

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052
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F000000	<p>This visit was for a Recertification and State licensure survey. This visit included the investigation of complaint #IN00148677.</p> <p>Complaint #IN00148677- Unsubstantiated due to lack of evidence</p> <p>Survey Dates: July 28, 29, 30, 31 and August 1, 2014</p> <p>Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470</p> <p>Survey Team: Mary Weyls RN TC Megan Burgess RN Kewanna Gordon RN July 28, 29, 31, and August 1, 2014 Lora Brettnacher RN July 30, 31 and August 1, 2014 Vickie Nearhoof RN</p> <p>Census Bed Type: SNF/NF: 32 Total: 32</p> <p>Census Payor Type: Medicare: 3 Medicaid: 27 Other: 2</p>	F000000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance effective 8/22/2014.</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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F000174 SS=D	<p>Total: 32</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 08/06/2014 by Brenda Marshall, RN.</p> <p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Based on observation, interview, and record review, the facility failed to ensure the right of the resident to have phone conversations without being overheard for 2 of 3 residents reviewed for privacy of phone calls (Resident #'s 29 and 49).</p> <p>Findings include:</p> <p>1. During a continuous observation on 7/30/2014 from 11:20 a.m. to 11:28 a.m., Resident #49 approached the DON (Director of Nursing) at the nurse's station and requested to make a phone call to his wife. The DON lifted the corded telephone from the desk to the top counter of the nurse's station, above Resident #49's eye level while in wheel chair, and asked Resident #49 for the</p>	F000174	<p>F174</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency. It is the policy ofthis facility to ensure all residents have reasonable access to the use of atelephone where calls can be made without being overheard. There is a telephone in the activity room forall residents to use to ensure privacy. Resident's identified in the alleged deficiency have been educated thatthey may no longer use the telephone at the nurse's station and directed to thetelephone in the activity area. It wasexplained to residents that if they need assistance to use the telephone theymay ask a staff member.</p> <p>1.Describe how the facility reviewed all clients in the facility</p>	08/22/2014	

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	<p>telephone number. The DON proceeded to dial the phone number and handed Resident #49 the telephone. She stood three feet from Resident #49 as he conversed on the phone. At 11:22 a.m., Resident #49 stated into the telephone, " I don't even know who to talk to here." The DON interjected during his phone conversation, "I can talk to you." The DON conversed with Resident #49 about topics he had spoken to his wife on the phone. He then stated to his wife on the phone, " Here, you talk to this lady," and the DON took the phone from Resident #49 and spoke with his wife from 11:23 a.m. to 11:24 a.m. After the DON completed her telephone conversation with Resident #49's wife, regarding his pain medication schedule and prune juice, she then handed the phone back to Resident #49. As Resident #49 continued his telephone conversation, the DON stood at the nurse's station, three feet away from Resident #49 and observed his phone conversation until it ended at 11:28 a.m.</p> <p>During an interview on 7/30/2014 at 12:05 p.m., Resident #49 indicated he was told by staff he could make phone calls from "a beauty shop or empty room down the hall" to his wife. He indicated he had not received education from the facility staff regarding how to properly</p>		<p>that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents who want to utilize the telephone have the potential to be affected. The Activity Director has reviewed the use of the telephone with residents at the resident council meeting on 8/13/14 and then reviewed with all cognitive residents individually that did not attend the meeting. This was completed on 8/18/14 (Attachment 1). A letter has been mailed to all resident's responsible parties and family members on 8/18/14 as well as hand delivered to all cognitive residents in the facility (Attachment 2). New residents will receive information about the use of the telephone in the activity room at time of admission.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All staff will be in service by 8/19/14 in regards to redirecting residents to the activity room when they want to use the telephone, rather than using the one at the nurse's station (Attachment 3). Staff will be required to assist the resident to</p>		

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	<p>dial out on the phone, which required extra steps besides dialing the phone number. He had attempted to use this phone independently and became frustrated with his unsuccessful attempts to dial out on the phone. He indicated when he approached the nurse's desk to request to make a phone call, staff rarely offered him a private setting, requested the phone number, and dialed for hi. He indicated he felt his phone calls were not private and could be overheard at the nurse's station. He indicated he did not require assistance to physically dial numbers on the telephone.</p> <p>During an interview on 8/1/2014 at 11:00 a.m., the Nurse Consultant indicated there was no policy for resident privacy during use of the telephone. She indicated residents made phone calls at the nurse's station and if they requested privacy on the phone, their phone calls could be made in the Activity Room or other offices.</p> <p>Resident #49's record was reviewed on 7/30/2014 at 11:40 a.m. Resident #49's diagnoses included, but were not limited to, CAD (coronary artery disease), DM (diabetes mellitus), HTN (hypertension), and COPD (chronic obstructive pulmonary disease).</p>		<p>the activity room and assist the resident as needed. Members of the management team will ask theresidents if they have privacy during their phone calls as part of theirGuardian Angel rounds that occur at least 5 days a week. They will report toAdministrator anyone who expresses a concern in this area (Attachment 4).</p> <p>Members of the interdisciplinary management teamwill also ask residents about private telephone usage as part of the monthlyQIS Resident Interview & Resident Observation questions. Any concerns willbe reported to the Administrator as well.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Administrator ordesignee will receive the results of the Angel rounds and will review them aspart of her daily routine for concerns with use of telephone and privacy. The Activity Director will review privatetelephone usage with residents during resident council meetings for the next threemonths and then quarterly thereafter. She will direct any noted concernsregarding privacy during telephone calls to the Administrator. The Administrator will report findings to theQA monthly for three (3) months. When no concerns over</p>				

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	<p>A Resident Admission Assessment Data Collection Form, dated 7/25/2014 indicated Resident #49 was alert, answered questions readily, had clear communication, and was talkative.</p> <p>An Interdisciplinary care plan dated 7/25/2014 indicated Resident #49 was able to establish his own goals.</p> <p>A Psychosocial Assessment dated 7/28/2014 indicated Resident #49 was able to make wants and needs known with clear speech and is alert and oriented to self, time, and place.</p> <p>2. During an interview with Resident #29's wife on 7/29/14 at 2:25 p.m., the resident's wife indicated the resident used the phone to call her. The wife indicated the resident could not converse on the phone without being overheard, because he was always on the phone at the nurses station.</p> <p>During an interview with LPN #3 on 8/1/14 at 9:56 a.m., the LPN indicated Resident #29 asked to call his wife frequently, but never asked for a private phone call. The LPN also indicated "No we never offer him a different phone than the phone at the nurses station. We only have this phone except for one (phone) in the dining room and his wife visits frequently so they can have privacy if</p>		<p>telephone privacy havebeen reported for 2 months in a row, the QA Committee may decide that furtherreporting to the Committee is no longer needed on a monthly basis. However, theAdministrator will bring the results of the quarterly resident council meetingsand any concerns expressed regarding telephone usage to the QA Committee on anongoing basis.</p>				

