STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING 00 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BRENTWOOD	30 EAST CHANDLER AVE EVANSVILLE, IN47713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Recertification and State Licensure survey. This survey visit included the investigation of Complaint #IN00093538 and Complaint #IN00093878. Complaint Numbers: IN00093538 substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F309. IN00093878 substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226, and F282 Survey Dates: July 11, 12, 13,14, 15, 18, 19, 20, 21, 22, 2011 Facility number: 000152 Provider number: 155248 AIM number: 100267510 Survey team: Amy Wininger RN, TC Diane Hancock RN Census Bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Medicaid: 65 Other: 7 Total: 83 Sample: 17 Supplemental Sample: 14 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 7/28/11 Cathy Emswiller RN			

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F0157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified for high blood sugars, in accordance with the physician's orders, for 1 of 3 residents reviewed for diabetes management, in the sample of 17. (Resident C)	F0157	**F157** The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: RC is no longer a resident at the facility. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as	08/21/2011

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	Finding includes: Resident C's clinical record was reviewed on 7/15/11 at 9:50 a.m. The resident was admitted to the facility at 4:00 p.m. on 6/22/11, via family car, with diagnoses including, but not limited to, aortic stenosis status post aortic valve replacement on 6/15/11, atrial fibrillation status post epicardial maze procedure on 6/15/11, peripheral artery disease-carotid artery, depression, coronary artery disease, type 2 diabetes mellitus, and previous chronic anticoagulation discontinued 5/2011 due to anemia. The resident arrived after being discharged the same day from an out of town hospital. The resident's discharge instructions included medication orders that included, but were not limited to, the following: Glipizide [to treat high blood sugar due to diabetes] 5 mg [milligrams] oral 1 tablet by mouth two times a day Metformin [glucophage] [to treat high blood sugar due to diabetes] 500 mg oral tablet 1000 mg by mouth two times a day Additional instructions were to "...treat blood sugars before all meals and bedtime. Call facility physician if less than 80 or over 200." The record indicated a local physician		follows: All other residents with an order for sliding scale insulin have been reviewed and if notification was needed the physicians have been notified. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: All licensed staff was educated by 8/19/11 related to family and MD notification with change including but not limited to, blood sugar readings noted to be outside of the parameters specified in the physician's order. DNS/Designee will ensure audits of blood sugar results and verification of MD notification will be completed 3 x weekly for 4 weeks, 2 x week for 4 weeks, weekly for 4 weeks then monthly x 3 months. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed.	

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	visited the resident on 6/24/11 and ordered the following: "Novolog Insulin to be given dependent on A/C [before meal] blood sugars." A sliding scale for insulin coverage was specified as follows: "0-150 - [no] insulin, 151-200 - 2 units, 201=250 - 3 units, 251-300 - 4 units, 301-350 - 5 units, 351-400 - 6 units >400 - call MD." Review of the Medication Administration Record, treatment record, and nurses' notes indicated the first time a blood sugar was checked was 6/24/11 at 1600 [4:00 p.m.]. Blood sugars were documented as follows: 6/24/11 2100 [9:00 p.m.] 262 6/26/11 2100, 234 There was no indication the physician was notified of the blood sugars greater than 200. There was no indication the physician was notified of any blood sugars until 6/26/11 at 17:09 [5:09 p.m.]. The nurse's note indicated, "Refused Glucophage at 1700 [5:00 p.m.]. Accucheck 87. Resident states she doesn't want her blood sugar to get any lower. Dr. [name] notified." And on 6/27/11 at 04:21 [4:21 a.m.], "Laboratory services here this am [morning] to draw CBC [complete blood count], TSH [thyroid stimulating hormone], HgBA1C [hemoglobin A1C indicates long term			

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	blood sugar levels], and CMP [Complete Metabolic Panel]. Faxed weekly accuchecks to MD for review." LPN # 8 was interviewed on 7/18/11 at 11:17 a.m. She indicated she would have to checked the blood sugars at the 9:00 p.m. blood sugar check on 6/26/11 and the 6:00 a.m. blood sugar on 6/27/11. She indicated she remembered checking them, but didn't recall what they were. She indicated she thought the resident was to receive sliding scale insulin. She indicated the resident would have gotten one of her blood sugar pills at 9:00 p.m., "I would remember if i help medication." She did not recall calling the physician about the blood sugar, but did fax the blood sugar history early in the morning 6/27/11. This federal tag relates to complaint number IN00093538. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0204 SS=D	A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Based on interview and record review, the facility failed to ensure a resident who was being discharged to home received discharge instructions, for 1 of 2 residents reviewed for discharge instructions, in the sample of 17. (Resident #84) Finding includes: The clinical record of Resident #84 was reviewed on 07/14/11 at 3:50 P.M. The record indicated the current diagnoses included, but were not limited, Schizophrenia, Bipolar disorder, and Uncontrolled Diabetes. The Nurse's Notes dated 06/22/11 at 16:20 [4:20 p.m.] indicated, "New order received and noted for resident d/c [discharge] from facility with home health and approp. [appropriate] equipment. Resident left facility at approx. [approximately] 1620."	F0204	F204 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R84 is no longer a resident at the facility. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All licensed staff was educated by 8/19/11 regarding the completion of the discharge summary, reviewing the discharge instructions and proper distribution of documents upon discharge. Licensed staff will document that summary was completed, reviewed with resident and copies of instructions given to resident. Audits of discharge summaries will be completed 3 x weekly for 4 weeks, 2 x weekly for 4 weeks, weekly for 4 weeks then monthly x 3months by DNS/Designee. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: All licensed staff was educated by 8/19/11	08/21/2011

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	The most recent Care Plan, dated 06/14/11, indicated, "I would like assistance in planning my next steps to be able to go home safely when my care/rehab goals are met." The care plan interventions included, but were not limited to, "Help me with developing transition strategies that will make my leaving go smoothly." The unsigned and undated Interdisciplinary Discharge Summary lacked documentation that Resident #84 had received discharge instructions. In an interview with the DoN [Director of Nursing], on 07/14/11 at 4:00 P.M., she indicated, "I have no proof that discharge instructions were given to [Resident #84]." A Policy and Procedure related to transferring a Resident from the facility to home was requested on 05/20/11 at 9:30 A.M. In an interview with RN #6, she indicated, "There is no policy for discharge summaries, we are to fill out the discharge summary form and give the white copy to the resident and keep the yellow copy for the facility. 3.1-12(a)(2)		regarding the completion of the discharge summary, reviewing the discharge instructions and proper distribution of documents upon discharge. Licensed staff will document that summary was completed, reviewed with resident and copies of instructions given to resident. Audits of discharge summaries will be completed 3 x weekly for 4 weeks, 2 x weekly for 4 weeks, weekly for 4 weeks then monthly x 3 months by DNS/Designee. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed.	

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F0223 SS=G	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review, observation, and interview, the facility failed to ensure 1 of 3 residents reviewed for allegations of sexual assault, was free of evidence of sexual assault, in that the hospital record indicated there were signs and symptoms of an assault. The facility failed to ensure facility staff on duty at the time of the allegation were interviewed timely, and failed to ensure two persons cared for the resident prior to the allegation, as indicated in the written plan of care. (Resident E) Finding includes: During interview on 7/19/11 at 1:00 p.m., the Interim Administrator and Director of Nurses [DoN] indicated Resident E had alleged she was raped by a CNA [CNA #6] on the previous night shift. The	F0223	**F223** The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Staff on duty at time of the alleged incident was interviewed on 7/22/11. Inservice was held on 7/22/11 to ensure all staff knew that 2 staff members were to care for Resident E at all times. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All alert and oriented residents were interviewed with no concerns. Residents that were not able to be interviewed had complete body assessments completed 7/20/11 and there were no signs of injury. Care plans were reviewed and C.N.A. care sheets updated and staff educated by 8/19/11 regarding residents requiring 2 staff members present	08/21/2011

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	Administrator indicated the resident had told a CNA [CNA #14], at around 11:30 a.m., who immediately informed the Director of Nurses and the facility had begun investigating. She indicated the resident was being sent to the hospital for examination and the police had been called. The CNA had been notified that he was not to report to work until further notice due to an investigation. During interview on 7/19/11 at 4:00 p.m., the DoN and Administrator indicated a detective from the local police department had been in and asked them not to talk to the alleged perpetrator until he had the opportunity to interview him. The resident was still at the hospital at that time. During interview on 7/20/11 at 8:30 a.m., the DoN indicated the resident had returned from the hospital during the evening and no new orders had been given and no information from the hospital was received. The resident had been placed on one to one observation, where a staff person monitored the room, from the hallway. Two staff were doing all care on the resident. On 7/21/11 at 5:22 a.m., the building was entered. CNAs #8 and #9 were observed working on the 400 hall. CNA #8		to provide care. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Care plans were reviewed and C.N.A. care sheets updated and staff educated on 7/22/11 regarding residents requiring 2 staff members present to provide care. DNS/RNAC/Designee will review and audit C.N.A. care sheets weekly for 8 weeks then every other week for 4 weeks and then monthly x 3 months to ensure all residents requiring 2 staff members for care are correct. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/RNAC/Designee will review and audit C.N.A. care sheets weekly for 8 weeks then every other week for 4 weeks and then monthly x 3 months to ensure all residents requiring 2 staff members for care are correct. ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans written and implemented as needed.	

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	indicated he was brand new and had only been working for a week. He indicated he and CNA #9 had been working as a team. They would get report, pass ice water, start bed checks, do paperwork, then restart bed checks. He indicated, because he was new, they were working together to do bed checks, so he could be introduced by the other CNA and learn what each resident needed. CNA #8 indicated he had not worked on 7/18-7/19 night shift. CNA #9 was then interviewed, at 5:30 a.m. She indicated she had worked Monday [7/18-7/19] night shift, Tuesday, and Wednesday. She indicated she worked 400 hall and CNA #6 had worked 500 hall. She indicated some CNAs chose to work their hall alone and some preferred to work together as a team. She indicated that she had worked by herself on Monday night, 7/18-7/19/11. She indicated she would still go over to the hall if help was needed, or to answer lights. The CNA indicated she had not been questioned by anyone else about that night, any other night, or questioned about anything else. A Hospice RN was present on the unit, at 5:40 a.m. on 7/21/11. She indicated Resident E was on her caseload. She indicated she was requested to come in on			

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	7/19/11 to witness an interview and physical assessment of Resident E. She indicated she and the Minimum Data Set [MDS] assessment coordinator had been in the room together. The resident reported to them she had been raped on the night shift and indicated it was CNA #6 who raped her. She indicated the physical assessment was completed. The resident was wet, so her brief was changed. She indicated they had put the brief and linens used to cleanse the resident in a bag and saved it for the police investigation. She indicated there were no red marks, no significant bruises, except for several small bruises, none of them new, on her arms and knees. There were no red marks. The resident had a flat affect throughout the interview and exam. She indicated the interview and assessment happened "around noon." She indicated, according to the MDS coordinator, the story was consistent. She further stated, "Unfortunately, I know this resident and she's not always truthful." CNA #10 was observed seated outside Resident E's room 5:45 a.m. on 7/21/11 and was interviewed at that time. She indicated the resident and her room were being observed one on one, since 7/19/11 at 11:00 p.m. She had come in at 3:00 a.m. and had been assigned to watch the room and resident. At that time, the			

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	resident was heard to yell "Help, Help." The CNA entered the room and asked the resident what she needed. CNA #10 indicated she had to get help and exited the room to find another CNA to help her. She indicated two staff were doing all care. CNA #11 was observed in the facility at 5:45 a.m. on 7/21/11. During interview at that time, she indicated she was taking over the one on one. She indicated she had heard Resident E had claimed CNA #6 raped her. She indicated she had worked Saturday night, Sunday night, and Monday night, 2:00 a.m. to 2:00 p.m. She indicated no one had questioned her about anything, "no nurse, no Administrator, no DoN [Director of Nurses], no detective..." She indicated staff were to always go with two persons to Resident E's room, even before the allegation, because the resident didn't always tell the truth. Upon observation, RN #5 was administering medications on the 400 and 500 halls on 7/18/11 at 5:50 a.m. She was interviewed at 5:50 a.m. on 7/21/11. She indicated she had worked the night shift 7/18/11 to 7/19/11. She indicated CNAs #6 and #9 had been the CNAs working with her. She indicated nothing unusual happened that night. The resident had not complained of anything to her. She			

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	indicated she had heard from co-workers that Resident E alleged CNA #6 had raped her during that night shift. She indicated she was always in the hallway, or at the nurses' station and heard staff in and out of rooms. She indicated again, nothing unusual occurred. "We all know who she is...when she knows he's working [CNA #6], she's always calling out his name." She indicated she had not had anyone from the facility staff, or anyone else ask her any questions about that night and had received no request for any statement, "You are the first to ask." On 7/21/11 at 8:30 a.m., the Interim Administrator, Corporate Nurse Consultant #1, Corporate Nurse Consultant #2, and the Corporate Director of Operations were interviewed. According to the Interim Administrator, the facility had not initiated staff interviews on 7/19/11. She indicated a police detective had arrived at 3:30 p.m. and indicated he did not want them to interview CNA #6 before he had a chance to do so. She indicated the detective called the CNA from her office and scheduled a time for him to come to the police department for an interview, 5:00 p.m. that date; the facility was not involved in the interview. She indicated the police detective did not ask them not to interview other staff.			

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	155248	A. BUILDING 00 B. WING	07/22/2011

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The Interim Administrator indicated, during the 8:30 a.m. interview, after the police detective's visit, she made a phone call to the corporate legal department. She indicated she was told the legal department would be involved and indicated she was asked not to interview staff, that "counsel needed to be on the ground." The Corporate Nurses indicated the attorney had arrived on 7/20/11 and was returning 7/21/11. They indicated she had done some staff interviews on 7/19/11, but they did not know who was interviewed.

The Administrator indicated, during the 8:30 a.m. interview, it was around 11:30 a.m. Tuesday morning [7/19/11] that Resident E reported the allegation to the CNA. The CNA immediately reported it to the DoN.

The hospital Emergency Department Record, dated 7/19/11, was received from the local hospital Accreditation and Regulatory Nurse, on 7/21/11 at 11:05 a.m. and reviewed at that time. The hospital clinical record indicated the resident arrived at the Emergency Department at 2:23 p.m. on 7/19/11. The chief complaint was "Alleged Sexual Assault." The resident's history included the following diagnoses: Bipolar

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	Disorder anxiety, depression, thyroid disease, and depression. The history and physical information indicated the following: "...female who presents with complaint of sexual assault. She lives at the [Name of Facility]. She stated that she was laying in bed about 4:00 this morning and a man who works there and put his penis in her vagina. She said he put his finger in her vagina as well. She denies any other complaints or injuries aside from the sexual assault." Documentation in the ED [Emergency Department] notes indicated a sexual assault kit was completed and the report indicated the following: debris found and collected from the resident's external genitalia, secretions found and collected externally and internally, abrasions noted in the vaginal canal, shearing force noted, the cervix was reddened and had bruising, abrasions noted internally, visible tears in the area and abrasions. The exam also indicated the resident had a bruise on her right buttock, 1 cm [centimeter] by 3 cm. The police were present for the exam and pictures were obtained. The resident was discharged from the hospital ED at 6:46 p.m. and was returned to the nursing home. The information sent with the resident to the facility only			

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	indicated for to return to the nursing home, resume prior orders, orders for an anti-nausea medication, and directions to report her progress to her physician the next day. Resident E's facility clinical record review began on 7/21/11 at 6:30 a.m. The record indicated the resident was admitted to the facility on 7/23/04 and had diagnoses including, but not limited to, the following: closed dislocation of hip, bipolar disorder unspecified, generalized anxiety disorder, history of urinary tract infection, malignant neoplasm of thyroid gland, unspecified personality disorder, depressive disorder, and hypo-osmolarity and/or hyponatremia, coronary atherosclerosis, congestive heart failure, cardiac dysrhythmias, arthropathy, dementia with behavioral disturbances, esophageal reflux, acute but ill-defined cerebrovascular disease, hypertension, unspecified psychosis. The resident's most recent quarterly Minimum Data Set [MDS] Assessment, dated 5/27/11, included, but was not limited to, the following: Unclear speech, rarely/never understood, rarely/never understands, long term and short term memory problems, severely impaired decision making, disordered thinking, delusions, extensive assistance			

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	of two staff for bed mobility, total dependence of two staff for transfers, and unable to ambulate. She was assessed as always incontinent of bowel and bladder, had signs and symptoms of pain, and had experienced unplanned weight loss. The resident's most recent full MDS assessment, a significant change MDS dated 11/26/10, included, but was not limited to, the following: communication clear, Brief interview for Mental Status score of 05/15, with 15/15 being alert and oriented, no delusions or behaviors identified, extensive assistance of two staff for bed mobility, and transfers, and unable to walk. The assessment indicated she was always incontinent of bowel and bladder, experienced pain, but had experienced no weight loss. The resident was currently receiving hospice services. The nurse aide assignment sheets for the 400 and 500 halls were provided by CNA #10 on 7/22/11 at 10:26 a.m. and reviewed at that time. Under "Special Needs," was indicated the following: "two for care non-skid slipper socks when out of bed BEHAVIORS. HOSPICE roho air mattress KEEP SET ON #4."			

