STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/29/2013
NAME OF PROVIDER OR SUPPLIER MAPLE MANOR CHRISTIAN HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 643 W UTICA ST SELLERSBURG, IN 47172	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00129844 and IN00129864. Complaint IN00129844-Substantiated. Federal/state deficiencies related to the allegation's are cited at F441. Complaint IN00129864-Substantiated. Federal/state deficiencies related to the allegation's are cited at F441. Survey Dates: July 22, 23, 24, 25, 26, & 29, 2013 Facility number: 000563 Provider number: 155766 AIM Number: 100267610 Survey Team: Gwen Pumphrey, RN-TC Gloria Reisert, MSW (7/22,7/23,7/24,7/25,7/26, 2013) Jennifer Carr, RN Sunny Jungclaus, RN (7/24,7/25, 7/26, 7/29, 2013) Nicole Wright, RN (7/29/2013)	F000000		

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

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

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	Census bed type: SNF/NF: 53 Total: 53 Census payor type: Medicare: 5 Medicaid: 34 Other: 14 Total: 53 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on 8/8/13 by Cheryl Fielden RN.			

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F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on record review, observation and interview, the facility failed to maintain each resident's dignity and respect in full recognition of his individuality during personal care, toileting, and medication administration for 2 of 3 resident's reviewed for dignity. (Resident #21 and #27) Findings include: 1. During an observation of personal care and toileting on 7/25/13 at 4:20 p.m., CNA #1 repeatedly addressed Resident #21 as "Sweetie", "Honey", and "Sweetie Pie". Additionally, as Resident #21 was being lifted from the bedside commode, CNA #1 indicated, "Did you pee pee?" 2. During an observation on 7/25/13 at 9:00 a.m., Resident #27 was noted to be awake in bed with a strong odor of feces in the room. Resident indicated that he was waiting for staff to assist him with toileting. A brown, semi-soft substance smelling of feces	F000241	Res# 21 – no action can be taken due to it being words spoken Res#27 – no action can be taken due to the issue being resolved when resident was provided incontinent care. The updated QA log will be utilized by an administrative staff member to interview all residents that are interviewable initially. Staff will be inserviced on dignity with these particular issues reviewed. The weekly abuse check QA will be updated to include: has any staff member addressed you by sweetie, honey, etc. and has care been provided to you in a way that is satisfactory. This QA will be completed 3x's weekly x 4wks with 3 residents then 2x's weekly with 3 residents x4 wks then 1x weekly with 3 residents x 4 wks then 1x q 2 weeks with 3 residents ongoing. Addendum: CNA was inserviced on Dignity and to not address residents by such things as honey, sweetie, etc. All residents have been asked the questions to determine if they are interviewable . If they are then they were asked the questions on the QA for Abuse, Neglect, Mistreatment and/or Misappropriation of resident	08/28/2013

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	was observed smeared on the bed spread, the resident's left posterior forearm, and on his shirt. When staff was notified, CNA #1 indicated she was already aware of the resident's condition and entered the resident's room 15 minutes later indicating, "Hi, Honey! " 3. On 7/25/13 at 9:15 a.m., during medication observation LPN #1 was observed to enter Resident #27's room with his medications and proceeded to give the resident his medications by taking the medication cup to his lips and tipping them into his mouth followed with a sip of water. During this same time CNA #1 was observed to continue to cleanse the resident's feces-covered hands with wet-wipes with a strong odor of feces present. An interview with the resident's wife was conducted on 7/24/13 at 4:00 p.m. She indicated that her husband was frequently incontinent and would lay in urine and feces due to staff not responding to his call light or her verbal requests for help in a timely fashion. A review of the current facility's Quality of Life; Dignity Policy and Procedure indicated, "It is the intent		property which includes "has anyone addressed you by sweetie, honey, etc.) see attached. Also included in the QA for abuse a question has been added - "has care been provide to your satisfaction". Staff was inserviced on each deficient practice within this tag, therefore, they have been instructed that medications cannot be given if a resident is obviously incontinent of bowel and bladder. All nursing staff were inserviced on Dignity by utilizing Appendix PP pages 70, 71 & 72. Abuse P&P (see attached) which includes dignity will continue to be placed in the new employee packets. Abuse, Resident Rights, etc. inservices are conducted at least twice annually, next one is scheduled to occur in October. Inservice agenda that was conducted on 8/22/13 is attached. As stated in the initial POC the attached QA will be completed 3x's weekly x 4 weeks with residents then 2x's weekly with 3 residents x 4 weeks then 1x weekly with 3 residents x 4 weeks then 1x q 2 weeks with 3 residents ongoing. This QA will be conducted by the SSD or other designated administrative staff member as needed.	

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	of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." 3.1-3(t)			

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on interview and record review, the facility failed to ensure a resident was given a choice related to her morning time and bathing preferences for 1 of 1 resident's family interview in a sample of 3 family interviews. (Resident #66). Findings include: On 7/23/13 at 11:52 p.m., during a family interview Resident #66's daughter indicated that her mother frequently went to bed later than she desired as a result of waiting for staff to answer her call light. Additionally, Resident #66's daughter indicated that she preferred a bath over a shower, but she had been receiving showers since admission. Resident #66's daughter indicated her mother was placed on a pre-set shower schedule, and she understood she was receiving showers instead of baths due to a recent history of	F000242	Res# 66 – review of chart reveals that resident had indicated to SSD (see attached) that she prefers to get up between 6a-630a and go to bed about 10pm. Spoke with resident on 8/15/13 at this time she indicated she gets up when her son-in-law comes in every morning and that she does not go to be early. Staff nurses confirmed that son-in-law does come in every morning and gets her up before breakfast. C.N.A. sheet has been updated to indicate baths only. Resident charts will be reviewed for preferred get up/bedtime/bathing type with updates to C.N.A. sheets to be made as needed. Upon admission SSD will give info to the D.O.N. administrative assistant in regards to get up/bed time/ bathing preferences so C.N.A. sheets can include this information. Nursing will be reeducated on resident choices of bedtime/get up time/bathing type at inservice 8/22/13. D.O.N. administrative assistant will complete the attached QA with	08/28/2013

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	frequent urinary tract infections. LPN #1 was interviewed on 7/26/13 at 10:15 a.m., and indicated residents did have to wake according to the facility's breakfast schedule. She also indicated, "That's not to say that if a resident doesn't wake up until ten (a.m.) and they want breakfast, we won't get it for them." LPN #1 indicated baths were discouraged for residents with a history of frequent urinary tract infections, and residents and families were made aware they do have a choice, if reasonable. Resident #66's record was reviewed on 7/24/13 at 2:45 p.m. Resident #66 was admitted to the facility on 7/2/13. The resident's diagnoses included, but were not limited to, hypertension, renal insufficiency, dementia, altered mental status, and urinary tract infection. The "CNA Care Plan Reference Sheet", was noted to be labeled with Resident #66's name and attending physician, but was not otherwise completed. There was no indication of her "Customary Routine", which was to include her cycle of daily events. A review of Resident #66's MDS (Minimum Data Set), dated 7/9/13 and reviewed on 7/26/13 at 2:50 p.m., indicated the resident BIMS (Brief Interview for		each new admission to facility. This will be ongoing. IDR Reason: information was taken from family member and information from resident does not appear to have been obtained.	

