

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155253	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2015
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NAME OF PROVIDER OR SUPPLIER MEADOWOOD HEALTH PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 2455 TAMARACK TR BLOOMINGTON, IN 47408
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 9, 10, 11, 14, and 15, 2015.</p> <p>Facility number: 000156 Provider number: 155253 AIM number: N/A</p> <p>Census bed type: SNF: 32 Total: 32</p> <p>Census Payor type: Medicare: 9 Other: 23 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 14466; on September 23, 2015.</p>	F 0000		
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY			

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

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

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	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident care to prevent urinary incontinence to maintain and promote a resident's dignity for 1 of 1 resident reviewed for dignity. (Resident #17)</p> <p>Findings include:</p> <p>On 9/9/15 at 2:46 p.m., Resident #17 indicated, "Sometimes I wait a 1/2 an hour for the call light to be answered. I have had accidents on myself. This has happened many times and I feel embarrassed. I tell the CNA's [Certified Nursing Assistant] about this and they tell me they are short handed."</p> <p>Resident #17's clinical record was reviewed on 9/14/15 at 9:00 a.m.</p> <p>The current Minimum Data Set (MDS) dated 8/6/15, indicated Resident #17 was interviewable and cognitively intact. Resident #17 needed extensive assistance of 1 staff person for bed mobility and extensive assistance of 2 staff persons for toileting.</p> <p>Care plan "Urinary Incontinence" dated</p>	F 0241	<p>F241 – Dignity and respect of individuality</p> <ul style="list-style-type: none"> - The Director of Nursing or designee will in-service the nursing staff on the policy for Personal Care Guideline - CL-AL-RS315 encompassing providing care in a manner to enhance and/or maintain resident dignity and respect to include not delaying care in the provision of incontinence care. In-services will be completed by 10/15/15. - Resident #17 will be interviewed by the Social Service Director to evaluate any psychosocial needs they may have and to address any further concerns with resident care. All alert and oriented residents as determined by MDS will be interviewed to determine if resident care is being provided in a manner such that resident dignity is upheld. All interviews will be completed by 10/9/15. The Social Service Director will interview 10 alert and oriented residents as determined by the MDS, weekly for 90 days. Any concerns will be immediately addressed by the Social Service Director or designee and reported to the Administrator. - We will monitor quarterly after compliance is established and report to Q.A. 	10/15/2015

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	<p>9/3/15 through 9/19/15, indicated "DX [diagnoses] UTI [urinary tract infection] ...Goal: Infection will be resolved, Approach: Labs as ordered, ...Notify doctor PRN, ...Monitor for worsening of infection LOC [level of consciousness] changes, increased confusion, fever or increased fever poor urinary output, blood in urine, ..."</p> <p>Review of physician's progress notes dated 7/23/14 through 6/30/15, indicated Resident #17 tested positive for a UTI 8 times.</p> <p>Nursing notes dated 9/12/15, indicated "... Res [resident] cont. [continue] to have urinary freq/urgency, ..."</p> <p>Nursing notes dated 9/13/15, indicated "... Still c/o [complain of] urgency /freq [frequent] increase of urination. Some incont [incontinence] this morning."</p> <p>On 9/15/15 at 3:25 p.m., interview with CNA #2 indicated Resident #17 had frequent urinary tract infections (UTI) and received hydration and good pericare wiping from front to back to prevent frequent UTI's. CNA #2 indicated Resident #17 was continent of urine except when she had a UTI. CNA #2 did not indicate a system being in place to prevent incontinent episodes.</p>			

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F 0279 SS=D Bldg. 00	<p>On 9/15/15 at 3:30 p.m., interview with LPN #1 indicated Resident #17 had frequent urinary tract infections (UTI) and received frequent lab monitoring to help prevent UTI's. LPN #1 indicated Resident #17 was continent of urine except when she had a UTI. LPN #1 did not indicate a system being in place to prevent incontinent episodes.</p> <p>There was no care plan to address urgency and frequent increase of urination to ensure Resident #17 was continent of urine.</p> <p>3.1-3(t)</p> <p>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.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>			

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	<p>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).</p> <p>Based on interview, observation, and record review, the facility failed to ensure a care plan had been revised and current interventions were in place after a fall for 2 of 2 residents reviewed for accidents (Resident #3 and Resident #52) and failed to ensure a care plan for 1 of 1 resident reviewed for dignity related to incontinent. (Resident #17).</p> <p>Findings include:</p> <p>1. Resident #3's clinical record was reviewed on 9/14/2015 at 9:00 a.m. Diagnosis included, but were not limited to dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment, completed on 7/17/2015, indicated a Brief Interview of Mental Status score (BIMS) of 03 and assessed Resident #3 as needing two person physical assist with locomotion while on unit.</p> <p>On 9/15/2015 at 12:31 p.m. the Director of Nursing (DON) provided the Fall Risk Review Tool with a date range between</p>	F 0279	<p>F279 – Develop comprehensive care plan</p> <p>- The DNS or designee will in-service nursing staff regarding the policies of Bladder Elimination Assessment CL-NUR-1151 and the Process for Care Plan Development and Communication CL-INTER-0115 encompassing the identification and assessment of incontinent residents; a baseline for urinary frequency; identification of increased urinary urgency/frequency; appropriate approaches to achieve continence, maintain current level of continence, or prevent increased urinary incontinence; and care plan goals and approaches for the revision and updating of care plans as related to urinary incontinence, urgency, and frequency. In-service to be completed by 10/15/15.</p> <p>- The DON or designee will ensure the completion of the “Initial Data Collection Tool for Bowel and Bladder Training” CL-NUR-1151.F1 along with the “3 Day Bowel and Bladder Flow Sheet” CL-NUR-1151.F2 for all current in-house residents to be completed by 10/15/15 to determine resident continence/incontinence, urinary</p>	10/15/2015