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	Nurses' notes/progress notes were reviewed from 6/8/11 through 7/22/11 and included, but were not limited to, the following: "7/18/11 07:57 [7:57 a.m.] Resident slept well during the night on no pressure mattress, with floor mats on floor for safety." "Late Entry 7/19/2011 12:40 [12:40 p.m.] Note text: Resident reported allegations of abuse, MD [medical doctor] made aware of allegations et new order received for resident to go to er [emergency room] for evaluation et tx [treatment]; poa [power of attorney] [name] notified of residents allegations of abuse et permission obtained for resident to go to [name of hospital] main campus for nessary (sic) tx related to allegations. Residents (sic) poa stated, "THIS WAS OBSERED ET RIDICULOUS ALSO A WASTE OF TIME BUT DO WHAT EVER WE WANTED TO DO." (sic) transportation arranged et resident transported to [name of hospital]." "7/19/2011 16:03 [4:03 p.m.] Resident refused ADL [activities of daily living] care this am [morning] despite 2 attempts by staff." "7/19/11 20:08 [8:08 p.m.] @ 1900 [7:00 p.m.] res [resident] return to [name of facility] on srecther (sic) per ambulance, escorted per 2 [name of ambulance company] personnel. No c/o [complaints]			

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	noted upon return. N.O. [new order] received for Zofran [for nausea] 4 mg Q 6 hrs [every six hours] PRN [as needed] times 3 doses and update Dr. [name] in AM." "7/19/11 23:27 [11:27 p.m.] Res. resting quietly in bed at this time. Res. in good humor, taking meds without difficulty, no periods of anxity (sic), normal demeaner (sic), res. calling out to staff by name as normal in ADLs." "7/20/11 06:55 [6:55 a.m.] "1 on 1 observation started. Resident had uneventful night, mainly sleeping. Verbalized needs and wants. C/O [complaint of] hurting. Reassurance and redirect provided with little success. Roxanol 0.25 ml [milliliters] given @ 0035 [12:35 a.m.] for pain and general discomfort. Resting comfortably during noc's. 1 on 1 observation provided by female staff thru the night. No further C/O of pain or discomfort and was resting comfortable..." "7/20/2011 14:55 [2:55 p.m.] General Note. Providing 1:1 with [name] 2:00 - 2:45 p.m. resident hollered "help." This SSD [Social Service Director] entered room, resident stated she was wet when asked what she needed. Nursing notified of need to provide peri-care. When asked if she remembered going to hospital yesterday, she responded, 'Yes'. (sic) When asked if she knew what the reason			

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	for transfer to hospital was, she responded, 'I was raped'. (sic)..." The resident's record indicated she was being followed by a Psychiatrist. The last visit was dated 6/27/11. The report indicated the behaviors and symptoms she was being seen for were agitation, afraid to die, anxiety, false beliefs, and jittery/nervous. During the visit, the Psychiatrist documented "denies mood or anxiety c/o." Hospice records were reviewed. A Nursing Clinical Note, dated 7/19/11 [no time], indicated the following: "No new orders per facility chart review. PRN [as needed] SNV [Skilled Nurse Visit] R/T [related to] allegation of abuse by facility staff. Requested to be present during questioning of pt. by facility RN MDS [name] RN. Witnessed. Pt. [with] [no] physical/mental/emotional s/s [signs/symptoms] abuse @ this time during this assessment. Pt. out [and] back to ER for evaluation. No results given to this RN." The Hospice Social Worker visited the resident on 7/20/11 at 11:10 a.m. She indicated the following: "Pt. made report to N. Home staff that she had been raped by a N. Home aide. N [nursing] Home is conducting investigation... Spoke to pt.			

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	about incident. Pt. is sticking to her story..." At 1:00 p.m. on 7/21/11, the Interim Administrator, Corporate Nurses #1 and #2, the Corporate Director of Operations, and the Corporate Attorney were interviewed. The Administrator indicated their investigation began as soon as the allegation was reported. She indicated they immediately interviewed the resident and did a physical assessment. They notified the physician, the family, and the police and got orders to send the resident to the hospital for evaluation and treatment. The facility Social Services employees began interviews of alert and oriented residents, and they began full body assessments on all dependent residents. When queried about staff interviews, they indicated the police detective had arrived at around 3:30 p.m. on 7/19/11. He had requested they not interview CNA #6 until he had a chance to. The Interim Administrator indicated she called her corporate office after the visit with the detective and was told to wait for legal representation prior to proceeding with staff interviews. At that time, they indicated the Corporate Attorney had arrived on 7/20/11 in the afternoon. When queried, they indicated			

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	four (4) staff members had been interviewed on 7/20/11, one nurse, two CNAs and a Social Worker; they did not identify the individuals. When queried further, they indicated the CNA and nurse who worked the 400/500 halls the night in question had not been interviewed, but "would be by the end of the day [7/21/11]." They indicated the investigation was still in process. The Corporate staff indicated their policy was to suspend the staff member immediately and begin the investigation. CNA #13 was interviewed, on 7/22/11 at 9:07 a.m. She indicated she had worked on 7/19/11, on the day shift. She indicated, "I think I took care of her...I did change her, by myself." She indicated she remembered changing the resident's incontinence brief; the resident had not complained. The resident's brief had an off-white colored discharge in it, but she indicated the resident always had that. She indicated the resident had said nothing to her and the first thing she heard about the allegation was when they were sending her to the hospital. CNA #14 was interviewed on 7/22/11 at 10:20 a.m. She indicated she had arrived on the unit that morning around 8:00 a.m. She indicated the resident did not want a bath that morning, which was a little			

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	unusual. She indicated she approached the resident again later, sometime around 11 a.m. or so. At that time, Resident E, stated to her, "[CNA #6's first name] raped me, [name] raped me." She indicated she immediately left the room and found the first nurse she could find, the Staff Development Nurse. The Staff Development Nurse told her to tell the DoN immediately and she did. She indicated she had provided the resident peri-care around 10:30 a.m. and nothing unusual had occurred or was observed, and the resident had not reported the allegation at that time. CNA #14 indicated she "normally" used two people in Resident E's room, but not all the time, "I don't always take ." She indicated the reason they normally used two staff was "based on her history." The DoN was re-interviewed, on 7/22/11 at 10:30 a.m. She indicated the instructions, "two for care," was on the assignment sheet prior to the allegation and the instructions were due to false reports in the past (not of rape). She indicated, if she had been able to interview CNA #6, she would have asked him if he had two people with him all the time, and if not, why, but law enforcement had not allowed the facility to interview him.			

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	CNA #9 was re-interviewed on 7/22/11 at 11:30 a.m. She indicated she worked the night shift 7/18/11-7/19/11. She indicated she worked the 400 hall and CNA #6 worked the 500 hall, where Resident E resided. She indicated she did not assist CNA #6 with Resident E at any time during that shift. She indicated some CNAs liked to stay on their own halls and some liked to do bed checks together and CNA #6 would usually work by himself. When queried about residents who needed two staff for assistance, she indicated there were times when she did not get a second staff member to help. RN #5 was re-interviewed, on 7/22/11 at 11:45 a.m. When queried, she indicated she could not say either way whether or not she assisted CNA #6 with Resident E on the night of 7/18-7/19/11. She did not remember. She indicated nothing unusual happened that night. When queried about bed checks and whether or not CNA #6 did them by himself, she indicated sometimes CNAs, in general, would take two, if it was a resident who fought, or needed more help. She indicated she had not taken a lunch break that night, that she was the only nurse, and was always on one hall or the other. She indicated she did not know, for sure, whether or not CNA #6 cared for Resident E by himself or not.			

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	The policy and procedure for "Reporting Alleged Violation," regarding abuse, no date, was provided by the HFA on 07/12/11 at 9:00 A.M., who indicated it was current. The policy and procedure included, but was not limited to, the following: "Policy It is the policy of this center to take appropriate steps to prevent the occurrence of: -abuse... Definitions: The following definitions are pursuant to the interpretive guidelines for F223. Abuse Abuse is the will infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, main or mental anguish... Sexual abuse Sexual abuse includes, but is not limited to: -sexual harassment -sexual coercion -sexual assault Where the circumstances of the alleged violation warrants, the DNS [Director of Nursing Services] or designee initiates a physical and mental assessment of the resident and documents the findings. Only factual information is documented,			

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	not assumptions. The DNS also notifies the attending physician regarding the alleged violation and findings and documents the contact... Investigation The ED [Executive Director, Administrator] or DNS conducts all investigations. In the event an alleged violation occurs when neither of these people are in the center, the charge nurse is responsible for initiating the investigation procedure. The investigation includes interviews of employees, visitors or residents who may have knowledge of the alleged incident. Only factual information is documented - not assumptions or speculation. Written statements from involved parties are not requested. The documentation of the investigation is kept in the ED's office in an administrative file. The medical record is reviewed to determine the resident's past history and condition and its relevance to the alleged violation..." This federal tag relates to complaint number IN00093878. 3.1-27(a)(1)			

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F0225 SS=G	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure the investigation, for 1 of 3 residents reviewed for allegations of sexual assault, was thorough and to ensure key parts of the	F0225	**F225** The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Staff on duty at time of the alleged incident was	08/21/2011

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	investigation were completed timely, in that staff members on duty at the time of the alleged incident were not interviewed timely. (Resident E) The facility also failed to ensure 1 of 3 resident allegations of sexual assault was reported immediately to the administrator of the facility, in that the administrator was unaware of the allegation until the record was reviewed after the resident was transferred to the hospital. (Resident F) Findings include: 1. On 7/19/11 at 1:00 p.m., the Interim Administrator and Director of Nurses [DoN] indicated Resident E had alleged she was raped by a CNA [CNA #6] on the previous night shift. The Administrator indicated the resident had told a CNA [CNA #14], at around 11:30 a.m., who immediately informed the Director of Nurses and the facility had begun investigating. She indicated the resident was being sent to the hospital for examination and the police had been called. The CNA had been notified that he was not to report to work until further notice due to an investigation. On 7/19/11 at 4:00 p.m., the DoN and Administrator indicated a detective from the local police department had been in and asked them not to talk to the alleged		interviewed on 7/22/11. Inservice was held on 7/22/11 to ensure all staff knew that 2 staff members were to care for Resident E at all times. Resident F's allegation was investigated immediately after management became aware of allegation. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows All alert and oriented residents were interviewed with no concerns. Residents that were not able to be interviewed had complete body assessments completed 7/20/11 and there were no signs of injury. Care plans were reviewed and C.N.A. care sheets updated and staff educated on 7/22/11 regarding residents requiring 2 staff members present to provide care. Inservice was conducted on 6/30/11 regarding reporting of all alleged allegations of possible abuse. Nurse that did not report allegation immediately was reeducated on 6/30/11. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Care plans were reviewed and C.N.A. care sheets updated and staff educated on 7/22/11 regarding residents requiring 2 staff members present to provide care. DNS/RNAC/Designee will review and audit C.N.A. care sheets weekly for 8 weeks then every	

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	perpetrator until he had the opportunity to interview him. The resident was still at the hospital at that time. On 7/20/11 at 8:30 a.m., the DoN indicated the resident had returned from the hospital during the evening and no new orders had been given and no information from the hospital was received. The resident had been placed on one to one observation, where a staff person monitored the room, from the hallway. Two staff were doing all care on the resident. On 7/21/11 at 5:22 a.m., the building was entered. CNAs #8 and #9 were observed working on the 400 hall. CNA #8 indicated he was brand new and had only been working for a week. He indicated he and CNA #9 had been working as a team. They would get report, pass ice water, start bed checks, do paperwork, then restart bed checks. He indicated, because he was new, they were working together to do bed checks, so he could be introduced by the other CNA and learn what each resident needed. CNA #8 indicated he had not worked on 7/18-7/19 night shift. CNA #9 was then interviewed, at 5:30 a.m. She indicated she had worked Monday [7/18-7/19] night shift, Tuesday,		other week for 4 weeks and then monthly x 3 months to ensure all residents requiring 2 staff members for care are correct. Inservice was conducted on 6/30/11 regarding reporting of all alleged allegations of possible abuse. Nurse that did not report allegation immediately was reeducated on 6/30/11. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/RNAC/Designee will review and audit C.N.A. care sheets weekly for 8 weeks then every other week for 4 weeks and then monthly x 3 months to ensure all residents requiring 2 staff members for care are correct. ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans written and implemented as needed.	

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	and Wednesday. She indicated she worked 400 hall and CNA #6 had worked 500 hall. She indicated some CNAs chose to work their hall alone and some preferred to work together as a team. She indicated that she had worked by herself on Monday night, 7/18-7/19/11. She indicated she would still go over to the hall if help was needed, or to answer lights. The CNA indicated she had not been questioned by anyone else about that night, i.e. no facility personnel, or others. A Hospice RN was present on the unit. She was interviewed at 5:40 a.m. on 7/21/11, and she indicated Resident E was on her caseload. She indicated she was requested to come in on 7/19/11 to witness an interview and physical assessment of Resident E. She indicated she and the Minimum Data Set [MDS] assessment coordinator had been in the room together. The resident reported to them she had been raped on the night shift and indicated it was CNA #6 who raped her. She indicated the physical assessment was completed. The resident was wet, so her brief was changed. She indicated they had put the brief and linens used to cleanse the resident in a bag and saved it for the police investigation. She indicated there were no red marks, no significant bruises, except for several small bruises, none of them new, on her			

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	arms and knees. There were no red marks. The resident had a flat affect throughout the interview and exam. She indicated the interview and assessment happened "around noon." She indicated, according to the MDS coordinator, the story was consistent. She further stated, "Unfortunately, I know this resident and she's not always truthful." CNA #10 was observed seated outside Resident E's room 5:45 a.m. on 7/21/11 and interviewed at that time. She indicated the resident and her room were being observed one on one, since 7/19/11 at 11:00 p.m. She had come in at 3:00 a.m. and had been assigned to watch the room and resident. At that time, the resident was heard to yell "Help, Help." The CNA was observed to enter the room and asked the resident what she needed. CNA #10 indicated she had to get help and exited the room to find another CNA to help her. She indicated two staff were doing all care. CNA #11 arrived at 5:45 a.m. on 7/21/11. She indicated she was taking over the one on one. She indicated she had heard Resident E had claimed CNA #6 raped her. She indicated she had worked Saturday night, Sunday night, and Monday night, 2:00 a.m. to 2:00 p.m. She indicated no one had questioned her about			

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	anything, "no nurse, no Administrator, no DoN [Director of Nurses], no detective..." She indicated staff were to always go with two persons to Resident E's room, even before the allegation, because the resident didn't always tell the truth. RN #5 was administering medications on the 400 and 500 halls. She was interviewed at 5:50 a.m. on 7/21/11. She indicated she had worked the night shift 7/18/11 to 7/19/11. She indicated CNAs #6 and #9 had been the CNAs working with her. She indicated nothing unusual happened that night. The resident had not complained of anything to her. She indicated she had heard from co-workers that Resident E alleged CNA #6 had raped her during that night shift. She indicated she was always in the hallway, or at the nurses' station and heard staff in and out of rooms. She indicated again, nothing unusual occurred. "We all know who she is...when she knows he's working [CNA #6], she's always calling out his name." She indicated she had not had anyone from the facility staff, or anyone else ask her any questions about that night and had received no request for any statement, "You are the first to ask." On 7/21/11 at 8:30 a.m., the Interim Administrator, Corporate Nurse Consultant #1, Corporate Nurse			

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	Consultant #2, and the Corporate Director of Operations were interviewed. According to the Interim Administrator, the facility had not initiated staff interviews on 7/19/11. She indicated a police detective had arrived at 3:30 p.m. and indicated he did not want them to interview CNA #6 before he had a chance to do so. She indicated the detective called the CNA from her office and scheduled a time for him to come to the police department for an interview, 5:00 p.m. that date; the facility was not involved in the interview. She indicated the police detective did not ask them not to interview other staff. The Interim Administrator indicated, during the 8:30 a.m. interview, after the police detective's visit, she made a phone call to the corporate legal department. She indicated she was told the legal department would be involved and indicated she was asked not to interview staff, that "counsel needed to be on the ground." The Corporate Nurses indicated the attorney had arrived on 7/20/11 and was returning 7/21/11. They indicated she had done some staff interviews on 7/19/11, but they did not know who was interviewed. The Administrator indicated, during the 8:30 a.m. interview, it was around 11:30			

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	a.m. Tuesday morning [7/19/11] that Resident E reported the allegation to the CNA. The CNA immediately reported it to the DoN. Resident E's facility clinical record review began on 7/21/11 at 6:30 a.m. The record indicated the resident was admitted to the facility on 7/23/04 and had diagnoses including, but not limited to, the following: closed dislocation of hip, bipolar disorder unspecified, generalized anxiety disorder, history of urinary tract infection, malignant neoplasm of thyroid gland, unspecified personality disorder, depressive disorder, and hyposmolality and/or hyponatremia, coronary atherosclerosis, congestive heart failure, cardiac dysrhythmias, arthropathy, dementia with behavioral disturbances, esophageal reflux, acute but ill-defined cerebrovascular disease, hypertension, unspecified psychosis. The resident's most recent quarterly Minimum Data Set [MDS] Assessment, dated 5/27/11, included, but was not limited to, the following: Unclear speech, rarely/never understood, rarely/never understands, long term and short term memory problems, severely impaired decision making, disordered thinking, delusions, extensive assistance of two staff for bed mobility, total			

