

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/28/2013
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NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June, 20, 21, 24, 25, 26, 27, and 28, 2013</p> <p>Facility number: 000162 Provider number: 155261 AIM number: 100284300</p> <p>Survey team: Laura Brashear, RN, TC Teresa Buske, RN Mary Weyls, RN, June 20, 21, 24, and 25, 2013 Karen Hartman, RN Brenda Nunan, RN, June 21 and 24, 2013</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census Payor type: Medicare: 3 Medicaid: 45 Other: 7 Total: 55</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Williamsburg Health and Rehab that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Williamsburg Health and Rehab.	
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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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	Quality review completed on 07/02/2013 by Brenda Nunan, RN.				

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F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure appeal notices were given to residents who discharged from the facility to home and without exhaustion of their medicare coverage for 3 of 3 discharge residents reviewed discharged to home [Resident #85, Resident #86, and Resident #77].</p> <p>Findings include:</p> <p>1. Upon interview of the Administrator on 6/27/13 at 10:21 a.m., the Administrator indicated Resident #85 was discharged to home on 3/11/13 by choice of the resident. The Administrator indicated Resident #85 had not exhausted her medicare coverage days. The Administrator also indicated that an appeal notice which included the residents remaining medicare coverage days was not given to the resident upon discharge and that she was unaware the appeal notice was to be given as the resident chose to go home.</p> <p>Upon review of information provided by the Administrator on 6/28/13 at 11:10 a.m., the documentation indicated the resident had an</p>	F000156	<p>F156 – Notices of Rights, Rules, Services, Charges I. Please note that residents #85, #86, and #77 were not negatively affected as a result of the failure to provide them with Notices of Medicare Non-Coverage.II. As all residents whose stays are covered by Medicare could be affected, the following corrective action was taken:III. As a means to ensure ongoing compliance with notifying residents of their Medicare days, the facility started issuing Notices of Medicare Non-Coverage to residents when they notify the facility that they are electing to return home. Observations of the issuance of Notices of Medicare Non-Coverage shall be completed at least twice monthly to ensure continued compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Administrator or her designee.IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings.V. Evidence of two such notices are provided in Attachments A and B. Evidence of the monitoring is provided in Attachment C. Due to the</p>	07/26/2013

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	<p>anticipated 2-3 more weeks of medicare therapy coverage.</p> <p>2. Upon interview of the Administrator on 6/27/13 at 10:21 a.m., the Administrator indicated Resident #86 was discharged to home on 3/13/13 by choice of the resident. The Administrator indicated Resident #86 had not exhausted her medicare coverage days. The Administrator also indicated that an appeal notice which included the residents remaining medicare coverage days was not given to the resident upon discharge and that she was unaware the appeal notice was to be given as the resident chose to go home.</p> <p>Upon review of information provided by the Administrator on 6/28/13 at 11:10 a.m., the documentation indicated the resident had an anticipated 1-2 more weeks of medicare therapy coverage.</p> <p>3. Upon interview of the Administrator on 6/27/13 at 10:21 a.m., the Administrator indicated Resident #77 was discharged to home on 2/8/13 by choice of the resident. The Administrator indicated Resident #77 had not exhausted her medicare coverage days. The Administrator also indicated that an</p>		evidence provided, Williamsburg Health and Rehab requests paper compliance on tag F156.				

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	<p>appeal notice which inlcuded the residents remaining medicare coverage days was not given to the resident upon discharge and that she was unaware the appeal notice was to be given as the resident chose to go home.</p> <p>Upon review of information provided by the Administrator on 6/28/13 at 11:10 a.m., the documentation indicated the resident had an anticipated 4-6 more weeks of medicare therapy coverage.</p> <p>3.1-4(a)</p>				

