

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/27/2016
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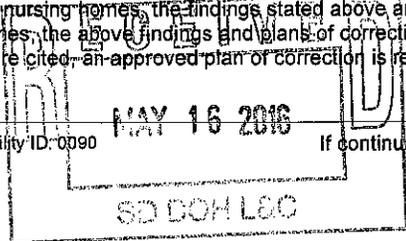
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET MENNO, SD 57045
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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	<p><i>*Addendums noted with an asterisk per 5/17/16 per telephone with facility administrator. SCISDPHEL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 30170 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 4/27/16. The area surveyed was nursing services. Menno-Olivet Care Center was found not in compliance with the following requirements: F157, F226, F441, and F514.</p>	F 000	<p>Tag Cited: F157</p> <p>483.10(b)(11) Notification of changes</p> <p>Issue Cited: Failure to notify of an injury of unknown origin.</p>	6/9/16
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 157	<p>1. Immediate action(s) for the resident(s) found to have been affected include:</p> <p>a. LPN (G) was promptly in-serviced on importance of notifying the physician of an injury of unknown origin.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:</p> <p>a. All residents' physicians will be notified of any allegations of abuse immediately.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/13/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident's (1) physician had been notified of an injury of unknown origin. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She was admitted on 3/6/12. *She had diagnoses for: -Dementia without behavioral disturbances. -Gastric reflux. -Arthritis. -Major depressive disorder. -Anxiety disorder. -High blood pressure. *Her 4/12/16 significant change Minimum Data Set assessment revealed: -She had a Brief Interview for Mental Status (test to measure ability to think and remember) score of six out of fifteen indicating severe cognitive impairment.</p> <p>Review of resident 1's interdisciplinary progress note on 4/24/16 at 9:06 a.m. by licensed practical nurse (LPN) G revealed: *A dark purple bruise was found on resident 1's left thumb. -It wrapped almost completely around her thumb. -There was no increased swelling.</p>	F 157	<p>3. As a condition of the system, the risk of future occurrences include:</p> <p>a. An in-service education program will be conducted by the Director of Nursing Services, Administrator and Nurse Educator on 5/18/16 with all licensed staff addressing circumstances that require notification of the resident's physician and legal representative or family member.</p> <p>4. How corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>a. The Director of Nursing Services and/or designee will conduct a random audit of five</p>		

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F 157	<p>Continued From page 2</p> <p>*There was no documentation of measurements of the bruise.</p> <p>*There was no documentation the physician was notified.</p> <p>Interview on 4/27/16 at 10:40 a.m. with LPN G regarding resident 1 revealed:</p> <p>*She was the charge nurse for the day shift on 4/24/16.</p> <p>*Restorative therapy brought the bruise to her attention on 4/24/16 at 9:00 a.m.</p> <p>*The resident was complaining of some pain and was given Tylenol to relieve discomfort.</p> <p>*She acknowledged the physician should have been notified regarding the bruise of unknown origin.</p> <p>Review of the provider's 12/5/15 Conditions Requiring Notification of MD/Midlevel ASAP policy revealed no information regarding when a physician should be contacted for a bruise of unknown origin.</p> <p>Review of the provider's April 2003 Incident Reports policy revealed:</p> <p>***"Notify the resident's physician if an injury is noted and receive orders for follow-through. Document doctor's name in nurse's notes..."</p> <p>*Documentation in nurse's notes of the medical record was to include:</p> <ul style="list-style-type: none"> -Location and time of incident. -Complete assessment of resident's condition. -The time the physician was notified. <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamental of Nursing, 8th Ed., St. Louis, Mo., 2013, pp. 357-358, revealed:</p> <p>***"Nurses communicate information about patients [resident] to help team members make</p>	F 157	<p>residents weekly for four consecutive weeks. These residents will be newly assessed to ensure that any declines in condition have been identified, properly evaluated and communicated to the appropriate people. This plan of correction will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met. Corrective action will be provided as needed.</p>		