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	Mental Status) score was 11 of 15 with a score of 8 to 15 indicating the resident was interviewable. 3.1-3(u)(1) 3.1-3(u)(3)			

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F000246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.			
	Based on observation and interview, the facility failed to ensure resident room call light's were within reach of residents when in bed or up in a chair for 3 of 53 residents currently residing in the facility who were observed for call light's within reach. (Residents #28, #44 and #66) Findings included: During the Environmental Tour on 7/25/13 between 9:15 a.m., and 10:00 a.m., the following was observed: 1. Room 102 - call light hanging on wall across bed. The resident was sitting up in her recliner at the foot of the bed. Per interview with the resident at this time, she indicated "I don't use that stupid thing anyway, would have to crawl across bed, but too much trouble anyway to use it even if it was over here. Just don't	F000246	No correction can be done at this time as this has already occurred and was addressed during the survey. The attached QA form will be initiated with all call lights being checked initially. Staff will be inserviced on the importance of ensuring call lights are within reach at all times unless res. Specifically indicates they do not want the call light (as we do have some) cord removed from the wall. An administrative person will utilize the attached QA form to monitor call light placement. This will be done 2x's daily 5 days/week for 2 weeks then 1x daily 5 days/week for 2 weeks then if 95% accuracy is achieved QA will end if 95% is not achieved then QA will continue 1x daily 5 days/week until met. Addendum: Res #28 has agreed to have the call light attached to her bedspread at the foot of her bed next to her recliner. She does not sleep in her bed, she sleeps in recliner per her choice. Criteria - if call lights are within reach of the residents 95% or greater of the time during the QA process (as sometimes the cord has been in reach but	08/28/2013

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	want to be bothered with it." (Resident #28) 2. Room 111 - call light was lying next to the recliner on the floor. The resident was observed to be in bed asleep. (Resident #66) 3. Room 308 - resident was observed in bed asleep at present with the call light on floor at foot of bed. (Resident #44) At 10:00 a.m., the Director of Nursing [DON] was informed of call lights not being in the proper place. At 10:10 a.m., the DON indicated "the resident originally told me 'NO' about moving the call light into place where she could reach it as she wasn't going to use it anyway, but then she agreed. I moved it to the edge of her bedspread so she can reach it when seated in her recliner. She still told me she had no intention of using it anyway. The other 2 call lights were moved to correct placement for them in bed." At 12:00 p.m., the DON indicated "I talked to the staff on 300 and 100		the resident has moved or moved the cord>) then the QA will end if not met then QA will continue 1x daily 5 days/week until the 95% threshold is met	

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	units and they indicated neither resident is capable of using the call light. If family is here, then they will push it if they need something but otherwise the staff just periodically monitors the residents in passing. " 3.1-19(u)(1)			

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F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A. Based on record review and interview, the facility failed to provide medically related Social Services to a resident who was displaying sexually inappropriate behaviors towards female staff. This deficient practice affected 2 of 27 residents reviewed or Social Services. (Resident #54 and #55) B. Based on record review, interview and observation, the facility failed to ensure a resident's psychosocial needs were met by not providing a medically social services plan of care for community discharge for 1 of 1 residents reviewed for discharge planning. (Resident #55). Finding includes: A. Review of the clinical record for Resident #54 on 7/24/13 at 10:39 a.m., indicated he was admitted to the facility on 1/26/12 from home. Diagnoses included, but were not limited to dementia with behavioral disturbance.	F000250	A: #55 – This resident was not affected in this situation. A: #54 – Social Services Designee has followed up on behaviors and completed appropriate documentation. B: # 55 – Discharge planning careplan has been completed. Charting has been completed by SSD to address discharge plans. A: All communication logs will be reviewed by SSD 7/26/13 forward. SSD will complete follow up for any identified issues that have not been addressed. B: Charts will be reviewed for residents that have indicated they want to be discharged. SSD will then ensure a discharge care plan is initiated on them. inappropriate behavior. Staff will be inserviced on the “Stop & Watch” forms. (see attached) This form will be placed in the new employee packets for nurses and C.N.A.’s. B: Upon admission the SSD will determine if plans are to be discharged. If this is the case then a discharge careplan will be initiated at that time. A: D.O.N. reviews communication logs daily when in building. When reviewed the attached QA form will be used to monitor follow up on noted	08/28/2013

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	Nursing Notes dated 7/14/13 at 4:30 p.m., indicated the following: "It was reported to this nurse that resident was in his room along with 2 other staff members. He pinned 1 female CNA [Certified Nursing Assistant] up against the wall and began running his hands all over her body. Another CNA came into the room to check other resident and assisted in redirecting resident away from other staff member. The resident then attempted to grab another staff member. Educated resident that it was inappropriate to touch other people without their permission. STM [Short Term Memory] impaired AEB [as exhibited by] supervisor also spoke with resident and immediately after she educated resident to not touch others, he replied with 'Okay' and reached over to grab CNA's stomach. Resident will be monitored by staff to ensure he will not be alone with females." Documentation was lacking by Social Services of having addressed the behaviors. During an interview with the Director of Nursing on 7/24/13 at 11:36 a.m., she indicated "We do not have a policy which addresses resident to staff inappropriate touching. We just		behaviors by SSD. B:The unit managers will ensure the discharge careplan (if applicable) has been initiated when new admit chart audit is completed. (see attached audit sheet #29) Addendum: Res#55 under letter A was not involved with displaying sexually inappropriate behaviors nor was she subjected to them. Letter A involved resident #54 and Letter B involved resident #55. Res#54 actions taken - res seen by psych serviced on 8/6/13. Dx of Alzheimers Dementia with disturbance of behavior with delusions and Psychosis NOS. Namenda ordered per titration. SSD has been following up on incident, notes made 7/24/13, 7/26/13, 7/30/13, 8/2/13, 8/7/13, 8/13/13 and 8/15/13. New careplan to address inappropriate sexual behaviors has been implemented as well as a behavior monitoring flowsheet. Social Service Consultant was in building on 8/9/13 and reviewed his chart.	

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	discourage him and when they called me about it, I told them to keep a close eye on him and away from any of the residents to make sure he does not do it again. He didn't. We got an order for a UA [urinalysis] and it came back negative. I don't think I specifically told the nurse who called me to fill out one of those "Stop and Watch" forms but everyone has been inserviced on the use of them and probably should have known already to have filled one out." During an interview with the Social Worker on 7/24/13 at 4:00 p.m., she indicated "In the past, I have contacted family regarding the behaviors. The MD [physician]usually follows them for the behaviors and medications unless they are being seen by the psychiatrist. I then check and update the care plan, check nursing and CNA [Certified Nursing Assistant] notes to see what is going on and then address issue with resident if able. I would check also to see if more is going on with the resident that could be attributed to causing the behaviors, like a urinary tract infection. Was not aware of the behavior on 7/14/13. We implemented at the nursing station a "stop and watch" form for staff to fill out for behaviors or a need for me to			

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	become involved but the staff do not always use them. I also just use them to make a note - I do not keep them, but I know I was not made aware of this situation." B. On 07/23/2013 at 2:00 p.m., record review was done for Resident #55, admitted on 04/11/13. Resident #55 admit MD orders dated 4/11/13 included orders for Physical Therapy and Occupational Therapy [OT]. Occupational Therapy evaluation and progress notes were reviewed with certification period for 4/12/13 through 5/10/13 for diagnoses of lack of coordination, difficulty in walking, abnormal posture, Parkinson's Disease, and Paralysis Agitans. The Background Summary includes back surgery precautions and fall risk. OT discharge summary was dated 5/9/2013 with discharge reason as maximum potential achieved, and referred for Restorative Nursing Program. Physical Therapy evaluation and progress notes noted that start of care was on 4/12/13 for 5 times per week times 4 weeks, and a discharge summary written on 5/9/13 was for the reason of Maximum Potential Achieved and referred to nursing for Functional Mobility Program. On 07/24/13 at 2:00 p.m., Resident			

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	#55 was observed sitting in her recliner in her private room. Resident was interviewed and Resident #55 indicated that she wants to try to get into assisted living as she came here from rehabilitation for further rehabilitation. Resident indicates that her son is in the process of finding an assisted living facility. Resident reported that she hasn't talked to Social Worker about discharge plans. On 07/25/13 10:45 a.m.,an interview with the Social Services Director (SSD) indicated the last time the daughter was in to visit the resident - the daughter and resident would look into other plans for discharge themselves. They were informed that this was available to them if they wanted. Family and resident were working on decisions for possible assisted living or other places. SSD reported she knew resident was working in selling her home and facility is continuing to provide restorative care for resident. Social Services Director reported that she was unsure when this conversation with resident/daughter took place and would have to review record to see if she made a notation about. SSD indicated that she has not heard back from family/resident as yet. SSD did say that she would be available to			

