifts on the floor. The facility will continue to add additional staff as needed. IV. In addition to the process noted above, staffing sheets showing actual hours worked will be reviewed by administrator or designee 5 times per week for 4 weeks, then twice weekly for 8 weeks, then once weekly for 12 weeks to monitor staffing patterns and coverage (see attached). Results will be shared monthly in Quality Assurance Meeting.</p>				

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	<p>end of the Memory care unit, playing Bingo. An unidentified female resident, who was noted to have a wheelchair alarm attached to her clothing and wheelchair, was noted to be standing, wiping at a resident's rights and contact information plaque on the wall across from the nurse's station. There were no staff at the nurse's station or in the hallway to observe the resident. The string to the wheelchair alarm was too long and the alarm was not sounding even though the resident was standing up. The Administrator entered the unit and convinced the resident to sit back in her wheelchair. The CNA assigned to the Memory care unit, CNA #9 then entered the unit from Unit 3.</p> <p>During an interview with alert and oriented, Resident I, conducted on 04/22/14 at 9:30 A.M., the resident indicated due to the lack of staff her incontinence brief was left unchanged all day, up to 8 or 9 hours. She indicated she was getting sore in her private area. She also indicated when she was assisted to the toilet, she was left on the toilet too long. Finally, she indicated there was some cream that was supposed to be put on her private area but not all staff took the time to put on the cream.</p> <p>The clinical record for Resident I was</p>						

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	<p>reviewed on 04/23/14 at 1:15 P.M. Resident #I was admitted to the facility on 01/31/14, with diagnoses, including but not limited to, paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle ligament and fascia, muscular wasting and disuse atrophy, and Parkinson's disease.</p> <p>The current health care plan related to incontinence for Resident I, revised on 02/18/14, indicated the resident was "functionally" incontinent. The interventions included: "Apply adult briefs when out of bed. Check and change every 2 hours and prn (as needed). Remove adult brief when in bed...If (resident's name) is unable to stand in the bathroom then obtain the bedside commode from the shower room next door, allow her to use that, then clean and return the bedside commode to the shower room when finished...offer assistance for toileting upon rising, before and after meals, at hs (bedtime), and prn...."</p> <p>On 04/24/14, Resident I was noted at the following times: 9:00 A.M. - in the beauty shop. 9:20 A.M. - now out of beauty shop and in the activity room watching television.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2014	
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	<p>She indicated she was gotten up at 7:00 A.M. this morning, cleaned her up and put a clean brief on her. She indicated she was not toileted but she stated they (staff) probably would have sat her on the toilet if she had asked.</p> <p>9:50 A.M. she was noted to be in the hallway by the dining room waiting to go into the dining room for exercises.</p> <p>10:00 A.M. - in main dining room for exercises.</p> <p>10:07 A.M. - pushed from the dining room to the end of unit 2 by the activity director. Resident and activity staff noted sitting at the end of unit 2 hallway waiting to vote.</p> <p>10:30 A.M. - back in activity room for a movie activity.</p> <p>10:45 A.M. - still in the activity room watching movies.</p> <p>11:00 A.M. - 11:35 A.M. still in activity room watching movies.</p> <p>12:00 P.M. - in the main dining room, in her wheelchair, participating in a Trivia activity. She indicated she had went straight from the activity room to the main dining room. She indicated she was not taken to her room for incontinence care.</p> <p>1:00 P.M. - resident observed in her room, in her bed still dressed. She indicated the noise in the dining room had upset her. She indicated she was assisted into her bed but was not toileted</p>						

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	<p>or offered a brief change.</p> <p>2:30 P.M. - was reported to have been in therapy. She was then weighed in the shower room by the therapy staff.</p> <p>During an interview on 04/24/14 at 2:30 P.M., CNA #3 indicated she had changed the resident's brief at around 10:00 A.M. She indicated CNA #4, had helped her stand the resident while she changed her.</p> <p>On 4/24/14 at 2:35 P.M., CNAs #3 and 4 were observed exiting Resident I's room. CNA #3 was carrying bags of soiled linens and trash/briefs. There was a strong urine odor noted in the room even after CNA's left the room. Resident I, who was noted to be lying in bed, indicated the CNAs had removed her wet brief but did not do any peri care.</p> <p>On 4/24/14 at 2:45 P.M., Resident I's skin was observed with the Director of Nursing. Resident I was noted to have large galded areas underneath her abdominal folds on each hip area. Her front peri area was reddened and had creases from the previous brief. There was an open blister noted on her posterior, right upper thigh. There were also two linear areas, near the open area, which had frank blood, one on the lower buttocks and the other on the upper left</p>			

