

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2014
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 06/09/14 and concluded on 06/12/14 with deficiencies cited at the highest scope and severity of an "E". This was a Nursing Home Initiative Survey with entrance to the facility on Monday, 06/09/14 at 6:05 PM.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law.	7/18/14
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Resident Handbook and Dignity Policy, it was determined the facility failed to protect and promote the dignity of two (2) of eighteen (18) sampled residents, (Resident #6 and Resident #11). Staff were reportedly talking rudely and would point and shake their fingers at Resident #6 in a scolding manner. Resident #11's family member reported she overheard staff talking about other residents in front of Resident #11 and this made the resident feel uncomfortable. In addition, Resident #11's family member reported the staff acted irritated when Resident #11 would request fresh ice water and acted nonchalant and bothered when the resident would request the oxygen tank be checked. The findings include:	F 241	F241 1. On 07/02/14 the Administrator (Admin) went to visit resident #6 to apologize for staff's behavior and to identify which staff members scolded him. Resident #6 stated this incident happened about a year ago and was no big deal. Admin explained that scolding a resident is unacceptable and informed Resident #6 that the Admin would address this matter with the employee involved. On 07/03/14, the DON and Admin spoke with the employee who stated he has not had any negative interaction with resident #6 and did not scold him. However, the DON and Admin educated the employee to ensure that he understands that scolding residents is unacceptable. Resident # 11 is no longer a resident at CHCW. She was discharged to home on 6/14/14. 2. All residents will be visited by their Guardian Angel by 07/11/14 to ascertain and ensure that they are being treated professionally and in a manner that reserves their dignity. Resident's Guardian angels consist of all members of the management team including the Administrator, Business Office Manager, Medical Records, HR Manager, SDC, Admissions Coordinator, SSD, FSD, Env. Services Director, Activity Director, Unit Managers and the MDS Coordinator. Education and corrective	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Beverly M. Edwards* TITLE: *Administrator* (X6) DATE: *7/16/14*

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

RECEIVED
JUL 16 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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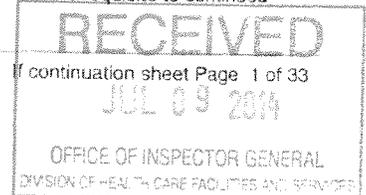
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Pamela M. Edwards

Administrator 7/9/14

(X6) DATE

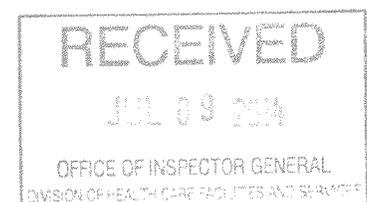
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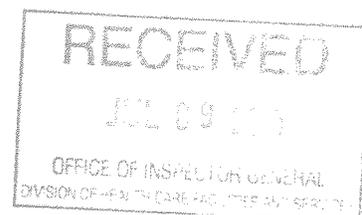
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F 241	Continued From page 1 Review of the Christian Health Center Resident Handbook, not dated, revealed each resident would be treated with consideration, respect, and full recognition of his dignity and individuality. Review of the Values in the Resident Handbook revealed they respect the dignity of each person. Review of the facility's policy Dignity, dated January 2013, revealed it was the policy of the facility to provide care in a manner that maintained or enhanced a resident(s) dignity by always speaking respectfully to/about residents. 1. Interview with Resident #11's family member, on 06/10/14 at 5:20 PM, revealed this admission was the worst thing to happen to Resident #11. The family member stated there was a change in staff behavior for the better since the survey began. Resident #11's family member reported overhearing staff talking about other residents in front of Resident #11 which made the resident uncomfortable. In addition, Resident #11's family member reported the staff had acted irritated with a request for fresh ice water and acted nonchalant and bothered with a request to check the oxygen tank in the resident's room. Review of Resident #11's record revealed the facility admitted the resident on 04/25/14 with diagnoses of End Stage Renal Disease, Hypertension, and Depression. The facility assessed the resident as being interviewable with a Brief Interview Mental score of thirteen (13) on 05/05/14. Interview with Resident #11, on 06/11/14 at 4:46 PM, revealed the staff would sometimes act irritated when he/she needed assistance and that	F 241	action up to and including termination will be administered to any CHCW employee determined to have treated any resident unprofessionally and with disregard to their dignity. 3. The Administrator, DON and/or SDC will in-service all staff on professionalism and reserving our resident's dignity by 07/17/14. The Administrator has also scheduled a training session for all available staff with the Ombudsman's office entitled "Ms. Sally" for 7/15/14 related to reserving our resident's dignity and helping residents with activities of daily living; to include grooming, nail care and administering showers. 4. The DON, Unit Managers, and/or assigned CNAs will audit 10% of staff interactions with residents daily x 5 days a week x 1 month, then 3 x weekly x 2 months, then once per week x 3 months. The DON will report the results to QA monthly x 6 months for further review and recommendations. 5. All corrective measures will be completed by 7/18/2014.	7/18/14	



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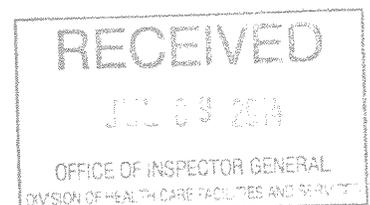
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F 241	<p>Continued From page 2</p> <p>would make him/her feel bad. Resident #11 further revealed the staff attitude did not make him/her cry and his/her needs had been met, but their attitude was not acceptable.</p> <p>Interview with the Director of Nursing (DON), on 06/12/14 at 3:00 PM, revealed the staff were trained on resident rights on hire and yearly and all of the residents were to be treated with dignity and respect.</p> <p>Interview with the Administrator, on 06/12/14 at 5:15 PM, revealed she was unaware of any resident/family concerns regarding residents not being treated with respect/dignity. She stated all of her staff are trained on resident rights on hire and at least yearly and she indicated it was her expectation that all of the residents are treated with respect/dignity.</p> <p>2. Interview with Family Member #1, on 06/11/14 at 10:30 AM, revealed he/she had overheard the facility staff talking rudely or inappropriately about residents in the hall and at the nursing station. The family revealed witnessing several different Certified Nursing Assistants (CNA) delivering meal trays to residents who were known to be visually impaired without orienting the resident as to where food and tray items were located on the tray.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 07/03/12, with Right Sided Paralysis. The facility completed a quarterly Minimum Data Set (MDS), on 04/04/14, and assessed the resident with a Brief Interview for Mental Status (BIMS) with a</p>	F 241			



