STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(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
W000000	This visit was for a post-certification revisit survey (PCR) to the investigation of complaint #IN00147483 completed on 4/25/14. This visit was in conjunction with pre-determined full recertification and state licensure survey. Complaint #IN00147483-Not Corrected. Dates of Survey: June 16, 17, 18, 19 and July 1, 2014. Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170 Surveyors: Paula Eastmond, QIDP-TC Keith Briner, QIDP (6/16/14 to 6/19/14) Susan Eakright, QIDP (6/16/14 to 6/19/14) Mark Ficklin, QIDP (6/16/14 to 6/19/14) Vickie Kolb, RN (6/16/14 to 6/19/14) Tim Shebel, QIDP (6/16/14 to 6/19/14) Kathy Wanner, QIDP (6/16/14 to 6/19/14) These federal deficiencies also reflect state findings in accordance with 410 IAC 16.2	W000000		

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

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

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	Quality Review completed 7/14/14 by Dotty Walton, QIDP and Ruth Shackelford, QIDP.			
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 14 of 14 sampled clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14) and for 121 additional clients (#15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, and #135), the facility's governing body failed to exercise general policy, budget and	W000104	W104 I Active Treatment. Cabinet in kitchen has been removed from service. Retraining completed with Dietary as to infection control. Reach in refrigerator has been repaired and now is at proper temperature. Retrain regarding safe temperatures of refrigerators. Pans with white build up have been delimed. Logs are now coded with numbers to identify the refrigerator they correspond with. Pest control company has assessed infestation and made recommendations. Dietary is now assuring that floor and kitchen thoroughly cleaned including mats next to dishwasher cleaned at end of day. Leaky valve in mop sink room has been replaced. Bedroom and Dining windows have haze and smudges either removed or	07/31/2014

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	operating direction over the facility to ensure the facility was maintained, kept in good repair and failed to prevent insect infestation. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure a client did not use her personal funds for needed adaptive equipment. Findings include:1. On 6/17/14 from 3:30pm until 4:30pm, the facility's kitchen was observed with Dietary Manager (DM) #1 and the following issues were found: -On 6/17/14 at 3:30pm, DM #1 indicated clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, and		a plan is in place to replace them. Second floor central bath floor has been cleaned, floor is clear and paint touched up. Hallway paint touched up on second floor. Client 5's bedroom walls are painted where patched, window sill area cleaned and Christmas decorations removed and she has knobs on her dresser drawers. Staff have been reeducated regarding appropriate purchases, decorations that are within season, repair of furniture and walls and window sills. Also staff has been reeducated with regard to items residents may pay for and those that North Willow will pay for. For sited residents QMRP assigned to them has been retrained on revised Community Integration Policy, when to revise an objective, schedule of assessment completion, Quarterly reviews purpose and schedule, schedule and methods for monitoring data, method of resident participation in dining room set up. Recreation has been trained on revised Community Integration policy. Staffing has been assessed in the dining room and staff assigned as needed. Client 12's FSA has been completed. Client 10's Quarterly review has been revised to include data on goals. Goals have been updated where regression was seen or other reasons when needed. Staff for sited residents have been	

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	#135 lived in the facility and had the potential to receive food and services generated by the dietary department. -Eight (8) one inch holes had penetrated through two of two metal doors of the metal utensil cabinet beside the steam table. DM #1 stated eight of eight holes exposed "jagged" edges to the metal and could not be sanitized. -Inside the metal utensil cabinet were two rows of four drawers (8 drawers total) and DM #1 stated 2 of 8 drawers had "unidentified" spillage debris mixed with utensils used for serving and cooking stored as "clean" utensils. -DM #1 stated and observation of inside the metal utensil cabinet indicated there were three of four (3 of 4) white rubber spatulas with a "brown build up" and they were missing sections of the "rubber" on the spatulas which exposed "frayed" edges and were stored as clean. -DM #1 indicated and observation of inside the metal utensil cabinet indicated there were two of seven (2 of 7) wire whisks with broken wires from the handles used for mixing and stirring food and stored as clean. -DM #1 stated and observation of inside		retrained to implement goals and objectives at formal and informal times. QMRP for residents sited complete Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. Resident 7 has been reimbursed for the body pillow and cover. Windows sited have been cleaned on the inside and will be cleaned on the outside. An outside company is being procured for this process and will have a date to complete the work. Windows that need to be replaced have been scheduled to be replaced. Two north classroom has been repainted. Second floor central bath has been cleaned, paint touched up and items removed from floor and tub. Hole was repaired near room 207. For sited residents QMRP assigned to them has been retrained on revised Community Integration Policy. Recreation has been trained on revised Community Integration policy. Residents are to be	

