

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 06-10, 2012 and February 14 & 15, 2012</p> <p>Facility number: 000418 Provider number: 155565 AIM number: 100274870</p> <p>Survey team: Debra Skinner, RN (TC) Teresa Buske, RN Laura Brashear, RN Mary Weyls, RN</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 02 Medicaid: 37 Other: 06 Total: 45</p> <p>Stage II Sample: 42</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the Deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Sunset desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective 3/15/2012.</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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	Quality review completed on February 22, 2012 by Bev Faulkner, RN				

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F0159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount</p>				

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	<p>in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure residents' personal funds were readily accessible on the weekends for 3 of 11 residents interviewed and identified with funds managed by the facility within the Stage 2 sample of 42 (Resident #'s 21, 32 and 62)</p> <p>Findings include:</p> <p>1. During interview of Resident #62 on 2/7/12 at 3:52 p.m., the resident indicated some of her funds were handled by the facility. The resident indicated the funds were not available on the weekends.</p> <p>Clinical record review on 02/15/12 at 2 p.m., indicated Resident #62's MDS (Minimum Data Set [assessment]) dated 01/12/12, identified the resident was cognitively intact.</p>	F0159	<p>It is the policy and standard of practice for this facility to ensure that our residents' personal funds are readily accessible on the weekend.1. What corrective action will be done?An envelope with each resident trust monies and a trust Distribution log will be given to the west wing charge nurse before the Business Office Manager leaves for the day on Friday. Both the BOM and Charge Nurse will count the money and initial the envelope. The envelope will be locked in the narcotic drawer. The Charge nurse will only remove money from the envelope when a resident requests personal funds from his/her trust account. The Charge nurse will record this transaction on the Distribution log and have resident sign Distribution log. The BOM will pick up the envelope and the distribution log each Monday morning. The Administrator and BOM will jointly review the log and remaining money to ensure that both are accurate.2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</p>	03/15/2012			

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	2). Interview of Resident #21 on 2/7/12 at 3:17 p.m., indicated the facility maintained funds for her. The resident also indicated she was		Any Resident that has a resident trust account has the potential to be affected. 3. What measures will be put into place to ensure this practice does not recur?The nurses will be edcuated regarding the new procedure by 3-15-12. Those residents who request money will be informed of the new procedure by the BOM and Administrator by 3-15-12 who will document that each has been informed by means of a note added to their financial file in the business office. Residents who are admitted from this time on will be informed of this procedure duringthe admission process.4. How will the corrective action be monitored to ensure the deficient practice does not recur?The residents will be asked by their Guardian Angel if they have had any issues with obtaining money over the weekend.The results of the Guardian Angel rounds are reviewed at each morning interdisciplinary management meeting that occurs at least 5 days a week. In addition, the Administrator will bring the results of the rounds to the monthly QA&A Committee Meeting for review and recommendations for further process improvement. This will continue on an ongoing basis.		

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	<p>unable to get funds on the weekends as the Administrator and the Business Office Manager were not in the facility. The resident indicated she "knows to get money before the weekend."</p> <p>Review of the clinical record of Resident #21 on 2/15/12 at 2 p.m., indicated the most recent Minimum Data Set (MDS) quarterly assessment was completed 11/15/11. The assessment identified the resident with independent decision and skills and cognition without deficit.</p> <p>3). During interview on 02/07/12 at 11:07 a.m., Resident #32 indicated resident funds were unavailable on weekends.</p> <p>Record review on 02/07/12 at 2 p.m., of Resident #32's clinical record indicated the resident was alert and oriented according to person, place and time with no memory problems. A quarterly MDS (Minimum Data Set) assessment, dated 02/09/12, indicated the resident had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>During interview of the Business Manager on 2/14/12 at 2 p.m., the</p>				

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	<p>manager indicated the resident could access funds Monday through Friday from 8 a.m. to 5:30 p.m. The Business Manager indicated the funds were handled by either the Business Manager or the Administrator. The Business Manager indicated the residents know we are not here on weekends so they get their money on Friday. The Business Manager indicated she does work one weekend a month.</p> <p>Review of the Facility policy titled "Resident Trust" on 2/14/12 at 3:40 p.m., received from the Business Manager, indicated documentation to indicate the hours or days of availability of the resident funds was lacking.</p> <p>3.1-6(f) 3.1-6(1)</p>				

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F0241 SS=B	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to maintain dignity for 3 of 3 residents with signs posted visibly in resident rooms with personal information in a stage 2 sample of 42 residents; in that personal information regarding Residents #40, #63 and #51 was posted within view of other residents and/or visitors.</p> <p>Findings include:</p> <p>1). On 2/7/12 at 2:00 p.m., two signs were observed posted in Resident #51's room. One was posted on a refrigerator on the resident's roommate's side of the room, visible from hallway, under a sign with Resident #51's name posting "DEAF Write on paper please and thank you." A duplicate sign was also observed posted on the wall above Resident #51's bed.</p> <p>Resident #51's clinical record was reviewed on 2/15/12 at 1:58 p.m. A Minimum Data Set [MDS]</p>	F0241	<p>It is the policy and standard of practice in this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality, including elimination of posted signs that are visible and contain residents' personal information.1. What corrective actions will be done?The signage in the rooms of residents #40, #51 and #63 has been removed. Families of the above residents were notified of the removal and how personal information is communicated within the facility. Personal information is placed on the care plan, in the communication book, and on the 24hr report form as well as the C.N.A. information sheet and C.N.A. daily assignment sheet.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Room rounds have been completed by the Administrator and Director of Nursing to ensure that no other signage was posted that did not provide dignity and respect to</p>	03/15/2012

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	assessment, dated 8/13/11, assessed the resident with highly impaired hearing. The cognitive assessment indicated the resident with moderately impaired cognition.		each resident. No other residents have been affected.3. What measures will be put into place to ensure this practice does not recur?Staff will be re-educated regarding the posting of signs and that our facility provides care of our residents in an environment that maintains and enhances each resident's dignity and respect, in full recognition of his or her individuality. This will be completed by the DON and Administrator by 3/15/12.A letter will be sent to residents' families on how personal information is communicated. Each new admission to the facility will also be provided with information regarding the communication of care information to staff.Daily room rounds will be completed and documented through our facility Guardian Angel program. Weekend rounds are commpleted by our weekend manager on duty. If signage is noted it will be removed immediately. Families will be contacted by the Administrator or Director of Nursing when signs are removed. Guardian Angel rounds and weekend manager on duty finding will be discussed at the next scheduleed interdisciplinary morning management meeting which is held at least 5 days a week. Follow up to any identified concerns will be done by the designated department manager or Administrator, as well as	

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	<p>2). On 2/9/12 at 11:05 a.m., instructions were visibly posted on the wall above Resident # 40's bed. The instructions were information regarding total hip replacement precautions, weight bearing, and getting up and about after surgery. The same instructions were noted to be posted on the wall above Resident #40's bed on 2/10/12 at 11 a.m. and 2/14/12 at 11 a.m.</p> <p>Interview of Resident #40 on 2/14/12 at 3:05 p.m., indicated she was unaware as to why the instructions were posted on the wall.</p> <p>Review of the clinical record on 2/14/12 at 1 p.m., indicated the most recent Minimum Data Set (MDS) assessment was completed on 12/16/11. The assessment identified</p>		<p>retraining for involved staff regarding the facility policy for protection of resident information.4. How will the crective action be monitored to enusre the deficient practice doe not recur?The results of the rounds as well as any identified concerns will be brought to the monthly QA&A Committe meeting for review. Theis will occur for the next three months, and then results will be reviewed quarterly on an ongoing basis once 100% compliance has been achieved,</p>		

