

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: April 8, 9, 13, 14, 15, 16, 2015.</p> <p>Facility number: 000439 Provider: 155716 AIM number 100275070</p> <p>Census bed type: SNF: 24 NF: 38 SNF/NF: 116 Residential: 8 Total: 186</p> <p>Census payor type: Medicare: 26 Medicaid: 115 Private: 45 Total: 178</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance by May 16, 2015 to the state findings of the Recertification and State Licensure conducted on April 8, 9, 13, 14, 15 and 16, 2015.</p>	
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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 272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment</p>			

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	<p>performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure comprehensive assessments were accurate in 2 of 30 stage 2 residents, in that, a resident's cognitive and behavioral status were not assessed and a resident receiving hospice services was not identified. (Resident #173, Resident #112))</p> <p>Findings include:</p> <p>1. During an observation on 4/9/15 at 9:10 a.m., Resident #173 was observed to be lying in bed. Resident #173 was alert and oriented.</p> <p>The clinical record of Resident #173 was reviewed on 4/13/15 at 10:16 a.m. The clinical record indicated Resident #173 had diagnoses including, but not limited to, hypertension, atrial fibrillation, glaucoma, anemia, anxiety, depression, mood disorder with psychotic features, chronic obstructive pulmonary disease, diabetes mellitus type 2 (two), hyperlipidemia, hypothyroidism, and coronary artery disease. The quarterly MDS (Minimum Data Set) assessment,</p>	F 272	<p>1).The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #173 has had a new assessment completed related to mental status and mood which accurately reflects the resident's condition.</p> <p>2).The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #112 has had a corrected MDS completed and submitted with accurate information related to a prognosis of less than six months. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house-wide audit of all MDSs shall be completed to ensure the accuracy of the information submitted. Any incorrect information shall be corrected and an accurate MDS submitted. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has implemented a new practice whereby each MDS will be rechecked by a different MDS coordinator other than the one who initially completed the MDS</i></p>	05/16/2015

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	<p>dated 1/15/15, indicated Resident #173 had not been assessed for mental status, staff mental status, or mood.</p> <p>During an interview on 4/14/15 at 8:57 a.m., SW #1 indicated she did not know why Resident #173 was not assessed. SW #1 indicated the MDS office would send notification for when an MDS assessment was due and the SS (Social Service) department would have 7 (seven) days to complete their part of the MDS assessment.</p> <p>During an interview on 4/14/15 at 9:45 a.m., DSS (Director of Social Services) indicated the MDS assessment was incorrectly marked. The DSS indicated Resident #173 was alert and oriented. The DSS further indicated she did not know why Resident #173's mental and mood status were not assessed.</p> <p>A policy titled, "MDS Completion/Transmission," obtained from the Nurse Consultant on 4/16/15 at 12:39 p.m., indicated all MDS assessments will be completed and encoded in accordance with current Federal regulations governing the completion and transmission of MDS data.</p>		to ensure the accuracy of the content of the information prior to submission. <i>The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the accuracy of the information submitted on the residents' MDSs. The tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</i>		

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	<p>2. On 4/14/15 8:39 a.m., Resident #112's clinical record was reviewed. Resident #112's diagnoses included, but was not limited to, end stage Alzheimer's disease.</p> <p>Resident #112's most recent signed physician's recapitulation orders, signed 4/14/15, included, but were not limited to, resident was receiving hospice services, ordered on 12/31/14.</p> <p>The Significant Change MDS (Minimum Data Set) Assessment, dated 1/7/15, indicated the resident had not had a prognosis of less than 6 months.</p> <p>The care plans included, but were not limited to: Resident receiving hospice services, initiated on 12/29/14.</p> <p>On 4/14/15 1:40 p.m., MDS Nurse #1 indicated there had been an error on Resident #112's MDS assessment. MDS Nurse #1 further indicated the assessment should have said the resident had a prognosis of less than six months.</p> <p>3.1-31(c)(3) 3.1-31(c)(6) 3.1-31(a)</p>			

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F 282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide services in accordance with the written plan of care, in that, a resident was transferred without the use of a mechanical lift. (Resident # 106)</p> <p>Findings include:</p> <p>On 4/13/15 9:26 a.m., Resident #106 was observed sitting in the wheelchair with a pad alarm in place.</p> <p>On 4/13/15 at 2:08 p.m., Resident #106's clinical record was reviewed.</p> <p>The most recent signed physician's recapitulation orders, signed 4/2/15, included but were not limited to: up with</p>	F 282	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #106 is now being transferred with the use of a mechanical lift and two staff members at all times. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house-wide audit has been completed by nursing to ensure that each resident is being transferred in accordance with their plan of care based on their abilities and the level of assistance needed to ensure safe transfers. This information has also been provided on the CNA assignment sheets. The measures that have been put into place to ensure that the deficient</i></p>	05/16/2015

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	<p>assistance of 1-2, mechanical lift for transfers.</p> <p>The care plans included, but were not limited to: resident is at risk for falls related to decreased mobility, impaired safety awareness due to cognitive deficits, use of psychotropic medications and a history of falls, initiated on 10/27/14. The interventions included, but were not limited to, up with mechanical lift and assistance of two, initiated on 10/27/14.</p> <p>On 4/13/15 at 2:15 p.m., CNA #1 and QMA #1 were observed to transfer Resident #106 without the use of the mechanical lift.</p> <p>On 4/14/15 at 9:16 a.m., UM (Unit Manager) #2 indicated Resident #106 transferred with the mechanical lift and assistance of two staff members.</p> <p>On 4/14/15 at 1:31 p.m., LPN #1 indicated Resident #106 required a mechanical lift for transfers.</p> <p>On 4/16/15 at 12:39 p.m., the Nurse Consultant provided the, "Care Plans-Comprehensive" policy, dated 9/2010. The policy included, but was not limited to, "Each resident's comprehensive care plan is designed to:</p>		<p>practice does not recur is that a mandatory in-service shall be provided for all nursing staff on the importance of following each resident's plan of care related to mode of transfers. The purpose of this in-service is to ensure that the staff understands the importance of each resident receiving the necessary care and services to meet their individualized needs in accordance with the plan of care. <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor through observation of care to ensure that each resident is receiving the care and services to meet their individualized needs with a focus on mode of transfers. The tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</i></p>				