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	the metal utensil cabinet indicated six of twenty (6 of 20) spoodles/ladles (used for mixing and stirring food) had a "dirty build up" onto each of the pieces of metal on each handle which connected the spoodles/ladles end to the handle of the utensil and stored as clean. -Two of four (2 of 4) doorway door jams leading into the kitchen on the "clean" side were stained. DM #1 stated each door jam had a "brown" material and was "dirty." -At 3:30pm, DM #1 indicated the temperature in the reach in refrigerator was fifty-eight degrees with a pan of individual containers of prepared pudding and a container of individually wrapped luncheon meat sandwiches for each of the clients for snacks and medication passes for 6/17/14. At 4:30pm, the reach in refrigerator was fifty-eight degrees. At 4:30pm, DM #1 stated the reach in refrigerator was "too hot" and should be less than "forty-one" degrees. -DM #1 stated inside the "Pan" room were seven of thirteen (7 of 13) three inch (3") stainless steel steam table pans, for food, had a "white powder" build up "residue" on each of the pans and were stored as clean.		scheduled for 1 outing each month that is community based Sited residents have had their Daily Activity Schedules reviewed and revised as needed and these schedules have been trained with their CNA staff for implementation of goals including hand washing when resident touches nasal cavity or other items to soil their hands. Their staff have been retrained to implement formal and informal goals and when it is appropriate to do so as well as suggestions on informal times to implement. QMRP for residents sited complete Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. Staff for sited residents trained to rotate attention at least every 15 minutes to resident and offer leisure materials, encourage interaction with leisure materials, and train a goal either formal or informal when indicated on their schedule. Sited residents have had their Daily Activity Schedules reviewed and revised as needed and these schedules have been trained with their CNA staff for implementation of goals. Their staff have been retrained to implement formal and informal goals and when it is appropriate to do so as well as suggestions on informal times to	

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	-DM #1 stated the kitchen "Mop" room sink had a "leaky" valve on the spicket and a "steady stream" of water ran from the spicket into the water reservoir at the base of the floor. -At 3:30pm, DM #1 indicated above the food prep area where staff were assembling food for supper was a cabinet. When containers of Chocolate syrup and Strawberry syrup were moved, DM #1 stated "a swarm" of kitchen flying insects (gnats) flew over the food prep areas of the kitchen. -At 4:00pm, when the door to Reach In Refrigerator #2 was opened a swarm of kitchen gnats flew over the food prep area. At 4:00pm, DM #1 stated the second "swarm" of kitchen gnats flew over the food prep areas of the kitchen when staff were mixing foods for supper. On 6/17/14 at 4:30pm, a record review of the facility's 6/2014, 5/2014, 4/2014 "Record of Refrigeration Temperatures" was conducted with DM #1. DM #1 stated the "Record of Refrigeration Temperature" log was the "current" record for monitoring the temperatures of the refrigerators inside the kitchen. DM #1 stated the kitchen had two "Reach In" refrigerators, but both were not "clearly"		implement including hand washing when resident touches nasal cavity or other items to soil their hands. Nurse for sited resident retrained to implement medication goal. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. Staff for sited residents have been reinserviced on schedules of documentation and procedures of taking data. QMRP for sited residents has been reinserviced on schedule for monitoring data and methods of follow up for incomplete data collection. Resident 7 has training in place for how long she is to remain up in her wheel chair. Resident 4 and 6 have current documentation regarding positioning. For resident 14 missing documentation has been addressed for the 24 hour flow sheet. Resident 1 ISP has plan for repositioning and documentation is now consistent. CNA staff retrained on documentation and QMRP staff for sited residents are checking documentation 3 times each week. Staff for sited residents retrained on family style dining including methods of including residents in set up of dining area and assisting to serve themselves. The IDT has	

