

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155696	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 COLLEGE AVE VINCENNES, IN 47591
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F0000	<p>This visit was for a recertification and state licensure survey. This visit resulted in an extended survey - substandard quality of care.</p> <p>Survey dates: 2/5, 2/6, 2/7, 2/8, 2/11, 2/12/13 Extended Survey Date: 2/13/13</p> <p>Facility Number: 003237 Provider Number: 155696 AIM Number: 200374360</p> <p>Survey Team: Martha Saull, RN TC Carole McDaniel, RN Terri Walters, RN Dorothy Watts, RN</p> <p>Census Bed Type: SNF: 22 SNF/NF: 39 Residential: 21 Total: 82</p> <p>Census By Payor Source: Medicare: 22 Medicaid: 26 Other: 34 Total: 82</p> <p>Residential Sample: 7</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 21, 2013, by Jodi Meyer, RN</p>				

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F0177 SS=B	<p>483.10(o) RIGHT TO REFUSE CERTAIN TRANSFERS</p> <p>An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or a resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.</p> <p>A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.</p> <p>Based on record review and interview, the facility failed to provide resident/responsible parties, appropriate reasons and information for informed choice in proposed room changes during 4 of 6 intrafacility transfers reviewed.</p> <p>Resident 13 Resident 46 Resident 38 Resident 66</p> <p>Findings include:</p> <p>Clinical record review for Resident 13, Resident 46, Resident 38, and Resident 66 was completed on 2/11/13 between 9:00 A.M. and 10:30 A.M. All 4 residents' records had intrafacility room change notifications with a documented reason "bed recertification in building" or "bed</p>	F0177	F177Resident #13, #46, #38, and #66 suffered no ill effects from the alleged deficient practice and through corrective action and inservicing will ensure residents/responsible parties are given appropriate reasons and information to make informed choices regarding room changes.Completion Date 3-15-13Systemic change will include staff education/in-service on interpretive guidelines as it relates to room changes/intrafacility transfers.Completion Date 3-15-13Executive Director or designee will review all room change documentation prior to moves occurring X 60 days and monthly thereafter to ensure proper procedure is followed. Any issues identified will be investigated and rectified	03/15/2013

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	<p>decertification:." Each of the residents had a payment source of Medicaid (NF) and was occupying a bed dually certified for either medicaid (NF) or medicare/other (SNF) payment source. Each of the residents had waived their right to 48 hr notice and /or a relocation planning conference and moved either the same day or within 24 hours.</p> <p>Facility certification change request and approval letters were reviewed on 2/13/13 at 10:30 A.M. On August 15, 2012 the facility corporation Licensure analyst requested a change of 6 beds in 3 rooms from dual certification (SNF/NF) to (SNF only) certification. On September 12, 2012 the Division of Long Term Care sent an approval letter for the change with an effective of October 1, 2012.</p> <p>The Social Service Director was interviewed on 2/11/13 at 1:00 P.M. in regard to the notifications she had provided to residents and the room changes completed. She indicated she was informed (on or before 8/31/12) to begin making the changes and did not realize there was an effective date of October 1, 2012. She indicated her understanding that since the certification change, the facility could then have the beds to</p>		<p>immediately to meet the federal requirement.Completion Date 3-15-13Summary of room changes with reasons will be submitted to QA committee monthly for 12 months for review and further recommendations.</p>				

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	<p>move (SNF) residents in. Documentation was lacking to indicate residents, who were being asked to move, were informed they had until October 1, 2012, rather than 48 hours to change rooms.</p> <p>The Business office manager was interviewed on 2/13/13 and provided information that reflected all residents were moved before the facility received the 9/12/12 approval of certification and before the 10/01/12 effective date as follows:</p> <p>Resident 13 vacated his/her room the same day of the notification on 8/31/12 and the room was given to Resident 87 with SNF pay source on the same day.</p> <p>Resident 46 vacated his/her room on the same day of the notification on 8/31/12 and the room was occupied the same day by Resident 70 (SNF payor source).</p> <p>Resident 38 and Resident 66 vacated their jointly occupied room on 9/5/12 and the accommodation was converted for a single occupant Resident 87, with an dual occupancy rate also of a SNF payor source.</p> <p>3.1-12(a)(14)</p>				

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F0204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>Based on observation, interview and record review, the facility failed to provide preparatory information and instruction for the safe and orderly discharge of 1 of 1 resident observed during discharge. Resident 21</p> <p>Findings include:</p> <p>On 2/11/13 at 10:50 A.M., Resident 21 was observed being discharged from the facility by RN 8. The resident was preparing to leave by wheel chair pushed by a family member. RN 8 handed the family member a form with some information.</p> <p>The form was folded and the family member briefly glanced at it and left with the resident after expressing social pleasantries with the nurse.</p> <p>Ten minutes later the family member returned with out the resident carrying the form. He/she indicated lack of information and understanding. Holding the form out to the RN 8, he/she noted the list of 17 medications which had been</p>	F0204	<p>F 204Res 21 suffered no ill effects from the alleged deficient practice and had her meds explained to her.Completion Date 3-15-13There were no other residents affected by the alleged deficient practice and through corrective actions will ensure post discharge instructions are complete.Compleiton Date 3-15-13Staff inserviced on discharge instruction form and requirement of process.Completion Date 3-15-13Director of Health Services /Designee will review all discharge forms daily for accuracy and completion prior to resident discharge X 3 months and monthly thereafter.Completion Date 3-15-13Results of monitoring will be forwarded to QA committee monthly X 12 months</p>	03/15/2013			