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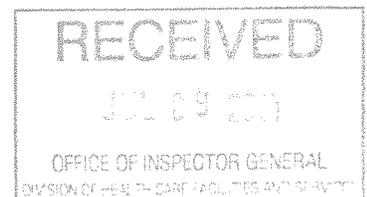
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F 241	Continued From page 3 result of fourteen (14) indicating the resident was cognitively intact and interviewable. Interview with Resident #6, on 06/11/14 at 9:21 AM, revealed staff members would talk rudely, and point and shake their finger at him/her in a scolding manner. The resident also stated a staff member came in his/her room and removed the chair stating the resident never had any visitors anyway and they needed the chair for someone else.	F 241	F282 1. The DON, Unit Manager, Licensed Nurse and/or CNA cut resident #5, #6, #7, #8, nails on 06/11/14, and resident # 13 nails on 06/10/14 respectively. Licensed Nurse and/or CNA gave resident #12 a shower on 06/12/14 and cut resident #8 and #13 facial hairs on 06/11/14 and 06/12/14 respectively. Licensed Nurse and/or CNA provided and/or assisted with set up for oral care to resident #6 and #12 on 06/11/14 and 06/10/14 respectively. 2. All residents will be visited by their Guardian Angel by 07/11/14 to ascertain and ensure that they are being treated professionally and in a manner that reserves their dignity. The Guardian Angels will also check all residents to ensure that they are groomed properly to include proper nail care, oral care, shaving facial hairs and are free from odor. Resident's Guardian angels consist of all members of the management team including the Administrator, Business Office Manager, Medical Records, HR Manager, SDC, Admissions Coordinator, SSD, FSD, Env. Services Director, Unit Managers and/or the MDS Coordinator. Education and corrective action up to and including termination will be administered to any CHCW employee determined to have treated any resident unprofessionally and with disregard to their dignity.	7/18/14
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's Care Plan policy, it was determined the facility failed to follow the Activities of Daily Living (ADL) care plan regarding showers, nail care, oral care, and/ or grooming of facial hair for six (6) of the eighteen (18) sampled resident (Resident's #5, #6, #7, #8, #12, #13). The findings include: Review of the facility's policy regarding Care Plans, revised 01/23/12, revealed the resident's care plan provided guidance to all staff caring for the resident and communicated changes in care	F 282		



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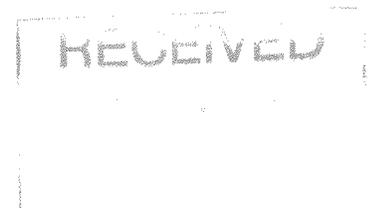
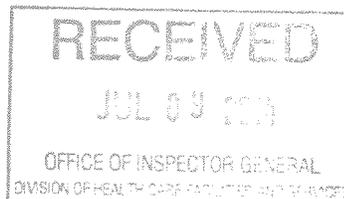
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F 282	Continued From page 4 to all direct care staff. 1. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 07/03/12, with Right Sided Paralysis. The facility completed a quarterly Minimum Data Set (MDS), on 04/04/14, and assessed the resident with a Brief Interview for Mental Status (BIMS) with a result of fourteen (14) indicating the resident was cognitively intact and interviewable. The facility assessed the resident as requiring extensive assistance with personal hygiene and total dependence with bathing. Review of the resident's care plan, dated 06/10/14, revealed a self care deficit. There was a goal for the resident to be clean, neat, appropriately dressed and odor-free. The care plan had interventions for morning and evening cares, and oral care. Observation of Resident #6, on 06/11/14 at 9:21 AM, revealed the resident's fingernails were long and soiled with a build up of a brown substance under the nail. The resident's teeth had a thick build up of plaque. The resident revealed his/her fingernails had not been trimmed in months and it had been a week since his/her teeth were last brushed. 2. Review of the clinical record for Resident #12 revealed the facility admitted the resident on 11/01/13, with a diagnosis of Muscular Dystrophy. The facility completed a quarterly MDS assessment, on 05/07/14, and assessed the resident as having a BIMS of 15, indicating the resident was cognitively intact and interviewable. The facility assessed the resident as requiring extensive assistance with personal hygiene, and total assistance with bathing. Review of the resident's care plan, dated	F 282	Immediate attention will be given to resident by the Guardian Angel, licensed nurse and/CNA who is determined to be improperly groomed; to include proper nail care, oral care, shaving facial hairs and remaining free from odor. Education and/or corrective action up to and including termination will be administered to any CHCW employee determined to have failed to properly groom a resident to include proper nail care, oral care, shaving facial hairs and remaining free from odor. 3. The Administrator, DON and/or SDC will in-service all staff on professionalism, reserving our resident's dignity, helping residents with activities of daily living; to include grooming, nail care, oral care, and administering showers by 07/17/14. The Administrator has also scheduled a training session for all available staff with the Ombudsman's office entitled "Ms. Sally" for 7/15/14 related to reserving our resident's dignity and helping residents with activities of daily living; to include grooming, nail care, oral care and administering showers. 4. The DON, Unit Managers, and/or assigned CNAs will audit the appearance of 25% resident's appearance daily x 5 days a week x 1 month, then 3 x weekly x 2 months, then once per week x 3 months. The DON will report the results to QA monthly x 6 months for further review and recommendations. 5. All corrective measures will be completed by 7/18/2014.	7/18/14	



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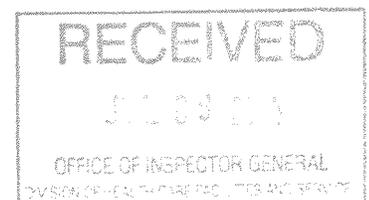
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F 282	<p>Continued From page 5</p> <p>06/12/14, revealed an ADL deficit with interventions to assist with showers twice a week and to assist with brushing the resident's teeth.</p> <p>Interview with Resident #12, 06/10/14 at 4:50 PM, revealed he/she was not receiving the scheduled evening showers. The resident stated the facility frequently utilized agency staff on the evening shift and basic hygiene was just not being completed. The resident revealed the nursing staff was not assisting or even setting up supplies for him/her to brush his/her teeth.</p> <p>Review of Resident #12's shower sheets and Shower Report revealed the resident had not received a shower since 06/04/14.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/14/14 at 1:40 PM, revealed she was aware Resident #6 and #12 had a self care deficit and was care planned for assistance. The LPN stated the care plan was used to drive the resident's care and had interventions to use to ensure care was provided. The LPN indicated not following the care plan could cause the resident's to not progress or decline in the identified problem area. Further interview with LPN #1, on 06/12/14 at 3:40, revealed she did not monitor the residents to ensure oral care or nail care was provided.</p> <p>3. Observation of Resident #5, on 06/10/14 at 11:25 AM and on 06/11/14 at 8:45 AM, revealed the resident was up in a wheelchair reading the paper. The resident had long finger nails with a brown substance under them.</p>	F 282			



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F 282	Continued From page 6 Review of the clinical record for Resident #5 revealed the facility admitted the resident with diagnoses of Hypertension and Insomnia. The facility completed a quarterly Minimum Data Set (MDS) on 4/14/14 and assessed the resident as requiring extensive assistance with bathing, transfer, ambulation, and dressing. The resident was cognitively intact. The resident was to have nail care on his/her shower day. Interview with Resident #5, 06/11/14 at 10:12 AM, revealed the resident was unable to trim his/her nails due to poor vision and stiffness in the hands from Arthritis. The resident stated nail care was not offered by staff and family were requested to do this task when they visited. 4. Observation of Resident #7, on 06/10/14 at 11:00 AM and at 4:14 PM, revealed the resident had long nails with a brown colored substance under them. Review of the clinical record for Resident #7, revealed the facility admitted the resident with a diagnosis of Cerebellar Ataxia. The facility completed a quarterly MDS on 04/02/14 and assessed the resident as cognitively intact, and required extensive assistance with hygiene, bathing, and dressing. The resident was transferred using a mechanical lift. The resident was to receive nail care on his/her shower days. Interview with Resident #7, on 06/11/14 at 7:52 AM, revealed the resident was not able to groom nails due to limited movement in the hands. The resident stated nail care was not offered by staff. He stated he was not sure how he would get his/her nails trimmed.	F 282			



