

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2014
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint Numbers IN00140789 and IN00139682.</p> <p>Complaint numbers: IN00140789 - Substantiated. Federal/state deficiencies related to the allegations are cited at F253 and F353. IN00139682 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: December 30, 31, 2013 , Jan 2, 7, 8, and 9, 2014</p> <p>Facility number :011049 Provider Number: 155670 AIM number: 200258520</p> <p>Survey Team: Denise Schwandner RN TC Diane Hancock RN Diana Perry RN Anna Villian RN Barb Fowler RN 1/7, 1/8, 1/9/14</p> <p>Census bed type : SNF/NF 79 Total 79</p>	F000000	<p>This Plan of Correction is submitted under the State and Federal regulations and statues applicable to long-term care providers. This Plan of Correction does not constitute an admission on the part of the facility. We request this written Plan of Correction serve as our credible allegation of compliance. In addition, we are requesting this Plan of Correction be considered for desk review compliance. Should you have any questions, please feel free to contact me at (812) 473-4761. Sincerely, Fairley (Lee) R Taylor Jr, HFA, Administrator Addendum completed on 1/28/14 as requested and resubmitted.</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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F000253 SS=E	<p>Census Payor Type: Medicaid 58 Medicare 11 Other 10 Total 79</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 15, 2014, by Jodi Meyer, RN</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure rooms were maintained in a clean and sanitary manner, for 6 of 29 sampled rooms, in that closet doors were scuffed, bathroom walls were scuffed, and bedroom walls were scuffed and/or marred, and had paint chipped off. (Room #106, Room #208, Room #218, Room</p>	F000253	<p>It is the practice of this facility to provide housekeeping and Maintenance Services necessary to maintain a sanitary, orderly and comfortable interior. I. The areas identified in rooms 106, 208, 218, 229, 207 have been corrected. Walls painted, closet door scuffs removed, valences washed, deep cleans completed. Deep clean and painting schedules have been put into place. Side rail for resident # 64 was immediately</p>	02/07/2014
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	<p>#229, Room #207, Room #229)</p> <p>Findings include:</p> <ol style="list-style-type: none"> During an observation on 12/30/13 at 12:00 p.m., Room #106 was observed to have debris on the floor of her room. An observation of the room on 1/7/14 at 3:00 p.m., indicated Room #106 to also have paint chipped off the wall under the window. During an observation on 12/31/13 at 9:47 a.m., Room #208 was observed to have black marks on the wall left of the door. On observation on 1/7/14 at 3:07 p.m., the scuff marks remained on the closet doors. During an observation on 12/30/13 at 4:23 p.m., Room #218 was observed to have closet doors with scuff marks on them. An observation on 1/7/14 at 3:11 p.m., indicated the room to have black marks on the closet doors. During an observation on 12/31/13 at 11:10 a.m., Room #229 was observed to have wheelchair marks on the bathroom wall. During an observation of Room #229 on 1/7/14 at 3:19 p.m., the room was 		<p>corrected by the Maintenance Director upon notification.II.All residents have the potential to be affected. Painting schedule (Exhibit A) implemented where as both resident rooms and bathroom's will be painted/touched up over a 90-day period on a continuous rotating schedule. Deep Clean schedules also implemented (Exhibit B) on a 30-day schedule. Side rail for resident #64 was immediately corrected by the Maintenance Director upon notification.III. Maintenance Director and Supervisor will make walking rounds daily validating completion of the assigned work based on the schedules by initialling the schedules. Administrator will make weekly random checks with the supervisors validating their follow-up. Coaching/counseling forms have been completed with both supervisors to address expectations of role/assignments and schedules. Inservicing of both directors over painting and cleaning schedules (Exhibit C) has been completed. Environmental rounds (Exhibit D) will be completed 5 times a week by department supervisor with routine random checks including the Administrator. All beds with side rails have also been checked for safety by the maintenance staff with corrective action taken as necessary.IV. Environmental rounds to be validated weekly by the</p>				

