

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2015
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 5, 6, 7, 8, and 9, 2015</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 100266240</p> <p>Survey team: Terri Walters RN,TC Amy Wininger RN Sylvia Scales RN Dorothy Watts RN (1/5, 1/6, 1/7, & 1/9/15)</p> <p>Census bed type: SNF: 6 SNF/NF: 62 Total: 68</p> <p>Census payor type: Medicare: 13 Medicaid: 41 Other: 14 Total: 68</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 17,</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective February 5, 2015 to the state findings of the Recertification and State Licensure Survey conducted on January 5, 6, 7, 8, and 9, 2015.</p>	

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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F000225 SS=D	<p>2015 by Jodi Meyer, RN</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is</p>			

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	<p>verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure allegations of abuse were immediately reported to the administrator and/ or to the State Department of Health for 2 of 3 resident allegations of abuse reviewed. (Resident #51, Resident #93)</p> <p>Findings include:</p> <p>1. On 1/5/15 at 11:37 A.M., Resident #51 was observed sitting in a chair in his room.</p> <p>On 1/5/15 at 12:06 P.M., due to the Administrator being unavailable (with a resident's family) the Director of Nursing (DON) was made aware of Resident #51 reporting a CNA had been "hateful" and had "cursed" about changing his brief. Resident # 51 had indicated the allegation had occurred approximately 2 to 5 months ago.</p> <p>Resident #51 had indicated he thought it might have been her (CNA's) break time. Resident #51 indicated he had told the Administrator of the facility. Resident #51 indicated he had talked to the Administrator and the owner of the facility regarding the allegation.</p> <p>The resident indicated the CNA was still working at the facility but, he did not</p>	F000225	<p>F - 225</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the alleged incident involving the resident identified as resident # 51 was reported to the Indiana State Department of Health. The facility conducted an investigation into the allegation. The allegation was unsubstantiated</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the alleged incident involving the resident identified as resident # 93 was reported to the Indiana State Department of Health. The facility conducted an investigation into the allegation. The allegation was unsubstantiated.</p>	02/05/2015

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	<p>know her name. The resident indicated the Administrator had indicated to the CNA that she couldn't go to break until his brief had been changed. The Resident indicated the CNA came back and changed his brief. The DON indicated at that time, she was not aware of the allegation of abuse and she would notify the Administrator.</p> <p>On 1/5/15 at 2:57 P.M., the Administrator and the DON were interviewed regarding the allegation of abuse voiced by Resident #51. The Administrator indicated he did not remember Resident #51 reporting the allegation of abuse to him. The DON indicated the facility had started the investigation of the allegation. She indicated the State Department of Health had not been notified.</p> <p>On 1/7/15 at 1:40 P.M., the Administrator was interviewed regarding the allegation of abuse reported by Resident #51 on 1/5/15. The Administrator indicated at that time, he had not reported the allegation of abuse to the Indiana State Department of Health. The Administrator indicated he did not report allegations of abuse to the Indiana State Department of Health unless the allegations were substantiated. The Administrator was made aware of</p>		<p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that based on a house wide audit/interview of all alert and oriented residents as well as interviews of all facility staff members there have been no other allegations of abuse at this time. Per the revised facility abuse policy all future allegations of abuse will be reported to the Executive Director and all appropriate agencies</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all facility staff members on the revised abuse policy. In addition during the interviews of all alert and oriented residents the definitions of each type of abused has been</p>	

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	<p>allegations of abuse were to be immediately reported to the state agency.</p> <p>On 1/5/15 at 12:40 P.M., the facility provided the documentation entitled "INDIANA STATE DEPARTMENT OF HEALTH Division of Long Term Care. (Revised 01/25/06, Reviewed 06/30/11)" The policy included but was not limited to, "...The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law..."</p> <p>On 1/7/15 at 1:00 P.M., the Administrator provided the facility abuse policy entitled, "Reporting Abuse to Facility Management (Revision November 2010)." The policy included, but was not limited to, "...7. The Executive Director must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Executive Director must be called at home or must be paged and informed of such incident..." The Administrator indicated the facility was "revamping" the facility abuse policy. He indicated the abuse policy should include the immediate</p>		<p>explained to those residents. The facility has also provided education on the definitions of abuse at the January 2015 resident council meeting.</p> <p><i>The corrective action taken to monitor to assure performanceto assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor for compliance related to the timely reporting of all allegations of abuse to the Executive Director and all appropriate agencies, including the Indiana State Department of Health.</i></p> <p>This tool will be completed by the Social Service Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</p>	

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	<p>notification of the administrator regarding any allegation of abuse and if the Administrator was not available to notify the DON.</p> <p>On 1/9/15 at 8:33 A.M., the Administrator indicated he had reported the allegation voiced by Resident #51 to the State Department of Health on 1/8/15.</p> <p>2. On 1/6/15 at 9:20 A.M., Resident #93 was observed sitting in a chair in her room. During an interview, at that time, the resident was asked if a staff member, another resident, or anyone else had abused her. Resident #93 indicated a CNA had got "hasty" with her. Resident #93 indicated the CNA had stated to get up and had pulled her bed covers off. The CNA had not wanted Resident #93 to wear the clothes Resident #93 had laid out to wear. Resident #93 indicated she had told her daughter the allegation. Resident #93 indicated her daughter had called the Assistant Director of Nursing (ADON). The resident indicated the allegation had occurred approximately a week ago. Resident #93 indicated she did not know the CNA's name.</p> <p>On 1/6/15 at 9:47 A.M., the Administrator and the Director of Nursing (DON) were made aware of Resident #93's allegation of abuse. The</p>			

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F000226 SS=E	<p>DON indicated she remembered when the allegation had occurred and had completed an investigation.</p> <p>On 1/7/15 at 1:00 P.M., the Administrator was interviewed regarding Resident #93 reporting the allegation to her daughter, and her daughter reporting the allegation to the facility. The Administrator indicated he had not been notified of the allegation until the morning staff meeting the next day.</p> <p>On 1/9/15 at 8:33 A.M., the Administrator indicated he had reported the allegation voiced by Resident #93 to the State Department of Health on 1/8/15.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure the facility's abuse policy indicated to immediately notify the state agency regarding any allegation of abuse and/or contained procedures for screening, training, prevention, and protection for 2</p>	F000226	<p>F – 226</p> <p>A 1. The corrective action taken for those residents found to be affected by the deficient practice is that the alleged incident involving the</p>	02/05/2015

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	<p>of 3 resident allegations of abuse reviewed. (Resident #51, Resident #93)</p> <p>B. Based on interview and record review, the facility failed to ensure the criminal background checks were performed in a timely manner, in that, criminal background checks were not performed within the 3 day time requirement for 7 of 10 employee files reviewed. (NA #1, CNA #4, LPN #1, CNA #2, ADON (Assistant Director of Nursing), DFS (Director of Food Service), CNA #3)</p> <p>Findings include:</p> <p>A.1. On 1/5/15 at 11:37 A.M., Resident # 51 was observed sitting in a chair in his room.</p> <p>On 1/5/15 at 12:06 P.M., due to the Administrator being unavailable (with a resident's family) the Director of Nursing (DON) was made aware of Resident #51 reporting a CNA had been "hateful" and had "cursed" about changing his brief. Resident #51 had indicated the allegation had occurred approximately 2 to 5 months ago. Resident #51 had indicated he thought it might have been her (CNA's) break time. Resident #51 indicated he had told the Administrator of the facility. Resident #51 indicated he</p>		<p>resident identified as resident # 51 was reported to the Indiana State Department of Health. The facility conducted an investigation into the allegation. The allegation was unsubstantiated. The abuse policy has been revised to include immediate notification of all appropriate State agencies of all allegations of abuse. The policy also includes the facility practice of obtaining criminal background checks on all employees, which will be completed and results reviewed prior to the prospective staff member being placed on a work schedule.</p> <p>A 2. The corrective action taken for those residents found to be affected by the deficient practice is that the alleged incident involving the resident identified as resident # 93 was reported to the Indiana State Department of Health. The facility conducted an investigation into the allegation. The allegation was unsubstantiated. The abuse policy has been revised to</p>	