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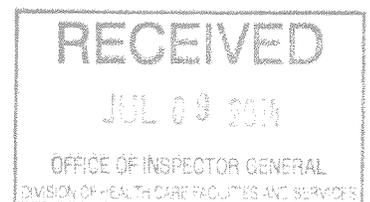
F 282	<p>Continued From page 7</p> <p>5. Observation of Resident #8, on 6/10/14 at 11:00 AM and on 6/11/14 at 7:55 AM, revealed the resident had long jagged fingernails, facial hair under the chin, and long thick great toes nails extending beyond the great toe on both feet.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident with diagnoses of Hypertension, and Chronic Ischemic Heart. The facility completed a quarterly MDS on 04/13/14 and assessed the resident as cognitively intact, and required extensive assistance with dressing, bathing, transfers, mobility, and continence. The resident was to receive nail care and shaving on his/her shower day.</p> <p>Interview with Resident #8, on 06/11/14 at 9:42 AM, revealed the resident had not been offered nail care or assistance with shaving.</p> <p>6. Observation of Resident #13, on 06/11/14 at 3:45 PM, revealed the resident sitting on the side of the bed, with long thick nails and thick facial hair.</p> <p>Review of the clinical record for Resident #13 revealed the facility admitted the resident with diagnoses of Blindness, Diabetes and Hypertension. The facility completed a quarterly MDS on 03/16/14 and assessed the resident as cognitively intact, and required limited assistance with bathing, hygiene and dressing. The resident was to receive nail care and shaving on his/her shower day.</p> <p>Interview with Resident #13, on 06/12/14 at 8:10 AM, revealed the resident had not been offered nail care or to be shaved by staff.</p>	F 282		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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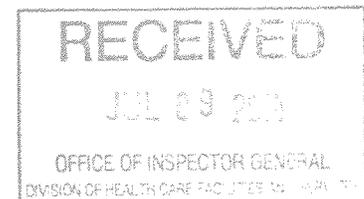
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203	
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F 282	Continued From page 8 Interview with Certified Nurse Assistant (CNA) #3, on 06/11/14 at 9:20 AM, revealed residents received nail care and a shave on their shower day. She stated she did not always get all the residents showered due to being busy. She revealed she only shaved female residents if they requested it. She stated being groomed would make residents feel better. Interview with CNA #9, on 06/11/14 at 10:20 AM, revealed all residents received nail care on shower day. She stated she did offer to shave female residents when she had enough time. She stated grooming was important to every one and made you feel better. Interview with the Director of Nursing, on 06/12/14 at 2:07 PM, revealed her expectations were for all residents to be clean and groomed and have good oral hygiene. She stated she made rounds several times a day; however, she had not identified any residents needing care.	F 282		7/18/14
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policies Bath-Showers, Bed Bath, Nails-Cleaning and Trimming, it was	F 312	F312 1. The DON, Unit Manager, Licensed Nurse and/or CNA cut resident #1, #5, #6, #7, #8, nails on 06/11/14, Resident #13 on 06/10/14 and resident #14 on 06/12/14 respectively. Licensed Nurse and/or CNA gave resident #12 a shower on 06/12/14 and cut resident #1, #6, #8, facial hairs on 06/11/14, and cut resident #14 and unsampled resident E facial hairs on 06/12/14. Licensed Nurse and/or CNA provided and/or assisted with set up for oral care to resident #6 and #12 on 06/11/14 and 06/10/14 respectively. 2. All residents will be visited by their Guardian Angel by 07/11/14 to ascertain and ensure that they are being treated professionally and in a manner that reserves their dignity. The Guardian Angels will also check all residents to ensure that they are groomed properly to include proper nail care, oral care, shaving facial hairs and are free from odor. Resident's Guardian angels consist of all members of the management team including the Administrator, Business Office Manager, Medical Records, HR Manager, SDC, Admissions Coordinator, SSD, FSD, Env. Services Director, Unit Managers and/or the MDS Coordinator. Education and corrective action up to and including termination will be administered to any CHCW employee determined to have treated any resident unprofessionally and with disregard to their dignity. Immediate attention will be given to any resident by the Guardian Angel, licensed nurse and/CNA who is determined to be improperly groomed; to include proper nail care, oral	



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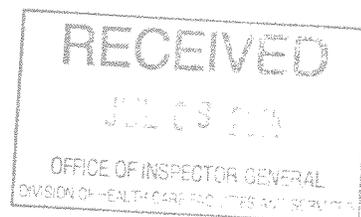
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F 312	<p>Continued From page 9</p> <p>determined the facility failed to provide dependent residents with the necessary Activities of Daily Living (ADL) care for showers, nail care, oral care, and grooming of facial hair for eight (8) of eighteen (18) sampled residents, (Residents #1, #5, #6, #7, #8, #12, #13 and #14), and one (1) of five (5) unsampled residents, (Unsampled Resident E).</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure regarding Morning Care, revised 01/23/12, revealed staff members would offer morning care to all residents in order to prevent the spread of infections and refresh the resident before meals. The staff person would encourage self-care or offer assistance with grooming and dressing.</p> <p>Review of the facility's policy/procedure titled Bath-Shower, not dated, revealed residents would be provided a shower, as appropriate, at least two (2) times per week, and additional showers may be given as necessary to keep the resident clean and odor free.</p> <p>Review of the facility's policy/procedure titled Bath-Bed, not dated, revealed bed baths were given to bedridden residents or residents that could not take other types of baths due to their condition, and the resident's fingernails and toenails were to be cleaned during the bed bath.</p> <p>Review of the facility's policy/procedure titled Nails-Cleaning & Trimming, revised 01/23/12, revealed regular fingernail care would promote cleanliness and prevent infection. The nursing staff would provide observation and care of nails for all residents daily, and as necessary.</p>	F 312	<p>care, shaving facial hairs and remaining free from odor. Education and/or corrective action up to and including termination will be administered to any CHCW employee determined to have failed to properly groom a resident to include proper nail care, oral care, shaving facial hairs and remaining free from odor.</p> <p>3. The Administrator, DON and/or SDC will in-service all staff on professionalism, reserving our resident's dignity, helping residents with activities of daily living; to include grooming, nail care, oral care, and administering showers by 07/17/14. The Administrator has also scheduled a training session for all available staff with the Ombudsman's office entitled "Ms. Sally" for 7/15/14 related to reserving our resident's dignity and helping residents with activities of daily living; to include grooming, nail care, oral care and administering showers.</p> <p>4. The DON, Unit Managers, and/or assigned CNAs will audit the appearance of 25% resident's appearance daily x 5 days a week x 1 month, then 3 x weekly x 2 months, then once per week x 3 months. The DON will report the results to QA monthly x 6 months for further review and recommendations.</p> <p>5. All corrective measures will be completed by 7/18/2014.</p>	7/18/14	



