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	155607	A. BUILDING 00 B. WING	02/22/2018

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BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 19, 20, 21, and 22, 2018 Facility number: 000436 Provider number: 155607 AIM number: 100275120 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 4 Medicaid: 44 Other: 12 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 28, 2018.	F 0000	The Facility respectfully requests to IDR for F657 and F686 at a face to face meeting. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective March 24, 2018 to the annual licensure survey conducted February 19, 2018 through February 22, 2018. **We are requesting paper compliance/desk review.**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

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

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to provide dignity for 2 of 7 residents observed for care. Doors were left open and curtains were not pulled during resident care. (Resident 23, Resident 33) Findings include:	F 0550	**It is the practice of Bethel Manor to respect, honor, and promote the dignity of our residents.** ***The corrective action taken for those residents found to be affected by the deficient practice include:***	03/24/2018

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	1. On 2/21/18 at 10:46 a.m., CNA 3 was observed to enter Resident 23's room. CNA 3 was observed to knock on the resident's door and walk in without announcing herself. 2. On 2/21/18 at 10:50 a.m., CNA 1 and CNA 2 were observed to enter Resident 33's room. The CNAs were observed to knock on the door and enter the room without announcing themselves. CNA 2 was observed to partially pull the curtain around Resident 33 and proceeded to place the resident on a bedpan. The resident was able to be seen by Resident 23 (roommate) in the mirror. CNA 2 was also observed to perform pericare to Resident 33 in view of Resident 23. After removing Resident 33 from the bedpan and performing pericare to Resident 33, the CNAs were observed to also leave the resident's door partially open and place a lift sling under Resident 33. Resident 33 was transferred onto a shower chair. On 2/21/18 at 2:01 p.m., CNA 1 indicated before entering a resident's room, you should knock and announce yourself. The current facility policy, undated and obtained from the Administrator on 2/21/18 at 3:15 p.m., indicated all staff members were to promote and maintain the resident's dignity and respect the resident's rights. 3.1-3(t)		Social Services have met with both Resident 23 and Resident 33 to perform psychosocial assessments with no signs or symptoms of sadness, anxiety, embarrassment, or any other negative effects noted related to the described events. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Staff have been educated in regard to shutting doors/fully pulling privacy curtain and announcing themselves after knocking prior to entering a resident room in order to promote the resident's dignity. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that staff are promoting dignity by fully closing doors/pulling privacy curtains during resident care, knocking/announcing self prior to entering resident rooms and that the above corrective actions and changes are being followed. This tool will be completed by the Assistant Director of Nursing or designee, weekly for four weeks,	

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			then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.			

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	(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to provide resident's responsible parties a notice of Medicare non-coverage for 1 of 3 residents reviewed. A resident's responsible party was not given a written notice nor had the "SNF (Skilled Nursing Facility) Advanced Beneficiary Form" been signed for a resident. (Resident 21) Findings include:	F 0582	**It is the practice of Bethel Manor to assure Notice of Medicare Non-Coverage forms are appropriately delivered to residents and/or their representatives.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** The NOMNC for the resident	03/24/2018

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	On 2/20/18 at 9:45 a.m., the clinical record for Resident 21 was reviewed. The record indicated Resident 21 was admitted on August 26, 2017, with Medicare Part A as the payor type. On 2/20/18 at 11:00 a.m., the "SNF Beneficiary Protection Notification Review" work sheet was provided by the Business Office Manager (BOM). The worksheet for Resident 21 indicated the resident had Medicare Part A skilled services, which were started on August 26, 2017. The worksheet indicated the resident's responsible party had been notified by telephone the resident's Medicare coverage for skilled nursing services would be ending on September 2, 2017. The "Notice of Medicare Non-Coverage" form had not been signed by Resident 21 or his responsible party. On 2/21/18 at 1:46 p.m., the BOM indicated the notice had not been signed as she had never seen the resident's responsible party, even though, the responsible party was employed at the facility. The BOM further indicated she had not sent the notice to the resident's responsible party either. The current facility policy, undated and obtained from the Administrator on 2/21/18 at 3:15 p.m., indicated the beneficiary or representative must sign and date the "Notice of Medicare Non-Coverage" form and the facility would be responsible for the delivery of the notice to all beneficiaries. 3.1-4(f)(3)		identified has been delivered and received by the resident's representative. ***Other residents that have the potential to be affected have been identified by:*** All residents that have had their Medicare stay end prior to 100 day maximum have the potential to be affected. Residents meeting criteria to receive a NOMNC for the past 6 months have been reviewed to ensure the Notice of Medicare Non-Coverage was appropriately issued. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Business Office Manager has received education regarding the appropriate delivery of NOMNCs. A policy and procedure has also been adopted to guide facility staff in regard to appropriate issuance and delivery of Advance Beneficiary Notices. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure the facility has properly delivered NOMNCs to residents and/or their representatives and that the above corrective actions and changes are being followed. This tool will be completed by the Administrator or	