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	help family/resident once they made decisions. On 07/29/13 at 5:00 p.m., the facility Duties for Social Service Designee Job description lists #7 as: Participate in discharge planning, development and implementation of social care plans and assessments. 3.1-34(a)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to develop a care plan which addressed a resident's inappropriate sexual behaviors for 1 of 1 residents reviewed for behaviors. This deficient practice affected 1 of 27 residents reviewed for care plans. (Resident #54) Finding includes: Review of the clinical record for Resident #54 on 7/24/13 at 10:39 a.m., indicated he was admitted to the	F000279	#54 - Social Services Designee has developed a careplan for this behavior (see attached) SSD will review all resident careplans to ensure the appropriate careplans for behaviors are in place. SSD is reviewing communication logs daily when here for any reports of inappropriate behavior with careplans updated as appropriate. Staff will be inserviced on the Stop & Watch forms (see attached). This form will be placed in the new employee packets for nurses and C.N.A.'s. D.O.N. reviews communication logs daily when in building. When reviewed the	08/28/2013

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	facility on 1/26/12 from home. Diagnoses included, but were not limited to: dementia with behavioral disturbance. A Nurse's Note dated 7/14/13 at 4:30 p.m., indicated " It was reported to this nurse that resident was in his room along with 2 other staff members. He pinned 1 female CNA [Certified Nursing Assistant] up against the wall and began running his hands all over her body. Another CNA came into the room to check other resident and assisted in redirecting resident away from other staff member. Resident then attempted to grab another staff member. Educated resident that it was inappropriate to touch other people without their permission. STM [Short Term Memory]impaired AEB [as exhibited by] supervisor also spoke with resident and immediately after she educated resident to not touch others, he replied with 'Okay' and reached over to grab CNA's stomach. Resident will be monitored by staff to ensure her will not be alone with females." Documentation was lacking of a care plan having been developed which addressed the resident's inappropriate behaviors towards		attached QA form will be used to monitor follow up and careplan update on noted behaviors by SSD this will be ongoing.Addendum: Communication logs are reviewed by DON daily when in building. The QA sheet is updated at that time with any noted issues with follow up on careplans verified at least 2x's weekly for any noted issues identified prior to that date.	

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	female staff. During an interview with the Social Worker on 7/24/13 at 3:30 p.m., she indicated that she would check to be sure there was a care plan in place and update it as needed. On 7/26/13 at 11:31 a.m., the Administrative Assistant presented a copy of the facility's current policy titled " Comprehensive Care Plan ". Review of this policy at this time included, but was not limited to: " Policy: ...It is also the intent of the facility that the comprehensive care plan is developed by the facility interdisciplinary team ...who has responsibility of the resident, all appropriate staff in disciplines determined by the resident's needs ... " 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(10 3.1-35(d)(2)(A)			

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F000311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observations, record review, and interview, the facility failed to maintain a resident's mobility through the use of the restorative nursing program for 1 of 2 residents reviewed for restorative program. (Resident #27) Findings include: 1. On 7/23/13 at 3:00 p.m., Resident #27 was observed lying in his bed with the TV on. The resident's walker was observed in the walk-in shower in his private bathroom. His wheelchair was observed several feet away from the resident. This same walker was noted to be in the same position during multiple observations on 5 consecutive days throughout the survey. On 7/25/13 at 11:20 a.m., Resident #27 was observed sitting up in his wheelchair in his room. He indicated he was waiting to go to lunch. On 7/25/13 at 12:30 p.m., Resident #27 was observed sitting in his	F000311	#27 – Resident has been placed on restorative walking and AROM programs effective 8/1/13 (see attached). Resident is able to ambulate and can get up unassisted AEB on 8/8/13 he ambulated to restroom from w/c in room unassisted. Residents who have been discharged from PT/OT since 7/26/13 will be reviewed for restorative program implementation.Therapy department forwards a copy of a FMP to restorative nurse when they see appropriate upon discharge. D.O.N. will also receive a copy for follow up to ensure it is completed.The attached QA form will be utilized when FMP is suggested per therapy. This will be an ongoing process. Addendum: DON will follow up within 3 days of receiving a FMP recommendation to ensure an appropriate restorative program has been implemented.	08/28/2013

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	wheelchair in the dining room eating his lunch. On 7/26/13 at 10:00 a.m., Resident # 27 was observed sitting in wheelchair in front of the 100-hall nursing station. 2. On 7/24/13 at 3:45 p.m., during an interview Resident #27's spouse indicated she was at the facility daily from mid-day until the resident went to bed at night. She indicated he had not been receiving restorative nursing care or had not been up to walk for "months". She also indicated that his walker had not been moved from the shower during this same time. Resident # 27's wife indicated the two staff members previously delegated to the restorative nursing program were relieved of their duties. Additionally, she indicated that her husband can no longer ambulate at all and "...can barely help lift himself." 3. On 7/25/13 at 1:45 p.m., during an interview LPN #1 indicated the two restorative nursing care positions were eliminated approximately two months ago, and the tasks were then delegated to the CNA's. She indicated restorative care was not being completed on most residents because the CNAs were "too busy." Additionally, she indicated Resident			

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	#27 was walking to and from (PT) Physical Therapy approximately 10 months ago, but he had not ambulated in several months since he was discharged from PT. At this time LPN #1 indicated Resident #27 was not currently receiving PT, OT (Occupational Therapy), or RNP (Restorative Nursing Program) services. 4. On 7/26/13 at 1:50 p.m., during an interview CNA #1 indicated the CNA's were given the additional responsibility of the Restorative Nursing Program approximately two months ago. She indicated they had not received any additional training, and she provided the newly orientated CNA's with training on range of motion exercises. CNA #1 also indicated she would occasionally have time to provide this care when transporting residents to the dining room. 5. On 7/29/13 at 4:50 p.m., during an interview LPN #8 indicated he was responsible for the restorative nursing program at the facility. LPN #8 also indicated CNA's were responsible for providing the restorative care and reporting to him. He indicated he was not aware the CNA's did not have enough time to complete their			

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	assigned tasks related to the restorative nursing program. Additionally, he indicated Resident #27 was not currently receiving restorative care. He indicated he did not learn about the referral from PT on 7/3/13 or from OT on 7/9/13 until the previous week. He indicated the normal procedure was for therapy (PT/OT) to notify him when he had a new referral, and he would begin Resident #27's next week. 6. On 7/29/13 at 5:40 p.m., during an interview the DON (Director of Nursing) indicated she was not aware of any issues with the restorative nursing program or Resident # 27 not receiving restorative nursing therapy as directed. 7. On 7/26/13 at 10:45 a.m. and 7/29/13 at 2:00 p.m.., Resident # 27's record was reviewed. The resident's diagnoses included, but were not limited to, memory loss, peripheral vascular disease, dementia, bi-polar disorder, pacemaker, coronary artery disease, Parkinson's disease, sick sinus syndrome and history of aortic aneurysm with repair. The signed July Physician's Orders listed the resident's rehabilitation potential as "good." The Fall Risk			

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	Evaluation, dated 3/14/13, rated the resident as a high risk. The MDS (Minimum Data Set) indicated BIMS (Brief Interview for Mental Status) scores of 10 of 15 on 12/21/2012 and 9 of 15 on 6/3/2013, respectively with a score of 8 to 15 as interviewable. Resident #27's care plans indicated the last review was on 6/12/2013. The approaches included, but were not limited to, call light in reach when in room; encourage resident to ask for assistance; encourage resident to use rolling walker when ambulating; frequent visual checks for safety. Restorative Nursing Progress Notes indicated in the last entry, dated 6/19/13 at 1:40 p.m., and was signed by LPN #51 indicated, "Resident currently being seen by PT and OT, will DC (discontinue) restorative AROM (active range of motion) and walking programs". The PT (physical therapy) Discharge Summary, dated 7/3/2013, indicated Resident #27 was discharged from PT on 7/3/13 due to "Maximum Potential Achieved, referred for RNP." The OT (occupational therapy) Discharge Summary, dated 7/9/2013, indicated Resident #21 was discharged from OT on 7/9/13 due to			