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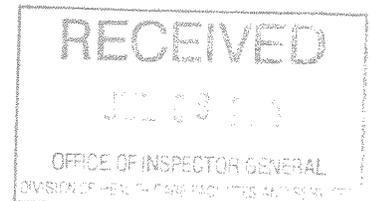
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F 312	<p>Continued From page 10</p> <p>Residents' nails would be trimmed with a snipper and file to round the tips of the nails, and nails would be cleaned around and under using a moistened cotton swab or orange stick. Further review of the policy revealed nail care would be performed by a licensed nurse if the resident had a diagnosis of Diabetes or Circulatory Disease.</p> <p>Review of the clinical record for Resident#1 revealed the facility admitted the resident on 11/09/12 with diagnoses of Paralysis Agitans, Cerebral Palsy, Muscle Disorders, Generalized Weakness, Diabetes Mellitus Type 2, Depressive Disorder, Hyperlipidemia, Hypothyroidism, Atrial Fibrillation, Renal Insufficiency, Urinary Frequency, A history of Seizures, and Bi-Polar Disorder.</p> <p>Review of the Minimum Data Set (MDS) Care Area Assessment (CAA) Documentation Notes, dated 08/03/13, revealed the facility assessed Resident #1 as needing extensive assistance with dressing, personal hygiene, and would be dependent for bathing.</p> <p>Review of the Certified Nursing Assistant (CNA) Care Record for Resident #1, dated 06/07/14, revealed Resident #1 was to have an assist of one (1) with ADLs, a bed bath on shower days unless the resident requested a shower, and the resident's hands were to be cleaned every shift.</p> <p>Observation, on 06/10/14 at 10:00 AM, revealed Resident #1 was in bed, awake and alert, dressed in bed clothes. A noticeable amount of dark facial hair was observed on the resident's chin and both sides of his/her upper lip. In addition, Resident #1's finger nails were long with a brown discoloration under his/her nails of both</p>	F 312			



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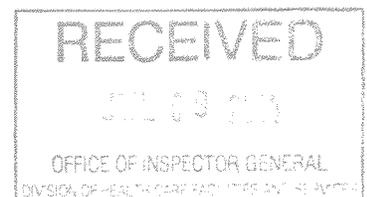
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F 312	<p>Continued From page 11</p> <p>hands. It was also noted that both of the resident's hands were tremulous.</p> <p>Observation, on 06/10/14 at 10:44 AM, revealed Resident #1 was seated in his/her wheelchair, dressed in dark slacks, and a very wrinkled, yellow, polo shirt. His/her hair was combed, but the facial hair was still present and his/her nails remained long with a brown substance underneath.</p> <p>Interview with Resident #1, on 06/10/14 at 10:50 AM, revealed the staff sometimes shaved the facial hair from his/her face, but it had been about three (3) weeks since his/her chin hairs had been removed, and he/she thought it was time to receive that care again. Resident #1 stated he/she thought his/her finger nails were long and they needed to be trimmed and filed. Resident #1 stated it did bother him/her that his/her facial hair was visible and long, and that his/her nails were long, but the resident was not sure how to explain exactly how it bothered him/her.</p> <p>Observation, on 06/11/14 at 8:10 AM, revealed Resident #1 was seated in the dining room, dressed in street clothes, his/her hair was combed, but a noticeable amount of dark facial hair remained on the resident's chin and upper lip, and his/her finger nails remained long with a brown substance underneath.</p> <p>Interview with Resident #1, on 06/11/14 at 10:35 AM, revealed it bothered him/her that the facial hair was visible and long, and that his/her finger nails were long, and was still not able to explain exactly how it bothered him/her. Resident #1</p>	F 312			



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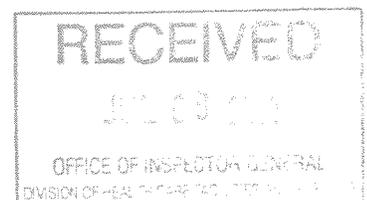
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F 312	<p>Continued From page 12</p> <p>stated, at one time, a the facility's beautician trimmed and groom his/her nails, but the new beautician did not perform that care. Resident #1 stated he/she thought the staff would eventually get around to helping with this care, and he/she thought they would do it if he/she asked them.</p> <p>Observation, on 06/11/14 at 4:40 PM, revealed Resident #1 was in bed and awake. His/her finger nails remained long with a noticeable brown substance underneath. The long/dark chin and upper lip hair remained on his/her face.</p> <p>Interview, on 06/12/14 at 8:50 AM, with CNA #1 revealed she frequently assisted Resident #1 with his/her bath, grooming, dressing, and incontinent care. CNA #1 stated Resident #1's hands were to be cleaned every shift because the resident tends to keep his/her hands in a closed position (like a fist), and his/her hands perspire. CNA #1 stated she noticed Resident #1's long finger nails, but she did not clip the resident's nails as Resident #1 was a diabetic. CNA #1 stated she had not noticed the facial hair on Resident #1's chin area, only on the the resident's upper lip area. CNA #1 stated she did shave facial hair for residents, not at every bath or shower time, only when needed. CNA #1 stated Resident #1 only liked certain care givers to perform this type of care, but the resident usually requested when he/she wanted the facial hair shaved. CNA #1 stated Resident #1 was usually agreeable to letting her perform his/her bathing and grooming. CNA #1 stated it was important for residents to be clean and appropriately groomed.</p> <p>2. Observation, on 06/11/14 at 12:20 PM, revealed Resident #14 was seated in the dining</p>	F 312			



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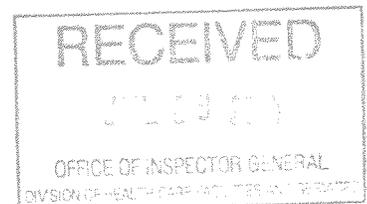
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F 312	<p>Continued From page 13</p> <p>room, eating lunch. The resident's finger nails were noticeably long, and light colored facial hair was noted on his/her chin. He/she stated he/she was a diabetic and took a diabetic diet.</p> <p>Review of Resident #14's clinical record revealed the facility admitted the resident on 02/18/14 with diagnoses of Diabetes Type 2, Schizophrenia, Cardiac Dysrhythmias, Hypertension, Anxiety State, and Generalized Pain. Review of the MDS 3.0, CAAs, Documentation Notes, dated 02/24/14, revealed Resident #14 required staff supervision and assistance with his/her ADLs.</p> <p>Review of the CNA Care Record for Resident #14, revealed Resident #14 required an assist of one (1) with his/her ADL's and routine skin care.</p> <p>Review of the CNA skin care alert forms completed by CNAs revealed a specific area for documenting nail trimming and stated in bold type that all residents with facial hair must be shaved (men & women). Review of the CNA skin care sheets for Resident #14, ranging from 05/08/14 to 06/02/14, revealed a check mark in the blank by "nails trimmed," on the skin alert form of 05/26/14 indicating the nails were trimmed.</p> <p>Review of the weekly Skin Integrity Review Sheets, from 04/10/14 to 05/29/14, completed by the licensed nurses, did not reveal evidence of Resident #14's long finger and toe nails or the thick appearance of his/her toe nails.</p> <p>Observation, on 06/12/14 at 9:10 AM, revealed Resident #14 continued to have long, unevenly shaped finger nails. In addition, his/her toe nails were long (extending beyond the flesh of the</p>	F 312			



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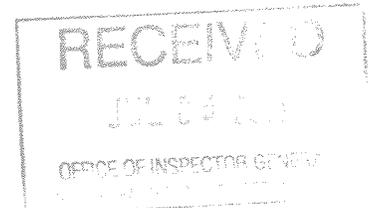
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F 312	Continued From page 14 toes), and were thickened and discolored in appearance. Interview, on 06/12/14 at 9:10:AM, with Resident #14 revealed he/she took showers and washed his/her own hair, but a staff person always stayed with him/her while he/she was in the shower room. Resident #14 stated he/she was concerned about how long and thick his/her toe nails were because he/she was a diabetic. Resident #14 stated he/she thought the Social Worker had recently added him/her to the list to see the podiatrist that came to the facility. The resident stated he/she had not asked staff members to trim his/her nails, but kept a pair of scissors/clippers in his/her room, and had tried to trim them him/herself. Interview, on 09/12/14 at 9:25 AM, with the Director of Social Services (DSS), revealed a podiatrist came to the facility every two (2) months to quarterly. The DSS stated, on 05/30/14, she added Resident #14 to the list of residents who needed to be seen by the podiatrist, and that she contacted One Health Services on 06/02/14 to determine the date of the next scheduled podiatry visit. The DSS stated she kept a running list of residents who needed podiatry care and she received referrals from the residents' direct care givers (licensed nurses and CNAs). The DSS stated the Director of Nursing (DON) informed her the licensed nurses could clip residents' nails when needed, especially if the care could not wait. However, she stated she had not been told by nursing staff that Resident #14's toe nail length had reached a critical point, and could not wait for podiatry care. Interview, on 06/12/14 at 10:25 AM, with LPN #1	F 312			