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	<p>the resident without cognitive impairment and independent in cognitive decision making skills, extensive assistance for transfers, and without limitation of upper/lower extremities.</p> <p>The resident was noted to have fallen on 12/6/11 and fractured her hip.</p> <p>Interview of the Administrator on 2/14/12 at 3:30 p.m., indicated she was unaware of who had posted the information, but possibly posted by therapy.</p> <p>3). On 2/9/12 at 11:15 a.m., a sign was noted on the wall of the Residents # 63's room. The sign indicated "I am allergic to petroleum Please be careful what soap/ lotion you put on me Thank You"</p> <p>On 2/14/12 at 10:20 p.m., the sign on the wall was noticed with the same information as on 2/9/12.</p> <p>On 2/15/12 at 3 p.m., the Administrator indicated the family requested the information be posted.</p> <p>Review of the nursing assignment sheet, received from the Administrator on 2/14/12 at 12:08 p.m., indicated documentation the</p>						

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	<p>resident was allergic to petroleum and to be careful as to the types of lotions and soaps used was lacking.</p> <p>3.1-3(t)</p>				

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F0309 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 1 of 40 residents reviewed in stage II sample of 42, requiring assistance with positioning, was maintained in a functional position to prevent impairment of lower extremities when in a wheelchair; in that lower extremities were observed dangling several inches above the floor and not supported (Resident #16).</p> <p>Finding includes:</p> <p>On 2/9/12 at 10:45 a.m., Resident #16 was observed in a wheelchair with a lap tray on in activities and the resident's feet were observed dangling several inches from the floor, not supported by any device. The resident was observed on 2/9/12 at 3:10 p.m., in a lounge area in the same position.</p> <p>On 2/10/12 at 1:37 p.m., the resident</p>	F0309	<p>It is the policy and standard of practice for this facility that each resident receives and is provided the necessary care and services to attain and maintain the highest practicable physical well being, including maintaining of functional position for residents' lower extremities.1. What corrective action will be done?Resident #16 had an adaptive foot rest placed on the wheelchair 2/15/12. A therapy screen was completed, on 2/17/12. Resident #16's care plan has been updated to reflect the therapist's recommendations and the addition of the adaptive foot rest.2. How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents in wheelchairs were assessed on 2/24/12. A list was made of those residents who did not have footrests. This list was given to therapy to screen to determine if the use of foot rests would be appropriate for these residents. All therapy screens have been completed. IDT reviewed each therapy screen</p>	03/15/2012	

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	<p>was observed positioned in the wheelchair with lap buddy in the lounge area with feet dangling unsupported, several inches from the floor.</p> <p>On 2/15/12 at 11:32 a.m., CNA #12 was interviewed regarding Resident #16's feet dangling several inches above floor [currently in wheelchair with lap tray in lounge with feet several inches above floor.] The CNA indicated the resident had utilized foot pedals in the past, but the resident wouldn't keep feet on them.</p> <p>On 2/15/12 at 11:50 a.m. the MDS [Minimum Data Set] Coordinator was interviewed. The staff member indicated she thought the resident did utilize foot pedals although the resident's feet didn't reach the pedals properly. The Coordinator indicated the resident utilized the lap tray for positioning and to prevent lunging forward and would not fit a smaller wheelchair properly. The Coordinator indicated the resident would be assessed by therapy for proper positioning.</p> <p>Resident #16's clinical record was reviewed on 2/15/12 at 1:00 p.m. The resident's diagnoses included, but was not limited to, Cerebral palsy,</p>		<p>and were in agreement with eight of nine recommendations. The one resident refused to have footrests placed. Any changes to resident seating has been added to each resident's care plan and C.N.A. assignment sheets, 3. What measures will be put into place to ensure this practice does not recur? Staff will be educated on use of foot rests with residents utilizing a wheelchair for mobility by 3/15/12. Any newly admitted resident who utilizes a wheelchair will be screened by therapy to determine appropriate use of footrests. The therapist's recommendations will be followed and any changes will be added to the resident's care plan and C.N.A. assignment sheet. All residents will continue to be screened quarterly by therapy to make sure that any potential problem areas or resident condition changes are identified and addressed. The DON or designee will check residents in wheelchairs to assure footrests and other adaptive positioning devices are in place, as deemed appropriate, 5 times weekly for the next month, then they will check on a weekly basis for the next 3 months. In addition the DON and Staff Development Coordinator will observe for proper use of foot rests and other adaptive devices as part of their frequent rounds made during each tour of duty. Any identified concerns will be addressed</p>	

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	<p>seizure disorder and mental retardation.</p> <p>An Minimum Data Set [MDS] assessment, dated, 9/13/11, assessed the resident with severe cognitive impairment, with long and short term memory impairment. The assessment coded the resident as requiring extensive assistance of two for transfers and ambulation. The area of functional status indicated the resident as balance during transitions and walking not steady, only able to stabilize with human assistance, utilizes a wheelchair. The assessment assessed the resident as requiring total assistance of staff.</p> <p>A plan of care with onset date of 12/1/09 and most recent target date of 3/16/12, addressed the problem of "I need a restorative PROM [Passive range of motion] exercise program because I am at risk for decline in lower extremity joint mobility R/T [related to] diagnoses: Osteoporosis & [and] CP [cerebral palsy]. Interventions included, but were not limited to, gentle range of motion to all major joints (hips, knee, ankle, and toes) OT [occupational therapy] eval [evaluation] and treatment as indicated."</p>		<p>immediately, and the situation will be corrected at that time. Once the resident is cared for, the DON or Staff Development Coordinator will re-educate the staff involved regarding the facility policy for maintaining proper functional positioning and use of adaptive devices designated for individual residents. Progressive disciplinary aciton will also be rendered for continued noncompliance.4. How will the corrective action be monitored to ensure the deficient practice does not recur?The DON or Staff Development Coordinator will bring the results of their audits and rounds to the QA&A Committee for review and recommendations. The monitoring will continue on an ongoing basis, even when the documented rounds are no longer required by the QA&A Committee.</p>	

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	3.1-37(a)				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received services to ensure cleansing of skin to maintain personal hygiene for 2 of 5 residents observed for personal hygiene in a stage 2 sample of 42. (Resident #35 and Resident # 63)</p> <p>Findings include:</p> <p>1). On 2/9/12 at 1 p.m., LPN #1 and CNA #2 were observed to transfer Resident #35 with the "sit to stand lift." The resident was toileted utilizing a bedside commode. The resident was observed to sit on the commode and did not void. With gloves on, CNA #2 was observed to wipe the resident's skin with a wet disposable cloth. As the CNA was pulling up the resident's brief, the resident was observed to begin having a bowel movement. The resident was observed to be sat back down on the commode. Bowel movement was observed on the commode seat . The LPN and the CNA were observed to remove their</p>	F0312	<p>It is the policy and standard of practice in this facility that residents who are unable to carry out activities of daily living receives services to ensure cleansing of their skin to maintain personal hygiene. 1. What corrective action will be done? (1) Both C.N.A. #2 and LPN #1 were counseled regarding proper peri-care and changing of resident #35. (2) Resident #63 will have a 5 day voiding pattern and post voiding pattern assessment completed. She will be placed on a toileting program, based upon the outcome of the assessment. 2. How will facility identify other residents having the potential fo be affected by the same practice and what corrective action will be taken? Residents who are incontinent have the potential to be affected. Nursing staff will be re-educated by the Staff Development Coordinator (SDC), on the policy of incontinent care and toileting programs, by 3/15/12. 3. What measures will be put into place to ensure this practice does not recur?The DON/SDC will perform peri care observations daily of C.N.A. staff caring for incontinent residents. This will be</p>	03/15/2012