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	"Maximum Potential Achieved, referred for RNP." The Restorative Care Flow Records for (AROM) active range of motion and walking for the month of June 2013 indicated no further RNP provided after 6/18/13. The Master Signature Logs, dated 6/19/13, and signed by LPN #51 indicated RNP was discontinued related to therapy. The June, 2013 Restorative Care Flow Records for AROM from 6/1 to 6/18 indicated the following: Zero minutes of the 15 minutes per day goal were met for 3 of 18 days; Only 10 of the 15 minutes (min) were met for 4 of the 15 days The June, 2013 Restorative Care Flow Records for walking from 6/1 to 6/18 indicated the following: Zero minutes of the 15 minutes per day goal were met for 11 of the 18 days; Only 10 min of the 15 min per day goal were met for 3 of those 11 days. 3.1-38(a)(2)(B)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and clinical record review, the facility failed to provide oral hygiene for 1 of 3 dependent residents reviewed for oral hygiene. (Resident #27). Findings include: 1. Interview with Resident #27's wife was conducted on 7/24/13 at 3:45 p.m. She indicated that she is at the facility daily from 3:00 p.m. until the resident goes to bed at night. The resident's wife indicated that the resident was not receiving routine oral care; leading to injury, loss of dentures, and the need to have all remaining teeth extracted as a result of poor dental hygiene as evidenced by the following: Resident #27's wife indicated that, on admission, resident had partial dentures on top and partial dentures on bottom. Additionally, she indicated that staff repeatedly incorrectly placed dentures in the resident's mouth. She relayed that the lower plate was	F000312	#27 – Oral assessment will be completed by the restorative nurse then will continue with regular schedule of quarterly.Oral assessments will be completed on all residents with any issues addressed and corrected as appropriate (see attached form).Staff will be inserviced on the importance of oral care. Administrative staff will be given a group of residents to check and ensure oral care has been completed.The attached QA sheet will be utilized by the administrative staff for oral care 1x daily M-F for 2 weeks then 3x's weekly M-F for 2 weeks then 1x weekly M-F for 2 weeks then 1x every 2 weeks for 18 weeks (9 checks) then D/C unless additional problems noted. Addendum: Once the QA is completed as written in initial POC QA checks will continue 1x monthly for each resident and this will be ongoing.	08/28/2013

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	"looped in his jaw", which required the physician to be called in to remove it. Resident #27's wife indicated that the facility handed her the top dentures and informed her that her husband took his dentures out during dinner, they fell on the floor, and they were broken when they were stepped on. Upon review of dental records, dated 7/21/13, the dentist indicated that resident's partial was "broken beyond repair." Resident #27's wife indicated that neither she nor her son (resident's POA) had ever observed staff provide oral care to the resident, despite being with him daily from approximately 3:00 p.m. until he went to bed each night. She produced multiple dated photographs on her iPhone depicting large pieces of food between resident's teeth and gums and indicated that the resident had not eaten solid food in "weeks" at the time the photos were taken. Additionally, she indicated that the resident's son went to the Director of Nursing and the Administrator to express concern and requested to see records of oral care. She indicated that oral care had been documented as completed every day and that teeth had been brushed			

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	morning and night. Resident #27's wife indicated that his oral surgeon recommended that all of his remaining teeth be pulled as a result of poor oral care and that such a procedure required general anesthesia and therefore posed a serious risk due to the resident's history of aortic aneurism. Review of Oral and Maxillofacial Surgery D.M.D note, dated 6/26/2013, provided by wife and reviewed on 7/29/2013 at 3:50 p.m. indicated, "Extract all remaining teeth." Resident #27 was observed sitting up in wheelchair beside bed on 7/25/13 at 11:15 a.m.. When asked directly, he indicated that facility staff had provided oral care that morning. The resident was observed to have few teeth, all of which were irregular in shape and dark yellow-brown in color. No food was observed in his teeth. Resident #27's clinical record review was conducted on 7/26/13 at 10:45 a.m. and 7/29/13 at 2:00 p.m. Resident #27's diagnoses included, but were not limited to, memory loss, peripheral vascular disease, dementia, bi-polar disorder,			

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	pacemaker, coronary artery disease, Parkinson's disease, sick sinus syndrome and history of aortic aneurism with repair. A review of the admission MDS (Minimum Data Set), dated 12/21/13, and the most recent quarterly assessment, dated 6/13/2013, indicated that the resident required extensive assistance for personal hygiene, including brushing teeth. MDS Oral/Dental Status, dated 12/21/2013 indicated, "Mouth and facial pain, discomfort or difficulty with chewing". No additional MDS assessments were completed. Dental Record Status Upon Admission, dated 9/21/2012 and completed by LPN #8, indicated, "Resident does not have/wear dentures". ADL Functional/Restorative Assessment and Progress sheet was initiated on admission and updated quarterly. The section "Dental Status" indicated the following numerical identifiers: 1 - Upper dentures; 2 - Lower dentures; 3 - Upper and lower dentures; 4 - own teeth; 5 - Edentulous. Admission assessment, dated 9/28/2012, and subsequent quarterly assessments dated 12/21/2012, 3/14/2013, and 6/10/2013, indicated "4" (own teeth)			

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	under "Dental Status." Review of the facility's policy and procedure for Activities of Daily Living indicates that, "Each resident shall show evidence of good personal hygiene, including, but not limited to, the following: ...Oral hygiene and care of the lips to prevent dryness and cracking". Additionally, the policy indicates that, "Each resident shall be given or assisted in oral care, at least daily, to promote clean and healthy gums and teeth. Dentures, when present, shall be properly cared for and cleaned at least daily." Review of the ADL flow sheet for July indicated that oral care had been completed both day and night on all but 2 of 25 days. 3.1-38(a)(3)(A)(B)(C)(D)(E)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, interview, and record review, the facility failed to provide necessary treatment and services to prevent and or promote healing for 2 out of 2 residents reviewed with skin conditions/pressure ulcers. (Resident #15 and #64) Findings include: 1. A staff interview on 7/23/13 at 9:59 a.m., indicated Resident #5 was admitted with a scabbed yellow area to coccyx. Within the first 30 days of admission to the facility, Resident #15 was identified with the development of 2 pressure ulcers. On 3/1/13 a stage 2 pressure ulcer was identified on the top of the left foot and was healed on 03/07/13. An unstageable area to left heel was identified on 3/12/13 and was healed	F000314	Res #15 - The stage 2 on top of foot was not on 2/23/13 and appeared to be from her shoes not from facility lack of pressure relief measures. Tx of cleanse area to top of left foot with normal saline, apply xeroform and cover with spot dressing was initiated at that time (see attached). Health shakes with med pass BID and with lunch and dinner was ordered on 2/18/13 for nutritional support. The left heel area noted on 3/12/13 appeared to be a deep tissue injury that had came to the surface. This injury most likely occurred prior to admission on 2/18/13. Tx was initiated upon observation for: clean left heel with normal saline, dry well, apply collagen to open area and secure with kerlix q day. Keep bilateral heels floated. Prior to this order skin prep had been ordered to bilateral heels q day at night as palliative care. X-flex pressure reducer was ordered on 3/13/13 (see attached) Promod 30ml qd	08/28/2013

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	on 4/07/13. Resident #15's record was reviewed on 07/24/13 at 2:00 p.m. The nurse's notes, dated 3/9/13, indicated the resident complained heel pain and was given Tylenol with relief. Also, no open areas to her heel's were indicated with the left heel a "little red." On 3/12/13 a left heel treatment was started and was indicated as healed on 4/5/13. The left heel was indicated on 5/27/13 as purple in color with skin prep being applied. The legs were elevated on pillows to float both heel's. The skin record for the left heel was indicated as follows: On 6/27/13 - measured 1.5 cm (centimeter) x (by) 4.5 cm; On 7/03/13 - measured 1.5 cm x 4.5cm; On 7/10/13 - measured 3 cm x 4 cm; On 7/17/13 - measured 3 cm x 4 cm with an open area measuring 0.8 cm x 1.5 cm with a depth of 0.3 cm. The physician's order, dated 07/23/13, was to clean the left heel with normal saline and apply skin prep. On 07/25/13 at 9:09 a.m., during an interview LPN #6 she indicated the		for wound healing ordered 3/13/13. She was added to NAR on 3/14/13 (see attached) Albumin level on 2/21/13 was low at 2.9, 4/2/13 3.3, 4/4/13 3.3, 4/16/13 3.2, 5/30/13 3.5, 8/15/13 3.2 and protein level on 2/21/13 was low at 4.3, 4/4/13 5.2, 4/16/13 5.0, 5/30/13 5.6, 8/15/13 6.1 Pressure relief mattress was in place to bed since admission. On 7/15/13 order for left heel : cleanse with normal saline, dry well, apply hydrogel gauze and cover with dry dressing q day. Skin prep to right heel BID. On 7/23/13 order was changed: cleanse left heel with normal saline, apply skin prep to surrounding intact tissue (not on open area), apply normal saline dampened collagen to open area, cover with foam dressing, wrap with kerlix, change daily. TAO was added on 7/29/13. on 7/31/13 treatment clarified to apply TAO to open area with the above treatment. Juven BID ordered 7/22/13. There is conflict in report of 7/29/13. Surveyor indicated C.N.A. left room without applying boot or floating heel then indicated during interview at this same time C.N.A. indicated she would report the complaint of pain then applied boot and floated heels. #64 Res was receiving facility barrier cream to buttock and peri area every shift for palliative care upon admission 6/17/13 which is the recommended treatment for	