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	<p>transcribed on the form. He/she asked "is there anything on here for pain? The first thing (resident name) will want is a pain pill. When did (resident name) have the last one and how often can I give them?" RN 8 responded there were no pain medications on the list and the resident had been receiving Percocet. She indicated to the family member that the last pain pill was given at 8:00 A.M., earlier that morning. She indicated the physician had not left an order for pain medicine and if one was needed "That's between you and the doctor now." The family member said the resident didn't have an appointment yet with the doctor and it would be a problem to take the resident out of town and then have to come back to the pharmacy to get medication. The nurse indicated the physician would have to be called, hesitated and then informed the family member she had to call the physician on another matter and would ask about (resident name) "in just a minute" so family would have to come back in town. Twenty minutes later at 11:20 A.M., the nurse had not called the physician or delegated the task.</p> <p>The clinical record copy of the post discharge instruction, which had been</p>			
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	<p>given to the family member, was reviewed on 2/11/13 at 12:50 A.M. The form had a column for "reason for medication" which had not been completed for 17 of 17 listed medications. There were 15 of the 17 medications not completed in the "next dose due" column. The 2 which were completed were alternating doses of Coumadin (blood thinner). One indicated only the date it was to be given and the other indicated only a time. The time and date of the next administration due was unclear.</p> <p>The Director of Nursing was interviewed on 2/12/13 at 2:00 P.M., regarding the discharge. She reviewed the Post Discharge Instructions which had been sent with the family member and indicated the form was inadequately completed.</p> <p>3.1-12(a)(21)</p>				

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F0253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on interview and record review, the facility failed to ensure 1 of 7 private rooms on the 400 hall were free from an odor caused by sewer gas for 2 of the residents reviewed that had resided in room 412. Resident # 8, 9</p> <p>Findings include:</p> <p>1. During an interview on 2/6/13 at 10:30 A.M., Resident # 8 indicated there was a problem with the sewage in his room. He said, "The sewer gas was so bad last night it gave me a headache. It was the worst since I have been here. I have noticed the smell since I moved in here at the end of December." Resident # 8 said, "I told them about it and they said it was the sewer trap." He indicated that sometimes the smell was worse than at other times. He also indicated the staff would come in and occasionally run the water in the shower drain if the room started to smell bad.</p> <p>On 2/12/13 at 3:10 P.M., the Intrafacility Transfer Form dated 2/6/13 was reviewed. The review indicated that Resident #8 requested to be moved out of room 412 due to sewer smell in the bathroom. The Resident was moved to Room 407 on 2/6/13.</p>	F0253	<p>F253Resident #8 and #9 suffered no ill effects by the alleged deficient practice and through corrective actions will ensure that rooms on the 400 hall remain free of odor from sewer gas. Completion Date 3-15-13 Room 412 had all traps, seals and vents checked, the vents in the attic space above the room were checked, HVAC unit above the room was found to in need of a trap and it was placed, powered exhaust fan was connected in bathroom, stack extended 2 feet on roof, contractor inspection of all drain work and sewer gas testing was performed. Completion Date 3-15-13 Systemic change is that room 412 will remain unoccupied for 30 days to ensure there are no further complicaion of sewer gas odor. Director of Plant Operations /designee will monitor 400 hall by rounding 3 random times per day X 30 days and daily thereafter. Results of audits will be forwarded to QA committe monthly for 12 months.</p>	03/15/2013	

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	<p>2. During an interview on 2/6/13 at 3:15 P.M., Resident # 9 indicated she was initially admitted to room 412, but she had to be moved because of the smell of sewer gas. Resident #9's husband was in the room during the interview and said, "The smell was unbearable, and I went out and told the nurse we needed to move. They moved us right away." Resident # 9's husband indicated staff would come in and occasionally run the water in the shower drain if they smelled the sewer gas. Resident # 9's husband said, " One time they ran the water for an hour and a half, but the smell always came back in a few days or a week."</p> <p>On 2/12/13 at 3:20 P.M., the Intrafacility Transfer form dated 2/13/13 was reviewed. The review indicated Resident #9 requested to be moved out of room 412. There was no documentation indicating the reason for the requested move. Resident #9 was moved to Room 402 on 2/13/13.</p> <p>During an interview with CNA #7 on 2/11/13 at 10:20 A.M., CNA # 7 indicated she took care of Resident # 8 when he was in room 412. CNA # 7 indicated Resident # 8 was moved out because, according to her, Room 412 stinks. CNA # 7 said, " It's the shower drain that stinks, but I know what to do. I just go in there and run the water when I notice it smells."</p>						

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	<p>3. During an interview with LPN #12 on 2/11/13 at 12:40 P. M., LPN # 12 indicated the smell in room 412 comes from the shower drain. LPN # 12 said, "When we notice it smells bad, we run the water for 15 minutes and it takes care of it. If you run water one day it may not smell again until the next day or few days later." LPN # 12 indicated she had not noticed the smell of sewer gas in any other rooms. She indicated that Room 412 used to be a medication storage room with a sink and little dining room. She indicated that neither she nor other staff members noticed a smell of sewer gas until Room 412 was converted it into a resident room.</p> <p>During an interview with the Maintenance Supervisor on 2/11/13 at 2:05 P.M., the Maintenance Supervisor (MS) indicated that Room 412 has had a problem with the smell for at least 2-3 years. MS indicated a plumber was called in the past but was unable to determine the problem. MS said, "We have flushed the vent pipe and we now run the water down the drain to keep it from smelling. My plan now is to put a flap in the drain and see if that works."</p> <p>During an interview with the Health Care Administrator (HCA) on 2/11/13 at 2:35 A. M., she indicated she had heard about room 412 having a sewer gas smell occasionally. HCA indicated the building was located in a low lying area and when it rained water needed to</p>						

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	<p>be run down the drain to prevent the odors. She indicated that running water in the shower drain must not be an effective solution for resolving the sewer gas issue.</p> <p>Review on 2/11/13 at 6:05 P.M., of the Sewer Gas Guide from the North Dakota Department of Health (www.ndhealth.gov/aq/iaq), read as follows: "Sewer gas can enter the home through the floor drain, or leaking of a blocked roof vent pipe. Sewer gas is a mixture of toxic and non-toxic gases. Sewer gas contains methane, carbon dioxide, sulphur dioxide and nitrous oxides. Possible risks and health effects associated with sewer gas exposure include: 1. Hydrogen sulfide. This gas smells like rotten eggs, even at extremely low concentrations. Exposure at low levels of hydrogen sulfide can irritate eyes, cause a sore throat, shortness of breath, and fluid accumulation in the lungs. Other symptoms include nervousness, dizziness, nausea, headache, loss of appetite, irritability, poor memory and drowsiness. It can be difficult to detect high concentration of hydrogen sulfide just by smelling, making this warning signal unreliable. 2. Methane. High concentrations of Methane in enclosed areas can lead to suffocation since elevated levels lead to decreased amounts of oxygen in the air. The effects of oxygen deficiency can include headache, nausea, dizziness and unconsciousness."</p>			