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	dependence of two staff for transfers, and unable to ambulate. She was assessed as always incontinent of bowel and bladder, had signs and symptoms of pain, and had experienced unplanned weight loss. The resident's most recent full MDS assessment, a significant change MDS dated 11/26/10, included, but was not limited to, the following: communication clear, Brief interview for Mental Status score of 05/15, with 15/15 being alert and oriented, no delusions or behaviors identified, extensive assistance of two staff for bed mobility, and transfers, and unable to walk. The assessment indicated she was always incontinent of bowel and bladder, experienced pain, but had experienced no weight loss. The resident was currently receiving hospice services. The nurse aide assignment sheets for the 400 and 500 halls were provided by CNA #10 on 7/22/11 at 10:26 a.m. and reviewed at that time. Under "Special Needs," was indicated the following: "two for care non-skid slipper socks when out of bed BEHAVIORS. HOSPICE roho air mattress KEEP SET ON #4." Nurses' notes/progress notes were			

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	reviewed from 6/8/11 through 7/22/11 and included, but were not limited to, the following: "7/18/11 07:57 [7:57 a.m.] Resident slept well during the night on no pressure mattress, with floor mats on floor for safety." "Late Entry 7/19/2011 12:40 [12:40 p.m.] Note text: Resident reported allegations of abuse, MD [medical doctor] made aware of allegations et new order received for resident to go to er [emergency room] for evaluation et tx [treatment]; poa [power of attorney] [name] notified of residents allegations of abuse et permission obtained for resident to go to [name of hospital] main campus for nessary (sic) tx related to allegations. Residents (sic) poa stated, "THIS WAS OBSERED ET RIDICULOUS ALSO A WASTE OF TIME BUT DO WHAT EVER WE WANTED TO DO." (sic) transportation arranged et resident transported to [name of hospital]." "7/19/2011 16:03 [4:03 p.m.] Resident refused ADL [activities of daily living] care this am [morning] despite 2 attempts by staff." "7/19/11 20:08 [8:08 p.m.] @ 1900 [7:00 p.m.] res [resident] return to [name of facility] on srecther (sic) per ambulance, escorted per 2 [name of ambulance company] personnel. No c/o [complaints] noted upon return. N.O. [new order]			

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	received for Zofran [for nausea] 4 mg Q 6 hrs [every six hours] PRN [as needed] times 3 doses and update Dr. [name] in AM." "7/19/11 23:27 [11:27 p.m.] Res. resting quietly in bed at this time. Res. in good humor, taking meds without difficulty, no periods of anxity (sic), normal demeaner (sic), res. calling out to staff by name as normal in ADLs." "7/20/11 06:55 [6:55 a.m.] "1 on 1 observation started. Resident had uneventful night, mainly sleeping. Verbalized needs and wants. C/O [complaint of] hurting. Reassurance and redirect provided with little success. Roxanol 0.25 ml [milliliters] given @ 0035 [12:35 a.m.] for pain and general discomfort. Resting comfortably during noc's. 1 on 1 observation provided by female staff thru the night. No further C/O of pain or discomfort and was resting comfortable..." "7/20/2011 14:55 [2:55 p.m.] General Note. Providing 1:1 with [name] 2:00 - 2:45 p.m. resident hollered "help." This SSD [Social Service Director] entered room, resident stated she was wet when asked what she needed. Nursing notified of need to provide peri-care. When asked if she remembered going to hospital yesterday, she responded, 'Yes'. (sic) When asked if she knew what the reason for transfer to hospital was, she			

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	responded, 'I was raped'. (sic)..." At 1:00 p.m. on 7/21/11, the Interim Administrator, Corporate Nurses #1 and #2, the Corporate Director of Operations, and the Corporate Attorney were interviewed. The Administrator indicated their investigation began as soon as the allegation was reported. She indicated they immediately interviewed the resident and did a physical assessment. They notified the physician, the family, and the police and got orders to send the resident to the hospital for evaluation and treatment. The facility Social Services employees began interviews of alert and oriented residents, and they began full body assessments on all dependent residents. When queried about staff interviews, they indicated the police detective had arrived at around 3:30 p.m. on 7/19/11. He had requested they not interview CNA #6 until he had a chance to. The Interim Administrator indicated she called her corporate office after the visit with the detective and was told to wait for legal representation prior to proceeding with staff interviews. At that time, they indicated the Corporate Attorney had arrived on 7/20/11 in the afternoon. When queried, they indicated			

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	four (4) staff members had been interviewed on 7/20/11, one nurse, two CNAs and a Social Worker; they did not identify the individuals. When queried further, they indicated the CNA and nurse who worked with CNA #6 on the 400/500 halls the night in question had not been interviewed, but "would be by the end of the day [7/21/11]." They indicated the investigation was still in process. The Corporate staff indicated their policy was to suspend the staff member immediately and begin the investigation. On 7/22/11 at 8:50 a.m., the Administrator and Corporate Nurses and Director of Operations indicated their attorney had given them permission to proceed with staff interviews, and interviews had been conducted the during the previous evening and night shifts. They provided documentation of those interviews. The questions for staff were typed on pieces of paper and each one had handwritten answers from each staff person interviewed. The questions included the following: "What have you heard? Have you ever seen or heard a staff member be inappropriate either verbally or physically with a resident? If so, who did you report to? Have you noticed a staff member be unaccounted for extensive periods of			

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	time? If so, did you report this and to whom did you report it? Is there anything else?" CNA #13 was interviewed, on 7/22/11 at 9:07 a.m. She indicated she had worked on 7/19/11, on the day shift. She indicated, "I think I took care of her...I did change her, by myself." She indicated she remembered changing the resident's incontinence brief; the resident had not complained. The resident's brief had an off-white colored discharge in it, but she indicated the resident always had that. She indicated the resident had said nothing to her and the first thing she heard about the allegation was when they were sending her to the hospital. CNA #14 was interviewed on 7/22/11 at 10:20 a.m. She indicated she had arrived on the unit that morning around 8:00 a.m. She indicated the resident did not want a bath that morning, which was a little unusual. She indicated she approached the resident again later, sometime around 11 a.m. or so. At that time, Resident E, stated to her, "[CNA #6's first name] raped me, [name] raped me." She indicated she immediately left the room and found the first nurse she could find, the Staff Development Nurse. The Staff Development Nurse told her to tell the DoN immediately and she did. She			

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	indicated she had provided the resident peri-care around 10:30 a.m. and nothing unusual had occurred or was observed, and the resident had not reported the allegation at that time. CNA #14 indicated she "normally" used two people in Resident E's room, but not all the time, "I don't always take ." She indicated the reason they normally used two staff was "based on her history." The DoN was re-interviewed, on 7/22/11 at 10:30 a.m. She indicated the instructions, "two for care," was on the assignment sheet prior to the allegation and the instructions were due to false reports in the past (not of rape). She indicated, if she had been able to interview CNA #6, she would have asked him if he had two people with him all the time, and if not, why, but law enforcement had not allowed the facility to interview him. CNA #9 was re-interviewed on 7/22/11 at 11:30 a.m. She indicated she worked the night shift 7/18/11-7/19/11. She indicated she worked the 400 hall and CNA #6 worked the 500 hall, where Resident E resided. She indicated she did not assist CNA #6 with Resident E at any time during that shift. She indicated some CNAs liked to stay on their own halls and some liked to do bed checks together and			

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	CNA #6 would usually work by himself. When queried about residents who needed two staff for assistance, she indicated there were times when she did not get a second staff member to help. RN #5 was re-interviewed, on 7/22/11 at 11:45 a.m. When queried, she indicated she could not say either way whether or not she assisted CNA #6 with Resident E on the night of 7/18-7/19/11. She did not remember. She indicated nothing unusual happened that night. When queried about bed checks and whether or not CNA #6 did them by himself, she indicated sometimes CNAs, in general, would take two, if it was a resident who fought, or needed more help. She indicated she had not taken a lunch break that night, that she was the only nurse, and was always on one hall or the other. She indicated she did not know, for sure, whether or not CNA #6 cared for Resident E by himself or not. On 7/22/11 at 2:50 p.m., the Interim Administrator, Corporate Nurse #1, the Director of Nurses [DoN], and the Director of Operations were interviewed. When queried if they had asked CNA #9 and RN #5 whether or not they ever helped CNA #6 in Resident E's room, they indicated they had only asked the questions on the paper.			

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The policy and procedure for "Reporting Alleged Violation," regarding abuse, no date, was provided by the HFA on 07/12/11 at 9:00 A.M., who indicated it was current. The policy and procedure included, but was not limited to, the following:
"Policy
It is the policy of this center to take appropriate steps to prevent the occurrence of:
-abuse...
Definitions:
The following definitions are pursuant to the interpretive guidelines for F223.
Abuse
Abuse is the will infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, main or mental anguish...
Sexual abuse
Sexual abuse includes, but is not limited to:
-sexual harassment
-sexual coercion
-sexual assault

Where the circumstances of the alleged violation warrants, the DNS [Director of Nursing Services] or designee initiates a physical and mental assessment of the resident and documents the findings.
Only factual information is documented,

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	not assumptions. The DNS also notifies the attending physician regarding the alleged violation and findings and documents the contact... Investigation The ED [Executive Director, Administrator] or DNS conducts all investigations. In the event an alleged violation occurs when neither of these people are in the center, the charge nurse is responsible for initiating the investigation procedure. The investigation includes interviews of employees, visitors or residents who may have knowledge of the alleged incident. Only factual information is documented - not assumptions or speculation. Written statements from involved parties are not requested. The documentation of the investigation is kept in the ED's office in an administrative file. The medical record is reviewed to determine the resident's past history and condition and its relevance to the alleged violation..." 2. Resident F's clinical record was reviewed on 7/21/11 at 6:50 a.m. A Nurse's note, dated 06/30/11 at 04:18 [4:18 A.M.], indicated, "[local ambulance company] her [sic] to transport. Resident			

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	told EMT's [Emergency Medical Technician's] that she had been rapped [sic], that she was being held hostage, that her fron [sic] teeth were knocked out...." The Nursing note lacked any documentation that the HFA [Health Facility Administrator] had been notified. In an interview with the HFA, on 07/21/11 at 8:15 A.M., she indicated, "We saw that one [the nursing note] the next morning, reviewing things in the morning meeting...The nurse did not call at that time, her assumption was [Resident F] was talking out of her head...didn't take it as an allegation of abuse...we re-educated the nurse for reporting..." An inservice training record, dated 6/30/11, provided by the HFA on 07/21/11 at 2:00 P.M., indicated, "Staff will understand that they are to report anything odd or unusual, even if they feel it is a behavior to their DON [Director of Nursing], ED [Executive Director] or ADON [Assistant Director of Nursing] at anytime AM or PM." The policy and procedure for abuse, provided by the HFA on 07/12/11 at 9:00 A.M., indicated, "Reporting Alleged Violations Responsibility: It is the responsibility of all associates to immediately report any alleged violation			

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	of abuse...Policy It is the policy of this facility to take appropriate steps to prevent...abuse...It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of ...abuse...are reported immediately to the Executive Director of the facility...The facility investigates each such alleged violation thoroughly..." This federal tag relates to complaint number IN00093878. 3.1-28(c) 3.1-28(d)			

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F0226 SS=G	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their policy and procedure to ensure the investigation, for 1 of 3 residents reviewed for allegations of sexual assault, was thorough and to ensure key parts of the investigation were completed timely, in that staff members on duty at the time of the alleged incident were not interviewed thoroughly and timely. (Resident E) The facility also failed to implement their policy and procedure to ensure 1 of 3 resident allegations of sexual assault was identified as an allegation of abuse and reported immediately to the administrator of the facility, in that the nurse thought the resident was "talking out of her head," and did not report it immediately to the administrator. (Resident F) Findings include: 1. On 7/19/11 at 1:00 p.m., the Interim Administrator and Director of Nurses [DoN] indicated Resident E had alleged she was raped by a CNA [CNA #6] on the previous night shift. The Administrator indicated the resident had told a CNA [CNA #14], at around 11:30 a.m., who	F0226	**F226** The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Staff on duty at time of the alleged incident was interviewed on 7/22/11. Inservice was held on 7/22/11 to ensure all staff knew that 2 staff members were to care for Resident E at all times. Resident F's allegation was investigated immediately after management became aware of allegation. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All alert and oriented residents were interviewed with no concerns. Residents that were not able to be interviewed had complete body assessments completed 7/20/11 and there were no signs of injury. Care plans were reviewed and C.N.A. care sheets updated and staff educated on 7/22/11 regarding residents requiring 2 staff members present to provide care. Inservice was conducted on 6/30/11 regarding reporting of all alleged allegations of possible abuse. Nurse that did not report allegation immediately was reeducated on 6/30/11. The measures put into place and the systemic changes	08/21/2011

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	immediately informed the Director of Nurses and the facility had begun investigating. She indicated the resident was being sent to the hospital for examination and the police had been called. The CNA had been notified that he was not to report to work until further notice due to an investigation. On 7/19/11 at 4:00 p.m., the DoN and Administrator indicated a detective from the local police department had been in and asked them not to talk to the alleged perpetrator until he had the opportunity to interview him. The resident was still at the hospital at that time. On 7/20/11 at 8:30 a.m., the DoN indicated the resident had returned from the hospital during the evening and no new orders had been given and no information from the hospital was received. The resident had been placed on one to one observation, where a staff person monitored the room, from the hallway. Two staff were doing all care on the resident. On 7/21/11 at 5:22 a.m., the building was entered. CNAs #8 and #9 were observed working on the 400 hall. CNA #8 indicated he was brand new and had only been working for a week. He indicated he and CNA #9 had been working as a team.		made to ensure that this deficient practice does not recur are as follows: Care plans were reviewed and C.N.A. care sheets updated and staff educated on 7/22/11 regarding residents requiring 2 staff members present to provide care. DNS/RNAC/Designee will review and audit C.N.A. care sheets weekly for 8 weeks then every other week for 4 weeks and then monthly x 3 months to ensure all residents requiring 2 staff members for care are correct. Inservice was conducted on 6/30/11 regarding reporting of all alleged allegations of possible abuse. Nurse that did not report allegation immediately was reeducated on 6/30/11. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/RNAC/Designee will review and audit C.N.A. care sheets weekly for 8 weeks then every other week for 4 weeks and then monthly xs 3 months to ensure all residents requiring 2 staff members for care are correct. ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans written and implemented as needed.	

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They would get report, pass ice water, start bed checks, do paperwork, then restart bed checks. He indicated, because he was new, they were working together to do bed checks, so he could be introduced by the other CNA and learn what each resident needed. CNA #8 indicated he had not worked on 7/18-7/19 night shift.

CNA #9 was then interviewed, at 5:30 a.m. She indicated she had worked Monday [7/18-7/19] night shift, Tuesday, and Wednesday. She indicated she worked 400 hall and CNA #6 had worked 500 hall. She indicated some CNAs chose to work their hall alone and some preferred to work together as a team. She indicated that she had worked by herself on Monday night, 7/18-7/19/11. She indicated she would still go over to the hall if help was needed, or to answer lights. The CNA indicated she had not been questioned by anyone else about that night, i.e. no facility personnel, or others.

A Hospice RN was present on the unit. She was interviewed at 5:40 a.m. on 7/21/11, and she indicated Resident E was on her caseload. She indicated she was requested to come in on 7/19/11 to witness an interview and physical assessment of Resident E. She indicated she and the Minimum Data Set [MDS]

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	assessment coordinator had been in the room together. The resident reported to them she had been raped on the night shift and indicated it was CNA #6 who raped her. She indicated the physical assessment was completed. The resident was wet, so her brief was changed. She indicated they had put the brief and linens used to cleanse the resident in a bag and saved it for the police investigation. She indicated there were no red marks, no significant bruises, except for several small bruises, none of them new, on her arms and knees. There were no red marks. The resident had a flat affect throughout the interview and exam. She indicated the interview and assessment happened "around noon." She indicated, according to the MDS coordinator, the story was consistent. She further stated, "Unfortunately, I know this resident and she's not always truthful." CNA #10 was observed seated outside Resident E's room 5:45 a.m. on 7/21/11 and interviewed at that time. She indicated the resident and her room were being observed one on one, since 7/19/11 at 11:00 p.m. She had come in at 3:00 a.m. and had been assigned to watch the room and resident. At that time, the resident was heard to yell "Help, Help." The CNA was observed to enter the room and asked the resident what she needed.			