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			designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.			

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	(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to revise a care plan for 1 of 4 residents reviewed for positioning and mobility (Resident 45). Passive range of motion was not removed from a care plan when discontinued. Findings include: On 2/21/18 at 10:32 a.m., Resident 45's clinical record was reviewed. Resident 45 had a diagnoses that included, but were not limited to, contractures to the right and left knee and complex regional pain syndrome of left lower limb. The Annual MDS (Minimum Data Set), dated 10/10/17, indicated the resident's cognition was severely impaired. Resident 45's self care deficit care plan had interventions that included, but were not limited to, PROM (Passive Range of Motion) daily to bilateral upper extremities, including neck, and bilateral lower extremities for 10 repetitions. Resident 45's clinical record did not contain documentation of PROM being done. On 2/22/18 at 3:16 p.m., the Director of Nursing indicated that the PROM had been discontinued on 11/6/17, due to causing the resident more distress than benefit, and excessive resistance to the PROM. She further indicated it had been removed from the task bar on the Point Click Care, but that the care plan had not been revised. 3.1-35(d)(2)(B)	F 0657	**The facility respectfully requests to IDR finding #2 in the Summary Statement of Deficiencies in a face to face meeting as finding #2** related to Resident 52 is inaccurate and omits significant information. It was cited that Resident 52's care plan was not revised to show a physician's order on 1/2/18 to float the resident's heels when in bed. This is inaccurate as the care plan shows the intervention of floating the resident's heels in bed that was created on 1/2/18. This intervention was documented as being present on the care plan in the Summary Statement of Deficiencies. See further details in attached written summary. **It is the practice of Bethel Manor to assure care plans are accurate and up to date.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** The intervention of "PROM" for Resident 45 was removed from the care plan at the time it was discussed with the surveyor. It was cited that Resident 52's care plan was not revised to show a physician's order on 1/2/18 to	03/24/2018

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			float the resident's heels when in bed. This is inaccurate as the care plan shows the intervention of floating the resident's heels in bed that was created on 1/2/18. This intervention was documented as being present on the care plan in the Summary Statement of Deficiencies. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. A review has been completed of all care plans to ensure accuracy. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Education has been completed with the individuals on the Interdisciplinary Team that are responsible for making updates to the care plan. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure the facility has accurate and up to date care plans and that the above corrective actions and changes are being followed. This tool will be completed by the Administrator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three	

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			quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure residents received care in accordance with professional standards of practice during transfer of a dependent resident for 1 of 2 residents observed for transfers. Resident 20 was transferred by 2 (two) staff members by putting arms under Resident 20's armpits and lifting. (Resident 20) Findings include: On 2/21/18 at 9:04 a.m., Resident 20 was observed in the main dining room being fed breakfast, not actively participating or acknowledging activity. She was positioned in a specialized wheelchair and staff indicated Resident 20 was nonverbal. She was observed to open and close eyes, and move head at times. On 2/21/18 at 10:13 a.m., Resident 20 was observed to be transported per specialized wheelchair to her room. CNA 4 was observed to	F 0677	**It is the practice of Bethel Manor to assure that our residents receive care in accordance with professional standards of practice.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 20 has been evaluated by therapy to assist in determining the most appropriate method of transferring. ***Other residents that have the potential to be affected have been identified by:*** All residents that require assistance to transfer could be affected. All residents have been assessed to with newly implemented “Transfer Assessment” to determine the	03/24/2018