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	<p>gloves and wash their hands. The LPN and CNA were observed to apply new gloves. The resident was again positioned to a standing position with the lift. CNA #2 was observed to wipe the resident's skin attempting to remove bowel movement with dry toilet paper. Bowel movement was observed to be smeared on the resident's buttocks. The CNA again attempted to remove with dry toilet paper. Peri care was observed not to be completed. A new disposable brief was observed to be applied to the resident. The resident was then transferred to bed utilizing the lift, and positioned in bed.</p> <p>Review of the clinical record of Resident #35 on 2/10/12 at 3 p.m., indicated the most recent Minimum Data Set (MDS) assessment was completed 11/29/11. The assessment identified the resident with moderate impairment in cognition, total dependence for transfers, toileting, and personal hygiene. The resident was also identified as always incontinent.</p> <p>The resident's current plan of care addressed the problem, dated 10/26/11, of "I am frequently incontinent of urine" with approaches which included but was not limited to</p>		<p>done at least 5 days a week until all C.N.A.s on all shifts have been observed and satisfactorily performed the peri care procedure. Once that is achieved, the DON or SDC will continue observing peri care at least weekly for another month to assure continued appropriate practice. If discrepancies are noted during any observations, the staff will be immediately re-educated regarding the facility policy. Progressive disciplinary action will be taken for continued noncompliance. 4. How will the corrective action be monitored to ensure the deficient practice does not recur? The DON or SDC will bring the results of their observations and monitoring to QA&A Committee for review and recommendations. Further auditing will be at the discretion of the QA&A Committee once 100% compliance has been achieved.</p>		

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	<p>assist me to bathroom or commode as needed and provide proper incontinence care as needed.</p> <p>Review of the facility's policy and procedure titled "Incontinence Care," dated 6/2004, on 2/14/12 at 11:10 a.m., indicated "...Procedure...3. Wash all soiled skin areas and dry very well, especially between skin folds...."</p> <p>2). On 2/9/12 at 1:20 p.m., LPN #1 and CNA #2 transferred Resident #63 with a stand up lift(med/care) from the wheelchair to a shower chair to place the resident over a toilet. The staff pulled the resident's brief down. The resident's brief was soiled with feces and urine. The resident's bottom and upper thighs were heavily indented and red.</p> <p>The resident was placed over the toilet. The resident had small bowel movement.</p> <p>During interview of LPN #1, the LPN indicated the resident was gotten up in a wheelchair around 7:30 a.m. The LPN indicated the resident "will usually tell us when she needs to go. She was really wet today."</p> <p>During interview of CNA #2 on 2/9/12</p>			

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	<p>at 1:20 p.m., the CNA indicated the resident had not been placed on toilet since 7:30 a.m. until now (at 1:20 p.m.)</p> <p>During interview of CNA #7 on 2/14/12 at 10:46 a.m., the CNA indicated resident #63 was up when she came on at 5:30 a.m. The CNA Indicated she took resident to the bathroom before breakfast and the resident had a large BM. The CNA indicated once in a while the resident will request to go to the bathroom, but "I just go in and check to see if she needs to go."</p> <p>Resident #63's clinical record was reviewed on 2/14/12 at 11:55 a.m.</p> <p>An admission date was noted of 1/12/12.</p> <p>A diagnosis was noted of , but not limited to, left-sided paralysis post CVA (cerebral vascular accident).</p> <p>A bladder assessment was completed on 01/16/12, and indicated the resident was incontinent upon admission, with a 5 day voiding pattern having indicated the resident was "to be kept clean and dry".</p> <p>A plan of care was noted, with a</p>			

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	<p>problem identified as onset date of 1/18/12, of "I am frequently incontinent of urine." With a goal of "I will decrease the number of daily episodes of urinary incontinence." Approaches were noted of, but not limited to, the following, "Provide me verbal cueing and assist me to bathroom or commode as needed".</p> <p>3.1-38(a)(3)(A)</p>			

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F0323 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, record review and interview, the facility failed to ensure the residents' environment was free from hazards in that 3 of 12 residents reviewed utilizing side rails, were observed with measurements of at least 8 inches between the rails. Four empty resident beds were also observed with the same side rails in a stage 2 sample of 42. [Residents #41 , #63, and #51]</p> <p>B. Based on observation and record review the facility failed to ensure assistive devices were utilized in accordance with manufacturers' directions or facility's policy to prevent injury for 1 of 4 residents reviewed utilizing personal safety alarms to prevent falls in that the alarm box was not secured in accordance with manufacturer's directions [Resident #41] ; and 1 of 2 residents observed transferred utilizing a gait belt and observed transferred in a wheelchair with foot dragging the floor and not supported in a stage 2 sample of 42</p>	F0323	<p>It is the policy and standard of practice of this facility ensures that the resident environment remains as free of accident hazards as is possible, including the presence and/or use of side rails.1. What corrective action will be done?A. The bottom rails on both left and right side of the beds of residents #41, #51 and #63 have been secured with zip ties, due to the fact the rails are not able to be removed from the bed, for safety. None of the residents were utilizing the lower bed rail.B.1 A foot rest was immediately (2/9/2012) placed on resident #53 wheelchair. Resident was screened by PT/OT to assure safe practice was in place. The care plan and C.N.A. assignment sheet has been updated to reflect the lift shoe and outcome of the therapy screen.b. C.N.A. #2 has received disciplinary action requiring gait belt usage and safe transfersB. 2 Resident #41 has been reassessed and her tag alarm has been discontinued in the recliner.Direct care staff will be re-educated by 3-15-12 by the therapy department re: appropriate utilization of the gait</p>	03/15/2012			

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	<p>[Resident #53].</p> <p>Findings include:</p> <p>A.1. On 2/9/12 at 11:15 a.m., with the Administrator present, four half side rails were observed on Resident #63's bed. The right side of the bed's side rails were zip tied to the bed frame, preventing the rails from being raised. The side rails on the left side of the bed (side against the wall) observed in the down position were not zip tied.</p> <p>The Administrator measured the distance of the space between the top rail and the bottom rail. The space on the upper part of the side rails measured 8 inches and the bottom measured 8 and 1/2 inches.</p> <p>During interview of the Administrator on 2/9/12 at 11:15 a.m., the Administrator indicated the maintenance person had applied the zip ties yesterday. The Administrator indicated the maintenance person had not applied the zip ties on the left side of the bed yet, because the resident had been asleep when he was in the room.</p> <p>A. 2. On 2/8/12 at 12:20 p.m. with the Administrator, Resident #41's bed</p>		<p>belt during transfers.2. How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?A. A complete room check was completed during the survey to identify any additional beds with bottom side rails that had the potential for entrapment. Any beds with risk factors have had their bottom rails secured with zip ties.B. 1 All residents in wheelchairs were assessed on 2/24/12. A list was made of those residents who did not have footrests. This list was given to therapy to screen to determine if the use of foot rests would be appropriate for these residents. All therapy screens have been completed and reviewed by the Interdisciplinary team. Changes have been implemented and care planned and placed on the C.N.A. assignment sheet. One resident of the nine did refuse footrests and this has been care planned.b. Any resident who is transferred using a gait belt is at risk.B. 2 All residents were assessed and no other residents were affected.3. What measures will be put into place to ensure this practice does not recur?A. All beds entering this facility will be evaluated by the Maintenance Supervisor for resident safety. Staff will be educated no to remove zipties from bottom rails of beds, by the Administrator, by 3/15/12.Monitoring of bedrails</p>		