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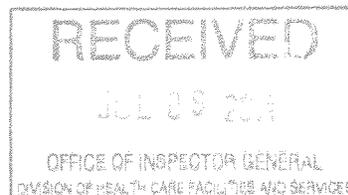
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F 312	<p>Continued From page 15</p> <p>revealed she had been employed by the facility for about one month, and had been oriented/trained by LPN #2. LPN #1 stated she had not had an opportunity to conduct Resident #14's skin assessment, but had observed the resident's finger and toe nails and had not been concerned with the length. LPN #1 said she had conducted skin assessments for other residents and examined their toe and finger nails and had reported long thick toe nails to other nursing staff who advised her to refer the resident for a podiatry consult.</p> <p>LPN #1 stated she knew good foot care was important for residents with diabetes, but was not sure why. She stated she knew diabetic residents that received cuts might have an increased risk for infection.</p> <p>Interview, on 06/12/14 at 10:05 AM, with LPN #2 revealed only licensed nurses were permitted to trim the finger/toe nails of a diabetic resident. LPN #2 stated the CNAs assigned to Resident #14 had not reported to her the resident had long/thick toe nails.</p> <p>3. Observation of Resident #6 during the morning meal, on 06/10/14 at 8:35 AM, revealed long whiskers under the resident's chin. The resident had a thick, brown colored, build up around his/her teeth with breath that was malodorous. The resident revealed he/she had a hard time with the staff not assisting with hygiene care.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident with Right Sided Paralysis. The facility completed a quarterly Minimum Data Set (MDS), on 04/04/14,</p>	F 312	



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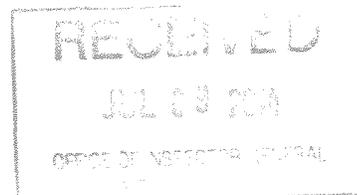
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F 312	<p>Continued From page 16</p> <p>and assessed the resident with a Brief Interview for Mental Status (BIMS) with a result of fourteen (14) indicating the resident was cognitively intact and interviewable. The facility assessed the resident as requiring extensive assistance with personal hygiene and total dependence with bathing.</p> <p>Observation of Resident #6, on 06/11/14 at 9:21 AM, revealed the resident's fingernails were long and soiled with a build up of a brown substance under the nail. The resident's teeth had a thick build up of plaque. The resident revealed his/her fingernails had not been trimmed in months and it had been a week since his/her teeth were last brushed. The resident was later observed being transported to the shower room by Certified Nursing Assistant #8, on 06/11/14 at 11:12 AM. During the meal observation, on 06/11/14 at 12:10 PM, the resident was observed in the dining room with the fingernails still long with a dark substance still under the nail beds. The resident revealed the CNA did not brush his/her teeth or provide any nail care during or after the shower.</p> <p>Interview with CNA #8, on 06/11/14 at 4:25 PM, revealed she did notice the condition of Resident #6's nails during the shower, but did not clean them. The CNA revealed she planned on cleaning and trimming nails once back in the Resident #6's room, but got busy and forgot. The CNA also revealed she did not provided oral care. The CNA revealed a potential for gum disease, bad breath, and poor appetite by not performing oral care. The CNA revealed a potential for bacteria under the resident's nails and a potential for the resident to get hurt by not trimming them and having them so long.</p>	F 312			



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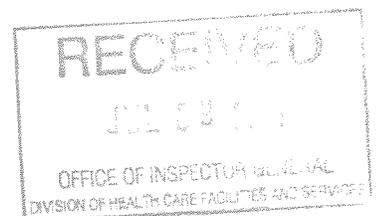
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2014
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F 312	Continued From page 17 Interview with the Unit Manager, on 06/12/14 at 2:25 PM, revealed she was not aware of Resident #6's nails or lack of oral care. The Unit Manager revealed nail and oral care should be completed by the CNA as part of morning and evening care. The Unit Manager revealed she did not know there was a problem with Resident #6 not receiving ADL care, but had not been checking to ensure it was done. Interview with the Corporate Clinical Support (CCS), on 06/12/14 at 2:00 PM, revealed Resident #6 requested she cut his/her fingernails after lunch on 06/11/14. The CCS stated the resident's nails were longer then they should have been and needed to be cleaned. The CCS stated that amount of dirt would not have just developed over night and the nail care should have been completed on Resident #6's bath days. 4. Review of the clinical record for Resident #12 revealed the facility admitted the resident with a diagnosis of Muscular Dystrophy. The facility completed a quarterly MDS assessment, on 05/07/14, and assessed the resident as having a BIMS of fifteen (15), indicating the resident was cognitively intact and interviewable. The facility assessed the resident as requiring extensive assistance with personal hygiene, and total assistance with bathing. Interview with Resident #12, 06/10/14 at 4:50 PM, revealed he/she did not receive scheduled showers. The resident revealed the facility frequently utilized agency staff on the evening shift and basic hygiene was just not being completed. The resident revealed he/she could complete some portions of bathing and hygiene if	F 312		



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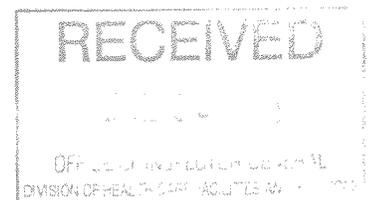
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F 312	<p>Continued From page 18</p> <p>they would set up the equipment because he/she was not able to access the sink with the motorized wheelchair. The resident revealed his/her disease had affected his/her speech and a lot of staff did not take the time to try and understand when requests were made to assist with setting up supplies for hygiene.</p> <p>Review of Resident #12's shower sheets and Shower Report revealed the resident had not received a shower since 06/04/14.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/14/14 at 1:40 PM, revealed she was aware Resident #6 and #12 had a self care deficit and was care planned for assistance. Interview with LPN #1, on 06/12/14 at 3:40 PM, revealed she did not monitor the residents to ensure oral care or nail care was provided.</p> <p>5. Observation of Resident #5, on 06/10/14 at 11:25 AM, revealed the resident was up in a wheelchair, dressed, and neat. The resident had long finger nails with a brown substance under them. Observation of Resident #5, on 6/11/14 at 8:45 AM, revealed the resident continued to have long fingernails with a brown substance under the nail.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident with diagnoses of Depression, Hypertension and Insomnia. The facility completed a quarterly Minimum Data Set (MDS) on 04/14/14 and assessed the resident as cognitively intact and required extensive assistance with bathing, ambulation, and dressing. In addition, the resident had an indwelling catheter.</p>	F 312			