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	<p>had talked to the Administrator and the owner of the facility regarding the allegation. The DON indicated at that time she was not aware of the allegation of abuse and she would notify the Administrator.</p> <p>On 1/5/15 at 2:57 P.M., the Administrator and the DON were interviewed regarding the allegation of abuse voiced by Resident #51. The Administrator indicated he did not remember Resident #51 reporting the allegation of abuse to him. The DON indicated the facility had started the investigation of the allegation. She indicated the State Department of Health had not been notified.</p> <p>On 1/5/15 at 12:40 P.M., the facility provided the documentation entitled "INDIANA STATE DEPARTMENT OF HEALTH Division of Long Term Care. (Revised 1/25/06, Reviewed 6/30/11)." The policy included but was not limited to, "...The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law..."</p>		<p>include immediate notification of all appropriate State agencies of all allegations of abuse. The policy also includes the facility practice of obtaining criminal background checks on all employees, which will be completed and results reviewed prior to the prospective staff member being placed on a work schedule.</p> <p>A 3. The corrective action taken for those residents found to be affected by the deficient practice is that there were no specific residents identified during the survey. Although the employee files of employees NA #1, CNA #4, LPN # 1, CNA #2, ADON, DFS, and CNA # 3 did not contain timely criminal background checks, those findings of the criminal background checks did not include any charges that would prohibit the facility from hiring those employees.</p> <p><i>The corrective action taken for</i></p>	

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	<p>On 1/7/15 at 1:00 P.M., the Administrator provided the facility abuse policy entitled, "Reporting Abuse to Facility Management (Revision November 2010)." The policy included but was not limited to, "...7. The Executive Director must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Executive Director must be called at home or must be paged and informed of such incident..."The Administrator indicated the facility was "revamping" the facility abuse policy. He indicated the abuse policy should include the immediate notification of the administrator regarding any allegation of abuse and if the Administrator was not available to notify the DON.</p> <p>On 1/9/15 at 8:33 A.M., the Administrator indicated he had reported the allegation voiced by Resident #51 to the State Department of Health on 1/8/15.</p> <p>The facility failed to notify the state agency immediately after Resident #51 had reported an allegation of abuse on 1/5/15. The State Department of Health had not been notified until 1/8/15, 3 days after the reported allegation. The current facility abuse policy entitled, "Reporting Abuse to Facility Management" lacked</p>		<p><i>the other residents having the potential to be affected by the same deficient practice is that the facility has revised the abuse policy to include the process that, criminal background checks, along with other reference and licensure/certification checks will be completed and reviewed by the facility prior to the prospective employee being placed onto the work schedule. The facility has made arrangements with the Indiana law enforcement agency to obtain criminal background check electronically which will provide timely completion of the required criminal background checks.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all staff on the revised facility's abuse policy. The in-service included a focus on the immediate reporting all</p>	

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	<p>documentation to immediately notify the state agency regarding an allegation of abuse.</p> <p>A. 2. On 1/6/15 at 9:20 A.M., Resident #93 was observed sitting in a chair in her room. During an interview at that time, the resident was asked if a staff member, another resident, or anyone else had abused her. Resident #93 indicated a CNA had got "hasty" with her. Resident #93 indicated the CNA had stated to get up and had pulled her bed covers off. The CNA had not wanted Resident #93 to wear the clothes the Resident #93 had laid out to wear. Resident #93 indicated she had told her daughter the allegation. Resident #93 indicated her daughter had called the Assistant Director of Nursing (ADON). The resident indicated the allegation had occurred approximately a week ago. Resident #93 indicated she did not know the CNA's name.</p> <p>On 1/6/15 at 9:47 A.M., the Administrator and the Director of Nursing (DON) were made aware of Resident #93's allegation of abuse. The DON indicated she remembered when the allegation had occurred and had completed an investigation.</p> <p>On 1/7/15 at 1:00 P.M., the Administrator was interviewed regarding</p>		<p>allegations of abuse to the ExecutiveDirector who in turn is responsible for notifying all appropriate Stateagencies. For all department directorsthe in-service also focused on the facility's process of obtaining appropriatecriminal background checks, along with reference checks and licensure/certificationchecks prior to any employee being placed on the work schedule.</p> <p><i>The corrective action taken to monitor to assureperformance to assure compliance through quality assurance is that a Quality Assurance tool has been developed andimplemented to monitor the compliance of following the revised facility policyon abuse with a focus on immediate notification of the Executive Director ofall allegations of abuse, along with the Executive Director immediately notifyingthe appropriate State agencies. The toolwill also monitor the facilities practice of ensuring that all criminalbackground</i></p>	

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	<p>Resident #93 reporting the allegation to her daughter, and her daughter reporting the allegation to the facility. The Administrator indicated he had not been notified of the allegation until the morning staff meeting the next day.</p> <p>The facility failed to follow their abuse policy in regard to staff had not immediately notified the administrator an allegation of abuse voiced by Resident #93. The allegation by Resident #93 had been reported to the State Department of Health on 1/8/15. The current facility abuse policy entitled, "Reporting Abuse to Facility Management" lacked documentation regarding immediate notification of the state agency.</p> <p>A. 3. On 1/8/15 at 2:06 P.M., the Administrator was interviewed regarding the facility's abuse policy. The Administrator indicated he had provided the "INDIANA STATE DEPARTMENT OF HEALTH Division of Long Term Care" reportable policy on 1/5/15. He indicated the facility had revamped the abuse policy and he had provided the "Reporting Abuse to Facility Management" on 1/7/15 at 1:00 P.M. The Administrator was made aware the facility's abuse policies were incomplete and lacked documentation in regard to addressing procedures for screening,</p>		<p>checks, as well as reference checks and licensure/certification checks have been completed and meet facility requirements prior to the prospective employee is placed on the work schedule. This tool will be completed by the Social Service Director and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</p>				

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	<p>training, prevention, and protection.</p> <p>On 1/9/15 at 8:33 A.M., the Administrator indicated he had reported the allegation voiced by Resident #93 to the State Department of Health on 1/8/15.</p> <p>The Administrator indicated the facility was still working on developing a new facility abuse policy.</p> <p>B. The Employee Files were reviewed on 1/09/15 at 9:00 A.M. and indicated the following:</p> <p>B.1. NA #1 was hired on 6/17/14 and started working with residents on 6/18/14. The criminal background check was requested on 6/25/14. (7 days)</p> <p>B. 2. CNA #4 was hired on 1/17/14 and started working with residents on 1/18/14. The criminal background check was requested on 1/24/14. (6 days)</p> <p>B.3. LPN #1 was hired on 1/23/14 and started working with residents on 1/24/14. The criminal background check was requested on 1/29/14 (5 days).</p> <p>B. 4. CNA #2 was hired on 11/24/14 and started working with residents on 11/28/14. The criminal background check was requested on 12/09/14. (11 days)</p>			

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F000282 SS=D	<p>B. 5. The ADON was hired on 07/22/14 and started working with residents on 7/24/14. The criminal background check was requested on 8/8/14. (15 days)</p> <p>B. 6. The DFS was hired on 09/16/14 and started working with residents on 9/16/14. The criminal background check was requested on 9/30/14. (14 days)</p> <p>B. 7. CNA #3 was hired on 7/22/14 and started working with residents on 7/23/14. The criminal background check was requested on 9/15/14. (54 days)</p> <p>During an interview with the HFA on 1/9/15 at 2:50 P.M. indicated the criminal background checks had not been completed within the 3 day time requirement due to an oversight.</p> <p>The Policy and Procedure for employee screening provided by the HFA (Health Facilities Administrator) on 1/9/15 at 10:36 A.M., lacked any documentation related to criminal background checks.</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>			

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	<p>persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the physician for 1 of 1 resident reviewed for medication errors. (Resident #34)</p> <p>Findings include:</p> <p>On 1/8/15 at 8:45 A.M., Resident #34 was observed sitting in her wheelchair in the restorative dining room.</p> <p>Resident #34's clinical record was reviewed on 1/8/15 at 9:25 A.M. Her current admission date was 2/22/14. Her diagnoses included, but were not limited to, severe Alzheimer's dementia, congestive heart failure, and coronary artery disease.</p> <p>Her current physician orders dated December 2014 included but were not limited to, "...FUROSEMIDE (a diuretic medication) 40 MG TAB (tablet) UD (unit dose) LASIX 40 MG TAKE 1 TABLET BY MOUTH ONCE DAILY FOR CHF (congestive heart failure) (order date 9/29/11)." (sic) Another Lasix order included, "...FUROSEMIDE 20 MG TABLET LASIX 20 MG TAKE 1 TABLET BY</p>	F000282	<p>F – 282</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident# 34 is now receiving her medications as ordered by the physician. Upon the physician notification of the medication error the physician did in fact change the 20 mg Lasix order to read Lasix 20 mg po QD instead of QOD. The resident has not had any negative outcome related to the administration of the Lasix 20 mg po QD.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been completed to ensure that each resident is receiving their medications in accordance with their physician's orders. No additional medication errors were identified.</i></p>	02/05/2015