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from physical restraints not required to treat medical symptoms for 2 of 2 random observations of residents reviewed utilizing two 1/2 siderails on the same side of the bed and/or full side rails [Residents #65 and #41].</p> <p>Findings include:</p> <p>1. On 6/24/13 at 11:45 a.m., Resident #65 was observed lying flat in bed, with the bed against the wall. Two 1/2 siderails were observed in the raised position on the side of the bed, not against the wall. The bed was a Hill-Rom bed with electronic bed controls in the upper siderail.</p> <p>On 6/27/13 at 10:40 a.m., the resident was observed in bed, with the bed against the wall, and a full siderail in the raised position on the side of the bed, not against the wall.</p> <p>On 6/21/13 at 11:09 a.m., LPN #6</p>	F000221	<p>F221 – Right To Be Free From Physical Restraints I. Residents #65 and #41 have had new side rail assessments completed. The side rails for residents #65 and #41 were changed to half rails as an enabler while still allowing them to get out of bed independently if so desired. II. In an effort to ensure the continued necessity of the use of side rails, each resident currently using side rails has been reassessed and necessary actions taken as warranted, including removal of the side rails and changes to the care plan. Any resident with a physical restraint of any type has also been reassessed for continued medical need. III. As a means to ensure ongoing compliance with ensuring residents remain free from physical restraints not required to treat the resident's medical symptoms, staff have been in-serviced of the need to continue to monitor for resident need of side rails and to document accordingly. The facility shall adhere to state rule 410 IAC 16.2-3.1-26 stating (s) "use of restraints must be reviewed by the interdisciplinary</p>	07/26/2013	

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	<p>was interviewed. The LPN indicated the resident utilized bilateral 1/2 siderails to assist with positioning. The LPN indicated the resident would not be able to get out of bed on her own.</p> <p>Resident #65's clinical record was reviewed on 6/25/13 at 12:22 p.m. The exterior cover of the resident's clinical record included a sticker noting "High Fall Risk."</p> <p>A form titled "Siderail assessment" (no date) provided by the Administrator on 6/24/13 at 12:21 p.m., included documentation in the form of a narrative which included, but was not limited to, "...12/10/12, Resident has bed with siderails which are used for positioning to promote independence. 3/9/13, Resident has bed rails which are used for positioning. Promotes Independence [sic]. 6/6/13-Resident has bed with 1/2 siderails-Continues on bed...."</p> <p>The assessment form included a checklist of 15 questions to address utilization of siderails but lacked any documentation of assessed need for and type of siderails.</p> <p>A plan of care, dated 1/10/13, reviewed on 6/27/13 at 2:15 p.m., addressed the problem of often</p>		<p>team within one (1) month after the application of the restraint, and every thirty (30) days for the first ninety (90) days of the restraints, and at least quarterly thereafter." Additionally, should a resident have a significant change in condition, review of use of siderails will be reviewed along with the completion of the assessment to ensure siderails remain appropriate for use. The outcome of the reassessment will determine if the side rails (or other physical restraint) shall be continued or discontinued (after consultation with the physician and responsible party). Monitoring for compliance will be conducted by the DON or her designee. Continued completion of the reassessments and subsequent action(s) taken will be reported to the Administrator. IV. As a mean of quality assurance, results of the aforementioned assessments and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings.V. Evidence of the in-servicing is provided in Attachment D. Evidence of the audit and subsequent monitoring is provided in Attachment E. Proof of revised side rail assessments for Resident #65 and #41 are provided in Attachment F and Attachment G, respectively. Due to the evidence provided, Williamsburg Health and Rehab requests paper compliance on</p>		

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	<p>delusional, often up and down several times each night, restless and often attempted to stand up by self when sitting in the wheelchair. The care plan indicated the resident was not safely able to walk by self, and unable to comprehend safety risk. Interventions included, but were not limited to, toileting, pain assessment, offer snack/drink, provide quiet environment, perform safety checks, administer meds, two staff offer to walk resident. A plan of care, dated 3/21/13, addressed the problem of history of falls. Interventions included, but were not limited to: "frequent reminders not to attempt to walk by myself...make sure cl [call light] within reach...maintain 1/2 rails in the up position when I am in bed...Maintain pressure pad alarm under me when in wc as well as bed to alarm if I should try to get up by self. Staff to respond to sounding alarm at once."</p> <p>Documentation on the June, 2013, recapitulation of physician's orders, included, but was not limited to: "Apply pressure pad to chair and bed for resident's safety." The Administrator was interviewed on 6/25/13 at 12:22 p.m. The Administrator indicated the resident had been placed in the Hill-Rom bed</p>		tag F221.				