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	<p>was observed with four 1/2 side rails on the bed. The side rails were raised for measurement and the space between the top and bottom rails was measured. The space at the top measured eight inches at the top of the rails and eight and one-half inches at the bottom of the rails.</p> <p>A. 3. On 2/8/12 at 12:40 p.m. Resident #51's bed was observed with four 1/2 siderails on the resident's bed in the down position.</p> <p>On, 2/8/12 at 12:33 p.m., the Administrator provided a list of beds in the facility with the same type of siderails in place. The Administrator identified Resident #51's, bed and Resident #63's bed. The Administrator also identified four other beds in the facility with the same type of rails, currently not being occupied by residents. The beds were located in Rooms: 1B, 10B, 13A, and 23A. The Administrator indicated the rails were not removable from the beds, but the bottom rails would be secured with zip ties to prevent from being raised.</p> <p>B. 1. On 2/9/12 at 11:30 a.m., LPN #1 and CNA #2 transferred Resident #53 to a w/c from the bed, utilizing a gait belt. A built up shoe was</p>		<p>has been placed on the weekly maintenance log. Any non complinace in the use of bed rails will result in disciplinary action.B. 1 & b. B. 2 Therapy will re-educate staff on correct transporting of residents in a wheelchair by 3/15/12. The SDC will re-educate staff regarding the use of footrests on those applicable residents and correct positioning of tag alarmson 3/6/12. Staff will also be educated by the therapy department regarding safe transfers and the use of gait belts.B. 1 The DON or designee will check residents in wheelchairs to assure footrests and other adaptive positioning devices are in place, as deemed appropriate, 5 times weekly for the next month, then they will check on a weekly basis for the next 3 months. In addition, the DON and SDC will observe for proper use of foot rests and other adaptive devices as part of their frequent rounds made during each tour of duty. b. As part of the DON and SDC checking for use of footrests and other positioning devices, they will observe staff performing transfers while utilizing a gait belt at the frequency indicated in the previous paragraph.If discrepancies are noted during any observations, the staff will immediately be re-educated regarding the facility policy. Progressive disciplinary action will</p>		

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	<p>observed on the resident's left foot. The resident was propelled in the wheelchair by LPN #1 from the resident room to the dining room. The wheelchair was observed without foot rests. The resident kept her right foot up during the propelling. The left leg was bent at the knee with the left lower leg and foot positioned under the wheelchair and the toe of the shoe dragging the ground. CNA #2 ambulated beside the resident during the transfer to the dining room. The LPN and the CNA encouraged the resident to lift the leg, but the resident kept the left leg bent with the foot under the wheelchair.</p> <p>During interview of LPN #1 on 2/9/12 at 11:30 p.m., the LPN indicated they had tried foot pedals but the resident would push against the pedals.</p> <p>On 2/9/12 at 1:15 p.m., a student CNA was pushing Resident #53 while resident was in a w/c. The student kept encouraging the resident to hold her right foot up. The resident would lift her foot a little and then place the foot back on floor.</p> <p>Resident #53's clinical record was reviewed on 2/9/12 at 2:30 p.m.</p> <p>An admission date was noted of</p>		<p>be taken for continued noncompliance. 4. How will the corrective action be monitored to ensure the deficient practice does not recur?The DON, SDC and Maintenance Supervisor will bring the results of the audits and observations to the QA&A Committee monthly meeting for review. Recommendations made by the committee will be followed up by the designated person and the results of those recommendations will be brought back the the next scheduled committee meeting for futher review. The documented auditing of these areas will cointinue after the time periods specified in this plan at the discretion of the committee after 100% compliance has been reached,. Even when the documentation is no longer required by the committee, the monitoring itself will continue on an ongoing basis.</p>				

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	<p>9/13/11. Admission diagnoses were noted of, but not limited to, Fracture of Left Hip, Late effect, left sided hemiparesis, from a CVA a few years earlier.</p> <p>Physical Therapist notes, dated 11/28/11, indicated "Continue with standing and stepping for improved transfers and pre-gait for when lift shoe comes. Pt had shoe fitted for lift and should have in 1-2 weeks."</p> <p>A plan of care addressing the elevated shoe or documentation concerning the resident utilizing a lift shoe was lacking.</p> <p>A CNA nursing assignment sheet, received on 2/14/12 at 12 noon, from the MDS (Minimum Data Set) Coordinator, did not address the resident as requiring a lift shoe, and indicated the resident was independent in a wheelchair.</p> <p>An admission assessment, dated 9/24/11, indicated the resident required extensive assist of one person with transfer and was totally dependant for locomotion on the unit.</p> <p>A quarterly assessment, dated 12/20/11, indicated the resident as requiring extensive assist of two</p>			

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	<p>persons during transfers and extensive assist of one person for locomotion on the unit.</p> <p>During interview of the Physical Therapist on 2/14/12 at 11:06 a.m. the physical therapist indicated the resident received the shoe lift about a week after he ordered it on 11/28/11. The physical therapist indicated the resident had been admitted to the facility with a fractured left hip which was the reason the resident was receiving therapy.</p> <p>b. On 2/9/12 at 2 p.m., LPN #1 and CNA #2 transferred Resident #53, utilizing a gait belt, from a wheelchair to a shower chair to take the resident to the bathroom. The CNA placed her arm under the resident's right arm pit and one hand on the gait belt. The CNA removed her hand from the gait belt to lower the resident's slacks. The resident's knees were bent during this transfer, pressure of the resident's weight was on the resident's armpit.</p> <p>Resident #53's clinical record was reviewed on 2/9/12 at 2:30 p.m.</p> <p>An admission date was noted of 9/13/11. Admission diagnoses were noted of, but not limited to, Fracture</p>			

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	<p>of Left Hip, Late effect, left sided hemiparesis, from a CVA a few years earlier.</p> <p>A CNA nursing assignment sheet, received on 2/14/12 at 12 noon, from the MDS (Minimum Data Set) Coordinator, addressed the resident as requiring assist of two persons during transfers.</p> <p>An admission assessment, dated 9/24/11, indicated the resident required extensive assist of one person with transfer and was totally dependant for locomotion on the unit.</p> <p>A quarterly assessment, dated 12/20/11, indicated the resident as requiring extensive assist of two persons during transfers.</p> <p>Policy and procedure received from the Administrator on 2/14/12 at 11:24 p.m., titled "Gait Belt Use" indicated the gait belt's following purposes, but not limited to, was to Provide a handle for staff to provide support for the resident, Ensure the safety of both staff and resident and when doing a two person transfer, the belt should still be used to guide and assist with lifting.</p>				