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F 328 SS=D Bldg. 00	<p>identify the professional services that are responsible for each element of care".</p> <p>3.1-35(g)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the proper procedure was followed for 1 of 1 residents reviewed for nebulizer treatments. (Resident #62)</p> <p>Findings include:</p> <p>The clinical record of Resident #62 was reviewed on 04/14/15 at 3:50 p.m. The record indicated the diagnoses included, but were not limited to, chronic airway obstruction and shortness of breath.</p>	F 328	The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #62 is now receiving their hand-held nebulizer treatments in accordance with facility policy which includes the nurse remaining with the resident during the entire treatment to ensure that the correct technique is being used by the resident and that all the medication has been utilized during the treatment. <i>The corrective action taken for the</i>	05/16/2015

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	<p>The BIMS (Brief Interview for Mental Status) dated 02/21/15, indicated Resident #62 was mildly cognitively impaired.</p> <p>The physician's order dated 06/25/14, indicated an order which included, but was not limited to, Duoneb 0.5 mg (milligram) -3 mg/3 ml (milliliter) via nebulizer 4 times a day for COPD (chronic obstructive pulmonary disease).</p> <p>On 04/14/15 at 3:42 p.m., RN #1 was observed providing a nebulizer treatment to Resident #62. RN#1 assessed Resident #62 and provided the ordered treatment, but left the resident's room after the treatment was started.</p> <p>A policy titled Licensed Nurse Or Respiratory Therapist Procedure Nebulized Mist Inhalation Treatment was provided by the DON (Director of Nursing) on 04/15/15 at 10:30 a.m. The policy and procedure included, but was not limited to, the following: "Remain with resident sufficiently long enough to ensure technique and use of all medication."</p> <p>An interview with the UM (Unit Manager) #1 on 04/16/15 at 9:30 a.m. indicated that the nurse should be in the</p>		<p><i>other residents having the potential to be affected by the same deficient practice is that all residents with current hand-held nebulizer treatment orders are receiving their treatments in accordance with facility policy including the nurses remaining with the resident during the entire course of the treatment to ensure proper technique and to ensure that all of the medication has been utilized during each treatment. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service shall be provided for all licensed nurses on the review of the facility policy related to hand-held nebulizer treatments with a focus on the nurse remaining with the resident during the entire treatment to monitor the resident for proper technique and to ensure that all of the medication has been utilized. The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to ensure that the facility policy on hand-held nebulizer treatments is being followed. The tool shall include direct observation of the residents during the receiving of their treatments to ensure that the nurses remain with the resident during the entire treatment to monitor for proper technique and to ensure that all medication is</i></p>	

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F 371 SS=F Bldg. 00	<p>resident's room during the nebulizer treatment.</p> <p>3.1-47(a)(6)</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</p> <p>Based on observation, interview, and record review, the facility failed to provide, store, distribute, and serve food under sanitary conditions, in that, the dishwasher did not attain the correct temperature during the rinse cycles for 2 (two) of 2 kitchens observed, chemical were stored in the dry food storage room, and dirt and debris were observed along the edges and in the corners of the main kitchen area. This had the potential to affect all 174 residents at the facility. (Main Kitchen, Pathways 2 Kitchen, Resident #127, Resident #164, Resident #92, Resident 112, Resident #105)</p>	F 371	<p>utilized. The tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</p> <p>1). The corrective action taken for those residents found to have been affected by the deficient practice is that all residents are now receiving their meals which have been stored, prepared, distributed and served under sanitary conditions as all residents were identified as being affected. The floor in the main kitchen has been cleaned and is free of dirt and debris build-up around the edges and in the corners of the kitchen. The wall behind the dishwasher has been cleaned and is no longer black. The entrance to the walk-in refrigerator has been cleaned, and there is no longer a build-up of dirt and debris. There are no</p>	05/16/2015

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	<p>Findings include:</p> <p>1. During the initial tour of the facility on 4/8/15 at 9:15 a.m., the floor in the main kitchen was observed to dirt and debris built up around the edges and in the corners throughout the kitchen. The wall under the dishwasher was black. The entrance to the walk-in refrigerator had dirt and debris built up and pieces of paper were in front of the the refrigerator door.</p> <p>The same was observed on 4/15/15 at 8:20 a.m. except the pieces of paper in front of the refrigerator door were missing and the dishwasher room floor was wet with water.</p> <p>During an interview on 4/15/15 at 12:05 p.m., the DFS (Director of Food Services) indicated the kitchen staff is responsible for cleaning the kitchen. The DFS indicated the day and evening shifts have certain responsibilities each day for cleaning the kitchen. The DFS further indicated if the kitchen needed to be totally clean, the kitchen staff would also be responsible for doing it.</p> <p>A cleaning schedule, provided by the DFS on 4/15/15 at 3:45 p.m., indicated the walls on the clean and dirty side of</p>		<p>longer pieces of paper in front of the refrigerator door. The dishwasher room floor is clean and free of excess water. 2).The corrective action taken for those residents found to have been affected by the deficient practice is that the facility is now running an empty flat through the dishwasher prior to placing soiled dishes in the machine to ensure that the dishwasher rinse cycle reaches the temperature level of 180 degrees. 3).The corrective action taken for those residents found to have been affected by the deficient practice is that all chemicals have been removed from the dry food storage area and have been stored in a separate secured area away from all food products. 4).The corrective action taken for those residents found to have been affected by the deficient practice is that the dishwasher in the pathways kitchen has been serviced to address the wash and rinse temperature issue. In addition, the staff has been instructed to run empty trays through the dishwasher before loading any dishes to ensure the proper temperatures for washing and rinsing are obtained. 5).The corrective action taken for those residents found to have been affected by the deficient practice is that the residents identified as resident #164 and #127 are now being assisted with their meals in accordance with acceptable</p>	