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	3.1-19(f)			

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F0323 SS=H	<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 interview and record review, the facility failed to ensure adequate supervision and/or interventions were properly implemented and/or provided to 4 of 8 residents reviewed for falls. Five residents were reviewed in Stage 2 for falls with 3 falls resulting in fractures, Resident #80, #54 and #41. The extended survey of 3 additional residents reviewed, indicated one added concern of Resident #33 for facility noncompliance to ensure the resident had adequate supervision to prevent falls. This resulted in substandard quality of care. Resident # 80, Resident # 54, Resident #41, Resident # 33</p> <p>Findings include:</p> <p>1. The clinical record of Resident # 80 was reviewed on 2/11/13 at 2 P.M. Resident #80 had been admitted to the facility on 12/6/11. Diagnoses included, but were not limited to, the following: Parkinsons, dementia, atrial fibrillation, frequent falls, back</p>	F0323	<p>We are requesting an IDR of this tag for reduction of scope and severity. Res #80's fall risks and careplan have been updated to reflect current interventions and all staff that care for her have been inserviced on these. She has not fallen in over 30 days and an intense evening schedule has been implemented to compensate for her more at risk time. Completion Date 3-15-13 Res #54's fall risks and careplan have been updated to reflect current interventions and all staff that care for her have been inserviced on these. Completion Date 3-15-13 Res #41 was discharged during survey Res #33 was a closed record All residents who are fall risk have the potential to be affected by the alleged deficient practice and therefore have been assessed to ensure careplan contains effective interventions to prevent/reduce falls and that these interventions are clearly communicated to staff. Completion Date 3-15-13 Systemic change is implementation of individual fall prevention log that includes careplan interventions and with</p>	03/15/2013			

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	<p>pain, depression, anxiety, muscle spasm, insomnia and chronic obstructive pulmonary disease.</p> <p>An MDS (minimum data set assessment) dated 8/13/12, indicated the following for the resident: cognition score of 11, which indicated moderately impaired cognition; bed mobility and transfer skills indicated the resident required extensive assistance (resident involved in activity, staff provided weight bearing support) for these tasks.</p> <p>An MDS dated 12/10/12, indicated the resident's total cognition score was a 10, which indicated moderately impaired cognition. Bed mobility and transfer skills remained the same as the 8/13/12 assessment.</p> <p>On 2/12/13 at 10:07 A.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated from 4/21/12 to 2/4/13, the resident had 10 falls. She indicated the fall on 1/21/13 resulted in a fractured hip.</p> <p>On 2/13/13 at 1 P.M., the DON (Director of Nursing) was interviewed. She indicated prior to the first fall, the resident had a patient protector alarm at all times (PPA) (this alarm has a tab which is attached by a string with</p>		<p>each fall the corresponding: date, time, place of fall and activity at the time. Completion Date 3-15-13 Licensed nurses inserviced on: fall risk and circumstance form to be completed and appropriateness of intervention post fall. Careplanning of risks identified and anticipating needs to reduce falls for those cognitive impaired that have no safety awareness and act impulsively. Alarm usage/manipulation and noncompliance alternatives. Completion Date 3-15-13 All nursing staff will be inserviced on rounding and anticipating needs expectations to reduce falls. Diversional activities and occupying those residents during their highest risk timeframes. DHS/designee will round and observe nursing staff for compliance with expectations regarding fall prevention: i.e anticipating needs and individual schedules followed for those at highest risk. Completion of individual fall prevention log and identification of trends. Results of rounding and fall prevention log will be forwarded to QA every 2 weeks for 3 months and monthly thereafter for the remaining 9 months.</p>		

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	<p>one end to the resident and the other end attached to the alarm box), self releasing alarmed seat belt in the wheelchair (wc) and bed in the lowest position. At that time, the DON provided copies of the Fall Circumstance, Assessment and Intervention (FCAI) form for each fall. The DON also provided her summary of each of the resident's falls. The information provided included, but was not limited to, the following information for each fall:</p> <p>Fall #1 on 4/21/12 at 9:50 P.M.: Resident was found on floor in her room; prior to fall had been in bed; "Safety equipment in place and functioning at time of incident? No"; "Pressure pad alarm functioning when res (resident) placed into bed. Alarm not sounding when res found on floor, alarm on. New alarm box installed." The DON's summary indicated the following: "Alarm in place, alarm connected an (sic) on, alarm functioning correctly but not sounding..." The intervention added in place after this fall was the bed against the wall and mat to the floor. The PPA at all times and self release alarming seatbelt (SRASB) and bed in lowest position continued.</p> <p>Fall #2 on 7/3/12 at 9 P.M.: Resident</p>			

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	<p>found on floor in her bedroom; Resident hit her head, ice was applied; was transferring herself from her wheelchair at time of fall; Wheel chair alarms were sounding. The intervention added after the fall was "re education" to the resident and a room monitor at all times (a auditory type monitor), which was placed in the room. "Safety equipment in place and functioning, yes." Upon interview at that time, the DON indicated staff did not respond to the alarm in time to prevent the resident from falling. The SRASB and PPA (at all times) and bed in lowest position also continued.</p> <p>Fall #3 on 7/13/12 at 9:45 P.M.: Resident found on her knees beside her bed, on the mat, praying. The current interventions included, but not limited to, the following: PPA, SRASB. The DON indicated at that time, the current interventions prevented injury. She also indicated the intervention added to the CNA assignment was to offer the resident time to pray. The FCAI form indicated the prevention update was to "re-educate res to ask for help before she gets up to pray." This form also indicated the safety equipment was in place and functioning at time of the incident.</p>				

