

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2013
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NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint #IN00136298.</p> <p>Survey dates: September 9, 10, 11, 12, 16, 17, 23, 2013.</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Survey team: Barbara Fowler RN TC 9/9, 9/10, 9/11, 9/16, 9/17, 9/23, 2013 Amy Wininger RN 9/9, 9/10, 9/11, 9/16, 9/17, 9/23, 2013 Denise Schwandner RN Diane Hancock, RN 9/9, 9/10, 9/12, 9/16, 9/17, 9/23, 2013 Diana Perry RN 9/9, 9/10, 9/12, 9/16, 9/17, 9/23, 2013 Anna Villain RN 9/9, 9/10, 9/11, 9/12, 9/16, 9/17, 2013 Sylvia Martin RN 9/9, 9/10, 9/11, 2013</p> <p>Census bed type: SNF 10 SNF/NF 70 Total 80</p>	F000000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.	

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

TITLE

(X6) DATE

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

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	<p>Census payor type:</p> <table> <tr> <td>Medicare</td> <td>7</td> </tr> <tr> <td>Medicaid</td> <td>54</td> </tr> <tr> <td>Other</td> <td>19</td> </tr> <tr> <td>Total</td> <td>80</td> </tr> </table> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 30, 2013, by Jodi Meyer, RN</p>	Medicare	7	Medicaid	54	Other	19	Total	80			
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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed ensure a physician was notified of residents' lab values, for 2 of 2 residents reviewed in a Stage 2 sample of 27,</p>	F000157	F-157 1. Medical records for Res #26 and Res #1 were reviewed for lab orders. Hard copies of labs ordered were placed on the chart after ensuring Doctor notification was	10/18/2013			

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	<p>in that laboratory tests were not completed and/or abnormal lab results were received and the incomplete labs and the abnormal labs were not reported to the physician. (Residents #26, #1)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #26 was reviewed on 9/11/13 at 11:05 a.m. Resident #26 had diagnoses including, but not limited to, diabetes mellitus, atrial fibrillation, hypothyroidism, and congestive heart failure.</p> <p>Resident #26 received medications including, but not limited to: Lanoxin 0.125 mg (milligrams) 1 (one) tablet orally daily Novolog insulin Flexpen 20 units subcutaneous tid (3 times a day) before each meal Levimir insulin 100 units/ml - give 15 units subcutaneous at bedtime daily Metformin 1000 units 1 tablet bid (2 times a day) with meals Januvia 100 mg 1 tablet orally daily Synthroid 0.05 mg 1 tablet orally daily before breakfast Lipitor 40 mg 1 tablet orally daily Plavix 75 mg 1 tablet orally daily Bumex 1 mg 1 tablet orally daily Zaroxolyn 2.5 mg 1 tablet every 48</p>		<p>completed. 2. An audit will be performed on current residents' medical records for lab orders. Hard copies of missing labs will be placed on the chart after ensuring physician notification. 3. Re-education will be done with all Professional Nursing staff on the Policy and Procedure concerning Labs and Doctor notification. Education will include the use of the "Lab/Diagnostic Test Tracking Sheet". This sheet will be reviewed each morning Monday thru Friday at the DON/ADON/Unit Manager Meeting. 4. Monthly Audits by the Administrator/Designee will be performed to ensure the DON/ADON/Unit Manager meetings are occurring and that the lab tracking sheet is being kept up to date. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>				

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	<p>hours</p> <p>A physician's clarification order, dated 6/24/13, indicated Resident #26 was to have the following laboratory tests completed every six (6) months in May and November for a CBC (complete blood count), BMP (basic metabolic profile), BNP (B-type Natriuretic Peptide- a cardiac test), T4 (a thyroid test), TSH (thyroid stimulating hormone), digoxin level, and a lipid profile.</p> <p>During record review, no laboratory test results from May, 2013, were found in the Resident #26's clinical record.</p> <p>During an interview with RN #2 on 9/16/13 at 11:30 A.M., RN #2 indicated she was unable to locate the laboratory test results for May, 2013, in Resident #26's clinical record. RN #2 was able to obtain the results from the computer. The test results for Resident #26's dated, 5/7/13, indicated the resident's glucose level was elevated with a result of 245 mg/dl(milligram per deciliter). The normal range was 70 to 99 mg/dl. The digoxin level was low with a result of 0.5 ng/ml(nanogram per milliliter). The normal range was 0.8 to 2.0 ng/ml.</p>			

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	<p>No results for the BNP were located on the laboratory results. RN #2 indicated the results should have been in Resident #26's clinical record. RN #2 also indicated the staff is to print "faxed " on the forms when they are sent to the physician with the day they are faxed. RN #2 also indicated the nurses are to document in the nurses notes when the results are faxed to the physician.</p> <p>2. Resident #1's clinical record was reviewed on 9/12/13 at 8:35 a.m. The resident's diagnoses included, but were not limited to, history of cerebrovascular accident, chronic psychosis, depression, status post craniotomy for hemorrhage, neurogenic bladder, hypertension, diabetes, chronic urinary tract infections, chronic upper respiratory infections, and edema.</p> <p>Nurses' notes indicated the resident was irritable and angry on 9/4/13 at 10:00 p.m., 9/5/13 at 10:00 p.m., and 9/6/13 at 8:30 a.m. Physician's orders for a urinalysis, chest x-ray, complete metabolic panel, and complete blood count were obtained on 9/6/13. A laboratory report from a urinalysis, dated 9/7/13, indicated greater than 100,000 gram negative rods (bacterial infection). The culture</p>			

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	<p>and sensitivity report, dated 9/9/13, indicated the resident had a urinary tract infection with greater than 100,000 escherichia coli.</p> <p>Orders for an antibiotic were not obtained until 9/11/13 at 4:20 p.m. An order for Rocephin 1 gram intravenously daily for 7 days was received.</p> <p>There was no indication when the urinalysis and culture and sensitivity reports were reported to the physician.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F000242 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation and record review, the facility failed to ensure residents' choices were honored in regards to food, for 5 of 15 resident meals observed prepared in the kitchen, in that foods identified as dislikes were served. (Residents #25, #59, #18, #2, #43)</p> <p>Findings include:</p> <p>On 9/12/13 at 11:36 a.m., Cook #1 was observed preparing trays for the lunch meal. Paper tray cards for each resident were on the trays. The following residents had foods placed on their tray that their tray cards indicated were foods they disliked: Resident #25 received carrots; the tray card indicated the resident did not like carrots. Resident #59 received carrots; the tray card indicated the resident did not like carrots. Resident #18 received coleslaw; the tray card indicated the resident did</p>	F000242	F-2421. Dietary staff did not remove the food on the plates from their dislike list for Resident #25, #59, #18, 32 and #43 as the meal was served. 2. An audit was completed by the Dietary Manager to identify residents' food dislikes. Resident trays cards were examined and updated as needed. 3. Dietary staff has been re-educated to follow the tray cards and honor a residents listed dislikes for food and dispense the food accordingly. 4. An audit of tray cards with tray presentation will be done by the Dietary Manager/Designee 5 x a week across all meals x 4 weeks and then weekly across all meals x 4 weeks and then monthly x 4 months. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in	10/18/2013			

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	<p>not like coleslaw. Resident #2 received coleslaw; the tray card indicated the resident did not like coleslaw. Resident #43 received peas; the tray card indicated the resident did not like peas.</p> <p>3.1-3(u)(3)</p>		<p>immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>		

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to ensure 2 of 40 stage 1 residents had the ability to request assistance, in that, their call lights were out of reach. (Residents B, #15)</p> <p>Findings include:</p> <p>1. Resident B was observed in bed on 9/12/13 at 9:17 a.m. The call light was positioned at the top of the bed on the resident's left side. He was unable to reach the call light. The Director of Nursing completed a treatment to the resident's foot at that time. When the treatment was done and the Director of Nursing left the room, the call light was still out of reach of the resident.</p> <p>2. Resident #15 was observed on 9/9/13 at 3:00 p.m. The resident's call light was positioned on the right side of the bed out of reach of the resident; the resident was laying towards the left. The resident</p>	F000246	<p>F-2461. Call lights for Res #15 and Res #B was immediately placed within their reach. 2. A 100% audit was conducted immediately to ensure all residents had their call lights within easy reach. 3. Re-education was done with the entire staff on the importance of keeping resident call lights within easy reach of the resident. 4. Audits will be conducted by the DON/Designee on the accessibility of resident call lights once a day, across all shifts x 4 weeks, and then monthly x 4 months. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>	10/18/2013			