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	<p>with the 1/2 siderails, for the electronic bed controls on the upper rail. The Administrator indicated the resident would not have been able to utilize the electronic controls due to cognition, and the bed had been changed to a bed with full siderails.</p> <p>Documentation was noted in a nursing note, dated 6/17/13 at 1:00 a.m., of "Res [resident] awake and yelling for 'mom.' Attempting to climb out of bed. Assisted to toilet and up in wc [wheelchair] with staff." Documentation in another note, dated 4/14/13 at 5:30 a.m., was noted of "Res made several attempts to climb out of bed over the side rail. Toileted and moved to wc in hallway...continued to attempt to stand from wheelchair since 8:00 p.m. even though res states she is tired...." A Nursing summary, dated 5/31/13-6/6/13, included, but was not limited to: "Poor safety awareness. Confused does not know date, time...attempts to transfer without assistance...severe impairment. No physical restraint."</p> <p>An annual Minimum Data Set [MDS] assessment, dated 3/9/13, coded the resident with moderately impaired cognitive ability, required minimal assistance of one for bed mobility,</p>						

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	<p>transfers and ambulation. Bed rails [restraints] not used.</p> <p>2. On 6/21/13 at 11:30 a.m., Resident #41 was observed sleeping in bed with a full siderail in the up position. The bed was positioned against the wall with the full siderail in place on the open side. The siderail was covered with sheepskin. On 6/25/13 at 12:17 p.m., the resident was noted to be asleep in the bed with a full siderail in the up position.</p> <p>Upon interview of LPN # 5 on 6/24/13 at 11:03 a.m., the LPN indicated the resident used a full siderail on the open side of the bed. The LPN stated the resident was a "huge fall risk."</p> <p>Upon interview of LPN #8 on 6/27/13 at 1:45 p.m., the LPN indicated she thought the resident used 1/2 siderails at one time, but the resident currently used a full siderail. The LPN stated that when the resident was first admitted she would try to get up on her own, but that the resident no longer attempted that as much. The LPN indicated the full siderail was used for "safety just because."</p> <p>Upon interview of the MDS (Minimum Data Set) coordinator on 6/27/13 at</p>				

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	<p>1:50 p.m., the LPN #9 indicated the siderail assessment did not indicate the type of siderail used. The LPN indicated the resident had no falls since admission, October 2012. The LPN indicated the assessment lacked justification for the use of the full siderail.</p> <p>Upon review of the resident's clinical record on 6/27/13 at 3 p.m., documentation indicated the most recent MDS assessment was completed 4/5/13. The assessment identified severe cognitive impairment, supervision/set up for bed mobility, extensive assist of one person for transfers, and no siderails restraints utilized.</p> <p>A "siderail assessment" dated 4/5/13 indicated siderails on bed, and used to promote independence with turning and pulling her self. Documentation to indicate type of restraint utilized and medical symptom warranting the use of the full siderail was lacking.</p> <p>The resident's current plan of care addressed the problem of "I am mentally confused due to Alzheimer's dementia and have poor safety awareness. I need limited assistance of staff with transfers. At times I will attempt to transfer myself even</p>						

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	<p>though I am not safe to stand or walk by myself. An alarm device is used to help me remember not to get up by myself. I have not fallen since my admission to this facility but I am at risk to fall," dated April 2013. The approaches included, but were not limited to, "when I am in bed, place both bed rails in the up position."</p> <p>3.1-3(w) 3.1-26(r)</p>			

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F000279 SS=D	<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, 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 observation, interview, and record review the facility failed to develop a comprehensive care plan that included a resident's use of siderails for 2 of 3 residents observed utilizing siderails [Resident #3, Resident # 54].</p> <p>Findings include:</p> <p>1. On 6/2/13 at 11:40 a.m., Resident #3 was observed in be bed with four 1/2 siderails up.</p> <p>During interview of Resident #3 on</p>	F000279	<p>F279 – Develop Comprehensive Care Plans</p> <p>I. Please note that residents #3 and #54 were not harmed by the lack of care plans for the use of side rails. The care plans for residents #3 and #54 were updated to reflect their use of side rails.</p> <p>II. As all residents who utilize side rails could be affected, the following corrective action was taken:</p> <p>III. As a means to ensure ongoing compliance with ensuring appropriate care planning for use of full or half side rails, an audit was conducted to identify those residents with current concerns</p>	07/26/2013			