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F000241 SS=D	<p>they want during the visit."</p> <p>Resident #29's clinical record was reviewed on 7/30/14 at 11:08 a.m. An annual assessment, dated 7/30/14, indicated the resident required limited assist of one person for locomotion on the unit. A plan of care, with most recent update of 5/20/14, identified the problem of "I have impaired cognition's AEB [as evidence by] BIMS [brief interview mental status] score less than 13. I am at risk for my wants and needs not being understood." An approach of, but not limited to, was noted of "Encourage daily decision making offer me choices.</p> <p>An undated document titled "Resident Rights" was provided by the Administrator on 8/1/2014 at 11:10 a.m. and indicated the following: " Telephone Usage...A resident has the right to have reasonable access to the private use of a telephone...."</p> <p>3.1- 3(f)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and record review</p>	F000241	F241	08/22/2014			

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	<p>the facility failed to provide an environment that enhanced a resident's dignity for 2 of 2 residents observed being assisted with a meal (Resident #1 and 8).</p> <p>Findings include:</p> <p>During observation of a lunch meal on 7/30/14, CNA (Certified Nursing Assistant) #2 fed Resident #1 and CNA #8 fed Resident #8. During the meal, CNA #2 removed paper work from her pocket and was heard discussing facility work assignments and orientation tasks with CNA #8 while feeding Resident #s 1 and #8.</p> <p>Resident #1's clinical record was reviewed on 8/1/14 at 9:30 a.m. Diagnoses were noted of, but not limited to, closed head injury and schizophrenia.</p> <p>An annual MDS (minimum data set), dated 5/13/14, indicated the the resident had adequate hearing and "usually understands."</p> <p>Resident #8's clinical record was reviewed on 8/1/14 at 10 a.m. A quarterly assessment, dated 7/22/14, indicated the resident required extensive assistance with eating.</p>		<p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p>It the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognitionof his or her individuality. The two employees involved in the alleged deficiency were immediately educated to theproper policy and procedure in regards to feeding a resident.</p> <p>1.Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Any resident who is dependent onstaff to be fed have the potential to be affected. Nursing staff were educated to the properpolicy and procedure in regards to feeding a resident.</p> <p>1.Describe the steps or systemic changesthe facility has made or will make to ensure that the deficient practice doesnot recur, including any in-services, but this also should include any systemchanges you made. All nursing staff willbe inserved by 8/19/14 (Attachment 5)in regards to the facility policy #F002, "Feeding the Resident." (Attachment 6) The charge nurse or designee will be</p>		

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	A facility policy, dated June 2014, titled "Feeding the Resident", indicated "Do not discuss unpleasant subjects while the resident is eating. Never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention and avoid talking 'over' the resident to another staff member on an unrelated subject." 3.1-3(t)		presentin the dining room for all meals to ensure all residents are provided dignityat meals. If any concerns are noted regarding staff conduct during diningservices, the charge nurse or designee will address it immediately and redirectthe staff in the appropriate behavior. The charge nurse will notify the DON, ifthe DON was not present at the time of the noncompliance, and the DON willfollow up with re-training and progressive disciplinary action as warranted. 1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The DON or Designee will observe and audit the dining room x three (3) meals per week for twelve(12) weeks to ensure all resident's dignity is enhanced during meal time usingthe dining room observation audit (Attachment7) . The DON will report findings tothe QA committee monthly for three (3) months and when 100% compliance isreached, the QA Committee may stop the auditing activities. The monitoring ofthe dining services activities of the staff with the residents will be ongoing,however, and any concerns noted will be brought to the next scheduled QAmeeting for review and recommendations by the committee members.		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a plan of care which informed staff of a resident needs as reflected in the Minimum Data Assessment Tool (MDS) for 1 of 24 residents reviewed for care plans (Resident #2).</p> <p>Findings include:</p> <p>During an interview on 7/29/14 at 11:55 A.M., Licensed Practical Nurse (LPN) #1 indicated Resident #2 fell within the last thirty days and sustained a fracture.</p>	F000279	<p>F279</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p><i>The facility is requesting a Face to Face IDR for this alleged deficiency due to surveyor inability to understand the MDS coding rules and how that affects care plans. It is the policy of this facilityto develop comprehensive care plans that includes measurable objectives andtimetables to meet a resident's medical, nursing and mental and psychosocialneeds that are identified in the</i></p>	08/22/2014	

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	<p>During an interview on 7/30/14 at 11:43 A.M., LPN #1 indicated Resident #2 was alone in the bathroom when she fell and fractured her hip. LPN #1 indicated she was not aware Resident #2 needed physical assistance from staff for transfers and/or toileting needs prior to the resident falling and fracturing her hip.</p> <p>During an interview on 7/30/14 at 12:10 P.M., with the MDS (Minimum Data Set Assessment Tool) nurse coordinator indicated she developed care plans based on MDS results. The MDS coordinator indicated she coded Resident #2 as needing extensive assistance for toilet use due to needing extensive assistance when she used the bed pan. She indicated the assignment sheets and/or the care plan did not reflect the assistance needed by the resident based on the most recent MDS assessment.</p> <p>During an interview on 7/30/14 at 12:15 P.M., CNA #1 indicated Resident #2 turned on her call light when she needed assistance. The CNA indicated the resident occasionally needed help. Otherwise she was independent. CNA #1 indicated she used the assignment sheets to identify the amount of assistance with care a resident required.</p>		<p>comprehensive assessment. The identified resident was readmitted from the hospital on 7/25/2014. The initial admission care plan for this readmission was completed on 7/26/2014. The resident was still in the assessment window for a full comprehensive assessment during the time the surveyors were in the building (7/28-8/1/14). Resident was discharged on 8/6/2014.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by this alleged deficiency. In July, 2014, prior to the survey, the facility had already identified this issue as part of their process improvement activities, had taken the issue to the QAC committee and developed an action plan in regards to care plans not accurately portraying the residents and their needs. As part of the action plan, it had been decided that all resident care plans would be reviewed, updated and rewritten by 8/30/14 (Attachment 10).</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services,</p>				

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	<p>During an interview on 7/30/14 at 12:17 P.M., CNA #2 indicated she learned how much assistance a resident needed based on the assignment sheets. She indicated she was not aware Resident #2 needed assistance for transferring and/or toilet use prior to her fall.</p> <p>During an interview on 7/31/14 at 1:21 P.M., Resident #2 stated, " Yes, I know I needed help but I don't always put on the call light because they are short of help..." She indicated she had taken herself to the bathroom when she fell and broke her hip. She stated, "...When I stood up I felt something running down my leg and I turned around and that's when I fell..."</p> <p>Resident #2's record was reviewed on 7/30/14 at 9:00 A.M. Resident #2 had diagnoses which included, but were not limited to, end stage renal disease, cardiomegaly, surgical wound to left hip, sacral wound, multiple bruised areas, uterine cancer, coronary pulmonary disease, congestive heart failure, hypertension, and polyarthritis.</p> <p>An annual Minimum Data Assessment Tool (MDS) dated 4/25/14, indicated Resident #2's was cognitively intact with a brief mental status score (BIMS) of 15 out of 15, her balance was not steady wh</p>		<p>but this also should include any system changes you made. As part of the morning clinicalmeeting that is done at least 5 days a week, physician telephone orders,incident reports, and other indicators of resident changes are discussed by theinterdisciplinary team. Resident condition changes will be identified andreflected in the residents' care plans at that time. The DON or designee willalso add any changes in interventions on the CNA assignment sheets so that carestaff will have the updated information to use for their assigned residents. If any member of theinterdisciplinary team finds that resident changes are not being reflected onthe care plan or CNA assignment sheets, he/she will bring that to the attentionof the Administrator who will re-train those staff members who are involved,including rendering counseling as indicated by the level of noncompliance.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The MDS/Care PlanCoordinator or designee will audit five (5) charts weekly to ensure care plansand C NA assignment sheets match the resident's current condition. MDS Coordinator will report the findings ofaudit to the QA</p>		