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	CNA #10 indicated she had to get help and exited the room to find another CNA to help her. She indicated two staff were doing all care. CNA #11 arrived at 5:45 a.m. on 7/21/11 and was interviewed at that time. She indicated she was taking over the one on one. She indicated she had heard Resident E had claimed CNA #6 raped her. She indicated she had worked Saturday night, Sunday night, and Monday night, 2:00 a.m. to 2:00 p.m. She indicated no one had questioned her about anything, "no nurse, no Administrator, no DoN [Director of Nurses], no detective..." She indicated staff were to always go with two persons to Resident E's room, even before the allegation, because the resident didn't always tell the truth. RN #5 was administering medications on the 400 and 500 halls. She was interviewed at 5:50 a.m. on 7/21/11. She indicated she had worked the night shift 7/18/11 to 7/19/11. She indicated CNAs #6 and #9 had been the CNAs working with her. She indicated nothing unusual happened that night. The resident had not complained of anything to her. She indicated she had heard from co-workers that Resident E alleged CNA #6 had raped her during that night shift. She indicated she was always in the hallway, or at the			

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	nurses' station and heard staff in and out of rooms. She indicated again, nothing unusual occurred. "We all know who she is...when she knows he's working [CNA #6], she's always calling out his name." She indicated she had not had anyone from the facility staff, or anyone else ask her any questions about that night and had received no request for any statement, "You are the first to ask." On 7/21/11 at 8:30 a.m., the Interim Administrator, Corporate Nurse Consultant #1, Corporate Nurse Consultant #2, and the Corporate Director of Operations were interviewed. According to the Interim Administrator, the facility had not initiated staff interviews on 7/19/11. She indicated a police detective had arrived at 3:30 p.m. and indicated he did not want them to interview CNA #6 before he had a chance to do so. She indicated the detective called the CNA from her office and scheduled a time for him to come to the police department for an interview, 5:00 p.m. that date; the facility was not involved in the interview. She indicated the police detective did not ask them not to interview other staff. The Interim Administrator indicated, during the 8:30 a.m. interview, after the police detective's visit, she made a phone			

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	call to the corporate legal department. She indicated she was told the legal department would be involved and indicated she was asked not to interview staff, that "counsel needed to be on the ground." The Corporate Nurses indicated the attorney had arrived on 7/20/11 and was returning 7/21/11. They indicated she had done some staff interviews on 7/19/11, but they did not know who was interviewed. The Administrator indicated, during the 8:30 a.m. interview, it was around 11:30 a.m. Tuesday morning [7/19/11] that Resident E reported the allegation to the CNA. The CNA immediately reported it to the DoN. Resident E's facility clinical record review began on 7/21/11 at 6:30 a.m. The record indicated the resident was admitted to the facility on 7/23/04 and had diagnoses including, but not limited to, the following: closed dislocation of hip, bipolar disorder unspecified, generalized anxiety disorder, history of urinary tract infection, malignant neoplasm of thyroid gland, unspecified personality disorder, depressive disorder, and hyposmolality and/or hyponatremia, coronary atherosclerosis, congestive heart failure, cardiac dysrhythmias, arthropathy, dementia with behavioral disturbances,			

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	esophageal reflux, acute but ill-defined cerebrovascular disease, hypertension, unspecified psychosis. The resident's most recent quarterly Minimum Data Set [MDS] Assessment, dated 5/27/11, included, but was not limited to, the following: Unclear speech, rarely/never understood, rarely/never understands, long term and short term memory problems, severely impaired decision making, disordered thinking, delusions, extensive assistance of two staff for bed mobility, total dependence of two staff for transfers, and unable to ambulate. She was assessed as always incontinent of bowel and bladder, had signs and symptoms of pain, and had experienced unplanned weight loss. The resident's most recent full MDS assessment, a significant change MDS dated 11/26/10, included, but was not limited to, the following: communication clear, Brief interview for Mental Status score of 05/15, with 15/15 being alert and oriented, no delusions or behaviors identified, extensive assistance of two staff for bed mobility, and transfers, and unable to walk. The assessment indicated she was always incontinent of bowel and bladder, experienced pain, but had experienced no weight loss.			

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The resident was currently receiving hospice services.

The nurse aide assignment sheets for the 400 and 500 halls were provided by CNA #10 on 7/22/11 at 10:26 a.m. and reviewed at that time. Under "Special Needs," was indicated the following: "two for care non-skid slipper socks when out of bed BEHAVIORS. HOSPICE roho air mattress KEEP SET ON #4."

Nurses' notes/progress notes were reviewed from 6/8/11 through 7/22/11 and included, but were not limited to, the following:
"7/18/11 07:57 [7:57 a.m.] Resident slept well during the night on no pressure mattress, with floor mats on floor for safety."
"Late Entry 7/19/2011 12:40 [12:40 p.m.] Note text: Resident reported allegations of abuse, MD [medical doctor] made aware of allegations et new order received for resident to go to er [emergency room] for evaluation et tx [treatment]; poa [power of attorney] [name] notified of residents allegations of abuse et permission obtained for resident to go to [name of hospital] main campus for nessary (sic) tx related to allegations. Residents (sic) poa stated, "THIS WAS OBSERED ET RIDICULOUS ALSO A

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	WASTE OF TIME BUT DO WHAT EVER WE WANTED TO DO." (sic) transportation arranged et resident transported to [name of hospital]." "7/19/2011 16:03 [4:03 p.m.] Resident refused ADL [activities of daily living] care this am [morning] despite 2 attempts by staff." "7/19/11 20:08 [8:08 p.m.] @ 1900 [7:00 p.m.] res [resident] return to [name of facility] on srecther (sic) per ambulance, escorted per 2 [name of ambulance company] personnel. No c/o [complaints] noted upon return. N.O. [new order] received for Zofran [for nausea] 4 mg Q 6 hrs [every six hours] PRN [as needed] times 3 doses and update Dr. [name] in AM." "7/19/11 23:27 [11:27 p.m.] Res. resting quietly in bed at this time. Res. in good humor, taking meds without difficulty, no periods of anxity (sic), normal demeaner (sic), res. calling out to staff by name as normal in ADLs." "7/20/11 06:55 [6:55 a.m.] "1 on 1 observation started. Resident had uneventful night, mainly sleeping. Verbalized needs and wants. C/O [complaint of] hurting. Reassurance and redirect provided with little success. Roxanol 0.25 ml [milliliters] given @ 0035 [12:35 a.m.] for pain and general discomfort. Resting comfortably during noc's. 1 on 1 observation provided by			

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	female staff thru the night. No further C/O of pain or discomfort and was resting comfortable..." "7/20/2011 14:55 [2:55 p.m.] General Note. Providing 1:1 with [name] 2:00 - 2:45 p.m. resident hollered "help." This SSD [Social Service Director] entered room, resident stated she was wet when asked what she needed. Nursing notified of need to provide peri-care. When asked if she remembered going to hospital yesterday, she responded, 'Yes'. (sic) When asked if she knew what the reason for transfer to hospital was, she responded, 'I was raped'. (sic)..." At 1:00 p.m. on 7/21/11, the Interim Administrator, Corporate Nurses #1 and #2, the Corporate Director of Operations, and the Corporate Attorney were interviewed. The Administrator indicated their investigation began as soon as the allegation was reported. She indicated they immediately interviewed the resident and did a physical assessment. They notified the physician, the family, and the police and got orders to send the resident to the hospital for evaluation and treatment. The facility Social Services employees began interviews of alert and oriented residents, and they began full body assessments on all dependent residents. When queried about staff interviews, they indicated the police			

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	detective had arrived at around 3:30 p.m. on 7/19/11. He had requested they not interview CNA #6 until he had a chance to. The Interim Administrator indicated she called her corporate office after the visit with the detective and was told to wait for legal representation prior to proceeding with staff interviews. At that time, they indicated the Corporate Attorney had arrived on 7/20/11 in the afternoon. When queried, they indicated four (4) staff members had been interviewed on 7/20/11, one nurse, two CNAs and a Social Worker; they did not identify the individuals. When queried further, they indicated the CNA and nurse who worked with CNA #6 on the 400/500 halls the night in question had not been interviewed, but "would be by the end of the day [7/21/11]." They indicated the investigation was still in process. The Corporate staff indicated their policy was to suspend the staff member immediately and begin the investigation. On 7/22/11 at 8:50 a.m., the Administrator and Corporate Nurses and Director of Operations indicated their attorney had given them permission to proceed with staff interviews, and interviews had been			

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	conducted the during the previous evening and night shifts. They provided documentation of those interviews. The questions for staff were typed on pieces of paper and each one had handwritten answers from each staff person interviewed. The questions included the following: "What have you heard? Have you ever seen or heard a staff member be inappropriate either verbally or physically with a resident? If so, who did you report to? Have you noticed a staff member be unaccounted for extensive periods of time? If so, did you report this and to whom did you report it? Is there anything else?" CNA #13 was interviewed, on 7/22/11 at 9:07 a.m. She indicated she had worked on 7/19/11, on the day shift. She indicated, "I think I took care of her...I did change her, by myself." She indicated she remembered changing the resident's incontinence brief; the resident had not complained. The resident's brief had an off-white colored discharge in it, but she indicated the resident always had that. She indicated the resident had said nothing to her and the first thing she heard about the allegation was when they were sending her to the hospital. CNA #14 was interviewed on 7/22/11 at			

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	10:20 a.m. She indicated she had arrived on the unit that morning around 8:00 a.m. She indicated the resident did not want a bath that morning, which was a little unusual. She indicated she approached the resident again later, sometime around 11 a.m. or so. At that time, Resident E, stated to her, "[CNA #6's first name] raped me, [name] raped me." She indicated she immediately left the room and found the first nurse she could find, the Staff Development Nurse. The Staff Development Nurse told her to tell the DoN immediately and she did. She indicated she had provided the resident peri-care around 10:30 a.m. and nothing unusual had occurred or was observed, and the resident had not reported the allegation at that time. CNA #14 indicated she "normally" used two people in Resident E's room, but not all the time, "I don't always take ." She indicated the reason they normally used two staff was "based on her history." The DoN was re-interviewed, on 7/22/11 at 10:30 a.m. She indicated the instructions, "two for care," was on the assignment sheet prior to the allegation and the instructions were due to false reports in the past (not of rape). She indicated, if she had been able to interview CNA #6, she would have asked him if he had two people with him all the			

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	time, and if not, why, but law enforcement had not allowed the facility to interview him. CNA #9 was re-interviewed on 7/22/11 at 11:30 a.m. She indicated she worked the night shift 7/18/11-7/19/11. She indicated she worked the 400 hall and CNA #6 worked the 500 hall, where Resident E resided. She indicated she did not assist CNA #6 with Resident E at any time during that shift. She indicated some CNAs liked to stay on their own halls and some liked to do bed checks together and CNA #6 would usually work by himself. When queried about residents who needed two staff for assistance, she indicated there were times when she did not get a second staff member to help. RN #5 was re-interviewed, on 7/22/11 at 11:45 a.m. When queried, she indicated she could not say either way whether or not she assisted CNA #6 with Resident E on the night of 7/18-7/19/11. She did not remember. She indicated nothing unusual happened that night. When queried about bed checks and whether or not CNA #6 did them by himself, she indicated sometimes CNAs, in general, would take two, if it was a resident who fought, or needed more help. She indicated she had not taken a lunch break that night, that she was the only nurse, and was always on			

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one hall or the other. She indicated she did not know, for sure, whether or not CNA #6 cared for Resident E by himself or not.

On 7/22/11 at 2:50 p.m., the Interim Administrator, Corporate Nurse #1, the Director of Nurses [DoN], and the Director of Operations were interviewed. When queried if they had asked CNA #9 and RN #5 whether or not they ever helped CNA #6 in Resident E's room, they indicated they had only asked the questions on the paper.

The policy and procedure for "Reporting Alleged Violation," regarding abuse, no date, was provided by the HFA on 07/12/11 at 9:00 A.M., who indicated it was current. The policy and procedure included, but was not limited to, the following:
"Policy
It is the policy of this center to take appropriate steps to prevent the occurrence of:
-abuse...
Definitions:
The following definitions are pursuant to the interpretive guidelines for F223.
Abuse
Abuse is the will infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical

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	harm, main or mental anguish... Sexual abuse Sexual abuse includes, but is not limited to: -sexual harassment -sexual coercion -sexual assault Where the circumstances of the alleged violation warrants, the DNS [Director of Nursing Services] or designee initiates a physical and mental assessment of the resident and documents the findings. Only factual information is documented, not assumptions. The DNS also notifies the attending physician regarding the alleged violation and findings and documents the contact... Investigation The ED [Executive Director, Administrator] or DNS conducts all investigations. In the event an alleged violation occurs when neither of these people are in the center, the charge nurse is responsible for initiating the investigation procedure. The investigation includes interviews of employees, visitors or residents who may have knowledge of the alleged incident. Only factual information is documented - not assumptions or speculation. Written statements from involved parties are not			

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	requested. The documentation of the investigation is kept in the ED's office in an administrative file. The medical record is reviewed to determine the resident's past history and condition and its relevance to the alleged violation..." 2. Resident F's clinical record was reviewed on 7/21/11 at 6:50 a.m. A Nurse's note, dated 06/30/11 at 04:18 [4:18 A.M.], indicated, "[local ambulance company] her [sic] to transport. Resident told EMT's [Emergency Medical Technician's] that she had been rapped [sic], that she was being held hostage, that her fron [sic] teeth were knocked out...." The Nursing note lacked any documentation that the HFA [Health Facility Administrator] had been notified. In an interview with the HFA, on 07/21/11 at 8:15 A.M., she indicated, "We saw that one [the nursing note] the next morning, reviewing things in the morning meeting...The nurse did not call at that time, her assumption was [Resident F] was talking out of her head...didn't take it as an allegation of abuse...we re-educated the nurse for reporting..." An inservice training record, dated			

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	6/30/11, provided by the HFA on 07/21/11 at 2:00 P.M., indicated, "Staff will understand that they are to report anything odd or unusual, even if they feel it is a behavior to their DON [Director of Nursing], ED [Executive Director] or ADON [Assistant Director of Nursing] at anytime AM or PM." The policy and procedure for abuse, provided by the HFA on 07/12/11 at 9:00 A.M., indicated, "Reporting Alleged Violations Responsibility: It is the responsibility of all associates to immediately report any alleged violation of abuse...Policy It is the policy of this facility to take appropriate steps to prevent...abuse...It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of ...abuse...are reported immediately to the Executive Director of the facility...The facility investigates each such alleged violation thoroughly..." This federal tag relates to complaint number IN00093878. 3.1-28(a)			

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F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure services provided were in accordance with each residents' written plans of care, for 4 of 17 sampled residents (Residents H, I, J, A), and 2 of 3 supplemental sample residents with allegations of abuse (Resident E, Resident F), in the supplemental sample of 14, in that door alarms were not responded to during an elopement, two persons did not care for residents with written instructions for two to assist, a resident was assisted to transfer with one when the care plan indicated two, pressure reducing devices and anti-tippers were not used, and blood pressure and pulse were not checked prior to giving medication. Findings include: 1. The clinical record of Resident H was reviewed on 07/12/11 at 8:45 A.M. The	F0282	F282 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: RH did not elope from the facility on 7/8/11 but went through a door off the ACU to regular side of facility and was immediately redirected back to Unit. Doors were checked and were in working order and alarm tone was increased. RE and RF both had care plans and C.N.A. sheets were reviewed and updated. Staff was educated on 7/22/11 regarding following C.N.A. sheets. RI had care plan and C.N.A. sheet reviewed and staff educated on 7/22/11. C.N.A. not following the sheets was counseled on 7/22/11 regarding following the C.N.A. sheets. RJ had cushion placed in her chair and antitippers were applied. RA had BP and pulse added to her MAR. Other residents having the potential to be affected by the same deficient practice will be	08/21/2011

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	clinical record indicated the current diagnoses of Resident # H included, but were not limited to, Alzheimer's dementia with behavioral disturbances. During initial tour, on 07/11/11 at 10:00 A.M., the DoN [Director of Nursing] identified Resident H as not interviewable, with a history of elopement, and had recently experienced an elopement from the facility. The DoN further indicated, at that time, that the door alarm did not sound loudly by the nurse's station so the staff thought it was somewhere else in the building, and did not immediately respond to the alarm. On 07/12/11 at 8:50 A.M., Resident H was observed to in her room rummaging through her purse. A Care Plan, dated 08/23/10, identified a problem of "I am at risk for elopement...I am an elopement risk with a hx [history] of elopement. I am not able to make good safety decisions." A Care Plan, dated 05/21/11, identified a problem of "Elopement" with interventions that included, but were not limited to, "...5. 1:1 [one to one] supervision 6. Monitor for exit seeking behavior and/or change in mood/behavior...8. Elopement protocol in		identified and the corrective actions taken are as follows: Care plans and C.N.A. sheets were reviewed on 7/22/11 to ensure any resident requiring 2 staff members in room or requiring 2 staff members for care was on sheets. Staff was educated regarding use of C.N.A. sheets on 7/22/11. Facility staff reviewed care plans to ensure all residents that had an intervention for antitippers to wheel chairs or cushions to wheel chairs had the equipment in place. Medication orders for residents receiving BP medicine that require BP and pulse had MARs audited to ensure that BP and pulse were being recorded. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Elopement drills will be held 3 times a week on various shifts for 4 weeks then every other week on various shifts for 4 weeks and then monthly on each shift x 4 months. Maintenance will check alarm sound during routine maintenance checks. DNS/Designee will audit MARs, charts, C.N.A. sheets and residents in wheel chairs 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks then monthly x 3 months. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice	

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	place per policy/procedure." A Nurse's Note, dated 05/22/11 at 22:50 [10:50 P.M.], indicated, "Situation: Resident eloped out of facility using ACU [Alzheimer's Care Unit] entrance door by Director's office. She had a wanderguard on left ankle. Visitor [name of visitor] told staff she thought one of the resident's went out the door...Response: Resident returned facility by visitor, [name of visitor] private vehicle as she observed her approximately 2 blocks from facility..." An undated incident summary was provided by the DoN on 07/12/11 at 11:00 A.M. The summary indicated, "On 05/22/11 [name of Resident H] exited the building unsupervised. The nursing staff [name of RN #2 and CNA [Certified Nursing Assistant] #5] stated that they did hear an alarm sounding but it was not at their station and that they continued to assist another resident. [RN #2] said that a visitor came up to the station, a couple of minutes later, and reported that she thought a resident had went out the door..." An undated verification of investigation witness statement provided by the HFA [Health Facility Administrator], on 07/13/11 at 2:00 P.M., from CNA #5		will not recur per the following: ED/DNS/Designee will review the results of the audits and drills and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans written and implemented as needed.	