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	identified on the log to determine staff knew which temperatures were recorded for each reach in refrigerator. On 6/18/14 at 7:25am, a record review of the facility's undated "Vermin Control" policy and procedure was conducted. The policy and procedure indicated "The dining services department must be free of Vermin at all times. Prevention...Keep doors to exterior areas closed, Keep screens tight fitting and in good repair, cover and store food properly...Avoid the use of foil and paper to line drawers, steam tables, shelves, and any other area that would allow the infestation and breeding of bugs...." On 6/18/14 at 7:25pm, a record review of the facility's undated "Storage of Refrigerated Foods" procedure indicated "The Dining Services department will store refrigerated foods at 41 (degrees) F (Fahrenheit) or below and in such a manner as to avoid spoilage and contamination according to policy guidelines and federal, state, and local regulations...." On 6/18/14 at 7:25am, DM #1 stated the facility Dietary Services did not follow their written policy for the dirty utensils stored as clean, damaged utensils which "continued" to be used for food		reassessed residents in dining skills and specified the type and method of assistance they will receive at meal time. Specific needs have been retrained with staff. Adequate staffing for meal is assured by Dining Monitor. II All residents may be at risk of this deficient practice. III Kitchen has been checked by Dietary Service Manager assuring that all equipment can be cleaned and sanitized. Storage of spoons and spoodles checked to assure they are clean and drawer is free of debris and utensils are in good repair. Pans have been checked for white build up and if found it has been delimed. Refrigerator logs have been checked to assure that the refrigerator they correspond with is identified in the kitchen. Refrigeration checked to assure at proper temperatures, and pans are checked to assure they do not have white build up. Dietary staff retrained on Vermin control policy. DSM checks kitchen at least 5 days each week to assure cleaning schedule followed. Any evidence of infestation is reported immediately to ED and Maintenance Director. Maintenance Director contacts pest control when report of infestation occurs. Windows in bedrooms and dining rooms are assessed by Maintenance and Housekeeping to be clean and free of haze. Central bath floors on	

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	preparation, temperature control of reach in refrigerator #2, and the two "swarms" of insects in the kitchen.2. The third floor where clients #8, #9, #10, #11, #12, #13, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, and #135 resided was inspected during the 6/16/14 observation period from 1:22 PM. until 5:00 P.M.. The windows in the bedrooms of clients #8, #9, #91, #92, #95, #97, #116, #117, #118, #119, #120, #121, #132, and #133 were smudged and hazy. The dining room windows and the windows in Program room 3 South were also smudged and hazy. This affected all clients living on the third floor of the facility. Program Director #1 was interviewed on 6/18/14 at 1:06 P.M. Program Director #1 stated, "Housekeeping is in charge of keeping the windows clean."3. Observations were conducted on the west hall of the second floor of the facility on 6/16/14 between 2 PM and 6:30 PM. __The shower room on the west hall second floor of the facility was observed to have particles of unidentifiable debris		first and third are clean, paint touched up if needed and floors are clear. Hallways have been assessed by Maintenance and touched up with paint if needed. Walls in bedrooms are checked by QMRP and painted where patched or scheduled for painting. Window sills that have been checked for unnecessary foam and if found it has been removed. Walls in hallways and classrooms have been assessed by QMRP, PD/Designee or Maintenance for need of patching or painting touch up. PDs/QMRPs have checked central baths on first and third floor to assure cleanliness, paint in good repair and they are picked up. Maintenance Director has scheduled painting for rooms. Building has been checked by QMRP/Designee for Christmas decorations and if found they have been removed. Business office has been trained to check expenditures and report to PD if something like bed linen or other potential items that are to be purchased by the facility are purchased with client funds. These purchases will be reimbursed. PD/QMRPs checked expenditures for items purchased in 2014 that residents need reimbursed for such as	

