

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2015
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
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F 0000 Bldg. 00	<p>This survey was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00177192.</p> <p>Complaint IN00177192 - Substantiated. Federal/State deficiencies related to the allegations are cited at F353.</p> <p>Survey dates: August 11, 12, 13, 14, 17, and 18, 2015</p> <p>Facility number: 012523 Provider number: 155789 AIM number: 201027870</p> <p>Census bed type: SNF: 28 SNF/NF: 39 Residential: 52 Total: 119</p> <p>Census payor type: Medicare: 28 Medicaid: 39 Total: 67</p>	F 0000		
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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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F 0241 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>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 interview, observation and record review, the facility failed to ensure each resident was cared for in a manner which maintained their dignity related to bathing for 2 of 3 residents reviewed of the 2 residents who met the criteria for dignity. (Residents #152 and #155)</p> <p>Findings include:</p> <p>1. During an interview on 08/11/2015 at 1:30 P.M., Resident #152 indicated he/she was questioned by staff twice when he/she asked for a bath. The resident indicated he/she could smell his/her own body odor. The resident indicated on one of the occasions a staff member response to the request for a bath was, "what for" and Resident #152</p>	F 0241	Residents #152 and #155 were bathed on 8/11/2015. Resident #152's hair was shampooed and styled on 8/11/2015. Social Services/designee will continue to follow up with those residents and/or families identified to ensure satisfaction. All resident shower documentation was printed for residents dependent on staff for bathing and were reviewed. Social Services will continue to follow up with residents to ensure satisfaction with bathing experience. DHS/Designee will inservice Nursing team members by 9/10/2015 regarding bathing and bathing documentation in caretraker. DHS will verify resident bathing through caretraker reports and observation of residents 3x per	09/14/2015

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	<p>advised the staff, "because I stink".</p> <p>During an interview on 08/13/2015 at 12:22 P.M., CRCA (Certified Resident Care Assistant) #7 indicated the resident's normal bathing day was Wednesday and Saturday on second shift. CRCA indicated not all baths are documented on the care tracker but most staff "wipe every resident off daily".</p> <p>During an observation on 08/13/2015 at 10:10 A.M., Resident #152's hair appeared uncombed and small pieces of food particles were on his/her face and neck.</p> <p>Review of Resident #152's "Bathing Type" Chart provided by the Director of Nursing (DON) on 08/13/2015 at 4:10 P.M., indicated the resident received 9 showers and 3 partial baths in a 30 day span from July 14 to August 13, 2015.</p> <p>Review of the Clinical Record on 08/13/2015 at 10:28 A.M. indicated Resident #152 had diagnoses including, but not limited to, neurogenic bladder, dementia, multiple sclerosis, Parkinson's disease, anxiety disorder, and depression. Resident 152's care plan for Activities of Daily Living indicated the resident would like to be showered at least two times a week and bathed on all other days.</p>		<p>week for 4 weeks, weekly x 4 weeks and monthly on an ongoing basis. Social Services will follow up weekly with a minimum of (6) residents regarding bathing for 4 weeks. Observations will be presented by the DHS and SS to the QA committee monthly ongoing until substantial compliance is achieved, then quarterly thereafter to insure ongoing compliance for review and recommendations. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective.</p>		

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	<p>The admission MDS (Minimum Data Set) assessment, dated 05/07/2015, indicated Resident #152 had a BIMS (Brief Interview for Mental Status) score of 15 and was alert and oriented. The assessment further indicated the resident needed extensive assistance of two staff members with bathing.</p> <p>2. During an interview on 08/12/2015 at 11:28 A.M., Resident #155's family member indicated, "on a few occasions when I visit, he/she has body odor". The family member indicated he/she did not think the resident was getting baths regularly.</p> <p>During an interview on 08/13/2015 at 3:04 .PM., CRCA #11 indicated Resident #155 receives a bath twice a week. Normally if the resident does not get a bath the staff try to "wash them up". CRCA #11 indicated "they could use more help" because it was difficult to monitor all the residents.</p> <p>During an observation on 08/13/2015 at 3:15 P.M., Resident #155 was sitting in the dining area and a foul body odor was noted.</p> <p>Review of Resident #155's Bathing Type Chart provided by the Director of</p>			

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	<p>Nursing (DON) on 08/13/2015 at 4:10 P.M., indicated the resident received 4 showers and 0 partial baths in a 30 day span from July 14 to August 13, 2015. Three of the shower sheets were not documented on the Bathing Type Chart and were located on the CNA Bath/Shower Skin Check Sheet. The resident did not receive the scheduled showers on 07/21/2015 and 08/07/2015. No partial baths were documented on the "Bathing Type Chart" or the "CNA Bath/Shower Skin Check Sheets".</p> <p>Review of the clinical record on 08/13/2015 at 2:36 P.M. indicated Resident #155 had diagnoses including, but not limited to, anemia, Alzheimer's disease, and depression. Resident #155's care plan for Activities of Daily Living indicated the resident would be showered at least two times a week and bathed on all other days.</p> <p>The admission MDS assessment, dated 04/09/2015, indicated Resident #155 had a BIMS score of 00 signifying the resident was severely cognitively impaired. The assessment further indicated the resident needed extensive assistance of two staff members for hygiene and was dependent on staff for bathing.</p>			

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F 0250 SS=D Bldg. 00	<p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide a Behavior Management Program to monitor the behaviors of 2 of 2 residents reviewed for behavior. (Resident #74 and #152)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #74 was reviewed on 08/11/2015 at 3:40 P.M. Diagnoses included, but were not limited to, dementia, anxiety, and depression.</p> <p>The care plan, dated 08/11/2015, indicated Resident #74 was to be</p>	F 0250	<p>Residents #74 and #152 had room changes immediately. Social Services notes for 8/6/2015 have been added to the chart. Resident #74 was interviewed again by Social Services to insure the resident was happy and denied any suicidal thoughts. Resident # 152 was re interviewed by Social Services and verified the resident was content with the room change and had no additional concerns. Resident # 74 and # 152's care plans were updated to reflect revisions. ED inserviced social services team regarding ensuring all documentation is thorough, timely and placed in the residents medical record.</p>	09/14/2015			

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	<p>observed for signs and symptoms of adverse side effects of medications. The physician was to be notified of any adverse side effects.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 06/18/2015, indicated Resident #74 had a BIMS (Brief Interview for Mental Status) score of 11 signifying the resident was mildly cognitively impaired. The assessment further indicated the resident had no behavioral symptoms.</p> <p>Review of the "Nurse's Notes" for Resident #74 indicated the following:</p> <p>06/13/2015, voiced to the nurse, statements related to killing herself. 06/16/2015, indicated the resident was complaining of anxiety. 07/24/2015, indicated the resident was crying when she came to the nurses desk. 08/14/2015, indicated the facility received a call from the psychiatrist inquiring about the resident's mood.</p> <p>The clinical record for Resident #74 lacked documentation in the nurses notes concerning the incident between Resident #74 and #152 on or around 08/06/2015.</p> <p>Review of Resident #74's Social Service notes indicated the following:</p>		<p>DHS will inservice nursing team members regarding recording behaviors in caretracker by 9/10/2015. ED will inservice campus team members regarding resident concern form process and notification process by 9/10/2015. Care tracker entries which includes behavior and mood entries will be reviewed in the daily Clinical Care Meeting by the IDT. Social Services will conduct random interviews with a minimum of 10 residents residing in semi-private rooms weekly x 4 weeks then monthly x 3 months to ensure roommates are content with their room arrangement by 9/14/2015. Any issues identified will be placed on a resident concern form for immediate follow up by the IDT and ED. Social Services will conduct and document a wellness check at resident 1st conferences ongoing and report results to the QA committee on a monthly basis until substantial compliance is achieved, then quarterly thereafter to insure ongoing compliance. The audits will be presented at the QA &A meeting by the Social Service Team for review and further recommendations if indicated. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective.</p>		