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	<p>This form also indicated the "alarm sounding..." The bed in lowest position, SRASB, room monitor and PPA (at all times) continued.</p> <p>Fall #4 on 8/3/12 at 11:15 P.M.: the resident was found on the floor on mat at bedside, reaching for water on nightstand. She rolled out of bed in lowest position. PPA on and functioning. The DON indicated the new intervention added was to provide water on a stool by the bed and begin 1 hour bedchecks at night as a nursing measure. The prior prevention interventions continued.</p> <p>Fall #5 on 9/4/12 at 4:05 P.M.: Resident found on the floor in her room. Fall resulted in an abrasion to her left forearm. Resident was transferring herself from her wheelchair. The DON indicated the resident had returned to her room from the beauty shop without the alarms connected (SRASB and PPA). She indicated the alarms were in place but not reapplied after being in the beauty shop. The new intervention in place after this fall, was to educate the beautician to ensure alarms were connected/notify staff when resident returned to room.</p> <p>The DON indicated at that time, the</p>						

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	<p>resident's hourly bed checks at night were discontinued on 9/5/12 because the resident was sleeping through the night.</p> <p>Fall #6 on 9/14/12 at 2:20 P.M.: That was a witnessed fall. The resident was at the nurses station in her wheelchair. The resident attempted to transfer herself. Alarms in place but not on/sounding. SRASB and PPA. The new intervention in place after the fall was to add 1 hour bed checks when resident in bed and put the alarm boxes in bags out of the resident's reach. The DON indicated at that time, the staff had been counseled. The DON indicated from their investigation, they were not sure if the resident disconnected the alarms or if the staff failed to connect the alarms. The DON indicated that during her investigation, staff had informed her that they would find the alarm cords unplugged and then they would reconnect them.</p> <p>At that time, the DON provided a copy of the following document: "Follow up and Re education" form. That form was dated 9/14/12 to "All CRCA's (certified registered care assistants) from nsg (nursing). That form indicated the following concern: "(resident's name) seatbelt alarm was</p>						

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	<p>not found on. Res (resident) was found standing up in the hallway, then she slid down the wall. No injury noted. It is everybody's job to make sure the alarms are on."</p> <p>Fall #7 on 9/28/12 at 10:25 P.M.: The FCAI form indicated the following: found on floor in room, climbed out of bed, safety equipment in place and functioning at time of incident? "yes." The DON indicated at that time the following: "The resident was in bed with PPA, bed in lowest position, call light in reach, mat beside bed, hourly bed checks, pressure pad alarm in bed (had been placed by staff as a nursing measure). Res found on floor mat bedside bed, stated she thought it was time to get up. Res holding pt (patient) protector in hand and bed pad alarm cord disconnected at box. Boxes in mesh bags, secured to bed frame. Res states she disconnected the alarm. Alarms did not sound." The new intervention added was an alarming floor mat.</p> <p>Fall #8 on 10/9/12 at 9 P.M., the resident had been in her wc at the nurses station. The FCAI indicated the following: "This was an unwitnessed fall." "Pt (patient) removed all alarms and slid down to floor, seat belt still</p>			

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	<p>intact...safety equipment was in place and functioning at time of incident "Yes...Pt keeps taking all alarm devices off and ambulating...Root cause: impulsive...zyprexia increased to 7.5 mg po (per os) at hs (bedtime)..."</p> <p>The DON indicated at that time, the resident removed the seatbelt (which was alarmed) and attempted to ambulate. She indicated the alarms were in place, SRASB, PPA and the resident had taken off the SRASB and then reconnected it behind her. The DON indicated the resident had also removed the clip alarm. The new intervention added was a pressure pad alarm at all times. The form "Interact" was dated 10/9/12 and indicated the following: "(resident name) slid down chair, took of (sic) alarms and slid under seatbelt..."</p> <p>A note on the DON's documentation of her summary of the resident's falls, she indicated on 11/27/12 the pressure pad alarm to the chair was discontinued due to the SRASB and PPA.</p> <p>Fall #9 on 1/21/13 at 11:30 P.M., the resident was found on the floor in her room. The FCAI form indicated the resident's safety equipment was not in place and functioning at the time of</p>				

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	<p>the incident. The DON's summary of the incident indicated the following: "...Found on floor with SRASB not sounding, buckled in wc. Pt. protector removed with gown. Sent to ER for tx (treatment) and eval (evaluation). The DON's summary also indicated the resident returned to the facility on 1/28/13 with the following information: seat belt/self release to wc when up (clip type belt), wanderguard, bed against wall and 1 hour checks on day and evening shift with 20 minute checks from 10 P.M. - 6 A.M. and pressure pad alarm at all times. Upon interview at that time, the DON indicated this fall resulted in the resident fracturing her right hip.</p> <p>A Restraint/Enabler Circumstance, Assessment and Intervention form was dated 1/29/13. That form indicated the resident was unable to release the seatbelt. The DON indicated upon interview at that time, the resident was unable to consistently release the seat belt on command.</p> <p>Fall #10 on 2/4/13 at 9:15 P.M., the FCAI form indicated the following for the resident: she was in her wheelchair in her bathroom and was found on the floor. She had an abrasion to her right lower leg. She</p>			
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	<p>was undressing herself while in the wheelchair; patient unbuckled her seat belt; the safety equipment was in place and functioning at the time of the incident. The DON's written summary indicated the resident's alarms were sounding, and the resident had unclipped the seat belt. The new intervention was they changed the type of seatbelt to a Velcro alarming seat belt and also added a PPA at all times.</p> <p>At that time, 1 P.M. on 2/12/13, the DON also indicated the 9/14/12 when she was in bed until 10/30/12, when this was changed to hourly bed checks around the clock. The DON indicated the hourly bed checks were then changed on 11/21/12 to hourly bed checks on the day and evening shift and every 20 minute checks on the night shift (10 P.M. - 6 A.M.). She indicated the resident was currently on every 20 minute checks at night and hourly checks during the day and evening shift.</p> <p>On 2/12/13 at 4 P.M., the DON provided a current copy of the facility policy and procedure titled "Falls Management Program Guidelines." That form was dated as revised 3/08. That form included but was not limited to the following: "Purpose:...strives to</p>			