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F 157	Continued From page 3 appropriate decisions about patient care. *A registered nurse makes a telephone report when significant events or changes in a patient's condition have occurred. *Always contact the patient's health care provider whenever an incident happens."	F 157	Tag Cited: F226	6/9/16	
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on interview, record review, and policy review, the provider failed to ensure: * A thorough and timely investigation had been completed for one of one sampled resident (1) who had obtained a bruise of unknown origin. *Policies and procedures were developed to protect all residents from abuse and to guide staff to complete an appropriate and thorough investigation. *Management staff appropriately identified direct care staff concerns related to one of one certified nursing assistant (CNA) C who had been involved in the bruise of unknown origin. Findings include: 1. Review of resident 1's medical record revealed: *She had been admitted on 3/6/12. *She had the following diagnoses:	F 226	Issue Cited: Develop/Implement Abuse/Neglect Policies and Procedures 1. Immediate action(s) taken for the resident(s) found to have been affected include: a. A thorough investigation was conducted by the Director of Nursing Services and the facility Administrator regarding the allegations, made in regard to resident #1. Results of the investigation were reported to the State Survey Agency. 2. Identification of other residents having the		

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F 226	<p>Continued From page 4</p> <p>-Anxiety disorder. -Dementia with behavioral disturbances. -Major depressive disorder. *She had been placed on Hospice services on 4/18/16 due to declining health issues. *There had been an incident of a noted bruise to her left thumb on 4/24/16 during the morning breakfast meal. The charge nurse was notified immediately.</p> <p>Review of resident 1's 4/12/16 significant change Minimum Data Set assessment revealed: *She could make her needs known. *She had a Brief Interview for Mental Status (test to measure ability to think and remember) score of six out of fifteen indicating being cognitively impaired. *She had mood and behavioral concerns. *She required extensive assistance of two staff for physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. *She was always incontinent of bowel and urine.</p> <p>Review of resident 1's 1/28/16 current care plan revealed: *She required assistance of two staff for toileting. *She required assistance of two staff and a gait belt to perform a pivot transfer. *The staff were to have provided a non-confrontational approach to provide cares as she had anxiety and behaviors related to dementia. *She was placed on Hospice services on 4/18/16.</p> <p>Interview on 4/27/16 at 10:05 a.m. with the administrator regarding CNA C and the incident involving resident 1 on 4/23/16 revealed: *CNA C had been offered the Employee</p>	F 226	<p>potential to be affected was accomplished by:</p> <p>a. A thorough and timely investigation will be completed for all residents who obtain an injury of unknown origin.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrences include:</p> <p>a. The policy for reporting allegations of abuse/neglect/exploitation was reviewed to ensure compliance with current state and federal regulations.</p> <p>b. New policies and procedures are being updated to ensure the appropriate steps are being taken when there is a potential abuse/neglect allegation.</p> <p>c. An all personnel in-service/education program</p>		

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F 226	<p>Continued From page 5</p> <p>Assistance Program several times in the past few months. He had declined the assistance and had stated he had been working with his minister. *She felt he had some mental issues, but there had been no official diagnosis. *He was terminated on 4/26/16.</p> <p>Review of resident 1's nursing progress notes from 4/24/16 revealed there was minimal documentation of the bruising. There had been no measurements or description of the bruise. There was no documentation of the physician being notified of the bruise.</p> <p>Review of the provider's initial and on-going investigation of resident 1's bruise of unknown origin involving CNA C revealed: *There was a Leave Request slip of paper that had CNA Cs name at the top. It was dated 4/22/16 handwritten on the leave slip by CNA C: "At home sick do to work stress vomiting and diarrhea someone should care!!!!" *Review of the Assignment Daily Log sheet dated 4/20/16 revealed a handwritten note from CNA C "CNAs are nobodys!" *On 4/25/16 CNA H hand wrote the following on a Concern Form "[Name of a CNA] told me that [CNA name] that one of these days he is afraid that he is going to strike out on [name of resident 1] that event happened on 4/12/16. The rest of the handwritten note went on to state, "The last time I worked with [name of CNA C] we walked in to [name of resident 1] room together. [resident 1 name] looked at [CNA C name] and said "don't touch me." [name of CNA C] stated, "what are you going to do hit me." "Come on hit me." We got her into bed and he was being rough with her when he lifted up her gown to change the brief he threw it over her face and didn't bother to say I'm</p>	F 226	<p>will be conducted on 05/18/16 by the Director of Nursing, Facility Administrator, Medical Director and Nurse educator regarding education on abuse and neglect, including but not limited to the warning signs of abuse and neglect, identifying and reporting suspected abuse immediately, employees managing their own stress properly and a background check as part of the hiring process.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>a. A thorough investigation of any abuse/neglect allegation will be conducted, and findings will be reported to the appropriate agencies in accordance with facility policy. The Director of Nursing Services, or</p>		