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	<p>06/13/2015, indicated the resident made a verbal suicide threat on 6/12/2015.</p> <p>No Social Service Progress Notes were documented in the resident's chart for 08/06/2015.</p> <p>08/12/2015 at 9:30 A.M., indicated Resident #74 stated, "I had the best night sleep I've had in awhile". Resident was upbeat, smiling, and happy with the new room [recent room change].</p> <p>Review of the "Compressed Mood Report", dated from 06/15/2015 to 08/13/2015 and provided by the Administrator on 08/14/2015 at 3:03 P.M., indicated Resident #74 had no behavioral or mood symptoms.</p> <p>During an interview on 08/12/2015 at 9:17 A.M., Resident #74 indicated she had advised the staff concerning her roommates television being too loud and she could not sleep since entering the facility six weeks ago. The resident indicated staff will come into the room and turn the volume down when her roommate falls asleep. The roommate gets upset and turns the volume back up when she wakes up.</p> <p>During an interview on 08/13/2015 at</p>			

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	<p>8:46 P.M., CRCA (Certified Resident Care Assistant) # 7 indicated she was aware of issues with Resident #74 being upset over the television noise level. CRCA #7 indicated the first shift nurse informed her about the issue between the residents three weeks ago.</p> <p>During an interview on 08/14/2015 at 8:47 A.M., the SSD (Social Services Director) indicated she was not aware of an incident between Residents #74 and #152 until Resident #152 stopped her in the hallway on 08/06/2015, indicating the event occurred two to three days prior.</p> <p>During an interview on 08/14/2015 12:47 P.M., the DON (Director of Nursing) indicated a Social Service circumstance form was not filled out because of the "three days past". [The resident had indicated it was two or three days ago.] A circumstance form was to be used within 72 hours of the occurrence. The DON could not answer why there was no documentation in the clinical record concerning the behaviors. The DON also indicated she did not know about the issue of Resident #74 not sleeping from the other resident's TV until yesterday [08/13/2015]. The DON indicated she did not find any notes in the resident's clinical record concerning the evaluation or any physician notes for a resident with</p>			

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	<p>suicidal indications. She indicated there was a physician's order for the resident to see the psychiatrist on 06/12/2015.</p> <p>2. The clinical record for Resident #152 was reviewed on 08/11/2015 at 3:50 P.M. Diagnoses included, but were not limited to, anemia, dementia, multiple sclerosis, Parkinson's disease, and depression.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 06/13/2015, indicated Resident #152 had a BIMS (Brief Interview for Mental Status) score of 15 indicating the resident was alert and oriented. The assessment further indicated the resident had no behavioral symptoms.</p> <p>During an interview on 08/11/2015 1:41 P.M., Resident #152 indicated she had spoken with the SSD concerning an incident with her roommate and nothing had been done about it.</p> <p>During an interview on 08/13/2015 1:49 PM, the SSD indicated Resident #152 had stopped her in the hallway on 08/06/2015 and indicated her roommate had hit him/her in the back three times. The SSD indicated she had talked to the roommate and that staff were unaware of the incident. The staff had informed the SSD of being aware of one incident of</p>			

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F 0282 SS=D Bldg. 00	<p>the resident's roommate being upset with the volume of the Resident's TV. The SSD indicated she was not aware of issues with the TV being loud. Resident #155 indicated to the SSD that she was not scared of the roommate, but she just didn't like her. The SSD indicated she did not fill out the paperwork, regarding the incident, until yesterday [08/12/2015] and placed it in the chart today.</p> <p>During an interview on 08/14/2015 at 2:30 P.M., Resident #152 indicated she did not understand why it took so long to have the issues concerning her roommate addressed but that she was happy with the recent roommate change and had slept better since.</p> <p>3.1-34(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>				

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	<p>persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written and failed to ensure physician orders were followed related to wound care, activities of daily living, and behaviors/moods, for 2 of 15 residents reviewed for care plans. (Resident #74 and #155)</p> <p>Findings include:</p> <p>1. During an observation on 08/17/2015 at 3:08 P.M., LPN (Licensed Practical Nurse) #3 performed wound care for Resident #155. LPN #3 filled a wash basin with an inch of tap water from the resident's bathroom. After soaking two wash cloths with tap water from the faucet, she placed the cloths into the wash basin. LPN #3 used the soap from the resident's bathroom dispenser and placed the soap on one wash cloth to cleanse the resident's wound. After the resident's wound was cleaned with a soapy wash cloth, LPN #3 picked the second cloth out of the wash basin and rinsed the resident's wound with the tap water in the basin.</p> <p>During an interview on 08/17/2015 at 3:27 P.M., LPN #3 indicated she was unsure of what supplies were in the</p>	F 0282	<p>Resident #155 received a shower on 8/11/2015. Resident # 74's social service documentation has been updated and placed in the residents medical record. Resident # 74 had a room change immediately. Social Services verified that the resident is content with room change and denies any suicidal ideation. Social Services notes for 8/6/2015 have been added to the medical record. LPN #3 was inserviced by DHS on following physician orders with emphasis placed on wound care, following the plan of care as written, activities of daily living in regard to bathing, and documentation of behaviors. All residents who are dependent on staff for bathing/showering, receiving wound treatments, and exhibit behavioral expressions, have the potential to be affected by the practice. All residents who are dependent on staff assistance for shower/bathing documentation were identified and interviewed by Social Services to verify they were satisfied with their current bathing. All residents receiving wound care were identified and updated wound assessments were completed by the wound nurse by 9/14/2015. Nursing team members will be inserviced by DHS by 9/10/2015 regarding following physician orders for wound care, following</p>	09/14/2015			

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	<p>resident's room, so she collected a new wash basin from the supply room to perform the cleaning of the wound on the resident's hand.</p> <p>During an interview on 08/17/2015 at 4:09 P.M., NP (Nurse Practitioner) #12 indicated the wound should have been cleaned with normal saline and not water out of the faucet.</p> <p>The clinical record for Resident #155 was reviewed on 08/13/2015 at 2:36 P.M. The resident had a physician's order, dated 08/12/2015, to cleanse skin tear to right hand, apply antibiotic ointment and cover with dry dressing every day until healed.</p> <p>The current "Basic Wound Interventions" policy was provided on 08/13/2015 at 3:34 P.M. by the Director of Nursing (DON). The policy was not dated. The policy indicated, "...Basic wound treatment:...Cleanse (normal saline)..."</p> <p>2. Review of Resident #155's "Bathing Type Chart", provided by the Director of Nursing (DON) on 08/13/2015 at 4:10 P.M., indicated Resident #155 did not receive the scheduled showers on 07/21/2015 and 08/07/2015. No partial baths or refusals were documented on the "Bathing Type Chart" or the "CNA Bath/Shower Skin Check Sheets".</p>		<p>the plan of care as written, activities of daily living in regard to bathing, and mood and behavior documentation. In addition, proper wound care technique and protocol will be reviewed and demonstrated by the DHS per the orientation checklist. DHS will inservice nursing team members regarding documentation of behaviors in caretracker by 9/10/2015. ED inserviced social services team regarding ensuring documentation is placed and maintained in the medical record in a timely fashion. DHS, ADHS will observe wound care procedures on varying halls and shifts to ensure proper wound technique is being followed 2 times weekly for 2 months, then ongoing until substantial compliance is reached. Action plans will be developed if areas of concern are identified. Results of the observations will be presented by the DHS to the QA committee for review and further recommendations if indicated. Social Services will conduct follow up interviews with a minimum of 10 residents or families if appropriate, who exhibit behavioral expressions and are dependent on staff for assistance with bathing to verify they are satisfied with their care and treatment plan. DHS will verify</p>	