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	<p>indicated she did not know where the call light was.</p> <p>3. Call lights being out of reach was reviewed with the Administrator and Director of Nursing on 9/17/13 at 4:00 p.m.; both indicated call lights should be in reach of the residents.</p> <p>3.1-3(v)(1)</p>			

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F000258 SS=E	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure comfortable sound levels were maintained, for 4 of 21 residents interviewed in the stage 1 sample of 35, and for 2 of 2 observations of noise for Resident #66. (Residents #77, #39, #85, A, #66)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #77 indicated during interview on 9/9/13 at 3:07 p.m., "it gets real noisy at times." 2. Resident #39 indicated during interview on 9/10/13 at 8:20 a.m., "sometimes at night one of the nurses will yell to the other nurse clear down the hall...they just talk loud..." 3. Resident #85 indicated during interview on 9/10/13 at 12:03 p.m., "one resident is noisy, plus staff stand outside the door gossiping." 4. Resident A indicated during interview on 9/9/13 at 11:53 a.m., a patient yelled "help me" a lot, sometimes two to three hours at a time. 	F000258	F-2581. "Nurse #5 was observed to go into the residents room (Resident #66) and the resident quieted down." Sound levels at that time were comfortable for resident #77, #39, 385, #A, and #66.2. Two alert and oriented residents from each hall will be interviewed 5x weekly by Department Heads during their Caring Partner rounds. Interviews will be reviewed during morning meeting and interventions implemented as needed 3. Re-education will be done with the entire staff about the importance of comfortable sound levels and the importance of sleep, as it concerns a residents' recovery process. 4. The Administrator/Designee will review all interviews and interventions put in place 5xweekly for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Interviews will cover all three shifts to identify the source of uncomfortable noise. Results of interviews will be presented to the Quality Assurance Committee on a monthly basis for further review and recommendations as deemed appropriate for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in	10/18/2013			

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	<p>5. On 9/11/13 from 11:00 a.m. to 11:25 a.m., Resident #66 was heard yelling continuously, "Help me, Help me." On 9/11/13 at 3:20 p.m., the resident was yelling, "Help me, Help me." RN #5 was observed to go into the resident's room and the resident quieted down.</p> <p>3.1-19(f)</p>		<p>immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>	

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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, interview, and record review, the facility failed to ensure a care plan was developed for 1 of 5 residents who met the criteria for review of dialysis, in that, a care plan was not developed for hemodialysis for a resident receiving dialysis. (Resident #53)</p> <p>Findings include:</p> <p>Resident #53 was observed on 09/11/13 at 8:05 a.m., lying in bed. Resident #53 had a catheter in his left neck area. Resident #53 indicated</p>	F000279	F-2791. Dialysis Care Plan for Res #53 was immediately reviewed and updated as appropriate. 2. An audit of residents receiving dialysis has been done to ensure Dialysis Care Plans are in place and updated as appropriate. 3. Re-education on the Policy and Procedure concerning "Dialysis Management (Hemodialysis)" which includes the development and revision of Hemodialysis Care Plans will be done with all Professional Nursing staff. 4. An audit will be performed by the IDT (Interdisciplinary Team) daily for three days after admission,	10/18/2013	

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	<p>the catheter was for his dialysis. Resident #53 indicated he received dialysis every Monday, Wednesday, and Friday.</p> <p>The clinical record of Resident #53 was reviewed on 09/16/13 at 8:03 a.m. Resident #53 was admitted to the facility on 6/11/13. The diagnoses of Resident #53 included, but was not limited to, dialysis.</p> <p>The most recent Quarterly MDS [Minimum Data Set Assessment] dated 08/16/13 indicated Resident #53 received dialysis.</p> <p>During an interview with RN #1 on 9/16/13 at 11:19 a.m., RN #1 indicated care plans are usually initiated when the resident is reviewed and the resident should have a plan of care in the clinical record.</p> <p>During an interview with the Adm (Administrator) on 9/23/13 at 9:23 a.m., the Adm indicated the Resident #53 had been discharged from the facility in the past. The resident was discharged on 3/10/13 previously. The Adm indicated the resident had a care plan when he was discharged, but did not have a care plan in the clinical record since returning on 6/11/13.</p>		<p>Mon thru Fri on all new admissions to ensure appropriate care plans (which includes Hemodialysis) are in place. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>				

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	<p>The clinical record lacked any documentation related to a plan of care for dialysis.</p> <p>A procedure, dated 4/12 and obtained from the DoN (Director of Nursing) on 9/17/13 at 11:35 a.m., indicated the facility was to review and revise the "Hemodialysis Plan of Care" as needed.</p> <p>3.1-35(b)(1)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review the facility failed to ensure a care plan for pain was revised, in that, 1 of 5 residents reviewed for pain did not have the care plan revised to address unrelieved pain. (Resident #112)</p> <p>Findings include:</p> <p>During an interview on 09/09/13 at 11:50 a.m., Resident #112 was observed sitting in a motorized wheelchair in his room and indicated he experienced back and stump pain constantly. He further indicated, at</p>	F000280	F-280 1. A pain assessment was completed for res #112. Pain regimen and Care Plan was updated as appropriate. 2. An audit will be completed on residents receiving PRN pain medication. Identified residents will be taken to the IDT and reviewed for unrelieved pain. Pain regimen and Care Plans will be updated as appropriate. 3. All Nursing Staff will be re-educated on the "Pain Management Program". This program includes, but is not limited to, "Pain Assessment and Management", "Side Effects", Non-pharmacological Approaches and Education. 4. Pain management will be audited	10/18/2013			

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	<p>that time, when the pain got really bad he would tell the nurses and would receive pain medication. Resident #112 then indicated, the pain affected his daily life and he never experienced complete pain relief.</p> <p>The clinical record of Resident #112 was reviewed on 09/16/13 at 11:20 a.m. The record indicated the diagnoses of Resident #112 included, but were not limited to, LBKA (Left Below Knee Amputation).</p> <p>The most recent Quarterly MDS [Minimum Data Set Assessment] dated 08/02/13 indicated Resident #112 experienced no cognitive impairment, experienced pain daily that affected his sleep, and limited his daily activities.</p> <p>The Admission Physicians Orders dated 04/29/13 included, but were not limited to, orders for, "...Requip 4 [four] mg [milligrams] by mouth TID [three times a day] for Restless leg syndrome at 0600 [6:00 a.m.], 1400 [2:00 p.m.], and 2200 [10:00 p.m.],</p> <p>...Oxycodone [a narcotic pain medication] 10 [ten] mg every 6 hours PRN [as needed] for pain,</p>		<p>with the use of the "Clinical Systems Review Audit" on Pain. This Audit will be performed bi-monthly by the IDT and includes, but is not limited to a question, "PRN Pain medications are assessed for scheduled pain management" and "Physician is notified of uncontrolled pain with current treatments. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>		

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	<p>...Flexeril [a muscle relaxer] 5 [five] mg by mouth TID as needed for muscle spasms..."</p> <p>A Physicians Telephone Order dated 06/12/13 included, but was not limited to, an order for, "...Neurontin [a medication for nerve pain] 400 mg by mouth TID-neuropathy" at 0600, 1400, and 2200..."</p> <p>The September 2013 MAR [Medication Administration Record] indicated Resident #112 received PRN pain medication on the following dates:</p> <p>09/01/13: Oxycodone 10 mg at 2100 (9:00 p.m.) for unidentified breakthrough pain</p> <p>09/03/13: Oxycodone 10 mg at 2000 for unidentified breakthrough pain.</p> <p>09/04/13: Oxycodone 10 mg at 1300 for breakthrough pain identified as 8 (eight) of 10 on the pain scale.</p> <p>09/04/13: Oxycodone 10 mg and Flexeril 5 mg at 2000 for unidentified breakthrough pain.</p> <p>09/05/13: Oxycodone 10 mg at 1900 (7:00 p.m.) for unidentified breakthrough pain.</p>			