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	all along the edge of the floor. A plastic toy was on the floor under one of the bath tubs. Strands of hair and residue were along the rim of one of the tubs and items of clothing were on the floor at the back of the shower room. __The paint was chipped along the bottom portion of the walls in the west hallway and there was a hole in the black border/round near room #207 on the second floor. During interview with LPN #2 on 6/16/14 at 5:30 PM, the LPN stated the walls "are probably" being damaged from all the wheel chairs. The LPN stated, "The walls need repainted." The LPN stated the shower room should be cleaned daily and "certainly between clients" bathing.4. Observation of client #5's and #81's bedroom was conducted on 6/17/14 at 3:45 P.M. There were areas on the walls patched but not painted, one area was 2 feet by 1 foot and the other area was 1 foot by 3 feet. The walls throughout the room were spattered with brown spots. The window sill was covered with a black foam which was peeling off. Client #5's bed was directly below the window. The window was smeared and streaked and there were Christmas window decorations on the glass. An Easter decoration was on the wall above the head of the bed and a		body pillows and covers and they have been reimbursed. Staff have been reeducated regarding appropriate purchases, decorations that are within season, repair of furniture and walls and window sills. Also staff has been reeducated with regard to items residents may pay for and those that North Willow will pay for. QMRP staff round weekly and submit work orders with regard to maintenance needs or paint touch up. Dietary staff have been retrained on maintaining a clean and sanitary environment and keeping utensils free of debris. Staff are trained to report any maintenance issues immediately to DSM(Dietary Service Manager)/ADSM(Assistant Dietary Service Manger) for action and follow up. DSM/ADSM round at least 5 times each week and monitor for maintenance issues. Windows sited have been cleaned on the inside and will be cleaned on the outside. An outside company is being procured for this process and will have a date to complete the work. Housekeeping has a schedule to clean windows when deep cleaning bedrooms and clean inside of dining rooms at least twice weekly or as needed. Windows that need to be replaced have been scheduled to be replaced.	

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	styrofoam snow flake hung above client #5's bed. Client #5's chest of drawers was missing knobs/pulls. Direct Care Staff (DCS) #61 was interviewed on 6/17/14 at 4:10 P.M. When asked about the walls and missing knobs, DCS #61 stated, "Yes, it's his (client #5's) chest and the knobs and walls have been like that quite awhile." The walls of the program room on 2 north were stained, spotted and had areas of missing paint. The left arm of the wooden rocking chair was not fastened securely to the spindles. The light colored tile flooring had gray areas around the base trim and the corners. Some of the floor tiles were cracked. An interview was conducted with QIDP #4 on 6/19/14 at 9:07 A.M. QIDP #4 stated, "They should paint the program room." 5. Client financial records for the past year were reviewed on 6/18/14 at 11:01 A.M. Client #7's record included a receipt dated 4/15/14 for "body pillow $9.99, body pillow cover $9.99 and pillow cover $9.99." The receipt indicated client #7 had purchased these items plus applicable tax with her own personal spending money.		QMRPs have been retrained on revised Community Integration Policy. Recreation has been trained on revised Community Integration policy. QMRPs will request assistance as needed from Recreation staff and report to Program Directors any issues. QMRPs have been retrained on revised Community Integration Policy, when to revise an objective, schedule of assessment completion, Quarterly reviews purpose and schedule, schedule and methods for monitoring data, method of resident participation in dining room set up. Recreation has been trained on revised Community Integration policy. QMRPs will request assistance as needed from Recreation staff and report to Program Directors any issues. Staffing has been assessed in the dining rooms and staff assigned as needed. Resident Quarterly reviews have been audited by PDs to assure needed information is present and goals are modified when needed. Staff have been retrained to implement goals and objectives at formal and informal times. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs.	