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	<p>observed to have blacks marks on the bathroom wall, a red mark on the bathroom door, black marks outside of the bathroom around the door, and a brown mark on the wall close to the entry door.</p> <p>5. During an interview on 1/8/1/8/14 at 10:00 a.m., the housekeeping director indicated rooms were deep cleaned when a resident is discharged.</p> <p>6. During an interview with the maintenance director on 1/8/14 at 10:07 a.m., he indicated there was not a painting schedule for the resident's rooms. He further indicated the staff creates a work order if something needs to be done and then he will do the job.</p> <p>7. Room 207 was observed on 1/7/14 at 5:30 p.m. The wall to the left of the window was scuffed with black marks. The valance had an accumulation of dust/lint. There was a urine odor in the bathroom.</p> <p>8. On 12/31/13 at 11:11 a.m., Resident #64's left bed rail, a 1/4 bed rail, was observed to be loose, in room #229. On 1/8/14 at 9:30 a.m., the bed rail was observed to be loose. The Administrator indicated, on 1/8/14 at 2:20 p.m., the</p>		<p>Administrator and up to 5 times a week by the Housekeeping and Maintenance Supervisors x 2 months, 3 times a week x 2 months and then weekly x 2 months, identifying any areas of concern with immediate corrective action being taken as needed. Findings will be reviewed in the QA Meeting monthly for 6 months or until 100% compliance has been achieved.</p>	

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	<p>side rail had been tightened.</p> <p>This federal tag relates to Complaint Number IN00140789.</p> <p>3.1-19(f)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure accurate comprehensive assessments were completed on 1 of 35 Stage 2 residents reviewed.</p>	F000272	It is the practice of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.I. Social	02/07/2014

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	<p>(Resident #5)</p> <p>Findings include:</p> <p>On 12/30/13 at 3:47 p.m., Resident #5 indicated she had two upper teeth pulled which made her dentures loose.</p> <p>On 1/2/14 at 10:36 a.m., Resident #5's clinical record was reviewed.</p> <p>The "Consult Note", dated 5/7/13 from the oral surgeon indicated two teeth required extraction.</p> <p>The most recent MDS (Minimum Data Set) Assessment dated 10/23/13 indicated no dental issues.</p> <p>The "Social Service Review", dated 12/12/13 lacked documentation pertaining to any dental issues.</p> <p>On 1/8/14 at 7:54 a.m., Resident #5 was interviewed. Resident indicated the dentist had adjusted dentures, but still had difficulty eating due to loose dentures.</p> <p>3.1-31(c)(9)</p>		<p>Services Director upon notification of concern immediately interviewed resident # 5 and scheduled her a follow-up dental appointment for January 20, 2014, in which the resident attended. Family was also made aware of this appointment. Resident # 5 had a previous dental follow-up appointment scheduled for December 2013 but was cancelled by family due to resident not feeling well.II. All residents have the potential to be affected. Social Services Director upon notification of concern immediately interviewed resident # 5 and scheduled her a follow-up dental appointment for January 20, 2014, in which the resident attended (Exhibit E). Family was also made aware of this appointment. Resident # 5 had a previous dental follow-up appointment scheduled for December 2013 but was cancelled by family due to resident not feeling well.III. Initially, all interviewable residents were interviewed by Social Services Director with non-interviewable residents having dental/oral assessments completed by a nurse with dental appointments, MD notification made as necessary for any areas of concern. These interviews and oral assessments will continue during the residents scheduled RAI assessment periods for 6 months. Resident # 5 dental concerns were not</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility</p>	F000279	<p>documented during October RAI assessment period during the required 7-day look-back period so not placed on MDS, as prior tooth extractions took place several months earlier. Nurses to be inserviced over documenting change of condition (Exhibit F) with immediate corrective action taken for non-compliance as necessary. IV. Findings will be reported to the facility QA Committee monthly x 6 months. After 6 months, QA Committee will determine if further monitoring required.</p> <p>It is the practice of this facility to use the results of the assessment</p>	02/07/2014	

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	<p>failed to develop care plans for 3 of 35 residents in the stage 2 sample, in that care plans for incontinence, tracheostomy, and fluid restrictions were not developed. (Resident #60, Resident #55, Resident #5)</p> <p>Findings include:</p> <p>1. Observation of the Resident #60 on 1/2/14 at 8:38 a.m., indicated the resident's tracheostomy was patent.</p> <p>The medical record failed to have a care plan addressing tracheostomy use.</p> <p>During an interview with LPN #2 on 1/7/14 at 11:00 a.m., she indicated the resident had a tracheostomy. She was unable to locate a care plan for the tracheostomy use.</p>		<p>to develop, review and revise the resident's comprehensive plan of care.I. Resident #60's care plan was immediately revised to include tracheostomy use/care with copy of this revision being given to the survey team on 1/8/14. Resident # 55's care plan was also revised to include allocation of fluid restriction and the MAR for this resident was also revised to show the fluid restriction. Resident # 5's care plan was revised to include nocturnal urinary incontinence.II. All residents with tracheostomy, fluid restriction and incontinence have the potential to be affected. Resident # 60's care plan was immediately revised to include tracheostomy use/care with copy of this revision being given to the survey team on 1/8/14. Resident # 55's care plan was also revised to include allocation of fluid restriction and the MAR for this resident was also revised to show the fluid restriction/ Resident # 5's care plan was revised to include nocturnal urinary incontinence.III. Nurses inserviced over appropriate care plan documentation/revisions(Exhibit F), review and updates as necessary and over fluid restrictions and allocation (Exhibit G).IV. New MD orders will be reviewed a minimal 5 times a week in AM Clinical Meeting by members of the nursing management team with updates to the care plan being made as</p>		