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	<p>10/23/2014 to 8/18/2015, which indicated Resident #3 as having a history of 2 or more falls within 1 month.</p> <p>A careplan with a start date of 10/29/2014 and current goal date through 10/20/2015, for Resident #3 indicated a problem of: " ... MODERATE risk for falls according to the FALLS RISK REVIEW TOOL r/t [related to] hx [history] of multiple falls at home, use of Restoril, and poor safety awareness ... GOAL: I will have no fall related injuries ... APPROACH: Pressure pad bed and chair, Call light is usable and within reach with frequent reminders to use. Keep room free from clutter. Ensure proper foot wear. Equipment needs of w/c [wheelchair]. All staff are informed of my fall risk. Fall documentation and analysis is completed if fall(s) occur to investigate root cause(s) and other prevention techniques. Keep urinal and fresh water within reach. Place my w/c in an area or position that I need it for next time. Clamp my call light onto my clothing or in the same place at all times. Adjust my bed height so that my feet are planted firmly on the floor during my transfers. 8/18/2015 fall-S.T's [skin tears]) to hands. ..."</p> <p>Nurses notes indicated Resident #3 sustained a fall with injury on 8/18/2015</p>		<p>frequency baseline, and predisposition to incontinence related issues.</p> <ul style="list-style-type: none"> - The MDS Coordinator or designee will review the urinary incontinence care plans of all residents currently in-house to ensure approaches and interventions are in place to address urgency, frequency, and incontinence to be completed by 10/15/15. - The MDS Coordinator or designee will continue to review urinary incontinence care plans for 5 residents weekly for 90 days. Any concerns will be immediately addressed by the MDS Coordinator or designee and reported to the DON/Administrator. We will monitor quarterly after compliance is established and report to Q.A. - The MDS Coordinator or designee will implement a 72 hour admission audit for compliance with the use of the Data Collection Tool Form CORP-02, Initial Data Collection Tool for Bowel and Bladder Training and 3 Day Bowel and Bladder Flow Sheet for all new admissions to the facility effective 10/1/15. Care plans will be developed based on admission information/audits to accurately reflect a resident's urinary incontinence upon admission and updated or modified for significant change in resident status or per MDS assessments. Any concerns will be immediately addressed by the MDS Coordinator and reported to the DON/Administrator. We will 	

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	<p>at 7:30 p.m., and a 3 day bowel and bladder (B&B) program would begin at midnight. The nurses notes lacked documentation for cause of the fall, implementation of a 3 day B & B program, nor updated interventions related to the B & B program.</p> <p>The care plan lacked updated intervention put in place for the fall on 8/18/2015, for Resident #3 which included a 3 day B&B program.</p> <p>On 9/15/2015 at 10:37 a.m., an interview with the Director of Nursing (DON) indicated, the only place in the clinical record where the fall is discussed for Resident #3's is in the nurses notes and they did implement a bowel and bladder program after his fall on 8/18/2015. They have put interventions in place for Resident #3's fall, but she doesn't know if they are charted anywhere and the care plan had not been updated.</p> <p>2. Resident #52's clinical record was reviewed on 9/14/2015 at 11:00 a.m. Diagnosis included, but were not limited to Parkinson's disease.</p> <p>The quarterly Minimum Data Set (MDS) assessment, completed on 7/13/2015, indicated a Brief Interview of Mental Status score (BIMS) should not be</p>		<p>continue these audits for 90 days on all new admissions. We will monitor quarterly after compliance is established and report to Q.A.</p> <ul style="list-style-type: none"> - Nursing staff will be in-serviced on the policies Process for Care Plan Development and Communication CL-INTER-0115 and Fall Management & Investigation Program (SNF) CL-INTER-0102 encompassing how to develop appropriate care plan goals and approaches, revision and updating of care plans, appropriate fall documentation. The in-service will be completed by 10/15/15. - New fall risk review tools will be completed on all in-house residents by 10/9/15 to determine current fall risk. Care plans will be developed or adjusted in accordance with fall risk review tool to be completed by 10/15/15. - The MDS Coordinator or designee will review all current resident fall care plans to ensure current interventions are in place and accurately reflected on the care plan upon admission, significant change in resident status or per MDS assessments. Reviews will be completed by 10/15/15. - The MDS Coordinator or designee will continue to review fall care plans for 5 residents weekly for 90 days. Any concerns will be immediately addressed by the MDS Coordinator or designee and reported to the DON/ Administrator. We will monitor quarterly after compliance is established and report to Q.A. 	

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	<p>completed due to resident being rarely/never understood and assessed Resident #52 as needing two person physical assist with locomotion while on unit.</p> <p>On 9/15/2015 at 12:31 p.m. the Director of Nursing (DON) provided the Fall Risk Review Tool with a date range between 5/9/2015 to 8/31/2015, which indicated Resident #3 as having a history of 2 or more falls within 1 month.</p> <p>A careplan with a start date of 1/14/2014 and current goal date through 10/16/2015, for Resident #52 indicated a problem of: " ... Resident at risk for falling R/T [related to] impaired cognition and mobility r/t dementia and Parkinson's ... GOAL: Resident will remain free from injury ... APPROACH: Provide toileting assistance before and after meals, at hs [bedtime] and prn [as needed] ... RA [restorative aide] to ambulate with walker ... Administer sinemet as ordered ... Give resident frequent verbal reminders not to ambulate/transfer without assistance ... Keep call light in reach at all times and remind resident how to use ... Keep personal items and frequently used items within reach ... Personal alarm at all times ... Provide proper, well maintained footwear ... 8/27/2015 fall with ST [skin</p>			