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	maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury. Definition: A fall is considered to be: "an unintentionally coming to rest on the ground, floor or other lower level...A fall without injury is still a fall...Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred...Procedure: The fall risk assessment is included as part of the Admission and Monthly Nursing Assessment and Review and Circumstance forms: Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling...Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form. The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT (Interdisciplinary						

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	<p>Team) to evaluate thoroughness of the investigation and appropriateness of the interventions..."</p> <p>2. Resident #54's clinical record was reviewed on 2/8/13 at 10:00 A.M. A nursing admission assessment dated 7/3/12, indicated Resident #54 had been admitted to the facility on 7/3/12. The assessment indicated on admission the resident had a left humerus fracture , short term memory deficits, and rambling /irrevelant conversation. Other diagnoses on admission included but were not limited to: breast cancer, depression, anemia, and osteoporosis.</p> <p>A Minimum Data Assessment Assessment (MDS) dated 7/10/12 (admission), indicated a cognitive score of 15 (13-15 cognition intact). An MDS dated 7/17/12 (14 day MDS) indicated a cognitive score of 14, a MDS of 8/28/12 (PPS unscheduled MDS), a cognitive score of 13, and a MDS dated 9/7/12 (significant change MDS), indicated a cognitive score of 11 (moderate cognitive impairment).</p> <p>On 2/11/13 at 9:58 A.M., the Director of Nursing (DON) had been interviewed, she indicated Resident #54, had a physician's order (dated</p>						

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	<p>7/9/12) for a patient protector alarm (clip alarm) when up in a chair.</p> <p>Fall #1: a fall circumstance, assessment and intervention documentation dated 8/29/12, indicated a fall had occurred in the resident's room at 8:15 P.M. That form indicated the resident had thought it was time to get up and the alarm had sounded. Documentation indicated the resident had left hip pain and was sent to the emergency room for evaluation.</p> <p>On 2/11/13 at 9:58 A.M., the DON had been interviewed, she indicated the resident had returned to the facility on 9/2/12, after hospitalization for a left hip fracture. She indicated on return on 9/2/12, she had a patient protector alarm and the assistance of 2 staff had been needed for transfers. She indicated on 9/7/12, the patient protector alarm had been changed to a pressure pad alarm.</p> <p>Fall #2: a fall circumstance, assessment and intervention documentation indicated a fall had occurred on 9/23/12 at 1:00 P.M. in the resident's room. The documentation indicated the resident had been transferred with a gait belt and a side rail used by the resident</p>				

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	<p>during the transfer had not locked. The side rail fell causing the resident to loose balance. No injury documented.</p> <p>On 2/11/13 at 9:58 A.M., the DON had been interviewed, she indicated there had been only one staff transferring Resident #54, during the 9/23/12 fall. She indicated there should have been 2 staff for this resident transfer. She indicated the CNA involved had been counseled.</p> <p>On 2/12/13 at 1:47 P.M., an Employee Counseling Record dated 9/23/12, had been reviewed. The counseling record indicated the resident fell and the CNA had not used a gait belt and had not transferred the resident with the assistance of 2 staff.</p> <p>Fall #3: a fall circumstance, assessment intervention form dated 10/27/12 at 11:00 A.M., indicated a fall had occurred in Resident #54's room. The documentation indicated the resident's alarm had sounded at the time of the fall. No injury had been documented. The immediate intervention documented had been to place the bed in the lowest position.</p> <p>On 2/11/12 at 9:58 A.M., the DON</p>						

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	<p>had been interviewed, she indicated the resident had been in bed and the alarm had been functioning. She indicated staff had been unable to assist resident before she fell. She indicated the Interdisciplinary Team review (IDT) of 10/29/12, indicated the resident had been climbing over and around the side rail attempting to transfer. She indicated the resident had been utilizing the side rail for positioning in bed and to sit up.</p> <p>Fall #4: documentation of a fall circumstance, assessment and intervention on 11/25/12 at 6:30 A.M., indicated a fall had occurred while the resident had been trying to toilet herself. No injury had been documented. That documentation indicated that safety equipment had not been in place and functioning at the time of the fall. Immediate intervention had been to keep the resident wheelchair out of sight. That documentation also indicated a urinalysis had been obtained and the resident had been given the antibiotic, Macrobid.</p> <p>Fall #5: a fall circumstance assessment intervention dated 12/6/12 at 7:30 P.M., indicated a CNA "... entered the bathroom and res.(resident) fell to floor, unable to</p>			

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	<p>catch her..." "...Had been toileted @ 7 pm per CNA; Res stated she felt like she had to urinate again..."</p> <p>Documentation indicated the alarm had sounded and there had been no injuries. Immediate interventions had been to toilet before bed and re-enforce the use of call light.</p> <p>On 2/11/13 at 9:58 A.M., the DON had been interviewed regarding the 12/6/12 fall, she indicated the alarm had been sounding at the time of the fall. She also indicated the resident had been still receiving the antibiotic, Macrobid for a urinary tract infection.</p> <p>Fall #6: a fall circumstance, assessment and intervention dated 12/26/12 at 10:15 A.M., indicated the resident had been found on the floor in the doorway to her resident room. No injuries had been documented. Documentation indicated the resident's alarm had not been plugged in and the alarm cord was out of the alarm box. The immediate intervention had been to re- educate staff.</p> <p>On 2/11/12 at 9:58 A.M., the DON had been interviewed, she indicated after the 12/26/12 fall, the alarm had been changed to a cord security alarm box.</p>			