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	<p>en she moved on and off the toilet. She was only able to stabilize with human assistance. This MDS indicated, she required the extensive assistance of one person to move between locations in her room and required extensive physical assistance for toileting.</p> <p>A current plan dated 5/5/14, indicated Resident #2 was at risk for falls with injury related to her impaired mobility and history of falls. A goal indicated Resident #2 would be free from fall related injuries. Resident #2's care plan lacked interventions which included physical assistance from staff to prevent falls and did not indicate interventions for reminding the resident to use her call light and wait for staff assistance with toileting.</p> <p>A nurse's note, dated 7/2/14 at 2:35 P.M., indicated Resident #2 was alert and oriented, could transfer independently, but needed the assistance of one staff for bed mobility and for toilet use.</p> <p>An incident report dated 7/12/14 at 11:00 A.M., indicated Resident #2 transferred off of the toilet alone and fell. As a result of the fall she injured her left hip and sustained a skin tear to her left elbow. Resident #2 reported to facility staff her legs gave out when she stood to get off of</p>		<p>committee monthly times three (3) months and as needed based upon QA recommendations. Even when the QA Committee no longer requires written audits, the review during the morning clinical meeting and subsequent activities to update the care plans and CNA assignment sheets, as well as the review of charts by the MDS/Care Plan Coordinator or designee to make sure that the care plans and CNA assignment sheets are current will continue on an ongoing basis.</p>	

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	<p>the toilet. She indicated she was in severe pain and could not move her left leg. The facility called the physician and orders were obtained to send her to the emergency room. This note indicated Resident 32 was in severe pain and could not mover her left leg.</p> <p>An untimed acute care hospital note, dated 7/12/14, indicated Resident #2 had been evaluated in the emergency after a fall. This note indicated, "...she was in the bathroom by herself changing her pad... she had turned to look in the toilet lost her balance causing her to fall injuring her left hip. She complained of severe pain and wanted to go to the emergency room for treatment and was found to have an intertrochanteric fracture of her left femur the patient has been declining in health over the past several years with end stage renal disease... prognosis at this time is extremely guarded because the patient's advanced cardiovascular however I think that she needs to have her hip fixed to have any possibility of survival..."</p> <p>A CNA assignment/resident information sheet identified as the "current" " assignment sheet for Resident #2 at the time of the fall by the MDS Coordinator and LPN #1 on 7/30/14 at 1:41 P.M., indicated Resident #2 was a fall risk,</p>						

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	<p>required the assistance of one person for transfers "at times mostly independent," required "set-up &/or Asst (assistance) X 1 prn (as needed), and utilized the bed pan. The CNA assignment sheet lacked documentation which indicated Resident #2's needed extensive assistance of one person to move between locations in her room and required extensive physical assistance for toileting which included how she used the toilet, bedpan, transferred on or off the toilet, cleansed herself after elimination, and to adjust her clothes.</p> <p>A policy titled "Care Planning" identified as a current facility policy by the Administrator on 7/31/14 at 1:50 P.M., indicated, "A care plan is initiated upon the admission/readmission of each resident to the facility, reviewed, and updated at intervals throughout the resident's length of stay. Purpose: To identify problems and developmental solutions for the coordination of resident care. To provide interdisciplinary, resident, and family input into the resident's plan of care....Within 7 days of completion of the MDS, a comprehensive care plan is completed and reviewed by the interdisciplinary team, resident, and/or family members... All disciplines involved in providing services to residents must attend care planning</p>						

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F000282 SS=E	<p>conferences to coordinate care and develop each resident's care plan...Problems will be identified through completion of interdisciplinary assessments, interviews and observations, and the Resident Assessment Instrument (MDS)... measurable, specific, time limited goals for each identified concern will be established...Nursing/MDS Coordinator has the responsibility of coordinating care among all disciplines to achieve established goals. At the care plan conference, nurse aide assignment sheets/care cards and face sheets are to be reviewed for accuracy and updated to reflect the resident's status..."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure</p>	F000282	F282 1.Describewhat the facility did	08/22/2014

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	<p>services were provided according to residents' care plans for 3 of 24 residents reviewed for care plan implementation (Resident #'s 25, 24 and 33).</p> <p>Findings include:</p> <p>1. During an observation on 7/31/14 at 2:23 P.M., with the Administrator and the MDS nurse coordinator present, Resident #25 was observed sitting in his wheelchair. A wedge cushion was not observed in his wheelchair.</p> <p>During an interview on 7/29/14 at 11:38 A.M., Licensed Practical Nurse (LPN) #1 indicated Resident #25 had fallen within the last 30 days.</p> <p>During an interview on 7/31/14 at 2:23 P.M., the MDS nurse coordinator indicated a wedge cushion was added as an intervention to prevent Resident #25 from falling on 7/30/14. She indicated it was not in his chair because therapy had to "order it."</p> <p>Resident #25's record was reviewed on 7/30/14 at 12:18 P.M. Resident #25 had diagnoses which included, but were not limited to, Parkinson's disease, hypertension restless leg syndrome, blind in left eye, insomnia, dementia, and schizophrenia.</p>		<p>to correct the deficient practice for each client cited in the deficiency.</p> <p>It is the policy of this facility that services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. The intervention of a wedge cushion to the resident #25's chair was added to the care plan on 7/31/2014 by the Interdisciplinary Team (IDT) after review of his incident. The wedge cushion is in use by the resident. Oral care for resident #18 has been added to the resident's ADL sheet to be signed off by nursing staff when completed.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents that fall have the potential to be affected by this alleged deficiency when new interventions are not initiated as recommended by the IDT. All incidents are reviewed by the IDT during daily clinical meeting that occurs at least 5 times a week. Care plans will not be updated with the suggested IDT interventions until new intervention is implemented. The DON or designee will also add any changes in interventions on</p>		