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	<p>2. Resident #55's clinical record was reviewed on 1/2/14 at 8:40 a.m. The resident was admitted to the facility on 2/23/13 with diagnoses including, but not limited to, end stage renal disease, diabetes mellitus, hemiplegia, and cerebrovascular accident.</p> <p>Physician's orders, dated 12/3/13, indicated an order for a 1500 cubic centimeter (cc) fluid restriction. The order specified 100 cc each shift from nursing, and 720 cc for breakfast, 240 cc for lunch and supper for dietary.</p> <p>A dietary note, dated 12/24/13, indicated the resident remained on a 1500 cc fluid restriction per day.</p> <p>On 1/7/14 at 9:10 a.m., the resident's care plan was reviewed. The care plan for dialysis/renal failure, dated 8/19/13 and reviewed 12/3/13, indicated the resident was</p>		necessary. MAR's will be checked to verify fluid restriction is present on all new admits, readmits or with new orders received by a member of the nurse management team. Findings to be reviewed in the QA Meeting monthly for 6 months or until 100% compliance has been achieved.		

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	<p>on a 1500 cc fluid restrictions, but did not specify how the 1500 cc was allocated. The medication administration record (MAR) was reviewed at that time and lacked any documentation regarding the fluid restriction. RN #1 indicated, at that time, the breakdown of fluids for residents on fluid restrictions was usually on the MAR.</p> <p>3. On 12/30/13 at 3:52 p.m., Resident #5's room was observed with urine odor in room.</p> <p>On 1/2/14 at 10:36 a.m., Resident #5's clinical record was reviewed.</p> <p>The "Weekly Summary", dated 12/27/13 indicated Resident #5 required limited assist toileting.</p> <p>The "Urinary Continence Evaluation", dated 10/18/13 indicated Resident #5 occasionally incontinent (less than 7 episodes of incontinence during the last 7 days).</p> <p>Care plans lacked documentation pertaining to resident incontinence.</p> <p>On 1/7/14 at 10:36 a.m., interviewed CNA #1. CNA #1 indicated Resident #5 incontinent at night.</p>						

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	On 1/8/14 at 9:10 a.m., the Care Plan Policy provided by the Staff Development Coordinator was reviewed. The policy indicated all residents will have care plans to provide guidance to staff caring for residents. 3.1-35(a)						
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to follow the care plan for alarm use and oral care, for 1 of 35 residents reviewed in stage 2 sample. (Resident #5)	F000282	It is the practice of this facility to ensure the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.I. Alarm for resident # 5 was immediately put into place by nurse upon	02/07/2014			

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	<p>Findings include:</p> <p>On 1/2/14 at 10:34 a.m., observed Resident #5 sitting in wheelchair, no alarm was observed in place.</p> <p>On 1/2/14 at 10:36 a.m., Resident #5's clinical record was reviewed.</p> <p>Care plans included, but were not limited to, high risk for falls. Interventions included, but were not limited to, bed/chair alarms in place to remind resident to ask for help.</p> <p>On 1/2/14 at 1:38 p.m., Resident #5 was observed in wheelchair, no alarm was observed in place.</p> <p>On 1/7/14 at 9:56 a.m., observed Resident #5's daily care. After Resident #5's care was completed, CNA #1 returned the resident to wheelchair, no alarm was observed to be placed.</p> <p>On 1/7/14 at 1:45 p.m., interviewed LPN #1. LPN #1 indicated Resident #5 should have bed or chair alarm in place.</p> <p>On 12/30/13 at 3:47 p.m., Resident #5 indicated she did not clean her own teeth, nor did staff offer to assist her.</p>		<p>discovery. No immediate corrective action was able to be completed for the oral care of resident #5.II. All residents with alarms have the potential to be affected and all residents requiring assistance with oral care have the potential to be affected. Alarm for resident # 5 was immediately put into place by the nurse upon discovery. No immediate corrective action was able to be completed for the oral care of resident # 5.III. Nursing staff inserviced over verifying alarms placement and function (Exhibit H) and oral care (Exhibit I). Safety Checks implemented to check alarm placement on all residents with alarm orders (Exhibit J) and resident interviews implemented (Exhibit J) to check oral care status of residents a minimal of 5 times a week. Both the safety checks and oral care resident interviews will be completed 5 times a week x 2 months, 3 times a week x 2 months and then weekly x 2 months with findings reported to the facility QA Committee. IV. Safety checks and oral care resident interviews will be reported to the facility QA Committee and Resident Council during monthly meeting x 6 months or until 100% compliance has been achieved.</p>		