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	wash her hands thoroughly, apply gloves, and requested OT (occupational therapy) student to assist with transfer. The OT student applied gloves and indicated she had never transferred this resident. CNA 4 indicated she would show her how to transfer Resident 20. They placed their forearms under Resident 20's underarms and lifted Resident 20 from her wheelchair to the side of the bed, with Resident 20's legs held stiffly in front of her, ankles crossed. CNA 4 assisted Resident 20 to swing legs up on bed while holding her steady, to a back lying position on the bed. CNA 4 proceeded to perform incontinence care and prepare Resident 20 to transfer back to wheelchair. CNA 4 requested CNA 6 to assist with transfer. CNA 4 assisted Resident 20 to sit on side of the bed, and CNA 6 placed her forearm along with CNA 4 under Resident 20's underarms and swung Resident 20 back to the wheelchair and positioned her to comfort. Resident 20 did not display any signs of fear or discomfort during process. On 2/21/18 at 2:43 p.m. the clinical record was reviewed, it indicated Resident 20 was total assist of 2 (two). The clinical record lacked documentation of an evaluation for use of a mechanical lift. On 2/21/18 at 2:42 p.m., the Administrator provided the current facility policy,"Transfer Activities," dated 2012. The Policy indicated, but was not limited to, To transfer the resident from bed to chair, toilet, to tub safely, ... apply transfer belt as needed. On 2/21/18 at 4:38 p.m., the Administrator further provided the current facility policy, "Safe Lifting and Movement of Residents," revised 12/2013. The Policy indicated, but was not limited to, Resident safety, dignity, comfort and medical		most appropriate way to transfer. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** A new “Transfer Assessment” has been implemented. This assessment will be performed upon admission, quarterly, and any time a significant change occurs. All nursing staff have received in-service education on providing safe transfers. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure the facility is properly transferring residents that require assistance and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. The Policy further indicated staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. On 2/22/18 at 8:58 a.m., the ADON (Assistant Director of Nursing) indicated CNA 4 had told on herself and they should not have transferred Resident 20 that way. On 2/22/18 at 9:11 a.m., CNA 5 indicated when transferring residents, she should use a gait belt and request another CNA to assist if unsure how the resident transferred. 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure residents	F 0686	**The facility respectfully requests to IDR F686 in a face to face meeting to request**	03/24/2018

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	who readmitted with no pressure ulcers, did not develop pressure related injury for 1 of 1 residents reviewed. This deficient practice resulted in Resident 52 developing an unstageable (full thickness tissue loss with base covered by eschar (black, tan, brown dead tissue) pressure injury to the left heel. (Resident 52) Findings include: On 2/20/18 at 9:15 a.m., Resident 52 was observed sitting in the common area with a blue boot to her left heel. On 2/20/18 at 9:56 a.m., the record for Resident 52 was reviewed. The record indicated, but was not limited to, Resident 52 readmitted to facility on 12/17/17 with a surgical site to the left hip. Progress note, dated 12/31/17 at 7:52 a.m., indicated a 2 cm (centimeter) x (by) 2 cm dark purple area on left heel. Denies any discomfort..... Fax sent to triage. Physicians orders as follows: 1/1/18 skin prep to both heels every shift for prevention of skin breakdown. 1/3/18 float heels in bed, nurse to check every evening and night shift for pressure relief. A nutritional progress note, dated 1/30/18, episodic, indicated, but not limited to, pressure injury of the left heel, no open, discolored, ... Braden 12 (tool to predict pressure ulcer risk).... receiving some protein supplementation as well as a very high calorie supplement twice daily also. The Care Plans were reviewed and indicated, but were not limited to, Actual impaired skin integrity r/t (related to): impaired mobility, pain second to recent L (left) hip Fx (fracture) AEB (as evidenced		**deletion as** key findings that indicate non-compliance in the Summary Statement of Deficiencies are inaccurate and also omits significant information. The Summary Statement of Deficiencies alleges that, "The care plan lacked any interventions for prevention of pressure injury prior to 1/2/18" and "No new interventions were initiated after the area was discovered" which is inaccurate as preventive interventions were in place prior to discovery of the area and new interventions were initiated following discovery of the area. Please see attached written summary for details. **It is the practice of Bethel Manor to assure residents without pressure ulcers do not develop them.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** A review of the resident's chart and plan of care has been performed. The findings indicate that "The care plan lacked any interventions for prevention of pressure injury prior to 1/2/18" and "No new interventions were initiated after the area was discovered". These statements are inaccurate as interventions for prevention were in place prior to	