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	<p>tear] noted to elbow. ..."</p> <p>Nurses notes indicated Resident #52 sustained a fall with injury on 8/27/2015 at 2:30 p.m., and a fall without injury on 8/31/2015 at 10:15 a.m. There was no documentation to indicate the facility had put interventions in place to prevent Resident #52 from falling again.</p> <p>The care plan did not address any interventions put in place for the fall on 8/27/2015 and 8/31/2015 for Resident #52.</p> <p>On 9/14/2015 at 11:09 a.m., Resident #52 was observed to be sitting in her wheelchair in her room about to fall out of her chair. Certified Nursing Assistant (CNA #1) was observed to walk by, look into the room and proceed to assist Resident #52 with sitting back onto the chair.</p> <p>On 9/15/2015 at 10:37 a.m., an interview with the Director of Nursing (DON) indicated, the care plan had not been updated for Resident #52's fall on 8/27/2015 and 8/31/2015.</p> <p>3. On 9/9/15 at 2:46 p.m., Resident #17 indicated, "Sometimes I wait a 1/2 an hour for the call light to be answered. I have had accidents on myself. This has</p>			

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	<p>happened many times and I feel embarrassed. I tell the CNA's [Certified Nursing Assistant] about this and they tell me they are short handed."</p> <p>Resident #17's clinical record was reviewed on 9/14/15 at 9:00 a.m.</p> <p>The current Minimum Data Set (MDS) dated 8/6/15, indicated Resident #17 was interviewable and cognitively intact. Resident #17 needed extensive assistance of 1 staff person for bed mobility and extensive assistance of 2 staff persons for toileting.</p> <p>Care plan "Urinary Incontinence" dated 9/3/15 through 9/19/15, indicated "DX [diagnoses] UTI [urinary tract infection] ...Goal: Infection will be resolved, Approach: Labs as ordered, ...Notify doctor PRN, ...Monitor for worsening of infection LOC [level of consciousness] changes, increased confusion, fever or increased fever poor urinary output, blood in urine, ..."</p> <p>Review of physician's progress notes dated 7/23/14 through 6/30/15, indicated Resident #17 tested positive for a UTI 8 times.</p> <p>Nursing notes dated 9/12/15, indicated "... Res [resident] cont. [continue] to have</p>			

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	<p>urinary freq/urgency, ..."</p> <p>Nursing notes dated 9/13/15, indicated "... Still c/o [complain of] urgency /freq [frequent] increase of urination. Some incont [incontinence] this morning."</p> <p>On 9/15/15 at 3:25 p.m., interview with CNA #2 indicated Resident #17 had frequent urinary tract infections (UTI) and received hydration and good pericare wiping from front to back to prevent frequent UTI's. CNA #2 indicated Resident #17 was continent of urine except when she had a UTI. CNA #2 did not indicate a system being in place to prevent incontinent episodes.</p> <p>On 9/15/15 at 3:30 p.m., interview with LPN #1 indicated Resident #17 had frequent urinary tract infections (UTI) and received frequent lab monitoring to help prevent UTI's. LPN #1 indicated Resident #17 was continent of urine except when she had a UTI. LPN #1 did not indicate a system being in place to prevent incontinent episodes.</p> <p>There was no care plan to address urgency and frequent increase of urination to ensure Resident #17 was continent of urine.</p> <p>On 9/15/2015 at 1:36 p.m., the</p>			

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F 0329 SS=D Bldg. 00	<p>Administrator provided "Process For Care Plan Development and Communication" dated 9/25/2014, and indicated it was the policy currently being used by the facility. The policy indicated, " ... 4.0 Procedure 8. Ongoing and quarterly review of the residents' plan of care will occur at the weekly care plan meetings. Problem statements, goals and approaches/interventions will reviewed, discussed and updated at this time ... 5.0 Documentation ... The direct care nurse will update the residents' care plan as the residents' needs change ..."</p> <p>3.1-35(a)</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 residents who received a psychotropic medication were monitored for targeted behaviors and for effectiveness of medication for 3 of 5 residents reviewed for unnecessary medication use. (Resident #17, #28, and #42)</p> <p>1). Resident #17's clinical record was reviewed on 9/14/15. Diagnoses included, but were not limited to anxiety and depression.</p> <p>Current Physician's order dated 9/1/15 through 9/30/15, indicated Resident #17 received 100 mg (milligram) Zoloft daily for depression since 6/11/15 and 2 mg Valium bid (twice a day) for anxiety since 7/31/15.</p> <p>Care plan "Psychotropic Drug Use" dated 7/1/15 through 9/29/15, indicated "...Resident self-isolates in room and has a flat affect. ...Goal: ...prescribed the lowest effective dose of medication. ... Approach: Monitor resident's functional</p>	F 0329	<p>F329 – Drug Regimen is free from unnecessary Drugs.</p> <ul style="list-style-type: none"> - Our consulting pharmacist will review/audit all residents taking psychotropic medications upon his next scheduled visit. - The Social Service Director will be implementing the use of "Resident Distressed Behavior Tracking Sheet" upon admission for all residents currently on psychotropic medications. This form will also be implemented on current in house residents with new or worsening behaviors. The Resident Distressed Behavior Tracking Sheet will be implemented for use on 10/15/15. - The Social Service Director will be implementing the use of "Resident Distressed Behavior Rule out Checklist". This checklist will be used after the 5 day MDS assessment is completed if a behavior was noted and with new or worsening behaviors. The Resident Distressed Behavior Rule out Checklist will be implemented for use on 10/15/15. - The nursing staff will be in-serviced by the Social Service Director or designee on the Behavior Intervention Program 	10/15/2015