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	<p>6/21/13 at 12:35 p.m., the resident indicated he had limited movement of his extremities. The resident stated he only had movement of his left wrist and hand. The resident also indicated he utilized the four 1/2 siderails while in bed.</p> <p>Upon review of the resident's clinical record 6/27/13 at 4:30 p.m., the resident's diagnosis included, but was not limited to, Guillian Barre. The resident's current plan of care did not address the use of four 1/2 siderails.</p> <p>Upon interview of the Administrator on 6/28/13 at 9:55 a.m., the Administrator indicated the resident's use of siderails on the careplan was lacking.</p> <p>2. On 6/24/13 at 11:20 a.m., Resident # 54 was observed to utilize 1/2 upper siderails on each side of the bed.</p> <p>During interview of the resident on 6/24/13 at 11:20 a.m., the resident indicated he used the 1/2 upper siderails to assist in turning, and that he used the bottom 1/2 siderails during the night at times.</p> <p>Upon review of the resident's clinical record on 6/28/13 at 3:30 p.m., the</p>		<p>regarding proper care planning for the use of side rails. For those residents found without a current care plan addressing side rail use a care plan was developed. A review of the care plan for any resident utilizing side rails shall be conducted on a quarterly basis or more frequently if there is a significant change in condition to confirm continued compliance. Monitoring for completion of the quarterly reviews will be completed by the DON or her designee. Continued completion of the quarterly reviews and subsequent action(s) taken will be reported to the Administrator.</p> <p>IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings.</p> <p>V. Evidence of the audit and subsequent monitoring is provided in Attachment H. Proof of revised care plans for Resident #3 and #54 are provided in Attachment I and Attachment J, respectively. Due to the evidence provided, Williamsburg Health and Rehab requests paper compliance on tag F279.</p>		

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	<p>resident's diagnoses included, but were not limited to, quadriplegia, vent dependent, tracheostomy, and above the knee amputation. The resident's current plan of care did not address the use of siderails.</p> <p>Upon interview of the careplan coordinator, LPN # 8, on 6/28/13 at 4 p.m., LPN #8 indicated the resident's careplan did not address the use of siderails. The LPN stated that the resident placed his arm on the siderails sometimes.</p> <p>3.1-35(b)(1)</p>				

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F000323 SS=E	<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 ensure residents utilizing Hill-Rom beds with siderails met the FDA (Federal Drug Administration) hospital bed dimensional limit recommendations of less than four and 3/4 inch space for Zone 1 (opening within the rail) for 7 of 7 Hill-Rom beds utilized, or available for use, within the facility. (Residents #25, #54, #3, #17, #65, #9 and Room 23 window, currently not in use.)</p> <p>Finding includes:</p> <p>On 6/24/13 at 11:45 a.m., Resident #65 was observed lying flat in bed, with the bed against the wall. Two 1/2 siderails were observed in the raised position on the side of the bed, not against the wall. The bed was a Hill-Rom bed with electronic bed controls in the upper siderail.</p> <p>On 6/24/13 at 12:15 p.m., with the Maintenance Supervisor and the Administrator, the Maintenance</p>	F000323	<p>F323-Free of Accident Hazards/Supervision/Devices I. Please note that no residents were harmed as a result of the failure to ensure that Zone 1 of the Hill-Rom upper 1/2 bed rails was within the FDA hospital bed dimensional limit recommendations of less than 4 and 3/4 inches. II. As all residents utilizing bed rails could be affected, the following corrective action was taken:III. As a means to ensure ongoing compliance with ensuring that Zone 1 of bed rails in use remains within the FDA hospital bed dimensional limit recommendations the facility installed bumper kits manufactured by Hill-Rom to make the rails meet requirements. The bumper kits were installed on all Hill-Rom beds on 6/25/13. The facility conducted an audit of side rails in use to ensure that there were no entrapment concerns. For those beds requiring an adaptive bumper be in place, the same will be added to the treatment administration record (TAR). The assigned nurse shall be responsible to visually confirm the presence of the bumper on each</p>	07/26/2013	