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	<p>thigh. Resident I complained of pain in her peri area, said her brief had been on too tight. A bed pillow with wet, yellow stains, was noted in the wheelchair. There was no other cushion in her wheelchair. Resident I was noted to be lying in bed with a brief untaped between her legs and two cloth quilted bed pads on top of each other underneath her. Resident I indicated prior to having her brief changed on 04/24/14 at 2:35 P.M., she had not been checked for incontinence, had her brief changed, or been offered any type of toileting since around 7:00 A.M. when she was gotten up for the morning, assisted to dress, and assisted to her wheelchair.</p> <p>On 04/25/14 at 9:30 A.M., Resident I was noted to be in her room, in a wheelchair, sitting on a folded bed pad. She was grimacing and indicated her buttocks hurt really bad and she was going to ask to go back to bed.</p> <p>On 04/25/14 at 9:40 A.M., Resident I was assisted to transfer into her bed by two restorative CNA's #5 and 6. She was not changed before she was put into bed, her clothes and briefs were not removed, and she was placed again on two quilted bed pads. She indicated her bottom felt better after she was placed in bed.</p>			

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	<p>On 04/25/14 at 10:40 A.M., Resident I was noted to still be bed awake, had snacks in her bed, and was lying slightly crossways in bed on top of a quilted bed pad and part of her blanked was also rumped up underneath the right side of her buttocks.</p> <p>Resident I was observed to remain in her bed without any care on 04/25/14 from 9:40 A.M. - 11:30 A.M. She indicated her brief had not been changed nor had she been offered any toileting assistance since 7:00 A.M., when she was assisted to dress and transfer to her wheelchair for the day.</p> <p>A2. On 04/27/14 at 5:15 P.M., Resident F was observed in the main dining room in her wheelchair. The evening meal had not yet been served. She remained in the dining room until 6:52 P.M. when she was pushed from the dining room to the hallway across from the nurse's station. At 6:56 P.M., she was pushed in her wheelchair into her room and left seated in her wheelchair at the bedside. She remain in her wheelchair by her bed from 6:56 P.M. until 8:27 P.M., when she was transferred, by CNA #1 and #7, utilizing a two person lift technique into her bed. She was placed in her bed, her outside pants were left on, and she did not receive incontinence care at the time.</p>			

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	<p>CNA #1 and #7 proceeded to transfer Resident F's roommate with a mechanical lift and then left the room. Resident F had not received incontinence care and was last observed, lying in her bed with a hospital gown on her top and her regular outside pants on her bottom at 8:45 P.M. CNA's #1 and #7 were noted to be on Unit 1 assisting another resident to be who required a two person lift transfer.</p> <p>The clinical record for Resident F was reviewed on 04/28/14 at 3:00 P.M. Resident F was readmitted to the facility on 03/01/14 with diagnoses, including but not limited to muscular wasting and disuse atrophy, abnormality of gait, recent extraction of teeth, and early Alzheimer's dementia.</p> <p>The current health care plans, initiated on 03/07/14, for Resident F indicated she required staff assistance of two to change her brief, was always incontinent of both her bowels and bladder, and was to be turn and repositioned at least every 2 hours. There was no specific instructions regarding how often Resident F was to have her brief checked for incontinence and/or changed.</p> <p>A3. Resident L was observed on 04/28/14 at 5:15 P.M. in her room, seated in her wheelchair. At 5:20 P.M., LPN #8</p>						

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	<p>cued Resident L to go to the dining room for the evening meal. Resident L remained in her wheelchair from 5:15 P.M. - 8:18 A.M. At 8:18 A.M., CNA #7 was noted to assist Resident L to remove her T-shirt and put on a hospital gown. Her white outside capri pants remained and the resident remained in the wheelchair. CNA #7 indicated she was waiting on CNA #1 to assist her to transfer residents to their beds. At 8:30 P.M., Resident L was in her room in a wheelchair eating a sandwich. CNA #1 and #7 then brought the mechanical lift into the room and prepared to transfer Resident L to her bed. When CNA #1 pulled the lift pad into position behind the resident, Resident L exclaimed, "Oh, that's wet." CNA #1 and #7 proceeded to transfer Resident L to her bed. The CNA's left her white capris pants and the wet hoyer pad under the resident and did not perform any incontinence care or assist the resident to finish dressing for bed. The resident exclaimed as she was being transferred "I smell a strong ammonia smell. Like baby diapers that have not been changed." There was a strong urine odor noted in the resident's room. CNA #1 and #7 left the room and LPN #8 entered the room to administer medication. LPN #8 was queried as to why Resident L had been placed in bed without any incontinence care and she</p>			