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	<p>status on a daily basis. ... Monitor resident's mood and response to medication. Monitor for any adverse SEs [side effects] ..."</p> <p>Care plan "Psychotropic Drug Use" dated 7/1/15 through 9/29/15, indicated "...receives ...Valium R/T [related to] dx [diagnoses] of anxiety. ...Goal: communicate on a ongoing basis concerning any changes in mood or behaviors and consult with N.P. [Nurse Practitioner]. ...Approach: Monitor resident's mood and response to medication, ...Offer reassurance and non pharmacological interventions such a snacks or activity ..."</p> <p>Resident #17's clinical record lacked documentation which indicated side effects for the month of July 2015, were being monitor for medications prescribed.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, a Black Box Warning for Zoloft included, but was not limited to: " monitor patient for suicidal tendencies ... Valium: Monitor elderly patients for dizziness, ... increase risk for falls ..."</p> <p>Resident #17's July 2015, behavior monitoring sheet lacked documentation</p>		<p>Policy - CL-SS-8030 encompassing the proper utilization of the behavior/intervention monthly flow record, the use of the Resident Distressed Behavior Rule Out Checklist and the use of the Resident Distressed Behavior Tracking Sheet. The in-service will be completed by 10/15/15.</p> <ul style="list-style-type: none"> - The Social Service Director or designee will in-service the nursing staff on the Psychopharmacological Medication Policy - CL-INTER-0700 encompassing the use of non pharmacological interventions and documentation of psychotropic drugs when given. The in-service will be completed by 10/15/15. - The Social Service Director will complete a whole house audit of all behavior/intervention monthly flow records for current residents receiving psychotropic medication to ensure the appropriate side affects are being monitored .The whole house audit will be completed by 9/30/15. The Social Service Director will continue to monitor the behavior/intervention monthly flow records for all current residents on psychotropic medications 5 times a week for 3 months for compliance with documentation standards beginning 10/1/15. We will monitor quarterly after compliance is established and report to Q.A. - The Director of Nursing or designee will audit the nursing notes of residents that have behavior/intervention monthly flow 	

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	<p>to indicate behaviors for which the medications were prescribed were monitored for 5 of 31 times on day shift and 7 out of 31 times on night for Zoloft. The Valium lacked documentation for 4 out of 31 times on night shift. The dates/boxes were blank.</p> <p>Resident #17's August 2015, behavior monitoring sheet lacked documentation to indicate behaviors for which the medications were prescribed were monitored for 2 of 31 times on day shift and 7 out of 31 times on night shift for Zoloft. The Valium lacked documentation for 3 out of 31 times on dayshift and 7 out of 31 times on night shift. The dates/boxes were blank</p> <p>Resident #17's September 2015, behavior monitoring sheet lacked documentation to indicate behaviors for which the medications were prescribed were monitored for 1 of 14 times on day and 4 out of 14 time on night shift for Zoloft. The Valium lacked documentation for 1 out of 14 times on dayshift and 4 out of 14 times on night shift. The dates/boxes were blank.</p> <p>On 9/14/15 at 8:43 a.m., the Director of Nursing indicated behaviors should be monitored on both shifts and the blank boxes is assumed not monitored. The</p>		<p>sheets to ensure the nursing documentation is congruent with the behavior monitoring tools currently in place. The Director of Nursing or designee will audit 5 resident charts per week for residents that are taking psychotropic medications for 90 days to ensure documentation compliance. We will monitor quarterly after compliance is established and report to Q.A.</p> <ul style="list-style-type: none"> - The facility will replace our current drug handbooks with "The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015". - The Social Service Director will perform a 72hr. audit on all new admissions to ensure appropriate behavior monitoring tools are in place. The Social Service Director or designee will being the 72 hr. auditing protocol on all new admissions beginning 10/1/15. The Social Service Director will continue the admission audit for 90 days. We will then monitor quarterly once compliance is established and report to Q.A. - The Social Service Director will audit all new behavior/intervention monthly flow records for appropriate side affects during monthly change over into a new month. The Assistant Director of Nursing or designee will perform a second check audit after the Social Service Directors audit is complete to ensure all current residents have appropriate behavior/intervention monthly flow records in place with 	

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	<p>DON indicated the behavior monitoring sheet was the only form which listed behaviors which staff should be monitoring. "If it's not documented it [monitoring] didn't happen."</p> <p>2). Resident #28's clinical record was reviewed on 9/14/15 at 8:29 a.m. Diagnosis included, but were not limited to: depression and anxiety.</p> <p>Current physician's order dated 9/1/15 through 9/30/15, indicated Resident #28 received Xanax 0.25 mg (milligram) qid (4 times a day) since 8/3/15, and Paxil 20 mg day for depression and anxiety since 5/16/15.</p> <p>Current physician's order dated 9/1/15-9/30/15, indicated "... PAXIL 20 mg TABLET *MEDICATION HAS BOXED WARNING *MAY CAUSE DROWSINESS/DIZZINESS, *MAY CAUSE BLURRED VISION ..."</p> <p>Care plan "Psychotropic Drug use" dated 8/24/15 through 11/24/15, indicated, "...Notify Md [medical doctor] of any changes in behavior either positive or negative, ..."</p> <p>Care plan "Anxiety" dated 8/24/15 through 11/24/15, indicated"... Monitor for side effects and report changes,</p>		<p>accurate side affects to monitor. This second check method will begin with the change over on 9/30/15.</p>		