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	<p>A quarterly Minimum Data Assessment Tool Dated (MDS) dated 5/29/14, indicated Resident #25 had cognitive impairment with a BIMS (Brief Interview Mental Status) score of 7 out of 15.</p> <p>A fall risk assessment dated 7/23/14, indicated Resident #25 had a score of 23. This record indicated if a resident scored over "10" they were considered at high risk for falls.</p> <p>A care plan dated 7/23/14, indicated Resident #25 was at a high risk for falls with injury related to his impaired mobility, shuffling gait, history of falls, medication use, and diagnosis of Parkinson's disease. A goal to prevent falls with injuries included his risk factors would be reduced in attempts to avoid significant injuries. Interventions to meet this goal included adaptive equipment as ordered, chair and bed alarm, assistance of one person for transfers, bed in lowest position, mat at side of bed, and for staff to monitor for fatigue and unsteadiness.</p> <p>A document titled "Falls Tracking Log" provided by the MDS nurse coordinator on 7/31/14 at 1:50 P.M., indicated Resident #25 had fell on 7/2/2014, on 7/23/12, and again on 7/30/14 at 7:30</p>		<p>the CNA assignment sheets so that care staff will have the updated information to use for their assigned residents. All residents that require assistance with oral care have the potential to be affected by this alleged deficiency. As of 8/1/14 oral care has been added to all resident ADL sheets (Attachment 11) to be signed off by nursing staff when completed, and oral care has been added to the CNA assignment sheets.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>All nursing staff will be serviced by 8/19/14 (Attachment 12) on follow through for care plan interventions that are listed on the CNA assignment sheets, oral care, and documentation when oral care is completed. Members of the IDT will observe residents for oral care as part of their Angel Rounds done at least 5 days a week by asking cognitive residents if they received oral care & observing others for oral care (Attachment 13). In addition the IDT members will observe for breath odors or other indicators that oral care has not been done as they make numerous rounds during their tour of duty. Any concerns identified will be reported to the</p>	

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	<p>P.M. This record indicated after Resident #25 fell on 7/30/14, an immediate intervention put into place to prevent future falls was "Wedge cushion to be placed in resident's wheelchair in an attempt to avoid sliding."</p> <p>2. During an observation on 7/29/2014 at 2:35 p.m., Resident #18's teeth were chipped, stained and with food debris between the teeth.</p> <p>During an observation on 7/31/2014 at 11:40 a.m., Resident #18 was observed with 6 bottom teeth that had one chipped tooth, a heavy brown tint, and food debris between the teeth and gums. Resident #18 's top teeth were observed with a brown tint. A heavy breath stench could be smelled from Resident #18 's mouth when sitting two feet from him at his wheel chair level.</p> <p>During an observation on 8/1/2014 at 11:00 a.m., Resident #18 was observed with a heavy breath stench, that could be smelled when sitting two feet from him at his wheel chair level, and food debris was noted in between his teeth.</p> <p>During an interview on 7/29/2014 at 2:37 p.m., Resident #18 indicated staff did not assist him with cleaning his teeth.</p> <p>During an interview on 7/31/2014 at</p>		<p>Administrator /DON for followup, which will be comprised of getting oral care done as quickly as possible, re-training staff regarding the facility policy, and written counseling or discipline for continued noncompliance. DON and/or Designee will audit the resident ADL sheet three times weekly to ensure oral care is being documented and completed. Any identified issues will be addressed with retraining and written disciplinary action. The Administrator, DON and IDT members will observe for the use of seat cushions and other devices that have been care planned for fall prevention as part of frequent rounds throughout the facility during each tour of duty. If any issues are identified, the Administrator, DON, or IDT member will go to the charge nurse to make sure that the item or piece of equipment is put into place as care planned as quickly as possible. Once the resident's safety is assured, the Administrator or DON will re-train the staff involved in the facility policy regarding the need to follow interventions for each resident and will utilize progressive discipline for those instances of continued noncompliance. In addition, the DON will check the CNA assignment sheets at least weekly to make sure that they are current with all revised interventions which have been</p>				

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	<p>11:15 a.m., CNA #5 indicated her assignment sheet did not provide directions for each resident 's oral care. She indicated that Resident #18 required assistance with brushing his teeth and she was aware of his need only because she had familiarity with the resident 's care during her three years of employment at the facility.</p> <p>During an interview on 7/31/2014 at 11:40 a.m., Resident #18 indicated his teeth had not been cleaned that morning. He indicated he required assistance to brush his teeth with his toothbrush and staff had not assisted him with brushing his teeth.</p> <p>During an interview on 7/31/2014 at 2:00 p.m., the MDS Coordinator indicated the facility did not have a policy on how MDS information is transferred to care plans.</p> <p>During an interview on 8/1/2014 at 11:00 a.m., Resident #18 stated his teeth had not brushed after breakfast.</p> <p>During an interview on 8/1/2014 at 11:15 a.m., CNA #4 indicated that night shift performed oral care for Resident #18 and night shift ended at 6:00 a.m.</p> <p>Resident #18 ' s record was reviewed on</p>		<p>added to the residents' care plans.</p> <p>1.Describehow the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place.</p> <p>The Administrator andDON will report the results of the Angel rounds and the routine roundsthroughout the facility, as well as the auditing of the ADL sheets and CNAassignment sheets to the QA Committee at the monthly meeting. The audit of theADL sheets will continue and be reported to the QA Committee for 3 months – theCommittee may decide to stop the auditing of the ADL sheets once the facilityhas achieved 100% compliance at the end of that time. Whenever that occurs, themonitoring of oral care and use of fall interventions, as well as theinterviews done through the Angel rounds will continue on an ongoing basis.</p>				

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	<p>7/30/2014 at 2:15 p.m. Resident #18 had current diagnoses which included, but were not limited to, fall with head injury, hypothyroidism, diabetes, hypertension, and mild mental retardation.</p> <p>A care plan, dated 1/24/2012 indicated Resident #18 required assistance from staff with grooming and personal hygiene, transfers and other activities of daily living related to a diagnosis of hemiparesis from a CVA (cerebrovascular accident). Interventions included staff assistance for Resident #18 with grooming and personal hygiene, and assist him in both the morning and evening with his care.</p> <p>The most recent Annual Minimum Data Set (MDS) Assessment, completed on 5/27/2014, assessed Resident #18 as requiring extensive assistance during personal hygiene, which includes brushing teeth, and assessed his Brief Interview for Mental Status (BIMS) score as 15 out of 15.</p> <p>A document titled " CNA Care Guide Sheet " dated 7/30/2014 was provided by the DoN on 7/31/2014 at 1:31 p.m. and did not address oral care for Resident #18.</p> <p>Upon review of the CNA documentation</p>						

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	<p>for Resident #18 on 7/31/2014 at 11:20 a.m., oral care provided was not documented during the month of June 2014.</p> <p>3. During interview of Resident #33, on 7/28/14 at 11:46 a.m., a stale breath odor was noted. The resident indicated she was assisted with mouth care on shower days, "which are two times a week." The resident indicated she would like to be able to brush her teeth at least once a day. The resident indicated she could brush her teeth in her room or bathroom if the equipment (i.e. toothbrush and toothpaste) was offered to her. The resident indicated she fell at home and fractured her arm and hip and was at the facility for therapy.</p> <p>During interview of CNA #2 on 7/31/14 at 11:21 a.m. the CNA indicated "We offer her (Resident #33) oral hygiene every morning.</p> <p>Resident #33's clinical record was reviewed on 8/1/14 at 10:30 a.m. Admitting diagnoses were noted of, but not limited to, right hip and right shoulder fracture.</p> <p>An admission assessment was noted, dated 7/8/14, indicating the resident was without cognitive impairment, and required extensive assistance with</p>						