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	indicated, "Was assisting nurse with another res [resident] up by nurses station on unit. Heard door alarm going off when visitor came up and said she though a resident went out..." The verification of investigation further indicated, "Resident Interview Summary: Res stated I just pushed the door and went out..." An interview summary, provided by the HFA on 07/13/11 at 2:00 P.M., regarding a phone interview conducted by the ACU Director with the visitor who reported a resident had exited the building, indicated, "[name of visitor] was ready to leave and kissed her mother goodnight and went to the door, but the alarm was going off. She put her purse in the car and ran back into the building worried that [Resident H] had left. She looked in the dining room and then ran to find the nurse and CNA who were busy with another resident. She reported incident to nurse and CNA. They stated they had heard the alarm but assumed it was in the main part of the building..." An inservice training record, dated 05/23/11 at 17:30 [5:30 P.M.], indicated, "Elopement Guidelines: 1. Answer alarms IMMEDIATELY 2. Do not assume it's another location 3. Check doors within your work area, if alarm is heard...			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BRENTWOOD	30 EAST CHANDLER AVE EVANSVILLE, IN47713

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	6. Watch for and report to nurse behaviors such as, pacing, anxiety. as well as residents verbalizing "I'm going home" A Nurse's Note dated 07/08/11 at 18:30 [6:30 P.M.], indicated, "Situation: Resident hyperactive, ambulating corridor and room to room testing all exit doors. Resident was successful in exiting skille [sic] dunit [sic] (skilled unit) door ... Behavior started at 3:00 P.M. and escalted [escalated] all evening." The Policy and Procedure for Elopement provided by the HFA on 07/14/11 at 2:30 P.M. indicated, "Elopement Policy...The purpose of the elopement policy is to:...Protect resident that are not capable of protecting themselves...Door alarms...A specific system has been developed to notify staff that an external door has been opened in an area accessible to residents..." In an interview with the HFA, on 07/14/11 at 2:00 P.M., she indicated the staff on duty at the time of the elopement should have responded immediately to the door alarm. 2. On 7/19/11 at 1:00 p.m., the Interim Administrator and Director of Nurses [DoN] indicated Resident E had alleged she was raped by a CNA [CNA #6] on the			

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	previous night shift. The Administrator indicated the resident had told a CNA [CNA #14], at around 11:30 a.m., who immediately informed the Director of Nurses and the facility had begun investigating. She indicated the resident was being sent to the hospital for examination and the police had been called. The CNA had been notified that he was not to report to work until further notice due to an investigation. On 7/21/11 at 5:22 a.m., the building was entered. CNAs #8 and #9 were observed working on the 400 hall. CNA #8 indicated he was brand new and had only been working for a week. He indicated he and CNA #9 had been working as a team. They would get report, pass ice water, start bed checks, do paperwork, then restart bed checks. He indicated, because he was new, they were working together to do bed checks, so he could be introduced by the other CNA and learn what each resident needed. CNA #8 indicated he had not worked on 7/18-7/19 night shift. CNA #9 was then interviewed, at 5:30 a.m. She indicated she had worked Monday [7/18-7/19] night shift, Tuesday, and Wednesday. She indicated she worked 400 hall and CNA #6 had worked 500 hall. She indicated some CNAs			

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	chose to work their hall alone and some preferred to work together as a team. She indicated that she had worked by herself on Monday night, 7/18-7/19/11. She indicated she would still go over to the hall if help was needed, or to answer lights. CNA #10 was observed seated outside Resident E's room 5:45 a.m. She indicated the resident and her room were being observed one on one, since 7/19/11 at 11:00 p.m. She had come in at 3:00 a.m. and had been assigned to watch the room and resident. At that time, the resident was heard to yell "Help, Help." The CNA entered the room and asked the resident what she needed. CNA #10 indicated she had to get help and exited the room to find another CNA to help her. She indicated two staff were doing all care. CNA #11 arrived, at that time. She indicated she was taking over the one on one. She indicated she had heard Resident E had claimed CNA #6 raped her. She indicated she had worked Saturday night, Sunday night, and Monday night, 2:00 a.m. to 2:00 p.m. She indicated staff were to always go with two persons to Resident E's room, even before the allegation, because the resident didn't always tell the truth.			

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RN #5 was administering medications on the 400 and 500 halls. She was interviewed at 5:50 a.m. She indicated she had worked the night shift 7/18/11 to 7/19/11. She indicated CNAs #6 and #9 had been the CNAs working with her. She indicated nothing unusual happened that night. The resident had not complained of anything to her. "We all know who she is...when she knows he's working [CNA #6], she's always calling out his name."

Resident E's facility clinical record review began on 7/21/11 at 6:30 a.m. The record indicated the resident was admitted to the facility on 7/23/04 and had diagnoses including, but not limited to, the following: closed dislocation of hip, bipolar disorder unspecified, generalized anxiety disorder, history of urinary tract infection, malignant neoplasm of thyroid gland, unspecified personality disorder, depressive disorder, and hyposmolality and/or hyponatremia, coronary atherosclerosis, congestive heart failure, cardiac dysrhythmias, arthropathy, dementia with behavioral disturbances, esophageal reflux, acute but ill-defined cerebrovascular disease, hypertension, unspecified psychosis.

The resident's most recent quarterly

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	Minimum Data Set [MDS] Assessment, dated 5/27/11, included, but was not limited to, the following: Unclear speech, rarely/never understood, rarely/never understands, long term and short term memory problems, severely impaired decision making, disordered thinking, delusions, extensive assistance of two staff for bed mobility, total dependence of two staff for transfers, and unable to ambulate. She was assessed as always incontinent of bowel and bladder, had signs and symptoms of pain, and had experienced unplanned weight loss. The resident's most recent full MDS assessment, a significant change MDS dated 11/26/10, included, but was not limited to, the following: communication clear, Brief interview for Mental Status score of 05/15, with 15/15 being alert and oriented, no delusions or behaviors identified, extensive assistance of two staff for bed mobility, and transfers, and unable to walk. The assessment indicated she was always incontinent of bowel and bladder, experienced pain, but had experienced no weight loss. The resident was currently receiving hospice services. The nurse aide assignment sheets for the			

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	400 and 500 halls were provided by CNA #10 on 7/22/11 at 10:26 a.m. and reviewed at that time. Under "Special Needs," was indicated the following: "two for care non-skid slipper socks when out of bed BEHAVIORS. HOSPICE roho air mattress KEEP SET ON #4." Nurses' notes/progress notes were reviewed from 6/8/11 through 7/22/11 and included, but were not limited to, the following: "7/18/11 07:57 [7:57 a.m.] Resident slept well during the night on no pressure mattress, with floor mats on floor for safety." "Late Entry 7/19/2011 12:40 [12:40 p.m.] Note text: Resident reported allegations of abuse, MD [medical doctor] made aware of allegations et new order received for resident to go to er [emergency room] for evaluation et tx [treatment]; poa [power of attorney] [name] notified of residents allegations of abuse et permission obtained for resident to go to [name of hospital] main campus for nessary (sic) tx related to allegations. Residents (sic) poa stated, "THIS WAS OBSERED ET RIDICULOUS ALSO A WASTE OF TIME BUT DO WHAT EVER WE WANTED TO DO." (sic) transportation arranged et resident transported to [name of hospital]." "7/19/2011 16:03 [4:03 p.m.] Resident			

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	refused ADL [activities of daily living] care this am [morning] despite 2 attempts by staff." "7/19/11 20:08 [8:08 p.m.] @ 1900 [7:00 p.m.] res [resident] return to [name of facility] on srecther (sic) per ambulance, escorted per 2 [name of ambulance company] personnel. No c/o [complaints] noted upon return. N.O. [new order] received for Zofran [for nausea] 4 mg Q 6 hrs [every six hours] PRN [as needed] times 3 doses and update Dr. [name] in AM." "7/19/11 23:27 [11:27 p.m.] Res. resting quietly in bed at this time. Res. in good humor, taking meds without difficulty, no periods of anxity (sic), normal demeaner (sic), res. calling out to staff by name as normal in ADLs." "7/20/11 06:55 [6:55 a.m.] "1 on 1 observation started. Resident had uneventful night, mainly sleeping. Verbalized needs and wants. C/O [complaint of] hurting. Reassurance and redirect provided with little success. Roxanol 0.25 ml [milliliters] given @ 0035 [12:35 a.m.] for pain and general discomfort. Resting comfortably during noc's. 1 on 1 observation provided by female staff thru the night. No further C/O of pain or discomfort and was resting comfortable..." "7/20/2011 14:55 [2:55 p.m.] General Note. Providing 1:1 with [name] 2:00 -			

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	2:45 p.m. resident hollered "help." This SSD [Social Service Director] entered room, resident stated she was wet when asked what she needed. Nursing notified of need to provide peri-care. When asked if she remembered going to hospital yesterday, she responded, 'Yes'. (sic) When asked if she knew what the reason for transfer to hospital was, she responded, 'I was raped'. (sic)..." The resident's record indicated she was being followed by a Psychiatrist. The last visit was dated 6/27/11. The report indicated the behaviors and symptoms she was being seen for were agitation, afraid to die, anxiety, false beliefs, and jittery/nervous. During the visit, the Psychiatrist documented "denies mood or anxiety c/o." The facility did have monitoring in place for anxiety, false beliefs and jittery or nervousness. Review of May, June, and July, 2011, did not indicate any issues. CNA #13 was interviewed, on 7/22/11 at 9:07 a.m. She indicated she had worked on 7/19/11, on the day shift. She indicated, "I think I took care of her...I did change her, by myself." She indicated she remembered changing the resident's incontinence brief; the resident had not complained. The resident's brief had an			

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	off-white colored discharge in it, but she indicated the resident always had that. She indicated the resident had said nothing to her and the first thing she heard about the allegation was when they were sending her to the hospital. CNA #14 was interviewed on 7/22/11 at 10:20 a.m. She indicated she had arrived on the unit that morning around 8:00 a.m. She indicated the resident did not want a bath that morning, which was a little unusual. She indicated she approached the resident again later, sometime around 11 a.m. or so. At that time, Resident E, stated to her, "[CNA #6's first name] raped me, [name] raped me." She indicated she immediately left the room and found the first nurse she could find, the Staff Development Nurse. The Staff Development Nurse told her to tell the DoN immediately and she did. She indicated she had provided the resident peri-care around 10:30 a.m. and nothing unusual had occurred or was observed, and the resident had not reported the allegation at that time. CNA #14 indicated she "normally" used two people in Resident E's room, but not all the time, "I don't always take another person." She indicated the reason they normally used two staff was "based on her history." The DoN was re-interviewed, on 7/22/11			

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	at 10:30 a.m. She indicated the instructions, "two for care," was on the assignment sheet prior to the allegation and the instructions were due to false reports in the past (not of rape). She indicated, if she had been able to interview CNA #6, she would have asked him if he had two people with him all the time, and if not, why, but law enforcement had not allowed the facility to interview him. CNA #9 was re-interviewed on 7/22/11 at 11:30 a.m. She indicated she worked the night shift 7/18/11-7/19/11. She indicated she worked the 400 hall and CNA #6 worked the 500 hall, where Resident E resided. She indicated she did not assist CNA #6 with Resident E at any time during that shift. She indicated some CNAs liked to stay on their own halls and some liked to do bed checks together and CNA #6 would usually work by himself. When queried about residents who needed two staff for assistance, she indicated there were times when she did not get a second staff member to help. RN #5 was re-interviewed, on 7/22/11 at 11:45 a.m. When queried, she indicated she could not say either way whether or not she assisted CNA #6 with Resident E on the night of 7/18-7/19/11. She did not remember. She indicated nothing unusual			

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	happened that night. When queried about bed checks and whether or not CNA #6 did them by himself, she indicated sometimes CNAs, in general, would take two, if it was a resident who fought, or needed more help. She indicated she had not taken a lunch break that night, that she was the only nurse, and was always on one hall or the other. She indicated she did not know, for sure, whether or not CNA #6 cared for Resident E by himself or not. 3. Resident F's clinical record was reviewed on 7/21/11 at 6:50 a.m. The resident had been admitted to the facility on 6/23/11. A Nurse's note, dated 06/30/11 at 04:18 [4:18 A.M.], indicated, "[local ambulance company] her [sic] to transport. Resident told EMT's [Emergency Medical Technician's] that she had been rapped [sic], that she was being held hostage, that her fron [sic] teeth were knocked out...." A Minimum Data Set Assessment, dated 6/30/11, indicated the resident required extensive assistance of two persons for bed mobility and transfers. CNA #10 provided a copy of the Nurse Aide assignment sheets, on 7/22/11 at 10:26 a.m. The Special Needs section for Resident F indicated, "FLOAT HEELS 2			

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	CNA'S WITH ALL CARE AT ALL TIMES NO MALE CARE GIVERS." CNA #9 was interviewed on 7/22/11 at 11:30 a.m. She indicated she worked the night shift 7/18/11-7/19/11 [Monday night/Tuesday morning]. She indicated she worked the 400 hall and CNA #6, a male CNA, worked the 500 hall, where Resident F resided. [CNA #6 had not worked the night Resident F indicated she was raped] She indicated she did not assist CNA #6 with Resident F at any time during that shift. She indicated some CNAs liked to stay on their own halls and some liked to do bed checks together and CNA #6 would usually work by himself. When queried about residents who needed two staff for assistance, she indicated there were times when she did not get a second staff member to help. RN #5 was interviewed on 7/22/11 at 11:45 a.m. She indicated she could not say for sure if two CNAs went in together to care for Resident F. She indicated CNA #6 and CNA #9 were working that night. She could not recall if she assisted with care for Resident F or not. 4. The clinical record of Resident I was reviewed on 07/14/11 at 9:50 A.M. During initial tour, on 07/11/11 at 11:00			

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	a.m., the DoN identified Resident I as interviewable and required extensive assistance for transfers. On 07/14/11 at 9:30 A.M., Resident I was observed lying in bed watching TV. The clinical record indicated the current diagnoses of Resident I included, but were not limited to, joint pain and lumbago [low back pain]. The current MDS [Minimum Data Set Assessment], dated 05/19/11, indicated Resident I had no cognitive impairment and required extensive assistance of two staff for transfers. The undated Skilled Unit Assignment Sheet 200 Hall, provided by LPN #2 on 07/13/11 at 1:00 p.m., indicated Resident I required assistance of two for transfers. A Care Plan, dated 12/21/10, indicated the problem of, "I have a physical functioning deficit related :...Mobility impairment..." with interventions that included, but were not limited to, "...Transfer assistance of (2) [two]..." A Care Plan, dated 04/06/11, indicated Resident #I was, "At risk for falls related to ...history of falls."			

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	A Nursing Note, dated 06/09/11 at 16:13 [4:13 P.M.], indicated, "Fall note:...Resident was lowered to floor on 06/08/11. Resident was trying to transfer from commode with one assist from staff..." In an interview with the DoN, on 07/14/11 at 11:15 A.M., she indicated, "[Resident I] should have been transferred by two staff before the fall. I wouldn't transfer her by myself." In an interview with CNA [Certified Nursing Assistant] #4, on 07/14/11 at 11:20 A.M., she indicated, "She has been a two person transfer for a long time. I would never transfer her by myself." 5. Resident J's clinical record was reviewed on 7/11/11 at 2:05 p.m. The resident's Minimum Data Set [MDS] assessments, dated 1/15/11 and 4/15/11, indicated the facility was using pressure reducing devices in the chair and the bed. Physician's orders, signed 5/5/11, indicated orders for pressure reducing devices to the chair. The physician's orders also indicated anti-tippers were to be in place on the wheelchair. The resident's care plan for pressure ulcer risk, dated 8/13/10 and current, indicated an intervention to provide a pressure			

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	reducing wheelchair cushion to the wheelchair. The resident was observed at the following dates and times without a pressure reducing device to the wheelchair and without anti-tippers to the wheelchair: 7/11/11 3:45 p.m. 7/12/11 9:00 a.m., 10:30 a.m., 3:30 p.m. 7/13/11 9:35 a.m., 11:30 a.m. 6. Resident A's clinical record was reviewed on 7/14/11 at 10:30 a.m. Medication orders, signed 6/23/11, and hospital return orders, signed electronically on 7/10/11, indicated the resident was to receive "Lopressor [anti-hypertensive, for high blood pressure] 25 mg [milligrams] tablet enteral tube - two times a day everyday: 1 tab pegtube BID [twice a day] check BP [blood pressure] et pulse before giving this med [medication]." The Medication Administration Record [MAR] for July, 2011 was reviewed on 7/15/11 at 10:30 a.m. The MAR indicated Lopressor 25 mg was to be given through the enteral tube BID, "CHECK BP ET PULSE BEFORE GIVING THIS MED." The MAR lacked any documentation of a blood pressure or pulse being taken before the medication was given. The clinical			

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	record lacked documentation blood pressure and pulse were checked twice a day before giving the medication. The Medical Records Clerk indicated, on 7/19/11 at 3:20 p.m., she could find no record of blood pressure and pulse checks prior to giving the Lopressor twice a day. She provided nurses' notes from 7/11/11 to 7/19/11 that contained occasions blood pressure and pulse assessments; none indicated they were prior to administering the medication. This federal tag relates to complaint number IN00093878. 3.1-35(g)(2)			

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F0309 SS=D	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. Based on record review and interview, the facility failed to ensure blood sugars were monitored in accordance with physician's orders, for 1 of 3 residents reviewed for diabetes management, in the sample of 17, in that the admission orders indicated blood sugar was to be monitored before meals and at bedtime and this monitoring did not start for 2 days. (Resident C) Finding includes: Resident C's clinical record was reviewed on 7/15/11 at 9:50 a.m. The resident was admitted to the facility at 4:00 p.m. on 6/22/11, via family car, with diagnoses including, but not limited to, aortic stenosis status post aortic valve replacement on 6/15/11, atrial fibrillation status post epicardial maze procedure on 6/15/11, peripheral artery disease-carotid artery, depression, coronary artery disease,	F0309	F309 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: RC is no longer a resident of the facility. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** All other residents with an order for accuchecks have been reviewed to ensure order is on MAR. New admissions/readmissions chart will be reviewed by DNS/Designee to ensure monitoring of blood sugar orders are correct. All licensed staff was educated by 8/19/11 regarding reviewing of transfer orders including all discharge orders with the MD upon admission and transcribing orders as indicated. The measures put into place and the systemic changes made to ensure that this	08/21/2011

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	type 2 diabetes mellitus, and previous chronic anticoagulation discontinued 5/2011 due to anemia. The resident arrived after being discharged the same day from an out of town hospital. The resident's discharge instructions included medication orders that included, but were not limited to, the following: Glipizide [to treat high blood sugar due to diabetes] 5 mg [milligrams] oral 1 tablet by mouth two times a day Metformin [glucophage] [to treat high blood sugar due to diabetes] 500 mg oral tablet 1000 mg by mouth two times a day Additional instructions were for "...blood sugars before all meals and bedtime. Call facility physician if less than 80 or over 200." The record indicated a local physician visited the resident on 6/24/11 and ordered the following: "Novolog Insulin to be given dependent on A/C [before meal] blood sugars." A sliding scale for insulin coverage was specified as follows: "0-150 - [no] insulin, 151-200 - 2 units, 201=250 - 3 units, 251-300 - 4 units, 301-350 - 5 units, 351-400 - 6 units >400 - call MD." Review of the Medication Administration Record, treatment record, and nurses'		deficient practice does not recur are as follows: All licensed staff was educated by 8/19/11 regarding reviewing of transfer orders including all discharge orders with the MD upon admission and transcribing orders as indicated. New orders will be audited daily by DNS/Designee. DNS/Designee will ensure audits of blood sugar results and verification of MD notification will be completed 3 x weekly for 4 weeks, 2 x week for 4 weeks, weekly for 4 weeks then monthly x 3 months. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed.	