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	<p>Fall #7: a fall circumstance, assessment and intervention form dated 12/30/12 at 9:45 A.M., indicated a fall had occurred at the bedside when the resident had attempted to stand from her wheelchair. The documentation indicated the pressure pad alarm had sounded. No injuries had been documented. The immediate intervention had been to add a patient protector alarm at all times.</p> <p>On 2/11/13 at 9:58 A.M., the DON had been interviewed, she indicated the pressure pad alarm had sounded. She indicated a patient protector alarm (clip alarm) had been added with the pressure pad alarm after this fall.</p> <p>Fall #8: a fall circumstance, assessment and intervention form dated 1/14/13, indicated a fall had occurred at 6:00 P.M., in the resident's room. Documentation indicated there resident had slid out of her wheelchair onto the floor. No injures had been documented. The immediate intervention had been to add dicem (non slip fabric) to her wheelchair.</p> <p>On 2/11/13 during 9:58 A.M., the</p>						

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	<p>DON had been interviewed, she indicated the alarm had sounded before the 1/14/13 fall. She indicated dicem had been added to the resident's wheelchair after the 1/14/13 fall.</p> <p>Fall #9: another fall had been documented on the fall circumstance, assessment and intervention form dated 1/19/13. The fall had occurred at 8:40 P.M., in the resident's room. No injuries had been documented. The documentation indicated an immediate intervention had been to place her bed in a low position.</p> <p>On 2/11/13 at 9:58 A.M., the DON had been interviewed, she indicated the new intervention had been from placing a regular bed to the lowest position to an actual low bed on the floor. She indicated both alarms (patient protector and pressure pad) had sounded before the 1/19/13 fall.</p> <p>Fall #10: a fall circumstance, assessment and intervention dated 2/4/13, indicated a fall had occurred in Resident #54's room at 3:40 P.M. No injuries had been documented. The immediate intervention had been to lay the resident down after lunch and an occupational therapy evaluation.</p>			

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	<p>On 2/11/13 at 9:58 A.M., the DON had been interviewed regarding the 2/4/13 fall. She indicated the resident had been trying to transfer herself back to bed. The DON indicated the alarms had been functioning properly at the time of the fall.</p> <p>Fall #11: a fall had been documented on 2/6/13 on a fall circumstance, assessment and intervention form. The documentation indicated the fall had occurred in the resident's room at 7:50 P.M. No injuries had been documented. Documentation indicated the resident had crawled out of bed onto her knees. The alarm had sounded. The immediate intervention had been to implement a mat beside the bed when the resident was in her bed.</p> <p>On 2/11/13 at 10:53 A.M., the DON was interviewed regarding Resident #54's falls from 8/29/12 through 2/6/13. The DON was made aware of the lack of supervision and assistance needed in regard to alarms functioning and that staff had frequently been unable to assist the resident before she fell. The DON indicated, at that time, the alarms were effective in alerting staff.</p>			

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	<p>3. On 2/12/13 at 2:45 P.M., Resident # 41's clinical record was reviewed. Her clinical record indicated she had been admitted to the facility on 12/1/12, after a left hip fracture. Other diagnoses included but were not limited to: a history of dementia, diabetes, depression, anxiety disorder, and a history of cardiovascular accident (CVA). An Admission nursing note 12/1/12 at 3:00 P.M., indicated, "... alert c (with) confusion..."</p> <p>A Minimum Data Set Assessment (MDS) dated 12/7/12 (admission MDS), indicated a moderate cognitive impairment with a score of 11. A skilled nursing assessment and data collection form dated 12/20/12, indicated signs and symptoms of dementia, forgetful with confabulations.</p> <p>Fall #1: a fall circumstance assessment, and intervention form dated 12/26/12, indicated at 4:45 P.M., on this date the resident had been found found on the floor. Documentation indicated the resident had been reaching for a box of candy on her bedside table and slid out of her wheelchair. No injuries had been documented. The immediate</p>						

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	<p>intervention had been to encourage the resident to ask for assistance and re-educate the resident.</p> <p>On 2/12/13 at 3:25 P.M., the Director of Nursing (DON) was interviewed regarding the 12/26/12 fall. She indicated the resident had slid from her wheelchair when reaching for chocolate on her bedside table.</p> <p>Fall #2: a fall circumstance, assessment and intervention form dated 1/10/13, indicated a fall had occurred in the resident's room on 1/10/13 at 6:30 A.M. No injuries had been documented. Documentation indicated the resident had not used her call light and her wheelchair had not been locked at the time of the fall. The immediate interventions had included : bed and chair alarm and to teach the resident wheelchair safety.</p> <p>On 2/12/13 at 3:25 P.M., during interview with the DON, she indicated a pressure pad alarm had been added to the resident's chair and bed at all times after the 1/10/13 fall.</p> <p>Fall #3: a fall circumstance, assessment and intervention form dated 1/13/13, indicated a fall had occurred in the resident's room at</p>			

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	<p>6:30 A.M. The documentation indicated the resident's pressure pad alarm had been in place and functioning. No injuries had been documented. Immediate interventions initiated had been to: teach wheelchair safety, diversional activities, bed in low position, staff to check and assist resident every A.M., at 6:15 A.M., with transfer.</p> <p>An Interdisciplinary Team (IDT) review dated 1/14/13, indicated the interventions that had been initiated included labs of a CBC and a Chem 14. Documentation indicated the resident had been started on Cipro (an antibiotic) to treat an urinary tract infection (UTI).</p> <p>On 2/12/13 at 3:25 P.M., during interview with the DON, she indicated the resident's pressure pad alarm had been functioning at the time of the 1/13/13 fall. She indicated lab work had been done and the resident had been started on Cipro for a UTI. She indicated also that staff were to start assisting the resident up in am at 6:15 A.M.</p> <p>On 2/12/13 at 3:35 P.M., during interview with the DON, she was made aware</p>			