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	<p>On 1/2/14 at 10:36 a.m., Resident #5's clinical record was reviewed.</p> <p>Care plans included, but were not limited to, self care ADL (activities of daily living) performance deficit. Interventions included, but were not limited to, requires staff participation with personal hygiene and oral care, assist of one.</p> <p>The "Care Plan Conference", dated 11/6/13 indicated resident would like to brush teeth at night.</p> <p>On 1/7/14 at 9:56 a.m., observed daily care for Resident #5. CNA #1 was not observed to offer or assist Resident #5 with oral care.</p> <p>On 1/7/13 at 2:06 p.m., the "Bathing Report " provided by Medical Records #1 indicated Resident #5 received a full bath on 1/7/14.</p> <p>On 1/7/14 at 4:32 p.m., interviewed DoN (Directon of Nursing). The DoN indicated oral care was documented under one block of personal hygiene on the kiosk (computer) documentation. The DoN indicated documentation does not individually indicate the type of care given.</p>			

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F000312 SS=D	<p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to provide services to maintain personal and oral hygiene, for 2 of 3 residents sampled for oral care, and 1 of 3 residents sampled for incontinence in the stage 2 sample of 35. (Resident #5, Resident #130, Resident #33)</p> <p>Findings include:</p> <p>1. On 12/30/13 at 3:47 p.m., Resident #5 indicated she did not clean her own teeth, nor did staff offer to assist her.</p> <p>On 1/2/14 at 10:36 a.m., Resident #5's clinical record was reviewed.</p>	F000312	<p>It is the practice of this facility to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.I. No immediate corrective action could be taken for resident's # 5, 130 or 33.II. All residents requiring assistance with ADL's have the potential to be affected. No immediate corrective action was able to be completed for residents # 5, 130 or 33.III. Nursing staff inserviced over oral care and pericare (Exhibits I, K) with return demonstration of the skills by the staff members also completed to validate skill sets. Routine random checks will also be completed and validated during actual resident ADL care by a member of the nurse</p>	02/07/2014	

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	<p>The resident's Minimum Data Set (MDS) assessment, dated 10/23/13, indicated she required extensive assistance of one staff person for personal hygiene.</p> <p>Care plans included, but were not limited to, self care ADL (activities of daily living) performance deficit. Interventions included, but were not limited to, requires staff participation with personal hygiene and oral care, assist of one.</p> <p>The "Care Plan Conference", dated 11/6/13 indicated the resident would like to brush teeth at night.</p> <p>The "Weekly Summary," dated 12/27/13 indicated Resident #5 required limited assist and supervision for dental disease prevention.</p> <p>On 1/7/14 at 9:56 a.m., observed daily care for Resident #5. CNA #1 was not observed to offer or assist Resident #5 with oral care.</p> <p>On 1/7/13 at 2:06 p.m., the "Bathing Report " provided by Medical Records #1 indicated Resident #5 received a full bath on 1/7/14.</p> <p>On 1/7/14 at 4:32 p.m., interviewed</p>		<p>management team (Exhibit Q) 5 times a week x 2 months, 3 times a week x 2 months and weekly x 2 months with findings being reported to the facility QA Committee. IV. Findings will be reviewed in monthly QA Meeting for 6 months or until 100% compliance has been achieved.</p>				

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	<p>DoN (Director of Nursing). The DoN indicated oral care documented under one block of personal hygiene on kiosk (computer) documentation. The DoN indicated documentation did not individually indicate the type of care given.</p> <p>2. On 12/31/13 at 12:01 p.m., Resident #130 indicated she did not get assistance to clean her teeth every day. She estimated 2-3 times per week.</p> <p>On 1/7/14 at 3:30 p.m., Resident #130 indicated she did not get any assistance to brush her teeth.</p> <p>Resident #130's clinical record was reviewed on 1/2/14 at 2:20 p.m. The resident was admitted on 12/18/13 with diagnoses including, but not limited to, diabetes mellitus, osteoarthritis, history of a fall, anemia, morbid obesity, hypothyroidism, bullous pemphigoid, hypertension, and asthma.</p> <p>The resident's care plan for activities of daily living self care deficit, dated 12/27/13, indicated she required extensive assistance for bed mobility, total assistance for transfers, extensive assistance for personal hygiene and bathing.</p>			