**by the administrator, DON, or designee SC/SBDO/HEL*

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F 226	<p>Continued From page 6</p> <p>sorry or take it off her face." *Multiple interviews with staff revealed the story had been consistent with the fact that CNA C was providing toileting for resident 1 by himself and had not been following the care plan. *On 4/25/16 there was an interview conducted regarding the incident with resident 1 with CNA C that revealed: -He had taken the resident to the bathroom by himself. The resident had been striking out at him. He had denied injuring resident 1.</p> <p>Interview on 4/27/16 at 10:30 a.m. with the chief of police regarding the incident of a bruise of unknown origin for resident 1 revealed he: *Had not been notified of the incident until 4/26/16. *Instructed the management staff to obtain pictures of the bruise. *Would speak with CNA C after the investigation had been completed on 4/29/16.</p> <p>Interview on 4/27/16 at 10:40 a.m. with licensed practical nurse G regarding resident 1's bruise of unknown origin revealed: *She was the charge nurse on April 24, 2016. *At 9:00 a.m. the restorative aide working the day shift notified her there was a bruise noted to the resident's left thumb. *When the nurse asked the resident what had happened the resident had stated, "The big guy came in and broke my thumb." "He did it." *She confirmed there were no other male CNAs that worked with the resident. *She notified the director of nursing (DON) immediately. *CNA C had worked the evening shift on 4/23/16. The CNA was off on 4/24/16. *She had interviewed CNAs H and I when they</p>	F 226	<p>designee, will interview five *random employees weekly for four consecutive weeks to verify understanding of current policy for reporting allegations of abuse/neglect/exploitation. Re-education will be provided at the time of the interview, if needed.</p> <p>b. Summary of the investigations, interviews, and incidence of re-education, [redacted] will be discussed with the QAPI team. *monthly until substantial compliance has been met. SC/SDDO/H/EL</p> <p>*the summary SC/SDDO/H/EL *by the DON or designee SC/SDDO/H/EL</p>		

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F 226	<p>Continued From page 7</p> <p>returned to work on 4/24/16 who had worked the night before.</p> <p>*The CNAs had discovered: -CNA C had been in resident 1's room alone on the evening of 4/23/16.</p> <p>*Resident 1 was confused and combative at times.</p> <p>*The resident had been placed on Hospice for failure to thrive due to her advancing dementia.</p> <p>*The resident was very limited with any movements of her extremities.</p> <p>*The resident was unable to reposition herself and would not have been able to move her arms.</p> <p>*The resident required two staff assistance with all transfers.</p> <p>*The bruise was described as a wrap-around dark purple bruise on to the resident's left thumb area.</p> <p>*She had not notified the physician, had given the resident Tylenol for pain, she had assessed the thumb, and did not believe there was any broken bones.</p> <p>*She agreed there should have been an incident form completed, and the physician should have been notified about the bruise.</p> <p>Telephone interview on 4/27/16 at 11:15 a.m. with CNA I regarding resident 1 and the evening of 4/23/16 revealed: *She was working 2:00 p.m. to 10:00 p.m. on 4/23/16. *She had only been working at the facility for two weeks and had been orientating with CNA H. *She had watched a video in regards to Abuse and Neglect prior to working on the floor. *Both her and CNA H noticed the door was closed to resident 1's room on the evening of 4/23/16. She just figured someone was in working with the resident.</p>	F 226			

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F 226	<p>Continued From page 8</p> <p>*On 4/24/16 afternoon during her shift resident one stated to her, "The big man did it." After she, CNA H, and another unidentified CNA had shown a picture of CNA C and had asked the resident who had done this.</p> <p>Telephone interview on 4/27/16 at 11:32 a.m. with CNA H regarding resident 1 and the evening of 4/23/16 revealed:</p> <p>*On the evening of 4/23/16 she and CNA I had noticed the door to resident 1's room was closed.</p> <p>*She knocked and opened the door and saw CNA C sitting in resident 1's wheelchair outside the bathroom while the resident was sitting on the toilet in the bathroom.</p> <p>*She stated, "We should have stayed in the room because the residents care plan indicated there should always be two persons assisting with transferring and toileting."</p> <p>*She has only been employed for two months with the provider.</p> <p>*On 4/24/16 she and another unidentified CNA asked the resident what had happened to her thumb, and the resident had replied, "The big man did it."</p> <p>*She was unsure as to why she did not inform the charge nurse that CNA C had been assisting resident 1 alone.</p> <p>Interview on 4/27/16 at 1:20 p.m. with the DON and registered nurse (RN) J regarding CNA C and the incident on 4/23/16 involving resident 1 revealed:</p> <p>*CNA C had been texting RN J for several months with explicit comments. She had to block him from her phone.</p> <p>*They felt as though CNA C had been depressed.</p> <p>*CNA C had been offered the Employee Assistance Program several times in the past</p>	F 226			