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	<p>personal hygiene, transfers and bed mobility.</p> <p>A psychosocial assessment, dated 7/1/14, indicated the resident was alert and oriented, with short and long term memory intact and judgement within normal limits.</p> <p>A plan of care, dated 7/11/14, identified a problem of "I require staff assistance with completing my daily care/needs (ADLS) [activities of daily living]. An approach was noted of, but not limited to, "I need assistance with oral care twice daily."</p> <p>A document titled " CNA Care Guide Sheet " dated 7/30/2014, was provided by the DON (Director of Nursing) on 7/31/2014 at 1:31 p.m. and did not address oral care for Resident #33.</p> <p>Upon review of the CNA charting binder documentation for Resident #33 on 8/1/2014 at 9:30 a.m., oral care provided was not addressed for documentation by the CNAs since admission on 7/8/14.</p> <p>A Policy titled "Oral Hygiene, Conscious and Unconscious Resident" dated June 2004 and identified as current by the Administrator on 7/31/14 at 2:30 p.m. indicated the following: "PURPOSE: To cleanse the mouth, teeth, and dentures.</p>						

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F000312 SS=D	<p>To prevent infection and irritation. To moisten the mucous membranes ... GUIDELINES: Offer oral hygiene before breakfast, after each meal, and at bedtime "</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review the facility failed to ensure oral hygiene was provided for 2 of 3 residents reviewed requiring assistance with activities of daily living (Resident # 18 and 33).</p> <p>Findings include: During an observation on 7/29/2014 at 2:35 p.m., Resident #18's teeth were chipped, stained and with food debris between the teeth. During an observation on 7/31/2014 at 11:40 a.m., Resident #18 was observed with 6 bottom teeth that had one chipped tooth, a heavy brown tint, and food debris between the teeth and gums. Resident #18 's top teeth were observed with a</p>	F000312	<p>F312 1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency. It is the policy of this facilitythat a resident who is unable to carry out activities of daily living receivesthe necessary services to maintain good nutrition, grooming and personal andoral hygiene. Oral care for resident #18and #33 has been added to the resident's ADL sheet to be signed off by nursing staffwhen completed. 1.Describe how the facility reviewed allclients in the facility that could be affected by the same deficient practice,and state, what actions the facility took to correct the deficient practice forany client the facility identified as being affected.</p>	08/22/2014			

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	<p>brown tint. A heavy breath stench could be smelled from Resident #18 's mouth when sitting two feet from him at his wheel chair level.</p> <p>During an observation on 8/1/2014 at 11:00 a.m., Resident #18 was observed with a heavy breath stench, that could be smelled when sitting two feet from him at his wheel chair level, and food debris was noted in between his teeth.</p> <p>During an interview on 7/29/2014 at 2:37 p.m., Resident #18 indicated staff did not assist him with cleaning his teeth.</p> <p>During an interview on 7/31/2014 at 11:15 a.m., CNA #5 indicated her assignment sheet did not provide directions for each resident 's oral care. She indicated that Resident #18 required assistance with brushing his teeth and she was aware of his need only because she had familiarity with the resident 's care during her three years of employment at the facility.</p> <p>During an interview on 7/31/2014 at 11:40 a.m., Resident #18 indicated his teeth had not been cleaned that morning. He indicated he required assistance to brush his teeth with his toothbrush and staff had not assisted him with brushing his teeth.</p>		<p>All residents that require assistance with oral care have the potential to be affected by this alleged deficiency. As of 8/1/14 oral care has been added to all resident ADL sheets (Attachment 11) to be signed off by nursing staff when completed, and oral care has been added to the CNA assignment sheets.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All nursing staff will be serviced (Attachment 12) by 8/19/14 on oral care, and documentation when oral care is completed. Members of the IDT will observe residents for oral care as part of their Angel Rounds done at least 5 days a week by asking cognitive residents if they received oral care (Attachment 13). In addition the IDT members will observe for breath odors or other indicators that oral care has not been done as they make numerous rounds during their tour of duty. Any concerns identified will be reported to the Administrator /DON for followup, which will be comprised of getting oral care done as quickly as possible, re-training staff regarding the facility policy, and written counseling or discipline for continued noncompliance.</p>				

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	<p>During an interview on 7/31/2014 at 2:00 p.m., the MDS Coordinator indicated the facility did not have a policy on how MDS information is transferred to care plans.</p> <p>During an interview on 8/1/2014 at 11:00 a.m., Resident #18 stated his teeth had not brushed after breakfast.</p> <p>During an interview on 8/1/2014 at 11:15 a.m., CNA #4 indicated that night shift performed oral care for Resident #18 and night shift ended at 6:00 a.m.</p> <p>Resident #18 's record was reviewed on 7/30/2014 at 2:15 p.m. Resident #18 had current diagnoses which included, but were not limited to, fall with head injury, hypothyroidism, diabetes, hypertension, and mild mental retardation.</p> <p>A care plan, dated 1/24/2012 indicated Resident #18 required assistance from staff with grooming and personal hygiene, transfers and other activities of daily living related to a diagnosis of hemiparesis from a CVA (cerebrovascular accident). Interventions included staff assistance for Resident #18 with grooming and personal hygiene, and assist him in both the morning and evening with his care.</p>		<p>DON and/or Designee will audit theresident ADL sheets three times weekly times to ensure oral care is beingdocumented and completed. Any identifiedissues will be addressed with retraining and written disciplinary action.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>DON and/or Designee will audit theresident ADL sheets three times weekly times to ensure oral care is beingdocumented and completed. Administratorwill review Angel Rounds weekly to ensure residents state they are receivingoral care. Administrator and DON willreport findings monthly times three (3) months to the QA committee and asneeded based upon QA recommendations.</p> <p>The Administrator andDON will report the results of the Angel rounds and the routine roundsthroughout the facility, as well as the auditing of the ADL sheets and CNAassignment sheets to the QA Committee at the monthly meeting. The audit of theADL sheets will continue and be reported to the QA Committee for 3 months – theCommittee may decide to stop the auditing of the ADL sheets once the facilityhas achieved 100%</p>		