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	<p>09/06/13: Oxycodone 10 mg at 2000 and Flexeril 5 mg at 2100 for unidentified breakthrough pain.</p> <p>09/08/13: Oxycodone 10 mg at 1030 (10:30 a.m.) for breakthrough pain identified as 8 of 10 on the pain scale and Flexeril 5 mg at 1830 (6:30 p.m.) for unidentified breakthrough pain.</p> <p>09/08/13: Oxycodone 10 mg at 1800 (6:00 p.m.) for breakthrough pain identified as 7 (seven) of 10 on the pain scale.</p> <p>09/09/13: Oxycodone 10 mg at 1800 and Flexeril 5 mg at 2000 for unidentified breakthrough pain.</p> <p>09/10/13: Oxycodone 10 mg and Flexeril 5 mg at 2000 for unidentified breakthrough pain.</p> <p>09/11/13: Oxycodone 10 mg at 0620 (6:20 a.m.) for unidentified breakthrough pain.</p> <p>09/11/13: Oxycodone 10 mg and Flexeril 5 mg at 2000 for unidentified breakthrough pain.</p> <p>09/12/13: Oxycodone 10 mg at 0750(7:50 a.m.) for breakthrough pain identified as 8 of 10 on the pain scale.</p>			

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	<p>09/12/13: Oxycodone 10 mg at 1540 (3:40 p.m.) for breakthrough pain identified as 8 of 10 on the pain scale.</p> <p>09/12/13: Flexeril 5 mg at 2200 for unidentified breakthrough pain and Oxycodone 10 mg at 2230 (10:30 a.m.) for unidentified breakthrough pain.</p> <p>09/13/13: Flexeril 5 mg at 1400 for unidentified breakthrough pain, Oxycodone 10 mg at 1400 for breakthrough pain identified as 8 of 10 on the pain scale, and received Flexeril 5 mg at 2000 for unidentified breakthrough pain.</p> <p>09/15/13: Oxycodone 10 mg [no time indicated] for unidentified breakthrough pain.</p> <p>Resident #112 received 17 doses of Oxycodone and 9 doses of Flexeril for significant breakthrough pain from 09/01/13 through 09/15/13.</p> <p>A Pain Data Collection and Assessment tool dated 09/12/13 indicated Resident #112 reported having experienced, "...9.5/10 [significant pain] ... throbbing, stabbing, pinching, pins and needle sensation pain during movement and</p>			

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	<p>rest... in the previous 5 days...". The assessment further indicated no change in pain medication regime was recommended.</p> <p>The plan of care for pain management dated 09/12/13 lacked any documentation the plan had been revised to address the resident's use of PRN pain medication to manage breakthrough pain.</p> <p>The Policy and Procedure for Pain Management provided by the DoN (Director of Nursing) on 09/17/13 at 11:39 a.m. indicated, "...9. Revise the care plan...".</p> <p>3.1-35(d)(2)(B)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided to effectively manage pain and to assess for complications post dialysis, for 1 of 3 residents reviewed for pain, in the sample of 5 who met the criteria for pain, and for 1 of 1 sampled resident reviewed for dialysis. Resident #112 received treatment for breakthrough pain 26 times in 15 days and the pain regime was not revised. Resident #53 was not assessed for complications post dialysis.</p> <p>Findings include:</p> <p>1. During an interview on 09/09/13 at 11:50 a.m., Resident #112 was observed sitting in a motorized wheelchair in his room and indicated he experienced back and stump pain constantly. He further indicated, at that time, when the pain got really bad he would tell the nurses and</p>	F000309	F-309 1. A pain assessment was immediately done for res #112. Pain regimen and Care Plan was updated as appropriate. Res #53 was assessed for pain and post dialysis complications. Resident #53 when interviewed felt comfortable with his pain regimen and there were no complications with dialysis at this time. 2. An audit will be performed on all residents receiving PRN pain medication. Identified residents will be taken to the IDT and reviewed for unrelieved pain. Pain regimen and care plans will be updated as appropriate. An audit will be performed to identify all residents currently receiving dialysis treatments. Residents identified will be assessed for pain and post dialysis complications. Appropriate treatment will be given where needed. 3. All Nursing Staff will be re-educated on the "Pain Management Program". This program includes, but is not limited to, "Pain Assessment and Management", "Side Effects", Non-pharmacological	10/18/2013			

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	<p>would receive pain medication. Resident #112 then indicated, the pain affected his daily life and he never experienced complete pain relief.</p> <p>The clinical record of Resident #112 was reviewed on 09/16/13 at 11:20 a.m. The record indicated the diagnoses of Resident #112 included, but were not limited to, LBKA (Left Below Knee Amputation).</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 08/02/13 indicated Resident #112 experienced no cognitive impairment, experienced pain daily that affected his sleep, and limited his daily activities.</p> <p>The Admission Physicians Orders dated 04/29/13 included, but were not limited to, orders for, "...Requip 4 [four] mg [milligrams] by mouth TID [three times a day] for Restless leg syndrome at 0600 [6:00 a.m.], 1400 [2:00 p.m.], and 2200 [10:00 p.m.],</p> <p>...Oxycodone [a narcotic pain medication] 10 [ten] mg every 6 hours PRN [as needed] for pain,</p> <p>...Flexeril [a muscle relaxer] 5 [five] mg by mouth TID as needed for</p>		<p>Approaches and Education.Re-education on the Policy and Procedure concerning "Dialysis Management (Hemodialysis)" which includes the "Post Dialysis Assessment Form" will be done with all Professional Nursing staff. 4. Pain management will be audited with the use of the "Clinical Systems Review Audit" on Pain. This Audit will be performed bi-monthly by the IDT and includes, but is not limited to a question, "PRN Pain medications are assessed for scheduled pain management" and "Physician is notified of uncontrolled pain with current treatments.Audits will be performed by the DON/Designee every day Mon thru Fri x 4 weeks and the Weekly x 4 weeks and then Monthly to ensure the Post Dialysis Assessment was completed on every resident who receives Dialysis. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>				

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	<p>muscle spasms..."</p> <p>A Physicians Telephone Order dated 06/12/13 included, but was not limited to, an order for, "...Neurontin [a medication for nerve pain] 400 mg by mouth TID-neuropathy" at 0600, 1400, and 2200..."</p> <p>The September 2013 MAR [Medication Administration Record] indicated Resident #112 received PRN pain medication on the following dates:</p> <p>09/01/13: Oxycodone 10 mg at 2100 (9:00 p.m.) for unidentified breakthrough pain.</p> <p>09/03/13: Oxycodone 10 mg at 2000 for unidentified breakthrough pain.</p> <p>09/04/13 received Oxycodone 10 mg at 1300 for breakthrough pain identified as 8 (eight) of 10 on the pain scale.</p> <p>09/04/13: Oxycodone 10 mg and Flexeril 5 mg at 2000 for unidentified breakthrough pain.</p> <p>09/05/13: Oxycodone 10 mg at 1900 (7:00 p.m.) for unidentified breakthrough pain.</p>			

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	09/06/13: Oxycodone 10 mg at 2000 and Flexeril 5 mg at 2100 for unidentified breakthrough pain.			
	09/08/13: Oxycodone 10 mg at 1030 (10:30 a.m.) for breakthrough pain identified as 8 of 10 on the pain scale and Flexeril 5 mg at 1830 (6:30 p.m.) for unidentified breakthrough pain.			
	09/08/13: Oxycodone 10 mg at 1800 (6:00 p.m.) for breakthrough pain identified as 7 (seven) of 10 on the pain scale.			
	09/09/13: Oxycodone 10 mg at 1800 and Flexeril 5 mg at 2000 for unidentified breakthrough pain.			
	09/10/13: Oxycodone 10 mg and Flexeril 5 mg at 2000 for unidentified breakthrough pain.			
	09/11/13: Oxycodone 10 mg at 0620 (6:20 a.m.) for unidentified breakthrough pain.			
	09/11/13: Oxycodone 10 mg and Flexeril 5 mg at 2000 for unidentified breakthrough pain.			
	09/12/13: Oxycodone 10 mg at 0750(7:50 a.m.) for breakthrough pain identified as 8 of 10 on the pain scale.			