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	<p>the dishwasher were to be cleaned on Mondays and the walk-in refrigerator floors were to be swept on Fridays.</p> <p>2. During the initial tour of the kitchen on 4/8/15 at 8: 55 a.m., the water temperature of the rinse cycle was observed to attain a temperature of 176 degrees F (Fahrenheit). The dishwasher had a manufacturer's label on it which indicated the rinse cycle water was to be 180 degrees F.</p> <p>During a repeat cycle of the dishwasher on 4/8/15 at 9:05 a.m., the water temperature of the rinse cycle was observed to obtain a temperature of 182 degrees F.</p> <p>During a third cycle of the dishwasher on 4/8/15 at 9:15 a.m., a thermometer was placed into the dishwasher by the DFS (Director of Food Services) and the water temperature of the rinse cycle was observed to be 180 degrees F. The DFS indicated if the dishwasher had not been ran for a while, the staff would need to run an empty flat.</p> <p>During an observation on 4/8/15 at 9:17 a.m., the dishwasher temperature log indicated the wash and rinse cycles had reached the correct temperatures.</p>		<p>standards of infection control practice as it relates to feeding residents and practicing acceptable standards of hand hygiene. The CNA identified as #6 has been instructed on acceptable standards of infection control practices as it relates to feeding residents and practicing proper hand hygiene. 6).The corrective action taken for those residents found to have been affected by the deficient practice is that the staff member identified as CNA # 3 has been instructed on the facility hand washing policy. All residents have the potential to be affected and are now receiving their drinks by staff members who follow the facility hand washing policy. 7).The corrective action taken for those residents found to have been affected by the deficient practice s that the resident identified as resident #92 is now being served her bread in accordance with acceptable standards of infection control practices. The CNA identified as # 2 has been instructed on the acceptable standards of infection control practices related to feeding residents including the fact that the residents' food items are not to be touched with the bare hands. 8).The corrective action taken for those residents found to have been affected by the deficient practice is that the residents identified as resident # 112 and # 106 are now being</p>	

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	<p>During an observation on 4/15/15 at 8:30 a.m., the water temperature of the dishwasher rinse cycle was observed to be 182 degrees F.</p> <p>During an interview on 4/8/15 at 8:58 a.m., food service employee #1 indicated he normally ran the dishwasher and he knew to run an empty flat if the dishwasher had not been ran in a while.</p> <p>During an interview on 4/15/15 at 11:35 a.m., the DFS (Director of Food Services) indicated the kitchen staff had been instructed to run an empty flat if the dishwasher had not been ran in a while</p> <p>3. During initial tour of the main kitchen on 4/8/15 at 9:23 a.m., cleaning supplies and chemicals were observed to be stored in the dry food storage area.</p> <p>During an interview on 4/8/15 at 9:24 a.m., the DFS (Director of Food Services) indicated the chemicals for the building are stored in the dry storage room so the room could be locked.</p> <p>During an interview on 4/16/15 at 11:00 a.m., the Adm (Administrator) indicated chemicals should not be stored with food.</p> <p>A policy for food storage, obtained from the Nurse Consultant on 4/16/15 at 12:39</p>		<p>assisted with their meals in accordance with acceptable standards of infection control practices. The CNA identified as CNA# 4 has been instructed on the acceptable standards of infection control practices as it relates to assisting residents with their meals including proper hand hygiene practices. 9).The corrective action taken for those residents found to have been affected by the deficient practice is that the CNA identified as CNA # 4 has been instructed on the facility policy of hand washing which requires 20 seconds of thoroughly washing of the hands in between each resident contact.</p> <p>1). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the above identified practices. All residents are now receiving their meals which have been stored, prepared, distributed and served under sanitary conditions as all residents were identified as being affected. The floor in the main kitchen has been cleaned and is free of dirt and debris build-up around the edges and in the corners of the kitchen. The wall behind the dishwasher has been cleaned and is no longer black. The entrance to the walk-in refrigerator has been cleaned, and there is no longer a build-up of dirt and debris. There are no longer pieces of paper in</p>	

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	<p>p.m., indicated all foods were to be stored to maintain food quality until served.</p> <p>4. During the initial tour of the Pathways (a closed dementia unit) kitchen on 4/8/15 at 9:40 a.m., the water temperature of the rinse cycle was observed to attain a wash water temperature of 154 degrees F (Fahrenheit). The dishwasher had a manufacturer's label indicating the water temperature for the wash should be 160 degrees F and the rinse water temperature should be 180 degrees F.</p> <p>During a second observation of the Pathways kitchen dishwasher on 4/8/15 at 9:45 a.m., the wash water was observed to attain a temperature of 154 degrees F.</p> <p>During a third observation of the Pathways kitchen dishwasher on 4/8/15 at 9:53 a.m., the wash cycle was observed to a attain a water temperature of 154 degrees F and the rinse cycle water was observed to only reach 104 degrees F.</p> <p>During an observation of the dishwasher temperature log, dated April 2015, the log indicated the wash and rinse cycles had reached the correct temperatures daily.</p> <p>During an interview on 4/8/15 at 10:00</p>		<p>front of the refrigerator door. The dishwasher room floor is clean and free of excess water. 2). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practices. The facility is now running an empty flat through the dishwasher prior to placing soiled dishes in the machine to ensure that the dishwasher rinse cycle reaches the temperature level of 180 degrees. 3). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all chemicals have been removed from the dry food storage area and have been stored in a separate secured area away from all food products. 4). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the dishwasher in the pathways kitchen has been serviced to address the wash and rinse temperatures issue. In addition, the staff has been instructed to run through the dishwasher empty trays before loading any dishes to ensure the proper temperatures for washing and rinsing are obtained. 5). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all</p>		

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	<p>a.m., the DFS (Director of Food Services) indicated the dishwasher would be checked out since the temperatures were not reaching the correct temperature for both the wash and rinse cycles.</p> <p>During an interview on 4/15/15/ at 10:15 a.m., the Adm (Administrator) indicated he was concerned regarding the dishwasher temperature in the main kitchen. The Adm indicated he would check with the Plant Operations Manager regarding the age of the dishwasher and the facility might be replacing it.</p> <p>A policy for dishwashing, obtained from the nurse consultant on 4/16/15 at 12:39 p.m., indicated the hot water sanitation temperature should be 150 degrees F or more and the final rinse should be 180 degrees or more.</p> <p>5. During an observation on 4/8/15 at 12:30 p.m., CNA #6 was observed to be feeding Resident #127 and Resident #164 in the Restorative dining room. CNA #6 was observed to hold a cup of fluid with a straw in it to Resident #164's mouth by the rim of the cup. CNA #6 was further observed to feed a spoonful of food to Resident #127 and wipe the resident's mouth with her bib, and using the same hand, obtained Resident #164's spoon, fed the resident a bite of food and wiped</p>		<p>residents who are in need of assistance with meal service have the potential to be affected by the deficient practice. All residents who are in need of assistance with meal service are being provided assistance in accordance with acceptable standards of infection control practices including proper hand hygiene. The CNA identified as #6 has been instructed on acceptable standards of infection control practices as it relates to feeding residents and practicing proper hand hygiene. 6). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the staff member identified as CNA# 3 has been instructed on the facility hand washing policy. All residents have the potential to be affected and are now receiving their drinks by staff members who follow the facility hand washing policy. 7). <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents who are in need of assistance with meal service have the potential to be affected by the deficient practice. All residents who are in need of assistance with meal service are being provided assistance in accordance with acceptable standards of infection control practices in that no food items are touched with any staff members'</i></p>	