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	<p>MOUTH EVERY OTHER DAY. TAKE WITH 40 MG= 60 MG FOR CHF (order date 12/15/11)."(sic)</p> <p>On 1/8/15 at 8:50 A.M., during Medication Administration Record (MAR) review, Resident #34's MAR from January 1 thru 1/7/15 had documentation of Lasix 20 mg being administered every day instead of every other day as ordered by the physician. The ADON was made aware the documentation indicated the medication of Lasix 20 mg had been administered every day. The ADON agreed there was an error in the administration of the Lasix 20 mg . She then drew a line on the MAR through the date of every other day on the month of January 2015 to indicate the medication should not be given every day. She then underlined "... EVERY OTHER DAY..."(sic) in the order of the Lasix 20 mg medication.</p> <p>On 1/8/15 at 10:40 A.M., Resident #34's MARS for December, November, and October, 2014 were reviewed. Resident #34's December 2014 MAR's documentation indicated she had been administered Lasix 20 mg every day in the month of December.</p> <p>Facility documentation entitled, "MEDICATION ERROR</p>		<p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all license nurses and QMAs on the facility's policy and procedure on the processing of a medication order as well as on the policy related to medication administration.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to ensure that the residents are receiving their medications in accordance with their physician's orders and facility policy. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality</i></p>	

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F000314 SS=G	<p>ASSESSMENT AND FOLLOW UP" was reviewed on 1/8/15 at 10:40 A.M. The documentation indicated the medication Lasix had been ordered 20 mg every other day. "...Description of error (include med, dose, route, and time administered)..." had been documented "... Medication was given daily..."</p> <p>A facility policy entitled "PREPARATIONS AND GENERAL GUIDELINES IIA1: EQUIPMENT AND SUPPLIES FOR ADMINISTERING MEDICATIONS was reviewed on 1/9/15 at 10:50 A.M. The policy included but was not limited to, "...B. Administration 2) Medications are administered in accordance with written orders of the attending physician..."</p> <p>On 1/9/15 at 1:55 P.M., during interview with the Director of Nursing (DON) she indicated she was aware of the Lasix medication error for Resident #34 and the physician had been notified of the medication error.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a</p>		Assurancecommittee meeting to determine if any additional action is warranted.	

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	<p>resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident admitted without a pressure ulcer, developed a stage 3 pressure ulcer after admission, was provided proper care for 1 of 3 residents who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident #76 experiencing a Stage 3 pressure area. (Resident #76)</p> <p>Findings Include:</p> <p>The clinical record of Resident #76 was reviewed on 1/9/15 at 10:00 A.M. The record indicated Resident #76 was admitted to the facility on 9/16/14 with diagnoses including, but not limited to, COPD, depression, chronic back pain and vascular dementia with psychosis. The clinical record further indicated Resident #76 was readmitted to the facility on 10/16/14 after a hospitalization. The Nursing Admission Assessment record dated 10/16/14 read, "...No areas noted on body..."</p>	F000314	<p>F -314</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident# 76 is no longer a resident at the facility.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide review of each resident's Braden scale has been completed to ensure that all residents at risk have been identified and has appropriate interventions in place in the prevention of pressure wounds. In addition a house wide head-to-toe body assessment has been completed on all residents to ensure that any current pressure wound has been identified and that an appropriate plan of care</i></p>	02/05/2015

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	<p>The Minimum Data Set (MDS) assessment dated 12/9/14 indicated Resident #76 experienced severe cognitive impairment, required the extensive assistance of two people for bed mobility and transfers and/or was at risk for developing a pressure area.</p> <p>A Weekly Pressure Ulcer Progress Assessment form dated 12/15/14 indicated Resident #76 developed a Stage 2 pressure area on the coccyx on 12/15/14. The measurements for the wound on 1/5/15 were 1.0 cm (centimeter) length by 0.6 cm width and less than .1 cm for the depth. The report further indicated the wound was pink and no exudate was noted.</p> <p>Physician's Orders dated 12/16/14 read as follows, "Hydrogel and Foam drsg (dressing) to coccyx q (every) 3 days.</p> <p>During an interview on 1/09/15 at 9:54 A.M., the Director of Nursing (DON) indicated Resident #76 was debilitated after returning from the hospital. The DON further indicated Resident #76's medications had been adjusted and as a result Resident #76 spent a lot of time in bed. The DON further indicated the area on Resident #76's coccyx may have occurred due to shearing when</p>		<p>is in place. No new pressure woundswere identified during this housewide audit.</p> <p>The measures or systematicchanges that have been put into place to ensure that the deficient practicedoes not recur is that thefacility has reviewed and revised their policy and procedure on the preventionand treatment of pressure wounds. Thefacility has conducted a mandatory in-service for all nursing staff on therevised facility policies on the prevention and treatment of pressure wounds. This in-service also included instruction onthe proper staging of pressure wounds.</p> <p><i>The corrective action taken to monitor to assureperformance to assure compliance through quality assurance is that a Quality Assurance tool has been developed andimplemented to ensure that all necessary interventions are in place in theprevention and treatment of pressure wounds. The tool also includes</i></p>	

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	<p>repositioning.</p> <p>During an observation of a dressing change for the pressure area located on Resident #76's coccyx on 1/09/15 at 10:15 A.M., Resident #76 was lying on her back. The wound Care Nurse (WCN) was observed to reposition the resident by grasping the draw sheet and pulling the resident across the surface of the bed. The WCN measured the wound as 1.4 cm length by 1.0 cm width, less than 0.1 cm in depth with 75% white slough covering the wound bed. At that time the WCN indicated Resident #76 spent a lot of time in bed after returning from the hospital.</p> <p>A Policy for Wound Staging dated 11/1/14 was provided by the Director of Nursing on 1/09/15 at 3:30 P.M., and it read as follows: "...Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle cannot be seen. Slough may be present but does obscure the dept (sic) of tissue loss..."</p> <p>A Policy for Pressure Wounds was provided by the Assistant Director of Nursing on 1/09/15 at 3:48 P.M., and it indicated that " ...It is the facilities practice...that a resident who enters the facility...without pressure sores does not develop pressure sores..."</p>		<p>the monitoring of appropriate staging of any pressure wound. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance committee meeting to determine if any additional action is warranted.</p>				

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F000323 SS=D	<p>During an interview on 1/09/15 at 4:16 P.M., the Director of Nursing (DON) indicated that the pressure wound for Resident #76 had been staged incorrectly and was a Stage 3 pressure area. The DON said, "We missed it."</p> <p>3.1-40(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure effective safety interventions and/or supervision were provided for residents, in that, residents identified as being at a high risk for experiencing falls had inadequate supervision and/or effective equipment, which resulted in falls for 2 of 3 residents who met the criteria for review of falls. (Resident #22, Resident # 23)</p> <p>Findings include:</p> <p>1. On 1/7/15 at 10:13 A.M., Resident #22 was observed lying in bed with her</p>	F000323	F – 323	02/05/2015			
			The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident#22 has been reviewed related to effective safety interventions and/or supervision in an effort to meet the resident's needs related to her high fall risk. The resident has not had any fall since the fall of 12-31-14.				