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	<p>09/12/13: Oxycodone 10 mg at 1540 (3:40 p.m.) for breakthrough pain identified as 8 of 10 on the pain scale.</p> <p>09/12/13: Flexeril 5 mg at 2200 for unidentified breakthrough pain and Oxycodone 10 mg at 2230 (10:30 a.m.) for unidentified breakthrough pain.</p> <p>09/13/13: Flexeril 5 mg at 1400 for unidentified breakthrough pain, Oxycodone 10 mg at 1400 for breakthrough pain identified as 8 of 10 on the pain scale, and received Flexeril 5 mg at 2000 for unidentified breakthrough pain.</p> <p>09/15/13: Oxycodone 10 mg [no time indicated] for unidentified breakthrough pain.</p> <p>Resident #112 received 17 doses of Oxycodone and 9 doses of Flexeril for significant breakthrough pain from 09/01/13 through 09/15/13.</p> <p>A Pain Data Collection and Assessment tool dated 09/12/13 indicated Resident #112 reported having experienced, "...9.5/10 [significant pain] ... throbbing, stabbing, pinching, pins and needle sensation pain during movement and rest... in the previous 5 days..." The</p>			

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	<p>assessment further indicated no change in pain medication regime was recommended.</p> <p>The plan of care for pain management dated 09/12/13 lacked any documentation the plan had been revised to address the resident's use of PRN pain medication to manage breakthrough pain.</p> <p>The Policy and Procedure for Pain Management provided by the DoN (Director of Nursing) on 09/17/13 at 11:39 a.m. indicated, "...17. Reassess resident status...need for increasing...amount of medication...".</p> <p>2. Resident #53 was observed on 09/11/13 at 8:05 a.m., lying in bed. Resident #53 had a catheter in his left neck area. Resident #53 indicated the catheter was for his dialysis. Resident #53 indicated he received dialysis every Monday, Wednesday, and Friday.</p> <p>The clinical record of Resident #53 was reviewed on 09/16/13 at 8:03 a.m. The record indicated the</p>						

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	<p>diagnosis of Resident #53 included, but was not limited to, dialysis.</p> <p>The most recent Quarterly MDS [Minimum Data Set Assessment] dated 08/16/13 indicated Resident #53 received dialysis.</p> <p>During an interview with RN #1 on 9/16/13 at 11:19 a.m., RN #1 indicated residents should be assessed after they return from dialysis by the nursing staff at the facility. RN #1 indicated the staff was to complete the form titled, "Dialysis Center Communication Record," which has been sent by the dialysis unit to the facility with the resident each time the resident returns from dialysis.</p> <p>The clinical record lacked any documentation which indicated Resident #53 was assessed post-dialysis on 8/21/13 and 9/11/13.</p> <p>A procedure for dialysis management, dated 4/2012 and obtained from the DoN (Director of Nursing) on 9/17/13 at 11:35 a.m., indicated the facility was to document post-dialysis assessment on the "Dialysis Center Communication Record."</p> <p>3.1-37(a)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 observation, interview, and record review, the facility failed to ensure a resident admitted without a pressure blister, developed a pressure blister, in that, a resident admitted to the facility without a pressure blister developed a Stage II pressure blister to the right heel for 1 of 4 residents in a sample of 4. The facility also failed to ensure 2 of 4 residents reviewed for pressure ulcers received timely treatment of the areas after they were assessed, in that orders were not received and/or started for 5-6 days. (Resident C, B, A)</p> <p>Findings include:</p> <p>1. The clinical record of Resident C was reviewed on 09/17/13 at 8:00 a.m. The record indicated Resident C</p>	F000314	F-314 The Skin Assessments of Resident #A and Resident #B were re-reviewed. Skin Grids had been completed on all areas identified, and treatment orders for all areas were clarified with the attending Physician. Resident #C no longer resides in this facility. A review of all admissions/re-admissions in the past 30 days will be completed to identify any resident that did not have an Admission Assessment in their chart. Skin Assessments will be completed as needed. Skin Grids and appropriate wound care orders will be verified or obtained for all identified areas as needed. Re-education has been scheduled for professional staff regarding the review of transfer orders from the hospital. The nurse on duty at the time of the Admission/re-admission will ensure the Admission Skin Assessment, and the Skin Grids, are completed. Appropriate wound orders for all identified	10/18/2013			

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	<p>was admitted on 11/13/12 with diagnoses that included, but were not limited to, Alzheimer's with dementia, h/o (history of) fall, and Right Hip Fx (fracture). The record further indicated Resident C was discharged on 02/17/13.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 11/20/12 indicated Resident C experienced severe cognitive impairment and required extensive assist of 2 for bed mobility.</p> <p>The Admission Nursing Assessment dated 11/13/12 lacked any documentation Resident C was admitted with skin impairment to the right heel.</p> <p>A Braden Risk Assessment Scale dated 11/13/12 indicated Resident C was a moderate risk for pressure-related skin impairment.</p> <p>A Braden Risk Assessment Scale dated 11/27/12 indicated Resident C was a minimal risk for pressure-related skin impairment.</p> <p>A Skin Grid-Pressure report dated 12/01/12 indicated Resident C experienced a Stage II pressure-related blister to the right</p>		<p>areas of skin impairment will be verified, clarified or obtained as needed. A review of the Admission/Re-admission orders will be conducted by the Interdisciplinary Team (IDT) on the following day after the Admission/Re-admission occurs, Mon thru Friday, and the Weekend Nurse Supervisor on Sat & Sun to ensure the Admission Skin Assessment, Skin Grids, Skin Integrity Care Plan, and appropriate wound orders are in place.</p> <p>DON/Designee will complete bi-monthly audit to ensure Admission/Re-admission wounds have appropriate assessment, physician orders & documentation. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>	

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	<p>heel. The report further indicated the blister was not present on admission.</p> <p>The Nursing notes from 11/13/12 through 12/02/12 were reviewed and lacked any documentation related to pressure relief interventions being implemented for the heels of Resident C.</p> <p>A Care Plan for Skin Impairment dated 11/13/12 lacked any documentation of pressure relief measures being implemented for the heels of Resident C</p> <p>During an interview on 09/23/13 at 10:00 a.m., the ADoN (Assistant Director of Nursing) indicated Resident C had an area of pressure on the right heel that was not present on admission. The ADoN further indicated, at that time, there was no documentation of pressure relief measures being implemented to prevent an area of pressure to the right heel of Resident C.</p> <p>The Policy and Procedure for Pressure Ulcer Prevention/Treatment provided by the DoN (Director of Nursing) on 09/17/13 at 11:39 a.m., indicated, "...At risk (15-18) [minimal risk]...reduce pressure to heels...Moderate risk (13-14)...reduce</p>			

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	<p>pressure to heels..."</p> <p>2. During staff interview of RN #1 on 9/10/13 at 7:40 a.m., she indicated Resident B had pressure ulcers on his heels and outer ankles, admitted with them, and they were using skin prep on them (a topical dressing).</p> <p>On 9/12/13 at 8:00 a.m., Resident B was observed to be in bed on his right side. The right outer foot was resting on the mattress.</p> <p>Resident B's clinical record was reviewed on 9/12/13 at 8:55 a.m. The resident was admitted to the facility on 8/30/13 with diagnoses including, but not limited to, deep vein thrombosis, pulmonary embolus, arthritis, dementia, benign prostatic hypertrophy, urinary retention, chronic kidney disease, congestive heart failure, orthostatic hypotension, and recurrent falls.</p> <p>The Admission Skin Assessment, dated 8/30/13, indicated the resident had areas on the right outer foot and right outer ankle. Documentation of the areas indicated they were, "escar." (sic)</p> <p>Nurses' notes indicated, on 9/4/13 at 1545 (3:45 p.m.) "New orders for skin</p>						

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	<p>prep to (R) [right] lateral foot and ankle..."</p> <p>The Skin Grid - Pressure/venous Insufficiency Ulcer/Other record, initiated 8/30/13, indicated the following information: The wound was present on admission, located on the right ankle, pressure wound, unstageable, 1.0 centimeter long by 1.0 centimeter wide, and "escar (sic)."</p> <p>Documentation on the skin grid on 9/5/13 and 9/9/13 indicated the same measurements and condition of the wound. On 9/10/13, documentation indicated the wound was still unstageable, 1.0 centimeter by 1.0 centimeter by 0.2 cm deep. Comments indicated, "Escar fell off this AM [morning]. Has some depth. Faxed Dr. to [change] tx [treatment] to Bacitracin [antibiotic ointment] and Allevyn [foam dressing]."</p> <p>The resident's record included a care plan, dated 9/5/13, for skin integrity assessment, prevention and treatment. The care plan included, but was not limited to, the following: Identified the resident at risk for skin breakdown, needing frequent turning, maximal remobilization, heels protected, moisture, nutrition, friction, and shear managed, and</p>			