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	<p>Supervisor measured interior openings of the top rail of Resident #65's bed. A measurement of one of two openings within the siderail was obtained of eight inches by 5 and one-half inches.</p> <p>At the same time other beds of the facility were checked. The same type of beds were observed in use for Residents #25, #54, #3, #17 [currently out of facility,] Resident #9, and a bed set up, but not currently in use, in Room 23 window.</p> <p>On 6/25/13 at 12:00 p.m., the Administrator was interviewed. The Administrator indicated the beds had been given to the facility from the hospital some time ago. The Administrator provided documentation from the bed company, along with newly acquired "bumpers," obtained from the company, to apply to the beds to comply with the FDA recommendations. The Administrator indicated the information and bumpers had been received and were being installed on 6/25/13. The manufacturer's directions received were dated 10/15/2001. The Administrator indicated the bumpers had been installed prior to the facility receiving the beds to the top opening within the top rail, and the facility</p>		<p>tour of duty and initial continued use/placement of said bumper to prevent zone 1 entrapment in an effort to prevent potential zone 1 entrapment. Continued monitoring of the entrapment zones of bed rails will occur twice monthly. Monitoring for compliance will be conducted by the Administrator or her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the placement of the bumper is provided in Attachment K. Evidence of the audit and subsequent monitoring is provided in Attachment L. Due to the evidence provided, Williamsburg Health and Rehab requests paper compliance on tag F323.</p>				

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	<p>currently was installing the bumpers to the bottom openings of the top rail. The Administrator indicated, a different type of bumper had been installed on the bottom rails of the beds prior to the facility acquiring the beds. The Administrator marked the type of beds utilized in the facility on the manufacturer's directions for applying the bumpers as the Centra, Century Series Bed, P8400 and P8500 beds.</p> <p>3.1-45(a)(1)</p>				

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F000334 SS=E	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>			

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to annually provide education regarding risks and benefits of the Influenza Vaccine immunization and consent by the resident or resident's legal representative to receive or refuse the vaccine for 4 of 5 residents reviewed for immunizations (Residents #2, #56, #65, and #23). This deficient practice had the potential to affect 42 residents of the facility present during the most recent flu season, (10/1/12 through 3/31/13,) not admitted during the time period.</p>	F000334	<p>F334 – Influenza and Pneumococcal Immunizations</p> <p>I. The influenza vaccination season of October 1, 2012 through March 31, 2013 has already passed so residents #2, #56, #65, and #23 have not received annual influenza vaccination education.</p> <p>II. As all residents could be affected, the following corrective action was taken:</p> <p>III. As a means to ensure ongoing compliance with ensuring administration of appropriate education regarding the influenza vaccine, the facility has revised its procedure regarding influenza vaccination notification and</p>	07/26/2013	

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	<p>Findings include:</p> <p>1. Resident #2's clinical record was reviewed 6/24/13 at 3:00 p.m. An admission date was noted of 2/19/87. A Minimum Data Set [MDS] assessment, dated 1/17/13, indicated the resident had refused the Influenza Vaccine. The resident's clinical record lacked documentation of the resident being provided with the information of the risk and benefits of the vaccination. The Director of Nursing (DON) and Administrator were interviewed on 6/25/13 at 2:45 p.m. The staff members indicated the resident had never received the vaccination. The staff members indicated documentation of the risk and benefit information had not been provided to the resident and acknowledgement by the resident or legal representative of being provided the information.</p> <p>2. Resident #56's clinical record was reviewed on 6/25/13 at 2:20 p.m.. An admission date of 7/1/11 was noted. A MDS assessment, dated 12/28/12, documented the resident received the Influenza Vaccine on 10/8/12. Documentation of the information regarding the risk and benefits of the vaccine was not noted as well as a consent for the vaccination.</p>		<p>education. Upon the next influenza vaccination season, observations shall be conducted a minimum of twice monthly to confirm compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Administrator or her designee.</p> <p>IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings.</p> <p>V. Evidence of the revised procedure is provided in Attachment M. Due to the evidence provided, Williamsburg Health and Rehab requests paper compliance on tag F334.</p>		