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	<p>her mouth with her bib.</p> <p>No hand hygiene was observed between residents.</p> <p>6. On 4/8/15 at 12:01 p.m., CNA #3 was observed to hand wash for ten seconds and then serve drinks to all the residents in the West Dining Room.</p> <p>7. On 4/8/15 at 12:16 p.m., CNA #2 was observed to handle Resident #92's bread with bare hands. CNA #2 had completed hand hygiene prior to serving Resident #92.</p> <p>8. On 4/8/15 at 12:26 p.m., CNA #4 was observed to be assisting Resident #112 and Resident #106 with their noon meal. CNA #4 was observed to wipe the mouth of Resident #112 with the clothing protector. CNA #4 proceeded to assist Resident #106 with her meal, without completing any hand hygiene.</p> <p>9. On 4/16/15 at 9:27 a.m., CNA #4 was interviewed. CNA #4 indicated if a resident needed cleaned up during the meal hand hygiene should be completed prior to assisting another resident. CNA #4 further indicated she was unsure of the amount of time required to perform a hand wash, but indicated she sang happy</p>		<p>bare hands. The CNA identified as # 2 has been instructed on the acceptable standards of infection control practices related to feeding residents including the fact that the residents' food items are not to be touched with the bare hands. 8). The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents who are in need of assistance with meal service have the potential to be affected by the deficient practice. All residents who are in need of assistance with meal service are being provided assistance in accordance with acceptable standards of infection control practices including the proper use of hand hygiene while assisting residents with their meals. The CNA identified as CNA# 4 has been instructed on the acceptable standards of infection control practices as it relates to assisting residents with their meals including proper hand hygiene practices. 9). <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents who are in need of assistance with meal service have the potential to be affected by the deficient practice. All residents who are in need of assistance with meal service are being provided assistance in accordance with acceptable</i></p>		

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	<p>birthday to cover the required time.</p> <p>On 4/16/15 at 12:39 p.m., the Nurse Consultant provided the, "Feeding the Impaired Residents" policy, dated 6/2000. The policy included, but was not limited to, "wash your hands thoroughly or use sanitizing gel before serving another resident if you attend to a resident during the serving process".</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>standards of infection control practices including the use of proper hand hygiene. 1). The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff on the facility policies as they relate to cleaning of the dietary department. The in-service included the policy on cleanliness of floors, including a thorough cleaning of floor edges, walls, entrances to refrigerators/freezers and the cleanliness of the dishwasher room. 2). The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff on the facility policy related to ensuring that the dishwasher temperatures (wash cycle and rinse cycle) are in accordance with facility policy prior to running through any soiled dishes. 3).The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff on the facility policy related to chemical storage which requires that all chemicals are stored in a separate area away from any type of food items or cooking materials. 4). The measures that have been put into place to ensure that the deficient practice</p>	

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			<p>does not recur is that a mandatory in-service has been provided for all dietary staff on the facility policy related to ensuring that the pathways dishwasher temperatures (wash cycle and rinse cycle) are in accordance with facility policy prior to running through any soiled dishes.</p> <p>5). The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the proper handling of any dinnerware including the handling of glasses and cups in accordance with acceptable standards of infection control practices. The staff was also in-serviced on the facility policy related to hand hygiene. 6). The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the facility's hand washing policy as it relates to assisting residents with their meals. 7). The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on infection control practices as it relates to assisting residents with their meals including the fact that the residents' food items are not to be handled with the bare hands. 8). The measures that have been put into place to</p>	

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			<p>ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the facility's hand washing policy as it relates to assisting residents with their meals. 9). The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the facility's hand washing policy as it relates to assisting residents with their meals. 1). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor the cleanliness of the dietary department. The tool includes the monitoring of the dietary floors, including floor edges, walls, entrances to the refrigerators/freezers. as well as the cleanliness of the dishwasher room floor. The tool will be completed by the Director of Dietary Services and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</i> 2). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been</i></p>	

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			<p>developed and implemented to ensure the proper washing and rinsing temperatures are obtained prior to the sanitizing of soiled dishes. The tool will be completed by the Director of Dietary Services and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted. 3). The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to ensure that all chemicals are properly stored away from any type of food items or cooking materials. The tool will be completed by the Director of Dietary Services and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</p> <p>4). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to ensure the proper washing and rinsing temperatures are obtained on the Pathways dishwasher prior</i></p>	

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			to the sanitizing of soiled dishes. The tool will be completed by the Director of Dietary Services and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted. 5). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor the proper handling of dinnerware including glasses and cups while assisting residents with their meals. The tool also monitors the proper use of hand hygiene while assisting residents with their meals. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted. 6). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor the proper utilization of hand hygiene while assisting residents with their meals in</i></i>	

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			<p>accordance with acceptable standards of infection control practices. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted. 7). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor the provision of assistance with meals in accordance with acceptable standards of infection control practices which includes the fact that the residents' food items are not to be handled with the bare hands. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted. 8). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor the proper utilization of hand hygiene while assisting</i></i></p>	

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F 441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to		residents with their meals in accordance with acceptable standards of infection control practices. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted. 9). <i>The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor the proper utilization of hand hygiene while assisting residents with their meals in accordance with acceptable standards of infection control practices. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</i>	

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	<p>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 for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to provide care to prevent the spread of infection, in that, residents perineal area was cleansed from back to front and hand hygiene was not performed between dirty</p>	F 441	1). The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #106 is now receiving perineal care in accordance with acceptable	05/16/2015