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	by) unstageable pressure injury to left heel, dated 1/2/18, revision date 2/20/18. Interventions included, but were not limited to, blue boot on left foot at all times when in bed, dated 1/16/18. Float heels when in bed, dated 1/2/18. Reposition resident q (every) two hours for pressure relief, dated 1/2/18. Treatments per order, dated 1/2/18. Weekly skin assessment by licensed nurse; notify physician of any new area of concern, dated 1/2/18. A progress note, dated 2/20/18 at 9:19 a.m., per the ADON indicated an unstageable pressure injury to the left heel, measured 3 cm (centimeter) x (by) 3 cm and showed no change this week. On 2/21/18 at 9:26 a.m., the ADON (Assistant Director of Nursing) was observed to sanitize her hands, apply gloves, and apply skin prep to Resident 52's left heel. The heel had an oblong brown area and dry with scaling edges, appearing as a large scab. The ADON was further observed to remove her gloves and wash her hands thoroughly. She then applied a blue boot, covered Resident 52, and sanitized her hands. Resident 52 denied pain or discomfort during observation. On 2/22/18 at 8:42 a.m., the ADON provided the Weekly Pressure Ulcer Assessment. The Assessment indicated, but was not limited to: Initial date, 12/31/17 and site/location L (left) heel. The area was listed as deep tissue injury. The area measured 2.0 x 2.0, with no depth, dark purple, surrounding skin color: pink, signature per the ADON. Weekly measurements continued to current, listed on 2/19/18 as Unstg. [sic] (unstageable), DTI (deep tissue injury) in origin 3.0 x 3.0, stable eschar, color: marked as black, dark purple, surrounding skin marked as normal		1/2/18 and new interventions were initiated after the area was discovered. ***Other residents that have the potential to be affected have been identified by:*** Residents that have been determined to be at risk for skin breakdown as identified by Braden Scale for Predicting Pressure Sore Risk Assessment could have the potential to be affected. All plans of care for the residents we identified as having a potential to be affected have been reviewed to ensure appropriate interventions are in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All plans of care for the residents we identified as having a potential to be affected have been reviewed to ensure appropriate interventions are in place. All nurses have received additional education regarding pressure ulcer prevention. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure the facility implements interventions to prevent pressure ulcers and that the above corrective actions and changes are being followed. This	

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	skin. On 2/22/18 at 8:45 a.m., the ADON indicated, upon review of the record, the intervention to elevate the heels was not implemented until after the pressure injury occurred. On 2/22/18 at 9:08 at a.m., CNA 4 indicated if she noticed a red or purple area on a resident's heel, she would notify the nurse and elevate until evaluated. On 2/22/18 at 11:56 a.m., the ADON provided the current facility policy," Pressure Ulcer Prevention Guidelines," dated 2016. The Policy indicated, but was not limited to: it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure ulcer present. The Policy further indicted, in the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure ulcer prevention guidelines to provide care, and will notify physician to obtain orders. 3.1-40(a)(1)		tool will be completed by the Assistant Director of Nursing (Wound Care Certified Nurse) or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and			