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	<p>The clinical record for Resident #155 was reviewed on 08/13/2015 at 2:36 P.M. The resident's care plan indicated the resident was to be showered at least two times a week and bathed on all other days. The resident was scheduled to be showered on Tuesdays and Fridays, each week.</p> <p>The admission MDS assessment, dated 04/09/2015, indicated Resident #155 had a BIMS (Brief Interview for Mental Status) score of 00 signifying the resident was severely cognitively impaired. The assessment further indicated the resident needed extensive assistance of two staff members for hygiene and was dependent on staff for bathing.</p> <p>During an interview on 08/13/2015 3:04 P.M., CRCA (Certified Resident Care Assistant) #11 indicated the resident received a bath twice a week. Normally if they do not get a bath the staff try to "wash them up".</p> <p>3. The clinical record for Resident #74 was reviewed on 08/11/2015 at 3:40 P.M. Resident #74's last psychiatric evaluation note was dated 03/25/2015. The resident's "Care Plan for Moods and Behaviors" indicated the resident was to be observed for signs and symptoms of</p>		<p>resident bathing through caretracker reports and observation of resident 3x per week for 4 weeks, then weekly x 4 weeks, then ongoing until substantial compliance is achieved, then quarterly thereafter to insure ongoing compliance. Social Services will follow up with a minimum of 10 residents regarding bathing weekly x 8 weeks, then ongoing until substantial compliance is achieved, then quarterly thereafter to insure ongoing compliance. The audits and observations will be presented at the QA & A meeting by the DHS, ED and Social Service Team for review and further recommendations if indicated. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective.</p>				

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	<p>effectiveness and adverse side effects of medications. The physician was to be notified of any adverse side effects.</p> <p>Review of the "Nurse's Notes", dated 06/13/2015, indicated Resident #74 reported to the nurse that she wanted to kill herself. The nursing note dated 06/16/2015 indicated the resident was complaining of anxiety. The nursing note, dated 07/24/2015, indicated the resident was crying when she came to the desk. The nursing note dated 08/14/2015, indicated the facility received a call from the psychiatrist inquiring about the resident's mood.</p> <p>Review of the "Compressed Mood Report", dated from 06/15/2015 to 08/13/2015 and provided by the Administrator on 08/14/2015 at 3:03 P.M., indicated Resident #74 had no behavioral or mood symptoms.</p> <p>During an interview on 08/14/2015 at 10:37 A.M., the SSD (Social Service Director) indicated the behavior monitoring record can be initiated whenever needed. The SSD indicated that she did not keep a tally for behaviors. The behavior monitoring record note book is no longer used for the residents. All behavior issues were to be placed into the Kiosk [CRCA computerized charting</p>			

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F 0323 SS=E Bldg. 00	<p>system]. The SSD indicated the staff do not utilize the Kiosk as often as they should.</p> <p>3.1-35(g)(1) 3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to maintain a functional and safe environment for the residents as evidenced by unsafe water temperatures for 5 of 40 resident rooms reviewed for environmental safety.</p>	F 0323	The entire water system was flushed with cold water immediately which brought the temperature to within range. Director of Plant Operations checked water temperatures every 2 hours throughout the campus in various resident rooms during business hours to ensure	09/14/2015

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	<p>Findings include:</p> <p>During an observation with the Assistant Director of Plant Operations, on 08/11/2015 at 2:22 P.M., the following water temperatures were recorded:</p> <p>Room 311 was 125° Fahrenheit (F) Room 315 was 124.6° F Room 301 was 123.7° F Room 202 was 124.5° F Room 103 was 121.5° F</p> <p>During an interview on 08/11/2015 at 2:27 P.M., the Assistant Director of Plant Operations indicated that the facility tried to check water temperatures every day and that he would be turning down the temperature immediately.</p> <p>During an interview on 08/11/2015 at 3:31 P.M. and 4:15 P.M., the Plant Operations Support indicated there had been no water temperatures recorded in the last 60 days. He further indicated that, during his last visit in June of 2015, he had suggested to Plant Operations that they keep up with their water temperature logs, but that he had not been back since that visit to ensure this was being done.</p> <p>During an interview on 08/11/2015 at 4:21 P.M., the Administrator indicated that the most recent water temperature</p>		<p>temperatures remained within range on 8/11/15. Logging of the water temperatures was initiated immediately, none have been out of range since initial occurrence. Residents in the remaining resident rooms had the potential to be affected by the practice. ED immediately inserviced Plant Operations team regarding water temperature range and logging water temperatures daily. Director of Plant Operations will log water temperatures daily and report in morning meeting 5 times per week ongoing. ED will visually review the water temperature entry 5 x per week during morning meeting to insure ongoing compliance. The divisional support for plan operations will review the water temperature log during campus visits. Water temperatures will be summarized and presented to the QA meeting on a monthly basis for review on an ongoing basis. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective.</p>		

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F 0353 SS=D Bldg. 00	<p>logs they could locate were from 09/22/2014. She further indicated that the facility policy is to take daily water temperatures and to follow the state guidelines.</p> <p>The most recent water temperature logs were provided by the Administrator on 08/11/2015 at 4:21 P.M. and dated 09/22/2014, 09/15/2014, 09/08/2014, and 09/01/2014.</p> <p>The facility policy, titled "Health Facilities; Licensing and Operational Standards", was provided and indicated as current by the Clinical Nurse Support on 08/22/2015 at 4:49 P.M. The policy indicated, "...The water temperature at the point of use must be maintained between: (1) one hundred (100) degrees Fahrenheit; and (2) one hundred twenty (120) degrees Fahrenheit ..."</p> <p>3.19(r)(1)(2)</p> <p>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</p>			

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	<p>physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to ensure sufficient staff were available to answer call lights in a timely manner, provide daily ADL (activities of daily living) assistance, and maintain a clean environment for 5 of 8 residents interviewed (Resident #150, #151, #152, #153, #154), 1 of 3 family members interviewed (Resident #155) and 5 of 6 staff interviewed (Staff #6, Staff #5, Staff #7, Staff #8, Staff #9).</p> <p>Findings include:</p> <p>During a confidential interview on 08/11/2015 at 2:32 P.M., Resident #150 indicated sometimes having to wait a long time for his/her call light to be</p>	F 0353	Resident # 150, # 151, #152, #153, #154, #155 have been interviewed by DHS, ADHS, Director of Environmental Services, and Social Services to verify their rooms, including bathrooms, have been cleaned to their satisfaction, as well as their bathing needs are being met and call lights are being answered timely in order to met their personal care needs. Daily staffing is reviewed everyday to ensure coverage is adequate to provide the needs of the residents. All residents have the potential to be affected by the practice. The campus has a specific call-in procedure and call offs are replaced on the daily schedule. The campus has recently place a full time employee in the scheduling	09/14/2015			