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	<p>The most recent Annual Minimum Data Set (MDS) Assessment, completed on 5/27/2014, assessed Resident #18 as requiring extensive assistance during personal hygiene, which includes brushing teeth, and assessed his Brief Interview for Mental Status (BIMS) score as 15 out of 15.</p> <p>A document titled " CNA Care Guide Sheet " dated 7/30/2014 was provided by the DoN on 7/31/2014 at 1:31 p.m. and did not address oral care for Resident #18.</p> <p>Upon review of the CNA documentation for Resident #18 on 7/31/2014 at 11:20 a.m., oral care provided was not documented during the month of June 2014.</p> <p>2. During interview of Resident #33, on 7/28/14 at 11:46 a.m., a stale breath odor was noted. The resident indicated she was assisted with mouth care on shower days, "which are two times a week." The resident indicated she would like to be able to brush her teeth at least once a day. The resident indicated she could brush her teeth in her room or bathroom if the equipment (i.e. toothbrush and toothpaste) was offered to her. The resident indicated she fell at home and fractured her arm and hip and was at the</p>		<p>compliance at the end of that time. Whenever that occurs, the monitoring of oral care and interviews done through the Angel rounds will continue on an ongoing basis.</p>				

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	<p>facility for therapy.</p> <p>During interview of CNA #2 on 7/31/14 at 11:21 a.m. the CNA indicated "We offer her (Resident #33) oral hygiene every morning.</p> <p>Resident #33's clinical record was reviewed on 8/1/14 at 10:30 a.m. Admitting diagnoses were noted of, but not limited to, right hip and right shoulder fracture.</p> <p>An admission assessment was noted, dated 7/8/14, indicating the resident was without cognitive impairment, and required extensive assistance with personal hygiene, transfers and bed mobility.</p> <p>A psychosocial assessment, dated 7/1/14, indicated the resident was alert and oriented, with short and long term memory intact and judgement within normal limits.</p> <p>A plan of care, dated 7/11/14, identified a problem of "I require staff assistance with completing my daily care/needs (ADLS) [activities of daily living]. An approach was noted of, but not limited to, "I need assistance with oral care twice daily."</p> <p>A document titled " CNA Care Guide</p>			

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F000315 SS=D	<p>Sheet " dated 7/30/2014, was provided by the DON (Director of Nursing) on 7/31/2014 at 1:31 p.m. and did not address oral care for Resident #33.</p> <p>Upon review of the CNA charting binder documentation for Resident #33 on 8/1/2014 at 9:30 a.m., oral care provided was not addressed for documentation by the CNAs since admission on 7/8/14.</p> <p>A Policy titled "Oral Hygiene, Conscious and Unconscious Resident" dated June 2004 and identified as current by the Administrator on 7/31/14 at 2:30 p.m. indicated the following: "PURPOSE: To cleanse the mouth, teeth, and dentures. To prevent infection and irritation. To moisten the mucous membranes ... GUIDELINES: Offer oral hygiene before breakfast, after each meal, and at bedtime "</p> <p>3.1-38(a)(3)(C)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to</p>						

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	<p>restore as much normal bladder function as possible.</p> <p>Based on observation and record review the facility failed to provide services to prevent urinary tract infections for 1 of 1 resident during a random observation(Resident #17).</p> <p>Findings include:</p> <p>On 7/27/14 at 11:15 a.m. Resident #17 was observed in bed. A urinary drainage bag was hung from the resident's bed with the bottom of the drainage bag touching the floor.</p> <p>On 7/28/14 at 11:20 a.m., CNA #2, after emptying the urinary drainage bag, threw the urinary drainage bag on the floor under the resident's wheelchair. CNA #7 picked the urinary drainage bag off the floor and placed the bag in a cloth bag.</p> <p>During review of Resident #17's clinical record on 8/1/14 at 10 a.m., diagnoses were noted of, but not limited to, UTI (urinary tract infections) and renal failure.</p> <p>History and physicals, dated 1/27/14 and 4/18/14 indicated the resident had a suprapubic catheter, and was on antibiotics for a urinary tract infection. Documentation on the 4/18/14 history and physical indicated the resident had</p>	F000315	<p>F315</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p>It is the facility of this policyto ensure that a resident who enters the facility without an indwellingcatheter is not catheterized unless the resident's clinical conditiondemonstrates that catheterization was necessary; and a resident who isincontinent of bladder receives appropriate treatment and services to preventurinary tract infections and to restore as much normal bladder function aspossible. C NA #2 was immediatelyeducated in regards to the proper way to handle a urinary drainage bag and tokeep it off the floor.</p> <p>1.Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>Any resident with a catheter has the potential to be affected. Allnursing staff has been educated on the proper way to handle a urinary drainagebag and to keep it off the floor. No other issues have been identifiedregarding the proper handling of the urinary bag.</p>	08/22/2014			

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	<p>recurrent UTI's and urosepsis.</p> <p>A plan of care was noted, dated 7/24/14, identifying "I have a supra-pubic catheter for urinary elimination" with an approach of "Keep drainage bag and tubing off of the floor."</p> <p>Review of a facility policy, dated June 2004, titled " Catheter Care-General Information", received from the Administrator on 8/1/14 at 11:16 a.m., documentation indicated under the sub-title of "Transferring Resident", "c. never allow bag to touch floor."</p> <p>3.1-41(a)(2)</p>		<p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All nursing staff will beinserviced by 8/19/14 (Attachment 14) inregards to the Catheter Care – General Info (Attachment 15). Members ofthe IDT will observe residents' urinary drainage bag during Angel Rounds whichoccur at least 5 days a week (Attachment16) to ensure dignity bag is in place and bag is not touching floor whenattached to bed or wheelchair. If a concern arises regarding the use and careof the drainage bag, the member of the IDT will notify the charge nurse and DON(if not already aware) of the concern. The DON or designee will review thefacility policy regarding the handling of urinary drainage bags with the staffinvolved and will observe them in handling the drainage bag to make sure thatthe practice has been corrected. Written counseling will be given as indicatedby the situation.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Administrator, DON and IDTmembers will observe the</p>		

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall prevention devises were in place and/or properly functioning to prevent falls for 2 of 4 residents reviewed for falls (Resident #'s 25, and 29).	F000323	positioning of urinary drainage bags throughout the facility during each tour of duty. The DON and/or designee will also observe transfer of residents with urinary drainage bags three (3) times weekly to ensure staff is handling the drainage bags appropriately. Observed or identified concerns will be addressed as indicated in question #3. The Administrator and DON will report the finding from Angel rounds, observations during routine rounds, and observations of transfers to the QA committee on a monthly basis for the next 3 months. When the outcome shows a 100% compliance in handling of urinary drainage bags, the QA Committee may decide to stop the audits; however, the observations during Angel rounds and routine rounds will continue on an ongoing basis. F323 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. It is the policy of this facility to ensure that the resident	08/22/2014	