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	services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure services were provided in accordance to the plan of care for 1 of 4 residents reviewed. A resident with a contracture of the left hand did not have a splint in place, gloves/socks covering her hands, or receive AAROM (Active Assisted Range of Motion) as per the care plan. (Resident 33) Findings include: On 2/19/18 at 7:15 p.m., Resident 33 was observed to be sitting in her wheelchair in the hall. Resident 33 had socks on her hands. On 2/20/18 at 10:05 a.m., Resident 33 was observed to have socks on her hands. Resident 33 did not have a splint on and her left hand was contractured. On 2/21/18 from 7:45 a.m. through 11:00 a.m., Resident 33 was observed to have no coverings or splints for her hand(s). Resident 33 indicated she had worn a splint in the past but had not worn one for quite some time and did not know where it was. On 2/21/18 at 2:15 p.m., Resident 33 was observed lying in bed. The resident did not have socks/gloves on either hand. The resident	F 0688	**It is the practice of Bethel Manor to assure range of motion and mobility services are provided according to the plan of care.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 33 has been reviewed with no negative effects noted. ***Other residents that have the potential to be affected have been identified by:*** All residents that have care plans related range of motion and mobility deficits that receive interventions to increase or prevent further deficits could be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Staff have received in-service education regarding the implementation of care plan interventions. Process for carrying out restorative nursing programs revised to improve coordination	03/24/2018

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	indicated at that time she had not worn the splint to the left hand on that day. The clinical record for Resident 33 was reviewed on 2/20/18 at 3:43 p.m. Diagnoses included, but were not limited to, left hand contracture and Parkinson's disease. The annual MDS (Minimum Data Set) assessment, dated 12/21/17, indicated the resident had slight cognitive impairment. A care plan, initiated 4/1/11 and reviewed on 12/6/17, indicated the resident was on a restorative nursing program related to the left hand contracture, decreased range of motion (ROM), potential for further contracture formation, and to maintain current joint mobility. Interventions included, but were not limited to, the following: Apply BendEase (a type of splint/brace) left hand splint/brace after ROM to hand/wrist per schedule - on at 10:00 a.m. and off at 11:00 a.m. A care plan, initiated 4/1/11 and reviewed on 12/6/17, indicated the resident required a restorative nursing program of AAROM (active assisted range of motion) to all extremities. Interventions included, but were not limited to, the following: AAROM to all extremities x (times) 10 reps (repetitions) daily. A physician's order, dated 7/7/17, indicated Left Bend Ease splint/brace. A physician order, dated 2/5/18, indicated soft gloves were to be worn to both hands while in bed, may take off for skin care and as resident requests.		between Restorative Aides and other CNAs. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure the facility carries out range of motion interventions per plan of care and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	The "POC (Plan of Care) Response" form, dated 1/23/18 through 2/21/18, indicated Resident 33 had AAROM to all extremities x 10 reps on 1/23/18, 1/30/18, 1/31/18, 2/4/18, 2/6/18, 2/12/18, 2/17/18, and 2/19/18. On 2/22/18 at 9:19 a.m., CNA 2 indicated she was providing the restorative nursing today. She indicated the resident received range of motion to her left hand of 10 (ten) repetitions daily and had a splint applied for 1 hour daily from 10:00 a.m. through 11:00 a.m. CNA 2 indicated the restorative range of motion that was provided would be documented in the kiosk. The current facility policy, undated and obtained from the Administrator on 2/21/18 at 4:38 p.m., indicated the purpose of range of motion exercises were to improve or maintain joint mobility. 3.1-42(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling			

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	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure hair nets were worn in the kitchen for 2 of 3 kitchen observations and hand hygiene was performed in 1 of 2 dining rooms. Hair was not contained under hair nets while staff was preparing foods, washing dishes, and working in the kitchen. No hand hygiene was observed prior to staff feeding a resident and staff touched straws with bare hands. (Kitchen, Resident 36) Findings include: 1. During an observation on 2/20/18 at 11:39 a.m., Dietary Aide 2 was observed taking the temperatures of food for lunch with hair uncovered on both sides and the base of the head with sprigs of hair sticking out. At the same time, Dietary Aide 5 was observed with hair uncovered on both sides and the base of the head with sprigs of hair sticking out. 2. During a kitchen observation on 2/21/18 from 9:48 a.m. to 9:58 a.m., the following was observed: Dietary Aide 3 was observed in the kitchen with hair uncovered on both sides and the base of the head with sprigs of hair sticking out. Dietary Aide 1 was observed with hair uncovered at the base of the head with sprigs of hair sticking out.	F 0812	**It is the practice of Bethel Manor to assure food is stored, prepared, and distributed under sanitary conditions.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 36 has been reviewed with no negative effects noted. All staff have been in-serviced regarding the appropriate and sanitary way to assist residents with meals. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Larger hair nets have been ordered for staff to utilize. Dietary staff have received education/training regarding the proper application and use of hair nets. All staff have received education regarding the use of hair nets in the kitchen, the appropriate way to assist	03/24/2018