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	notes indicated the first time a blood sugar was checked was 6/24/11 at 1600 [4:00 p.m.]. Blood sugars were documented as follows: 6/24/11 1600, 120 6/24/11 2100 [9:00 p.m.] 262 6/25/11 0600 [6:00 a.m.] 104 6/25/11 1100 [11:00 a.m.] 99 6/25/11 1600, 93 6/25/11 2100, 105 6/26/11 0600, 92 6/26/11 1100, 81 6/26/11 1600, 87 6/26/11 2100, 234 6/27/11 0600, 107 There was no indication the physician was notified of the blood sugars greater than 200. There was no indication the physician was notified of any blood sugars until 6/26/11 at 17:09 [5:09 p.m.]. The nurse's note indicated, "Refused Glucophage at 1700 [5:00 p.m.]. Accucheck 87. Resident states she doesn't want her blood sugar to get any lower. Dr. [name] notified." And on 6/27/11 at 04:21 [4:21 a.m.], "Laboratory services here this am [morning] to draw CBC [complete blood count], TSH [thyroid stimulating hormone], HgBA1C [hemoglobin A1C indicates long term blood sugar levels], and CMP [Complete Metabolic Panel]. Faxed weekly accuchecks to MD for review."			

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A facsimile transmittal, dated 6/26/11, and time stamp indicating it was faxed to the physician at 17:14 [5:14 p.m.], indicated the following: "AC [before meal] running 80-104 since admission. She is receiving Glipizide 5 mg BID and Glucophage 1000 mg BID. Plus sliding scale insulin. Res. [resident] refused glucophage @ 1700 6-26-11. Stated she didn't want blood sugar getting too low. Appetite good this weekend. Could you please review these diabetic meds. Afraid she's going to get too low."

LPN # 9 was interviewed on 7/18/11 at 11:15 a.m. She indicated she worked until 7:00 p.m. on 6/26/11. She indicated she was supposed to call the physician if the blood sugar got below 80, but it had been 81. She discussed the resident's medications with her and the resident decided not to take her glucophage at 5:00 p.m. She indicated she had faxed the physician the resident's blood sugars from 6/24/11 through 6/26/11 at 4:00 p.m.

LPN # 8 was interviewed on 7/18/11 at 11:17 a.m. She indicated she would have to checked the blood sugars at the 9:00 p.m. blood sugar check on 6/26/11 and the 6:00 a.m. blood sugar on 6/27/11. She indicated she remembered checking them, but didn't recall what they were. She

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	indicated she thought the resident was to receive sliding scale insulin. She indicated the resident would have gotten one of her blood sugar pills at 9:00 p.m., "I would remember if i help medication." She did not recall calling the physician about the blood sugar, but did fax the blood sugar history early in the morning 6/27/11. She also remembered the morning blood sugar was within normal limits and indicated the resident was alert and even requested to be taken to the bathroom, which she did around 7:00 or 7:30 a.m. This federal tag relates to complaint number IN00093538. 3.1-37(a)			

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F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review and interview, the facility failed to ensure 1 of 1 sampled resident with a feeding tube, in the sample of 17, received physician's orders for, and had documentation of water administration via the tube, for 5 days, following a hospitalization. (Resident A) The facility also failed to ensure 1 of 1 supplemental sample resident with a feeding tube, in the supplemental sample of 14, had the feeding tube placement checked prior to medication administration. (Resident #69) Finding includes: 1. Resident A's clinical record was reviewed on 7/14/11 at 10:30 a.m. The resident's record indicated diagnoses including, but not limited to, history of acute respiratory failure, tracheotomy, aphasia, schizophrenia, diabetes mellitus, renal failure, and hypertension. The resident had a gastrostomy tube. On 7/4/11, the resident dislodged her	F0322	**F322 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: RA orders were reviewed and the order for water flush and placement of tube check prior to admission of water or feeding was placed on MAR. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All other residents that have a G tube had their orders reviewed and if needed water flush orders and placement of tube was added to MAR.** The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: DNS/Designee will review all residents with G tubes weekly ongoing to ensure that placement and water flushes are correct and on MARs. RD will review any new admissions/readmissions	08/21/2011

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	tracheotomy tube and was sent out to the emergency room. She was hospitalized from 7/5/11 through 7/10/11. Prior to the hospitalization, the resident had a physician's order, dated 6/23/11, to flush the gastrostomy tube with 150 cc [cubic centimeters] of water every four hours. The order had been obtained following a recommendation from the Registered Dietitian, on 6/22/11. Upon return from the hospital, no orders for water through the tube were on the order sheet, or obtained. The resident's orders, prior to the hospitalization, indicated she was to have nothing by mouth except small sips of water, supervised with nursing and speech therapy only. On 7/15/11 at 2:15 p.m., the Medication Administration Record [MAR] was reviewed. There were no water flushes indicated to be given. LPN #1 was interviewed, on 7/15/11 at 2:20 p.m. She indicated the water administration would be on the MAR. She indicated she had put in the orders when the resident returned from the hospital and didn't realize there weren't orders for water. She indicated she had given 150 cc of water at around 8:00 a.m. that morning, and at around 12:30 p.m. She indicated she		with G tubes to ensure water flush orders are accurate. Present G tube residents will be reviewed quarterly ongoing. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed.	

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	knew to do so because the resident had been getting the water before she went to the hospital. She indicated the resident had been drinking some water by mouth and getting continuous tube feeding. When queried about whether or not they were tracking the resident's intake and output, she indicated she didn't know if that was indicated in long term care. The resident was observed, at 2:30 p.m. on 7/15/11, to be laying in bed with the continuous tube feeding running at 60 cc per hour, as ordered. There were no obvious signs/symptoms of dehydration. The record information was reviewed with the Director of Nursing at 3:50 p.m. on 7/15/11. She indicated a thorough assessment would be conducted and the physician would be notified and water flushes re-started. On 7/18/11 at 4:40 p.m., The Director of Nursing indicated laboratory tests had been done 7/15/11 and the physician had been notified and orders had been obtained for water to be given via the tube, 150 cc every 6 hours. The record was reviewed again on 7/18/11 at 4:45 p.m. There was no indication the resident was experiencing dehydration. 2. During observation of the medication pass, on 07/18/11 at 8:25 A.M., RN #1			

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	indicated she was preparing to administer medications and through a g-tube for Resident #69. RN #1 prepared Aspirin [to thin the blood] 81 mg [milligrams], Furosemide [a diuretic] 40 mg, Ativan [for anxiety] 0.5 mg, Potassium Chloride [an electrolyte replacement] 7.5 meq [milliequivalents] and MAPAP [Tylenol, medication for pain] 500 mg. A pill review/count was conducted at that time, which resulted in RN #1 indicating she had only prepared Tylenol 500 mg when Tylenol 1000 mg was the ordered dose. RN#1 was then observed to apply gloves without handwashing, crush the Aspirin, Furosemide, Ativan and Tylenol, pour the crushed medications and the Potassium Chloride directly into a 237 ml [milliliter] can of Jevity 1.5 Cal [a calorie dense liquid medical food] and stir it with a straw. In an interview with RN #1, on 07/18/11 at 8:30 A.M., she indicated, "This lady has a g-tube, but she can take the feeding by mouth, so I am gonna give her pills p.o. [by mouth]." Resident #69 was observed, on 07/18/11 at 8:35 A.M., to be sitting in her room in a wheelchair. RN #1 was then observed to enter the room of Resident #69 and hold the can			

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with a straw up to the mouth of Resident #69 and say, "take a drink." Resident #69 was observed, at that time, to drink from the can multiple times and then indicated, by shaking her head, that she did not want anymore. At that time, RN #1 informed Resident #69, "Then I will have to use your tube."

RN #1 was then observed to retrieve a syringe, insert the tip of the syringe into the g-tube port, instill a 10 cc [cubic centimeter] air bolus, and check for a residual. RN #1 indicated at that time, "There is no residual." She did not have a stethoscope to listen for any air flow into the stomach.

RN #1 was then observed to begin to administer the remainder of the Jevity 1.5 Cal, which included the prepared medications. RN #1 was stopped from proceeding and queried if she had ensured the g-tube was in the proper location. RN #1 indicated at that time, "I should have listened for air." RN #1 was then observed to exit the room and return with a stethoscope. RN #1 was then observed to place the bell of the stethoscope directly on the shirt of Resident #69 in the area of the left upper quadrant of the abdomen and instill a small amount of air. At that time, RN #1 indicated, "I heard air." She then proceeded to administer the

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	feeding with the medications mixed in it. The Policy and Procedure for Enteral Nutritional Therapy (tube feeding), provided by the DoN on 07/18/11 at 11:00 A.M., indicated a procedure to check placement by injecting a small amount of air into the tube and listen with a stethoscope for the air. The Geriatric Medication Handbook, Eighth Edition, reviewed on 0718/11 at 3:00 p.m., indicated the following: "Medication administration via enteral tubes procedures: ...8. Check for proper tube placement..." During an interview with the DoN, on 07/18/11 at 10:20 A.M., she indicated, "g-tube meds should not be given by mouth, ...feedings and meds should be allowed to flow by gravity, ... g-tube placement should be checked every time it is used." 3.1-44(a)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide supervision and assistance to 2 of 14 current sampled residents, in the sample of 17, to prevent accidents, in that one resident was able to exit the building unknown to the staff, and the other resident was transferred with only one staff assisting when two were care planned, resulting in the resident being lowered to the floor. (Residents H, I) Findings include: 1. The clinical record of Resident H was reviewed on 07/12/11 at 8:45 A.M. The clinical record indicated the current diagnoses of Resident # H included, but were not limited to, Alzheimer's dementia with behavioral disturbances. During initial tour, on 07/11/11 at 10:00 A.M., the DoN [Director of Nursing] identified Resident H as not interviewable, with a history of elopement, and had recently eloped from the facility. The DoN further indicated, at	F0323	F323 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: RH did not elope from the facility on 7/8/11 but went through a door off the ACU to regular side of facility and was immediately redirected back to Unit. RI had care plan and C.N.A. sheet reviewed and staff educated on 7/22/11. C.N.A. not following the sheets was counseled on 7/22/11 regarding following the C.N.A. sheets. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Care plans and C.N.A. sheets were reviewed on 7/22/11 to ensure any resident requiring 2 staff for transfers were correct and indicated on C.N.A. sheets. Staff was educated regarding use of C.N.A. sheets on 7/22/11. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Elopement drills will be held 3 times a week on various shifts for 30 days then every other week on	08/21/2011

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	that time, that the door alarm did not sound loudly by the nurse's station so the staff thought it was somewhere else in the building, and did not immediately respond to the alarm. On 07/12/11 at 8:50 A.M., Resident H was observed to be in her room rummaging through her purse. In an interview with the DoN, on 07/12/11 at 9:40 A.M., she indicated that Resident H was being admitted that day to [name of geriatric psychiatric unit]. An Initial Psychiactric [sic] Evaluation, dated 08/09/10, indicated, "[Resident H] transferred from [name of hospital] due to ... elopement risk, and attempting to leave her home while living with her family. The family has had to notify the police to escort her back to the house. She was recently found running down the center of [name of Avenue]...Family is worried about her safety. The patient walked away from [name of hospital] and security officer had to bring her back." The evaluation further indicated, "Diagnostic Summary: Patient with moderate cognitive impairment now demonstrating behavior such as leaving her home and wandering out into the pubic [sic] areas where she could easily be injured in traffic... Weaknesses: Elderly with		various shifts for 30 days and then monthly on each shift x 4 months. Maintenance will check alarm sound during routine maintenance checks. DNS/Designee will audit C.N.A. sheets to ensure that any resident requiring 2 assist for transfers is correct 5 times a week for 30 days, 3 times a week for 30 days, weekly for 30 days, then monthly x 3 months. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed.	

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multiple health problems and having poor insight and judgment [sic]."

A Care Plan, dated 08/23/10, identified a problem of, "I am at risk for elopement...I am an elopement risk with a hx [history] of elopement. I am not able to make good safety decisions".

The Quarterly Clinical Health Status Summary, dated 04/09/11, included an assessment titled "Section K. Risk for Elopement." The assessment indicated:
"1. Is resident physically able to leave building on their own?..." Answer: "yes"
"2. Is the resident cognitively impaired?..."Answer: "no"
"3. Does the resident have impaired decision making skills?..." Answer: "no"...
"5. Is there a history of wandering or elopement?..." Answer: "no"...
"7. Wanders aimlessly about the facility and/or exhibits night wandering?..." Answer: "no"

The current MDS [Minimum Data Set Assessment] dated 4/12/11 indicated Resident H was cognitively impaired, had no behaviors problems, and had no history of wandering.

A Care Plan dated 05/21/11 identified a problem of "Elopement" with interventions that included, but were not

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limited to, "...5. 1:1 [one to one] supervision 6. Monitor for exit seeking behavior and/or change in mood/behavior...8. Elopement protocol in place per policy/procedure."

A Nurse's note, dated 05/19/11 at 20:06 [8:06 P.M.], indicated, "Res [Resident] somewhat anxious-packing clothes-Res finaly [sic] convinced to lie down..."

A Nurse's note, dated 05/20/11 at 21:15 [9:15 P.M.], indicated, "cont [continues] to be confused-packing clothes and asking for rides..."

A Nurse's Note, dated 05/22/11 at 22:50 [10:50 P.M.], indicated, "Situation: Resident eloped out of facility using ACU [Alzheimer's Care Unit] entrance door by Director's office. She had a wanderguard on left ankle. Visitor [name of visitor] told staff she thought one of the residents went out the door...Response: Resident returned facility by visitor, [name of visitor] private vehicle as she observed her approximately 2 blocks from facility..."

An undated incident summary was provided by the DoN on 07/12/11 at 11:00 A.M. The summary indicated, "On 05/22/11 [name of Resident #H] exited the building unsupervised. The nursing

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	staff [name of RN #2 and CNA [Certified Nursing Assistant #5] stated that they did hear an alarm sounding but it was not at their station and that they continued to assist another resident. [RN #2] said that a visitor came up to the station, a couple of minutes later and reported that she thought a resident had went out the door..." An undated verification of investigation witness statement, provided by the HFA [Health Facility Administrator] on 07/13/11 at 2:00 P.M., from CNA [Certified Nursing Assistant] #5 indicated, "Was assisting nurse with another res [resident] up by nurses station on unit. Heard door alarm going off when visitor came up and said she thought a resident went out..." The verification of investigation further indicated, "Resident Interview Summary: Res stated I just pushed the door and went out..." In an interview with the HFA [Health Facility Administrator], on 07/12/11 at 11:30 A.M., she indicated, "The nursing station alarm malfunctioned, it did not sound loudly at the nursing station." An interview summary, provided by the HFA on 07/13/11 at 2:00 P.M., regarding a phone interview conducted by the ACU Director with the visitor who reported a			

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resident had exited the building, indicated, "[name of visitor] was ready to leave and kissed her mother goodnight and went to the door, but the alarm was going off. She put her purse in the car and ran back into the building worried that [Resident H] had left. She looked in the dining room and then ran to find the nurse and CNA who were busy with another resident. She reported incident to nurse and CNA. They stated they had heard the alarm but assumed it was in the main part of the building..."