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	resident had a previous healed pressure area on her left heel, where the present pressure area was now. She indicated Resident #15 did turn herself at times in bed resulting in her heels touching the bed. On 07/29/13 at 9:52 a.m., Resident #15's personal care was observed. A pillow was observed under the resident's legs with the heels touching the bed. No boot was observed on the resident's left heel. At this same time Resident #15 indicated her left heel was hurting. After her personal care was completed, CNA #2 was observed to leave the room without applying the resident's left heel boot or floating the resident's heels off of the bed. During an interview at this same time, CNA #2 indicated she would need to report to the nurse concerning the pain as she then applied the boot to the resident's left heel and floated both heels off of the bed. Resident 15 then indicated left heel did feel better with the boot on and her heels off of the bed. 2. On 07/24/13 at 2:41 p.m., during an interview LPN #6 indicated Resident #64 liked to stay in bed. She indicated her coccyx pressure ulcer was now healed and was not receiving any further treatment.		redness/stage 1. Pressure relief mattress in place to bed. Promod 30cc BID added on 6/16/13. Albumin 6/12/13 3.1, 6/26/13 2.8, 7/18/13 3.0. Protein 6/12/13 6.7, 6/26/13 5.3 as stated in 2567 treatment was received 6/21/13 with area healed on 7/10/13. No other pressure areas are noted in our facility. Will continue to have weekly skin assessments completed during shower/bath 1x weekly along with unit managers completing weekly skin rounds. Wound nurse will continue to visit monthly. IDR reason : above additional information not contained in 2567 Addendum: Res# 15 - On 7/24/13 areas to left heel was 3x3 with UTD depth. On 8/1/13 order was received for clean w/ normal saline, mix TAO and Santyl ointment, apply to necrotic area, cover with hydrogel drsg, apply skin prep to area surrounding wound. Cover with foam drsg and apply kerlix wrap qd. On 8/16/13 area smaller at 1x1x0.2 with no exudate, odor or pain. As noted in initial POC Albumin and Protein levels were still low on 8/15/13. Res# 64 - discharged home on 8/6/13 with skin intact. All residents were assessed for skin breakdown due to pressure. with no other areas noted. Unit Managers review and initial for review the weekly skin assessment (see attached) completed by staff nurses when completing their weekly skin rounds.C.N.A.'s and Nurses are	

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	On 07/25/13 at 10:30 a.m., Resident #64's personal care was observed. Resident #64 indicated her "bottom" was sore again. Redness to the coccyx area was observed during this personal care observation. On 7/25/13 at 3:00 p.m., Resident #64's coccyx area was observed with LPN #6. At this same time Resident #64 indicated her "bottom" was sore and used her left index finger and pointed to her coccyx area. The coccyx was observed to be red with blanching as demonstrated by LPN #6. On 07/26/13 at 11:09 a.m., during an interview LPN #7 indicated the facility's policy for skin care for residents with healed pressure ulcers was to do weekly skin checks. She was unaware of any other procedure's for follow up for healed pressure ulcers. Resident #64's record was reviewed on 07/25/13 at 11:00 a.m. The resident was admitted from the hospital on 06/17/13 post Cholecystectomy with a reddened coccyx indicated as a pressure area. The physician's order, dated 6/20/13, was for skin prep to right outer ankle		given and sign for "Guidelines for Good Skin Care" upon hire. Inservice is conducted at least annually and more frequently as needed related to skin breakdown/position/etc. If a resident is identified with skin breakdown they are placed on NAR with next dietician visit.	

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	only. The physician's order, dated 6/21/13, was to cleanse the Stage 2 coccyx area with soapy water, pat dry, or use facility incontinent care cleanser, apply xeroform and cover with telfa, change daily and as needed for soilage or dislodgement. The nurse's notes, dated 6/21/13, indicated a new physician order to treat the coccyx area, which was now open. This area was indicated as healed on 7/10/13. 3.1-40(a)(2)			

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F000315 SS=D	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. Based on observation, interview, and record review, the facility failed to ensure peri care was provided in a manner to prevent urinary tract infections for 1 of 4 personal care observation's. (Resident #64) Findings include: On 07/25/13 at 10:30 a.m., Resident #64's personal care was observed. CNA #2 was observed to clean the Resident's rectal area followed by the Resident's front peri area. At this same time, during an interview, CNA #2 indicated one should cleanse the peri area first followed by the rectal area. Resident #64's record was reviewed on 07/25/13 at 10:45 a.m. The physician's order, dated 06/29/13, was Cipro (antibiotic) 500mg 2 times	F000315	#64 No action can be taken at this time for this resident as it was completed at that time. C.N.A. did verbally tell surveyor correct procedure but in the stress of being monitored unfortunately evidently made a mistake.Each nurse and C.N.A. will be watched doing incontinent care per facility policy.Incontinent	08/28/2013

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	a day for 10 days. The results of a urine culture lab report, dated 06/29/13, indicated the growth of Morganella morganii and Enterococcus faecalis. The nurse's notes, dated 06/29/13, indicated Cipro was started due to a urinary tract infection. The facility policy for Incontinent Care, was provided by the Administrator on 07/29/13 at 4:20 p.m. This current policy indicated the following: #7 wipe from front to back and from center of perineum to thighs, change washcloth or disposable wipe as necessary. For females 1.) Separate labia. wash urethral area first. 2.) wash between and outside labia in downward strokes, alternating form side to side and washing outward to thighs. Use different part of washcloth or disposable wipe for each stroke. 3.1-41(a)(2)		care procedure will be reviewed at inservice (see attached). Incontinent care policy and procedure will continue to be placed in new employee packets with acknowledgement form signed (see attached). The attached QA sheet will continue to be utilized. QA will be done for each nurse/C.N.A. initially per above then within 2 weeks then monthly x 5 months then quarterly. New nurses/C.N.A.'s will have QA completed during their orientation days.	

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			This will be will be ongoing.	

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F000353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. 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.			
	Based on observation, interview, and record review, the facility failed to ensure meals were served timely and resident's personal care needs were met for 3 of 3 residents observed/interviewed and for 1 of 2 dining observation's. This had the potential to impact 53 of 53 residents residing in the facility. (Resident #27, #55 and #29) Findings include: On 7/22/13 at 12:05 p.m., during the	F000353	#27 No action can be taken due to the issue being resolved when resident was provided incontinent care. Call light usage for this resident was reviewed on system archives for 7/15/13 – 8/12/13. Call light is only used when wife is in building. Average time for staff to respond was 15 minutes. #55 No action can be taken due to this issue being in the past. Staff is assisting residents to dining room @ 1145a they are not disappearing. Call light usage for this resident from 7/17/13 – 8/14/13 was reviewed on the archives of system. Average time	08/28/2013