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	<p>eyes closed.</p> <p>The clinical record of Resident #22 was reviewed on 1/7/15 at 9:18 P.M. The clinical record indicated the diagnoses of Resident #22 included, but were not limited to, osteoporosis, depression, lung cancer, and senile dementia.</p> <p>The Physician Orders dated 12/29/14 read as follows: "...pressure pad to W/C (wheelchair) @ (at) all times check placement and functioning q (every) shift..."</p> <p>The most recent MDS (Minimum Data Set) assessment dated 9/30/14 indicated Resident #22 experienced severe cognitive impairment. The MDS further indicated Resident #22 required the extensive assistance of 2 staff for transfers, extensive assistance of two staff for toileting, and was only able to stabilize balance with human assistance.</p> <p>A Fall Risk Assessment completed on 9/14/14 documented Resident #22 was at a high risk for falls.</p> <p>Fall #1: A Fall Documentation Form, which documented that a fall occurred on 12/26/14 at 1640 (4:40 P.M.), read as follows: "...QMA was called by [name]</p>		<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident# 23 has been reviewed related to effective safety interventions and/or supervision in an effort to meet the resident's needs related to his high fall risk. New interventions have been added and the resident has not had a fall since the fall of 12-03-14.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility has conducted a housewide audit of all residents to identify those residents at high fall risk. The care plans have been reviewed and revised as needed for all residents at high fall risk to ensure effective safety interventions and/or supervision are in place in. The CNA assignments sheets have been up-dated to include effective safety interventions for those residents identified at high fall risk. The treatment</i></p>	

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	<p>visitor...D/T (due to) res (resident) standing up in room. We both ran found res on floor on Rt (right) side of body...Res was incont (incontinent) B+B (bowel and bladder) at that time 2 (hour) toileting program started..."</p> <p>A Care Plan for Falls, which was dated 5/9/14 and last updated on 12/26/14, identified a problem of "...Falls with potential for injury related to:... Hx (History) of fall, poor safety awareness...and indicated the intervention was 12/26/14 bed/chair alarm..."</p> <p>A Fall Risk Assessment completed on 12/26/14 documented Resident #22 was at a high risk for falls.</p> <p>Fall #2: A Fall Documentation Form, which documented that a fall occurred on 12/31/14 at 0930 (9:30 A.M.), read as follows: "...Alarm in place to W/C (wheelchair) [not functioning] changed to box that you don't turn on and off...Resident was up in w/c sitting @ (at) dining table... Attempted to stand up et (and) resident slipped out of chair landing on B (bilateral) knees and R (right) elbow...Noted when this writer assessed resident with head lying on floor..."</p> <p>During an interview on 1/7/15 at 11:08</p>		<p>records have been reviewed and up-dated to ensure effective safety interventions are being monitored to ensure they are in place and functioning properly.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised their policies and procedure on fall risk assessment and management. A mandatory in-service has been provided for all nursing staff on the facility's revised fall risk assessment and management policies. In addition a special focus was made related to staff's responsibility to ensure that all safety interventions are in place in accordance with the resident's individualized safety plan.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a</i></p>	

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	<p>P.M., the Unit Manager #1 (UM) indicated Resident #22 had been identified as being at a high risk to experience a fall and had experienced a fall on 12/31/14 due to the alarm not sounding. The UM #1 indicated the alarm box was replaced with an alarm which could not be turned off. At that time, the UM indicated it was the facility's practice to prevent falls and implement effective interventions.</p> <p>During an interview on 1/9/15 at 3:39 P.M., the Health Care Administrator (HCA) indicated the facility recently replaced most of the chair alarms with new alarms which could not be easily turned off.</p> <p>On 1/9/15 at 4:03 P.M., the facility's Fall Safety policy was received and reviewed. The policy included, but was not limited to, the following provisions: "...It is the facilities (sic) practice that each resident receives adequate supervision and assistance devices in an attempt to prevent accidents..."</p> <p>2. On 1/6/15 at 12:15 P.M., Resident #23 was observed transferring himself to the restroom. No staff was observed to be assisting resident #23 and his personal alarm was sounding.</p> <p>The clinical record for Resident #23 was</p>		<p>Quality Assurance tool has been developed and implemented to monitor residents at high risk for falls to ensure that that they have effective safety interventions in place. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance committee meeting to determine if any additional action is warranted.</p>				

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	<p>reviewed on 1/8/15 at 1:30 P.M., diagnoses include, but were not limited to, dementia, weakness and a history of falls.</p> <p>The care plans included, but were not limited to, fall risk with potential for injury initiated 5/9/15, interventions included, but were not limited to, keep call light and most frequently used personal items within reach. Provide level of assistance require for ambulation and transfers. Encourage resident to participate as much as he is able. non skid strips at bedside on right side, 9/13/14 pressure pad to bed, patient teaching, added 9/13/14 and gripper socks at night and nightlight 10/15/14, resident not to be left alone in room while in w/c (wheel chair), fall pad on floor next to bed added 10/16/14, place alarm box out of reach added 11/15/14 and nurses counseled re (regarding) alarms, added 12/3/14.</p> <p>A fall assessment dated 10/13/14 was reviewed, it indicated resident had fallen, no description of event, the interventions added were supervision while in room, in wheel chair and pressure alarms in wheel chair and fall pad to the floor.</p> <p>A fall assessment dated 10/15/14 was reviewed, it did not include a description</p>			

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	<p>of the event, the interventions added were gripper socks at night and a night light.</p> <p>A fall risk assessment dated 10/16/14 was reviewed it included, a fall risk score of 17 indicating Resident #23 was at high risk to experience falls.</p> <p>A fall assessment dated 11/15/14 at 5:45 A.M., was reviewed it included, found on bathroom floor, floor wet, states slid off commode, "alarm box zip tied out of reach, pt (patient) turned off alarm"</p> <p>A fall assessment dated 12/3/14 at 6:00 A.M., was reviewed it included, "Resident found lying on back next to bed, resident stated 'I was trying to get up out of bed and set in my chair', No fall pad found next to bed, No pressure alarms in place to be."</p> <p>During an interview with the Director of Nursing, (DON) on 1/9/15 at 1:20 P.M., she indicated Resident #23 had experienced several falls. She indicated at that time there was no nursing documentation related to the falls on 10/13/14 and 10/15/14. She reviewed the facility incident report and indicated on 11/15/14 at 5 A.M., Resident #23 was found sitting on the floor next to his bed,</p>			

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F000334 SS=D	<p>she indicated the immediate intervention was to place a night light and gripper socks on Resident #23. She indicated Resident #23 had experienced a fall on 10/16/15 at 3:00 P.M., she indicated the intervention put into place at that time was not to leave Resident #23 in his room unsupervised while up in his wheel chair. She further indicated Resident #23 had also experienced a fall on 11/15/14 at 5:45 a.m., in his bathroom. She indicated he was attempting to toilet self and slid off the commode, she further indicated the alarm was not sounding as Resident #23 had turned it off. She indicated the last fall had occurred on 12/3/14 at 6:00 A.M., Resident #23 was found laying on his back next to his bed, she indicated Resident #23 was attempting to get out of bed and sit in his wheel chair. She indicated, the interventions of a fall pad and alarm were not in place at the time of the fall and the immediate action was to counsel all staff on duty at the time of the fall.</p> <p>3.1-45(a)(2)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p>			

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

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	<p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility immunization policy was correctly implemented for 3 of 5 residents reviewed for immunizations, in that, 2 of 5 residents reviewed did not have documentation of education and/or signed consent and/or refusal of flu vaccinations and 1 of 5 residents reviewed did not have signed consent/and or refusal of pneumonia vaccination. (Resident #23, Resident #62 and Resident #73)</p> <p>Findings include:</p> <p>1. Resident #62 was observed on 1/6/15 at 10:40 A.M., sitting in a wheelchair in</p>	F000334	F – 334 The corrective action takenfor those residents found to be affected by the deficient practice is that the resident identified as resident# 62 has been provided education of the risks versus the benefits of receivingthe flu immunization. The residentand/or responsible party has chosen ***** The corrective action takenfor those residents found to be affected by the deficient practice is that the resident identified as resident# 23 has been provided education of the risks versus the benefits of receivingthe flu immunization. The residentand/or responsible party has chosen ***** The corrective action takenfor those residents found to be affected by the deficient practice is that the	02/05/2015			