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	<p>Notify MD if behavior worsens or improves, ..."</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, a Black Box Warning for Paxil included, but was not limited to: " Record mood changes. Monitor patient for suicidal tendencies ... "</p> <p>The clinical record lacked documentation which indicated targeted behaviors for which the medications were prescribed were monitored for Resident #28's Paxil during the month of July, August, and September, 2015.</p> <p>On 9/14/15 at 8:43 a.m., the Director of Nursing indicated behaviors should be monitored on both shifts and the blank boxes is assumed not monitored. The DON indicated the behavior monitoring sheet was the only form which listed behaviors which staff should be monitoring. "If it's not documented it [monitoring] didn't happen."</p> <p>On 9/15/15 at 1:36 p.m., the Administrator provided the facility's policy, "Psychopharmacological Medication," revised on 4/9/07, and indicated it was the policy currently being used by the facility. The policy did not address daily monitoring for target</p>						

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	<p>behaviors for which the medication was prescribed related to psychotropic medication use.3. The clinical record was reviewed for Resident #42 on 9/14/15 at 11:44 a.m. The resident was admitted on 7/06/15. Diagnoses included, but were not limited to: depression and insomnia.</p> <p>The physician's September 2015, orders for Resident #42 indicated the following:</p> <p>On 7/6/15, the resident was ordered Trazodone (hypnotic medication) 100 mg (milligrams) daily.</p> <p>On 7/16/15, the resident was ordered Cymbalta (antidepressant medication) 60 mg every morning.</p> <p>The clinical record lacked documentation which indicated targeted behaviors for which the medications were prescribed were monitored for Resident #42's Trazodone and Cymbalta during the month of August 2015.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, a Black Box Warning for Cymbalta and Trazodone included, but was not limited to: " drug may increase risk of suicidal thinking and behavior ... monitor patient for worsening of depression or suicidal behavior ..."</p>			

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	<p>During an interview, on 9/14/15 at 8:43 a.m., the Director of Nursing indicated staff should monitor for behaviors on both shifts and document on the behavior monitoring sheets.</p> <p>On 9/15/15 at 4:30 p.m., the Administrator (ADM) indicated the staff could not find any behavior monitoring sheets for Resident #42 for the month of August, 2015.</p> <p>On 9/15/15 at 1:36 p.m., the Administrator provided the facility's policy, "Psychopharmacological Medication," revised on 4/9/07, and indicated it was the policy currently being used by the facility. The policy did not address daily monitoring for target behaviors for which the medication was prescribed related to psychotropic medication use.</p> <p>3.1-48(a)(3)</p>						
F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>						

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	<p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was labeled, identifiable, and discarded when out of date from 1 of 1 walk in freezer, 1 of 1 walk in refrigerator, and 1 of 1 dry storage room; the covering of hair/beard while working in the kitchen; handwashing, the display of food on the table in the dining room by facility staff, expired chemical test strips were discarded, and ice was not exposed through a cracked lid as indicated by facility policy and the Retail Food Establishment Sanitation Requirement Manual. These deficient practices had the potential to affect 32 out of 32 residents being served out of the kitchen.</p> <p>Findings include:</p> <p>1). On 9/9/15 at 10:00 a.m., with the Dietary Manager (DM) present the following were observed in the walk in freezer:</p> <p>There was an unidentifiable bag of meat without an open date. The DM indicated the meat was steak.</p> <p>There was an unidentifiable baggie of meat with a use by date of 7/21/15. The DM indicated the meat was turkey.</p>	F 0371	<p>F371 – Food Procure, store/prepare/serve – sanitary</p> <p>- 1) The Food and Beverage Director or designee will implement and in-service the food service department on the use of the following updated policies, Food Safety in Receiving and Storage – FB-6108, Food Safety – FB-6049 and Freezer Storage Guidelines – Appendix 9 in regards to labeling food items and chemical strips. All in-services will be completed by 10/15/15.</p> <p>1a) New product labels have been ordered that will allow documentation for: Item, Date, Use by Date & Initial of staff creating the label. The new labels were ordered on 10/2/15. The labels will be implemented immediately upon arrival at the facility no later than 10/9/15.</p> <p>1b) The Food and Beverage Director or designee will audit the freezers, refrigerator, dry storage areas and chemical testing strips for proper label use for 5 times a week for 2 weeks, 3 times a week for 2 week, then 1 time a week for 60 days.</p> <p>1c) Proper cold food storage as it relates to food preparation will be audited through the use of “The Daily Production Sheet”. The Daily Production sheet will be audited by the Food and Beverage Director or designee for 5 times a week for 2</p>	10/15/2015

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	<p>There was a baggie of beef tenderloin with a use by date of 7/3/15.</p> <p>There was a baggie of chicken drummett with no use by date.</p> <p>There was an unidentifiable baggie of meat with no use by date. The DM indicated the meat was steak strip.</p> <p>There were 3 baggies of cooked ham with freezer burn, with no use by date.</p> <p>There were 3 baggies of hotdogs covered with ice and no use by date.</p> <p>There were 3 baggies of cinnamon rolls with a used by date of 7/30/15.</p> <p>There was a tray with scallops with a use by date of 7/21/15.</p> <p>There were 2 pans of liquid brownies with a use by date of 2/18/15.</p> <p>There were 2 trays of cinnamon rolls with a use by date of 9/1/15.</p> <p>There was a tray of hard hotdog buns and bread with no open nor use by date.</p> <p>There was a tray with 15 mini diet pecan pies with a use by date of 9/1/15.</p>		<p>weeks, 3 times a week for 2 week, then 1 time a week for 60 days. We will monitor quarterly after compliance is established and report to Q.A.</p> <p>- 2) The Food and Beverage Director or designee will in-service the food service department on the Dress Code policy FB-6014 encompassing the use of hair and beard nets while in the kitchen. All in-services will be completed by 10/15/15.</p> <p>2a) The Food and Beverage Director or designee will randomly audit for appropriate employee use of hair and beard nets 5 times a week for 2 weeks, then 3 times a week for 2 weeks then 1 time a week for 60 days. We will monitor quarterly after compliance is established and report to Q.A.</p> <p>- 3) The Food and Beverage Director will in-service the food service department on the Hand Washing Policy – Appendix 2 along with the article from the Centers for Disease Control and Prevention titled, “Handwashing: Clean Hands Save Lives...When and How to Wash Your Hands...How should you wash your hands?”. The in-service will be completed by 10/15/15.</p> <p>3a) The Food and Beverage Director or designee will randomly audit all shifts within the dietary department 5 times a week for 2 week, then 3 times a week for 2 weeks then 1 time a week for 60 days. We will monitor quarterly after compliance is established and report</p>	