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	lunch dining observation, the unidentified cook indicated the kitchen was ready to serve but were unable to do so due to the lack of nursing staff. At 12:07 p.m., an unidentified LPN arrived in the dining room and began to serve the first table. At 12:12 p.m., an unidentified Dietary Aide indicated with only 1 nurse serving the lunch trays the kitchen would be behind in serving the lunch meal timely. At 12:15 p.m., more nursing staff were observed to have arrived and began to serve the lunch meal. On 7/25/13 at 9:00 a.m., Resident #27 was observed in his bed with a strong odor of feces in the room. Resident indicated he was waiting for staff to assist him with toileting. A brown, semi-soft substance smelling of feces was observed smeared on the bedspread, the resident's left posterior forearm and on his shirt. CNA #1 indicated she was aware of the resident's present incontinence and was observed to begin care at 9:15 a.m. On 7/24/13 at 4:00 p.m., during an interview Resident #27's spouse indicated her husband was frequently incontinent and had laid in urine and feces due to staff did not respond to		for staff to respond was 6 minutes. #29 DO NOT KNOW who this resident #29 is (not on my resident list provided by surveyors) Do not know of any resident that has a son that comes in every night. Residents are back to the units before 6:45 pm nightly unless there is an activity and they want to stay. According to the 2567 this could have affected all residents. Call light usage for all residents for 2 random dates was calculated. 7/17/13 3:13p – 7/18/13 2:14pm average response time 14 minutes, 8/15/13 12a – 8/16/13 2:30p average response time 11 minutes resulting in overall average response time for all residents to be 12.5 minutes. Staff will be inserviced on need to be in dining room at 12pm however this may not be feasible if there are situations occurring which requires staff to be on the units. Incontinent care procedure will be reviewed at inservice (see attached) . Incontinent care policy and procedure will continue to be placed in new employee packets with acknowledgement form signed (see attached).The attached QA form will continue to be utilized. QA will be done for each nurse/C.N.A. initially per above then within 2 weeks then monthly x 5 months then quarterly. New nurses/C.N.A.'s will have QA completed during orientation days (this will be ongoing).Average call light	

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	his call light or her verbal requests for help in a timely fashion. On 7/25/13 at 10:30 a.m., during an interview Resident #55 indicated on a daily basis the nurses are down in the lunch room leaving no one on the floor. She also indicated the staff disappear at 11:45 a.m. She indicated she had her call light on for 30 minutes before it would be answered. Additionally, when she use to have a bed alarm on her bed, she would get up at night and use the bathroom, returned to her bed with the alarm going off the entire time. On 7/24/13 at 5:00 p.m., during an interview the Administrator he indicated staffing had not been cut back in the facility. He indicated for the first 12 hour shift 6 CNA's and 4 nurses were scheduled. For the second 12 hour shift 4 CNA's and 3 nurses were scheduled. On 07/25/13 at 7:15 p.m., Resident #29's family member indicated he arrived at the facility every evening around 6:45 p.m. and generally would take the resident from the dining room to her room. He indicated the staff were aware the resident liked to go to bed between 6:15 p.m. and 7:15 p.m. He indicated when he left at 7:30		response time will be calculated for all residents 1x weekly by utilizing the attached QA form. This will be done weekly x4 weeks then 1x q 2 weeks for 2 months if less than 15 minute average response time is maintained then QA will be D/C'd. The attached QA will be utilized to monitor times staff arrive in dining room. This will be done 3 meals/day 4 days/week x 2 weeks then 2 meals/day x 4 days/week x 2weeks then 1meal/day x 5 days/week x 2 weeks then 3 meals/week x 2 weeks then 1 meal week x 4 months then D/C if effective.Information that was included in 2567 when there is only 4 C.N.A.'s on dayshift the administrative nurses assist with more direct resident care than on a full C.N.A. staffed day. Administrative nurses as well as administrator (who is also a C.N.A.) toilet residents, give showers, assist with all ADL's, feed, etc. Therefore the numbers on 2567 are not reflecting the actual hours of direct care staff. In addition other information not included is that many of the days listed with 3 C.N.A.'s on night shift there are student nursing assistants in the building being supervised/trained by one of our facility nurses (as they also work for the C.N.A. training site) and will be caring for as many or more than the number residents a staff C.N.A. would be responsible for	

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	p.m., she would still be up with the staff reportedly indicating she was going to put her to bed next. On 07/25/13 at 8:30 a.m., the posted nursing staffing for 07/25/13 was observed. The census was 54 with the listed hours as 6:30am - 6:30pm: RN 1/8hrs (hours), LPN 6/72hrs, QMA 0, CNA 5/62.5hrs. with the total hours of 142.5; 6:30pm - 6:30am: LPN 3/36hrs, CNA 4/50hrs, 0 QMA, with the total hours of 86. On 7/25/13 at 6:57 p.m., the staffing observation at this time was 3 LPN's and 4 CNA's with CNA #50 indicating she was scheduled to work from 6:00 PM to midnight. On 07/26/13 at 3:55 p.m., during an interview the Administrative Assistant indicated she liked to schedule 3 to 4 CNA's on the 6:00 PM to 6:30 AM shift and 4 - 5 CNA's on the 6:00 AM to 6:30 PM shift but would like to have 6 CNA's scheduled. On 7/26/13 at 3:55 p.m., the administrative assistant provided the staffing schedule for actual worked hours for dates of 06/12/13 through 07/25/13. This staffing schedule indicated the following numbers of CNA staff for the 6:00 PM to 6:00 a.m. shift for the dates of: 07/05/13 -		on the shift. The students are on the unit until at least 9:30pm. Above for the reasoning of IDR: attached is also a copy of our staffing hours per resident per day compared to state and national averages.	

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	3 CNA's, 07/06/13 - 3 CNA's, 07/07/13 - 3 CNA's, 07/08/13 - 3 CNA's, 07/10/13 - 2 CNA's with additional 1 CNA scheduled 6:30 AM to 8:00 PM, 07/11/13 - 3 CNAs with additional 1 CNA scheduled 6:30 AM to 8:00 PM, 07/12/13 - 3 CNA's, 07/16/13 - 3 CNA's, 07/17/13 - 3 CNA's with 1 additional CNA scheduled 6:00 AM to 8:00 PM, 07/19/13 - 3 CNA's, 07/20/13 - 3 CNA's, 07/22/13 - 3 CNA's. This staffing schedule indicated the following numbers of CNA staff for the 6:00 AM to 6:30 PM shift for dates of 07/04/13 through 07/08/13 - 4 CNA's. Daily Census posting that was provided was indicated as follows: 07/04/13-54, 07/05/13 - 54, 07/06/13 - 54, 07/07/13 - 54, 07/08/13 - 55, 07/12/13 - 55, 07/19/13 - 55,07/22/13 - 53, 07/25/13 - 54. Census was not provided for 7/10, 7/11, 7/16, 7/17, and 7/20. On 07/29/13 a.m., during an interview the DON indicated there were 4 CNA's working each 6:00 AM to 6:30 PM shift for dates of 07/04/13 through 07/08/13 inclusive. On 07/29/13 at 9:52 a.m., during an interview CNA #2 indicated she frequently gave up her break time to			

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	do care for residents. 3.1-17(a)			

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F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure the accuracy of the posted total hours worked for 7 (12.5 hours for CNA's) of 18 (12.5 hours CNA's staffing shifts) working shifts	F000356	There was no actual affects to the residents as this was a form not accurately	08/28/2013

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	reviewed. This had the potential to impact 53 of 53 residents residing in the facility. Findings include: On 07/25/13 at 6:57 p.m., observation of the posted nursing staffing for 07/25/13 for a census of 54 listed as 6:30am - 6:30pm: RN 1/8, LPN 6/72, QMA 0, CNA 5/62.5 total hours 142.5 6:30pm - 6:30am: LPN 3/36, CNA 4/50, 0 QMA, total 86. Observation of staffing in the facility at this time was for a total 3 LPN's and 4 CNA's of which CNA #50 stated she was scheduled to work from 6:00 PM to midnight. On 07/26/13 at 3:55 p.m., an interview was conducted with the administrative assistant who relayed that she likes to schedule 3 to 4 CNA's on the 6:00 PM to 6:30 AM shift and also relayed that likes to schedule 4 - 5 CNA's on the 6:00 AM to 6:30 PM shift but would like to have 6 CNA's scheduled. On 7/26/13 at 3:55 p.m., the administrative assistant provided the staffing schedule for actual worked hours for dates of 06/12/13 through 07/25/13. This staffing schedule indicated the following numbers of		updated. The D.O.N. administrative assistant has been advised of the need for the posting to be updated for changes in the schedule during the day.D.O.N. administrative assistant will continue to complete the form. The attached QA sheet will be utilized to ensure changes are being made to the form. This will be completed daily 5 days a week x 2 weeks then 3x week x 2 weeks then 1x week x 2 weeks then will d/c if posting has been accurate when checked during that	