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	<p>indicated CNA #7 would be back later to provide care. It was uncertain how much later it would be before the CNA returned. The resident had not received incontinence care or dressing assistance at 8:45 P.M. and both CNAs #1 and #7 were noted to be in a resident room on unit 1 providing transferring assistance.</p> <p>The clinical record for Resident #L was reviewed on 04/23/14 at 2:43 P.M. Resident #L was admitted to the facility on 09/24/13, with diagnosis, including but not limited to, diabetes, stage iv pressure ulcers, abdominal/pelvic swelling/mass, muscular disuse and wasting atrophy, symbolic dysfunction, left below the knee amputation, chronic schizophrenia, gerd, anemia, depression, cad, arthritis, hyperlipidemia, cardiovascular disease, obesity, seizures, congestive heart failure.</p> <p>The current health care plans for Resident L indicated the resident required mechanical lift for transfers and was totally dependent upon staff for toileting needs. The plan indicated the resident was to be checked every 2 - 3 hours and as required for incontinence. "Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes." was also included. Resident L also currently had a stage 4 pressure ulcer on her upper</p>			

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	<p>right buttocks.</p> <p>A4. Resident H was observed, on 04/27/14 at 5:15 P.M., seated in a geri chair type wheelchair in the main dining room. He remained in the dining room until 7:03 P.M. when he was pushed by CNA #7 from the dining room into the hallway.</p> <p>He remained in his geri chair until 8:40 A.M. when he was transferred from his geri chair into his bed by CNA #1 and #7 utilizing a mechanical lift. At 8:45 P.M., Resident H was noted to be lying in his bed awake. His outside shorts were noted to be visibly soiled and wet. There was a very malodorous smell of urine in the resident's room. The resident was wearing a hospital gown but still had on his outside plaid shorts. His T-shirt and a towel were noted on the floor beside his bed. CNA #1 and #7 had left the room and were on unit 1 providing transferring care to another resident.</p> <p>The clinical record for Resident H was reviewed on 04/28/14 at 11:00 A.M. Resident H was admitted to the facility on 06/15/06, with diagnoses, including but not limited to, toxic encephalopathy, abnormal posture, senile dementia, diabetes, and major depressive disorder.</p>			

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F000356 SS=C	<p>The health care plans, current through 07/07/14, indicated the resident required two person staff assistance and mechanical lift for transfers, and was to be checked and changed every 2 hours and as needed.</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law,</p>						

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	<p>whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the daily nurse staff posting was complete for 6 of 6 days. (4/22, 23, 24, 25 and 27/2014)</p> <p>Finding includes:</p> <ol style="list-style-type: none"> <li>During the initial tour of the facility, conducted on 04/21/14 at 10:40 A.M., the daily nurse staff posting was noted to be posted outside the social service office, located on the front hall of the facility. The posting indicated there were 4 licensed nurses working, one nurse on each unit, and 4 certified nursing assistants working. However, observation of each nursing unit, indicated there were only 3 licensed nurses working. The nurse for Unit 3 was also assigned to Unit 4. There was also no daily census number on the posting and while each shift had hours documented the total number of hours for registered nurses, licensed practical nurses, and certified nursing assistants was not indicated.</li> </ol> <p>The staff posting, without the daily census number or the total daily hours for each entity was noted on 04/22/14, 04/23/14, 04/24/14, 04/25/14 and 04/27/14.</p>	F000356	<p>F 356 483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>Woodland Manor does post nurse staffing data daily at the beginning of each shift.</p> <ol style="list-style-type: none"> <li>Daily nurse staffing poster was revised (see attached) to include daily census, total hours, and actual hours worked for RN, LPN, and CNA. This form is posted daily and updated at the beginning of each shift.</li> <li>All have the potential to be affected.</li> <li>A new daily staffing poster was revised and implemented. Nurses will be educated on the completion and posting of the form.</li> <li>In addition to the process noted above, the Administrator or designee will monitor completion and posting of the daily staffing poster during walking rounds 5 times per week. This monitoring will continue until 100% compliance is achieved for one full quarter. Results will be presented in Quality Assurance Meeting monthly.</li> </ol>	05/28/2014