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	<p>B.2. On 2/9/12 at 10:15 a.m., Resident #41 was observed napping in a recliner in the resident's room. The foot rest of the recliner was raised. A clip personal alarm was observed attached to the right upper shoulder of the resident's clothing and the alarm box was sitting on top of the back of the chair, not secured. Both parts of the device were within reach of the resident. The call light was observed not within reach of the resident.</p> <p>Resident #41's clinical record was reviewed on 2/9/12 at 10:35 a.m. The resident's diagnosis included, but was not limited to Alzheimer's disease. A Minimum Data Set [MDS] assessment, dated 1/17/12, assessed the resident with memory impairments, required extensive assistance of one for transfers, total assistance of one for toilet use and total assistance of two for bed mobility.</p> <p>An episodic Care plan was noted, dated 1/23/12, which addressed fall onto buttocks. Approaches included, but were not limited to: " Keep call lite [sic] and personal items within reach. Reinforce safety awareness, encourage res [resident] to call for assist. Follow up charting X [times]</p>	F0323	<p>It is the policy and standard of practice of this facility ensures that the residwent environment remains as free of accident hazards as is possible, including the presence and/or use of side rails.1. What corrective action will be done?A. The bottom rails on both left and right side of the beds of residents #41, #51 and #63 have been secured with zip ties, due to the fact the rails are not able to be removed from the bed, for safety. None of the residents were utilizing the lower bed rail.B.1 A foot rest was immediatly (2/9/2012) placed on resident #53 wheelchair. Resident was screened by PT/OT to assure safe practice was in place. The care plan and C.N.A. assignment sheet has been updated to reflect the lift shoe and outcome of the therapy screen.b. C.N.A. #2 has received disciplinary action requiring gait belt usage and safe transfersB. 2 Resident #41 has been reassessed and her tag alarm has been discontinued in the recliner.Direct care staff will be re-educated by 3-15-12 by the therapy department re: appropriate utilization of the gait belt during transfers.2. How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?A. A complete room check was completed during the survey to identify any additional beds</p>	03/15/2012	

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	<p>72 hrs [hours] Merry Walker, Monitor for fatigue unsteadiness. Notify res, family and responsible party."</p> <p>A plan of care, dated 6/7/10, was noted of "I am at risk for injury/falls due to taking an antianxiety medication and my wandering behavior. Interventions included, but were not limited to, 4/28/11- Merry Walker for independent ambulation ...educate staff not to leave res for long periods of time unattended ..7/13/11 tag alarm while in recliner and/or bed; 12/9/11 place in my recliner after meals and toileting."</p> <p>Manufacturer's direction for the deluxe Attendant Magnet Alarm, provided by the Administrator on 2/15/12 at 10:05 a.m. included, but not limited to, "Stays with resident-clip attaches securely to resident's clothing; alarm attaches to wheelchair, headboard or bed rail utilizing S-shaped spring steel clip."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>		<p>with bottom side rails that had the potential for entrapment. Any beds with risk factors have had their bottom rails secured with zip ties.B. 1 All residents in wheelchairs were assessed on 2/24/12. A list was made of those residents who did not have footrests. This list was given to therapy to screen to determine if the use of foot rests would be appropriate for these residents. All therapy screens have been completed and reviewed by the Interdisciplinary team. Changes have been implemented and care planned and placed on the C.N.A. assignment sheet. One resident of the nine did refuse footrests and this has been care planned.b. Any resident who is transferred using a gait belt is at risk.B. 2 All residents were assessed and no other residents were affected.3. What measures will be put into place to ensure this practice does not recur?A. All beds entering this facility will be evaluated by the Maintenance Supervisor for resident safety. Staff will be educated no to remove zipties from bottom rails of beds, by the Administrator, by 3/15/12.Monitoring of bedrails has been placed on the weekly maintenance log. Any non complinace in the use of bed rails will result in disciplinary action.B. 1 & b. B. 2 Therapy will re-educate staff on correct transporting of residents in a wheelchair by 3/15/12. The SDC</p>		

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			<p>will re-educate staff regarding the use of footrests on those applicable residents and correct positioning of tag alarmson 3/6/12. Staff will also be educated by the therapy department regarding safe transfers and the use of gait belts.B. 1 The DON or designee will check residents in wheelchairs to assure footrests and other adaptive positioning devices are in place, as deemed appropriate, 5 times weekly for the next month, then they will check on a weekly basis for the next 3 months. In addition, the DON and SDC will observe for proper use of foot rests and other adaptive devices as part of their frequent rounds made during each tour of duty. b. As part of the DON and SDC checking for use of footrests and other positioning devices, they will observe staff performing transfers while utilizing a gait belt at the frequency indicated in the previous paragraph.If discrepancies are noted during any observations, the staff will immediately be re-educated regarding the facility policy. Progressive disciplinary action will be taken for continued noncompliance. 4. How will the corrective action be monitored to ensure the deficient practice does not recur?The DON, SDC and Maintenance Supervisor will bring the results of the audits and observations to the QA&A</p>	

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			Committee monthly meeting for review. Recommendations made by the committee will be followed up by the designated person and the results of those recommendations will be brought back the the next scheduled committee meeting for futher review. The documented auditing of these areas will cointinue after the time periods specified in this plan at the discretion of the committee after 100% compliance has been reached,. Even when the documentation is no longer required by the committee, the monitoring itself will continue on an ongoing basis.		

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F0353 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 interview, observation and record review, the facility failed to provide sufficient staffing to ensure resident needs were adequately met regarding transfers, toileting, changing, monitoring of alarms, and/or being put to bed for 5 of 5 residents reviewed in the stage II sample of 42 (Residents #32, 63, 12, 50 and 17).</p> <p>Findings include:</p> <p>1). During interview on 02/08/12 at 11:07 a.m., Resident #32 indicated</p>	F0353	It is the policy and standard of practice for this facility to provide services by sufficient numbers on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and needs.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?Residents #32, #12, #63, #50 have been interviewed daily by their Guardian Angel beginning 2/16/12 and have voiced no concerns regarding timely provision of care.Resident #17 has expired.2. How other	03/15/2012			

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	<p>that she sometimes had to wait to have a bowel movement for an hour or longer, or had to wait an hour or longer to be put to bed, or to be changed due to insufficient staff because of staff having to use stand-up lift to transfer as it took 2 staff members.</p> <p>Record review of Resident #32 on 02/10/12 at 2:16 p.m., indicated the resident was admitted to the facility with the diagnoses of chronic respiratory failure, HTN (hypertension), DM type II (diabetes mellitus type II), anemia, OA (osteoarthritis), chronic constipation, and morbid obesity.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 02/09/12, indicated: The resident's BIMS score was 15 which indicated no cognitive impairment. The resident required assist of 2 for transfers and toileting.</p> <p>February 2012 Physician's orders included, but were not limited to medications which would predispose a resident to require frequent toileting:</p> <p>Bumex 2 mg (milligrams) po (by mouth) daily for fluid retention (08/11/11)</p>		<p>residents having the potential to be affected will be identified and what corrective action will be taken?All residents have the potential to be affected, but no other residents have been identified at this time.However, if there are any issues or concerns expressed by the resident, it will be written onto the Resident/Family concern form and taken to the Administrator for review with the IDT and follow up. All efforts to resolve the concern, as well as the actual resolution will be documented on the concern form itself. During this process, if any staff is identified as having been involved in the concern without reporting it prior to the Administrator's or IDT member's knowledge that a concern existed,they will be retrained by the Administrator or designee regarding the facility's policy and procedure for noting concerns, writing them on the appropriate form, and giving them to the department manger or Administrator as quickly as possible so that resolution can be obtained. Progressive disciplinary action will also be rendered for continued non-complainance.3. What measures will be put in place to ensure that the deficient practice does not recur?The facility Guardian Angels which consist of facility Department managers were re-educated by the Administrator on 2/17/12</p>		