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	<p>The resident had a care plan for exhibiting dental/mouth problem, having own teeth, dated 12/27/13. The care plan indicated the resident required set-up assistance for oral care.</p> <p>3. Resident #33 was observed being transferred to bed by a mechanical lift, and provided perineal care and clothing change on 1/2/14 at 3:00 p.m. The resident's incontinene brief was observed to be heavily wet with urine and the resident had been incontinent of a moderate amount of soft feces. CNA #3 was wearing gloves. She used a towel that she had wet and added "a little soap." She washed the feces off of the resident's buttocks and posterior thighs. She did not wash the front of the perineal area or the front of the thighs or lower abdomen. She wore the same soiled gloves to put the resident's clean brief and gown on. CNA #3 was asked if the resident had been wet with urine and she indicated she had been. When asked about washing the front areas of the resident that had been in contact with the urine, she indicated she didn't have any peri-wash. The resident's brief had been place on</p>			

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	<p>the resident and the resident was covered up and the staff left the room.</p> <p>The resident's clinical record was reviewed on 1/2/14 at 2:18 p.m. The resident's MDS assessment, dated 10/21/13, indicated the resident required total assistance of two staff for hygiene and was always incontinent.</p> <p>The policy and procedure for Perineal Care-Female, dated 12-2010, was provided by the Staff Development Coordinator on 1/8/14 at 9:10 a.m. The policy and procedure included, but was not limited to, the following: "Guideline ...Perineal care will cleanse the perineum and prevent infections and odors." "Equipment needed for perineal care: -toilet paper -1 or 2 washcloths -soap and water - periwash - and/or incontinent wipes -clean pad/brief/linen as needed -bath towel... Clean heavy soil with toilet paper and discard... Wet one washcloth, apply soap or periwash to cloth and wipe resident</p>			

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F000314 SS=D	<p>from front of perineum to back of perineum (anal area)... Rinse with clean cloth and clear water... Pat skin dry with towel... Apply lotion or barrier cream to perineal area..."</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(C)</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 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 record review and interview, the facility failed to ensure 1 of 3 residents reviewed for pressure sores, in a sample of 4 who met the criteria, received treatment and services to promote healing, in that a treatment order was not obtained for two days after the area was discovered. (Resident #119)</p>	F000314	It is the practice of this facility based on comprehensive assessment of a resident, the facility must ensure that a 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	02/07/2014

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	<p>Finding includes:</p> <p>Resident #119's clinical record was reviewed on 1/7/14 at 10:15 a.m. The resident was readmitted to the facility on 7/16/13 with diagnoses including, but not limited to, infected postoperative seroma, rehabilitation, healing traumatic fracture upper leg, hypotension, glaucoma, pacemaker, hypertension, cerebral degeneration, osteoarthritis, and atrial fibrillation.</p> <p>The resident's admission Minimum Data Set assessment, dated 7/23/13, indicated he required extensive assistance with bed mobility and transfers.</p> <p>The resident's Patient Nursing Evaluation, dated 7/16/13 at 5:22 p.m., indicated no pressure ulcers were present. The resident's only skin impairment was a surgical incision on the right trochanter (hip).</p> <p>Nurses' notes, dated 7/18/13 at 7:30 a.m., indicated a "Weekly Pressure Ulcer Report" had been completed. The area was on the left heel, a pressure area, and was 4.0 centimeters (cm) long by 4.8 cm wide with no depth. It was a suspected deep tissue injury and the</p>		<p>to promote healing, prevent infection and prevent new sores from developing.I. No immediate corrective action was able to be completed for resident # 119 as resident had been discharged from facility (closed record review).II. All residents at high risk for developing pressure sores have the potential to be affected. No immediate corrective action could be completed for resident # 119 as resident had been discharged from the facility (closed record review).III. Nurses will be inserviced over timely MD notification (Exhibit F) and change of condition (Exhibit F). All residents requiring extensive-total assistance with care needs have had skin checked and care plans reviewed to ensure effective preventative measures are in place with updates made as necessary. CNA assignment sheets also updated with changes as necessary.IV. Scheduled daily skin assessments will be audited during AM Clinical Meeting by a member of the nurse management team 5 times a week x 2 months, 3 times a week x 2 months and weekly x 2 months with corrective action being taken as necessary. Findings will be reviewed monthly in the QA Meeting for 6 months or until 100% compliance has been achieved.</p>				