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	CNA staff for the 6:00 PM to 6:30 AM shift for the dates of: 07/05/13 - 3 CNA's, 07/06/13 - 3 CNA's, 07/07/13 - 3 CNA's, 07/08/13 - 3 CNA's, 07/10/13 - 2 CNA's with additional 1 CNA scheduled 6:30 AM to 8:00 PM, 07/11/13 - 3 CNAs with additional 1 CNA scheduled 6:30 AM to 8:00 PM, 07/12/13 - 3 CNA's, 07/16/13 - 3 CNA's, 07/17/13 - 3 CNA's with 1 additional CNA scheduled 6:00 AM to 8:00 PM, 07/19/13 - 3 CNA's, 07/20/13 - 3 CNA's, 07/22/13 - 3 CNA's. This staffing schedule indicated the following numbers of CNA staff for the 6:00 AM to 6:00 PM shift for dates of 07/04/13 through 07/08/13 - 4 CNA's. On 07/29/13 review of the facility posted Census/shift staff/hours for CNA 6:00 PM to 6:30 AM shift staffing only as compared with the schedule for actual CNA hours worked for dates that follow indicate the variance between the posted CNA staffing and actual staffing: 07/03/13 posted = 50 hours & actual worked 46 hours, 07/05/13 posted = 50 hours & actual worked = 37.5 hours, 07/18/13 posted = 50 hours & actual worked = 34 hours, 07/25/13 posted = 50 hours & actual worked = 43.5 hours. On 07/29/13 review of the facility		time.	

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	posted census/shift staff/hours for CNA 6:00 AM to 6:30 PM shift staffing only as compared with the schedule for actual CNA hours worked for dates that follow indicate the variance between the posted CNA staffing and actual staffing: 07/04/13 posted = 62.5 hours & actual worked = 50 hours, 07/06/13 posted = 62.5 hours & actual worked = 50 hours, 07/07/13 posted = 62.5 & actual worked = 50 hours. On 07/29/13 AM an interview conducted with the DON indicated there were 4 CNA's working each 6:00 AM to 6:30 PM shift for dates of 07/04/13 through 07/08/13 inclusive. 3.1-17(b)			

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview, the facility failed to distribute and serve food under sanitary conditions by ensuring proper handwashing and/or sanitizing employee hands between each resident tray pass occurred during meal service for 1 of 2 meal observations. This deficient practice had the potential to affect 53 of 53 residents currently residing in the facility. Findings included: During the Dining Room meal service on 7/25/13 between 12:15 p.m. and 12:40 p.m., the following was observed: - 12:27 p.m. - CNA [Certified Nursing Assistant] #1 adjusted and re-positioned Resident #21 in her geri-chair for better posture to eat and then resumed feeding resident - no handwashing or alcohol gel used prior to resuming feeding the resident.	F000371	#21 & #2 This has already occurred therefore no corrective action can fix this particular instance. Per the 2567 this could have affected all residents.Staff will be inserviced on the need to utilize hand sanitizer between each tray and wash hands if they re-adjust/reposition a resident before they resume feeding.The attached QA will be utilized by an administrative staff	08/28/2013

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	- 12:34 p.m. - observed LPN #2 pull out Resident #2's chair for her to sit down and then picked up the food tray and prepared her food by uncovering it and arranging it for her. He then went onto Resident and placed her food tray in front of her, cutting up meat and baked potato, then giving the resident back her silverware.- no handwashing observed in between residents. During an interview on 7/25/13 at 3:00 p.m., with LPN #1, she indicated "Staff are supposed to use at least alcohol gel in between each patient trays. If they re--adjust or re-position a resident at anytime, then they should have washed their hands before resuming feeding the resident, even if it was the resident they were already feeding that they had to re-position." On 7/25/13 at 3:36 p.m., the Director of Nursing presented a copy of the facility's current policy titled "Handwashing: Clean Hands Save Lives". She indicated this was the handwashing policy used facility-wide to address handwashing. Review of this policy at this time, included but was not limited to: "...When Should You Wash Your Hands? *Before, during and after preparing food;		member to monitor hand sanitizing /washing during meal pass. This will be completed 3 meals day 4days/week x 2 weeks then 2 meals a day 4 days/week x 2 weeks then 1 meal/day x 5 days week x 2 weeks then 3 meals week x 2 weeks then 1 meal a week x 4 months then d/c if effective	

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	*Before and after caring for someone who is sick..." 3.1-21(i)(3)			

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F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure proper medication labeling. This deficient practice affected 1 of 2	F000431	#46 Correct medication with label is now in the med cart.* Exelon patches on 300 hall med cart - all have labels (some are on bottom of box, some have label on bed	08/28/2013

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	observations of medication administration and 3 of 3 medication carts reviewed. This deficient practice affected 5 residents observed during medication administration. (Resident #2, #22, #32, #35, and #46) Findings include: 1. During an observation of medication administration for Resident #46, LPN #1 on 7/25/13 at 8:50 a.m., a medication labeled "Metoprolol 25mg ER Take 1 tablet by mouth daily for HTN (Hypertension)" was being administered when the MAR indicated "Metoprolol 50mg ER Take 1 tablet by mouth daily for HTN (Hypertension)". In an interview on 7/25/13 at 8:50a.m., LPN #1 indicated the nurses were using the medication labeled Metoprolol 25mg until empty. LPN #1 indicated the nurses were administering two tablets to the resident. LPN#1 indicated the nurses should have requested a change of direction form from the pharmacy if they were going to use the current supply. She indicated she would contact the pharmacy to request a label.		that folds back and was under the patches)#2 The bottle of MOM referenced has been completed, the new bottle has resident name and physician name.#35 Both meds listed have resident name and physician name on them#22 Don't know who this resident is, not on resident list from surveyors#32 Don't know who this resident is, not on resident list from surveyors#31 Label for Exelon patch was underneath the patches in the boxAll OTC meds will be checked to ensure they have resident name and physician name. All other meds will have med package checked against MAR to ensure change of direction stickers are in place if needed.Nurses will be re-educated on the use of the change of direction stickers and that OTC meds need to have resident name and physician name on them.The attached QA will be utilized by an administrative nurse 1x week for 1 month then 1x q 2 weeks x 2 months then monthly x 3 months then D/C is no findings.IDR reason: According to 410 IAC 156.2-3.1-25 Pharmacy services. Over the counter medications must be identified with the following: 1.) Resident name, 2.) Physician name, 3) Expiration date, 4.) Name of drug, 5.) strength	

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	During an observation on 7/26/13 at 2:30p.m., the medication for Resident #46 labled "metoprolol 25mg ER" had a handwritten "Metoprolol 50mg daily". A copy of the policy entitiled, "Medication Ordering and Receiving from Pharmacy" was provided by CNA #3 on 7/26/13 at 11:13 a.m., indicated medications are not altered, modified, or marked in any way by nursing personnel. The policy also indicated if the physician's directions for use change or the label is inaccurate, the nurse places a "change of order-check cart" label on the containter indicating there is a change in directions for use. 2. During an observation of the 300 hall medication cart on 7/25/13 at 11:27 a.m., a box of exelon patches handwritten "Resident's name" on it. The box did not have a pharmacy label on it. In an interview with DON on 7/25/13 at 12:00 p.m., indicated over the counter medications have the residents name, expiration date and get the directions from the chart" During observation of the medication			

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	cart on the 200 hall on 7/26/13 at 2:12 p.m., Resident #2 had Milk of Magnesia with the following hand written "family provides, (resident's name), open 7-15-13". The printed directions on the container indicated " adults and children 12 years or older 2-4 TBSP". There was no physician or specific direction. Resident #35 had a over the counter Calcium D handwritten "(Resident's name, 5-15-13, (room #)". Directions on the bottle indicated " for adults, take one tab once or twice daily, preferably with a meal." There was no physican nor specific direction on the bottle. Resident #35 also had over the counter acetaminophin with only the Resident's name handwritten on the botttle. Resident #22 had a over the counter bottle of Calcium D unopened with the Resident's name handwritten on the bottle only. Resident #22 also had a bottle of aspirin 81mg handwritten with " family provides...". Resident #32 had a medication flonase 50mcg with a label from another facility "...OPENED 6-3-13" "2 SPRAY". In an interview on 7/26/13 at 2:43			