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	<p>HCTZ 12.5 mg po q (every) evening for fluid retention (08/03/11)</p> <p>Aldactone 25 mg po q evening for fluid retention (08/03/11)</p> <p>Colace 100 mg po bid (twice daily) for stool softener (10/11/11)</p> <p>Social Service notes from December 01, 2011 to January 06, 2012, indicated no documentation was present to indicate resident had concerns/complaints regarding care.</p> <p>Review of the grievance log on 02/14/12 at 9:59 a.m., for the months of August 2011 through January 2012 indicated the resident had voiced concerns regarding being put to bed/changed and about not enough staff. Log did not address how issues were resolved only that "HFA (Administrator) talked with res."</p> <p>During interview on 02/14/12 at 2 p.m., the Administrator indicated she was aware the resident had complaints regarding staffing and not being toileted, being changed, and/or put to bed, which had necessitated the Administrator checking in with the resident on a daily basis regarding care for the past couple weeks.</p>		<p>regarding revision of the interview form, content of the interview, resolution time frame, and response to concerns. The SSD was also re-educated by the Administrator regarding thorough documentation, resident interviews and staff interviews required to assure the resident concern was completely addressed. If additional staff is required to satisfactorily resolve concerns the Administrator will evaluate the situation and designate others, as deemed necessary. Residents are assigned a Guardian Angel upon admission who visits his/her assigned residents at least 5 days a week. During these visits, the residents are encouraged to voice any complaints/concerns regarding care or any other issue. Expressed concerns are written onto the Resident/Family concern form. The results of the visits are brought to the next scheduled interdisciplinary morning management meeting which occurs that same day and meets 5 times a week. Any concerns brought to and discussed in the meeting are addressed immediately by the appropriate department head for resolution. The goal is to resolve the concern within 72 hours or sooner depending on the severity of the concern. The Social Service Designee will follow-up with the resident within the designated</p>		

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	<p>During interview on 02/15/12 at 10 a.m., Resident #32 indicated she had spoken with the Administrator several times regarding insufficient staffing and the Administrator indicated "staffing was sufficient for the number of residents."</p> <p>2). On 2/9/12 at 1:20 p.m., LPN #1 and CNA #2 transferred Resident #63 with a stand up lift (med/care) from the wheelchair to a shower chair to place the resident over a toilet. The staff pulled the resident's brief down. The resident's brief was soiled with feces and urine. The resident's bottom and upper thighs were heavily indented and red.</p> <p>The resident was placed over the toilet. The resident had small bowel movement.</p> <p>During interview of LPN #1, the LPN indicated the resident was gotten up in a wheelchair around 7:30 a.m. The LPN indicated the resident "will usually tell us when she needs to go. She was really wet today."</p> <p>During interview of CNA #2 on 2/9/12 at 1:20 p.m., the CNA indicated the resident had not been placed on toilet since 7:30 a.m. until now (at 1:20 p.m.)</p>		<p>time frame of 72 hours or sooner if necessary to assure the concern has been addressed with resolution. The SSD will also follow up weekly times 2 with the resident to make sure the resolution was effective and the resident has no further complaints. She will document her follow up on the back of the concern form and will forward the completed form to the Administrator for final review before filing. If the concern has not been resolved, the Administrator will follow up with the resident and/or family to discuss and find a mutually agreed upon resolution if possible. The Administrator will also document her conversations and activities on the back of the concern form where indicated. ADDITION: The families of non-interviewable as well as interviewable residents are contacted on a weekly basis by an assigned staff member to determine if there are any complaints or concerns. If a concern is voiced the facility grievance/concern form is initiated and reviewed by the administrator and appropriate department head. An investigation and resolution is required within 72 hours. The family member and or resident will then be notified by the department head of the resolution to assure the concern has been appropriately addressed and the</p>				

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	<p>During interview of CNA #7 on 2/14/12 at 10:46 a.m., the CNA indicated resident #63 was up when she came on at 5:30 a.m. The CNA Indicated she took resident to the bathroom before breakfast and the resident had a large BM. The CNA Indicated once in a while the res will request to go to the bathroom but "I just go in and check to see if she needs to go."</p> <p>Resident #63's clinical record was reviewed on 2/14/12 at 11:55 a.m.</p> <p>An admission date was noted of 1/12/12</p> <p>A diagnosis was noted of , but not limited to, Left side/paralysis post CVA (cerebral vascular accident).</p> <p>With a goal of "I will decrease the number of daily episodes of urinary incontinence."</p> <p>A plan of care was noted, with a problem identified as onset date of 1/18/12, of "I am frequently incontinent of urine." With a goal of "I will decrease the number of daily episodes of urinary incontinence." Approaches were noted of, but not limited to, the following, Provide me</p>		<p>family and or resident is satisfied with the resolution. Follow-up will occur within 7 days and also within 14 days to assure the concern has been resolved. 2) The DON/Staff Development Coordinator (SDC) will perform peri care observations per an audit tool daily at least 5 days per week for 4 weeks per resident's plan of care and C.N.A. care guide. Observations will then continue weekly ongoing. If non-compliance is noted during the observation, the staff will immediately be re-educated regarding the resident's plan of care and C.N.A. care guide and facility policy. Disciplinary action will be taken for continued non-compliance. 4. How the corrective action will be monitored to ensure the deficient practice will not recur?The Administrator and SSD will bring the Guardian Angel rounds, concerns and resolutions to the monthly QA&A committee meeting for review of outcomes and any trends or patterns of concerns that are indicative of other action that needs to be taken. Any recommendations made by the committee will be given to the designated manager for follow up. He/She will bring the results of those recommendations to the committee at the next monthly meeting for further review. All aspects of this response will continue on an ongoing basis. ADDITION:The grievance</p>	

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	<p>verbal cueing and assist me to bathroom or commode as needed.</p> <p>3). On 2/7/12 at 10:30 a.m., Resident #12 was interviewed. During the interview the resident indicated she did not feel there were enough staff to take care of her. The resident indicated she has had to wait for long periods of time for assistance, but was unsure of how long. The resident did not elaborate on any specific circumstances.</p> <p>Resident #12's clinical record was reviewed on 2/7/12 at 2:00 p.m. The Minimum Data set [MDS] assessment, dated 11/25/11, assessed the resident with no cognitive or memory impairments.</p> <p>4). During the interview of the Administrator and Social Service Director on 2/14/12 at 2 p.m., the Administrator indicated the following concerns were reported to the facility by residents:</p> <p>a. On 12/6/11, Resident #12 reported</p>		<p>log is reviewed monthly at the QA &A meeting to identify trends and assure follow-up is ongoing with effective results. 2) The DON or SDC will bring the results of peri-care audits to the QA &A Committee for review and recommendations. Further review of audits will be at the discretion of the QA committee once 100% compliance is achieved.</p>		

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	<p>the concern of wanting her clothes changed before lunch and CNA #5 indicated to the resident she had all of these other things to do. The Administrator indicated that during her investigation and follow up the CNA was not asked if there was enough staff to allow her to complete her tasks for residents.</p> <p>b. On 12/16/11, Resident #50's spouse reported the concern of Resident #50 not being changed and lack of politeness of staff. The Administrator indicated the staff was inserviced regarding Charge nurses ensuring the CNAs were doing jobs and Charge nurses overseeing the CNAs. The Administrator indicated the nursing staffing pattern was not reviewed.</p> <p>c. On 12/20/11, Resident #32 reported the concern of not being put to bed when requested. The Administrator indicated that when the concern was discussed with CNA #6 (CNA responsible for evening care on the resident's unit), the CNA told the Administrator it was difficult to care for 20 or more residents in an 8 hour shift. The Administrator indicated she talked with corporate at that time about adding staff for the evening shift.</p>			

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	<p>d. On 11/16/11, another resident's family member reported that Resident #17 was observed to activate personal alarm by standing while in the lounge area at 5:15 p.m. The family member indicated there were no staff in the area to answer the sounding alarm. The Administrator indicated the staffing pattern was not reviewed and that she was unsure if there were staff in the area or not during the incident.</p> <p>Interview of the Corporate RN on 2/14/12 at 3:20 p.m., indicated she had reviewed previous emails and that the facility had considered increasing staff on evening; however, the evening staff had not been increased.</p> <p>5). Interview of Resident #21 on 2/7/12 at 3:30 p.m., indicated she was concerned with having enough staff available to assist her roommate (Resident # 32). The resident indicated the staff did not come and check on her roommate every two hours like they were supposed to and that the roommate's call light took too long to be answered when she wanted to go to bed.</p> <p>Review of clinical record of Resident</p>						