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	<p>pressure-reduction support surfaces needed.</p> <p>Protect elbows and heels if being exposed to friction</p> <p>Position body with pillows and/or other support devices</p> <p>Monitor wound weekly and as needed</p> <p>Provide treatment per MD order</p> <p>The Director of Nurses (DoN) was observed to do treatments to the right lateral foot and right lateral ankle on 9/12/13 at 9:17 a.m. He wore gloves and applied skin prep to the area on the right lateral foot and left it open to air. The area had dark eschar, less than .5 centimeters in diameter. The DoN then removed the old dressing from the right ankle. The area was 1.0 centimeter in diameter, red/pink with yellow slough in the middle of the wound. No glove change or handwashing was completed. He cleansed the area with saline and a gauze pad. He then removed the gloves and washed his hands for less than 5 seconds. New gloves were applied and Bacitracin was applied to the foam dressing and the dressing was applied to the right outer ankle.</p> <p>On 9/16/13 at 3:13 p.m., the DoN was interviewed. He indicated no treatment orders were obtained until 9/4/13. He indicated the areas had</p>			

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	<p>been assessed on admission on 8/30/13, but nothing treated until 9/4/13; "it was missed."</p> <p>3. On 9/9/13 at 11:54, Resident A was observed lying on his back with his left foot and ankle resting on the mattress. During a staff interview on 9/10/13 at 10:43 a.m., RN #1 indicated Resident A had a stage 2 pressure ulcer to the left ankle. RN #1 indicated Resident A was admitted to the facility with the wound.</p> <p>The clinical record for Resident A was reviewed on 9/17/13 at 8:13 a.m. Resident A was admitted to the facility on 4/26/13 with diagnoses including, but not limited to, CVA (cerebral vascular accident) with left - side hemiparesis.</p> <p>The "Admission Skin Assessment," dated 4/26/13, indicated Resident A had a right ankle ulcer measuring 1.5 cm (length) x 1.0 cm (width) x 0.5 cm (depth).</p> <p>On 5/2/13, the "Skid Grid - Pressure /Venous Ulcer Insufficiency / Other" record indicated the right ankle wound measured 1.5 cm (length) x</p>			
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	<p>1.0 cm (width) x 0.1 cm (depth).</p> <p>A physician's order, dated 5/6/13, was obtained to apply Santyl to necrotic area on resident's right ankle, cover site with foam dressing, and wrap with Kerlix. The dressing was to be changed daily.</p> <p>The clinical record lacked documentation for wound care prior to 5/6/13.</p> <p>Interview with the DoN (Director of Nursing) on 9/23/13 at 9:18 a.m., indicated the facility failed to obtain or start wound care for Resident A on admission.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000323 SS=E	<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>A. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for falls/accidents, in the sample of 6 who met the criteria, had orders to leave the facility grounds unattended for the purpose of smoking cigarettes, and/or was assessed for the ability to do so safely. (Resident #70)</p> <p>B. Based on observation and interview, the facility failed to ensure chemicals and medicated creams were inaccessible to residents on an Alzheimer's unit, in that they were in unlocked unattended rooms and/or cabinets. This had the potential to affect 16 residents residing on the Alzheimer's unit.</p> <p>Findings include:</p> <p>A1. RN #1 was interviewed on 9/10/13 at 10:37 a.m. She indicated Resident #70 might have had a fall. She indicated he was outside smoking and came in with a black eye and that he had told two stories about</p>	F000323	F-3231. A chart audit was immediately performed for Resident #70 to ensure that there were Physician LOA orders and A Smoking Assessment. A building wide inspection was done immediately to ensure all harmful chemicals were properly secured. 2. Re-education will be done with all staff concerning the smoking policy/assessments and how to properly secure all chemicals away from Residents. 3. After verifying with residents' physician, the admitting nurse is responsible to write an order allowing the resident to go LOA. If a resident expresses a desire to smoke a smoking assessment will be completed. A chart audit has been completed to ensure all residents with a desire to smoke have orders allowing them to have a LOA The Charge Nurse on each unit will be responsible to ensure all chemicals are kept secured. 4. Audits will be conducted by the DON/Designee throughout the building daily 5x weekly for 4 weeks then weekly x 4 weeks and then monthly x 4 months to ensure all chemicals are properly secured from residents	10/18/2013			

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	<p>what happened.</p> <p>Resident #70 was observed on 9/12/13 at 8:00 a.m., seated in a wheelchair in the lobby. He was observed to have bruising and an abrasion around the left eye.</p> <p>Resident #70's clinical record was reviewed on 9/12/13 at 10:29 a.m. The resident was admitted to the facility on 3/17/12 and readmitted on 8/8/13. Diagnoses included, but were not limited to, type I diabetes, hypertension, end stage renal disease on dialysis, chronic pain syndrome, legally blind, history of respiratory failure, peripheral neuropathy, seizure disorder, hyperlipidemia, history of sepsis, and history of pericardial effusion.</p> <p>Nurses' notes included, but were not limited to, the following: "8/18/13 1430 [2:30 p.m.] has been smoking by front door. Told him he could not smoke by front door that he has to go out of park (sic) lot and has to sign out LOA [leave of absence]..." "9/8/13 0245 [2:45 a.m.] Resident sign himself out at 0222 [2:22 a.m.] to go smoke, came back in at 0240 [2:40 a.m.]. Stated he was twitching and fell in front of the building. Has raise area over (L) [left] eye. At 0330</p>		<p>reach. Audits will be done by Social Service/Designee the following day after admission or when a resident expresses the wish to smoke, Monday thru Friday, to ensure those residents wishing to exercise their right to smoke, have Smoking Assessments and LOA orders if appropriate. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>				

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	<p>[3:30 a.m.] accu [check] [blood sugar] 71."</p> <p>The facility obtained a physician's order on 9/8/13 at 10:50 a.m., indicating the resident was to be supervised with smoking and could not go out alone for his safety.</p> <p>The record contained a printed out progress note, with a print date of 9/9/13 at 3:23 p.m. The note indicated the resident was "out smoking off the property, came back in with the left eye swollen and turning colors, resident said he ran into a car mirror." The note indicated the time of the incident as 9/8/13 at 2:30 a.m.</p> <p>Physician's orders, signed 8/27/13, indicated there were no orders for the resident to go on leave of absence. At the time of the record review on 9/12/13 at 10:29 a.m., there was no smoking safety assessment in the record for the resident.</p> <p>A physician's progress notes, dated 8/27/13, indicated, "not competent per psych (sic)."</p> <p>The Director of Nurses (DoN) and Administrator were interviewed on 9/12/13 at 11:00 a.m. The Administrator indicated all smokers</p>			

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	<p>were deemed to need supervision with smoking upon admission. He indicated they had set smoking times for the residents to be supervised. He further indicated that he had been informed by their legal department, if a resident was "their own person," responsible for him or herself, the facility could not keep them from leaving the property to smoke. He did indicate they should have a physician's order to go on leave of absence (LOA).</p> <p>The resident's record was reviewed with the DoN and Administrator at that time, indicating no order was in place at the time the resident had signed out LOA on 9/8/13.</p> <p>The Social Service Designee (SSD) was interviewed on 9/12/13 at 11:00 a.m. She indicated the resident had been placed at the facility by Adult Protective Services, but they no longer had guardianship of the resident. She did not know anything about the resident's ability to go LOA.</p> <p>The SSD was interviewed again on 9/16/13 at 3:10 p.m. She indicated each resident had a smoking safety assessment. She indicated they would be in the social service/activity section of the record, but she also</p>			

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	<p>kept copies. She checked her file and none was present for resident #70. She then indicated it might be in the Activity Director's office. She was unable to find an assessment for Resident #70.</p> <p>On 9/17/13 at 2:00 p.m., Resident #70's record was checked again. A smoking safety assessment indicating the resident was safe to smoke was on the record; the date of the assessment was 8/13/13.</p> <p>The resident had a care plan, dated 8/8/13, for being at risk for injury related to smoking. The interventions included the following: Smoking will be supervised by staff Smoking materials will be kept at nursing station Provide smoking materials Monitor compliance to smoking policy</p> <p>The procedure for smoking safety, effective November 2004, revised October 2012, was provided by the Director of Nurses on 9/17/13 at 11:39 a.m. The procedure for this facility included, but was not limited to, the following: "All residents who smoke will be screened using the Smoking Safety Data Collection and Assessment form upon admission, quarterly and with a</p>						

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	<p>significant change of condition to determine any special smoking needs." "...residents may only smoke under staff supervision, in designated smoking areas and at times established by the Center..."</p> <p>B1. An environmental tour was conducted with the Maintenance Director and the Housekeeping Director on 9/12/13 at 2:15 p.m. The following items were observed:</p> <p>a. The Alzheimer's unit common shower/bath room was unlocked and unattended. There was a spray bottle of quaternary sanitizer (an ammonia based sanitizer), labeled to "keep out of reach of children" and "harmful if swallowed," stored in an unlocked cabinet in the room. The cabinet also contained razor blades.</p> <p>b. A cabinet in the dining/activity common area of the Alzheimer's unit contained the following items: Alcohol gel, labeled "keep out of reach of children," Tree Pruning Sealer, labeled "Caution: flammable," "keep out of reach of children," and Antifungal cream labeled "keep out of reach of children."</p>			