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	<p>answered, up to half an hour. The resident further indicated it is usually slow at night because there are only two aides for the whole building.</p> <p>During a confidential interview on 08/11/2015 at 11:08 A.M., Resident #151 indicated having to wait half an hour for assistance at times. The resident further indicated he/she has to wait longer when medications are being given out on day shift.</p> <p>During a confidential interview on 08/11/2015 at 1:41 P.M., Resident #152 indicated when calling for assistance, sometimes staff members do not respond. The resident further indicated he/she has to wait for a bath and at times doesn't receive one. Resident #152 indicated that staff questioned the resident when he/she requested a bath, asking "what for?", to which the resident responded, "because I stink". During an observation of the resident on 08/13/2015 at 10:10 A.M., the resident's hair appeared uncombed and small pieces of food particles were on his/her face and neck.</p> <p>During a confidential interview and observation on 08/12/2015 at 10:59 A.M., Resident #153 indicated staff members will turn off his/her call light, but help will not be given. The resident</p>		<p>position. All Staff were re-educated on the guideline for answering call lights, guidelines for providing adl assistance in regard to bathing and toileting by the DHS and ADHS. All remaining interviewable dependent residents in the campus were interviewed by Social Services, DHS, and ADHS to verify their needs are being met in regard to their call lights being answered timely, bathing, and toileting needs. Review of Call lights, room cleanliness, bathing and toileting needs will be topics in resident council meetings to insure that issues are being identified and addressed timely. The staffing will be reviewed by the Executive Director and Director of Health Services daily. Sufficient staffing will be verified by administration daily ongoing. The campus will continue to have an on call to fill in when a staff member is unable to fulfill their work schedule. If the staffing level is determined to be insufficient the on call staff member will be notified. In the instance the on call employee is unavailable, nursing administration will be responsible to insure adequate staffing numbers to meet residents needs.</p>	

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	<p>further indicated he/she has had to bag his/her own trash and had to ask for his/her carpet to be vacuumed. Resident #153 also indicated the toilet had a dirty ring at the water level and the bathroom sink needed to be wiped clean. The bathroom floor tiles were observed to be dirty with black grime and the white grout was black in areas. There was a thick layer of dust observed on the television and the television stand.</p> <p>During a confidential interview on 08/11/2015 at 2:36 P.M., Resident #154 indicated he/she had an accident with incontinence while waiting for assistance. The resident further indicated that at meal times, staff are more busy and the residents have to wait longer for help.</p> <p>During a confidential interview on 08/12/2015 at 11:31 A.M., Resident #155's family member indicated there was not enough staff to complete bathing and that laundry had been left on the floor for three days before. The family member further indicated that he/she had to change the resident themselves before because staff were too busy. During an observation on 08/13/2015 at 3:15 P.M., Resident #155 was sitting in the dining area and a sweaty body odor was noted.</p> <p>During a confidential interview on</p>				

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	<p>08/13/2015 at 2:27 P.M., Staff #5 indicated that the facility as a whole was definitely understaffed, especially the housekeeping department. During an observation on 08/18/2015 at 10:56 A.M., the housekeeper for Legacy Lane was pulled to the main building due to being short on housekeepers, which left Legacy Lane with no housekeeper.</p> <p>During a confidential interview on 08/13/2015 at 08:48 P.M., Staff #6 indicated that staff had been asked to work 16 to 24 hour shifts with no help. Staff #6 further indicated that nurses have 27 to 28 residents each and don't get to leave work until several hours after their shift is over.</p> <p>During a confidential interview on 08/13/2015 at 9:02 P.M., Staff #7 indicated there are 28 residents on the hall, three of which required a hooyer lift and one which required a stand up lift, with only 2 staff to assist them. The CRCA's are responsible for giving five showers every day on every shift. Staff #7 further indicated residents have to wait if they want to go to bed or get their medications.</p> <p>During a confidential interview on 08/13/2015 at 9:07 P.M., Staff #8 indicated sometimes it is hard to get</p>				

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F 0371 SS=E Bldg. 00	<p>medications passed on time and more staff would benefit the residents.</p> <p>During a confidential interview on 08/13/2015 at 9:13 P.M., Staff #9 indicated during meal times some residents have to wait longer than normal to get assistance.</p> <p>During a confidential interview with on 08/13/2015 at 3:04 P.M., Staff #11 indicated the staff could use more help and that it was difficult to monitor all the residents with the staff they had.</p> <p>This Federal tag relates to the Investigation of Complaint IN00177192.</p> <p>3.1-17(a)</p> <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 (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure</p>	F 0371	Main kitchen shelves and floor under center work tables were clean immediately by Dining	09/14/2015			

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	<p>food was stored and served under sanitary conditions, related to condensation in the freezer, scoop and cups in dry bulk goods, crumbs on shelving, food particles on the floor and hands free garbage can for hand washing paper towels for 4 of 4 kitchen observations. (Main Kitchen and Legacy Lane Kitchen)</p> <p>Findings include:</p> <p>During the initial kitchen tour of the Main Kitchen, conducted on 08/11/2015 at 11:22 A.M. with the KM (Kitchen Manager), the following was observed.</p> <ol style="list-style-type: none"> 1. In the walk in freezer a pipe in the back of the freezer had an icicle measuring three inches in diameter at the top, ending in a point and measuring 13 inches in length. 2. The kitchen shelves located by the oven, contained pans and were speckled with food crumbs. 3. The floor under the two center work tables had multiple brown crumbs and white powder patches. <p>During the initial kitchen tour of the Legacy Lane kitchen, conducted on 08/11/2015 at 11:26 A.M. with the KM,</p>		<p>Services team members. The observed dented can was removed from the shelf immediately by DFS on 8/11/15. Legacy kitchen scoop in brown sugar container and cup in flour container were discarded. Garbage cans with hands-free foot pedals were purchased and placed in the Legacy Kitchen by the sinks. The walk in freezer in the main kitchen was serviced by a contractor and the pipe causing the ice formation was reinsulated. Dietary Manager implemented routine cleaning schedule to specify indicated areas to include. All dietary staff were re-educated by the Dietary manager on the policy and procedure for Storage Procedures and Cleaning Schedules. ED will conduct audits of kitchens 2 x per week for 4 weeks, then weekly x 4 weeks, then monthly ongoing until substantial compliance is achieved, then quarterly thereafter to insure ongoing compliance. Dining Support for the Division will conduct follow up audits of the kitchens during routine campus visits. Results of the audits will be presented by the dietary manager on a monthly ongoing basis to the QA committee for review and recommendations. the compliance department will attend the next 3 months of QA meetings to review audits and</p>	