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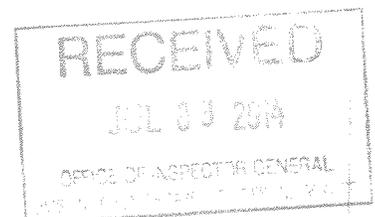
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F 312	Continued From page 19 Interview with Resident #5, 06/11/14 at 10:12 AM, revealed the resident was not able to see well enough to groom his/her own nails. The resident stated there were limitations in the flexibility of both hands due to Arthritis. The resident stated nail care was not offered by staff. 6. Observation of Resident #7, on 06/10/14 at 11:00 AM and at 4:14 AM, revealed the resident had long nails with a tan colored substance under them. Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Cerebellar Ataxia and Spinal Stenosis. The facility completed a quarterly MDS on 04/02/14 and assessed the resident as cognitively intact, and required extensive assistance with bathing and dressing and was unable to walk. In addition, the resident was incontinent. Interview with Resident #7, on 06/11/14 at 7:52 AM, revealed the resident was not able to groom his/her nails due to physical condition and limited movement in hands. The resident stated nail care was not offered by staff. 7. Observation of Resident #8, on 6/10/14 at 11:00 AM and on 6/11/14 at 7:55 AM, revealed the resident had long, jagged fingernails, and long, thick great toe nails extending 1/2 inch beyond the great toe on both feet. In addition, the resident had facial hair under the chin. Review of the clinical record for Resident #8 revealed the facility admitted the resident with diagnoses of Hypertension, and Chronic Ischemic	F 312			



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F 312	<p>Continued From page 20</p> <p>Heart. The facility completed a quarterly MDS on 04/13/14 and assessed the resident as cognitively intact, and required extensive assistance with bathing, hygiene, transfer and dressing.</p> <p>Interview with Resident #8, on 06/11/14 at 9:42 AM, revealed the resident had not been offered nail care or assistance with shaving. The resident stated plucking the hairs with fingernails was how the task was accomplished.</p> <p>8. Observation of Resident #13, on 06/11/14 at 3:45 PM, revealed the resident sitting on the side of the bed, and dressed. The resident had thick facial hair under the chin and long thick toenails.</p> <p>Review of the clinical record for Resident #13 revealed the facility admitted the resident with diagnoses of Blindness, Diabetes and Hypertension. The facility completed a quarterly MDS on 03/16/14 and assessed the resident as cognitively intact, and required limited assistance with bathing, hygiene and dressing.</p> <p>Interview with Resident #13, on 06/12/14 at 8:10 AM, revealed the resident had requested visits with the podiatrist since admission in December 2013. The resident stated staff did not offer to work on nails or assist the resident with shaving.</p> <p>Interview with Certified Nurse Assistant (CNA) #3, on 06/11/14 at 9:20 AM, revealed residents received nail care and shaving on their shower day. She stated she did not always get all the residents showered due to being busy. She stated she tried to get them later in the week. She revealed she only shaved female residents if they requested it. She stated being groomed would make residents feel better.</p>	F 312		



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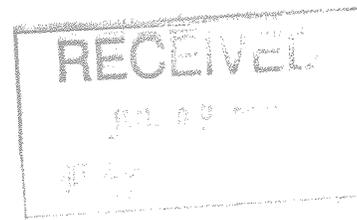
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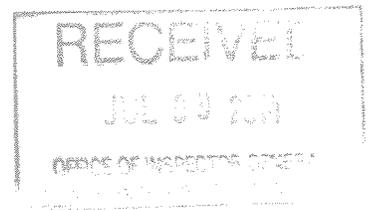
F 312	<p>Continued From page 21</p> <p>Interview with CNA #9, on 06/11/14 at 10:20 AM, revealed all residents received nail care on their shower day. She stated she did offer to shave female residents when she had enough time. She stated grooming was important to every one and made you feel better.</p> <p>Interview, on 06/12/14 at 10:05 AM, with LPN #2 revealed residents' toe nails should be observed by nurses during skin assessments, and CNAs were to monitor residents' finger and toe nail length during other cares, such as showers/bed baths. CNAs were to report long, thick nails to nurses so residents in need of care could be referred to the facility's podiatrist. If necessary, licensed nurses may trim a resident's nails when needed, especially for residents who were diabetic.</p> <p>Interview with the Director of Nursing, on 06/12/14 at 2:07 PM, revealed her expectations were for all residents to be clean and groomed and have good oral hygiene. She stated she made rounds several times a day; however, she had not seen any residents needing care. She stated licensed nurses and CNAs monitor the condition of residents' finger and toe nails, and trim and groom nails whenever needed. Only licensed nurses were to trim the nails of residents with Diabetes. Volunteers (who visited the facility to paint the female residents' nails) should not clip the residents' nails. Licensed nurses should identify long nails through the routine skin assessments, document this information on the residents' skin assessment reports, and make podiatry referrals. Facial hair should be removed regularly for both men and women when the</p>	F 312		
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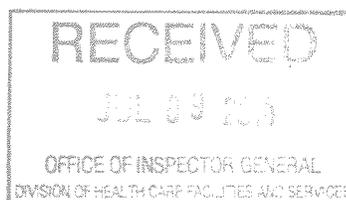
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F 312	Continued From page 22 residents were assisted with bathing and grooming. Additional interview with the DON, on 06/12/14 at 3:25 PM, revealed showers should be completed twice a week. The DON revealed CNA's should be completing a shower sheet and turning them in to the nurse to review and sign. The DON revealed shower sheets were turned in to the Unit Manager to track and ensure baths were completed. The DON revealed she had not been monitoring to ensure showers and baths were completed.	F 312		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide adaptive dining utensils and dishware, as ordered for one (1) of eighteen (18) sampled residents (Resident #1), and three (3) of five (5) unsampled residents, (Unsampled Residents B, C and D). The findings include: The facility did not provide a policy for adaptive dining equipment. 1. Review of the clinical record for Resident #1	F 369	F369 Resident #1 was given a Sippy cup during her next meal on 06/11/14. Unsampled resident B's built up silverware was discontinued on 06/11/14. Resident C and Resident D were given the proper silverware at their next meals 06/10/14 on 06/11/14 respectively. By 07/14/14, the Occupational Therapist will review all 15 residents previously noted to require assistive devices to determine if any previously identified resident continues to require the use of assistive devices. The Occupational Therapist will continue to review all residents upon admission, re-admission and/or notification of a decline to determine if they require the use of assistive devices. On 7/3/14 the Food Services Director (FSD) posted a list of residents requiring adaptive equipment to assist dietary staff in preparing the equipment and ensuring that residents receive the proper items. In addition to the above noted posting, the Food Services Director (FSD) will in-service all dietary staff on the importance of ensuring all residents requiring the use of assistive devices have the devices to remain as independent as possible while eating beginning on 7/9/14. Beginning on 07/9/14, the FSD will instruct all dietary staff that is loading at the end of the tray line and serving in the main dining room to double check the required adaptive equipment to be utilized and served to ensure that the tray card is being followed correctly before loading and/or delivering the tray. The FSD, RD, and/or licensed nurse will audit	7/14/14