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	<p>of the re-education intervention of the resident to ask for assistance as inappropriate in regard to the 12/26/12 fall due to the resident's documented confusion. The DON also had been made aware of the staff not assisting and/ or providing adequate supervision to prevent the fall in regard to the alarm functioning before the 1/13/13 fall. The DON did not provide further information at that time.</p> <p>4. The Clinical Record for Resident # 33 was reviewed on 2/12/13 at 1:00 P.M. Resident #33's admission date to the Transitional Care Unit was 10/26/13. Diagnoses for Resident 33 included, but were not limited to, Alzheimer's Dementia, Hypertension, Hyperthyroidism, Osteoporosis.</p> <p>Resident # 33's Minimum Data Set Assessment dated 11/2/12, indicated a cognitive score of 7, which indicated a severe cognition impairment.</p> <p>Nursing notes for Resident #33 were reviewed on 2/12/13 at 1:00 P.M. The review indicated the following: On 9/27/12 at 9:00 A.M., the "Resident was noted to be sitting on the floor in front of the wheelchair. When asked what happened, resident unable to answer. Assessment done and no</p>			

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	<p>injuries noted. Resident alert et (and) WNL (with in normal limits) per V/S (vital signs) 132/64, 74, 18, 97.. Family notified. alarm functional and sounding."</p> <p>Nursing note dated 10/27/12 at 12:45 P.M., indicated Dycem foam would be placed in the wheelchair seat.</p> <p>Fall # 1: on Fall Circumstance, Assessment, and Interview Form was reviewed on 2/12/13 at 1:00 P.M. The review indicated Resident #33 fell on 10/27/12 at 9 A. M., in the Resident's room. The fall was not witnessed. The Resident was unable to tell the nursing staff what happened. When nursing staff responded to the sound of a pressure pad alarm, Resident #33 was found in a sitting position on the floor directly in front of wheelchair. The physician was notified. Placing Dycem foam in the seat of Resident #33's wheelchair was the follow-up intervention to that fall. The intervention was reviewed by the Interdiscilipnary Team (IDT) team on 10/29/12, and the Intervention was deemed by the IDT team to be appropriate.</p> <p>On 2/12/13 at 1:00 P.M., the following Skilled Nursing Assessment and Data Collection forms were reviewed and they indicated:</p>				

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	<p>Nurse's notes/comments dated 10/27/12, at 5:30 P.M., " Requires constant supervision r/t patient's desire to be up walking and rummaging . Will not follow redirection, does not benefit from divisional activities, does not watch TV, does not choose to sit in wheelchair, straight chair, or couch. Monitored 1:1 by this RN and CNA. Wanders into other patients' rooms and picks things up. Monitored 1:1 and sometimes 2:1 for safety. Unsteady on feet. Chair pressure pad of no value."</p> <p>Nursing notes/comments dated 10/30/12, at 6 P.M., "Resident #33 requires 1:1 supervision of staff. Does not use call light to alert staff of needs. Would go to other residents' rooms without 1:1. Lacks basic safety awareness. Will get up from unlocked wheelchair and then sit down in unlocked wheelchair. Unable to appreciate the risk of falls related to Dementia. Does not benefit from education related to dementia and impulsiveness."</p> <p>Nursing notes/comments dated 11/2/12, 3-11 shift, "Resident #33 requires 1:1 assist/observation related to safety. Does not follow instruction,</p>						

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	<p>rooms and rummages. Gait and ambulation unsteady. Does not comprehend need for alarms and safety protocol. Family is here throughout day to provide care. Patient is generally pleasant with increased confusion."</p> <p>Nursing notes/comments dated 11/4/12, 11-7 shift, "Up at night to toilet, does not use call light and needs assistance to toilet, will sit on shower chair or trash can to toilet, must reorient to commode. Is usually pleasant and cooperative when redirected."</p> <p>Fall # 2: Circumstance, Assessment, and Interview Form was reviewed on 2/12/13 at 1:00 P.M. The review indicated that Resident # 33's, 2nd fall was in the dining room, on 11/8/12 at 8:15 AM. Resident #33 was sitting in a wheelchair at the dining room table and got up to return to room. Resident #33 caught foot on front wheel and fell forward, falling to the floor. An alarm sounded. Interventions implemented after fall were as follows: 1.) Self releasing alarm seat belt installed in wheelchair. 2.) Pressure pad alarm discontinued in wheelchair, and 3.) Continue pressure pad alarm in Resident #33's bed.</p>			

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	<p>On 2/12/13 at 1:00 P.M., Resident #33's Care Plan for falls dated 10/29/12 was reviewed. The Care Plan for Resident #33 indicated that the Resident was "at risk for fall/injury related to a history of falls, potential for falls,disease process, functional problems, decreased safety awareness and poor cognition." Interventions were as follows: 1.) Remind resident to reinforce safety awareness. 2.) Lock brakes on bed, wheelchair before transferring. 3.) Educate/remind resident to request assistance prior to ambulation. 4.) Pressure pad alarm at all times. Do not leave unattended if alarm off. 5.) Check functioning et placement of alarm every shift and prn. Care Plan was updated 10/30/12. New intervention as follows: 1.) Up adlib in room when family present because Resident has signed self determination of care form. Care Plan updated 11/8/12. New intervention as follows: 1.) Pressure pad alarm while in bed. 2.) Self release alarm seat belt to W/C when up. 3.) Check twice a day that resident can release the self releasing seat belt..</p> <p>A radiology report from the hospital Dated 11/8/12 was reviewed on 2/12/13 at 1:00 P.M. The report read</p>			
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	<p>as follows: "New right superior/inferior pubis bone fractures."</p> <p>During an interview with the Director of Nursing (DON) on 2/12/13 at 4:00 P.M., the DON indicated that on 11/8/12 at 8:30 A.M., Resident # 33 was in the dining room sitting at the dining room table (in her wheelchair with a functioning alarm) for breakfast. When Resident # 33 stood up from her wheelchair and took a step forward, the alarm sounded, but the CNA was delivering a food tray to the table next to where Resident #33 was sitting. The DON indicated that as soon as the CNA set the food down on the adjacent table, the CNA then immediately turned to get Resident # 33, recognizing that Resident #33 already was in the process of falling. The DON indicated that the CNA could not reach Resident #33 in time to prevent the fall. Resident #33 was subsequently sent by ambulance to the ER where she was determined to have a pelvic fracture.</p> <p>3.1-45(a)(2)</p>				