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	<p>the following was observed:</p> <p>4. In the dry storage bins, a scoop was noted laying directly on the brown sugar and a cup was laying directly on the flour.</p> <p>5. The garbage can did not have a foot pedal for hands-free opening.</p> <p>A follow-up tour of the Main Kitchen was conducted on 08/14/2015 at 2:09 P.M. with the KM and the following was observed:</p> <p>6. In the walk-in freezer a pipe in the back of the freezer had an icicle measuring three inches in diameter at the top, ending in a point and measuring 13 inches in length.</p> <p>7. A dented can, labeled "three beans", received on 05/13/2015, and a dented can labeled "cream style corn", received on 07/11/2015, were noted in the dry storage area, canned goods rack, with dents observed on the sides and rims.</p> <p>During an interview on 08/14/2015 at 2:11 P.M., the KM indicated dented cans should not be on the canned goods rack. The KM indicated all dented cans should be placed on the corner bottom rack for return and should not be used.</p>		<p>recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective.</p>	

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	<p>A follow-up tour of the Legacy Kitchen was conducted on 08/14/2015 at 2:19 P.M. with the KM and the following was observed:</p> <p>8. In the dry storage bins, a scoop was noted laying directly on the brown sugar and a cup was laying directly on the flour.</p> <p>9. There were no trash cans with foot pedals located by either sink in the Legacy kitchen for towels to be disposed after hand washing. There was one large trash can, with the lid closed, located by the three compartment sink.</p> <p>During an observation on 8/14/2015 at 2:20 P.M., the KM entered the Legacy Kitchen, washed his hands and then lifted the lid of the closed large trash can with his bare hand to dispose of the paper towel he had just used to dry his hands.</p> <p>The current policy titled, "Storage Procedures", dated 2009, was provided by the Administrator on 08/17/2015 at 2:53 P.M. The policy indicated, "...Frozen food equipment is routinely cleaned and defrosted and free from garbage and other waste... do not use... any can that is dented, rusted, leaking or bulging... scoops are stored separately in</p>			

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F 0428 SS=D Bldg. 00	<p>a covered, protected area, which are washed and sanitized at least weekly..."</p> <p>The current "Cleaning Schedules" policy, dated 2009, was provided by the Administrator on 08/17/2015 at 2:53 P.M. The policy indicated, "...Detailed routine cleaning procedures are followed... counters are cleaned after each use, floors are cleaned daily, and freezers are cleaned monthly..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure that a</p>	F 0428	Residents #40 and #47's will receive a medication regimen	09/14/2015	

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	<p>medication regimen review was completed monthly for 2 of 5 residents reviewed for unnecessary medications. (Resident #40 and #47)</p> <p>Findings include:</p> <p>During an interview on 08/14/2015 at 2:48 P.M., RPH (Registered Pharmacist) #10 indicated a pharmacist comes to the facility monthly. She further indicated a resident who was admitted in May would be included on the schedule for medication review in June.</p> <p>During an interview on 08/17/2015 at 12:23 P.M., the DON (Director of Nursing) indicated there were no medication regimen reviews recorded for February, March, May, or June of 2015 for Resident #47. She also indicated there was no medication regimen review recorded for June of 2015 for Resident #40, but one should have been done because the resident was admitted before the June review was completed. During a follow-up interview on the same date, the DON indicated their current pharmacist could not find any further medication regimen reviews for Resident #40 and Resident #47.</p> <p>Clinical record review for Resident #47 was conducted on 08/14/2015 at 1:00</p>		<p>review by the pharmacist by 9/14/2015. All residents had the potential to be affected. All remaining residents drug regimens will be reviewed and any residents identified as needing an updated drug regimen review will be evaluated by the consulting pharmacist. Clinical Support inserviced Director of Health Services regarding medication regimen review regulation guidelines. DHS will monitor Pharmacy consultant visits to insure routine monthly visits are timely and the medication regimen reviews are conducted in a timely manner. The pharmacy consultant will provide a report of all residents reviewed during each visit to the DHS. DHS will monitor the pharmacy consultant report to ensure resident medications are review within specified guidelines monthly ongoing. The results will be reported to the QA committee on a monthly ongoing basis for review and recommendations to ensure compliance. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective.</p>		

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	<p>P.M. The "Medication Regimen Review" sheets indicated a review was completed on 12/16/2014, 01/14/2015, 04/12/2015, and 07/13/2015. There were no medication regimen reviews recorded for the months of February, March, May, or June of 2015.</p> <p>Clinical record review for Resident #40 was conducted on 08/14/15 at 9:46 A.M. The "Medication Regimen Review" sheet for the resident indicated that a review was completed on 07/13/2015. There was no medication regimen review for June, 2015.</p> <p>The documents titled, "Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations", were provided by the DON on 08/17/2015 at 12:16 P.M. for January thru June of 2015. Resident #47 and Resident #40 were not listed as reviewed on these documents.</p> <p>The current facility policy, titled "Consultant Pharmacist Reports" and dated 02/01/2010, was provided by the Clinical Support Nurse on 08/18/2015 at 5:00 P.M. and reviewed at that time. The policy indicated, "...The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly ..."</p>						

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F 0431 SS=D Bldg. 00	<p>3.2-25(h)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>			

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	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were labeled properly and failed to ensure expired or discontinued medications were disposed of properly for 2 of 4 halls reviewed. (Tanner Trail & Dearborn Drive)</p> <p>Findings include:</p> <p>An observation and record review of the Tanner Trail medication cart was conducted with LPN (Licensed Practical Nurse) #1 on 08/17/2015 at 1:24 P.M. The following was observed:</p> <p>1. Levalbuterol HCl 1.25/3 ml for Resident #66 was dated as received on 07/26/2015 and had no open date on the opened inner foil package or the box. LPN #1 indicated that the medication was only good for 7 days after the foil package was opened.</p> <p>2. Symbicort 160/4.5 for Resident #43 was dated as opened on 07/04/2015 and expired on 08/04/2015. The current MAR (Medication Administration Record) indicated that Resident #43 had last received the medication on 08/17/2015 in</p>	F 0431	<p>Medications for residents #66- Levalbuterol HCL 1.25/3ml was discarded and a replacement order completed.</p> <p>Resident #43,- Symbicort 160/4.5 and Artificial Tears eye drops were discarded and a replacement order completed.</p> <p>Resident#23, - Ear Drops 6.5% were removed from the MAR as they were completed on 8/11/15.</p> <p>Resident #124 - Artificial Tears were discarded and a replacement order sent.</p> <p>Resident #29, - Ear drops 6.5% was discarded and removed from the MAR, as this medication had been discontinued. Resident #9 - Travatan 0.004% eye drops was discarded and a replacement ordered. Resident #69 - Travatan 0.004% eye drops were discarded and a replacement ordered. All residents has the potential to be affected.</p> <p>Pharmacy completed a review of all medication rooms, carts and treatment carts on 8/25/2015. DHS will inservice nursing team members by 9/10/2015 regarding proper medication storage/expiration of medications.</p> <p>DHS in conjunction with pharmacy will audit all medication rooms, carts and treatment carts for proper labeling, expired medications and discharge</p>	09/14/2015	