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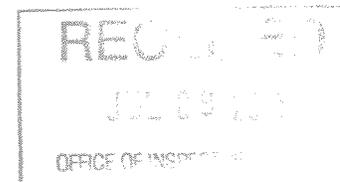
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F 369	<p>Continued From page 23</p> <p>revealed the facility admitted the resident on 11/09/12 with diagnoses of Paralysis Agitans, Cerebral Palsy, Muscle Disorders, Generalized Weakness, Diabetes Mellitus Type 2, Depressive Disorder, Hyperlipidemia, Hypothyroidism, Atrial Fibrillation, Renal Insufficiency, Urinary Frequency, A history of Seizures, and Bi-Polar Disorder.</p> <p>Observation of Resident #1, on 06/11/14 at 12:10 PM, revealed the resident was seated and eating his/her noon meal in the facility's dining room. The meal ticket at the resident's place setting revealed he/she was to have a divided plate and a sippy mug. The resident's food was served on a divided plate, but his/her beverage was in a regular coffee mug with no lid. A mild tremor was observed in Resident #1's hands.</p> <p>Interview with Resident #1, on 06/11/14 at 12:20 PM, revealed he/she was able to drink from a regular mug just fine, and did not think he/she needed a specialized mug (sippy cup) in order to drink the beverage.</p> <p>Interview, on 06/11/14 at 12:30 PM, with Licensed Practical Nurse (LPN) # 2 revealed Resident #1 was originally evaluated to need a lidded cup, but the resident's tremors had lessened since that evaluation and he/she had asked for a regular cup. LPN # 2 stated the facility's therapy services may need to re-evaluate Resident #1 in order to determine if this intervention could be discontinued.</p> <p>Interview, on 06/12/14 at 3:40 PM, with the facility's Speech and Language Pathologist (SLP), revealed Occupational Therapy (OT) staff would have evaluated Resident #1 for the lidded</p>	F 369	<p>meal services 2 x daily x 5 days weekly x 3 months, then 1 x daily x 5 days weekly x 3 months to ensure that resident's receive the proper adaptive equipment. The FSD will report the results to QA monthly x 6 months for further review and recommendations. All corrective measures will be completed by 7/18/2014.</p>	7/18/14



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F 369	<p>Continued From page 24</p> <p>sippy cup, but the resident would have the right to decline the use of the sippy cup. The SLP stated Resident #1 had not demonstrated problems with swallowing, so it was likely the intervention had been ordered due to his/her tremulous hands. The SLP stated if Resident #1 felt he/she no longer needed this form of adaptive equipment and was managing safely without it, then he/she should be reassessed by therapy services to determine if the sippy cup could be discontinued.</p> <p>The facility staff could not locate the original assessment for Resident #1's sippy cup; however, a clarification order, dated 09/21/12, revealed the resident was to use regular utensils, a divided plate, and a straw cup to increase self feeding.</p> <p>3. Observation of Unsampled Resident B during the morning meal, on 06/10/14 at 8:25 AM, revealed the resident did not get the built up utensils listed as necessary adaptive equipment on the tray card. Observation of Unsampled Resident B during the afternoon meal, on 06/11/14 at 12:10 PM, revealed the resident still did not receive the built up utensils listed on the tray ticket. The resident was observed picking up the regular fork placed next to resident and softly saying "they messed up, I can't use this". The resident was observed trying to eat with regular fork and frequently dropping food on him/herself.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/11/14 at 12:20 PM, revealed the dietary staff were responsible to pass the appropriate utensils. The LPN stated Unsampled Resident B</p>	F 369			



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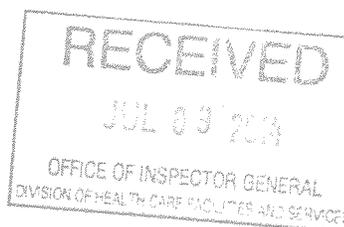
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F 369	<p>Continued From page 25</p> <p>should have built up utensils according to ticket. The LPN revealed whoever delivered the meal tray should have checked the tickets to ensure all equipment was present. The LPN was then observed retrieving a set of built up utensil from the dietary counter and set it on the table out of the resident's reach.</p> <p>Interview with the Speech Language Pathologist (SLP), on 06/12/14 at 3:00 PM, revealed Unsampld Resident B had poor vision and used a curved spoon to prevent food spillage. The SLP revealed the resident had been active with therapy trying to find the appropriate adaptive equipment.</p> <p>4. Observation of Unsampld Resident C during the morning meal, on 06/10/14 at 8:38 AM, revealed the resident did not receive the built up fork or spoon listed and adaptive equipment for meals on the tray ticket.</p> <p>5. Observation of Unsampld Resident D, on 6/11/14 at 12:20 PM, during the lunch meal revealed the resident received his/her meal tray and the meal card indicated Unsampld Resident D was to have received built-up utensils on the meal tray. However, further observation revealed regular utensils were present on Unsampld Resident D's meal tray to use. Interview with Unsampld Resident D at this time revealed he/she wanted his/her built-up utensils because he/she kept spilling food on his/her clothing.</p> <p>Interview with CNA #1, on 6/11/14 at 12:25 PM, revealed all CNAs and other nursing staff that are available to assist during any meal service are</p>	F 369		

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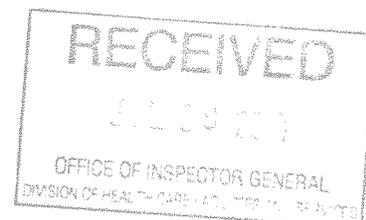
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F 369	Continued From page 26 responsible for passing out utensils and making sure each resident had the correct utensils. CNA #1 stated Unsampld Resident D needed his/her built-up utensils to help feed him/herself. CNA #1 stated if any staff noticed a resident did not get the correct utensils then that staff person would get the correct utensils at that time. Observation of Unsampld Resident D, on 6/11/14 at 12:45 PM, during the lunch meal service revealed Unsampld Resident D did not receive his/her built-up utensils and was eating with regular utensils. Unsampld Resident D was observed spilling food on his/her clothing.	F 369	F371 1. On 6/11/12, the FSD inserviced Dietary Aide #15 on the proper way to handle resident's silverware to prevent the contamination. On 6/10/14, the Unit Manager in-serviced CNA #2 on the proper way to handle resident's food utilizing the proper PPE to prevent contamination. 2. All residents will be visited by their Guardian Angel by 07/11/14 to ascertain and ensure that they are being served their meals and eating utensils in a manner that prevents contamination. Education and/or corrective action up to and including termination will be administered to any CHCW employee determined to have served a resident's meal or eating utensils in a manner that contaminates their meal or eating utensil. 3. The DON, Unit Manager, FSD, and/or SDC will in-service all nursing and dietary staff on the proper way to handle resident's silverware and the proper way to serve resident's food to prevent contamination by 7/17/14. 4. The FSD, RD, DON, Unit Manager and/or licensed nurse will audit meal services 2 x daily x 5 days weekly x 3 months, then 1 x daily x 5 days weekly x 3 months to ensure that staff are handling resident's food and silverware properly to prevent contamination. The FSD will report the results to QA monthly x 6 months for further review and recommendations. 5. All corrective measures will be completed by 7/18/2014.	7/18/14	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to distribute food under sanitary conditions when handling resident food items, for one (1) of eighteen (18) sampled and five (5) unsampled residents (Unsampld Resident A). The staff was observed to touch food and eating utensils with their bare hands.	F 371			



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F 371	<p>Continued From page 27</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding handling of food or serving dishes/utensils with bare hands.</p> <p>1. Observation, on 06/11/14 at 11:58 AM, during the noon trayline revealed Dietary Aide #15 touched the tines of a fork and the bowl of a spoon with her bare hands before handing them to a Certified Nursing Assistant (CNA) to give to a resident.</p> <p>Interview with Dietary Aide #15, on 06/11/14 at 5:10 PM, revealed she had been trained on infection control practices on hire and at least once in the past year. She indicated she realized she had touched the tines of the fork and bowl of the spoon and she knew that was wrong because it could pass infection to the residents. Dietary Aide #15 stated she had been trained not to touch the tines of a fork or the bowl of a spoon as well as the tops of plates or interiors of bowls with her bare hands, but she had forgotten.</p> <p>Interview with the Dietary Manager, on 06/12/14 at 4:20 PM, revealed her staff was trained on infection control and not to touch food or utensils/dishware tops or interiors with their bare hands. She stated she had trained her staff on infection control practices in order to prevent cross contamination of eating utensils/dishware.</p> <p>2. Observation of the dining room, on 06/10/14 at 8:20 AM, revealed residents eating breakfast. Unsampled Resident A was attempting to set-up the meal tray and a staff member took the residents bread into her bare hands to butter it.</p>	F 371			