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F0371 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 and interview, the facility failed to ensure sanitary conditions for food preparation, serving, and storage during 2 of 2 kitchen tours with the potential to impact 61 certified residents.</p> <p>Findings include: On 2/5/13 at 9:45 A.M., the first kitchen tour was started. Four unwrapped, prebaked pizza crusts were observed in the walk-in freezer sitting on top of a case of pizza crust. The Assistant Food Service Manager (AFSM) removed the crust and said, "I will throw those away." A box of exposed pork fritters was observed sitting on the 2nd shelf of the walk-in freezer. The box lid and inner plastic bag was left opened, leaving the product exposed. The ASFM closed the box and indicated the box should not be open. An open bag of Tater Tots was observed on the bottom shelf of the walk-in freezer, leaving the product exposed.</p>	F0371	<p>F 371There were no residents affected by the deficient practice and through corrective actions will ensure that sanitary conditions for food preparation, serving, and storage areas are maintained.Completion Date 3-15-13Radio was removed from the kitchen and new trash receptacles were placed in the kitchen.Completion Date 3-15-13Ice machine has been cleaned.Completion Date 3-15-13Food stored in the walk-in freezer is arranged properly.Completion Date 3-15-13Systemic change is that a daily cleaning schedule for the ice machine has been implementd, sanitizing solution is being checked every hour and changed every 2 hours to maintain efficacy of >200 ppm.Completion Date 3-15-13Kitchen staff have been inserviced on proper sanitaiton requirements and food storage as well as cleaning schedule for ice machine.Completion Date 3-15-13Director of Food Service/designee will Imonitor sanitation compliance by rounding 2 random times per day X 30 days and daily thereafter.</p>	03/15/2013			

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NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 COLLEGE AVE VINCENNES, IN 47591		
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	<p>On 2/11/13 at 1:10 P.M., a second tour of the kitchen was conducted. The Food Service Manager (FSM) was asked to check the concentration of sanitation solution. He gathered 3 red buckets containing the sanitation solution used for cleaning the food preparation areas. The FSM placed a test strip in the sanitation solution for 10 seconds. He then compared the results of each strip to the results chart on the container. The concentration of sanitation solution in the first bucket was 190, the concentration of sanitizing solution in bucket 2 was 150 and the concentration of the sanitizing solution in the 3rd bucket was 180. He indicated the concentration of sanitation solution should be 200 or above and he would start changing the solution more frequently.</p> <p>The ice machine located in the kitchen, near the door that accesses the assisted living dining room had a slick, pink substance on the ice maker inside the storage bin. The pink substance was visible on the towel when wiped. The FSM indicated he did not have a cleaning schedule for the ice machines. He indicated that he just cleaned the ice machine when needed.</p>		RD will also conduct full sanitation audits weekly. Results of audits will be forwarded to QA committee monthly for 12 months.		

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	<p>On top of the clean dish storage cart, located over the clean bowls, a radio which had a thick dust build-up on the speaker covers and a thick, sticky unknown substance on the operational buttons was observed. Upon sharing this observation with the FSM, the FSM acknowledged the device and its condition and responded by saying, "This is bad."</p> <p>There were covered trash receptacles located next to each of the 3 sinks. The underside of the lid was covered with a black substance that appeared to be mold and dirt. The FSM said, "They're just old and I need to get new ones."</p> <p>3.1-21(l)(2) 3.1-21(l)(3)</p>			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact 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</p>	F0441	F441There are no residents affected by the alleged deficient	03/15/2013			

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	<p>ensure glucometers were effectively disinfected following use by 1 of 2 nurses with potential to effect 1 of 4 residents. Resident 3 Resident 19 Resident 51</p> <p>Findings include:</p> <p>The medication administration pass by RN 8 was observed on 2/11/13 at 11:00 A.M. She had a sequence of 3 residents scheduled for glucometer readings (blood sugar tests) with the same glucometer unit. She began by performing a test on Resident 19. Following the test she cleansed the unit with a PDI Sani-Cloth (registered trade mark) chlorine based disinfectant swab which was provided on her medication cart and was deemed effective against target blood borne pathogens.</p> <p>RN 8 then proceeded to perform a test on Resident 51 with the same unit which she had sanitized. Following the test, she used an alcohol swab to clean the glucometer but failed to disinfect it. She stored the unit for reuse, indicating she still had one test to perform for Resident 3. She left the medication cart briefly and upon return prepared to use the unit for Resident 3. She was informed there had been no effective</p>		<p>practice and resident #3 had the potential to be affected as stated in the 2567, but through inservicing and monitoring will ensure proper cleaning of glucometers occur. Completion Date 3-15-13RN #8 has individual inservicing provided and competency testing regarding sanitizing of glucometers. Completion Date 3-15-13 Licensed nursing staff will inserviced on proper sanitizing procedure for glucometers. Completion Date 3-15-13DHS/Designee will randomly monitor 3 accuchecks per day X 2 weeks on all skilled units, then 3 randomly per week X 3 months, the 3 randomly per month. Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter.</p>		

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	<p>disinfection of the unit and she stated "Well I used the alcohol, isn't that ok as long as I cleaned it ?"</p> <p>The Director of Nursing was interviewed on 2/11/13 at 12:10 P.M. regarding the policy and procedure for glucometer cleaning. She indicated the nurse had not followed the guidelines.</p> <p>On 2/11/13 at 12:45 P.M. the undated facility "Glucometer Cleaning Guidelines " were reviewed. The guidelines included :...disinfect after each use ...with an EPA (Environmental Protection Agency) registered detergent/germicide with a tuberculoidal or HBV(Hepatitis B Virus) /HIV (Human Immune Deficiency) Virus label claim, or a dilute bleach solution...Sani-cloth bleach wipe..." chlorine based. "Alcohol is not an EPA-registered detergent/disinfectant."</p> <p>3.1-18(b)(1)</p>				

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