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F000441 SS=D	<p>Interview with the Administrator, during the exit conference for the survey, conducted on 04/28/14 at 5:15 P.M. indicated the staff posting form had been changed after the previous annual survey and she was not aware of the need to put the daily census or total the nursing hours on the form.</p> <p>3.1-13(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as 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.</p>			

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	<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 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 one of one staff observed performing incontinence care changed their gloves appropriately for 1 of 2 residents who were observed receiving care. (CNA #1 and Resident I)</p> <p>Findings include:</p> <p>During an observation of incontinence care for Resident I, conducted on 04/27/14 at 7:40 P.M., CNA #1 donned disposable gloves, retrieved two washcloths and a towel from a stack of folded linen which had been placed on top of a carton of soda in Resident I's room. She then went into the bathroom and put water and soap on the washcloths. Next, CNA #1 placed the wet washcloths on the handles of the resident's wheelchair while she opened two trash bags from a roll of trash bags she had in her pocket. CNA #1 then</p>	F000441	<p>F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>Woodland Manor has established and maintained 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>I. The CNAs will change gloves appropriately when providing care to Resident I.</p> <p>II. All Residents have the potential to be affected by improper use of gloves. The CNAs will change gloves appropriately when providing care.</p> <p>III. A Proper Use of Gloves policy was reviewed and approved for use through the Quality Assurance Committee (see attached.) All Nursing staff will be in-serviced on the proper use of gloves.</p> <p>IV. In addition to the process noted above, the DON or</p>	05/28/2014			

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	<p>assisted Resident I with removing her incontinence brief. The brief was noted to be soaked with urine and there was a very strong odor. CNA #1 then took one of the washcloths and washed Resident I's abdominal folds and the front of the resident's perineal area. She then dried the resident's abdominal folds and front perineal area. Then, without removing her gloves, CNA #1 got two more washcloths and a clean brief, wet the washcloths, and assisted the resident to roll over, removed the soiled brief from underneath the resident. There were deep indentations from the brief and the resident's skin on her buttocks and right upper thigh were noted to be reddened. There was also an open area on the right upper thigh. CNA #1 took the second wash cloth and washed and dried the resident's backside. CNA #1 also removed the two cloth incontinence pads from underneath the resident. Then without removing or changing her gloves, CNA #1 obtained a tube of Aloe Vesta cream, opened the tube, and generously placed the cream all over the resident's back side including over top of the open area. There were no remnants of any type of cream noted on the resident's backside before the Aloe Vesta cream was applied. Then CNA #1 removed her gloves, washed her hands, and donned a clean pair of gloves. She then placed two clean</p>		<p>designee will monitor 6 residents care per week for 8 weeks, then 6 residents per month until 100% compliance is achieved for one full quarter on the proper use of gloves during direct care (see attached). Results of the audit will be reviewed during the Quality Assurance meeting monthly.</p>				

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F000465 SS=E	<p>bed pads and the clean brief on the resident and adjusted her gown and blankets.</p> <p>Review of the facility policy and procedure, titled, Activities of daily living - Perineal Care, provided by the Assistant Director of Nursing on 04/28/14 at 5:00 P.M., indicated the policy did not instruct the staff to remove their gloves until just prior to arranging bed clothes and linens after the whole procedure was completed. There were no instructions to change gloves after handling soiled linens and briefs before initiating the cleaning process, after having contaminated gloves during the cleaning process, or before handling hygiene items such as lotion or cream containers.</p> <p>3.1-18(b)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to</p>	F000465	F 465 483.70(h) SAFE/ FUNCTIONAL/ SANITARY/ COMFORTABLE	05/28/2014			