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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
	Client #7's record was reviewed on 6/18/14 at 3:02 P.M. a staff in-service training dated 5/5/14 indicated "Body pillow placed behind her (client #7's) back to hold her side lying position." An interview was conducted with facility Office Assistant (OA) #1 on 6/18/14 at 2:00 P.M. When asked if client #7 should pay for bedding and linens, OA #1 stated, "[Name of social worker #2] did the shopping. I never really thought about the purchase. Normally the facility pays for regular linens." An interview was conducted with the facility's social worker (SW) #2 on 6/19/14 at 9:20 A.M. When asked about client #7 paying for the body pillow, SW #2 stated, "The facility should reimburse her." This deficiency was cited on 4/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-13(a) 3.1-13(r)		Residents Daily Activity Schedules have been reviewed and revised as needed and these schedules have been retrained with CNA staff for their respective residents including implementation of formal and informal goals . Their staff have been retrained to implement formal and informal goals and when it is appropriate to do so as well as suggestions on informal times to implement including hand washing when resident touches nasal cavity or other items to soil their hands. CNA staff have been trained to rotate attention at least every 15 minutes to resident and offer leisure materials, encourage interaction with leisure materials, and train a goal either formal or informal when indicated on their schedule. Residents Daily Activity Schedules have been reviewed and revised as needed and these schedules have been retrained with CNA staff for their respective residents including implementation of formal and informal goals . Their staff have been retrained to implement formal and informal goals and when it is appropriate to do so as well as suggestions on informal times to implement including hand washing when resident touches nasal cavity or other items to soil their hands. CNA staff have been trained to rotate attention at least every 15 minutes to resident and offer leisure materials, encourage interaction with leisure materials, and train a goal either	

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			formal or informal when indicated on their schedule. Nurses retrained to implement medication goals at formal and informal times. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. CNA staff reinserviced on schedules of documentation and procedures for taking data. QMRPs reinserviced on schedules of monitoring data collection. QMRPs check documentation 3 times per week with follow up with CNA staff as needed. Staff have been retrained on family style dining including methods of including residents in set up of dining area and assisting to serve themselves. The IDT has reviewed resident dining skills. Any changes have been retrained with staff. Adequate staffing for meal is assured by Dining Monitor. Dining Monitor also checks to assure goals both formal and informal are trained during mealtime. IV Active Treatment. Program Directors audit daily for two weeks then weekly for 3 months with regard to clear windows, central bath clean and in good repair, walls that need paint touch up, foam build up on window sills, out of season	

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			decorations, bedroom furniture repair, and hallway paint touch up. Program Directors report to ED when maintenance issues that have been reported are not acted on within one week. DSM checks kitchen area at least 5 days per week for evidence that cleaning schedule followed and that it is free of pest infestation. Maintenance Director has created a preventive maintenance schedule for outside window cleaning. Maintenance Director/Designee assesses rooms monthly and schedules them for needed repair of drywall and paint touch up. DSM/ADSM check utensils five times a week for two weeks, then three times a week for two months, then as part of their regular audit process and follow up as needed to assure clean utensils. Housekeeping Director follows up on cleaning schedules. Registered Dietitian audits monthly for sanitation and maintenance issues. All reports shared and monitored by ED. Program Directors review planned outings prior to implementation to assure that at least two are planned for each resident and that one is community based. Follow up including progressive discipline is completed for issues resulting from not following the policy. Program Director will report to ED any issues with Recreation staff providing	

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			assistance with outings. ED is to assure that Recreation provides requested assistance. Program Directors will continue to provide monthly report to QA as to outings taken and if not IDTs are provided stating reason resident did not attend an outing. Program Directors review planned outings prior to implementation to assure that at least two are planned for each resident and that one is community based. Follow up including progressive discipline is completed for issues resulting from not following the policy. Program Directors assure QMRPs complete their work in a timely manner including but not limited to; Quarterly reviews which include objective data, assessments, data monitoring, meal preparation activity in dining rooms. Program Directors assure adequate staff are present in the dining rooms for meals. Program Director will report to ED any issues with Recreation staff providing assistance with outings. ED is to assure that Recreation provides requested assistance. Program Directors will continue to provide monthly report to QA as to outings taken and if not IDTs are provided stating reason resident did not attend an outing. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per	

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			week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. Program Directors (PDs) review Daily Activity schedules for accuracy and appropriateness. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. QMRPs observe goals implemented as part of Active Treatment audit. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. QMRP, nurses, PDs and other North Willow management staff observe for active treatment and model and prompt as necessary to assure it occurs as prescribed. North Willow Management staff Observes regularly for infection Control. Program Directors check QMRP monitoring at least weekly with follow up as needed. Issues will be dealt with first with counseling and then progressive discipline if issues persist.	