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	Dietary Aide 2 was observed with hair uncovered on both sides and the base of the head with sprigs of hair sticking out while preparing mechanical soft turkey. Dietary Aide 4 was observed with hair uncovered at the base of the head with sprigs of hair sticking out while rinsing dishes and placing them in the dishwasher. Activity Assistant 1 was observed entering the kitchen with no hair net on to retrieve a snack cart. During an interview on 2/21/18 at 9:59 a.m., Dietary Aide 1 indicated everyone should have a hair net on when entering kitchen. Dietary Aide 1 indicated hair nets are located outside of the kitchen doors and all hair should be covered when in kitchen. 3. On 2/20/18 at 11:50 a.m., CNA 5 was observed to enter Resident 36's room. CNA 5 moved a chair beside the resident's bed and sat down. CNA 5 placed a clean towel across the resident's chest and pulled the resident's lunch tray next to the resident's bed. CNA 5 was observed to open the resident's straw by touching the entire straw with her bare hands. CNA 5 placed the straw into a cup of juice and held the cup with the straw between her fingers to give the resident a drink. CNA 5 was then observed to begin feeding the resident her lunch. No hand hygiene was observed by CNA 5 prior to opening the straw or feeding the resident. On 2/22/18 at 11:33 a.m., CNA 5 indicated hand hygiene should be performed before feeding a resident and straws should not be touched. The current facility policy, undated and obtained		residents with meals, and hand hygiene. Signs have been placed on kitchen entry doors to alert those entering that a hair net must be worn. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that dietary staff are properly utilizing hair nets and that the above corrective actions and changes are being followed. This tool will be completed by the Dietary Manager or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	from the Administrator on 2/21/18 at 2 :42 p.m., indicated hand hygiene should be performed before and after eating or feeding a resident. An undated policy titled, "Employee Hygiene," was provided by the Administrator on 2/21/18 at 2:42 p.m. The policy indicated, "Employees must keep hair from contacting exposed food, clean equipment, utensils and linens." The "Retail Food Establishment Sanitation Requirements," was provided by the Administrator on 2/21/18 at 4:38 p.m. The policy indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: exposed food, clean equipment, utensils, and linens, and unwrapped single-service and single-use articles." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident			

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	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to perform proper hand hygiene and glove use when providing care for 2 of 7 residents observed for care. (Resident 10, Resident 36) Findings include: 1. During an observation on 2/20/18 at 10:47 a.m., CNA 4 gave Resident 10 a shower. CNA 4 was observed to enter the shower room with gloves on. She did not remove the gloves or perform hand hygiene when entering the shower room with Resident 10. CNA 4 left the shower room to place Resident 10's hearing aids on a shelf outside the shower room. She then reentered the shower room, removed her gloves, and donned new gloves without performing hand hygiene. CNA 4 then removed a sheet from Resident 10's legs and placed it into a trash bag sitting on the shower room floor. She then removed Resident 10's shirt and did the same. CNA 4 unfastened Resident 10's brief and tossed it into the trash bin. CNA 4 then	F 0880	**It is the practice of Bethel Manor to assure the spread of infection is controlled and prevented through the use of appropriate methods including hand hygiene and proper glove use.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 10 and Resident 36 have been reviewed with no negative effects noted. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur***	03/24/2018