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	p.m., LPN #9 indicated over the counter medications are labeled with the resident's name and physicians name. During an observation of the medication cart on the 100 hall on 7/26/13 at 2:27 p.m., an open box of 8 excelon patches was observed to have the hanwritten label "Resident's name". There was no pharmacy label on the box. Review of the facility census indicated the medicaiton belonged to Resident #31. Resident #21 a tube of over the counter oragel had a handwritten "Resident's name, physians name". The printed directions indcated up to 4 times a day. 3.1-25(j)(k)(l)			

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F000441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review the facility failed to help	F000441	1.a) No corrective action can be taken as this was a precautionary	08/28/2013

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	prevent the development and transmission of infection. This deficient practice was on 3 of 3 pericare observations and handwashing, and facility wide spread of scabies. (Resident #14, #28, #44, and #63). Findings Include: 1. Review of the medical records for Stage 1 sampled residents indicated all the residents were prescribed a parameterize cream 5%. In an interview on 7/22/13 at 11:00 a.m., the DON indicated the facility treated all residents with one application of permetherine cream 5% prophylacatically due to a potential outbreak of scabies. She indicated the facility had determined there were no residents with scabies based on physician assessment of several residents. She also indicated several residents had skin scraping that were negative. When asked to provide documentation of the facilities initial response to the potential outbreak of scabies she was unable to provide any documentation because,"The tests came back negative." Review of the infection control log on 7/26/13 at 9:45 a.m., lacked documentation of residents treated		measure that was taken and is now over. 2.a) No corrective action can be taken as this has already occurred. 3.a) Infection reports will be completed 5.a) No action can be taken at this time as it has already been completed. 1.a) Everyone was treated along with all staff as a precautionary measure 2.a) The attached QA form will be initiated 3.a) Infection reports back to 7/1/13 will be reviewed for completeness 5.a) Each nurse/C.N.A. will be watched doing incontinent care per facility policy 1.a) It is not felt anything was done incorrectly in this situation. When physician/NP decided to initiate the precautionary measure all residents were kept in their rooms, showers were given to every resident prior to medication application then again the next day after the medication had been in place for 14 hours. All laundry/trash was put in biohazard bags. Medication was called in for all staff members. Facility pharmacy was efficient in sending medication on a stat run following the receipt of the orders. The day after the medication was applied to the residents and it was going to be washed off the housekeeping department did thorough cleaning of all rooms, office, common areas, etc. curtains steamed, carpets extracted, bedframes cleaned, etc. This would not have been tracked as an infection	

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	prophylacatically for scabies. In an interview on 7/26/13 at 10:31a.m., LPN #4 indicated the facility does not track skin rashes in the infection control program. 2. During an observation on 7/22/13 at 12:45 p.m., the laundry aide transported a basket of personal clothes that was not properly covered. During an observation of dining on 7/22/13 a staff member was found to be buttering bread with an ungloved hand and touching the tip of the straw with a ungloved hand 3. Review of the Infection Control Log on 7/26/13 at 9:47 a.m., indicated a form titled "Infection Report" was not completed in its entirety for Resident #28, #44, and #63. In an interview on 7/26/13 at 10:31a.m., LPN #4 and LPN #5 indicated the Infection Control program tracked residents receiving a physician order for an antibiotic. They indicated the form titled "Infection Report" can be initiated by the nurse. The infection control nurse is responsible for completing the follow up portion of the form. LPN #4 indicated the facility does not track skin rashes, suspected		because testing was negative.2.a) A rubber tote with a lid has been placed in the linen cart and will be used for transport of linens to the units. DM is ordering baggies/sheets of deli paper or some type of product for staff to hold bread items so it is not touched when being prepared for the resident. 1.a) IDR – no QA 2.a) The attached QA will be utilized to monitor the transport of laundry 2x's daily x 5days/week for 2weeks, 1x daily x 5 days/week for 2 weeks, 1x daily x 3 days/week for 2 weeks, 1x/week for 2 weeks then will D/C if there have been no findings. If not QA will continue. The attached QA form will be utilized to monitor staff for touching food/bread items with hands 3 meals/day 4 days/week x 2 weeks then 2 meals/day 4days/week x 2 weeks then 1 meal/day x 5 days week x 2 weeks then 3meals week x 2weeks then 1 meal weeks x 4 months then D/C if effective 3.a) The attached QA form will be utilized by the unit managers to ensure the Infection Control Logs are completed in their entirety with each entry ongoing. 5.a) The attached QA form will continue to be utilized. QA will be done for each nurse/C.N.A. initially per above then within 2 weeks then monthly x 5 months then quarterly. New nurses/C.N.A.'s will have QA completed during their orientation days (this will be	

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	infections on admission, and infections related to employees. When asked regarding tracking trends in the facility LPN #4 indicated the unit managers monitor trends on their individual units. There is no facility wide tracking of infection trends. 5. During an observation of incontinent care on 7/26/13 at 2:00 p.m., CNA #4 was observed using the "Sit to Stand lift" without cleaning in between residents. CNA #4 did not perform hand hygiene nor use gloves when removing Resident #14's brief. When the Resident was placed on the toilet, CNA #4 then put on gloves. CNA #4 placed the clean brief face down on the lift, then used it on the Resident #14. This Federal tag relates to Complaints IN00129844 and IN00129864. 3.1-18(1)(2)(3)		ongoing) IDR Reason : there was not a scabies outbreak.	

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F000504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and staff interview, the facility failed to provide or obtain only those laboratory services ordered by the attending physician. This deficient practice affected 1 of 1 resident reviewed for laboratory services. (Resident #21). Findings include: 1. Resident #21's clinical record was reviewed on 7/26/13 at 3:00 p.m. Resident's diagnoses included, but were not limited to, hypertension, peripheral vascular disease, deep vein thrombosis, and pulmonary embolism. Physician's orders, signed 7/1/13, indicated an order for Coumadin, an anti-coagulant medication, related to Resident #21's history of pulmonary embolism and deep vein thrombosis. Physician's Orders for July, 2013, indicated a standing order for a PT/INR (prothrombin time/international normalized ratio), a blood test to determine how long it takes blood to clot, every Monday. Physician's orders dated 6/27/13	F000504	There were no CBC's drawn on dates indicated (see attached)Addendum: Res# 21 did not have CBC's drawn without orders as per the 2567. Attached are copies of lab results sent with initial POC. These results have been numbered with explanations to follow of the results. Page 1A - Dated 7/1/13 has results of CBC and PT/INR which was accurate in 2567 that there was an order for both of these on that date, also on this report were PT/INR results for 6/28/13, 6/25/13 and 6/17/13. Page 2A Dated 7/4/13 (2567 indicates CBC was drawn on this date) the results on this page are for PT/INR dates 7/4/13, 7/1/13, 6/28/13 and 6/25/13 along with the CBC results from 7/1/13. Page 3A- Dated 7/10/13 (2567 indicates CBC was drawn on this date) the results on this page are for PT/INR dates 7/10/13, 7/4/13, 7/1/13 and 6/28/13 along with the CBC results from 7/1/13. Page 4A - dated 7/22/13 (2567 indicates CBC was drawn on this date) the results on this page are for PT/INR dates 7/22/13, 7/15/13, 7/10/13 and 7/4/13, there are no CBC results on this report. Labs for all residents are monitored by and this is a normal	08/28/2013

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	indicated that a 14-day course of the oral antibiotic Levaquin was initiated on 6/28/13 for a diagnosis of pneumonia. Review of the Medication Administration Record confirmed the medication was administered as ordered. The physician's order dated 6/29/13 at 5:00 p.m. indicated resident #21 was to receive a PT/INR every 3 days while on antibiotic (..."7/1, 7/4, 7/7"...); then continue every Monday schedule. Laboratory PT/INR results dated 7/4/2013, 7/10/13 and 7/22/13 indicated that a CBC (complete blood count) was also completed. No order for a CBC was indicated in the clinical record for the above dates. LPN # 1 was interviewed on 7/26/13 at 3:20 p.m., and indicated that she was unable to locate orders in the clinical record for the completed CBCs. Additionally, she indicated that in all three instances, the CBCs should not have been completed. 3.1-49(a)		procedure for the Unit Managers. See attached QA sheet that they utilize to monitor. This QA is completed 2-3 times weekly. This will continue to be the process since it is effective and will be ongoing,.IDR reason: Labs were not completed as noted in 2567	

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