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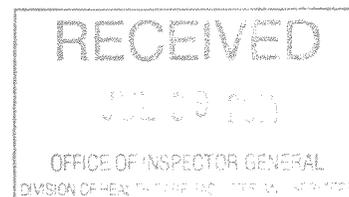
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F 371	Continued From page 28 The staff person was not wearing gloves.	F 371			
F 441 SS=D	Interview with Certified Nurse Aide (CNA) #2, on 06/10/14 at 8:30 AM, revealed the CNA had received training on how to handle residents' food. She stated she should have been wearing gloves to handle the resident's foods. Interview with Licensed Practical Nurse (LPN) #2, on 06/10/14 8:55 AM, revealed resident's food should not be handled without gloves. She stated everyone had been trained to handle food with gloves. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441	F441 1. On 06/12/14, the DON in-serviced RN#1 on the proper way to utilize the glucometer to prevent the spread of infection. On 06/12/14, the DON in-serviced LPN #2 on proper catheter cares for resident #5. 2. By 07/11/14, the DON, Unit Manager and/or Licensed nurse will review all residents requiring the use of catheters and blood glucometer testing to determine if further use of the catheter and blood glucometer testing is needed. They will also place an electronic indicator in the respective resident's medical record to remind the licensed nurse to deliver proper catheter care and/or to utilize the glucometer in a manner to prevent the spread of infection when delivering care as ordered. Resident #5's catheter bag was changed on 06/12/14 by the licensed nurse. On 06/11/14 all four glucometers were sanitized by the licensed nurse. 3. The DON, Unit Manager and/or SDC will in-service all licensed nurses on the proper way to utilize the glucometer to prevent the spread of infection and on proper catheter care by 7/17/14. All licensed nurses will be required to take a competency test to ensure understanding.	7/18/14	



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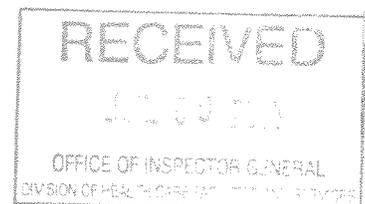
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F 441	<p>Continued From page 29</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Blood Glucose Monitoring System and review of the facility's procedure for indwelling catheter care, it was determined the facility failed to ensure standard infection control practices were observed for one (1) of four (4) glucometers not stored properly and was potentially contaminated. In addition the facility failed to ensure indwelling catheters systems were not contaminated for one (1) of four (4) indwelling catheters being utilized by residents, (Resident #5).</p> <p>The findings include:</p> <p>1. Review of the glucometer manufacturer's booklet, not dated, revealed all parts of the TRUEbalance Blood Glucose Monitoring System are considered potentially infectious, and capable of transmitting blood-borne pathogens. The booklet also revealed healthcare professionals should wear gloves when cleaning and</p>	F 441	<p>4. The DON, Unit Manager and/or SDC will randomly audit 40% of all licensed nurses daily x 5 days weekly x 1 month, then 3 x weekly x 2 months, then once per week x 3 months to ensure that they are utilizing the glucometer properly to prevent the spread of infection. The DON, Unit Manager and/or SDC will also audit the licensed nurses assigned to Resident #5 to ensure that he receives proper catheter care daily x 5 days weekly x 1 month, then 3 x weekly x 2 months, then once per week x 3 months. The DON will report the results to QA monthly x 6 months for further review and recommendations.</p> <p>5. All corrective measures will be completed by 7/18/2014.</p>	7/18/14



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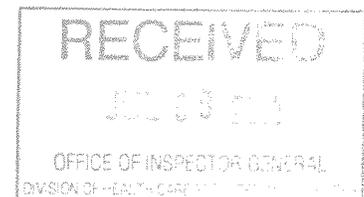
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F 441	<p>Continued From page 30 disinfecting the glucometer.</p> <p>Observation of a medication pass, on 06/10/14 at 8:15 AM, with RN #1 revealed an uncovered TRUEbalance glucometer taken from a cubicle in the medication cart, carried into a resident's room and placed on the resident's overbed table with no barrier allowing the glucometer and the resident's overbed table to become contaminated. Observation at that time also revealed RN #1 did not wear gloves to return the glucometer to the medication cart, did not place a barrier on the top of the cart and did not wear gloves to clean the glucometer as recommended by the glucometer manufacturer.</p> <p>Telephone interview with RN #1, on 06/12/14 at 3:20 PM, revealed she had been trained by the facility on standard infection control practice on hire and at least annually since hire. She stated she guessed it would be wrong to lay the glucometer on the resident's bedside table without a barrier and she did not remember she was to wear gloves when disinfecting the glucometer after use. RN #1 further stated it would be a good idea to lay the glucometer on a barrier and not directly on the resident's bedside table to prevent infection. RN #1 indicated she also did not remember the glucometer should be stored in the black bag it came in from the company, but thought this would be a good idea to keep it from being contaminated in the medication cart cubicle which contained other items.</p> <p>Interview with the Director of Nursing (DON), on 06/12/14 at 3:00 PM, revealed the facility glucometers should be stored in the medication carts in the black bags they came in from the</p>	F 441			



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F 441	<p>Continued From page 31</p> <p>manufacturers to help ensure their cleanliness. She stated the glucometer should be placed on a clean paper towel on the resident's bedside table prior to use and the nurse should wear gloves prior to cleansing the glucometer with the appropriate cleansing towelettes to help prevent cross contamination and infection. The DON revealed she was not aware there were any breaks in the facility procedure for nurses handling the glucometers for glucose testing.</p> <p>2. Review of the facility's procedure regarding indwelling catheter care, dated 01/23/12, revealed catheter care was contraindicated in some residents.</p> <p>Observation of Room 302, on 06/12/14 at 1:10 PM, revealed a urine-like smell coming from the room. On closer examination, an open clear plastic trash bag was noted on the back of the commode top. The inside of the bag was identified by Licensed Practical Nurse (LPN) #2 as the drainage bag for the indwelling catheter used by Resident #5. The bottom of the trash bag contained a yellow liquid smelling like urine. Tubing was connected to the bag; however, there was no evidence of a plug in the tubing. She stated the drainage bag was to be reconnected to the resident's indwelling catheter that night.</p> <p>Interview with LPN #2, on 06/12/14 at 1:10 PM, revealed the drainage bag was to be reconnected to the resident's indwelling catheter at night time. She stated she placed the bag on the back of the commode that morning. She stated she would not use this drainage bag now, but would throw it away. She stated the bag should not have been placed on the back of the commode, especially</p>	F 441			



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F 441	Continued From page 32 open. She stated the tubing should have been plugged. She indicated that all these problems increased the risk of the resident getting a urinary tract infection. Interview with the Director of Nursing, on 06/12/14 at 2:07 PM, revealed the nurses were not inserviced that drainage bags were to be reused. She stated the drainage bag should have been emptied and the tubing plugged. This would increase safety for the resident.	F 441			