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	removed her gloves, performed hand hygiene, donned new gloves, and handed Resident 10 a clean washcloth to cover her eyes. She then turned on the water and allowed Resident 10 to test the temperature. She rinsed Resident 10 with the water. Resident 10 had a medium sized bowel movement on the shower floor. CNA 4 picked up the bowel movement with her gloved hand and tossed it into the trash bin. CNA 4 removed her gloves, performed hand hygiene, and donned new gloves. Bowel movement was observed still smeared on the shower room floor. CNA 4 washed and rinsed Resident 10's hair. She then washed Resident 10's back with a clean cloth, and handed Resident 10 a clean cloth to wash her breasts and abdominal area herself. Resident 10 washed her periarea with clean cloth. CNA 4 washed Resident 10's arms and legs. She washed Resident 10's feet with a clean cloth. Bowel movement was still noted as smeared on the shower floor under the shower chair. CNA 4 washed Resident 10's buttocks. Resident 10 then had another small bowel movement on the shower floor. CNA 4 rinsed Resident 10 off with the warm water, and turned off the water. CNA 4 grabbed a clean towel with her gloved hand and dried Resident 10's hair. She used another clean towel to dry off the resident's back,and then laid the towel on the back of the shower chair. She dried Resident 10's face, chest, and arms with another clean towel. CNA 4 grabbed another clean towel to dry off Resident 10's legs, feet and buttocks. CNA 4 removed her gloves and donned a new pair of gloves without performing hand hygiene. CNA 4 assisted Resident 10 with putting on her brief, shirt, and pants. The shower chair wheel was observed to roll into the small bowel movement. CNA 4 placed slippers on Resident 10. CNA 4 removed her gloves without performing hand hygiene. She then wheeled the shower chair, with		***include:*** All staff have received infection control/prevention education including hand hygiene and proper glove use. Quality Assurance Tool implemented to ensure staff perform hand hygiene and glove changes appropriately. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that facility staff perform hand hygiene and glove changes appropriately and that the above corrective actions and changes are being followed. This tool will be completed by the Assistant Director of Nursing (Infection Preventionist) or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155607	A. BUILDING 00 B. WING	02/22/2018

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	Resident 10 sitting on it, through the small bowel movement into the hallway to Resident 10's wheelchair. CNA 4 placed a towel into the seat of the wheelchair and donned gloves without performing hand hygiene. She then pulled a gait belt out of her pocket and placed it around Resident 10. CNA 4 assisted Resident 10 to her wheelchair and then assisted her with her hearing aids. CNA 4 removed her gloves, no hand hygiene was observed. CNA 4 returned the shower chair to the shower room and indicated it would need to be cleaned. CNA 4 then wheeled Resident 10 to her room. CNA 4 performed hand hygiene and assisted Resident 10 with cleaning her dentures and combing her hair. She then removed her gloves and performed hand hygiene. CNA 4 was not observed to reenter the shower room to clean or disinfect the bowel movement from the shower chair or shower room floor. During an interview with CNA 4 on 2/21/18 at 2:55 p.m., she indicated staff should wash hands prior to and after performing resident care. She further indicated staff should change gloves when soiled and between tasks. She indicated hand hygiene should be performed before donning and after removing gloves. When questioned, CNA 4 indicated staff should clean up a bowel movement immediately from the floor and then spray the floor with disinfectant. She then indicated staff should notify housekeeping for a deeper clean after using the disinfectant. 2. On 2/21/18 at 10:15 a.m., CNA 1 and CNA 2 were observed to be providing pericare to Resident 36. CNA 1 was observed to have 2 (two) basins on a towel which was on the overbed table. CNA 1 was observed to wash the resident's peri area. While washing the periarea, CNA 1 was observed to place the used washcloths on the resident's upper thighs. After obtaining several			

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	wet washcloths to rinse the resident off, CNA 1 was observed to place the clean wet cloths between the resident's legs on a pad on which the resident had been laying, next to the soiled brief. The resident was dried with the towel that was drawn across her thighs. After completing the pericare, both CNAs removed their gloves and performed hand hygiene. CNA 1 provided the resident with a drink of water, obtained a comb, and combed the resident's hair. CNA 1 then repositioned the oxygen tubing on the resident's face and obtained a Kleenex and wiped the resident's lips. CNA 1 and CNA 2 performed hand hygiene and left the room. On 2/21/18 at 2:01 p.m., CNA 1 indicated gloves should be changed and hands washed prior to and after providing care to a resident and when going from a dirty area to a clean area. The current facility policy, undated and obtained from the Administrator on 2/21/18 at 2:42 p.m., indicated hand hygiene would be done before and after direct resident care, after removal of gloves and on completion of each job/task. 3.1-18(b) 3.1-18(l)			