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	<p>Findings include:</p> <p>1. On 7/29/14 at 12:28 p.m., Resident #29 was observed with steri strips on his forehead.</p> <p>During interview of LPN #1 on 7/29/14 at 11:32 a.m., the LPN indicated the resident had a fall and injured his forehead, which required steri-strips.</p> <p>Resident #29's clinical record was reviewed on 7/30/14 at 11:08 a.m. A nurses note, dated 7/25/14 at 10 p.m. indicated "Res [resident] found in his room, on floor beside bed, laying on left side, 3 lacerations on forehead measuring 2 cm [centimeter] , 1 cm, 0.5 cm, minimal amount of blood present..."</p> <p>A plan of care, identifying a problem of "I am at risk for falls with injury" was noted, with an original date of 9/1/11, and a "rewritten" date of "6/20/14" Approaches was noted of, but not limited to, "Re-educate staff to lay me down after meals" and "Pressure alarm in bed and chair at all times."</p> <p>During interview of the MDS (minimum data set) on 7/31/14 at 2:15 p.m., the coordinator indicated she had been assigned to track falls. The MDS</p>		<p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #29's alarm was evaluated and inspected and was in proper working order. The intervention of a wedge cushion to the resident #25's chair was added to the care plan on 7/31/2014 by the Interdisciplinary Team (IDT) after review of his incident. The wedge cushion is in use by the resident.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents at risk for fall have the potential to be affected. All fall interventions for each resident were reviewed to ensure they were present and all devices were in good working order. All incidents are reviewed by the IDT during daily clinical meeting that occurs at least 5 times a week. The DON or designee will add any changes in fall interventions that were developed from the IDT review on the CNA assignment sheets so that care staff will have the updated information to use for their assigned residents.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that</p>		

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	<p>coordinator, while reviewing notes, indicated, prior to the fall on 7/25/14, Resident #29 had two falls since January 2014. One fall was on 2/26/14, and one was on 5/28/14. The MDS coordinator indicated the fall on 7/25/14 at 10 p.m. occurred while resident was sitting in the wheelchair in his room. Documentation indicated the resident's alarm was not sounding on the falls which occurred on 2/26/14 and 7/25/14, and documentation as to why the alarms did not sound was lacking.</p> <p>During interview of the DON on 8/1/14 at 10 a.m., the DON indicated she did not know why the alarm did not sound prior to the fall on 7/25/14, but she could call the nurse on duty and speak with the nurse that was on duty that evening. At 1:30 p.m., the DON indicated she spoke with the nurse and the nurse indicated the alarm was not sounding at first when checked, but started sounding again. The DON indicated there was no further investigation as to why the alarm did not sound, and the resident was still utilizing the same alarm.</p> <p>2. During an observation on 7/31/14 at 2:23 P.M., with the Administrator and the MDS nurse coordinator present, Resident #25 was observed sitting in his wheelchair. A wedge cushion was not observed in his wheelchair.</p>		<p>the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All nursing staff to be inserviced by 8/19/14 (Attachment 17) in regards to proper use of fall interventions and alarms in good, functioning condition. The resident's Treatment Record already identifies that alarms will be checked each shift, daily to ensure in place and functioning and a nurse must sign off. If not functioning properly, said alarm will be immediately replaced. Members of the IDT will review for these fall interventions at least 5 days a week during Angel Rounds (Attachment 18) to ensure they are identified and in place and that all alarms are functioning. In addition to the Angel rounds, the Administrator, DON and IDT members will observe for the use of seat cushions, alarms, and other devices that have been care planned for fall prevention as part of frequent rounds throughout the facility during each tour of duty. If any issues are identified, the Administrator, DON, or IDT member will go to the charge nurse to make sure that the item or piece of equipment is put into place as care planned as quickly as possible. Once the resident's safety is assured, the Administrator or DON will re-train the staff involved in the facility policy regarding the need to</p>				

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	<p>During an interview on 7/29/14 at 11:38 A.M., Licensed Practical Nurse (LPN) #1 indicated Resident #25 had fallen within the last 30 days.</p> <p>During an interview on 7/31/14 at 2:23 P.M., the MDS nurse coordinator indicated a wedge cushion was added as an intervention to prevent Resident #25 from falling on 7/30/14. She indicated it was not in his chair because therapy had to "order it."</p> <p>Resident #25's record was reviewed on 7/30/14 at 12:18 P.M. Resident #25 had diagnoses which included, but were not limited to, Parkinson's disease, hypertension restless leg syndrome, blind in left eye, insomnia, dementia, and schizophrenia.</p> <p>A quarterly Minimum Data Assessment Tool Dated (MDS) dated 5/29/14, indicated Resident #25 had cognitive impairment with a BIMS (Brief Interview Mental Status) score of 7 out of 15.</p> <p>A fall risk assessment dated 7/23/14, indicated Resident #25 had a score of 23. This record indicated if a resident scored over "10" they were considered at high risk for falls.</p>		<p>follow interventions for each resident and will utilize progressive discipline for those instances of continued noncompliance. In addition, the DON will check the CNA assignment sheets at least weekly to make sure that they are current with all revised interventions which have been added to the residents' care plans.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>DON and /or Designee will check two alarms three (3) times weekly to ensure they are functioning. The Administrator and DON will report the results of the Angel rounds and the routine rounds throughout the facility, as well as the auditing of the alarm documentation and CNA assignment sheets to the QA Committee at the monthly meeting. The audit of the alarm documentation will continue and be reported to the QA Committee for 3months – the Committee may decide to stop the auditing of the alarm documentation once the facility has achieved 100% compliance at the end of that time, however the nurses will continue to check placement and functioning of alarms each shift daily and sign off accordingly. The observation for use of fall</p>				

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F000371 SS=F	<p>A care plan dated 7/23/14, indicated Resident #25 was at a high risk for falls with injury related to his impaired mobility, shuffling gait, history of falls, medication use, and diagnosis of Parkinson's disease. A goal to prevent falls with injuries included his risk factors would be reduced in attempts to avoid significant injuries. Interventions to meet this goal included adaptive equipment as ordered, chair and bed alarm, assistance of one person for transfers, bed in lowest position, mat at side of bed, and for staff to monitor for fatigue and unsteadiness.</p> <p>A document titled "Falls Tracking Log" provided by the MDS nurse coordinator on 7/31/14 at 1:50 P.M., indicated Resident #25 fell on 7/2/2014 on 7/23/12, and again on 7/30/14 at 7:30 P.M. This record indicated after Resident #25 fell on 7/30/14, an immediate intervention put into place to prevent future falls was, "Wedge cushion to be placed in resident's wheelchair in an attempt to avoid sliding."</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>		<p>interventions, as well as the interviews done through the Angel rounds will continue on an ongoing basis.</p>				

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to maintain appropriate temperatures on the low temperature dishwashing machine, and failed to keep temperature logs for the three compartment sink. These practice's had the potential to negatively impact 34 of the 35 residents receiving meals from the kitchen.</p> <p>Findings include:</p> <p>During a tour of the kitchen on 7/28/14 from 7:35 a.m. until 8:33 a.m., the Dietary Manager (DM), was observed operating the dishwashing machine. The temperature gauge on the machine was observed to reach 108 degrees on the wash and 110 degrees on the rinse cycle during four attempts to run the wash/rinse cycle on the machine. During the fourth attempt the DM checked the temperature manually with her pocket thermometer and the temperature read 95 degrees for the wash cycle temperature and 95.6 degrees for the rinse cycle temperature. The dietary manager then logged the temperature on the temperature log. She used her thermometer to check the temperature of the water coming from the</p>	F000371	<p>F371</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p><i>Thefacility is requesting an IDR for this alleged deficiency due to the surveyornot accepting the fact that the sink is not utilized as a sanitizer unless dishmachine would be out of commission.</i></p> <p>It is the policy of this facilityto procure, store, prepare and serve food in a sanitary manner. When the dish machine did not reach the appropriatetemperature, the Dietary Services Manager (DSM) stopped the machine andnotified the Maintenance Director. Whendish machine reached appropriate temperature, the dishes that were in the dishmachine were rewashed when appropriate temp was not reached.</p> <p>1.Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No residents were affected by thisalleged deficiency. Maintenancecompleted a check of water heater and dish machine</p>	08/22/2014