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F 226	<p>Continued From page 9</p> <p>several months. His mother had died of cancer three months ago, and he was estranged from two adopted brothers.</p> <p>*He was described as a "loner."</p> <p>*They both had feared retaliation after he had been fired on 4/26/16.</p> <p>*His co-workers started revealing concerns of CNA C to the DON after the incident had happened to resident 1. Some staff thought he was "unstable."</p> <p>*The DON had felt sorry for him because of his situation and felt as though that might have clouded her judgement to take action prior to the incident on 4/23/16. He had refused the employee assistance program several times.</p> <p>*The DON agreed it was the provider's responsibility to protect all the residents in the facility.</p> <p>*The DON was unsure as to the reason staff would not come to management staff with their concerns of CNA C.</p> <p>*CNA C had not followed resident 1's plan of care, and that was the reason he had been terminated.</p> <p>Review of resident 1's nursing progress notes from 4/24/16 revealed there was minimal documentation of the bruising. There had been no measurements or description of the bruise. There was no documentation of the physician being notified of the bruise.</p> <p>Interview on 4/27/16 at 2:45 p.m. with CNA L regarding CNA C revealed:</p> <p>*Resident 1 would sometimes hit at staff.</p> <p>*She stated approximately one month ago everyone (two or three other CNAs and the charge nurse for the shift) were sitting in report before work and CNA C made the comment "I</p>	F 226			

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F 226	<p>Continued From page 10</p> <p>hope I never get upset with her [resident 1]."</p> <p>*When asked why she had not reported that to management, she stated, "She thought the charge nurse would have reported it."</p> <p>*Resident 1 was supposed to have been a two person transfer at all times.</p> <p>Interview on 4/27/16 at 3:00 p.m. with the DON regarding the incident with resident 1 and CNA C revealed:</p> <p>*She was unable to find the Abuse and Neglect policy that had the required seven components which included:</p> <ul style="list-style-type: none"> -Screening of employees. -Training of employees. -Protection of residents. -Prevention of abuse. -Identification of abuse. -Investigation. -Reporting. <p>*She agreed the Abuse policy should have been more comprehensive to include the above components to ensure the protection of all residents residing in the facility.</p> <p>*The investigation into resident 1's incident should have been started immediately after the charge nurse had become aware of the incident.</p> <p>Review of the provider's 3/1/16 Certified Nursing Assistant Job Description revealed "Fully understands all aspects of residents' rights, including the right to be free of restraints and free of abuse. Is responsible for promptly reporting to the charge nurse or administrative staff incidents or evidence of resident abuse or violation of residents' rights."</p> <p>Review of the provider's undated Director of Nursing Job Description revealed: "Monitors</p>	F 226			

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F 226	<p>Continued From page 11</p> <p>complaint reports daily for allegations of potential abuse or neglect, and participates in these investigations."</p> <p>Review of the provider's undated Charge Nurse RN/LPN Job Description revealed: "Maintains accurate and complete records of nursing observations and care."</p> <p>Review of the provider's undated Administrator Job Description revealed: "The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guideline, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to our residents at all times."</p> <p>Review of the provider's September 2009 Resident Abuse and/or Neglect policy revealed: *The seven components mentioned above were absent from the policy. *The purpose of the policy was to ensure the facility had in place an effective system that regardless of the source prevented mistreatment, neglect, and abuse of resident or misappropriation of their property. *To ensure all residents were not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. *To ensure all identified incidents of alleged or suspected abuse/neglect were promptly investigated and reported. *To ensure all identified injuries of unknown origin were promptly investigated to determine probable</p>	F 226			