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	<p>provide a safe and clean resident environment related to, holes in the walls of resident rooms, stained and missing floor tiles in resident restrooms, urine odors in resident restrooms, dirty toilet seat risers, improperly stored BiPap equipment (a machine used to support breathing), and a wheelchair that was dusty and had a sticky substance on it. This had the potential to affect 9 of 18 residents residing on Unit 1, 12 of 18 residents residing on Unit 2, 1 of 7 residents residing on Unit 3 and 3 of 17 residents residing on Unit 4.</p> <p>Findings include:</p> <p>On 4/25/14 from 10:00 A.M. to 11:30 A.M., an environmental tour was conducted with the Maintenance Supervisor and the Housekeeping Supervisor, during which the following was observed:</p> <p>1. Unit 1:</p> <p>At 10:00 A.M., Room 100 was observed with broken tile at the bottom of the restroom door. The wall beside the head of the bed for bed A had a large scrape 8 x 10 inches in size exposing the drywall underneath. The cover for the call light above the doorway in the hall was missing. The air conditioning unit was</p>		<p>ENVIRONMENTWoodland Manor provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. I. The areas identified to require tile repair in 100, 110, 228 and 225 will be repaired. The areas needing fresh toilet caulk in rooms 228, and 227 will be repaired. The areas needing wall repair in 100, 110, 116, 123, 227, and 228 will be repaired. The light/ call light covers in 100 and 110 will be replaced. The air-conditioning grates and/ or knobs will be replaced for 100, 112, and 116. The bed alarm was replaced in room 100. The toiled risers have been cleaned in 100, 110, 123, 229, and 400. The leak around the toiled base in room 112 will be repaired. The corners in room 111 have been cleaned. The sink handles and/ or stoppers will be repaired/ replaced in room 229 and 228. The overhead light will be repaired in room 225. The wall has been cleaned in room 225. The ceiling stain has been repaired in room 228. The bed in room 112b has been moved and the books stored properly. The towel rack will be corrected in room 222. The sinks in room 113 and 225 will be repaired to drain correctly. The rusty doors/ vents and chipped paint in room 225, 229, 400, and 113 will be repaired. The odor has been removed from rooms 113 and 123. Social services will work with</p>				

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	<p>missing the grate cover on the control panel. A bed alarm for bed A was observed with a wire cut in half exposing the wires between the alarm pad and the control.</p> <p>At 10:05 A.M., the shared restroom for Room 110 bed A and B was observed with a toilet seat riser uncovered and sitting on the tile floor beside the toilet. There was missing floor tiles around the base of the toilet. The light cover above the mirror in the restroom was missing. The wall beside the head of the bed for bed A had a large scrape 8 X 10 inches in size exposing the drywall underneath.</p> <p>At 10:10 A.M., the shared restroom for Room 111 bed A and B was observed with a dried brown substance on the toilet seat riser, this same dried substance was observed on the seat riser on 4/22 and 4/23/14. The corners of the tile floor in the restroom had a dark brown sticky substance.</p> <p>During an interview on 4/25/14 at 10:11 A.M., the Housekeeping Supervisor indicated that the toilet seat risers are to be cleaned daily by housekeeping. She further indicated that at times some of the toilet seat risers need to be cleaned more often than once a day and if the nursing staff find the seat risers soiled they</p>		<p>the resident in room 228 on proper storage of his belongings. The light in room 228 will be checked and repaired if needed. The bipap mask in room 229 has been correctly stored. The peeling wall paper in room 407 has been corrected. Odors have been removed from identified rooms and ongoing deep cleaning continues to keep the issue resolved. II. All rooms in the facility will be inspected for cleanliness and repairs needed. Any rooms with identified issues will be cleaned and repaired. III. All staff will be in-serviced on the necessity to utilize the clipboards to report repairs needing maintenance attention. Nursing staff will be in-serviced on the necessity to clean toilet risers if soiled between housekeeping rounds. IV. Administrator or designee will audit 4 rooms per week for 12 weeks, then 4 rooms per month until 100% compliance with housekeeping and maintenance concerns is achieved for one consecutive quarter (see attached). Results will be reviewed in Quality Assurance meetings monthly.</p>		

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	<p>should clean them.</p> <p>At 10:12 A.M., the shared restroom for Room 112 bed A and B was observed with a small amount of water on the tile floor around the base of the toilet. When the toilet was flushed water leaked from the pipe behind the toilet onto the floor. Bed B was observed pushed up against the radiant heater. Two books were observed to be stored between the heater and the air conditioning unit. A control knob was missing on the air conditioner that controls the temperature of the unit.</p> <p>At 10:20 A.M., the shared restroom for Room 113 bed A and B was observed to have an unmarked toothbrush on the handwashing sink with the end of the brush touching the sink. The handwashing sink was not draining properly. There was paint missing from the base of the bathroom door frame. There was a strong urine odor in the bathroom.</p> <p>During an interview on 4/25/14 at 10:21 A.M., the Housekeeping Supervisor indicated that this restroom is cleaned and mopped daily, and more frequent if needed. She further indicated that the resident uses a urinal and spills the urine all over the floor in the restroom.</p>						