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	<p>sink faucet near the grill and the temperature measured 115 degrees F. The three sinks of the three compartment sink were noted to be overfilled by an inch to an inch and a half over the fill lines. No temperature logs were available for the three compartment sink.</p> <p>During an interview on 8/1/14 at 11:14 a.m., with the DM and Cook #2, the DM indicated, the water temperature was supposed to be checked before washing dishes prior to meals. She indicated the temperature is to reach a minimum of 120 degrees F. Cook # 2 indicated she had failed to log the temperature prior to washing dishes that morning.</p> <p>During an interview with the Maintenance Director (MD), on 7/28/14 at 8:35 a.m., he indicated the water heater held 80 gallons of water and was used solely to supply the hot water for the kitchen. He further indicated that the temperature of the water heater was set to 150 degrees F. He indicated the best way to check the temperature was to check either the water from the faucets or the dishwashing machine, because there was not a temperature gauge that could be viewed on the water heater.</p> <p>During an interview with the MD on 8/1/14 at 11:30 a.m., he indicated the 3</p>		<p>and could not find an issue. The DSM had filled the three compartment sink with hot water just prior to the observation by the surveyor. It was determined that the DSM used all of the hot water to fill the three compartment sink and the water heater needed time to recycle. GFS was contacted and the maintenance tech came to the facility and determined there was nothing wrong with the dish machine. Three compartment sink temperature log was not in place at that time due to non-usage for sanitizing purposes. The three compartment sink is not used to sanitize kitchenware.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Dietary staff was in serviced (Attachment 19) on the proper procedure of how to take dish machine temperatures and log it appropriately. If temperature is not appropriate, they are to notify maintenance immediately and stop washing dishes until desired temp is reached. Dishes that may have been in the dish machine at that time will be rewashed. Also in serviced that three compartment sink is not utilized to sanitize kitchenware - all kitchenware that is washed by</p>				

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	<p>compartment sink had been filled incorrectly, and that is why there was not enough hot water.</p> <p>During an interview on 8/1/14 at 11:30 a.m., the DM indicated the kitchen staff did not take the temperatures for the 3 compartment sink, and they did not keep a log sheet to track this information.</p> <p>A document entitled, "Cleaning Procedure-Dishwasher (Low or High Temperatures), received from the Administrator (ADM) on 7/28/14, at 10:20 a.m., indicated staff was to, "Check that water temperature is correct before washing dishes of all meals. Low temperature dishwashing machines require minimum of 120 degrees F."</p> <p>A document entitled, "Test for Low Temperature Dish Machine," received from the DM on 7/28/14 at 9:15 a.m., indicated the temperatures for the dishwashing machine were recorded as 100 degrees and 105 degrees on July 8th and 9th respectively, for the breakfast measurements on those days.</p> <p>A document entitled, " Manual Washing of Dishes & Cookware in a 3 Compartment Sink," received from the ADM, on 8/1/14 at 12:36 p.m., indicated, "Sink One- 1. Fill sink with water</p>		<p>hand will then go through the dish machine so a temperature log for the three compartment sink is not needed.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>DSM and/or HFA will monitor the dish machine temperature log five (5) times weekly to ensure that proper temperatures are maintained as well as watching staff during dish time to ensure that any items washed by hand also go through the dish machine. DSM and/or HFA will report the results of the monitoring and performance observations to the QA Committee on a monthly basis for the next three (3) months. At the end of that time, when 100% compliance has been reached, the QA Committee may decide to change the frequency of the monitoring activities to twice a week, which will continue on an ongoing basis.</p>	

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	<p>between 120-125 F, Assure enough water is added to cover the items to be washed....Sink Two- Fill sink with water between 120-160 F."</p> <p>A copy of the temperature log for the 3 compartment sink was requested from the DM on 7/28/14 at 9:30 a.m., and she indicated she was unable to provide documentation of temperature logs for the 3 compartment sink.</p> <p>A document entitled, "Three Sink Washing & Sanitizing," received from the DM on 8/1/14 at 11:52 a.m., indicated, "1 Fill wash sink to appropriate level....3. Fill middle sink to appropriate level....1. Fill 3rd sink to appropriate level." The document contained illustrations of the appropriate fill lines that the water was to stop at.</p> <p>3.1-21(i)(2)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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</p>			

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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure staff washed hands after contamination during 1 of 1 random observation of urinary catheter care (Resident #17).</p> <p>Findings include:</p> <p>On 7/28/14 at 11:20 a.m., CNA (Certified Nursing Assistant) #7, handled Resident #17's urinary drainage bag to place the bag in a cloth bag hanging from a wheelchair. Without removing gloves or washing hands, the CNA made the resident's bed, touched the overbed table and moved the call light closer to the resident.</p> <p>During review of a facility policy identified as current, dated June 2004 and titled, "Handwashing/Alcohol-Based Hand Rub," documentation indicated handwashing should have been performed, "After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms (including urinary catheter components and containers used to collect and measure urine.)</p> <p>3.1-18(l)</p>	F000441	<p>F441</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p>It is the policy of this facilityto establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the developmentand transmission of disease and infection. C NA #7 was educated to proper hand washing technique and when to removegloves and wash hands.</p> <p>1.Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All residents who have a catheterhave the potential to be affected by this alleged deficiency. Nursing staff were educated to proper handwashing technique and when to remove gloves and wash hands. If the DON ordesignee observes any concern in technique, glove use, or hand washing whenworking with urinary drainage bags, the observer will stop the staff member andre-train her in the correct procedures. Once the resident is properly caredfor, the DON may render written</p>	08/22/2014

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			<p>counseling/discipline for the noncompliance.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All nursing staff was inserviced by 8/19/14 (Attachment 20) in regardsto facility Hand washing / Alcohol Based Hand Rub policy (Attachment 21). All nursingstaff will have a hand washing skills checklist completed by 8/27/14 (Attachment 22). Identified issues willbe handled as outlined in question #2.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The DON and/or Designee will observe the transfer of residents with urinary drainage bags three (3)times weekly for proper handwashing and glove use. DON will report findings of her observationsmonthly times three (3) months to the QA Committee. Once 100% compliance hasbeen achieved, the QA Committee may decide to stop the auditing activities;however, the DON or designee will continue to observe staff for handwashing andglove use during transfer and handling of urinary drainage bags at leastmonthly on varied shifts on</p>		

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			an ongoing basis. Identified concerns will be handled as in question #2 and will be reported to the next scheduled monthly QACCommittee meeting.		