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F 226	<p>Continued From page 12</p> <p>cause of unknown origin injuries and were reported.</p> <p>*To identify and remedy any abusive situations.</p> <p>*To prevent future injuries.</p> <p>*To ensure a complete review of existing incidents were documented.</p> <p>*To identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that might constitute abuse and to determine the direction of the investigation.</p> <p>Surveyor: 29354</p> <p>Observation on 4/27/16 at 8:35 a.m. in resident 1's room revealed she was lying on her back in bed. The bed had been lowered to a low position, the room was dark, and there was a mat on the floor next to the bed.</p> <p>Observation and interview on 4/27/16 at 12:45 p.m. in resident 1's room with the director of nursing (DON) revealed:</p> <p>*Resident 1:</p> <p>-Had been sitting up in her wheelchair with the television on.</p> <p>-Had her left hand positioned on her lap.</p> <p>*The DON took the resident's left hand and held it out for the surveyor to look at it.</p> <p>*Resident 1's left hand revealed areas of light to dark purple bruising extending over most of the thumb and radiating down over the inner aspect of the palm and wrapping around to the front of the thumb.</p> <p>*The DON confirmed the light to purple bruising to the residents left hand thumb region was larger than on Monday.</p> <p>Observation and interview on 4/27/16 at 3:30 p.m. in resident 1's room with certified nursing assistants (CNA) J and K revealed:</p>	F 226			

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F 226	Continued From page 13 *They had placed a portable commode (stool) next to the resident's bed. *They placed a gait belt around the resident and assisted her with doing a pivot transfer from the bed to the commode. *They cleaned the resident's glasses and placed the glasses on her face. *CNA A revealed: -They had a difficult time trying to get the resident into the bathroom, so they had been using the commode for quite awhile. -They were to always use two staff when transferring the resident.	F 226	F Tag sited: F441 483.65 Infection Control Issue cited: 483.65 (b) (3) Preventing the Spread of Infection – Hand Washing	6/9/16	
F 441 SS=D	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	1. Immediate action(s) taken for the resident found to have been affected include: a. The certified nursing assistant (CNA# A) was immediately in-serviced on proper hand washing procedures. Corrective action was completed for CNA# A. 2. Identifications of other residents having the potential to be affected was accomplished by: a. All staff will be in compliance with the facilities policies and procedures regarding		

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F 441	<p>Continued From page 14</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure hand hygiene was maintained for four of seven sampled residents (2, 3, 4, and 5) by one of six observed staff (A) during residents' personal care. Findings include:</p> <p>1. Observation on 4/27/16 at 9:10 a.m. in resident 2's room with certified nursing assistants (CNA) A and B revealed: *Without performing hand hygiene they both put on a pair of gloves. They then: -Transferred resident 2 with a full body mechanical lift from her wheelchair to the bed. -They removed the sling from under the resident. -They pulled her slacks down. -They repositioned the resident in bed towards CNA B. -They removed the incontinent brief from the resident. -CNA A took several wipes and cleaned bowel</p>	F 441	<p>Infection Control including but not limited to handwashing to provide a safe and sanitary environment to help prevent the transmission of disease and infection.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>a. All personnel will be in-serviced 5/18/2016 on the facility's policy for hand washing. In-service training will include random observation of personnel performing hand washing procedures according to facility policy. Corrective action will be provided as needed.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p>		

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F 441	<p>Continued From page 15 movement from the resident. -They applied a new brief. -They pulled her slacks up. -CNA A removed her gloves. Without performing hand hygiene she clipped the call light to the resident's bed, took the bed control and lowered the bed, and pulled the room divider curtain. *Took the mechanical lift and pushed it into the hallway, and threw the garbage away. *Returned to resident 2's room.</p> <p>2. Observation on 4/27/16 at 9:20 a.m. in resident 3's room with CNAs A and B revealed: *CNA A had not performed hand hygiene from the above observation. *Without performing hand hygiene or applying gloves she assisted CNA B with transferring resident 3 with a stand mechanical lift from the wheelchair to the toilet. *CNA A pulled the resident's slacks down and then assisted him onto the toilet. *At 9:25 a.m. CNA A left the room.</p> <p>3. Observation on 4/27/16 at 9:27 a.m. CNA A entered resident 4's room. Without performing hand hygiene or applying gloves she: *Put a gait belt on the resident and assisted her to the toilet. *Assisted the resident back to the chair. *Left the room without performing hand hygiene.</p> <p>4. Observation on 4/27/16 at 9:35 a.m. with CNA A revealed she returned to resident 3's room. Without performing hand hygiene or applying gloves she: *Pulled up the residents' slacks. *Attached the foley catheter bag to the wheelchair. *Without performing hand hygiene she left the</p>	F 441	<p>a. Director of Nursing (DON), Infection Control Nurse or designee will complete random audits of personnel timing and technique of hand washing procedures to ensure personnel are performing the procedure in accordance with our facility's Hand Washing Policy. Ten random audits will occur every week for one month.</p> <p>b. Audits will be discussed at the monthly QAPI meeting until the QAPI team decides that consistent, substantial compliance has been met. → *The DON or designee will bring the audits to the QAPI meeting. SC/SDDO/H/EL</p>		