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	<p>the facility main dining room.</p> <p>The clinical record for Resident #62 was reviewed on 1/8/15 at 8:40 A.M., documentation of current influenza vaccination and/or consent or declination was not observed in the chart. The signed physician ' s order dated 12/1/14 included, but was not limited to may have annual influenza vaccination if not contraindicated. The clinical record lacked any documentation to indicate education had been influenza vaccination had been provided.</p> <p>2. On 1/5/15 at 11:12 A.M., Resident #23 was observed sitting in a wheel chair in the facility lounge.</p> <p>The clinical record for Resident #23 was reviewed on 1/8/15 at 8:45 A.M., documentation of current influenza vaccination and/or consent or declination was not observed in the chart. The signed physician ' s orders dated 12/1/14 included, but was not limited to, may have annual influenza vaccination if not contraindicated. The clinical record lacked any documentation to indicate education for the influenza vaccination had been provided.</p> <p>3. On 1/7/15 at 8:21 A.M., Resident #73 was observed sitting up in a wheel chair</p>		<p>resident identified as resident# 73 has received education on the risks versus the benefits of the pneumoniaimmunization and has signed a declination for the pneumonia immunization. <i>The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that the facility has completed a housewide education forall residents and/or their responsible parties on the risks versus the benefitsof receiving the flu and/or the pneumonia immunizations. A new informed consent and authorization forimmunization form has been developed and provided to all residents and/or theirresponsible parties. The completed formshave been placed on the clinical records of each resident and the appropriateimmunizations have been administered per personal preference of each residentand/or their responsible party. The measures or systematicchanges that have been put into place to ensure that the deficient practicedoes not recur is thatthe facility has reviewed and revised its process in the administration oftheir immunization program. The facility has reviewed and revised the informedconsent and authorization for immunization form. This form is being completed upon admissionby the Admission Director. Upon admission the resident and/or</i></p>	

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	<p>in her room.</p> <p>The clinical record for Resident #73 was reviewed on 1/8/15 at 8:50 A.M., documentation of education for pneumococcal vaccination and/or consent or declination was not observed in the chart.</p> <p>During an interview with the Director of Nursing (DON) on 1/8/15 at 9:50 A.M., she indicated they had sent out resident education to families in August. She indicated if they were not returned she just took it as they did not want. She further indicated they had not done any education and/or administration of the pneumonia vaccination since she had started in August 2014.</p> <p>During an interview with LPN #2 on 1/8/15 at 10:25 A.M., she indicated there was no pneumococcal vaccination declination for Resident #73, she further indicated the clinical record for Resident #62 and Resident #23 lacked documentation current education and consent and/or refusal of influenza vaccination.</p> <p>An undated policy titled "Immunizations" was provided by the Administrator on 1/5/15 at 12:40 P.M., it included, and " ...Each resident is offered an influenza</p>		<p>responsible party is advised that they may change their personal preference related to immunizations at any time during their stay at the facility by simply notifying nursing administration and a new consent/authorization form will be completed. Upon completion of the form it is forwarded to the appropriate unit manager who in turn is responsible for assuring that immunizations are being administered per resident's personal preference. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the facility immunization program to ensure that there is documentation on the clinical record related to the resident and/or responsible party receiving education on the risks versus the benefits of receiving the flu and pneumonia immunizations, The tool will also monitor to ensure that there is an informed consent and authorization for immunization form on the clinical record and that the immunization record reflects that the immunizations have been administered per the resident and/or responsible party's personal preference. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks,</i></p>		

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F000353 SS=E	<p>immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. Pneumonia immunizations may be administered upon admission and at any time during their stay upon receipt of a physician's order. The resident and/or resident's responsible party have the opportunity to refuse the immunizations. The resident and/or responsible party will be provided a consent/declination form to indicate their choice in writing..."</p> <p>The policy also included, "The resident's clinical record will contain the following information; that the resident and/or responsible party has been provided education regarding the benefits and potential side effects of influenza and pneumonia immunization. That the resident either received the influenza and pneumonia immunizations or did not receive the immunizations due to medical contraindications or refusal."</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p>		<p>then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance committee meeting to determine if any additional action is warranted.</p>	

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	<p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staffing was sufficient to perform ADL (Activities of Daily Living) care promptly for 5 of 6 residents, answer call lights timely according to 1 of 3 Resident Council minutes reviewed, and/or adequate supervision to prevent falls was not provided for 1 of 3 resident who met the criteria for review of falls. (Resident # 200, Resident #201, Resident #202, Resident #4, Resident #23, Resident #74) Findings Include:</p> <p>1. During a confidential interview on 1/6/15 at 8:35 A.M., Resident #201 indicated they had experienced a call light waiting time of 20 minutes or more frequently. The Minimum Data Set assessment (MDS) dated 12/23/14 was</p>	F000353	<p>F – 353</p> <p>The corrective action takenfor those residents found to be affected by the deficient practice is that the resident identified as resident# 201 is now having her call light answered promptly.</p> <p>The corrective action takenfor those residents found to be affected by the deficient practice is that the resident identified as resident# 200 is now having her call light answered promptly. There has been no increase in the resident's frequency of incontinence.</p> <p>The corrective action takenfor</p>	02/05/2015

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	<p>reviewed on 1/6/15 at 8:36 A.M., it indicated Resident #200's Brief Interview Mental Status (BIMS) score was 15 indicating the was cognitively intact.</p> <p>2. During a confidential interview on 1/5/15 at 11:45 A.M., Resident #200 indicated they had experienced call light waiting times anywhere from 30 minutes to 2 hours. Resident #200 further indicated they had experienced urinary incontinence while waiting for assistance. An MDS dated 12/16/14 was reviewed on 1/5/15 at 11:50 A.M., it indicated Resident #200's BIMS score was 13 indicating they were cognitively intact. The MDS further indicated Resident #200 required extensive assistance of two for bed mobility and transfers. The MDS for Resident #200 further indicated they were always continent of both urine and bowel.</p> <p>3. During a confidential interview on 1/6/15 at 9:44 A.M., Resident #202 indicated they had experienced incontinence while waiting for the call light to be answered. The MDS for Resident #202 dated 11/27/14 was reviewed on 1/6/15 at 9:50 A.M., it included a BIMS score of 15 indicating Resident #202 was cognitively intact. Resident #202 was listed as experiencing occasional incontinence. Resident #202</p>		<p>those residents found to be affected by the deficient practice is that the resident identified as resident# 202 is now having her call light answered promptly. The resident has not had any increase in herincontinence problem and is currently receiving medication to aide in herincontinence issue.</p> <p>The corrective action takenfor those residents found to be affected by the deficient practice is that the resident identified as resident# 4 is now receiving time care and services with additional focus on the timelyemptying of his colostomy bag.</p> <p>The corrective action takenfor those residents found to be affected by the deficient practice is that the resident identified as resident# 23 has been reviewed related to safety and toileting needs. Additional interventions have been put inplace. The resident is now receivingassistance promptly related to his toileting needs.</p>	

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	<p>was listed as requiring total assistance of two people for toileting and transfers.</p> <p>4. During observations on 1/6/15 at 9:40 A.M., Resident #4 was observed asking LPN #3 to empty his colostomy bag. LPN #3 indicated she would be right back to assist him.</p> <p>During observations on 1/6/15 at 10:50 A.M., Resident #4 was observed with his call light on, LPN #2 responded, Resident #4 indicated he had requested for his colostomy bag to be emptied and they had never come back. LPN #2 was observed assisting Resident #4 empty the bag which was observed to be full of bowel movement.</p> <p>The MDS dated 12/5/14 for Resident #4 was reviewed for on 1/6/15 at 11:00 A.M., it indicated a BIMS score of 7 for Resident #4 indicating he was severely cognitively impaired.</p> <p>5. On 1/6/15 at 12:15 P.M., Resident #23 was observed transferring himself to the restroom. No staff was observed to be assisting resident #23 and his personal alarm was sounding.</p> <p>The clinical record for Resident #23 was reviewed on 1/8/15 at 1:30 P.M., diagnoses include, but were not limited to, dementia, weakness and a history of</p>		<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident# 74</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility has reviewed and revised its policies and procedures on Answering Call Lights and Accommodation of Needs.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the revised policies related to Answering Call Lights and Accommodation of Needs. In addition the night shift staff was directed related to the use of cell phones during work hours and appropriate noise levels during the night hours.</p>	