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	<p>3. Resident #65's clinical record was reviewed on 6/25/13 at 12:22 p.m. An admission date of 3/8/12 was noted. A MDS assessment, dated 12/28/12, documented the resident received the Influenza Vaccine on 10/8/12. Documentation of the resident or legal representative receiving the risk/benefit information was lacking as well as a consent for the vaccination.</p> <p>4. Resident #23's clinical record was reviewed on 6/24/13 at 1:56 p.m. An admission date was noted of 4/30/05. A MDS assessment, dated 1/18/13, documented the resident received the Influenza vaccination on 10/8/12. Documentation of the resident or legal representative receiving the risk/benefit information was lacking as well as a consent for the vaccination.</p> <p>LPN #13 was interviewed on 6/25/13 at 2:00 p.m. The LPN indicated the Influenza and Pneumonia Vaccination consents were obtained upon admission. The LPN indicated the information and consents were not provided annually thereafter. LPN #13 indicated the Social Service Director (SSD) was in charge of getting the consents signed.</p> <p>The SSD was interviewed on 6/25/13</p>						

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	<p>at 2:55 p.m. The SSD indicated the information was provided to the resident and/or legal representative upon admission during the flu season. The SSD indicated consents and information were not obtained annually thereafter.</p> <p>A facility policy titled "Policy Regarding Influenza and Pnemococcal Vaccine," dated 11/1/05, reviewed on 6/25/13 at 2:45 p.m., included, but was not limited to, "It is the policy of this facility to provide vaccination against influenza and pneumonia to all residents. Vaccinations for influenza are done on a yearly basis. Vaccinations for pneumonia are done once per lifetime...Should the resident or their legal representative choose to refuse immunization, [facility name] will provide appropriate education of the benefits of receiving immunization to the resident and/or their legal representative. The medical record will contain record of immunization or, if immunization is refused, record of immunization related education provided to the resident and/or their legal representative."</p> <p>3.1-13(a)</p>				

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F000371 SS=F	<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, record review, and interview the facility failed to store dishes under sanitary conditions for 2 of 3 kitchen observations and failed to ensure food storage temperatures to prevent possible foodborne illnesses for 3 of 3 personal resident refrigerators observed.</p> <p>Findings include:</p> <p>1. On 6/20/13 at 11:30 a.m., the following was observed in the kitchen with dietary staff persons #1 and #2:</p> <p>a. The handwashing sink nearest to the dishwasher was heavily soiled with a dark substance.</p> <p>b. A two shelve storage cabinet on the east side of the kitchen, housing water and coffee pitchers had food debris on the shelves and 4 of 18 water pitchers stored as clean had wet interiors. The shelves were heavily coated with rust.</p>	F000371	<p>F371 – Food Procure/Store/Prepare/Serve - Sanitary Conditions I. 1-2. The dietary manager was addressed regarding maintaining the kitchen in a sanitary manner and corrective action taken relative to items 1a – 1e and 2a – 2c upon discovery.II. 1-2 As all residents could be affected, the following corrective action was taken:III. 1-2. As a means to ensure ongoing compliance with ensuring sanitary conditions, staff received in-service training on kitchen cleanliness and food storage, including but not limited to, cleaning procedures. Following education provided, observations shall be conducted a minimum of weekly by the Human Resources and Maintenance Supervisor or her designee to confirm continued compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted.IV. 1-2. As a mean of quality assurance, the aforementioned monitoring shall be reported to the Administrator on a weekly basis. Continued monitoring and any necessary corrective measures initiated as a</p>	07/26/2013	