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	<p>nurses note indicated it was first observed on 7/16/13. "Fax M.D. for skin prep to L [left] heel q [every] shift..."</p> <p>Nurses' notes dated 7/20/13 at 6:30 a.m. indicated the physician had been faxed again related to the area on the left heel and "has heels [up] off bed during the night..." A nurse's note on 7/20/13 at 7:30 a.m. indicated an order had been received at that time.</p> <p>A Weekly Pressure Ulcer report, dated 7/18/13 at 7:30 a.m., indicated a new onset of a pressure ulcer on the left heel, 4.0 cm long by 4.8 cm wide, suspected deep tissue injury. The record also indicated the date of initial observation was 7/16/13.</p> <p>The resident's treatment record for 7/1/13 through 7/31/13 indicated a treatment of skin prep (topical medicated treatment) to the left heel every shift was started on 7/20/13. Also started on 7/20/13 was an order to elevate the left and right heel off of the bed.</p> <p>Interview with the Director of Nurses on 1/8/14 at 11:30 a.m. indicated the initial assessment on 7/16/13 had not identified the area. He indicated</p>			

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F000332 SS=D	<p>the night shift nurse probably found the area when doing the weekly skin assessment on 7/18/13. He was unsure why a treatment was not obtained for an additional 2 days.</p> <p>3.1-40(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation and record review, the facility failed to ensure it was free of medication error rates of five percent or greater, for 2 of 5 residents observed during medication administration, in that 3 errors were made out of 25 opportunities for error, resulting in an error rate of 12 percent. Two of 5 licensed nurses observed made errors. (Residents #5, #87) (LPN #3, QMA#1)</p> <p>Findings include:</p> <p>1. On 1/2/14 at 3:17 p.m. LPN #3</p>	F000332	<p>It is the practice of this facility to ensure that it is free of medication error rates of five percent or greater. I. No immediate corrective action could be taken for residents # 5 or 87. II. All residents have the potential to be affected. No immediate corrective action could be taken for residents # 5 or 87. III. Nurses/QMA's inserviced on Medication Pass Procedure (Exhibit L). Routine medication pass observations will be completed with the nurses/QMA's by a member of the nurse management team 5 times a week x 1 month, 3 times a week x 1 month and then weekly x 1 month (Exhibit M). Residents MAR's have also been audited to</p>	02/07/2014

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	<p>was observed administering medications to Resident #87. She administered Calcium (mineral supplement) 500 mg (milligrams) 1 tablet by mouth and Sinemet 25-100 mg 1 tablet by mouth with water only. The MD (Medical Doctor) orders were checked at 3:40 p.m. The orders indicated the resident was to receive Oyst-cal 500 mg PO (by mouth) tid (three times a day) with meals and Sinemet (medication for Parkinson's disease) 25-100 mg. PO bid with meals. The meal service was observed to be given at 5:00 p.m.</p> <p>2. On 1/7/14 at 3:40 p.m. QMA #1 was observed administering medications to Resident #5. She administered Calcium 600 mg 1 tablet by mouth with water only. The current MD orders indicated the resident was to receive Caltrate plus 600 mg PO bid (twice a day) with meals. The meal service was observed to be given at 5:00 p.m.</p> <p>3.1-25(b)(9)</p>		<p>ensure if meds listed requiring food to be taken, it is indicated on MAR.IV. Medication pass observations will be completed by a member of the nurse management team 5 times a week x 2 month, 3 times a week x 2 month and then weekly x 2 month. Results of these medication pass observations will be reported to the facility QA Committee monthly x 3 months. After 3 months, if 100% compliance is achieved, the QA Committee will determine if further monitoring required.</p>	

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F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>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>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 sufficient staff were present to meet the needs of residents, for 11 of 24 residents interviewed during stage 1 interviews, 3 of 12 months of resident council minutes, and for 1 of 1 randomly observed resident observed waiting for</p>	F000353	It is the practice of this facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychological well-being of each resident, as determined by resident assessments and individual plans of care.I. No immediate corrective action could be completed for	02/07/2014