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	<p>falls. The record had falls documented on 10/15/14 at 5:00 A.M., 11/15/14 at 5:45 A.M., and 12/3/14 at 6:00 A.M.</p> <p>The MDS dated 11/10/14 indicated Resident #23's BIMS score was 00 indicating he was severely impaired and experienced frequent inattention. The MDS also indicated Resident #23 required extensive assist of two persons for toileting and transfers.</p> <p>6. During an interview on 1/7/15 at 1:34 P.M., Resident #74 indicated she needed assistance to turn and reposition in bed, as well as assistance to use the restroom. She indicated on night shift she would ring and either her call light went unanswered for up to an hour and/or staff would turn off the call light and not return to assist her. She further indicated she experienced incontinent episodes while waiting for assistance. The MDS for Resident #74 was reviewed on 1/7/15 at 1:44 P.M., it indicated that Resident #74's BIM score was 15 indicating she was cognitively intact. Resident #74 was listed as experiencing occasional urinary incontinence and requiring extensive assist of two persons for transfers, and hygiene and extensive assist of one with toileting.</p> <p>7. The Resident Council minutes were reviewed on 1/8/15 at 2:20 P.M., they</p>		<p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the timely answering of call lights as well as the timely accommodation of meeting each residents' personal needs. This tool will be completed by the Social Service Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance committee meeting to determine if any additional action is warranted.</i></p>	

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	<p>included:</p> <p>On August 19 2014, the concerns included, Call lights not being answered timely, no snacks are being passed in evening time.</p> <p>The Resident Council minutes for October 2014, included the following concerns, " 3rd shift still on phones ." The facility response was, the DON to do one on one regarding phones.</p> <p>The Resident Council minutes dated November 26, 2014, included the following concerns, " CNA on phone a lot. Suggest a no cell phone policy, some trouble with 3rd shift aides including on cell phones a lot, talking loudly down the hall. The facility response was to in-service 3rd shift aides."</p> <p>On 1/9/15 at 1:45 P.M., during an interview with the Director of Nursing she indicated she was aware of the concerns on the night shift. She indicated they had moved some staff around and were actively monitoring. She further indicated she was unaware of the concerns with Resident #23 and would talk to staff about providing supervision.</p> <p>3.1-17(a)</p>			

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was prepared according to the recipe, in that, staff did not follow the recipe for the preparation of pureed food for 1 of 2 kitchen observations. This had the potential to affect 11 of 11 residents who received a pureed diet. (Resident #18, Resident #62, Resident #70, Resident #77, Resident #2, Resident #71, Resident #58, Resident #32, Resident #30, Resident #27, Resident #36)</p> <p>Findings include:</p> <p>The following was observed on 1/5/15 at 11:05 A.M.:</p> <p>During an interview, Cook #1 indicated she was preparing to start the puree process of 10 servings of Chicken and Dumplings for the noon meal. Cook #1 then indicated she had halved the recipe because it was for 20 servings. Cook #1 was observed, at that time, to not have a recipe in sight and placed 10 drained</p>	F000364	F - 364	02/05/2015			
		<p>The corrective action taken for those residents found to be affected by the deficient practice is that residents identified as residents # 18, # 62, # 70, # 77, # 2, # 71, #58, # 27 and # 36 are now receiving their pureed diets which have been properly prepared in accordance with approved facility recipes. The residents identified as #32 and # 30 no longer reside at the facility.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the cook identified as cook # 1 has received ateachable moment related to her responsibility in following the recipes to ensure that the food is prepared by methods that conserve nutritive value,</i></p>					

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	<p>scoops of chicken and dumplings into a food processor. Cook #1 was then observed to pour an unknown amount of liquid from a metal pitcher with unidentified markings into a food processor. During an interview, at that time, Cook #1 indicated she had added a little more than half a quart of water to the food processor. Cook #1 was then observed to process the Chicken and Dumplings, stir with a spatula, and pour into a serving pan. The pureed Chicken and Dumplings were observed, at that time, to have a thin liquid consistency.</p> <p>The recipe for Chicken and Dumplings Pureed provided by the DFS (Director of Food Service) on 1/5/15 at 11:15 A.M. indicated, "... For 20 servings ... Low-Sodium Chicken Base: 1 (and) 2/3 tablespoon... Water: 1 and 1/4 Quart ...Gradually add hot broth to mixture while processing. All liquid may not be required..."</p> <p>During an interview on 1/5/15 at 11:20 A.M., the DFS indicated 11 residents received a pureed diet, the pureed Chicken and Dumplings should not be a thin liquid consistency, the recipe should have been followed in regards to, using hot broth instead of water and adding</p>		<p>flavor, and appearance; and food that is palatable, attractive and at the proper temperature.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff on their responsibility in following facility recipes in the preparation of each food item served.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to ensure that all food items are prepared in accordance with the approved facility recipes. This tool will be completed by the Food Service Manager and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of</i></p>	

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F000371 SS=F	<p>liquid gradually to the recipe. The DFS further indicated, at that time, the pureed Chicken and Dumplings would be discarded and Cook #1 was preparing the pureed Chicken and Dumplings according to the recipe for 11 residents. A list of residents who received pureed diets was provided by the DFS, at that time. The list indicated Resident # 18, Resident #62, Resident #70, Resident #77, Resident #2, Resident #71, Resident #58, Resident #32, Resident #30, Resident #27, Resident #36 received pureed diets.</p> <p>3.1-21(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was prepared and/or stored under sanitary conditions, and kitchen equipment was clean, in that, kitchen staff did not have hair completely contained within a hair restraint during 2 of 2 kitchen observations and 1 of 1 random observation, and/or the drip pan</p>	F000371	<p>this tool willbe reviewed at the facility Quality Assurance committee meeting to determine ifany additional action is warranted.</p> <p>F – 371</p> <p>1. The corrective action taken for those residents foundto be affected by the deficient practice is that all residents have the potential to be affected bythis deficient practice.The Food Service</p>	02/05/2015			

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	<p>under the stove burners contained black debris, the floor under the food storage shelf had food debris, and the food storage shelves had food spillage during 1 of 2 kitchen observations. This had the potential to affect 67 of 68 residents who resided in the building.</p> <p>Findings include:</p> <p>The following was observed on 1/5/15 at 8:45 A.M.:</p> <ol style="list-style-type: none"> 1. The DFS (Director of Food Service) was observed to have hair extruding from the sides of a bandana. 2. Cook #1 was observed to have hair extruding from the sides of a hairnet. 3. The drip pan under the range burners were observed to be soiled with black debris. 4. Syrup spillage was observed around the bottom of a syrup container in the dry storage area. 5. Food debris was observed under the shelving in the dry storage area. <p>During an interview on 1/5/15 at 9:15 A.M., Cook #1 indicated there was no specific schedule for cleaning the range</p>		<p>Director is nowwearing hair attire with all hair, including the sides contained within thehair attire.</p> <p>2. The corrective action taken for those residents foundto be affected by the deficient practice is that all residents have the potential to be affected bythis deficient practice. The Cook identified as Cook #1 is now wearing hair attire withall hair, including the sides contained within the hair attire.</p> <p>3. The corrective action taken for those residents foundto be affected by the deficient practice is that all residents have the potential to be affected bythis deficient practice. The drip panunder the range burners has been cleaned and is free of debris.</p> <p>4. The corrective action taken for those residents foundto be affected by the deficient practice is that all residents have the potential to be affected bythis deficient practice. The syrupcontainer</p>	

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	<p>drip pan, but it should be cleaned if it was dirty.</p> <p>During an interview on 1/5/15 at 9:25 A.M. the DFS indicated the range drip pan should be cleaned as needed and weekly, and the dry storage area should be kept clean at all times.</p> <p>During a random observation on 1/6/15 at 8:15 A.M. the following was observed:</p> <p>6. The DON (Director of Nursing) and CNA #5 were observed in the kitchen standing next to a food preparation table with 2 uncovered bowls of cereal. The DON and CNA #5 were observed, at that time, to not have a hair restraint.</p> <p>The following was observed on 1/7/15 at 9:00 A.M.:</p> <p>7. Cook #2 was observed to have hair extruding from the sides of a hairnet.</p> <p>8. Cook #1 was observed to have hair extruding from the sides of a hairnet.</p> <p>9. The DFS was observed to have hair extruding from the sides of a bandana.</p> <p>During an interview on 1/7/15 at 9:30 A.M., the DFS indicated she was aware the proper use of hair restraints and staff</p>		<p>stored in the dry food storage area has been cleaned and is free of spillage.</p> <p>5. <i>The corrective action taken for those residents found to be affected by the deficient practice is that all residents have the potential to be affected by this deficient practice. The area under the dry food storage area has been cleaned and is free of good debris.</i></p> <p>6. <i>The corrective action taken for those residents found to be affected by the deficient practice is that all residents have the potential to be affected by this deficient practice. The DON and CNA #5 are now wearing hair restraints when entering the kitchen.</i></p> <p>7. <i>The corrective action taken for those residents found to be affected by the deficient practice is that all residents have the potential to be affected by this deficient practice. The cook identified</i></p>	