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	<p>the morning.</p> <p>3. Artificial Tears eye drops for Resident #43 was dated as received on 07/11/2014 and had no open date. LPN #1 indicated Artificial Tears expire six weeks after being opened.</p> <p>4. Ear Drops 6.5% for Resident #23 were indicated as completed [no longer in use] on 08/11/2015 in the current MAR.</p> <p>5. Artificial Tears eye drops for Resident #124 was dated as opened on 10/18/2014. LPN #1 indicated Artificial Tears expire six weeks after being opened.</p> <p>6. Ear Drops 6.5% for Resident #29 was dated as received on 06/25/2015 and had no open date. The current MAR indicated this medication was discontinued on 07/01/2015 and was last given on that date.</p> <p>An observation and record review of the Dearborn Drive medication cart was conducted with LPN #2 on 08/17/2015 at 1:48 P.M. The following was observed:</p> <p>7. Travatan 0.004% Eye Drops for Resident #9 was dated as opened on 07/05/2015. The current MAR indicated that Resident #9 had last received the medication on 08/16/2015.</p>		<p>resident medications 2x weekly for 4 months. A minimum of 3 medication and treatment carts will be randomly audited by pharmacy consultant and DHS/ADHS on a monthly basis ongoing to insure compliance. The results of the audits will be presented to the QA committee for further review and recommendations as indicated. the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective</p>		

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	<p>8. Travatan 0.004% Eye Drop for Resident #69 was dated as opened on 05/03/2015. The current MAR indicated that Resident #69 had last received the medication on 08/16/2015.</p> <p>During an interview on 08/17/2015 at 2:51 P.M., LPN #3 indicated that expired medications are destroyed and discontinued medications are either destroyed or returned to the pharmacy.</p> <p>The current facility policy, titled "Ophthalmic Solutions and Ointments", dated June, 2012, was provided by the DON (Director of Nursing) on 08/17/2015 at 2:28 P.M. and reviewed at that time. The policy indicated, "...Most ophthalmics expire 6 months after opened...Except: Travatan...expire 6 weeks after opened..."</p> <p>The current medication storage policy, titled "Medication Storage in the Facility", dated 02/01/2010, was provided by the DON on 08/17/2015 at 2:45 P.M. and reviewed at that time. The policy indicated, "...Outdated, contaminated, or deteriorated medications...are immediately removed from stock, disposed of according to procedures for medication disposal..."</p>			

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F 0441 SS=E Bldg. 00	<p>3.1-25(j) 3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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</p>			

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	<p>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 and standards were maintained related to, hand washing, wound care, linens, equipment, intravenous access removal, and isolation precautions for 3 of 4 observations of isolation rooms, 1 of 1 observations of intravenous access removal and 1 of 2 observations of wound care. (Residents #23, #46, #66 and #155)</p> <p>Findings include:</p> <p>1. During an observation on 08/13/2015 at 2:10 P.M., HSK (Housekeeper) #5 entered resident #46's room, which was an isolation room, without washing her hands or donning gloves beforehand. The housekeeper then picked up the resident's lunch tray and carried the tray to the meal tray cart in the hallway. HSK #5 then went to assist Resident #66 until the nurse could get there. The housekeeper went into Resident #66's room, retrieved his walker, and opened the walker for the resident, rubbed the residents back, then walked back into Resident #46's isolation</p>	F 0441	<p>Resident # 66 IV site was reassessed and there are no signs or symptoms of infection. Resident #155 wound was re assessed by DHS and no signs or symptoms of infection were noted and wound is healing in a timely fashion. Resident # 23 was assessed and has not exhibited any signs or symptoms of infection. Resident # 46 has been assessed and has not incurred any additional infections or worsening of current infection and continues in contact isolation. All residents had the potential to be affected. DHS immediately began inservicing for all nursing and housekeeping employees, regarding infection control policy and procedure protocols specifically regarding handwashing, linen guidelines, wound care and isolation protocols. Inservicing of team members will be completed by 9/10/2015. DHS/ADHS will audit infection control related to isolation protocols through observations of room tray delivery 2x per week for 4 weeks x2 months, then monthly x 4 months, then quarterly thereafter to insure ongoing compliance. DHS will observe wound care</p>	09/14/2015

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	<p>room. HSK #5 collected a cup and cloth napkin, which she placed in the meal tray cart. The housekeeper then used hand gel. Hand sanitization or hand washing were not observed prior to this occurrence.</p> <p>During an interview on 08/13/2015 at 2:17 P.M., HSK # 5 indicated that anytime staff enter an isolation room, they should use soap and water or sanitize their hands with gel and wear gloves.</p> <p>During an interview on 08/17/2015 at 1:53 P.M., the DON (Director of Nursing) indicated she monitors the infections that occur through out the facility.</p> <p>2. During an observation on 08/14/2015 at 1:09 P.M., CRCA (Certified Resident Care Assistant) #15 walked into Resident #46's room, picked up a meal tray and cover laying on the resident's bed, and carried these items to the meal tray cart. Without washing or sanitizing her hands, CRCA #15 entered Resident #23's room where she assisted the resident off the toilet. CRCA #15 then placed Resident #23's knee divider between her legs. After assisting the resident to the general resident area, CRCA #15 returned to Resident #46's room without washing or sanitizing her hands. Gloves were not</p>		<p>procedures 2 times weekly for 2 months, then monthly x 4 months then quarterly thereafter. DHS will observe team members handwashing practices to ensure compliance on varying shifts 4x weekly for 2 months, then monthly x 4 months then quarterly thereafter. Results will be presented to the QA committee for further review and further recommendations as indicated. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective.</p>		

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	<p>observed to be worn during any part of this observation.</p> <p>During an interview on 08/14/2015 at 1:12 P.M., LPN (Licensed Practical Nurse) #1 indicated Resident #46 was in contact isolation for MRSA (Methicillin-Resistant Staphylococcus Aureus) in his left foot and he would stay in isolation until the facility had confirmation that the resident was no longer contagious.</p> <p>3. During an observation on 08/14/2015 at 1:19 P.M., HSK #5 walked out of Resident #46's room with bagged, soiled laundry. The housekeeper was not wearing gloves. HSK #5 then walked back into the resident's room carrying a rag and bottle of cleaning solution. After using the rag, it was placed back into the cleaning cart. The housekeeper then took the vacuum cleaner and broom into Resident #46's room to clean. After use, neither the vacuum cleaner nor the broom were wiped off. Hands were not washed or sanitized and gloves were not worn at any point during this observation.</p> <p>4. During an observation on 08/14/2015 at 1:29 P.M., LPN #1 gathered supplies from the supply room, retrieved Resident #66 from the pool table area, and returned the resident to his room. LPN #1</p>			

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	<p>then lifted the resident's sleeve, opened the 4x4 gauze dressing package, and donned gloves without washing her hands. The LPN then removed tape from around the resident's IV (intravenous) line and proceeded to remove the IV. LPN #1 removed her gloves, placed the removed IV hub into her used gloves and placed it in her jacket pocket, applied a Band-Aid to the resident's arm with her bare hands, and cleaned up the soiled items in her work area, also with bare hands. LPN #1 washed her hands before leaving the room. At 1:39 P.M., LPN #1 removed the soiled gloves containing the removed IV hub out of her jacket pocket, walked into the medication preparation room, and disposed of the gloves with the IV line inside. LPN #1 returned to the nurse's station and began working on paperwork in the "Treatment Book". LPN #1 did not wash her hands after disposing of the soiled gloves.</p> <p>5. An observation of Resident #155's dressing change was conducted on 08/17/2015 at 3:08 P.M. LPN (Licensed Practical Nurse) #3 filled a wash basin with an inch of tap water and placed two wash cloths into the basin with her bare hands. She then donned gloves, removed the soiled dressing from the resident's hand by cutting through it with her scissors, and laid the scissors on the</p>			