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	<p>assistance to the bathroom. (Residents #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #49) (February, April, December, 2013)</p> <p>Findings include:</p> <p>1. During stage 1 interviews from 11:50 a.m. on 12/30/13 to 2:16 p.m. on 12/31/13, the following residents indicated there was not enough staff to meet the needs of residents, without having to wait a long time: Residents #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141. Comments included, but were not limited to, the following: "Had to wait one and a half hours one time. If there is enough staff you don't have to wait so long." "Not enough staff, has waited more than 30 minutes; on weekends it is more difficult to get staff." "Have to wait to get on the bed pan and to get off the bed pan. The last few days a little better. Weekends and holidays have been bad. Once I waited over 1 hour to get off the bed pan." "Have to wait a long time to go to the bathroom. I hate to ring." "Wait more than 30 minutes, less than one hour." "Has had to wait a few times more</p>		<p>resident #'s 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141 and 49.II. All residents have the potential to be affected. No immediate corrective action could be completed for residents #'s 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141 and 49.III. Staff inserviced regarding timeliness of call light response time (Exhibit N). Oral Care corrections have previously been addressed in this POC under F 282 and 312).IV. Call light response times will be audited (Exhibit J) via routine rounds 5 times a week for 2 months (to include weekends and holidays as applicable), 3 times a week x 2 months and then weekly x 2 months with immediate corrective action taken as necessary. Administrator or designee will also follow progress in monthly resident council meeting with additional corrective action taken as necessary. Findings of these audits will be reviewed in the monthly QA Meeting for 6 months or until 100% compliance has been achieved. Oral care audits and follow-up have been previously addressed in this POC under F 282 and 312.</p>				

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	<p>than 30 mintues for assistance."</p> <p>2. On 12/31/13 at 12:01 p.m., Resident #141 indicated she did not get assistance to clean her teeth every day. She estimated 2-3 times per week. Staff were always in a rush.</p> <p>On 1/7/14 at 3:30 p.m., Resident #141 indicated she did not get any assistance to brush her teeth.</p> <p>Resident #141's clinical record was reviewed on 1/2/14 at 2:20 p.m. The resident was admitted on 12/18/13 with diagnoses including, but not limited to, diabetes mellitus, osteoarthritis, history of a fall, anemia, morbid obesity, hypothyroidism, bullous pemphigoid, hypertension, and asthma.</p> <p>The resident's care plan for activities of daily living self care deficit, dated 12/27/13, indicated she required extensive assistance for bed mobility, total assistance for transfers, extensive assistance for personal hygiene and bathing.</p> <p>The resident had a care plan for exhibiting dental/mouth problem, having own teeth, dated 12/27/13. The care plan indicated the resident</p>						

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	<p>required set-up assistance for oral care.</p> <p>3. Review of Resident council minutes from January, 2013 through December, 2013, indicated staffing concerns for the following months: February, 2013 April, 2013 December, 2013, "All residents in attendance agreed that response time to call lights is untimely. One resident complained about being left on a bed pan for an unreasonable amount of time. Residents stated that nurses rarely, if ever, help the aides answer call lights or respond to alarms..."</p> <p>4. On 1/7/14 at 10:15 a.m. resident #49 was observed to have her call light on. Resident #49 was yelling "nurse." Resident #49 stated she had to go to bathroom. Her light remained on. Social Service #1 and RN #1 were observed sitting at the desk. They were notified of need of Resident #49 assistance to go to restroom. RN #1 walked the opposite way. Resident #49 continued to yell "nurse." Social Service #1 again notified Resident #49 was yelling "nurse." Social Service #1 immediately got up and</p>				

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	<p>went to the resident's room. Social Service #1 came back to nurses station and spoke to RN #1 and then stated, "I will do it myself if I have too." The call light was still on. An unidentified CNA came out of another resident room then and went to assist resident #49. The time was 10:33 a.m.</p> <p>This federal tag relates to Complaint Number IN00140789.</p> <p>3.1-17(a)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 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 and record review, the facility failed to ensure medications were not stored longer than recommended, for 2 of 3</p>	F000431	It is the practice of this facility to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	02/07/2014			

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	<p>medication carts observed. This affected 4 residents who had medications stored on the carts. (100 hall cart, 200 hall cart) (Residents #82, #19, #64, #33)</p> <p>Findings include:</p> <p>Observation of a medication cart on 1/2/14 at 3:00 p.m. on the 100 hall indicated medications with expiration dates exceeding the recommended time frames listed in the facility policy. Novolog for Resident #82 was opened on 11/28/13 and Levemir for Resident #19 was opened and not dated.</p> <p>Observation of a medication cart on 1/8/14 at 9:25 a.m. on the 200 hall indicated medications with expiration dates exceeding the recommended time frames listed in the facility policy. Lantus for Resident #64 was opened on 11/20/14 and Lantus for Resident #33 was opened on 11/27/13.</p> <p>The facility policy titled Medications With Special Expiration Date Requirements, was obtained from the DoN (Director of Nursing) on 1/8/14 at 11:40 a.m. Guidelines for time frames were addressed and indicated the above insulins expired</p>		<p>controlled substances in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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. I. Insulin for resident #'s 82, 19, 64 and 33 were removed from the medication carts, discarded and new vials dated and put into place. Insulin in other carts also checked and corrective action taken as necessary. II. All</p>		