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	<p>2. Unit 2:</p> <p>At 10:22 A.M., Room 116, 2 holes each the size of a dime was observed in the wall at the foot of the bed. The air conditioner unit was observed to have a grate missing on the control panel.</p> <p>At 10:25 A.M., the shared restroom for Room 123 bed A and B was observed to have a brown dried substance on the back of the toilet seat riser. The restroom also had a strong urine odor. An unlabeled toothbrush was observed on the handwashing sink. Two dime sized holes were observed on the wall beside the toilet.</p> <p>At 10:30 A.M., Room 222 was observed to be missing a towel rack in the restroom.</p> <p>At 10:31 A.M., the shared restroom for Room 225 bed A and B were observed to have a handwashing sink that was not draining properly. The base of the door frame in the restroom was rusty. The vent grates for the restroom heater was dusty and rusted. There was missing tile on the floor and wall behind the toilet. Bed A had 3 long brown stains above the head of the bed. The over head light for Bed A was not working. The resident indicated it had not worked for weeks.</p>			

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	<p>At 10:35 A.M., Room 227 was observed with caulking smeared around the base of the toilet and was discolored. The wall surface beside the soap dispenser was rough and had drywall compound on it that had not been sanded.</p> <p>At 10:40 A.M., the shared restroom for Room 228 was observed to have 3 tiles missing on the wall behind the toilet. The caulking around the base of the toilet was smeared and discolored. The handwashing sink in the restroom was missing the hot indicator on the handle. There was clothing and cardboard boxes stacked in the tub. The light was dim in the restroom. The wall beside the soap dispenser had 2 dime sized holes with unsanded drywall compound on it. The ceiling above Bed B had a 10 x 10 inch brown stain in the ceiling.</p> <p>During an interview on 4/25/14 at 10:41 A.M., the Maintenance Supervisor indicated the restroom lighting did seem dim. He further indicated the corporation had recently went with new fluorescent bulbs that were not as bright.</p> <p>At 10:45 A.M., the shared restroom for Room 229 bed A and B was observed to have a brown dried substance on the toilet seat riser. The sink stopper for the</p>			

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	<p>handwashing sink was missing, and the handwashing sink were missing the cold indicator on the handle. The vent grates for the restroom heater was dusty and rusty. Bed A was observed to have an open plastic bag on the floor beside the head of the bed, the inside of the bag contained Bi-pap equipment (equipment used to support breathing).</p> <p>During an interview on 4/25/14 at 10:46 A.M., LPN #16 indicated that this was not the proper way to store breathing equipment and that she would make sure it was stored properly.</p> <p>Unit 3:</p> <p>At 11:15 A.M., Room 310 bed A, a wheelchair was observed to have a sticky dusty substance on the seat and the bars underneath the seat. The resident indicated she has had the same wheelchair for 2 years.</p> <p>During an interview on 4/25/14 at 11:16 A.M., the Maintenance Supervisor indicated he was unsure who's responsibility it was to clean the chairs but that he would personally clean the chair today.</p> <p>Unit 4:</p>			

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	<p>At 11:20 A.M., Room 400 was observed to have a rusty heating unit in the restroom. The handwashing sink and toilet seat riser had a brown dried substance on them.</p> <p>At 11:25 A.M., Room 407 was observed to have wallpaper border peeling off in the restroom.</p> <p>During an interview on 4/25/14 at 11:30 A.M., the Maintenance Supervisor indicated each nurses station had a maintenance request/repair form. He further indicated all staff had access to the forms and the expectation of staff was to fill the form out indicating what and where the concern was, and he reviewed the forms daily and prioritized what needed to be repaired first.</p> <p>On 4/25/14 at 11:40 A.M., review of the "Housekeeping Daily Task Sheet" undated, and received from the Housekeeping Supervisor, indicated "...Rooms:...clean sink and toilet with Virex first then use the Works if needed...Spot wash walls and doors if needed (make sure there is no BM [fecal matter] on walls or doors if so clean it immediately)...Sweep/mop rooms and bathrooms...."</p> <p>3.1-19(f)</p>			

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