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F 441	Continued From page 16 room. 5. Observation on 4/27/16 at 9:40 a.m. with CNA A revealed she entered resident 5's room. Without performing hand hygiene or applying gloves she applied a gait belt on the resident and began to assist her with standing up. 6. Interview on 4/27/16 at 2:35 p.m. with the director of nursing regarding the above observations revealed: *Her expectations would have been for the staff to do hand hygiene between each resident and following perineal care. *CNA A would need to be retrained on how to do hand hygiene. Review of the provider's undated Hand Hygiene/Hand Washing policy revealed: *"Hand washing continues to be the primary means of preventing the transmission of infection. *Hand washing or use of hand sanitizers should be used at a minimum in these situations: -Before and after direct resident contact. -Before and after assisting a resident with personal care. -Upon and after coming in contact with a resident's intact skin (transferring a resident). -Before and after assisting a resident with toileting (hand washing with soap and water). -After removing gloves. -After handling soiled items (catheters)."	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514			

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F 514	<p>Continued From page 17</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to ensure documentation was complete for one of one resident (1) with a bruise of unknown origin. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She was admitted on 3/6/12. *She had diagnoses for: -Dementia without behavioral disturbances. -Gastric reflux. -Arthritis. -Major depressive disorder. -Anxiety disorder. -High blood pressure. *Her 4/12/16 significant change Minimum Data Set assessment revealed: -She had a Brief Interview for Mental Status (test to measure ability to think and remember) score of six out of fifteen indicating severe cognitive impairment.</p> <p>Review of resident 1's interdisciplinary progress</p>	F 514	<p>Tag Cited: F514</p> <p>483.75 (I) (1) – Resident Records</p> <p>Issue Cited:</p> <p>Complete/Accurate/Accessible</p> <p>1. Immediate action(s) taken for resident found to have been affected include:</p> <p>a. The licensed practical nurse (LPN# G) was immediately in-serviced on the importance/need for complete and timely documentation of wounds/injuries to include bruises.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:</p> <p>a. All licensed staff will document accurately and in a timely manner.</p>	6/9/16	

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F 514	<p>Continued From page 18</p> <p>note on 4/24/16 at 9:06 a.m. by licensed practical nurse (LPN) G revealed: *A dark purple bruise was found on resident 1's left thumb. -It wrapped almost completely around her thumb. -There was no increased swelling. *There was no documentation of measurements of the bruise. *There was no documentation the physician was notified.</p> <p>Interview on 4/27/16 at 10:40 a.m. with LPN G regarding resident 1 revealed she: *Was the charge nurse for the day shift on 4/24/16. *Had not measured the bruise and documented the information. *Acknowledged she had not notified the physician of the bruise of unknown origin. *Had not initiated an incident report.</p> <p>Review of the provider's April 2003 Incident Reports policy revealed: **"An incident report and the appropriate documentation will be completed by the end of the shift. *Notify the resident's physician if an injury is noted and receive orders for follow-through. Document doctor's name in nurse's notes..." *Documentation in the nurses notes of the medical record was to include: -Location and time of incident. -Complete assessment of resident's condition. -The time the physician was notified.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamental of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 348 and p. 358, revealed: **"Nursing documentation must be accurate,</p>	F 514	<p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>a. All nurses will be in-serviced 5/18/2016 on the facility's policy for the need of documentation on any wound such as skin tears, abrasions, bruises, etc. If the facility policy for documentation is not followed then corrective action will be provided.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>a. Director of Nursing or designee will monitor documentation of wounds weekly for one month by checking the Stop and Watch forms for reported wounds. Then the Stop & Watch forms will be monitored for correct and</p>		

**All nurses will monitor and document bruises, skin tears, abrasions, and any other issues weekly. KSC/SDD/DEL*

**all SDD/DEL*

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F 514	Continued From page 19 comprehensive, and flexible enough to retrieve clinical data, maintain continuity of care, track patient outcomes, and reflect current standards of nursing practice. *...document an objective description of what happened, what you observed, and the follow-up actions taken in the resident's medical record."	F 514	timely documentation of wounds every 2 weeks. b. This plan of correction will be monitored/discussed at the monthly QAPI meeting until the QAPI team decides that consistent, substantial compliance has been met.		