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			As part of the dining monitor process Social Worker's, QMRPs and PDs observe And assure training of mealtime Objectives both formal and informal. QMRP, nurses, PDs and other North Willow management staff observe for active treatment and model and prompt as necessary to assure it occurs as prescribed Active Treatment audits may include dining. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. QMRP, nurses, PDs and other North Willow management staff observe for active treatment and model and prompt as necessary to assure it occurs as prescribed. North Willow Management staff Observes regularly for infection Control.	
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 14 sampled clients (#7) and for 8 additional clients (#74, #92, #100, #112, #116, #117, #118 and #121), the facility failed to implement its written policy and procedures to prevent	W000149	W149 I IDT for resident 74 has devised a plan to assist her in remaining safe and free from harm. Staff for resident 74 has been trained on this plan. Resident 121 has had her plan for physical aggression revised.	07/31/2014

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	neglect of client #74 in regard to a pattern of injuries of unknown source, and in regard to client #121's pattern of client to client abuse/aggression toward clients #92, #100, #112, #116, #117, #118. The facility failed to implement its written policy and procedures to prevent neglect of client #7 in regard to skin breakdown/skin integrity issues due to the client's wheelchair. Findings include: 1. Observations were conducted on the west hall of the second floor of the facility on 6/17/14 between 3:30 PM and 4:45 PM. Client #74 was sitting in a wheelchair using her legs to maneuver her wheelchair. Client #74 was wearing a soft padded helmet on her head and a night gown that exposed her legs. Client #74 had a large greenish blue bruise approximately 6. 5 centimeters (cm) by 4 cm on the outer anterior aspect of her right arm, a dark greenish purple bruise approximately 2.5 cm on her right inner knee area and a larger greenish blue bruise approximately 5 cm on her right outer leg at the knee area. Interview with QIDP (Qualified Intellectual Disabilities Professional) #4 on 6/17/14 at 4:45 PM indicated client #74 had gotten the bruises on her legs		When approved by the Human Rights Committee that plan will be trained with her staff. Her current plan has been retrained with her staff. Residents who may have been involved in an incident with resident 121 have had mental anguish assessments completed. IDT has met and determined whether a formal goal for safety needs implemented with each of them. QMRP for resident 74 has been retrained on process for addressing pattern of unknown injuries, any more than 2 unknown injuries in a 30 day period must have a formal plan for safety. Resident 7 has their new wheel chair seat. Repositioning program has been retrained with staff and Nursing and QMRP. Staff for resident 7 has been retrained on positioning including method of documentation. QMRP for resident 7 completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. II All residents may be at risk of this deficient practice. III QMRPs have been retrained on process for addressing pattern of unknown injuries, any more than 2 unknown injuries in a 30 day period must have a formal plan for safety.	

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	from holding a large basket between her legs. The QIDP indicated client #74 pressed her legs together to hold the basket in place. When asked what happened to her arm and how did she get the bruise on the outer aspect of her leg, the QIDP indicated he did not know and would look into it. The facility's reportable incident reports, investigations and/or internal incident reports were reviewed on 6/16/14 at 3:23 PM. The facility's reportable incident reports, investigations and/or internal incident reports indicated the following (not all inclusive): -5/6/14 "[Client #74] present to social service coordinator with discolorations to both forearms. Nursing notified, and 3 bruises noted to right arm, 2 purple in color and 1 yellow in color. One bruise, purple in color, also noted to left lower arm. No further discolorations or other signs of injury noted or observed...[Client #74] uses wheelchair, propelling self. She is verbal with limited skills. [Client #74] uses gestures and pointing as well as speech to communicate wants and needs...Investigation in progress...." The facility's 5/13/14 follow-up report and/or undated Unknown Injury/Fracture Investigation indicated "...[Client #74]		IDTs have assessed data to assure that any resident with a pattern of unknown injury has a safety plan in place which is trained with staff and monitored by the QMRP. Residents who have physical aggression have been assessed by the IDT to assure that any pattern of aggression is addressed by the IDT in updating the Behavior Support Plan and if updated retrained by the QMRP. Residents who have been the victim of a pattern of aggression have been assessed by the IDT to determine whether a formal goal for saftey needs implemented. New goals have been trained with staff and QMRPs are monitoring them. Repositioning program has been retrained with staff and Nursing and QMRP. Staff has been retrained on positioning including method of documentation. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. IV Program Directors have reviewed safety plans, IDTs, updated BSPs, formal goals for quality. Program Directors assisted the IDTs with review of data to determine if a pattern exists for a resident with regard to unknown injury or being a victim of aggression. Morning meeting reviews reportable	