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	<p>coming into the kitchen without proper hair restraint was a problem. The DFS further indicated, at that time, no specific policy could be provided for cleaning the range drip pans, but it was common facility practice to keep the kitchen equipment clean.</p> <p>A Policy and Procedure for Employee Hygiene and Sanitary Practices provided by the DFS on 1/8/15 at 9:40 A.M. indicated, "...12. Hair nets...must be worn to keep hair from contacting exposed food, clean equipment..."</p> <p>A Policy and Procedure for Food Receiving and Storage provided by the DFS on 1/8/15 at 9:45 A.M. indicated, "...Clean storage areas...1. Food services...will maintain clean food storage areas at all times...Dry Storage: 4. Non-refrigerated food...kept clean..."</p> <p>A Kitchen Sanitation Audit dated 1/06/14 provided by the HFA (Health Facilities Administrator) on 1/9/15 at 3:00 P.M. indicated the dry storage area and/or the range was not clean.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>as Cook #2 isnow wearing hair attire with all hair, including the sides contained within thehair attire.</p> <p>8. The corrective action taken for those residents foundto be affected by the deficient practice is that all residents have the potential to be affected bythis deficient practice. The Cook identified as Cook #1 is now wearing hair attirewith all hair, including the sides contained within the hair attire.</p> <p>9. The corrective action taken for those residents foundto be affected by the deficient practice is that all residents have the potential to be affected bythis deficient practice.The Food Service Director is nowwearing hair attire with all hair, including the sides contained within thehair attire.</p>		

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			<p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the responses are the same as listed above since all residents have the potential to be affected by these deficient practices.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary and nursing staff on the proper use of hair restraints. A mandatory in-service was also provided for all dietary staff on the revised cleaning schedules which includes the cleaning of the drip pan under the range burners, cleaning of containers upon spillage and the cleaning of the shelves and floors in the dry food storage area.</p>	

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of		<i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented on the proper use of hair restraints in dietary as well as the proper cleaning of kitchen equipment and the cleaning of food storage areas. This tool will be completed by the Food Service Manager and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance committee meeting to determine if any additional action is warranted.</i>	

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	<p>all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review the facility failed to return and/or dispose of expired medications and/or discontinued medications in a timely manner for 1 of 1 medication storage rooms and 1 of 1 medication carts reviewed contained in that expired injectable medications were stored past acceptable use by dates following opening were stored in a refrigerator and an oral medication was stored past the allotted time. (Resident #37, Resident</p>	F000431	<p>F – 431</p> <p>1. The corrective action taken for those residents found to be affected by the deficient practice is that the Novolog flexpen belonging to the resident identified as resident #37 has been destroyed and a new flexpen is being utilized within the manufacturer timeline guidelines.</p>	02/05/2015

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	<p>#41, Resident #91)</p> <p>Findings Include:</p> <p>1. During an observation of medication administration on 1/8/15 12:08 P.M., with LPN #3 a Novo log flex pen for Resident #37 was observed to have an open dated of 11/26/14. LPN #3 indicated she would have to get a different Novolog flexpen because it was only good for 28 days after being opened. LPN #3 confirmed the medication had been kept a total of 16 days past the expiration date.</p> <p>2. On 1/9/15 at 8:33 A.M., the west wing medication room was observed with the unit supervisor LPN #3. During the observation the following was observed stored in the refrigerator.</p> <p>a. A bottle of Leukeran, containing 22 pills for Resident #91. The bottle was delivered July 25, 2014. LPN#3 indicated the Resident #91 had passed away and the medication needed to be disposed of. The clinical record for Resident #91 was reviewed on 1/9/15 at 9:00 A.M., it included, but was not limited to, "11/18/14 D/C [discontinue] Leukeran." LPN #3 confirmed the medication was kept for a total of 52 days following the</p>		<p>2. a The corrective action taken for those residents found to be affected bythe deficient practice is that all medications identified belonging to the resident identified asresident # 91 have been disposed of .</p> <p>2.b <i>The corrective action taken for those residents found to be affected bythe deficient practice is that the two half full bottles of allergy serumidentified as belonging to resident # 48 have been destroyed and a new supplyhas been obtained.</i></p> <p><i>The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that a house wide audit has been completed of allmedication carts, medication rooms and med refrigerators to ensure no otherdiscontinued or expired medications are in service for medicationadministration.</i></p> <p>The measures or systematicchanges that have been put into place to ensure</p>	

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	<p>discontinuation of the medication.</p> <p>b. Two half full multi dose injection bottles of allergy serum belonging to Resident #48. The vials expiration date was listed as 12/3/14. LPN #3 confirmed the medication was kept a total of 37 days past the expiration date.</p> <p>An undated policy titled "Disposal of Medications and Medication -Related Supplies: was provided on 1/9/15 at 10:36 A.M., by the Administrator. The policy included, but was not limited to, "When medications are discontinued by a prescriber... the medications are marked as "discontinued" and destroyed, or, if the packages are unopened, returned to the issuing pharmacy within 48 hours..."</p> <p>3.1-25(m) 3.1-25(o)</p>		<p>that the deficient practicedoes not recur is that thefacility policy on medication storage and disposal has been reviewed andrevised. A mandatory in-service has beenprovided to all licensed nurses on the proper disposal of discontinued orexpired medications in accordance with the revised policy.</p> <p><i>The corrective action taken to monitor to assureperformance to assure compliance through quality assurance is that a Quality Assurance tool has been developed andimplemented to monitor the proper disposition of discontinued and/or expiredmedications in a timely manner in accordance with facility policy. This toolwill be completed by the Director of Nursing and/or her designee weekly forfour weeks, then monthly for three months and then quarterly for threequarters. The outcome of this tool willbe reviewed at the facility Quality Assurance committee meeting to</i></p>	

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F000441 SS=E	<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>		determine if any additional action is warranted.	
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	<p>transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure hand hygiene was performed, in that, staff did not perform hand hygiene properly during 3 of 4 infection control observations completed. (Resident #4, Resident #76)</p> <p>B. Based on interview and record review, the facility failed to ensure employees were screened and/or evaluated for communicable disease upon employment for 7 of 10 employees reviewed. (CNA #2, CNA #3, CNA #4, LPN #1, ADON (Assistant Director of Nursing), DFS (Director of Food Service), RN #1)</p> <p>Findings Include:</p> <p>A. 1. on 1/6/15 at 10:50 A.M, LPN #2 was observed doing care for Resident #4. During that observation LPN #2 was observed emptying the colostomy bag of Resident #4. LPN #2 indicated she needed to get something from the supply room, she removed her gloves and washed her hands for 6 seconds.</p> <p>On 1/6/15 at 10:56 P.M., LPN #3 came in to finish with the colostomy care of Resident #4. After completing the</p>	F000441	<p>F – 441</p> <p>A. 1 The corrective action taken for those residents found to be affected bythe deficient practice is that the resident identified as resident # 4 isnow receiving personal care, including the changing of his colostomy bag bynursing staff that are correctly following the facility hand hygienepolicy. The LPN identified as LPN # 2has been re-inserviced on the facility’s hand hygiene policy.</p> <p>A. 2. The corrective action taken for those residents found to be affected bythe deficient practice is that the resident identified as resident # 76 nolonger resides at the facility. Thenurse identified as RN # 2 has been re-inserviced on the facility’s policy onhand hygiene and glove usage. B. 1 The corrective action taken for those residents found to be affected bythe deficient practice is that the employee identified as CNA # 2 has shownno signs or symptoms of any type of communicable disease. B. 2 The corrective action taken for those residents found to be affected bythe deficient practice is that the employee identified as</p>	02/05/2015