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	<p>and clean tasks. (Resident #34, Resident #106, CNA #1, CNA #5, QMA #1)</p> <p>Findings include:</p> <p>1. On 4/13/15 at 2:15 p.m., CNA #1 and QMA #1 were observed to transfer and provide care for Resident #106. CNA #1 and QMA #1 performed hand hygiene and applied gloves. The gait belt was applied to Resident #106 and they assisted the resident from the wheelchair to the bed. CNA #1 removed the gloves and gathered the needed items for incontinence care. QMA #1 changed gloves and CNA #1 applied new gloves. The staff members removed Resident #106 pants and soiled brief. CNA #1 used a wash cloth to cleanse Resident #106's perineal area. CNA #1 was observed to cleanse Resident #106 perineal area from back to front. CNA #1 was observed to remove gloves and applied new gloves. There was no hand hygiene observed to be performed in between glove changes. CNA #1 applied a new brief for Resident #106. CNA #1 and QMA #1 repositioned the resident.</p> <p>2. On 4/13/15 at 3:04 p.m., CNA #5 and QMA #1 were observed to provide incontinence care for Resident #34. CNA #1 and QMA #1 performed hand hygiene and applied gloves. CNA #5</p>		<p>standards of practice. Staff members identified as CNA #1 and QMA #1 are now providing perineal care and hand hygiene in accordance with acceptable standards of infection control practices and facility policy in that the perineal area is cleaned from front to back and hand hygiene is performed after each removal of gloves prior to applying clean gloves. 2). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident # 34 is now receiving incontinence care by staff members who are utilizing acceptable standards of infection control practices in that proper hand hygiene is being completed upon removal of gloves prior to applying clean gloves. Staff members identified as CNA # 5 and QMA #1 are now providing incontinence care while utilizing acceptable standards of infection control practices in that proper hand hygiene is performed after each removal of gloves prior to applying clean gloves. 3). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the facility has reviewed its hand washing policy and revised it to include that hand washing is to be completed each time gloves are removed and before applying clean gloves. <i>The corrective action taken for the other residents having the potential to</i></i></i></p>				

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	<p>removed Resident #34's soiled brief. CNA #5 cleansed Resident #34's perineal area. CNA #5 was observed to change gloves, no hand hygiene was observed to be performed in between glove changes. CNA #5 cleansed Resident #34's buttocks and again changed gloves. CNA #5 was observed to apply a clean brief to Resident #34.</p> <p>3. On 4/16/15 at 9:27 a.m., CNA #4 was interviewed. CNA #4 indicated when cleansing a resident's peri area it should be done from front to back. CNA #4 further indicated hand hygiene should be performed in between dirty and clean tasks.</p> <p>On 4/16/15 at 12:39 p.m., the Nurse Consultant provided, the "Hand Washing/Hand Hygiene" policy, dated 3/2014. The policy included, but was not limited to, "Employees must wash their hands for twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin".</p> <p>On 4/16/15 at 12:39 p.m., the Nurse Consultant provided, the "Perineal Care" policy, dated 5/2014. The policy included, but was not limited to, "wash</p>		<p><i>be affected by the same deficient practice is that all incontinent residents have the potential to be affected by this deficient practice. All residents are now receiving incontinent care in accordance with acceptable standards of practice in that the perineal area is cleansed from the front to the back and hand washing is completed upon removal of gloves prior to applying clean gloves. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the acceptable standards of practice related to incontinence care with a focus on cleansing from front to back along with the revised policy on hand washing is to be completed upon the removal of gloves prior to applying clean gloves. The corrective action taken to monitor to ensure the deficient practices do not recur is that a Quality Assurance tool has been developed and implemented to monitor the acceptable standard of infection control practices as it relates to perineal care and hand hygiene upon removal of gloves. The in-service included a focus on cleansing the perineal area from the front to the back along with proper hand hygiene upon removal of gloves and prior to applying clean gloves. This tool will be completed by the Director of Nursing and/or her designee</i></p>				

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F 465 SS=E Bldg. 00	<p>perineal area, wiping from front to back".</p> <p>3.1-18(b)(1) 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 and interview the facility failed to provide a safe, functional, and sanitary environment, in that, dirt and debris was built up, resident equipment was stored improperly, door frames and walls were missing paint, and mats were soiled for 13 of 39 rooms reviewed. (Room #414, Room # 659, Room #583, Room #591, Room #660, Room #669, Room #580, Room #419, Room #554, Room #672, Room #581, Room #585, Room #553)</p> <p>Findings include</p> <p>1. On 4/8/15 at 11:28 a.m., Room #414</p>	F 465	<p>weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</p> <p>1). The corrective action taken for those residents found to have been affected by the deficient practice is that the bathroom door frame of room #414 has been painted and is free of chipped paint. 2). The corrective action taken for those residents found to have been affected by the deficient practice is that the bathroom floor of room #659 has been thoroughly cleaned and is free of dirt and debris build up along the edges and in the corners of the flooring. 3). The corrective action taken for those residents found to have been affected by the deficient practice is that the bottle of unlabeled mouth wash found in room #583</p>	05/16/2015

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	<p>was observed. The door frame to the bathroom was observed with chipped paint. ON 4/14/15 at 2:02 p.m., the same was observed.</p> <p>2. On 4/8/15 at 11:39 a.m., Room #659 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom floor. On 4/14/15 at 9:53 a.m., the same was observed.</p> <p>3. On 4/8/15 at 2:18 p.m., Room #583 was observed. In the bathroom, a bottle of mouthwash was observed to be unlabeled, dirt and debris was observed to be built up in the corners and along the edges, and a black stain was observed on the floor. ON 4/14/15 at 11:23 p.m., the same was observed.</p> <p>4. On 4/8/15 at 2:48 p.m., Room #591 was observed. In the bathroom, the wall had missing paint and the mat in front of the commode was soiled with dirt and debris. The heating and air conditioning unit had missing paint and a broken cover. On 4/14/15 at 11:11 a.m., the same was observed.</p> <p>5. On 4/8/15 at 3:16 p.m., Room #660 was observed. In the bathroom, a tile was observed to be missing and dirt and debris was observed to be built up in the</p>		<p>has been removed. All of the resident's personal care items are appropriately labeled. The bathroom floor has been thoroughly cleaned and is free of any build-up of dirt and debris and is free of stains. 4). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that</i> the walls of the bathroom in room # 591 have been painted and are free of any missing paint. The mat in front of the commode has been thoroughly cleaned and is free of dirt and debris. The heating and air conditioning cover has been repaired and is free of any missing paint. 5). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that</i> the missing bathroom tile has been replaced in room #660. The floor has been thoroughly cleaned and is free of dirt and debris including along the edges and in the corners. 6). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that</i> the missing tile has been replaced in the bathroom of room #669. The bathroom floor has been thoroughly cleaned and is free of dirt and debris build-up along the edges and corners. 7). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that</i> the bathroom of room #580 has had the drywall</p>	