An inservice training record, dated 05/23/11 at 17:30 [5:30 P.M.], indicated, "Elopement Guidelines:
1. Answer alarms IMMEDIATELY
2. Do not assume it's another location
3. Check doors within your work area, if alarm is heard...
6. Watch for and report to nurse behaviors such as, pacing, anxiety. as well as residents verbalizing "I'm going home"

The Clinical Health Status Summary, dated 06/21/11, included an assessment titled, "Section K. Risk for Elopement." The assessment indicated:
"1. Is resident physically able to leave building on their own?..." Answer: "yes"
"2. Is the resident cognitively impaired?..."Answer: "no"
"3. Does the resident have impaired

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	decision making skills?..." Answer: "no"... "5. Is there a history of wandering or elopement?..." Answer: "no"... "7. Wanders aimlessly about the facility and/or exhibits night wandering?..." Answer: "no" A Nurse's Note, dated 07/08/11 at 18:30 [6:30 P.M.], indicated, "Situation: Resident hyperactive, ambulating corridor and room to room testing all exit doors. Resident was successful in exiting skille [sic] dunit [sic] (skilled unit) door ... Behavior started at 3:00 P.M. and escalted [escalated] all evening." The most recent Care plan for elopement lacked any indication that it had been updated with any new intervention after the elopement of 07/08/11. The Policy and Procedure for Elopement, provided by the HFA on 07/14/11 at 2:30 P.M., indicated, "Elopement Policy...The purpose of the elopement policy is to:...Protect resident that are not capable of protecting themselves...Door alarms...A specific system has been developed to notify staff that an external door has been opened in an area accessible to residents..." In an interview with the HFA, on 07/14/11 at 2:00 P.M., she indicated the staff on			

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	duty at the time of the elopement should have responded immediately to the door alarm. 2. The clinical record of Resident I was reviewed on 07/14/11 at 9:50 A.M. During initial tour, on 07/11/11 at 11:00 a.m., the DoN [Director of Nursing] identified Resident I as interviewable and required extensive assistance for transfers. On 07/14/11 at 9:30 A.M., Resident I was observed lying in bed watching TV. The clinical record indicated the current diagnoses of Resident I included, but were not limited to, joint pain and lumbago [low back pain]. The current MDS [Minimum Data Set Assessment], dated 05/19/11, indicated Resident I had no cognitive impairment and required extensive assistance of two staff for transfers. The undated Skilled Unit Assignment Sheet 200 Hall, provided by LPN #2 on 07/13/11 at 1:00 p.m., indicated Resident I required assistance of two for transfers. A Care Plan, dated 12/21/10, indicated the problem of, "I have a physical functioning deficit related to:...Mobility			

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	impairment...," with interventions that included, but were not limited to, "...Transfer assistance of (2)..." A Care Plan, dated 04/06/11, indicated Resident # I was, "At risk for falls related to ...history of falls." A Nursing Note, dated 06/09/11 at 16:13 [4:13 P.M.], indicated, "Fall note:...Resident was lowered to floor on 06/08/11. Resident was trying to transfer from commode with one assist from staff..." In an interview with the DoN, on 07/14/11 at 11:15 A.M., she indicated, "[Resident I] should have been transferred by two staff before the fall. I wouldn't transfer her by myself." In an interview with CNA [Certified Nursing Assistant] #4, on 07/14/11 at 11:20 A.M., she indicated, "She has been a two person transfer for a long time. I would never transfer her by myself." 3.1-45(a)(2)			

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F0332 SS=E	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 10 medication errors out of 47 opportunities for error, resulting in an 21.27% error rate. This affected 3 of 14 residents observed for medication pass (Residents #69, #81, #76), and 2 of 7 nurses observed to pass medications. (RN #1, LPN #3) Findings include: 1. During observation of the medication pass, on 07/18/11 at 8:25 A.M., RN #1 indicated she was preparing to administer medications and through a g-tube for Resident #69. RN #1 prepared Aspirin [to thin the blood] 81 mg [milligrams], Furosemide [a diuretic] 40 mg, Ativan [for anxiety] 0.5 mg, Potassium Chloride [an electrolyte replacement] 7.5 meq [milliequivalents] and MAPAP [Tylenol, medication for pain] 500 mg. A pill review/count was conducted at that time,	F0332	**F332** The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: RN#1 was immediately reeducated regarding giving medications through a G tube and to give medications with food if indicated on 7/26/11. R 76's order was clarified and corrected on 7/15/11. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All licensed staff has been audited by observation of medication pass of giving medications through a G tube and giving medications with food if indicated by 8/2/11. Medical records were reviewed to ensure medication orders were transcribed correctly by 8/19/11. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: All licensed staff has been audited by observation of medication pass of giving medications through a G tube and giving medications with food if	08/21/2011

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	which resulted in RN #1 indicating she had only prepared Tylenol 500 mg when Tylenol 1000 mg was the ordered dose. RN#1 was then observed to apply gloves without handwashing, crush the Aspirin, Furosemide, Ativan and Tylenol, pour the crushed medications and the Potassium Chloride directly into a 237 ml [milliliter] can of Jevity 1.5 Cal [a calorie dense liquid medical food] and stir it with a straw. In an interview with RN #1, on 07/18/11 at 8:30 A.M., she indicated, "This lady has a g-tube, but she can take the feeding by mouth, so I am gonna give her pills p.o. [by mouth]." Resident #69 was observed, on 07/18/11 at 8:35 A.M., to be sitting in her room in a wheelchair. RN #1 was then observed to enter the room of Resident #69 and hold the can with a straw up to the mouth of Resident #69 and say, "take a drink." Resident #69 was observed, at that time, to drink from the can multiple times and then indicated, by shaking her head, that she did not want anymore. At that time, RN #1 informed Resident #69, "Then I will have to use your tube." RN #1 was then observed to retrieve a		indicated by 8/2/11. All new nurses will be audited by DNS/ADNS/DCE on medication pass with G tube medications during orientation. New medication orders will be reviewed daily to ensure medications are transcribed correctly. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the medication observations and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans written and implemented as needed.	

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syringe, insert the tip of the syringe into the g-tube port, instill a 10 cc [cubic centimeter] air bolus, and check for a residual. RN #1 indicated at that time, "There is no residual."

RN #1 was then observed to begin to administer the remainder of the Jevity 1.5 Cal, which included the prepared medications.

On 07/18/11 at 8:40 A.M., RN #1 was observed to administer the Jevity/medication mixture by pouring the mixture into the open syringe and pushing the bolus through the syringe with the plunger. RN #1 was not observed to administer a flush before or after administering the medications. RN #1 was observed to add an unmeasured amount of water to the syringe and indicated, "Her feeding is slow, it helps to thin it down." RN #1 then indicated she had added 50 cc [cubic centimeters] of water to the g-tube.

The Clinical Record of Resident #69 was reviewed on 07/18/11 at 11:10 A.M. The record indicated the diagnoses of Resident #69, included, but was not limited to, Aphagia.

In an interview with the Speech Therapist, on 07/18/11 at 2:00 P.M., she indicated,

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	"I have never heard of Aphagia, she has Dysphagia [a swallowing impairment]." The May 2011 Physician's Order Recap included, but was not limited to, orders for "Tylenol 500 mg tablet gastrostomy tube three times a day Everyday: 2 tabs, ASA [Aspirin] 81 mg tablet gastrostomy tube-once a day everyday, Ativan (Lorazepam) 0.5 mg tablet gastrostomy tube-two times a day everyday..., Lasix (Furosemide) 40 mg tablet gastrostomy tube-once a day everyday...Potassium Chloride 10 meq/50 ml solution gastrostomy tube-two times a day everyday: 10 meq..." The Recaps further indicated, "Diet:...Regular Mechanical Soft... Special Instructions: Regular Mechanical Soft diet with thin liquids P.O. for oral gratification only...Enteral Feedings...Special Instructions: Flush g-tube with 100 cc H2O [water] every 4 hours...Monitoring order...Check g-tube placement q [every] shift...Check g-tube residual q shift...May crush meds and administer per g-tube..." A Physician's telephone order, dated 05/06/11, indicated the current enteral feeding order was, "Give 200 cc of Jevity 1.5 Cal Bolus four times daily tube." The current care plan, dated 06/30/10, indicated, "Nutrition: dependent on tube			

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	feeding/inadequate oral intake due to: CVA [stroke],..." with interventions which included, but were not limited to: "Check tube placement every feeding...Enteral...feedings as ordered...water flushed as ordered..." The failure to flush the tube before and after the medication administration, and the failure to administer all the medications to the resident by the ordered route, resulted in seven [7] medication errors for this observation. The Policy and Procedure for Enteral Nutritional Therapy (tube feeding), provided by the DoN on 07/18/11 at 11:00 A.M., indicated, "Procedure: 5. ...pour prescribed amount of water into the syringe. 6. Administer the amount of feeding to be given by holding the syringe 12 to 14 inch's above the level of the stomach. Allow the feeding to flow into the stomach very slowly. 7. Follow the feeding with the prescribed amount of water and administer in the same manner..." The Geriatric Medication Handbook, Eighth Edition, reviewed on 0718/11 at 3:00 p.m., indicated the following: "Medication administration via enteral tubes procedures: ...8. Check for proper tube placement...12. Put 15-30 ml			

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	[milliliters] water in syringe and flush tubing using gravity flow...13. Pour dissolved/diluted medication in syringe...14. Flush tubing with 15-30 ml of water, or prescribed amount..." During an interview with the DoN, on 07/18/11 at 10:20 A.M., she indicated, "g-tube meds should not be given by mouth, ...feedings and meds should be allowed to flow by gravity, ... g-tube placement should be checked every time it is used." 2. During observation of the medication pass, on 07/18/11 at 9:15 A.M., RN #1 was observed to prepare and administer medications for Resident #81. The medications RN #1 administered included, but were not limited to, Carvedilol 6.25 mg [a medication for high blood pressure] and Vitamin C 500 mg [a vitamin supplement]. Resident #81 was observed, on 07/18/11 at 9:20 A.M., sitting in a wheelchair conversing with other residents. In an interview with RN #1, on 07/18/11 at 9:20 A.M., she indicated, Resident #81 "had breakfast at 8:00 A.M." The Clinical Record of Resident #81 was			

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	reviewed on 07/18/11 at 3:00 P.M. The record indicated the current diagnoses for Resident #81 included, but were not limited to, Hypertension [high blood pressure]. The June 2011 Physician's Recap included, but was not limited to, orders for "Ascorbic Acid 500 mg tablet by mouth-two times a day 1 tab p.o. with meals...Coreg (Carvelidol) 6.25 mg tablet by mouth-two times a day everyday..." The Physician Progress Note dated 01/24/11 indicated, "Continue Carvedilol tablet, 6.25 mg, orally, 1 tablet with food twice a day." A policy and procedure for Medication Administration, dated 10/2007, was provided by the DoN on 07/18/11 at 1:10 P.M. The policy indicated, "Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. 3. b. Medications to be given with meals are to be scheduled for administration at the resident's meal times." The 2010 Nursing Spectrum Drug Handbook, page 194, indicated, "Carvedilol...give immediate release form with food to slow absorption and minimize orthostatic hypotension [low blood pressure]."			

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	In an interview with DoN, on 07/18/11 at 10:20 A.M., she indicated, "If meds are ordered with food they should be given with meal." 3. On 7/13/11 at 5:00 p.m., LPN 3 was observed administering medications to Resident #76. The medications included, but were not limited to, Pramipexole Dihydrochloride 1 milligram [mg] [antidyskinetic, used for symptoms of Parkinson's disease] one tablet. The one tablet was given orally with water. Resident #76's clinical record was reviewed on 7/15/11 at 11:15 a.m. Physician's orders, signed on 5/5/11, indicated the resident was to receive Pramipexole 2 mg every day. 3.1-25(b)(9) 3.1-48(c)(1)			

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure 1 of 14 sampled current residents, in the total sample of 17, was free of significant medication error, in that blood pressure medications were not given as ordered, with continued high blood pressures. (Resident #57) Finding includes: Resident #57's clinical record was reviewed on 7/11/11 at 2:45 p.m. The resident was admitted to the facility on 5/27/11, and diagnoses included, but were not limited to, a history of cerebrovascular accident [CVA] [stroke]. The admission physician's orders, dated 5/27/11, indicated an order for "Clonidine 0.1 mg [milligrams] three (3) times a day." The order on the Medication Administration Record [MAR] for May, 2011, indicated the following: "Clonidine HCL [hydrochloride] 0.1 mg, Dose: 1 tab Order date: 5/27/11 once a day 1 tab TID [three times a day]. Hold for SBP [systolic blood pressure] < [less than] 120." The medication was scheduled for once a day at 0900 [9:00 a.m.].	F0333	F333 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: **R57's orders were reviewed and corrected.** Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Other resident's orders were reviewed to ensure dosage was transcribed correctly and corrected as indicated. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: All licensed staff was educated by 8/19/11 regarding transcribing orders as indicated. New orders will be audited daily by DNS/Designee. DNS/Designee will ensure audits of medication transcribing will be completed 3 x weekly for 4 weeks, 2 x week for 4 weeks, weekly for 4 weeks then monthly x 3 months. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6	08/21/2011

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	The resident received the Clonidine once a day from 5/28/11 through 7/8/11. On that date, the medication was changed on the MAR to the ordered three times a day. The physician saw the resident on 6/13/11. She wrote new orders, by hand, at the end of a physician's recapitulation of orders, as follows: "Start Bystolic [for high blood pressure] 5 mg po [by mouth] q [every] daily." "[increase] Lisinopril [for high blood pressure] to 60 mg po q daily." These medications were not transcribed, or started. The failure to start the ordered medications was reviewed with the Director of Nurses, on 7/15/11 at 3:50 p.m. During interview on 7/18/11 at 4:40 p.m., the Director of Nurses indicated, during interview, she had reviewed the medication orders for Resident #57 and indicated the medications had not been started as ordered. She indicated the physician had been notified and the medication had been initiated at that time, on 7/18/11. Blood pressure readings documented on the MAR included, but were not limited to, the following:		months. Data will be analyzed for patterns and trends and action plans will be written and implemented as needed.	

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	5/29 140/78 5/30 126/70 5/31 170/88 6/2 154/90 6/3 170/110 6/5 148/88 6/9 180/92 6/15 186/96 6/19 122/66 6/20 170/84 6/25 156/80 6/29 180/90 7/1 170/84 7/4 190/90 7/6 180/90 7/8 174/104 After Clonidine given as ordered, starting 7/8/11: 7/10 128/76 7/13 194/110, 150/78 7/16 174/82 7/17 148/82 After Bystolic started and Lisinopril increased: 7/16 174/82 7/17 162/98 7/18 154/92 3.1-25(b)(9) 3.1-48(c)(2)			

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F0364 SS=E	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 interview, observation and record review, the facility failed to ensure food that was palatable and at the desired temperature, for 5 of 6 alert and oriented residents in the group interview, and for 1 of 3 additional residents interviewed individually, and for 2 of 2 meals observed. (Residents #86, #88, #90, #91, #92, #87) (Evening meal 7/13, Noon meal 7/15/11) Findings include: 1. The group interview was held on 7/13/11 at 9:10 a.m. Six [6] of the 7 residents present were identified as alert and oriented by the Activity Director. Five [5] of 6 of the alert and oriented residents indicated food that was supposed to be warm was often cold. (#91, #90, #88, #86, #92) 2. Resident #87 was interviewed, on	F0364	**F364 Food prepared by methods that conserve nutritive value, flavor, and appearance; food served is palatable, attractive, and at the proper temperature.** **Corrective action was immediately conducted by the DSM and maintenance by servicing the plate warmer and repairing the internal thermostat. DSM to monitor food thermometer calibration as per policy and thermometer usage daily (at least 5 times per week for 4 weeks) DSM to monitor steam table temperatures and plate warmer operation (early plug in and maximum heating) daily (at least 5 times per week for 4 weeks) In-service given by DSM to all cooks and diet aides on taking food temperatures, recording and maintaining steam table temperatures, and ensuring proper plate warmer operation (early plug-in and**	08/21/2011

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	7/12/11 at 11:30 a.m., and indicated his food was cold most of the time. The resident indicated he always ate in his room. According to the resident's Minimum Data Set assessment, dated 5/27/11, he was alert and oriented and cognitively intact. 3. The Resident Council minutes for dietary were reviewed on 7/19/11 at 3:40 p.m. They were dated 5/17/11, 6/15/11, and 7/11/11, and indicated the residents complained of hot food not being hot, "not if you eat on hall. All meals, due to excessive talking among staff," "No, in rooms," and "No, residents say staff is yakking too much." 4. On 7/13/11 at 5:30 p.m., the temperatures were observed being checked on the tray line in the kitchen. The hot foods, including the chicken patty, were observed to be greater than 180 degrees. The 500 hall tray cart was observed to be delivered to the hall at 6:08 p.m. All the trays were delivered at 6:23 p.m. Resident #86 indicated, at that time, her chicken patty sandwich was cold. The temperature of the meat was checked and was 94 degrees Fahrenheit and felt lukewarm to cool to touch. Another sandwich was ordered for her. Alert and oriented Resident #87 indicated,		**maximum heating) by 8/19/11. The Dietary Services Manager will report any heating malfunction of steam table and /or plate warmer immediately to ED and maintenance for repair. The Registered Dietitian during visits will monitor for temperature records and equipment function. All staff / department in-service provided by Registered Dietitian on 08/04/11 with discussion of timely pre-meal beverage pass and timely meal pass. Test tray evaluations will be conducted by DSM at least 3 times per week for 5 weeks and by other department heads 2 times per week for 5 weeks to total at least 5 evaluations per week, then weekly x 1 month, then monthly x 3 months. The Registered Dietitian during visits will monitor test tray evaluations. The DSM, DNS or designee will monitor for timely service of meal trays from carts to residents in rooms daily (at least 3 times per week for 4 weeks). Data will be analyzed for patterns and trends and action plans will be written and implemented as needed. ED/DNS/DSM will review the results and any concerns will be reported at monthly QA meetings x 6 months.**	