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	<p>There was a tray of frozen biscuits with a use by date of 9/1/15.</p> <p>There was a tray of desserts with a use by date of 8/8/15.</p> <p>There was a tray of desserts with a use by date of 9/1/15.</p> <p>There was a tray with carrot cake rolls with a use by date of 9/6/15.</p> <p>There was a tray of hot dog buns with a use by date of 7/13/15.</p> <p>There was a tray of expired cakes and pies.</p> <p>There were 2 trays with open baguettes without a use by date.</p> <p>There were 2 trays of diet cherry pie with a use by date of 8/17/15.</p> <p>There was a bag of berry pie filling with a use by date of 4/21/15.</p> <p>There was a tray with 3 open, unidentifiable pies with no use by dated.</p> <p>There were 2 open bags of chicken thighs with a use by date of 7/7/15.</p>		<p>to Q.A.</p> <p>4) The Food and Beverage Director or designee will in-service the food service department on the guidelines for preparing the tables prior to the start of a meal. The in-service will be completed by 10/15/15.</p> <p>4a) The Food and Beverage Director or designee will randomly audit all meal shifts 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then 1 time a week for 60 days. We will monitor quarterly after compliance is established and report to Q.A.</p> <p>- 5) The Food and Beverage Director or designee will in-service the food service department on the policy for Manual Cleaning and Sanitizing with Three – Compartment Sink – FB-6112. In-services will be completed by 10/15/15.</p> <p>5a) The Food and Beverage Director or designee will audit for compliance with policy FB-6112, 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then 1 time a week for 60 days. We will monitor quarterly after compliance is established and report to Q.A.</p> <p>- 6) A new ice machine lid was ordered on 9/11/15 to replace the existing cracked lid. The new ice machine lid will be installed immediately upon arrival at the facility and no later than 10/15/15.</p> <p>- 7) To address the clean and dirty boundaries in kitchen the facility will permanently mark the</p>	

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	<p>There was a bag of beans and rice with a used by date of 2/1/13.</p> <p>The DM was observed to removed the items in question from the walk in refrigerator and place on the counter to be discarded at that time.</p> <p>2). In the walk in refrigerator the following was observed:</p> <p>There was a cooked pan of angel hair pasta with a used by date of 9/8/15.</p> <p>There was a baggie with discolored corn beef with a use by date of 9/5/15.</p> <p>There was a pan of sausage gravy with a used by date 9/6/15.</p> <p>There was a container of cranberry sauce with a use by date of 8/19/15.</p> <p>There were 3 bags of shredded carrots with a use by date of 9/6/15.</p> <p>There was a bag of fresh spinach open without a used by date.</p> <p>There were 3 bags of sunshine blend vegetable with creamy color moisture inside and no used by date.</p> <p>There was a bag of green beans with</p>		<p>separation of the clean vs. dirty areas. These markings will be in place no later than 10/15/15.</p>	

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	<p>moisture inside with no use by date.</p> <p>There was a bag of red cabbage with moisture inside and no use by date.</p> <p>There was a container of pecan pudding with a use by date of 9/8/15.</p> <p>There was a container of peanut butter frosting with use by date of 9/8/15.</p> <p>The DM was observed to removed the items in question from the walk in refrigerator and place on the counter to be discarded at that time.</p> <p>3). In the dry storage room the following was observed:</p> <p>There was an unidentifiable bag of what appeared to be dough with no open date. The Dietary Manager (DM) indicated the item was cracker crumbs.</p> <p>There were 2 bags of pasta open with a use by date of 8/27/15.</p> <p>There was a bag of open rice with a use by date of 5/2015.</p> <p>There was a 25 pound open bag of corn meal with no use by date nor open date.</p> <p>There was a shelf of spices with no open</p>			

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(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	
	<p>nor expiration date.</p> <p>The DM was observed to removed the items in question from the walk in refrigerator and place on the counter to be discarded at that time.</p> <p>4). On 9/11/15 at 8:30 a.m., with the Dietary Manager (DM) the following was observed in the kitchen:</p> <p>There was a wet metal bowl observed stored on the shelf. The DM indicated the wet item should have not been placed on the storage shelf. The DM was observed to remove the wet bowl and place in the dishwasher area.</p> <p>There were 2 trays of chicken breast observed uncovered on a open rack near the clean sink in front of a wall. The DM indicated the meat should be covered and the cook was going to prep the chicken to cook.</p> <p>There was a bowl of raisins observed on the counter, dated 9/2/15-9/5/15. The DM was observed to remove and discard.</p> <p>5). On 9/11/15 at 9:30 a.m. Prep cook #1 and Server #2 were observed in the kitchen with no beard covered.</p> <p>6). On 9/11/15 at 10:100 a.m., with the</p>				