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	<p>colostomy care on Resident #4, LPN #3 removed her gloves and washed her hands for 10 seconds.</p> <p>A. 2. On 1/9/15 at 10:15 A.M., during an observation of a dressing change for Resident #76 with the RN #2. RN #2 was observed completing incontinence care on Resident #76. She than was observed to perform a dressing change without changing gloves and/or performing hand hygiene.</p> <p>During an interview on 1/9/15 at 2:15 P.M., the DON indicated in servicing had been completed on hand washing in November. She further indicated staff should wash hands for 20 seconds. She further indicated gloves should be changed and hand hygiene performed during a dressing change especially when going between potentially dirty and clean actions.</p> <p>A policy dated 2001 titled "Hand washing/Hand Hygiene" was provided by the Administrator. It included, but was no limited to; employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:</p> <p>a. When coming on duty, c. Before and after direct resident contact (for which</p>		<p>CNA # 3 has shownno signs or symptoms of any type of communicable disease. B. 3 <i>The corrective action taken for those residents found to be affected bythe deficient practice is that the employee identified as CNA # 4 has shownno signs or symptoms of any type of communicable disease. B. 4 <i>The corrective action taken for those residents found to be affected bythe deficient practice is that the employee identified as LPN # 1 has shownno signs or symptoms of any type of communicable disease. B. 5 <i>The corrective action taken for those residents found to be affected bythe deficient practice is that the employee identified as the ADON hasshown no signs or symptoms of any type of communicable disease. B. 6 <i>The corrective action taken for those residents found to be affected bythe deficient practice is that the employee identified as the DFS has shownno signs or symptoms of any type of communicable disease. B. 7 <i>The corrective action taken for those residents found to be affected bythe deficient practice is that the employee identified as RN # 1 has shownno signs or symptoms of any type of communicable disease. <i>The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that all</i></i></i></i></i></i></p>		

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	<p>hand hygiene is indicated by acceptable professional practice, h. Before and after assisting a resident with personal care (e.g., oral care, bathing), r. After handling soiled or used linens, dressings, bedpans, catheters and urinals."</p> <p>B. The Employee Files were reviewed on 1/9/14 at 9:00 A.M., and the following was noted:</p> <p>B. 1. CNA #2: The Employee Health Examination completed on 11/24/15 lacked any documentation the employee was free of communicable disease.</p> <p>B. 2. CNA #3: The Employee Health Examination completed on 7/24/14 lacked any documentation the employee was free of communicable disease.</p> <p>B. 3. CNA #4: The Employee Health Examination completed on 1/13/14 lacked any documentation the employee was free of communicable disease.</p> <p>B. 4. LPN #1: The Employee Health Examination completed on 1/22/14 lacked any documentation the employee was free of communicable disease.</p> <p>B. 5. ADON: The Employee Health Examination completed on 7/18/14 lacked any documentation the employee was free of communicable disease.</p>		<p>residents have the potential to be affected bythis deficient practice. Each nursing employee has successfully completed areturn demonstration on following the facility hand washing policy andprocedure. All resident are nowreceiving personal care by nursing staff members who are following the facilityhand washing and glove usage policy and procedures. As far as the employee's physicals lackingthe verbiage related to being free of communicable diseases, no employee havebeen identified to have any signs and symptoms of any communicable disease. The measures or systematicchanges that have been put into place to ensure that the deficient practicedoes not recur is that amandatory in-service has been provided for all nursing staff on the facilityhand washing and glove usage policy and procedures. The facility has also reviewedand revised its employee physical form to include the screening and/orevaluation for communicable disease on all prospective employees prior toemployment. Any potential employee whois determined to have a communicable disease will not be permitted to workuntil the health issue is resolved and they has been found to be free ofcommunicable disease by the facility physician. <i>The corrective action taken to monitor to assureperformance to assure</i></p>	

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F009999	<p>B. 6. DFS: The Employee Health Examination completed on 9/15/14 lacked any documentation the employee was free of communicable disease.</p> <p>B. 7. RN #1: The Employee Health Examination completed on 10/27/14 lacked any documentation the employee was free of communicable disease.</p> <p>During an interview on 1/9/15 at 2:30 P.M., the BOM (Business Office Manager) indicated, she was not aware staff should be screened for communicable disease and then indicated, at that time, it was her understanding screening for Tuberculosis was sufficient.</p> <p>During an interview on 1/9/14 at 3:00 P.M., the HFA (Health Facilities Administrator) indicated the Employee Health Examination would be updated to include the screening for communicable disease.</p> <p>3.1-18(b)(1)(A) 3.1-18(l)</p> <p>Personnel 3.1-14</p>	F009999	<p><i>compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to ensure that the nursing staff is following the facility policy and procedure on hand washing and glove usage while providing personal care to the residents. The tool has also been designed to monitor the results of the employee physical forms. Each potential employee will have a check list completed on their employee file to ensure that the physical examination form indicates that the employee is free of communicable disease prior to being placed on the work schedule. This tool will be completed by the Director of Nursing and/or her designee. The tool will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</i></p> <p>F 9999 1. The corrective action taken for those residents found to</p>	02/05/2015	

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	<p>(e) Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual: (1) is a full-time employee in a training and competency evaluation program approved by the division; or (2) can prove that he or she has recently successfully completed a training and competency evaluation program approved by the division and has not yet been included in the registry. Facilities must follow up to ensure that such individual actually becomes registered.</p> <p>(f) A facility must check with all state nurse side registries it has reason to believe contain information on an individual before using that individual as a nurse aide.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure CNA certifications were verified with the Indiana registry, in that, 3 of 4 CNA certifications were not verified with the Indiana registry prior to employment. (CNA #2, CNA #3, CNA #4)</p> <p>Findings include:</p>		<p>be affected by the deficient practice is that the Indiana certification for the CNA identified asCNA # 2 has been checked and is active and in good standing. 2. The corrective action taken for those residents foundto be affected by the deficient practice is that the Indiana certification for the CNA identified asCNA # 3 has been checked and is active and in good standing. 3. The corrective action taken for those residents foundto be affected by the deficient practice is that the CNA identified as CNA # 4 has successfully passedher Indiana Nurse's Aide test. TheIndiana certification for the CNA identified as CNA # 4 has been checked and isactive and in good standing. The corrective action takenfor the other residents having the potential to be affected by the samedeficient practice is thatall residents have the potential to be affected by this deficient practice. A house wide audit of all nurse's aides certifications have been re-checked andhave been found to be active and in good standing.</p> <p>The measures or systematicchanges that have been put into place to ensure that the deficient practicedoes not recur is that thefacility has adopted the practice that a prospective employee checklist is nowbeing completed on all certified nursing assistants and</p>	

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	<p>The employee certification/licensure log was reviewed on 1/8/15 at 3:00 P.M. and lacked any evidence of an active Indiana CNA certification for CNA #2, CNA #3, and CNA #4.</p> <p>During an interview 1/8/15 at 3:30 P.M., the ADON (Assistant Director of Nursing) indicated the following:</p> <ol style="list-style-type: none"> 1. The Indiana CNA certification for CNA #2 had not been checked because the ADON had previously worked with the CNA #2 at another facility. 2. The Indiana CNA certification for CNA #3 had not been checked because the testing center was having trouble getting their students certification processed. 3. The Indiana and/or Kentucky CNA certification for CNA #4 had not been checked because CNA #4 had been a CNA in another state. <p>The Policy and Procedure for "Personnel Files...CNA Certification" provided by the HFA (Health Facilities Administrator) on 1/9/15 at 10:36 A.M. indicated, "...It is the facility policy that prior to employment that the prospective employee's...certification will be verified by the facility..."</p>		<p>licensed nurses as well, to ensure that there is documentation to support that the prospective employee's certification/licensure is active and in good standing prior to the prospective employee being placed on the work schedule. The person responsible for conducting these certification/licensure checks is now the Business Office Manager. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor prospective employee files to ensure that all certifications/licensures have been checked prior to being placed on the work schedule. The tool will also monitor to ensure that the certifications/licensures are active and in good standing. This tool will be completed by the Business Office Manager and/or her designee on all new hires. This will be an on-going process. This tool will be completed by the Business Office Manager and/or her designee on all new hires. This will be an on-going process.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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