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	3.1-45(a)(1) 3.1-45(a)(2)			

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F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure tracheotomy care was completed in a manner to prevent potential infection for 1 of 1 resident sampled with a tracheotomy, in a sample of 1 who had a tracheotomy, in that, glove change and hand washing was not completed between the soiled inner cannula and the clean one. (Resident #1)</p> <p>Finding includes:</p> <p>Resident #1's clinical record was reviewed on 9/12/13 at 8:35 a.m. The resident's diagnoses included, but were not limited to, history of cerebrovascular accident, chronic psychosis, depression, status post craniotomy for hemorrhage, neurogenic bladder, hypertension, diabetes, chronic urinary tract infections, chronic upper respiratory</p>	F000328	F-328 1. RN #2 was immediately re-educated on the Policy and Procedure concerning Trach Care. Resident #1 is currently the facility's only resident with a trach 2. All professional Nursing Staff will be re-educated on the Policy and Procedure concerning Trach Care, with return demonstration and proper handwashing techniques required. 3. An in-depth in-service on Trach Care will be presented to the professional Nursing staff by a licensed Resp Therapist to cover all aspects of Trach care with return demonstration. The Education and Training Director will ensure all newly hired Professional staff have proper training and can demonstrate proper technique upon hire. 4. The Education and Training Director will observe/audit trach care 3x a week x 4 weeks then weekly x 4 weeks and then monthly x 4 months. The audit will take place on all shifts. Results	10/18/2013			

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	<p>infections, tracheotomy, and edema.</p> <p>Signed physician's orders with the date range of 7/1/13 through 7/31/13, included, but were not limited to, the following regarding trach care: "change inner cannula every shift along w[with]/trach care."</p> <p>The resident's care plan, initiated 5/28/13 and reviewed 8/28/13, for potential/actual alteration in oxygen included, but was not limited to, the following: "Trach care per physician order."</p> <p>On 9/16/13 at 9:13 a.m., RN #2 was observed doing tracheotomy care for Resident #1. RN #2 wore clean gloves and cleaned the external part of the tracheotomy apparatus. She cleansed the skin/stoma area under the trach. She removed the inner cannula and disposed of it. She cleaned more of the external apparatus. She then opened a new inner cannula package, removed the inner cannula and placed it into the tracheotomy tube. She did not change gloves or wash her hands between the old soiled inner cannula and the new one.</p> <p>The policy and procedure for hand hygiene, dated April 1999, revised</p>		<p>of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>		

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	<p>November 2011, was provided by the Director of Nurses on 9/17/13 at 11:29 a.m., included, but was not limited to, the following:</p> <p>"A plain soap and water handwash or an alcohol hand rub may also be used:</p> <p>After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if the hands are not visibly soiled."</p> <p>"During resident care if moving from a contaminated-body site to a clean-body site."</p> <p>"After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident."</p> <p>"After removing gloves."</p> <p>3.1-47(a)(4)</p>			

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F000363 SS=E	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview and record review, the facility failed to ensure menus were followed for puree diets, in that recipes were not used to prepare the pureed food. This affected 7 of 7 residents with pureed diets. (Residents #53, #2, #25, #65, #66, #22, #120)</p> <p>Finding includes:</p> <p>Cook #1 was observed preparing pureed meat and vegetables for the noon meal, on 9/12/13 at 9:50 a.m. Cook #1 indicated he was pureeing food for seven residents. The food processor was observed to have chunks of pork in it. Upon query on 9/12/13 at 9:50 a.m., Cook #1 indicated pork was in the food processor. Cook #1 indicated the pork had not been weighed or measured and he "just put how much [he] thought would serve seven." Cook #1 then added an unmeasured amount of broth and food thickener and pureed the meat.</p>	F000363	<p>F-363 1. An audit of resident diets was done to identify all residents on pureed diets. Tray cards were reviewed to ensure they were marked correctly. 2. Re-education for the staff responsible to prepare the pureed food will be completed by the dietary manager on puree recipes. 3. Audits will be done by the Dietary Manager 5 x a week across all meals x 4 weeks and then weekly x 4 weeks and then monthly x 4 months to ensure the recipe for the preparation for pureed food is being followed. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>	10/18/2013

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	<p>Upon pureeing of the carrots, the carrots were poured into the food processor without being measured or weighed. Cook #1 indicated he placed "just what he thought would be needed for 7."</p> <p>The cook then prepared mashed potatoes, as the menu called for carrots and potatoes.</p> <p>The recipe for puree pork pot roast, printed 9/12/13 at 7:59 a.m., was observed on a food preparation table. A copy of the recipe or pureed pork pot roast was provided by the Dietary Manager on 9/12/13 at 11:00 a.m. The recipe was for 10 servings. The recipe indicated that for 10 servings, the food was to have 1 1/4 teaspoons of beef base to 3/4 cups of hot water. The puree pork pot roast was to have food thickener added to the beef stock to make a slurry which was to be added to the meat.</p> <p>The carrots and potatoes puree recipe was provided by the Dietary Manager on 9/12/13 at 11:00 a.m. The recipe had been printed out on 9/12/13 at 8:01 a.m. The recipe indicated the potatoes and carrots were to be separated for the pureed version. Ten servings were to be</p>			
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	<p>measured out. Thickener and margarine were to be added and the carrots were to be processed. Then carrots and potatoes were to be served separately, a #12 scoop of carrots and a #8 scoop of potatoes.</p> <p>The Dietary Manager provided a list of residents on puree diets on 9/23/13 at 8:50 a.m. The list included the following residents: #53, #2, #25, #65, #66, #22, #120.</p> <p>3.1-20(i)(4)</p>			

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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. Based on observation and interview, the facility failed to provide food that was palatable, in that 10 of 21 residents interviewed during stage 1 complained of food not being good and/or being cold, and 1 of 1 tray service observation indicated the meat and vegetables were served with too much liquid. (Residents #85, #52, #77, #10, #15, #26, #112, #92, #62, A)</p> <p>Findings include:</p> <p>1. The following residents indicated problems with food quality during Stage 1 interviews:</p> <p>a. Resident #85 was interviewed on 9/10/13 at 12:07 p.m. and indicated the food didn't taste good, and "one time the spaghetti was okay." The resident also indicated the food was cold when he received it.</p> <p>b. Resident #52 was interviewed on 9/9/13 at 12:09 p.m. The resident indicated the hot food was cold and the cold food was melted. The</p>	F000364	F-3641. The server that was preparing trays on 9/12/13 was re-educated on proper technique concerning liquid/content. 2. All servers that are responsible for preparing trays have been re-educated on proper technique concerning liquid/content. 3. Re-education will be done with the dietary staff on food temps, appearance, the following of the preparation recipes and serving techniques. The Nursing staff will be re-educated on the serving food immediately when it is delivered to the hall ways and the importance of food temps. 4. Test tray audits will be done with the residents who are capable of interview concerning the palatability of the food over the past 24 hours. Audits will be completed 3x weekly by the Dietary Manager. Interventions will be put into place as needed. Results of the audits will be presented to the Quality Assurance Committee on a monthly basis for further review and recommendations as deemed appropriate for at least 6 months or until the QA committee determines the issue has been resolved. Identified	10/18/2013	

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	<p>resident indicated food was cold, greasy, vegetables under or overcooked, and no seasoning.</p> <p>c. Resident #77 was interviewed on 9/9/13 at 3:15 p.m. The resident indicated the food wasn't good, and indicated a weight loss of 17 pounds because of the food.</p> <p>d. Resident #10 was interviewed on 9/10/13 at 8:48 a.m. The resident indicated the food was cold most of the time.</p> <p>e. Resident #15 was interviewed on 9/9/13 at 2:49 p.m. and indicated the food was cold and the milk was warm.</p> <p>f. Resident #26 was interviewed on 9/9/13 at 3:57 p.m. The resident indicated the coffee was served cold at times and macaroni was served cold recently. The resident indicated the food was getting worse.</p> <p>g. Resident #112 was interviewed on 9/9/13 at 11:51 a.m. The resident indicated the food did not taste good or look appetizing, "...no, I've had [food] in Vietnam that tasted better."</p> <p>h. Resident #92 indicated during interview on 9/9/13 at 3:39 p.m., the food tasted good 40% of the time.</p>		<p>non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>	