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	<p>resident's bed. The dressing was stained with a two inch in diameter red blotch with a ¼ inch border of yellow. LPN #3 removed gloves and, with bare hands, cleansed the wound with the soapy wash cloth, held the resident's hand over the basin and squeezed water from the second wash cloth over her hand and patted the hand dry with a third, dry wash cloth. LPN #3 then donned gloves and indicated it was too late and she should have had gloves on prior, the LPN opened the dressing (Adaptic), cut it to size with the scissors laying on the bed, placed it directly on the wound, placed the scissors back on the bed, wrapped the wound with gauze, removed gloves, taped the gauze dressing, left the room to look for supplies, returned to the room with an Ace wrap, and, with bare hands, wrapped the resident's hand. LPN #3 placed the scissors back in her pocket, rinsed the pan in the sink, wrung out the wash cloths, and carried the wash cloths down the hall to the soiled linen closet with bare hands. Hands and scissors were neither washed, or sanitized throughout the procedure.</p> <p>During an interview on 08/17/2015 at 3:27 P.M., LPN #3 indicated she should not have removed her gloves and should have left them on for the entire procedure. She further indicated she had</p>			

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F 0465 SS=E Bldg. 00	<p>gotten a new wash basin prior to the procedure.</p> <p>The "Guideline for Handwashing/Hand Hygiene" policy was provided by the Administrator on 08/17/2015 at 2:53 P.M. and identified as current. The policy indicated, "...Health Care Workers shall wash their hands ...Before/after preparing/serving meals ...Before/after having direct physical contact with residents ...After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc... After touching infective secretions or materials contaminated by them ..."</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review the facility failed to maintain a functional, safe and sanitary</p>	F 0465	Resident # 153's room was thoroughly cleaned. Resident # 40's room was thoroughly cleaned. Resident # 71's room	09/14/2015

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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025		
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	<p>environment for the residents as evidenced by dirty bathrooms, dusty furniture and strong urine odor for 4 of 4 units observed and a dirty wheel chair in the front lobby.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation and interview with Resident #153 on 08/12/2015 at 10:45 A.M., the resident's bathroom tiles were dirty with dark streaks, water spots and the white grout was black in areas. There was a thick layer of dust observed on the television and the television stand. Resident #153 indicated at times he/she had to bag his/her own trash and had to ask to have the carpet vacuumed. The resident also indicated the toilet frequently had a dirty ring at the water level as well as the sink needed to be wiped clean. 2. During an interview, on 08/12/2015 at 11:04 A.M., Resident #40 indicated the facility was not clean. The resident further indicated the housekeepers don't dust. During an observation at this same time, there was a layer of dust observed on the television. 3. During an observation, on 08/12/2015 at 11:48 A.M., Resident #71's bathroom floor tiles were dirty with dark streaks 		<p>including the bathroom has been thoroughly cleaned. Resident # 22's room has been thoroughly cleaned Resident # 47 and room 705 has been thoroughly cleaned and the mattress has been replaced. ED immediately inserviced Environmental Services Director regarding standard of cleanliness in resident rooms and bathrooms. ESD or housekeeping team members assigned to clean all resident bathrooms immediately. All residents had the potential to be affected. ED will inservice housekeeping team members regarding job description and necessity for attention to resident bathrooms by 9/10/2015. ED re-educated on room cleaning schedules and room cleaning guidelines. ED will interview a minimum of 5 residents and conduct room observation /bathrooms for cleanliness weekly x8 and monthly x2 months then quarterly thereafter to insure ongoing compliance. Any concerns will be addressed through the resident concern process and corrected.</p> <p>The results of the interviews and room audits will be presented to the QA committee for further review and recommendations as indicated. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED,</p>		

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	<p>and the white grout was black in areas.</p> <p>4. During a family interview, on 08/12/2015 at 3:48 P.M., the Power of Attorney (POA) for Resident #22 indicated she didn't feel like the housekeepers dusted or cleaned the rooms well.</p> <p>5. During three observations from 08/12/2015 to 08/18/2015, there was a strong urine odor in room #705 on Legacy Lane. During an interview, on 08/18/2015 at 10:43 A.M., Certified Resident Care Assistant (CRCA) #13 and CRCA #14 indicated the strong urine odor was coming from the mattress of Resident #47. The CRCA's indicated the bed is changed daily. A mattress cover had been used in the past, the odor remains. They also indicated the housekeepers don't do anything to help the odor other than general cleaning. On 08/18/2015 the housekeeper for Legacy Lane was moved to the health care building due to a shortage of housekeepers in that building.</p> <p>During an interview, on 08/18/2015 at 2:57 P.M., the Director of Plant Operations indicated the facility currently doesn't have a housekeeping supervisor and he is "filling the role" at this time. The Director of Plant Operations</p>		DHS and Committee members to insure the QA process is thorough and effective.				

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	<p>indicated the housekeepers are to deep clean two rooms on each hall daily, in addition to the routine cleaning that is done each day.</p> <p>6. On 08/11/2015 at 4:00 P.M., an observation was made of a wheelchair sitting by the front door of the facility with dried spaghetti from lunch in the seat of chair. There was also a personal alarm on the back of the chair.</p> <p>On 08/11/2015 at 4:30 P.M., another observation was made of the same wheelchair in the same condition by the front door.</p> <p>On 08/12/2015, the wheelchair with the spaghetti in the seat and personal alarm attached was observed by the front door at 8:51 A.M., 9:33 A.M., 11:24 A.M., and at 4:55 P.M.</p> <p>On 08/13/2015 at 8:32 A.M., the same wheelchair remained by the front door. During an interview with the Business Office Manager (BOM) at this time, she indicated she didn't know who the wheelchair belonged to. The BOM transported the dirty wheelchair away from the front door and took it to the soiled utility room on the 200 hall.</p> <p>During an interview, on 08/13/2015 at</p>			

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F 0516 SS=D Bldg. 00	<p>10:05 A.M., the Administrator indicated Resident #17 had been discharged on 08/11/2015 and the wheelchair "most likely" had been used by him.</p> <p>3.1-19(f)</p> <p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation, interview and record review, the facility failed to maintain the confidentiality of personal, resident-identifiable information for 1 of 1 confidential documents viewed.</p> <p>Findings include:</p> <p>During an observation on 08/11/2015 at</p>	F 0516	Resident #77's informations was immediately removed from public view. All other residents had the potential to be affected by the practice. DHS will inservice team members regarding resident information privacy practices by 9/10/2015. DHS will audit through observation of nursing stations resident information privacy practices 3x per week x2 months then quarterly thereafter to insure ongoing compliance.	09/14/2015

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	<p>11:21 A.M., the Wilson's Way chart cart was left beside the nurses station, instead of behind it. Lying on top of the cart was a resident information sheet for Resident #77, which included the resident's full name, address, insurance information, and social security number.</p> <p>During an interview on 08/11/2015 at 1:58 P.M., CRCA (Certified Resident Care Assistant) #4 indicated if a piece of paper had resident information on it, it should be kept flipped over. It would never be appropriate to leave a page with resident information face up where anyone can see the information.</p> <p>The current facility policy, titled "Resident Confidentiality Agreement", dated 03/01/2012, was provided by the Clinical Support Nurse on 08/18/2015 at 8:45 A.M. and reviewed on 08/18/2015 at 5:00 P.M. This policy indicated, "...Confidentiality of resident's hospitalization, history and behavior will be maintained at all times ...It is the obligation of each employee to protect the confidentiality of any private information which the employee may</p>		<p>The results of the audits will be presented to the QA committee for further review and recommendations if indicated. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective</p>				