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	<p>corners and along the edges. On 4/14/15 at 9:59 a.m., the same was observed.</p> <p>6. On 4/8/15 at 3:39 p.m., Room #669 was observed. In the bathroom, a tile was observed to be missing and dirt and debris was observed to be built up in the corners and along the edges. ON 4/14/15 at 9:55 a.m., the same was observed.</p> <p>7. On 4/9/15 at 8:17 a.m., Room #580 was observed. In the bathroom, the mat in front of the commode was soiled with dirt and debris, dirt and debris was observed to be built up in the corners and along the edges of the floor, and the drywall was observed to be chipped. ON 4/14/15 at 11:17 a.m., the same was observed.</p> <p>8. On 4/9/15 at 9:23 a.m., Room #419 was observed. A clean, uncovered bed pan was observed to be stored in a shared bathroom. On 4/14/15 at 1:46 p.m., the same was observed.</p> <p>9. On 4/9/15 at 10:16 a.m., Room #554 was observed. In a shared bathroom, two clean, uncovered bed pans were observed to be stored. On 4/14/15 at 9:48 a.m., the same was observed.</p> <p>10. On 4/9/15 at 10:24 a.m., Room #672 was observed. In the bathroom, the door</p>		<p>repaired and is free of any chipped areas. The mat in front of the commode has been thoroughly cleaned and is free of any dirt and debris. The bathroom floor has been thoroughly cleaned and is free of any dirt and debris build-up along the edges and in the corners. 8). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the clean uncovered bed pan was removed from the shared bathroom of room # 419. Bed pans are now stored clean, covered and labeled with the resident's name. 9). The corrective action taken for those residents found to have been affected by the deficient practice is that the two clean uncovered bed pans in the shared bathroom of room #554 were removed. Bedpans are now stored clean, covered and labeled with the resident's name. 10). The corrective action taken for those residents found to have been affected by the deficient practice is that the bathroom door frame of room #672 has been painted and is free of any chipped paint. The bathroom floor has been thoroughly cleaned and is free of any build-up of dirt and debris including along the edges and in the corners. 11). The corrective action taken for those residents found to have been affected by the deficient practice is that the bedroom and bathroom floors of</i></p>	

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	<p>frame was observed with chipped paint and dirt and debris was observed to be built up in the corners and along the edges. On 4/14/15 at 9:57 a.m., the same was observed.</p> <p>11. On 4/9/15 at 10:41 a.m., Room #581 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom and bedroom. On 4/14/15 at 1:37 p.m., the same was observed.</p> <p>12. On 4/9/15 at 11:02 a.m., Room #585 was observed. In the bathroom, dirt and debris was observed to be built up in the corners and along the edges and an exposed screw was on the side of the commode. On 4/14/15 at 11:20 a.m., the same was observed.</p> <p>13. On 4/9/15 11:14 a.m., Room #553 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom. On 4/14/15 at 9:49 a.m., the same was observed.</p> <p>On 4/14/15 at 2:04 p.m., CNA #3 was interviewed. CNA #3 indicated resident equipment should be labeled and placed in a trash bag for storage.</p> <p>On 4/16/15 at 9:20 a.m., Housekeeper #1</p>		<p>room # 581 have been thoroughly cleaned and are free of any build-up of dirt and debris including along the edges and in the corners. 12). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the bathroom floor of room # 585 has been thoroughly cleaned and is free of any build-up of dirt and debris including along the edges and in the corners. The exposed screw on the side of the commode has been repaired.</i></p> <p>13). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the bathroom floor of room #553 has been thoroughly cleaned and is free of any build-up of dirt and debris along the edges and in the corners. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house-wide audit has been completed of each resident's room and bathroom to identify any areas of chipped paint, broken equipment, safety hazards or any build-up of dirt and debris along the edges and in the corners of the flooring. The residents' rooms and bathrooms were also checked for any unlabeled personal care items, as well as improperly stored equipment. All areas in need of repair and thorough cleaning have been completed. In</i></p>	

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	indicated bathroom floors should be swept and mopped daily. 3.1-19(f)		addition, all personal care items and equipment were properly labeled and covered for proper storage. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all housekeeping and maintenance staff to review the facility's policies on the cleaning of resident rooms and bathrooms. In addition, the policy on identifying any needed repairs or maintenance was reviewed to ensure that the staff had knowledge of the process to ensure that all resident areas were properly maintained in a safe, sanitary, functional and comfortable environment for the residents. A mandatory in-service has also been conducted for all nursing staff on the proper labeling and storage of the residents' personal equipment to ensure a safe and sanitary environment. <i>The corrective action taken to monitor to ensure the deficient practices does not recur is that a Quality Assurance tool has been developed and implemented to monitor the cleanliness of the residents' environment. The tool will also monitor for any areas in need of repair or replacement to ensure that a safe, functional, clean and comfortable environment is maintained for the residents. This tool will be completed by the</i>	

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F 514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure documentation was complete for 1 of 5 residents in a total sample who met the criteria for falls in a total of 40 residents sampled, in that, documentation was lacking for a resident with a fall and 1 of 5 residents in a total sample of 40 residents reviewed for unnecessary medications, had allergies incorrectly</p>	F 514	<p>Director of Facility Operations and/or his designee weekly for (4) four weeks, then monthly for (3) three months and then quarterly for (3) three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</p> <p>1). <i>The corrective action taken for those residents found to have been affected by the deficient practice is that although the documentation was lacking for the resident identified as resident #227, related to the treatment for the cut on the forehead, the area has healed without complications as first aid was provided at the time of the event.</i> 2). <i>The corrective action taken for those residents found to have been affected by the deficient practice</i></p>	05/16/2015

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	<p>listed on the MAR (Medication Administration Record). (Resident #227, Resident #173)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #227 was reviewed on 4/13/15 at 1:23 p.m. Resident #227 had diagnoses including, but not limited to, acute subdural hematoma, dementia, psychosis, anxiety state, depressive disorder, panic attacks, stage 3 (three) chronic kidney failure, and osteoporosis. The admission MDS (Minimum Data Set) assessment, dated 3/26/15, indicated Resident #227's BIMS (Brief Interview for Mental Status) was staff assessed. The assessment indicated Resident #227 was severely impaired.</p> <p>The progress notes indicated Resident #227 had a fall on 3/22/15 at 9:30 a.m. The progress notes indicated Resident #227 was observed on the floor in the hallway with a bruise and a cut in the middle of the resident's forehead. The progress note indicated the resident was bleeding from the cut on the forehead and a call was placed to the physician.</p> <p>The clinical record lacked any further documentation regarding treatment for the cut and/or physician notification.</p>		<p><i>is that</i> the allergy listing on the electronic charting has been corrected for the resident identified as resident # 173 and contains an accurate listing of the resident's allergies. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that</i> the interdisciplinary team has reviewed all falls within the past 30 days and found no other residents who lacked documentation related to treatments required at the time of their falls. In addition, a house-wide audit was completed on all residents to ensure that an accurate listing of allergies was documented in the electronic clinical record. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the facility's policy related to documenting physician notification and response related to the need for treatment following any fall. The in-service also instructed the nurses on the importance of accurate recording of the residents' allergies in the electronic clinical record. <i>The corrective action taken to monitor to ensure the deficient practices does not recur is that</i> a Quality Assurance tool has been developed and implemented to monitor the documentation post</p>		