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	<p>Dietary Manager (DM) observed the storage room to have a shelf of undated open spices. The DM indicated could not tell when spices expire if the spices have no open date.</p> <p>7). On 9/11/15 at 11:00 a.m., Executive Cook #1 was observed in the kitchen prep area with no beard cover on. Prep cook #1 was observed with no beard cover on.</p> <p>8). On 9/11/15 at 11:05 a.m., Server #1 was observed to enter the kitchen. No handwashing was not observed wearing a hairnet to enter the walk in refrigerator and retrieve tarter sauce. Server #1 was observed to exit the kitchen with a bowl of tarter sauce into the independent dining room. Server #1 indicated she did not handwash and should be wearing a hairnet. She indicated she had contaminated the food by not handwashing.</p> <p>9). On 9/11/15 at 11:15 a.m., the Front House manager was observed to enter the kitchen area with no hairnet on, walk into an office in the prep area. He was observed to walk over to the rack with the hairnet without placing a hairnet on, turn around and walk through the kitchen and exit the kitchen.</p>				

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	<p>On 9/11/15 at 1:45 p.m., interview with the Dietary Manager indicated all staff should have their hair and beard covered when entering the kitchen.</p> <p>On 9/14/15 at 3:48 p.m., the Dietary Manager indicated the area from the door back to the left, in the production area, toward the office was considered a "dirty area." "I think I will have strips placed."</p> <p>10). On 9/14/15 at 11:30 a.m. with the Dietary Manager (DM) present observed the chemical testing strips to not change colors and to have an expiration date of 3/1/14. The DM was not aware the chemical strips were expired. The DM was observed to remove the expired chemical strips and provide a current box of testing strips.</p> <p>11). The lid on the ice machine in the kitchen had a cracked lid exposing the ice. The DM indicated the ice machine belonged to Independent Living.</p> <p>On 9/14/15 at 11:00 a.m., The Dietician indicated the dietary staff used the ice machine in the kitchen to transfer ice to a chest and bring the ice to the health care dining room.</p> <p>On 9/14/15 at 3:14 p.m., the Administrator (ADM) provided the</p>			

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	<p>policy "MANUAL CLEANING AND SANITIZING STATIONARY EQUIPMENT AND WORK SURFACES" undated, and indicated the policy was the one currently used by the facility. The policy did not address how to test the chemical solution nor monitoring expiration dates on the testing strips.</p> <p>12). On 9/15/15 at 12:08 p.m., with the Dietary Manager; observed 6 tables in the main dining room with drinks, bread, and dessert uncovered with no residents present. The DM indicated food should be covered while on the table unattended.</p> <p>On 9/16/15 at 12:00 p.m., review of the RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS MANUAL dated November 13, 2004, indicated, " ... Sec. (section) 138 (a) Except as provided in subsection (b), food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, ... that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles. (b) This section does not apply to food employees, ..."</p> <p>On 9/16/15 at 12:00 p.m., review of the</p>			

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	<p>RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual dated November 13, 2004, indicated ... "Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately before engaging in food preparation. ... and the following... (6) After handling soiled surfaces, equipment, or utensils ... after engaging in other activities that contaminate the hands."</p> <p>On 9/9/15 at 1:37 p.m., the Dietary Manager (DM) provided the policy "RECOMMENDED MAXIMUM FOOD STORAGE PERIODS" dated 11/4/05, and indicated the policy was the one currently used by the facility. The policy indicated, "... Gravy, ...maximum storage ... 1-2 days, Leftover cooked meats ... maximum storage 1-2 days, ... All other vegetables ...maximum storage 5 days maximum ; 2 weeks for ...root vegetable ... DRY STORAGE, ... Seasonings,</p>			

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	<p>...Spices and herbs [whole] Recommended Maximum Storage Period if unopened, 2 years to indefinite." The policy did not address the maximum storage period for spices, bread, and meals once opened.</p> <p>On 9/10/15 at 1:43 p.m., the Dietary Manager provided the policy, "FREEZER STORAGE GUIDELINES" dated June 3, 2010, and indicated the policy was the one currently used by the facility. The policy indicated, "...Freezer storage is for quality only ...Ham, Hotdog, ...1 to 2 months, Meat,cooked 2 to 3 months, ..."</p> <p>On 9/11/15 at 11:29 a.m., the Dietary Manager provided the policy, "DRESS CODE" dated 8/6/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "... 8. Hair is to be completely covered and restrained with a hair net ... while in the food preparation area and /or kitchen. 9. beard coverings where applicable for facial hair covering. ..."</p> <p>On 9/14/15 at 3:47 p.m., the Administrator provided the policy "KITCHEN SECURITY" dated 8/6/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...In accordance with health regulations and accepted food handling</p>			

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	<p>procedures, non-dietary staff ... may not enter the kitchen during normal hours of operation. ..." The policy did not address clean and dirty boundaries in the kitchen.</p> <p>On 9/14/15 at 3:47 p.m., the Administrator provided the policy "FOOD SAFETY IN RECEIVING AND STORAGE" dated 8/6/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...2. Expiration dates and use-by dates will be checked to assure the dates are within acceptable parameters. ... 5. ... old stock will be rotated to the front and utilized first. ...General Food Storage Guidelines ...3. Food that is repackaged will be placed in a ... container The container will be labeled with name of the contents and dated with the date it was transferred ... Dry Storage Guidelines ... 2. Open packages will be resealed tightly and dated with date open to prevent contamination and dated with opened date."</p> <p>On 9/15/15 at 12:42 p.m., the Dietary Manager provided the policy "HAND WASHING" undated, and indicated the policy was the one currently used by the facility. The policy did not address hand washing upon entering the kitchen.</p> <p>On 9/15/15 at 12:42 p.m., the Dietary</p>			

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F 0372 SS=C Bldg. 00	<p>Manager provided the policy "MEAL SERVICE DELIVERY" dated 8/6/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...1.1. Meals are served in the dining room by nursing or dietary staff, per facility policy. ..." The policy did not address how to prevent contamination of food placed on the table in absence of the resident.</p> <p>On 9/15/15 at 1:14 p.m., the Dietary Manager provided the policy, "Meadowood Meal Service Delivery Per Five Star Policy FB-6050" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...1.1.2 Tables are set with beverages and side items no longer than 30 minutes prior to meal. ..." The policy did not address how prevent contamination of food placed on the table in absence of the resident.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and</p>				