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	<p>c. A two shelve cabinet on the east wall of the kitchen housing condiments, were heavily coated with rust.</p> <p>d. A two shelve cabinet on the east wall of the kitchen housing pot and pans, were soiled with food debris.</p> <p>e. A sink, identified by dietary person #2, as a "salad sink, no longer used as salad sink," was observed with a heavy coating of dark substance around the faucet.</p> <p>2. On 6/20/13 at 11:30 a.m., the following was observed with the FSS (Food Service Supervisor):</p> <p>a. The fan in the walk in refrigerator was heavily coated with dust.</p> <p>b. A paper towel used by the FSS to wipe the inside top of the ice machine was soiled with a dark and orange substance.</p> <p>c. The lid on top of a trash can on the west side of the kitchen, was soiled with a white and dark substance.</p> <p>During interview of the FSS on 6/21/13 at 11:45 a.m., the FSS</p>		<p>result of said monitoring shall be reported to the Quality Assurance Committee during quarterly meetings.V. 1-2. Evidence of the monitoring is provided in Attachment N. I. 3-5. As Resident #58's and #79's refrigerators were determined to not be working, they were asked to remove those refrigerators from use. A thermometer was placed in Resident #3's refrigerator and the temperatures were monitored.II. 3-5. As all residents with personal refrigerators could be affected, the following corrective action was taken:III. 3-5. As a means to ensure ongoing compliance with ensuring sanitary conditions, the facility conducted an audit of residents with refrigerators. Thermometers were placed in the applicable refrigerators and housekeeping staff were in serviced and were assigned the task of recording the temperature within the refrigerators. Residents and family members are advised upon admission and/or upon bringing a resident refrigerator to the facility of the potential of food borne illness should the refrigerator operation fail. The facility Housekeeping Supervisor or her designee will monitor proper temperatures of resident refrigerators on a weekly basis. Should there be concern in regard to maintaining proper temperature, the</p>		

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	<p>indicated the Maintenance Supervisor was responsible for cleaning the ice machine.</p> <p>During interview of the Maintenance Supervisor on 6/20/13 at 1:50 p.m., the Supervisor indicated he de-limed and cleaned the ice machine every 12 weeks.</p> <p>A form titled "Procedure for de-liming and cleaning the machine" was received from the Maintenance Supervisor on 6/20/13 at 3 p.m. The procedure indicated the ice machine was to be cleansed and de-limed every two weeks.</p> <p>A form identifying which staff were responsible for cleaning areas of the kitchen was provided from the FSS on 6/25/13 at 11:55 a.m. The form indicated the cleansing of the handsink was to be performed by the "PM Dishwasher" at the end of the shift. The cleaning of the cupboards on east wall were the responsibility of the 8:00 a.m. -4:30 p.m. cook on Saturday.</p> <p>3. On, 6/24/13 at 1:56 p.m., Resident #58's room was observed. A personal refrigerator was noted containing some food items. A round thermometer was in the refrigerator with a reading of 50 degree</p>		<p>resident/responsible party will be notified and the continued use of resident refrigerator, repair or replacement shall be addressed. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted.IV. 3-5. As a mean of quality assurance, the aforementioned monitoring shall be reported to the Administrator on a weekly basis. Continued monitoring and any necessary corrective measures initiated as a result of said monitoring shall be reported to the Quality Assurance Committee during quarterly meetings.V. 3-5. Evidence of the in-servicing is provided in Attachment O and P. Evidence of the monitoring is provided in Attachment Q. VI. Due to the evidence provided, Williamsburg Health and Rehab requests paper compliance for tag F371.</p>				

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	<p>Fahrenheit. The resident indicated it was his own personal refrigerator.</p> <p>4. On, 6/21/13 at 3:22 p.m., Resident #79's room was observed. A personal electric cooler/refrigerator was observed on top of a bedside table in an upright position. The refrigerator contained food items including, but not limited to, a bucket of Kentucky Fried Chicken. The interior of the refrigerator did not feel cool. A thermometer was not observed in the refrigerator.</p> <p>5. On 6/21/13 at 12:35 p.m., a personal refrigerator was noted in Resident #3's room. The refrigerator lacked a thermometer to monitor the internal temperature of the refrigerator.</p> <p>Upon interview of the Administrator on 6/27/13 at 5 p.m., the Administrator indicated thermometers were placed in all personal refrigerators after the concern was identified. The Administrator stated that prior to 6/21/13 the facility did not monitor residents' personal refrigerator internal temperatures. The Administrator also indicated the facility did not a policy and procedure for the residents' personal</p>				

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	refrigerators, but that they will be developing a policy. 3.1-21(g)(3)				