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	during interview after he received his tray on 7/13/11 at 6:22 p.m., his sandwich was not warm. On 7/14/11 at 10:35 a.m., the Dietary Service Manager indicated she had heard the chicken patty was checked the evening before and asked what the temperature was. Upon hearing it was 94 degrees, she indicated there was always a problem on the 500 hall. She indicated they had to take the cart through the whole building to get there and could not use a previous shortcut, which added time. She indicated she had been doing testing too and had issues with the 500 hall. 5. During observation on 7/15/11 at 12:28 p.m., the 500 hall room tray cart was delivered to the hall. Resident #88 was interviewed at 12:43 p.m. and indicated the food was not warm. Resident #87 was observed eating his lunch at 12:50 p.m. He indicated the potatoes were not warm. Resident #86 indicated, at 12:50 p.m., her food was "warm enough." Temperatures were checked on a trays left on the cart, at 12:52 p.m., as follows: Milk was 54 degrees, noodles were 110 degrees, ground meat was 112 degrees, spinach was 114 degrees. 3.1-21(a)(2)			

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F0441 SS=E	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure staff members always sanitized the glucometer between residents, washed their hands before and after resident care,	F0441	**F441** The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: All residents cited in 2567 were reviewed and none	08/21/2011

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	between residents, and when changing gloves, for 7 of 8 sampled residents observed during care and/or medication administration, in the sample of 14 current residents, and 6 of 6 supplemental sample residents observed during care and/or medication administration, in the supplemental sample of 14, in that nursing staff failed to sanitize a glucometer between residents, until stopped, moved from soiled activities to clean without handwashing, and administered medications to multiple residents without washing hands or performing hand hygiene between residents. (Sampled Residents #16, #25, #21, #74, I, A, J) (Supplemental Sample Residents #40, #4, #6, #22, #81, #76) (RN #1, RN #3, LPN #2, LPN #6, LPN #3, LPN #1, CNA #3) Findings include: 1. On 7/13/11 at 4:52 p.m., LPN #3 was observed to take a blood glucometer into Resident #74's room and check his blood sugar level. The LPN wore gloves. LPN #3 returned to the medication cart, laid the glucometer on top of the cart, kept the gloves on, and proceeded to draw up the resident's insulin and administer the insulin to Resident #74. He removed his gloves and returned to the medication cart and started preparing Resident #76's		had any infections related to the deficient practice. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Nursing staff was educated by 8/19/11 regarding hand washing, cleaning the glucometer and glove changing. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing staff was educated by 8/19/11 regarding hand washing, cleaning the glucometer and glove changing. Audits will be conducted on every shift 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks then monthly x 3 months to ensure hand washing, glove changing and glucometer cleaning in done appropriately. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans written and implemented as needed.	

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	medications, without performing hand hygiene. After preparing Resident #76's medications, LPN #3 proceeded to pick up the glucometer off of the top of the cart and the cups with the resident's medications in them, and headed towards the resident's room. He indicated he was going to check the resident's blood sugar. At that time, he was stopped and queried about any procedures for the use of the glucometer between residents. He indicated there was a procedure and he had special wipes to use. He then returned to the cart, opened up the cart and obtained a sanitizing wipe. He sanitized the glucometer and proceeded to take the medications to Resident #76 and check her blood sugar. Following the blood sugar check, he returned to the medication cart, obtained a fresh sanitizing wipe and sanitized the glucometer. He then gave the resident's insulin. He took his gloves off after giving the insulin, but did not perform any hygiene. 2. During an observation of a dressing change, on 07/12/11 at 3:10 P.M., RN #3 was observed to apply gloves and remove an old dressing from the left lower extremity of Resident #16 and place it in a trash bag. RN #3 indicated, at that time,			

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	"there is a lot of drainage." RN #3 was then observed to apply a new dressing without removing the contaminated gloves and washing hands. 3. During an observation of care, on 07/14/11 at 9:30 A.M., LPN #2 was observed to enter the room of Resident I with a suppository and a pair of gloves. LPN #2 was observed to apply gloves and attempt to open the suppository's foil package. LPN #2 was unable to open the foil package with gloved hands and was observed to remove the gloves and open the foil package with her bare hands. LPN #2 was then observed to leave the room and return to the medication cart to retrieve lubricant gel. LPN #2 then returned to the room, re-applied the gloves she had removed and administer the suppository without performing handwashing. 4. During an observation of a medication pass, on 07/14/11 at 2:40 P.M., LPN #2 was observed to begin preparing medications for Resident #40. LPN #2 was not observed to perform hand hygiene prior to preparing the medications. 5. During an observation of a medication pass, on 07/15/11 at 11:00 A.M., RN #3 was observed to administer medications to Resident #4. RN #3 was then observed			

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	to prepare and administer medications to Resident #6. RN #3 was not observed to perform hand hygiene prior to administering medications to Resident #6. 6. During an observation of a medication pass, on 07/14/11 at 12:15 P.M., LPN #6 was observed to prepare and administer medications to Resident #25. LPN #6 was then observed to prepare and administer medications to Resident #21. LPN #6 was not observed to perform hand hygiene prior to administering medications to Resident #21. LPN #6 was then observed to prepare and administer medications to Resident #22. LPN #6 was not observed to perform hand hygiene prior to administering medications to Resident #22. In an interview with LPN #6, on 07/14/11 at 12:40 P.M., she indicated, "I should have washed my hands in between patients. 7. During an observation of a medication pass, on 07/18/11 at 9:15 A.M., RN #1 was observed to apply gloves, prepare, and administer medications to Resident #81. After the medications were administered, RN #1 was observed to remove the gloves and was not observed to perform hand hygiene. RN #1 was then observed to administer eye drops to			

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	Resident #81 with bare hands. 8. On 7/13/11 at 3:15 p.m., LPN #1 and CNA #3 were observed providing care for Resident A. Resident A had been incontinent of loose brown feces. LPN #1 wore gloves and used the incontinence brief to wipe some of the feces off of the resident. She removed the gloves and put on clean gloves. She proceeded to use body wash on a dry wash cloth to cleanse the feces from the resident's skin. The resident complained of the bottom itching. The resident continued to ooze feces from the rectum. The LPN took off her gloves and exited the room, going to the clean linen cart and obtaining more clean wash cloths and towel and then proceeded down the hall. The nurse returned to the room with a medicine cup filled with a beige cream. She indicated it was Magic Butt Cream for the resident [a medicated cream for use in the perineal area]. The put on new gloves, wet a wash cloth and placed some soap from the dispenser in the bathroom on the cloth. She cleansed feces from the resident's skin, changing gloves twice during the process. The resident was observed to have a small open area, 0.5 cm [centimeters] by 2 cm between the buttocks. LPN #1 put on			

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	gloves, cleansed the area with normal saline, changed gloves, applied Norml gel [treatment] to the open area, and then covered the area with a Mepilix [foam barrier] dressing. She then used the gloved fingers to spread Magic Butt Cream onto the resident's buttocks and coccyx area. The resident continued to ooze bowel movement. CNA #3 was assisting with repositioning and changing the resident. She took off her gloves, exited the room, and went to the clean linen cart and obtained clean linens. LPN #1 was then observed to reattach the resident's tube feeding, wearing gloves. She also gave the resident a sip of water from a cup. She then took off the gloves, put new gloves on, and set the flow rate for the tube feeding. LPN #1 then prepared to do tracheotomy care. She did not wash her hands between any glove changes and did not wash her hands after perineal care or working with the tube feeding. She did not wash her hands prior to setting up for the tracheotomy care [trach care]. She obtained a sterile trach care kit from the bedside. She put on sterile gloves from the kit and proceeded to cleanse around the trach stoma, and then cleanse the			

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	plastic trach itself, using 4 by 4s and pipe cleaners. Following the trach care, the LPN gathered the trash she had accumulated and placed it in a bag. She took her gloves off. She then placed one glove on her right hand to finish gathering trash. At that point, she indicated, "I'm finished." She took the glove off, left the room and went to the medication cart. She unlocked the cart with her keys from her pocket, and obtained some alcohol gel. She placed some alcohol gel in her hand and rubbed her hands together. The observation was reviewed with the Director of Nurses, on 7/15/11 at 3:50 p.m. She indicated, at that time, "she didn't wash her hands?" during all that time. 9. Resident J was observed having a treatment done to an open area on her left elbow by LPN #1, on 7/15/11 at 9:00 a.m. LPN #1 wore gloves, cleansed the area with normal saline on a 4 by 4 gauze pad, applied bacitracin to the wound and covered the area with a dressing. She indicated, at that time, the resident had been incontinent of urine and she was going to change her. LPN #1 wore the same gloves as she had			

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worn for the treatment. She obtained a commercial wet wipe and cleansed the resident's perineal area. Wearing the same gloves, she then went to the bedside cabinet and opened the drawer, picked up a tube of barrier cream, handled her uniform, obtained a clean pull up type incontinence brief and placed it on the resident. No handwashing was done between glove changes and between soiled and clean activities.

10. During an interview with RN #6, the infection control nurse, on 07/18/11 at 2:50 P.M., she indicated, "hands should be washed in between resident contact, gloves should be removed and hands washed after a dirty dressing is removed and a clean dressing applied, and hands should be washed and gloves applied before doing eye drops."

The Policy and Procedure for the Administration of Eye Drops, provided by RN #6 on 07/18/11 at 2:15 P.M., indicated, "Procedure* 1. Put on gloves...."

The Clean Dressing Change Audit form, provided by RN #6 on 07/18/11 at 2:15 P.M., indicated, "7. Put on first pair of disposable gloves. 8. Remove soiled dressing. 9. Dispose of gloves...10. Wash hands and put on clean pair of gloves...11.

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	Cleanse wound...12. Wash hands and put on clean pair of gloves..." The Policy and Procedure for Handwashing, provided by the DoN [director of Nursing] on 07/18/11 at 11:00 A.M., indicated, "General Instructions: Wash hands before and after resident contact..." An inservice training record titled, "Hand Hygiene and Proper Handwashing Technique," provided by RN #6, indicated, "To prevent the spread of pathogens (infections), always wash hands: before and after resident contact...After contact with blood or body fluids...even if gloves were worn. The use of gloves does not replace hand hygiene..." 3.1-18(b)(1) 3.1-18(l)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to ensure clinical records were complete and accurately documented, for 1 of 1 resident at risk for elopement, in the sample of 17, in that the elopement risk assessment was inaccurate. (Resident H) Finding includes: 1. The clinical record of Resident H was reviewed on 07/12/11 at 8:45 A.M. The clinical record indicated the current diagnoses of Resident H included, but were not limited to, Alzheimer's dementia with behavioral disturbances. During initial tour on 07/11/11 at 10:00 A.M. the DoN [Director of Nursing] identified Resident H as not interviewable, with a history of elopement, and had recently eloped from the facility. The DoN further indicated, at that time that the door alarm did not	F0514	F514 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: RH had her elopement assessment updated immediately. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All other residents that are risk for elopement had assessments reviewed and updated as indicated. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Licensed staff was educated by 8/19/11 regarding accurate completion of assessments. DNS/Designee will audit the elopement assessment weekly for 4 weeks, then monthly for 4 weeks, then quarterly with the care plan schedule. These corrective actions will be monitored and a quality assurance program implemented to ensure the	08/21/2011

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	sound loudly by the nurse's station so the staff thought it was somewhere else in the building, and did not immediately respond to the alarm. On 07/12/11 at 8:50 A.M., Resident H was observed to in her room rummaging through her purse. An Initial Psychiactric [sic] Evaluation dated 08/09/10 indicated, "[Resident H] transferred from [name of hospital] due to ... elopement risk, and attempting to leave her home while living with her family. The family has had to notify the police to escort her back to the house. She was recently found running sown the center of [name of Avenue]...Family is worried about her safety. The patient walked away from [name of hospital] and security officer had to bring her back." The evaluation further indicated, "Diagnostic Summary: Patient with moderate cognitive impairment now demonstrating behavior such as leaving her home and wandering out into the pubic [sic] areas where she could easily be injured in traffic... Weaknesses: Elderly with multiple health problems and having poor insight and judgment [sic]." A Care Plan, dated 08/23/10, identified a problem of, "I am at risk for elopement...I am an elopement risk with a hx [history]		deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed	

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	of elopement. I am not able to make good safety decisions". The Quarterly Clinical Health Status Summary, dated 04/09/11, included an assessment titled "Section K. Risk for Elopement." The assessment indicated: "1. Is resident physically able to leave building on their own?..." Answer: "yes" "2. Is the resident cognitively impaired?..."Answer: "no" "3. Does the resident have impaired decision making skills?..." Answer: "no"... "5. Is there a history of wandering or elopement?..." Answer: "no"... "7. Wanders aimlessly about the facility and/or exhibits night wandering?..." Answer: "no" The current MDS [Minimum Data Set Assessment] dated 4/12/11 indicated Resident H was cognitively impaired, had no behaviors problems, and had no history of wandering. A Care Plan, dated 05/21/11, identified a problem of "Elopement," with interventions that included, but were not limited to, "...5. 1:1 [one to one] supervision 6. Monitor for exit seeking behavior and/or change in mood/behavior...8. Elopement protocol in place per policy/procedure."			

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	A Nurse's Note, dated 05/22/11 at 22:50 [10:50 P.M.], indicated, "Situation: Resident eloped out of facility using ACU [Alzheimer's Care Unit] entrance door by Director's office. She had a wanderguard on left ankle. Visitor [name of visitor] told staff she thought one of the residents went out the door...Response: Resident returned facility by visitor, [name of visitor] private vehicle as she observed her approximately 2 blocks from facility..." The Clinical Health Status Summary dated 06/21/11 included an assessment titled "Section K. Risk for Elopement". The assessment indicated: "1. Is resident physically able to leave building on their own?..." Answer: "yes" "2. Is the resident cognitively impaired?..."Answer: "no" "3. Does the resident have impaired decision making skills?..." Answer: "no"... "5. Is there a history of wandering or elopement?..." Answer: "no"... "7. Wanders aimlessly about the facility and/or exhibits night wandering?..." Answer: "no" A Nurse's Note dated 07/08/11 at 18:30 [6:30 P.M.] indicated, "Situation: Resident hyperactive, ambulating corridor and room to room testing all exit doors. Resident was successful in exiting skille			

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	[sic] dunit [sic] (skilled unit) door ... Behavior started at 3:00 P.M. and escalted [escalated] all evening." 3.1-50(a)(1) 3.1-50(a)(2)			
F0518 SS=F	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on interview and record review, the facility failed to ensure 2 of 2 staff interviewed in the laundry room were trained in emergency procedures related to the gas dryers, in that the staff were unable to identify where the emergency shut off was located for the gas dryers and what to do in the event of a laundry fire. (Laundry Supervisor, Maintenance Assistant) This had the potential to affect all 83 residents in the facility.	F0518	F518 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Housekeeping supervisor and maintenance assistant were educated on emergency shut off mechanism location is event of fire in dryer on 7/18/11. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:	08/21/2011

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	Finding includes: During the environmental tour of the Laundry Department, on 07/18/11 at 2:00 P.M., the housekeeping supervisor was queried as to where the emergency shut off mechanism was located in the event of a fire in the dryer. The Housekeeping Supervisor indicated, "I don't know, I wouldn't know what to do in the event of a fire in the dryer." During an interview with the Maintenance Assistant, on 07/18/11 at 2:20 P.M., he indicated, "There is no emergency shut off to the gas dryer...they would have to leave the laundry area and flip a breaker to shut it off, but I keep that breaker box locked for safety." Upon query, at that time, of what action would be taken in the event of a fire in the laundry, the Maintenance Assistant further indicated, "That's a good question and something we need to address." During an interview with the HFA [Health Facility Administrator], on 07/18/11 at 2:35 P.M., she indicated that if a staff member discovered a fire in the laundry, "They would check the firepull and go to the panel and respond to that location." During an interview with the HFA, on		Staff was educated on 7/18/11 regarding the emergency shut off mechanism. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: New hires in laundry/housekeeping will have the emergency shut off mechanism added to their orientation. Housekeeping supervisor and ED will monitor new hire files to ensure that this education has been completed. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED/DNS/Designee will review the results of the audits and any concerns will be reported at monthly QA meetings x 6 months. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed.	

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	07/18/11 at 2:50 P.M., she indicated, "There is an emergency shut off behind the dryer, I am inservicing everyone immediately." The Policy and Procedure for Fire, provided by the HFA on 05/18/11 at 3:00 P.M., indicated, "What To Do in Case of Fire...Specific Instructions: ...Laundry staff: turn off all equipment and fans in the laundry area. Close all doors. Report to nurses' station." 3.1-51(b)			