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	<p>refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper disposal of garbage as indicated by facility policy and the 410 IAC Retail Food Establishment Sanitation Requirements Manual for 7 of 7 outdoor waste dumpsters.</p> <p>Findings include:</p> <p>On 9/11/15 at 8:30 a.m., with the Dietary Manager (DM) present observed 2 large outside dumpsters with the door and lids open. There were 5 recycle bins with the lids open, plastic bags with large cans hanging out of the recycle cans. One of the recycle bin's lid was broken. The DM indicated the lids should have been closed. Maintenance was responsible for notifying the recycle company to empty the recycle cans. The DM was observed to close the lids and door on the dumpsters. The recycle can's lids remained open due to over flow of trash.</p> <p>On 9/16/15 at 12:28 p.m., review of the RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual dated November 13, 2004, indicated, ... Sec. 385. (a) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside</p>	F 0372	<p>F372 – Dispose Garbage & Refuse Properly</p> <ul style="list-style-type: none"> - The community will be getting rid of the 5 individual recycle bins and obtaining one big recycling dumpster. The new dumpster will replace the 5 individual recycle bins no later than 10/15/15. - The maintenance, food service and housekeeping departments will be in-serviced on the Pest Control Policy – FB-6113 educating the departments on the need to close the lids on the recycling and trash dumpsters. In-services will be completed by 10/15/15. - The Maintenance Director or designee will randomly audit the trash and recycling dumpsters daily for 2 weeks, then 3 times a week for 2 weeks, and weekly for 60 days. The Maintenance Director or designee will be auditing for dumpster lids/doors being closed along with the appropriate volume of trash for the dumpster size. 	10/15/2015

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F 0441 SS=D Bldg. 00	<p>the retail food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. ...Sec. 392. (a) Receptacles and waste handling units for refuse, ... shall be kept covered: ... (2) with tight-fitting lids or doors if kept outside the retail food establishment. ..."</p> <p>On 9/14/15 at 3:17 p.m., the Administrator provided policy "PEST CONTROL, dated 8/6/2012, and indicated the policy was the one currently used by the facility. The policy indicated, " ...1. Garbage is ...disposed of in a manner that does not create a breeding place for insects or rodents. Garbage is disposed of as quickly as possible. Bags are tightly sealed. 2. Dumpster lids and doors are kept closed. ... 3. Garbage containers ... have close-fitting covers. ..."</p> <p>3.1-21(i)(5)</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</p>			

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	<p>and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing in that a Certified Nursing Assistant (CNA #2) failed to wash their hands for 20 seconds and change gloves while performing perineal care for 1 of 1 randomly</p>	F 0441	<p>F441 – Infection control, prevent spread , linens</p> <p>- The nursing department will be in-serviced on the Hand Washing Policy – CL-IC-3024 along with the article from the Centers for Disease Control and Prevention titled, “Handwashing: Clean Hands Save Lives...When and How to Wash</p>	10/15/2015

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	<p>observed resident. (Resident #17).</p> <p>Findings include:</p> <p>On 9/15/2015 at 5:00 p.m., CNA #2 was observed to wash hands, put on clean gloves, remove an incontinent brief that was dirty with bowel movement (BM), and to perform perineal care on Resident #17. CNA # 3 was then observed to go to the closet, obtain a clean incontinent brief, and roll the clean brief under Resident #17, while wearing the same pair of dirty gloves. CNA #2 was observed to remove the dirty gloves, to hand wash for 10 seconds, apply new gloves and turn Resident #17 onto their back. CNA #3 was then observed to perform perineal care on the front, pull the residents gown down and pull blanket up while wearing the same pair of dirty gloves. CNA #3 was observed to remove gloves, handwash for 10 seconds, apply new gloves, empty the dirty bedpan, remove old gloves, and handwash for 10 seconds.</p> <p>On 9/15/2015 at 5:16 p.m., CNA #3 indicated, you should wash hands for 20 seconds while saying 1/1000, 2/1000 and she washed hands for 20 seconds the first time, but did not the rest of the times. CNA #3 further indicated the gloves should have been changed after</p>		<p>Your Hands...How should you wash your hands??. The in-service will be completed by 10/15/15. The Director of Nursing, Assistant Director of Nursing or designee will visually audit licensed nursing staff while providing resident care. Licensed nursing staff will be randomly audited encompassing all shifts daily for 1 week, then 3 times a week for 3 weeks, then weekly for one month then bi-weekly audits will continue for 1 month.</p> <p>- We will monitor quarterly after compliance is established and report to Q.A.</p>	

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	<p>performing perineal care each time and before touching anything clean.</p> <p>On 9/15/2015 at 5:16 p.m., the Administrator provided the policy, "Hand Washing" dated 10/15/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "1. d. Wash hands if moving from a contaminated body site during resident care ... 1. o. Before applying and after removal of medical/surgical or utility gloves ... 3. c. Rub hands together using friction for 15-20 (CDC guidelines) ..."</p> <p>On 9/16/2015 at 10:00 a.m., review of Center for Disease Control at www.cdc.gov/handwashing/, dated December 16, 2013 indicated, "When should you wash your hands? ... Before and after caring for someone who is sick ... Before and after treating a cut or wound ... How should you wash your hands? Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Scrub your hands for at least 20 seconds. Need a timer? Hum the (Happy Birthday) song from beginning to end twice. ..."</p> <p>3.1-18(l)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2015
FORM APPROVED
OMB NO. 0938-0391

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