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	<p># 21 on 2/15/12 at 2 p.m., indicated the most recent Minimum Data Set (MDS) assessment was completed 11/15/11. The assessment identified the resident with cognition intact.</p> <p>6). During interview of Resident #62 on 2/7/12 at 3:32 p.m., the resident indicated she was upset about another resident (Resident #32). Resident #62 indicated after meal time Resident #32 will request to go to the bathroom. Resident #62 indicated after meals it usually takes her about 40 minutes to perform her personal hygiene and go back down to the dining room/ lounge area. Resident # 62 indicated when she (resident #62) returns to the dining room/lounge, resident #32 is usually still waiting to be placed on the toilet.</p> <p>Review of the nursing schedule, CNA assignment sheets, and facility census on 02/15/12 at 12 p.m., indicated the following:</p> <p>Facility census was 45 residents most of which were dependent for care and assistance of at least one.</p> <p>Days: Four- 8 hour (hr) CNA's Evenings: Two- 8 hr CNA's and one-</p>				

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	<p>4 hr CNA Nights: Two- 8 hr CNA's</p> <p>During interview of the Administrator on 2/15/12 at 2:30 p.m.. the Administrator indicated the Quality Assurance Committee (QA) identified a significant increase in number of family concerns from September 2011 to October 2011. The Administrator indicated the family concerns decreased from October 2011 to November and December 2011. The Administrator indicated the Quality Assurance Committee had identified care issues were most prevalent on evening shift. The Administrator indicated the committee had identified the possibility of hiring a CNA for the 4-9 shift. The Administrator indicated the extra CNA was not hired for the 4-9 p.m. shift. The Administrator indicated the January 2012 concerns of care issues were not prevalent on any one shift.</p> <p>3.1-17(a)</p>				

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F0441 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 failed to</p>	F0441	It is the policy and standard of practice of this facility to maintain	03/15/2012			

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	<p>ensure the prevention and transmission of disease and infection related to following established policy and procedures for Clostridium Difficile (C.Diff) for 1 of 1 resident identified with C. Diff in the Stage 2 sample of 42. (Resident #54). In addition, the facility failed to ensure staff changed gloves to prevent contamination of resident items for 1 of 5 residents observed during incontinence care in the Stage 2 sample of 42. (Resident # 35)</p> <p>Findings include:</p> <p>1). Observation on 02/09/12 at 12:49 p.m., Resident #54 was observed being put to bed by CNA #10 and #11. Both CNA's washed their hands before touching the resident. A gait belt was applied to the resident while in the w/c (wheelchair) and the resident was transferred to bed. The resident had been incontinent of loose stool, with the brief removed and incontinence care provided by CNA #11. CNA #10 held a clear trash bag for the other CNA to place soiled disposable products. Both CNA's removed their gloves and washed their hands appropriately. Neither CNA were observed to wear a gown, nor were any signs in the resident's room to indicate either</p>		<p>an Infection Control Program that is designed to provide a safe, sanitary and comfortable environment and to help prevent the transmission of disease and infection including when caring for residents with C. Difficile.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?Resident #54 was placed in a private room on 2/09/12 with gowns and gloves located at the entry to the room. Signage has been placed on the door alerting visitors to contact the nurse prior to entering the room. Housekeeping staff was educated on 2/10/12 regarding proper disinfection procedures which includes the appropriate disinfectant agent for C-Difficile.2. How other residents having the potential to be affected will be identified and what corrective action will be taken?No other resident has been affected. Resident #51 has exhibited no signs or symptoms of C-Difficile. Resident #51's room was deep cleaned on 2/10/12. If a resident has a diagnosis of C-Difficile the person will be placed in a private room or cohorted. Cohorting would only occur after both residents were thoroughly assessed and were deemed safe.If a current resident or newly admitted resident is diagnoed with C-Difficile, all staff will be notified of the diagnosis via the morning meeting, the</p>		

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	<p>resident was in isolation. There was not any other personal protective equipment in the resident's room. During this time CNA #10 indicated Resident #54 had C-diff and was dependent for all care with the roommate (Resident #51) ambulatory per self with this resident not having C-diff and toileted self.</p> <p>Review on 02/10/12 at 9:43 a.m., of Resident #54's clinical record indicated:</p> <p>The resident was admitted to the facility with diagnoses which included, but were not limited to, pneumonia, stroke with right-sided hemiplegia, affective disorder, moderate cognitive impairment, and malnutrition. The resident had been receiving antibiotics at the time of admission for pneumonia.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 01/13/12, indicated the resident was not alert to time, was dependent for all care and was non-ambulatory, was incontinent of both bowel and bladder, and had the behavior of being socially inappropriate.</p> <p>Nurse's notes with the following dates indicated the resident had the</p>		<p>communication book, the 24 hour report form, and the daily C.N.A. assignment sheet. A sign will also be placed on the resident's door advising visitors to "check with the Nurse prior to entering room." The Housekeeping Supervisor informs the housekeeping staff daily of any resident with an infection via a communication board that is placed on the housekeeping cart and updated when needed.3. What measures will be put into place to ensure that the deficient practice does not recur?Facility staff will be re-educated by the Administrator and DON on 3/06/12 regarding the facility policy r/t C-Difficile and how communication will be received which will alert staff to any resident with infectious process. The re-education will include the signage, when to wear protective gowns and the proper disinfecting product for a resident with C-Difficile.(12) C.N.A. #2 was counseled regarding proper peri-care which includes when to wash hands and change gloves. The nursing staff will be re-educated by the SDC on the policy and procedure regarding incontinent care which includes standard precautions of washing hands and changing gloves. This will occur on 3/06/12.The DON and SDC will monitor care of those residents diagnosed with C-Difficile to assure signage is posted, and staff is following the</p>		

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	<p>behavior of "playing in BM (feces)": 11/16 and 12/09/11, 01/07, 01/08, 01/11, 01/14, 01/23, and 02/06/12.</p> <p>Care plans: "11/10/11. Problem: Incontinent and smears feces on bed, call light, window sill...Interventions...Universal Precautions..." 10/14/11: C-diff...Universal Precautions..."</p> <p>Telephone orders included:</p> <p>02/04/12- Vancomycin 500 mg (milligrams) po (by mouth) tid (three times daily) and Flagyl 500 mg po bid (two times daily) for positive test for C-diff.</p> <p>During interview on 02/07/12 at 11 a.m., QMA #13 indicated the resident was incontinent of bowel and bladder, wore incontinence briefs, and was checked and changed at least every 2 hours and as needed by staff. The QMA further indicated the resident had just recently tested positive for C-diff and did not use the toilet.</p> <p>2). On 2/7/12 at 2:00 p.m. and 2/10/12 at 10:45 a.m., Resident #51's room was observed. Resident #51 shared the room with Resident #54. No isolation signage or protective personal equipment, other than disposable gloves were observed in</p>		<p>facility policy and procedure for infection control r/t C-Difficile as part of their routine rounds during each tour of duty. The housekeeping supervisor will observe housekeeping staff daily for 1 week then weekly for 1 month to assure the correct disinfectant agent is being used and all areas of the resident room are being properly disinfected. If any concerns are noted during these monitoring activities, the department manager will re-train the staff involved on the facility policy and disciplinary action will be used for continued non-compliance.4. How will the corrective action be monitored?The DON, SDC and Housekeeping Supervisor will bring the results of the auditing to the QA&A Committee at the monthly meeting for review and further recommendations for process improvement. Once 100% compliance has been achieved in the observation and monitoring, the committee may decide to stop the documented audits; however, the monitoring rounds and activities will continue to be done on an ongoing basis.</p>				