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	<p>During an interview on 4/24/15 at 11:33 a.m., UM #1 indicated the clinical record lacked any documentation regarding whether the physician was notified and/or any treatment was done for the cut and bruising of the forehead.</p> <p>A procedure, dated October, 2010, and obtained from the Nurse Consultant on 4/16/15 at 12:39 p.m., indicated when a resident falls, interventions, first aid, and treatments administered to the resident should be documented. The procedure further indicated the attending physician should be notified of the fall and the notification documented..</p> <p>2. The clinical record of Resident #173 was reviewed on 4/13/15 at 10:16 a.m. The clinical record indicated Resident #173 had diagnoses including, but not limited to, hypertension, atrial fibrillation, glaucoma, anemia, anxiety, depression, mood disorder with psychotic features, chronic obstructive pulmonary disease, diabetes mellitus type 2 (two), hyperlipidemia, hypothyroidism, and coronary artery disease.</p> <p>Resident #173 had a physician's order, dated 9/30/14 and signed on 4/7/15, for Norco (a narcotic medication used for pain) 7.5-325 mg 1 (one) tablet orally bid (twice a day) for pain and Norco 7.5-325</p>		<p>fall to ensure it includes documentation of any treatments needed to treat an injury obtained during a fall. The tool will also monitor the accuracy of documentation of the residents' allergies in the electronic clinical record. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</p>	

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	<p>mg 2 (two) tablets every 4 hours prn (as needed) for pain.</p> <p>Resident #173 also had a physician's order, dated 9/22/14 and signed on 4/7/15, for Loperamide (an anti-diarrheal medication) 2 mg caps 1 capsule after each loose stool as needed with a maximum of 8 (eight) times per day.</p> <p>Resident #173's allergies on the MAR and on the computerized chart indicated Resident #173 had allergies which included Hydrocodone (a narcotic medication used in Norco) and Loperamide.</p> <p>During an interview on 4/14/15 at 1:45 p.m., UM #1 indicated Resident #173 was not allergic to Hydrocodone or Loperamide. UM #1 indicated the allergies listed in the computer were incorrect.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			

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	<p>Based on observation, interview, and record review, the facility failed to provide, store, distribute, and serve food under sanitary conditions, in that, the dishwasher did not attain the correct temperature during the rinse cycles. This had the potential to affect 7(seven) of 7 residents on the residential unit.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 4/8/15 at 8: 55 a.m., the water temperature of the rinse cycle was observed to attain a temperature of 176 degrees F (Fahrenheit). The dishwasher had a manufacturer's label on it which indicated the rinse cycle water was to be 180 degrees F.</p> <p>During a repeat cycle of the dishwasher on 4/8/15 at 9:05 a.m., the water temperature of the rinse cycle was observed to obtain a temperature of 182 degrees F.</p> <p>During a third cycle of the dishwasher on 4/8/15 at 9:15 a.m., a thermometer was placed into the dishwasher by the DFS (Director of Food Services) and the water temperature of the rinse cycle was observed to be 180 degrees F. The DFS indicated if the dishwasher had not been</p>	R 148	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the facility is now running an empty flat through the dishwasher prior to placing soiled dishes in the machine to ensure that the dishwasher rinse cycle reaches the temperature level of 180 degrees. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practices. The facility is now running an empty flat through the dishwasher prior to placing soiled dishes in the machine to ensure that the dishwasher rinse cycle reaches the temperature level of 180 degrees. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff on the facility policy related to ensuring that the dishwasher temperatures (wash cycle and rinse cycle) are in accordance with facility policy prior to running through any soiled dishes. <i>The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to ensure the proper washing and rinsing temperatures are obtained prior to the sanitizing of soiled dishes. The tool will be</i></p>	05/16/2015	

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R 156 Bldg. 00	<p>ran for a while, the staff would need to run an empty flat.</p> <p>During an observation on 4/8/15 at 9:17 a.m., the dishwasher temperature log indicated the wash and rinse cycles had reached the correct temperatures.</p> <p>During an observation on 4/15/15 at 8:30 a.m., the water temperature of the dishwasher rinse cycle was observed to be 182 degrees F.</p> <p>During an interview on 4/15/15 at 11:35 a.m., the DFS (Director of Food Services) indicated the kitchen staff had been instructed to ran an empty flat if the dishwasher had not been ran in a while. The DFS further indicated the dishwasher was used for the dishes and utensils on the residential unit.</p> <p>410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24.</p> <p>Based on observation and interview, the</p>	R 156	<p>completed by the Director of Dietary Services and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</p> <p>The corrective action taken for those residents found to have been affected by the deficient</p>	05/16/2015	

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	<p>facility failed to provide, store, distribute, and serve food under sanitary conditions, in that cleaning supplies and chemicals were stored in the dry storage area of the main kitchen. The has the potential to affect 7 of 7 residents residing on the residential unit.</p> <p>Findings include:</p> <p>During initial tour of the main kitchen on 4/8/15 at 9:23 a.m., cleaning supplies and chemicals were observed to be stored in the dry storage area.</p> <p>During an interview on 4/8/15 at 9:24 a.m., the DFS (Director of Food Services) indicated the chemicals for the building are stored in the dry storage room so the room could be locked.</p> <p>During an interview on 4/16/15 at 11:00 a.m., the Adm (Administrator) indicated chemicals should not be stored with food.</p> <p>A policy for food storage, obtained from the Nurse Consultant on 4/16/15 at 12:39 p.m., indicated all foods were to be stored to maintain food quality until served.</p>		<p>practice is that all chemicals have been removed from the dry food storage area and have been stored in a separate secured area away from all food products. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all chemicals have been removed from the dry food storage area and have been stored in a separate secured area away from all food products. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff on the facility policy related to chemical storage which requires that all chemicals are stored in a separate area away from any type of food items or cooking materials. The corrective action taken to monitor to ensure the deficient practices does not recur is that a Quality Assurance tool has been developed and implemented to ensure that all chemicals are properly stored away from anytype of food items or cooking materials. The tool will be completed by the Director of Dietary Services and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any</p>		