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	<p>i. Resident #62 indicated during interview on 9/9/13 at 2:29 p.m., the breakfast was cold, the food was horrible, and pasta was served too often.</p> <p>j. Resident A indicated during interview on 9/9/13 at 12:00 p.m., the eggs were cold and the resident had just about quit eating breakfast.</p> <p>2. The lunch meal tray service was observed on 9/12/13 at 11:36 a.m. The pork was observed to be setting in a large amount of pale liquid. The combined diced carrots and potatoes were being served with a scoop without draining of excess liquid. The plates had excess liquid on them.</p> <p>3.1-21(a)(2)</p>						

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the kitchen equipment</p>	F000371	<p>F-3711. Items identified in the survey have been cleaned.2. Kitchen equipment is on a facility cleaning schedule and will be followed per facility policy 3. Re-education has been done with all Dietary Staff and the Dietary Manager on proper sanitary conditions in the Kitchen. Education will be on an on-going basis. 4. Audits will be done by the Administrator/Designee on sanitary conditions in the Kitchen daily 5 x a week x 4 weeks and then weekly x 4 weeks and the monthly x 4 months. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>	10/18/2013

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	<p>was clean and that food was prepared and served under sanitary conditions, during 2 of 2 kitchen observations. This had the potential to affect 80 of 80 residents who resided in the facility.</p> <p>Findings include:</p> <p>The following was observed on 9/9/13 at 8:47 a.m.:</p> <ol style="list-style-type: none"> 1. The meat slicer was soiled with meat debris, soiled silverware, and an unlabeled glass of white powder all under a plastic cover, stored as clean. 2. The cast iron stove plates were rusty and had an accumulation of grease and burned on residue along the edges. The grease traps/drawers had accumulated food, a paper towel, and debris on the inside of them. 3. The convection oven had dirt, grease, and debris on the top of it. 4. The window-type air conditioner was dusty and dirty with the air blowing over the food preparation area. 5. The floors were sticky and dirty under the floor mat, along the edges, and around the equipment. 			

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	<p>6. The interior of the microwave oven was dirty with food splatters.</p> <p>7. Three (3) fans were dirty and dusty with the air blowing over the clean dish area.</p> <p>8. Interview with Dietary Manager on 9/9/2013 at 8:47 a.m., during the initial kitchen tour, indicated that she would be writing someone up for the unsanitary condition of the meat slicer.</p> <p>9. The kitchen was visited again on 9/12/13 at 9:50 a.m. The floors, the fans, the air conditioner were still soiled.</p> <p>10. On 9/23/13 at 10:05 a.m., the Administrator provided the facility's sanitation policy dated April 2013. The policy indicated, "The Nutrition Services team maintains clean and sanitary kitchen centers and equipment. Walls, floors, ceilings, equipment, and utensils are clean and/or sanitized, and in good working order."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and</p>	F000441	F-4411. Staff working with Residents #114, #1, #65, and B	10/18/2013			

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	<p>record review, the facility failed to ensure a glucometer was disinfected between residents for 1 of 2 observations of glucometer use, and proper handwashing was performed for 3 of 8 residents observed for medication administration and 2 of 3 residents observed receiving treatments, in that gloves were not changed and/or hands washed between clean and soiled tasks. (Resident #114, Resident #1, Resident #65, Resident B)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 09/11/13 at 11:20 a.m., RN #5 indicated he was preparing to perform a blood glucometer check for Resident #114. RN #5 was observed, at that time, to apply clean gloves and enter the room of Resident #114. RN #5 was then observed to pick up a piece of trash from the floor and place it in trash can. RN #5 was then observed to remove the gloves, apply new gloves without performing handwashing or hand hygiene. On 09/11/13 at 11:22 a.m. Resident #5 was observed to perform a blood glucose check using a glucometer for Resident #114. RN #5 was observed, at that time, to not disinfect the</p>		<p>were notified of improper infection control techniques and made corrections as appropriate. 2. All Professional staff has been in-serviced on Infection Control Techniques including hand washing, appropriate gloving and cleaning of the Glucose Monitor. 3. All Staff was re-educated on the infection control policy which includes proper hand washing and appropriate gloving. A second Glucose Monitor was added to each med cart. By rotating from one monitor to the other will allow the nurse to keep the "used" monitor wet the appropriate time for correct disinfecting. 4. The Education and Training Director will observe/audit handwashing, appropriate gloving and glucose monitor cleaning at least once per day across all shifts x 4 weeks then weekly x 4 weeks and then monthly x 4 months. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with progressive disciplinary action up to and including termination.</p>		

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	<p>glucometer and place it in a medication cart drawer. RN #5 was observed, at that time, to not perform handwashing or hand hygiene.</p> <p>On 09/11/13 at 11:25 a.m., RN #5 was then observed to remove the same glucometer from the drawer and enter the room of Resident #1. At that time, RN #5 was observed to apply clean gloves without performing handwashing or hand hygiene. RN #5 was then observed to wipe the glucometer with a Sani-wipe (a disinfecting product) for 30 seconds and place the glucometer on a counter. The glucometer was observed to stay wet for an additional 30 seconds. During an interview, at that time, RN #5 stated, "...I think it is to be wet for one minute...the label says it should stay wet for two minutes if it is soiled...". RN #5 was then observed to remove the gloves, apply new gloves, and clean the glucometer for two minutes with a disinfecting wipe. RN #5 was then observed to apply gloves, without performing handwashing or hand hygiene, and perform the blood glucometer check. RN #5 was then observed to remove the gloves and apply new gloves without performing hand washing or hand hygiene, prepare the insulin for injection and</p>						

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	<p>administer the insulin to Resident #1.</p> <p>The policy and procedure for Glucose monitoring equipment dated September 2010 provided by the DoN on 09/17/13 at 11:39 a.m. indicated, "...disinfect devices between residents according to manufacturer recommendation...".</p> <p>The Sani-Wipe Manufacturer's Instructions provided by the DoN (Director of Nursing) on 09/17/13 at 11:39 a.m. indicated, "... remove a wipe from container and follow product label instruction to disinfect meter...".</p> <p>The Sani-Wipe product label provided by the DoN on 09/17/13 at 11:39 a.m. indicated, "...to disinfect...treated surface must remain visible wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time...".</p> <p>2. During an interview on 09/11/13 at 1:40 p.m., LPN #5 indicated she was preparing to administer eye drops to Resident #65. On 09/11/13 at 1:42 p.m., LPN #5 was observed to set the eye drops on Resident #65's bed and reposition Resident #65. The eye drop bottle was observed, at that</p>			
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	<p>time, to fall on the floor. LPN #5 was then observed to retrieve the box from the floor with gloved hands. LPN #5 was then observed to remove the gloves and apply new gloves, without performing handwashing or hand hygiene, and administer the eye drops to Resident #65.</p> <p>The policy and procedure for hand hygiene provided by the DoN on 09/17/13 at 11:39 a.m., indicated, "...A plain soap and water handwashing or an alcohol hand rub may also be used...before having direct contact with residents...after contact with a resident's intact skin...after contact with body fluids...after removing gloves...</p> <p>3. Resident #1's clinical record was reviewed on 9/12/13 at 8:35 a.m. The resident's diagnoses included, but were not limited to, history of cerebrovascular accident, chronic upper respiratory infections, and tracheotomy.</p> <p>Signed physician's orders with the date range of 7/1/13 through 7/31/13, included, but were not limited to, the following regarding trach care: "change inner cannula every shift along w[with]/trach care."</p>			

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	<p>On 9/16/13 at 9:13 a.m., RN #2 was observed doing tracheotomy care for Resident #1. RN #2 began by washing her hands and donning clean gloves. She then removed the gloves and left the room to get a plastic bag for trash. She returned to the room and started the treatment without washing her hands again.</p> <p>RN #2 wore clean gloves and cleaned the external part of the tracheotomy apparatus. She cleansed the skin/stoma area under the trach. She removed the inner cannula and disposed of it. She cleaned more of the external apparatus. She then opened a new inner cannula package, removed the inner cannula and placed it into the tracheotomy tube. She did not change gloves or wash her hands between the old soiled inner cannula and the new one.</p> <p>4. The Director of Nurses (DoN) was observed to do treatments to the right lateral foot and right lateral ankle of Resident B on 9/12/13 at 9:17 a.m. He wore gloves and applied skin prep to the area on the right lateral foot and left it open to air. The area was dark eschar, less than .5 centimeters in diameter. The DoN then removed the old dressing from the right ankle.</p>			