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	<p>the residents' room.</p> <p>Resident #51's clinical record was reviewed on 2/15/12 at 1:58 p.m. The resident's diagnoses included Dementia with behavioral disturbance. The resident did not have a diagnosis of Clostridium difficile.</p> <p>A Minimum Data Set [MDS] assessment, dated 8/13/11, assessed the resident with moderate cognitive impairment, limited assistance of one for transfers, independent for ambulation. Extensive assistance of one for toilet use, continent of bowel and bladder. The assessment coded the resident with the behavior of wandering 1 to 3 days of assessment period.</p> <p>On 2/10/12 at 10:35 a.m., CNA #11 was interviewed. The CNA indicated Resident #51 can ambulate independently and can take self to the bathroom.</p> <p>3). Interview of Housekeeper #20 on 2/10/12 at 10:20 a.m., indicated there were no residents currently in precautions. The housekeeper was observed to be working the unit where Resident # 54 resided. The</p>						

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	<p>housekeeper indicated she utilized "Mint Quat Disinfectant" to clean the resident room i.e. tables, bed , and bathroom. The housekeeper also indicated she utilized a cleaner with bleach, but was "not sure of the concentration" and the bleach cleaner was utilized only in the bathroom. According to the housekeeper, the mop water concentration was automatically dispensed from a wall unit in housekeeping closet and that the mop heads were changed after being used in every 3rd resident room. The housekeeper also indicated if precautions were in place that the mop head would be changed after the room in precautions. The housekeeper indicated Resident #54 currently had no precautions. The housekeeper indicated that gloves and gowns would be utilized while cleaning rooms with precautions implemented.</p> <p>Housekeeper #20 was observed to utilize gloves while cleaning the resident room on 2/10/12 at 10:20 a.m.</p> <p>4). Interview of Housekeeper #21 on 2/10/12 at 10:25 a.m., indicated "Neutral Floor Cleaner" was utilized to clean the floors in residents' rooms. The Housekeeper also indicated "Mint</p>			

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	<p>Quat" was used to clean the residents' rooms i.e. beds and tables and that the bleach concentration was utilized in the bathroom.</p> <p>5). Review of the 24 hour report provided by the Administrator on 2/10/12 at 11:20 a.m., indicated Resident #54 was positive for Clostridium Difficile.</p> <p>6). Review of the communication book maintained at the nursing station on 2/10/12 at 11:30 a.m., indicated "Re: [Resident #54] After toileting episodes on the commode. Please be sure to sanitize the commode with disinfectant "Mint Quat" which is in the east wing soiled utility room each time" and Contact Precautions in place- Resident in this room if Positive for C-diff [Clostridium Difficile]- Gloves and Hand Hygiene with soap and water, are mandatory with patient care or housekeeping.</p> <p>7). Interview of the Housekeeping Supervisor on 2/10/12 at 12:10 p.m., indicated the "Quat" disinfectants were utilized in all resident rooms and the bleach cleaners were utilized in the bathroom only.</p> <p>8). Interview of the Administrator on 2/10/12 at 12:30 p.m., indicated the</p>				

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	<p>"Quat" disinfectants were not effective according to manufacturer's guidelines for Clostridium Difficile.</p> <p>9). Interview of the Assistant Director of Nursing (ADON) on 2/10/12 at 10:30 a.m., regarding Precautions for Resident #54 indicated the staff were made aware of the precautions with CNA assignment sheets and 24 hour nursing reports. Resident #54 was indicated to be in "Contact Precautions." The ADON indicated the precautions were not posted on Resident #54's door. The ADON was unaware as to how visitors and families were informed of the resident's precautions. The ADON also indicated if staff noted the resident to be incontinent of feces, then gowns should be utilized. The ADON indicated Resident #54 was the only resident with C-diff.</p> <p>Interview of the ADON on 2/10/12 at 11:20 a.m., indicated she was unsure why staff had not been instructed to wear gowns when caring for Resident #54.</p> <p>10). Interview of the Administrator and ADON on 2/10/12 at 11:30 a.m., indicated the reason for Resident #54 being roomed with another resident was due to the resident needing to be</p>				

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	<p>around people. The Administrator indicated private rooms were available.</p> <p>11). Review of the facility's current policy and procedure titled " Clostridium Difficile Infection" dated 6/2008 on 2/10/12 at 11:10 a.m. indicated "POLICY: It is the policy of this facility to prevent, treat, and control the spread of Clostridium Difficile in residents who are exhibiting diarrhea stools due to the infection in the following situation: When the resident is incontinent and soiling of the environment is likely; When the resident is noncompliant with basic personal hygiene and handwashing; When contaminated stool cannot be contained; and/or ; When the resident is confused and cannot comply with appropriate hygiene measures...PREVENTING CLOSTRIDIUM DIFFICILE: ...Use contact precautions for know [sic] or suspected Clostridium Difficile: Place these residents in a private room or cohort; Wash hands frequently with soap and water; Use gloves when entering resident's room and during resident care; Use gowns if soiling of clothes likely; Dedicate equipment whenever possible...CLEANING AND DISINFECTING THE ENVIRONMENT: Ensure adequate</p>			

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	<p>cleaning and disinfection of environmental surfaces and reusable devices, especially items likely to be contaminated with feces and surfaces that are touched frequently; Use an Environmental Protection Agency (EPA) registered hypochloride-based [sic]disinfectant for environmental surface disinfecting after cleaning in accordance with label instructions; generic sources of hypochloride [sic] (e.g. household chlorine bleach) also may be appropriately diluted and used. NOTE: alcohol based disinfectants are not effective against Clostridium Difficile and should not be used to disinfect environmental surfaces; The resident's room should be cleaned last, and the water and mop head changed prior to cleaning another room. STAFF RESPONSIBLE: RN, LPN, Nursing Assistants, Housekeeping Staff. "</p> <p>12). On 2/9/12 at 1 p.m., LPN #1 and CNA #2 were observed to transfer Resident #35 with the "sit to stand lift." The resident was toileted utilizing a bedside commode. The resident was observed to sit on the commode and did not void. With gloves on, CNA #2 was observed to wipe skin with wet disposable cloth. As the CNA was pulling up the resident's brief, the resident was observed to begin</p>			

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	<p>having a bowel movement. The resident was observed to be sat back down on the commode. The LPN and the CNA were observed to remove their gloves and wash their hands. The LPN and CNA were observed to apply new gloves. The resident was again positioned to a standing position with the lift. CNA #2 was observed to wipe the resident's skin attempting to remove the bowel movement with dry toilet paper. Peri care was observed not to be completed. Without changing the contaminated gloves, CNA #2 was observed to apply a new disposable brief to the resident, transfer the resident to the bed with the sit to stand lift, move the bedside commode, and adjust the resident's pillow under the resident's head. The CNA was then observed to remove the contaminated gloves.</p> <p>Review of the facility's current policy and procedure titled "Standard Precautions" [no date] on 2/10/12 at 11:10 a.m. indicated "...Handwashing: Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to</p>						

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	<p>avoid transfer of microorganisms to other residents or environments. It may be necessary to wash hands between tasks and procedures on the same resident to prevent cross-contamination or different body sites.... Gloves: Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and nonintact skin. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments..."</p> <p>3.1-18(b)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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