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	28 days after being opened. 3.1-25(o)		residents have the potential to be affected. Insulin for resident #'s 82, 19, 64 and 33 were removed from the medication carts, discarded and new vials dated and put into place. Insulin in other medication carts also checked and corrective action taken as necessary.III. Nurses/QMA's inserviced over Medication Storage, Labeling and Dating of Medications(Exhibit L). Routine medication cart audits (Exhibit O) will be completed by a member of the nurse management team 5 times a week x 1 month, 3 times a week x 1 month and then weekly x 1 month. These audits will be reported to the facility QA Committee monthly.IV. Results of the audits will be reported to the facility QA Committee monthly x 3 months. Once 100% compliance is achieved for 3 consecutive months, QA Committee will determine if furthering monitoring required.		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility</p>	F000441	It is the practice of this facility to establish and maintain an	02/07/2014			

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	<p>failed to ensure infection control procedures were implemented to prevent potential infection for 3 of 10 residents observed receiving care, in that glove changes and hand washing were not sufficient between clean and dirty tasks. (Resident #33, #113, #5)</p> <p>Findings include:</p> <p>1. On 1/2/14 at 3:00 p.m., CNA #3 was observed providing perineal care to Resident #33. The resident was wearing an incontinence brief and was observed to be very wet and have a moderate amount of feces in the brief. The CNA was wearing gloves. She used a towel she indicated she had wet with water and a little soap. She wiped feces off of the resident's buttocks and back of the thighs. With the same gloves, she handled the clean incontinence brief, a clean gown, and the resident to assist turning and dressing. The CNA removed her gloves and then proceeded to handle the oxygen tubing, placing the resident's nasal cannula on the resident. She then washed her hands for less than 5 seconds before leaving the room.</p>		<p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.I. No immediate corrective action could be completed for resident #'s 33, 113 and 5.II. All residents have the potential to be affected. No immediate corrective action could be completed for resident #'s 33, 113 and 5.III. Nursing staff inserviced over Infection Control Procedures (Exhibit P) -handwashing, glove use, pericare, non-clinical staff also included in handwashing inservice. Return skill demonstrations completed with staff for handwashing, glove use and pericare.IV. Staff compliance with handwashing, glove use, pericare and general infection control protocols (Exhibit Q) to be monitored during routine random rounds and resident care observations by a member of the nurse management team 5 times a week x 2 months, 3 times a week x 2 months and weekly x 2 months. Findings will be reviewed in the monthly QA Meeting for 6 months or until 100% compliance has been achieved.</p>		

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	<p>2. The clinical record Resident #113 was reviewed on 1/7/14 at 9:15 a.m. Resident #113 had diagnoses including, but not limited to, colostomy, urostomy, and neoplasm of colon.</p> <p>On 1/7/14 at 10:08 a.m., during observation of Resident #113's personal care, CNA #2 and LPN #2 with gloved hands were observed to provide a bed bath. During the bath, CNA #2 completed perineal care and proceeded to dress and shave the resident with assistance from LPN #2. No hand washing/hand gel or glove changes were observed after pericare and dressing the resident. LPN #2 changed gloves and sanitized her hands for less than 5 seconds before reapplying gloves.</p> <p>3. On 12/30/13 at 12:19 p.m., observed CNA #1 hand wash for 4 seconds.</p> <p>4. On 1/7/14 at 9:56 a.m., observed daily care for Resident #5.</p> <p>CNA #1 removed gait belt from around waist and placed it on Resident #5. After Resident #5 was transferred to toilet, CNA #1 removed gait belt. CNA #1</p>						

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	<p>attempted to hang gait belt on towel rack, gait belt fell on the bathroom floor. After Resident #5's daily care was completed, CNA #1 removed gait belt from floor and applied it to Resident #5's waist.</p> <p>After Resident #5 was transferred from wheelchair to toilet, observed CNA #1 remove gloves and hand wash for 7 seconds.</p> <p>After care was completed, observed CNA #1 hand wash for 15 seconds.</p> <p>On 1/8/14 at 8:40 a.m., interviewed CNA #4. CNA #4 indicated hands should be washed for 30 seconds or longer.</p> <p>On 1/8/14 at 4:12 p.m., the DoN (Director of Nursing) provided the "Hand Washing and Glove Use" policy. The policy indicated handwashing should be performed before and after resident care and after handling contaminated articles. The policy indicated hands should be washed before and after touching wounds, after contact with surfaces or items which are contaminated with blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin. The policy also indicated hands should be washed</p>			

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	vigorously for 15-30 seconds. 3.1-18(b)(1) 3.1-18(l)			