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	<p>The area was 1.0 centimeter in diameter, red/pink with yellow slough in the middle of the wound. No glove change or handwashing was completed. He cleansed the area with saline and a gauze pad. He then removed the gloves and washed his hands for less than 5 seconds. New gloves were applied and Bacitracin was applied to the foam dressing and the dressing was applied to the right outer ankle.</p> <p>Following the treatment, he took off his gloves, exited the room, put things back in the treatment cart, then returned to the room and washed his hands for 5 seconds. He then took the paper towel he dried his hands with and removed food debris from the resident's gown, disposing the food debris and paper towel in the trash. He then left the room.</p> <p>3.1-18(b) 3.1-18(l)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the environment was functional, sanitary, and comfortable for residents, staff and the public, for 2 of 3 units observed, in that odors were present, and floors, walls, equipment, curtains were soiled and/or needed repair. This affected 15 of 24 rooms observed during stage 1. (Whispering Willows, The Gardens) (Rooms 150, 142, 207, 124, 140, 141, 143, 157, 138, 134, 121, 135, 139, 159, 149)</p> <p>Findings include:</p> <p>1. During Stage 1 resident interviews, Residents #52 and #92 indicated the large bathroom on Whispering Willows was soiled at least once a week, with towels on the floor, the toilet not flushed, and "mold in the showers."</p> <p>2. Room 150 was observed on 9/9/13 at 2:46 p.m. A gray stain was observed under the sink. The wallpaper/paint was peeling behind bed 2.</p>	F000465	<p>F-465 1. Deep cleaning on all hallways was performed immediately by the Housekeeping Services. Shower room on "Willows" was also deep cleaned. 2. Deep cleaning on all hallways was performed immediately by the Housekeeping Services. Shower room on "Willows" was also deep cleaned. 3. Education was done with all staff on the importance of keeping the facility and clear of any odors. How to identify and correct situational odors. The importance of keeping soiled linen hampers empty and clean. 4. Audits will be done daily Mon thru Friday 5x a week x 4 weeks and then weekly x 4 weeks and then monthly x 4 months by the Administrator/Designee and the Housekeeping Supervisor to look at cleanliness and observe for odors. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved. Identified non-compliance will result in immediate 1:1 re-education with</p>	10/18/2013

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	<p>3. Room 142 was observed on 9/10/13 at 11:21 a.m. There was a strong urine odor in the room. The bed sheet on the resident's bed had a large stain with a brown drying ring. The edges of the floor and corners were soiled. The bathroom floor edges and corners were soiled with a build-up of yellow-gray substance. The overbed table was soiled. The floor was soiled in the room and bathroom. An empty glove box was setting in water by the sink. The bathroom wall and cove base was soiled.</p> <p>4. Room 207 was observed on 9/10/13 at 9:19 a.m. There was a strong urine odor with dried yellow stains on the floor.</p> <p>5. Room 124 was observed on 9/10/13 at 8:53 a.m. There was a strong urine odor, the floors were dirty, the left bed rail was loose, the covering on the arms of an electric scooter was cracked and off, a urinal was laying in the bathroom floor. There was old urine in the commode, walls with paint missing, part of the sink missing, and the call light in the bathroom was difficult to cancel.</p> <p>6. Room 140 was observed on</p>		progressive disciplinary action up to and including termination.	

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	<p>9/9/13 at 3:37 p.m. There was a very strong foul urine type odor, possibly coming from the hallway. The bathroom tub was soiled. The floor in the bathroom along the tub was soiled with a dried substance.</p> <p>7. Room 141 was observed on 9/10/13 at 11:37 a.m. There was a strong urine odor in the room. The floor was soiled/stained along the edges and at the threshold of the door. There were brown smears on the wall across from bed 1 and on the bedside chair for bed 1. There were brown smears on the privacy curtain.</p> <p>8. Room 143 was observed on 9/9/13 at 3:36 p.m. The drawers on the night stand were falling apart. There was a strong urine odor in the bathroom.</p> <p>9. Room 157 was observed on 9/9/13 at 3:13 p.m. There was a very strong urine odor. A urinal was observed on the bedside cabinet, 1/3 full of urine. The wall behind the bed was marred with black marks and soiled.</p> <p>10. Room 138 was observed on 9/9/13 at 12:22 p.m. There was a strong urine odor in the room; the shower floor was soiled.</p>			

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	<p>11. Room 134 was observed on 9/9/13 at 11:41 a.m. There was a strong urine odor in the room.</p> <p>12. Room 121 was observed on 9/9/13 at 3:21 p.m. The caulking around the sink and outside the shower was dirty. Soiled wet wash cloths were on the floor under the sink.</p> <p>13. Room 135 was observed on 9/9/13 at 3:00 p.m. There was chipped paint around the bathroom floor.</p> <p>14. Room 139 was observed on 9/9/13 at 4:02 p.m. The stopper was laying in the tub, the tile was chipped around the commode; loose hardware was observed around the grab bars.</p> <p>15. Room 159 was observed on 9/10/13 at 12:33 p.m. The threshold of the door to the bathroom had gray build-up. There was no privacy curtain around bed 1. The resident indicated it had not been there for awhile; they had come to replace it but left and hadn't done it. The room was observed again on 9/16/13 at 11:35 a.m. and had a strong urine odor.</p>			

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	<p>16. Room 149 was observed on 9/9/13 at 11:00 a.m. The walls had peeling wallpaper; there were several pieces of tape on the walls. The overbed tables were soiled with dry spills. The edges of the overbed tables were worn. The tile along the wall was missing sections and had accumulated soil in the missing areas. The bathroom floor was soiled with gray build-up and the call cord was soiled yellow. The sink faucet was loose.</p> <p>A tour of the general environment was conducted with the Maintenance Director and the Housekeeping Director on 9/12/13 at 2:15 p.m.</p> <p>17. The oxygen storage room was observed to have a soiled floor with dirt/debris and trash. The vent to the outside was soiled with dirt and lint.</p> <p>18. Five clothing protectors stored in a cabinet in Gardens unit dining area were excessively worn and peeling.</p> <p>19. The shower room on the Whispering Willows Unit had a urine/musty odor.</p> <p>20. The E Hall had a strong fecal/urine odor.</p>						

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	<p>21. On 9/16/13 at 11:35 a.m., Room 159 was observed to have a very strong urine odor.</p> <p>3.1-19(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2013	
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000469 SS=D	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation and interview, the facility failed to ensure it was free of flies, during 1 of 1 observation of meal preparation and for 1 of 35 residents observed during stage 1 observations, in that a fly was observed in the cabbage being cooked, and flies were observed flying around and landing on a resident. (Lunch meal 9/12/13, Resident #82)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #82 was observed on 9/10/13 at 11:37 a.m. He was seated in a wheelchair at the threshold of his room's doorway. He had a dressing on his left forearm. Two flies were observed flying around the resident and lighting on his shoulder, arms, and legs. The resident was observed to attempt to swat the flies. 2. On 9/12/13 9:50 a.m., preparation of the lunch meal was being observed. A large steam table pan was observed on the stove. A dead fly was observed in the cabbage. The Dietary Manager was shown the fly 	F000469	<p>F-469 1. Maintenance did an immediate sweep to look for flies and dispatched as needed. 2. Pest control service was immediately called to come into the building and treat both inside and outside. 3. It was determined that the most used door by staff and residents to be the door at the end of E Hall. An "Air Curtain" was installed on this door by the maintenance Dept. 4. Audits will be done 5x a week x 4 weeks and then weekly x 4 weeks and then monthly x 4 months by the Administrator/Designee/Director of Maintenance to observe for flies. All observed flies will be dispatched as needed and Pest Control will be called as needed as well as continue their scheduled visits. Results of audits will be presented to the Quality Assurance (QA) Committee on a monthly basis for further review and recommendations as deemed appropriate, for at least 6 months or until the QA committee determines the issue has been resolved.</p>	10/18/2013			

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	<p>and indicated they would not serve the cabbage. She indicated the cabbage was fresh produce and they washed it as best as they could, but sometimes insects were found.</p> <p>3. The observations were reviewed with the Administrator on 9/17/13 at 4:00 p.m. He indicated they had frequent visits from their pest management company, and tried to control the flies.</p> <p>3.1-19(f)(4)</p>			