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R 214 Bldg. 00	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review the facility failed to ensure a pre-admission evaluation had been completed prior to admission for 1 of 7 residents reviewed. (Resident #236)</p> <p>Finding includes:</p> <p>On 4/15/15 at 10:08 a.m., Resident #236's clinical record was reviewed. Resident #236 was admitted on 12/12/14. The clinical record lacked a documented pre-admission evaluation.</p> <p>On 4/15/15 at 3:42 p.m., the Director of Admission indicated she had been unable to locate Resident #236's pre-admission evaluation.</p>	R 214	<p>additional action is warranted.</p> <p><i>The corrective action taken for those residents found to have been affected by the deficient practice is that since the pre-admission evaluation of the resident identified as resident # 236 could not be located, an evaluation of the resident's needs has been completed by a licensed nurse, and the resident's individual needs are currently being met. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house-wide audit has been completed on all residential residents, and all pre-admission evaluations are on their clinical records. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses to ensure their knowledge on the facility's policy related to the completion of pre-admission evaluations of all residents admitted to the residential unit.</i></p>	05/16/2015

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R 216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living.		The in-service also included instructions on the completion of these assessments at least semi-annually or with any substantial change in the resident's condition or upon request of the resident or facility. <i>The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the clinical records to ensure that pre-admission evaluations are being completed in accordance with facility policy, upon admission, semi-annually, with any substantial change in condition or upon resident or facility request. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</i>	

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	<p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on interview and record review, the facility failed to ensure the evaluation of the resident's ability to self-administer medications was completed, for 1 of 2 residents reviewed who self administered medications in a total sample of 7. (Resident #231)</p> <p>Finding includes:</p> <p>On 4/15/15 at 10:55 a.m., Resident #231's clinical record was reviewed. Resident #231 was admitted on 4/1/12. Resident #231's diagnoses included, but were not limited to, macular degeneration (vision problems). Resident #231's Service Plan indicated Resident #231 self administered most of her medications. The last completed Medication Self Administration Assessment was completed on 12/31/13.</p> <p>On 4/16/15 at 9:25 a.m., UM (Unit Manager) #2 indicated she was unable to locate a more recent assessment.</p> <p>On 4/16/15 at 12:39 p.m., the Nurse Consultant provided, the "Medication Self-Administration" policy, dated</p>	R 216	<p><i>The corrective action taken for those residents found to have been affected by the deficient practice is that a self-administration of medication assessment has been completed on the resident identified as resident # 231 to support the fact that the resident is safe to administer their medications.</i></p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house-wide audit was completed on all other residential residents who expressed a desire to self-administer their own medications. All assessments were completed in accordance with facility policy in that they were completed upon admission, yearly or with a change in the resident's condition. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the facility policy related to completion of the self-administration of medication assessment, upon admission, yearly or with any change in the resident's condition. The corrective action taken to monitor</i></p>	05/16/2015	

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R 217 Bldg. 00	<p>3/2014. The policy included, but was not limited to, "An assessment will be done upon admission, yearly or with a change in the resident's condition". The facility had not completed a yearly evaluation.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p>		<p><i>to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the timely completion of the self-administration of medication assessment in accordance with facility policy. This tool will be completed by the Director of Nursing and/or her designee weekly for (4) four weeks, then monthly for three(3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</i></p>	

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	<p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on observation and record review, the facility failed to ensure service plans were developed for 6 of 7 residents reviewed for service plans in that the residents had not signed their service plans.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 4/15/15 at 2:30 p.m. the closed record of Resident #237 was reviewed. Resident #237's Service Plan dated 6/27/14, lacked the resident's signature. On 4/15/15 at 2:35 p.m. the closed record of Resident #238 was reviewed. Resident # 238's Service Plan dated 11/25/14 lacked the residents signature on the Service Plan. On 4/15/ 15 at 2:45 p.m. the clinical record for Residents #235 and resident # 234, were reviewed and lacked the resident's signature on the Service Plan. On 4/15/15 at 9:50 a.m., Resident #233's clinical record was reviewed. 	R 217	<p>1 & 2). The corrective action taken for those residents found to have been affected by the deficient practice is that the closed records of the residents identified as residents # 237 and # 238 no longer reside at the facility.</p> <p>3). The corrective action taken for those residents found to have been affected by the deficient practice is that the service plans for the residents identified as residents # 234 and # 235 have been reviewed with each resident, and the residents' signatures have been placed on the service plans.</p> <p>4). The corrective action taken for those residents found to have been affected by the deficient practice is that the service plan for the resident identified as resident # 233 has been reviewed with the resident, and the resident has signed the service plan.</p> <p>5). The corrective action taken for those residents found to have been affected by the deficient practice is that the service plan for the resident identified as resident #236 has been reviewed with the resident, and the resident has signed the service plan.</p> <p>6). The corrective</p>	05/16/2015			

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	<p>Resident #233 was admitted on 8/12/10. Resident #233's Service Plan, dated 5/20/14, lacked Resident #233's signature.</p> <p>5. On 4/15/15 at 10:08 a.m., Resident #236's clinical record was reviewed. Resident #236's Service Plan, dated 1/27/15, lacked Resident #236's signature.</p> <p>6. On 4/15/15 at 10:55 a.m., Resident #231's clinical record was reviewed. Resident #231's Service Plan, dated 11/25/14, lacked Resident #231's signature.</p> <p>On 4/15/15 at 3:04 p.m., UM (Unit Manager) #2 was interviewed. UM #2 indicated the resident's signature should be on the Service Plan.</p> <p>On 4/15/15 at 3:28 p.m., SW (Social Worker) #2 indicated residents only sign their service plan if the resident attends the service plan meeting.</p> <p>On 4/16/15 at 12:39 p.m. a Policy on Residential Service Plan was received from the Nurse Consultant indicated the service plan should be developed and initiated and signed upon admission and is reviewed and revised semiannually and on an as needed basis.</p>		<p><i>action taken for those residents found to have been affected by the deficient practice is that the service plan for the resident identified as resident #231 has been reviewed with the resident, and the resident has signed the service plan. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house-wide audit of all residential residents has been completed. All service plans have been signed by each resident. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses and social workers on the facility policy related to service plans for residential residents. The staff was instructed that each service plan is to be reviewed with the resident and signed by the resident. The corrective action taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the proper completion of residential service plans. The tool includes monitoring to ensure each resident has signed their service plan upon admission, semi-annually and on an as needed basis. This tool will be completed by the Director of Nursing and/or her designee</i></p>		

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			weekly for (4) four weeks, then monthly for three (3) months and then quarterly for three (3) quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.		