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F 0520 SS=E Bldg. 00	<p>acquire from a resident, or from any source about a resident ..."</p> <p>3.1-50(d) 3.1-50(e)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to identify concerns and successfully</p>	F 0520	It is is the mission of this facility's Quality Assessment and Assurrance committe to develop and implement a plan of	09/14/2015

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	<p>implement a plan of action to address hand washing, water temperatures, medication storage and charting for bathing and behaviors. This deficient practice had the potential to impact 67 of 67 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During an observation on 08/13/2015 at 2:10 P.M., HSK (Housekeeper) #5 entered Resident #46's room, which was an isolation room, without washing her hands or donning gloves beforehand. The housekeeper then picked up the resident's lunch tray and carried the tray to the meal tray cart in the hallway. HSK #5 then went to assist Resident #66 until the nurse could get there. The housekeeper went into Resident #66's room, retrieved his walker, and opened the walker for the resident. After this, HSK #5 rubbed Resident #66's back then walked back into Resident #46's isolation room and collected a cup and cloth napkin, which she placed in the meal tray cart. The housekeeper then used hand gel. Hand sanitization or hand washing were not observed prior to this occurrence.</p> <p>During an interview on 08/13/2015 at 2:17 P.M., HSK # 5 indicated that anytime staff enter an isolation room, they should use soap and water or</p>		<p>action to assure the facility provides accepted standards of clinical practice to assure the campus has proper medication storage, acceptable water temperature, proper handwashing technique, and charting according to acceptable documentaion regulations. The QA meetings will be scheduled weekly x 2 months then monthly ongoing. These meeting will include the DHS, ED, Medical Director/ ARNP and 3 other team members. All residents have the potential to be affected by the deficient practice. The ED, and DHS were inserviced by the Director of compliance on the regulatory requirements of a QA committee with an emphasis of a thorough QA meeting. The focus of the next 6 months of QA meeting will be on medication administration as well as any other opportunities noted by the committee. A member of the compliance and or clinical support department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective</p>		

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	<p>sanitize their hands with gel and wear gloves.</p> <p>During an interview on 08/17/2015 at 1:53 P.M., the DON (Director of Nursing) indicated she monitors the infections that occur through out the facility.</p> <p>2. During an observation with the Assistant Director of Plant Operations, on 08/11/2015 at 2:22 P.M., the following water temperatures were recorded:</p> <p>Room 311 was 125° Fahrenheit (F) Room 315 was 124.6°F Room 301 was 123.7°F Room 202 was 124.5°F Room 103 was 121.5°F</p> <p>During an interview on 08/11/2015 at 2:27 P.M., the Assistant Director of Plant Operations indicated that they tried to check water temperatures every day and that he would be turning down the temperature immediately.</p> <p>During an interview on 08/11/2015 at 3:31 P.M. and 4:15 P.M., the Plant Operations Support indicated there had been no water temperatures recorded in the last 60 days. He further indicated that, during his last visit in June of 2015, he</p>			

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	<p>had suggested to Plant Operations that they keep up with their water temperature logs, but that he had not been back since that visit to ensure this was being done.</p> <p>During an interview on 08/11/2015 at 4:21 P.M., the Administrator indicated that the most recent water temperature logs they could locate were from 09/22/2014. She further indicated that the facility policy is to take daily water temperatures and to follow the state guidelines.</p> <p>The most recent water temperature logs were provided by the Administrator on 08/11/2015 at 4:21 P.M. and dated 09/22/2014, 09/15/2014, 09/08/2014, and 09/01/2014.</p> <p>3. An observation and record review of the Tanner Trail medication cart was conducted with LPN (Licensed Practical Nurse) #1 on 08/17/2015 at 1:24 P.M. Six medications were found to be expired on this medication cart. An observation and record review of the Dearborn Drive medication cart was conducted with LPN #2 on 08/17/2015 at 1:48 P.M. There were two expired medications on this cart.</p> <p>During an interview on 08/17/2015 at 2:51 P.M., LPN #3 indicated that expired</p>			

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	<p>medications are destroyed and discontinued medications are either destroyed or returned to the pharmacy.</p> <p>4. Review of Resident #155's "Bathing Type Chart", provided by the Director of Nursing (DON) on 08/13/2015 at 4:10 P.M., indicated Resident #155 did not receive the scheduled showers on 07/21/2015 and 08/07/2015. No partial baths or refusals were documented on the "Bathing Type Chart or the CNA Bath/Shower Skin Check Sheets".</p> <p>Review of the Clinical Record on 08/13/2015 at 2:36 P.M. indicated Resident #155 was care planned to be showered at least two times a week and bathed on all other days. The resident was to be showered on Tuesdays and Fridays.</p> <p>In the Quality Assessment and Assurance meeting, the DON (Director of Nursing) and the Administrator described the most common issues they have been dealing with and what their plan of action has been to correct those issues. Despite the attempts to correct the aforementioned issues, the facility's plan has not been effective, as evidenced by continuing deficiencies in the areas of hand washing, water temperatures, medication storage, and charting.</p>			

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R 0000 Bldg. 00	3.1-52(b)(2) This visit was for a State Residential Licensure Survey. Residential Census: 52 Sample: 8 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents.			

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	<p>Based on observation, interview and record review, the facility failed to ensure medications kept in resident rooms for self-administration were stored appropriately in locked compartments for 2 of 2 residents reviewed for self-administration of medications. (Resident #2 and #8)</p> <p>Findings include:</p> <p>During an observation on 08/18/2015 at 2:30 P.M., Resident #2 had Levemir and Novolog insulin pens laying on a table in her room. The resident indicated she does not lock up her medications.</p> <p>During an interview on 08/18/2015 at 2:32 P.M., Resident #8 indicated she keeps her medication in the cabinet above the kitchen sink. Resident #8 further indicated she has a drawer that can be locked to keep them in, but that she does not use that drawer.</p> <p>During an interview on 08/18/2015 at 4:01 P.M., LPN (Licensed Practical Nurse) #1 indicated the medications that residents keep in their room should be</p>	R 0295	<p>Resident #2's medications were immediately secured in a locking device. DHS inserviced all nursing team members regarding need to ensure residents who self administer medications are secured in a locking device. DHS will educate residents who self administer medications of need to ensure medications are storage in a locked device by 9/10/2015. DHS will educate nursing team members regarding need for medications for resident who self administer medications to be secure in a locking device by 9/10/2015. DHS will audit rooms of those residents who self administer medications to ensure medications are stored properly in a locking device 3x per week for 2 months then every 6 months thereafter to insure ongoing compliance. The audits will be presented to the QA committee for further recommendations. A member of the compliance department will attend the next 3 months of QA meetings to review audits and recommendations with the ED, DHS and Committee members to insure the QA process is thorough and effective</p>	09/14/2015			

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	<p>locked in a lockbox.</p> <p>During an interview on 08/18/2015 at 4:03 P.M., the DON (Director of Nursing) indicated medications kept in a resident's room for self-administration should be locked in the bedside table or in a lockbox in the resident's room.</p> <p>The current facility policy, titled "Guidelines for Self Administration [sic] of Medications", dated December 2011, was provided by the Administrator on 08/18/2015 at 3:42 P.M. and reviewed at that time. The policy indicated, "...The medication will be kept in a locked drawer in the residents' room ..."</p>			