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	has no pattern of unknown injuries. She was noted with a bruise to her upper left arm on 2/17/14. [Client #74] was noted to consult with ortho (orthopedic) specialist on 2/17/14 receiving diagnosis of Osteoarthrosis. She was noted on that same day, 2/17/14 to refuse vital sign assessment. [Client #74] also received a new order to begin Relafen 750 mg (milligrams) BID (two times a day) d/t (due to) Osteoarthrosis. Relafen (pain and inflammation) is a NSAIA (non-steroidal anti-inflammatory analgesic) which is noted to have a common side effect of bruising. [Client #74] receives Depakote to treat symptoms of Intermittent Explosive Disorder. Depakote is also noted to cause one to bruise easily. She has no noted client to client events this year. There are no falls reported. No documented BIRs (Behavior Incident Reports) noted which would account for the bruises...." The 5/13/14 follow-up report and/or undated facility's investigation indicated "...Conclusion: The bruises remain but continue to fade at this time. There has been no further injuries or concerns noted or observed. [Client #74's] BSP (Behavior Support Plan) remains appropriate at this time. The exact cause of the bruises have not been determined, but the team agrees that they are likely inadvertently self-inflicted.		behaviors, monitors unknowns and any client to client aggression. Client Advocates collect evidence of corrective action. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. Positioning is checked as part of the Active Treatment audit process by QMRPs and PDs. Nursing assures positioning as part of their rounds on their assigned area during their shift.	

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	Staff and nursing will continue to monitor for injuries and continued bruising. Nursing will also continue to monitor for other adverse effects due to use of non-steroidal anti-inflammatory analgesics." -5/22/14 "Nursing noted bluish discolorations to [client #74's] left lower leg (sic) knee as well as 2 small bluish areas to lower left thigh. No edema noted or observed. No signs of discomfort or distress noted. No further signs of injury noted or observed. MD (Medical Doctor) and next of kin notified. [Client #74] denies discomfort. [Client #74] propels self in wheelchair. She is active. She is verbal with limited skills. Diagnosis (sic) includes Profound Intellectual Disabilities, Osteoarthritis, Unspecified Disorder of Muscle, Ligament, and Fascia, Intermittent Explosive Disorder, Dysphagia, and Asthma. [Client #74] has a formal BSP addressing Agitation, Temper Tantrum, and Physical Aggression. Aggressive behaviors are assisted with medication (Depakote). Investigation in progress. [Client #74] was noted with unknown bruising on 2 other occasions to her arms on 2/17/14 and 5/6/14. She has no reported falls or client to client events." The facility's 5/22/14 Verification Of			

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	Investigation indicated client #74 was not able to tell the facility how the client received the bruises to her lower legs. The facility's 5/30/14 follow-up report and/or undated Unknown Injury/Fracture Investigation indicated "...[Client #74] has been noted with occasional episodes of maladaptive behaviors of temper tantrum and self-injurious behavior which includes hitting self. She refused her podiatry examination on 5/16/14. [Client #74] receives medications which tend to increase the tendency to bruise. Depakote and Relafen. The Depakote is used for aggressive behaviors, and the Relafen is to aid in [client #74's] Osteoarthrosis. Staff interviews provided the following information: Staff from both day and evening shifts report that [client #74] is active. She propels herself about the unit and her room. Staff working days and evenings state [client #74] takes clothing out of drawers often wanting to change. Day nurse stated she may have bumped leg on partially open dresser drawers in room. Day staff report she may have bumped legs or even struck herself during a temper tantrum. All shifts deny knowledge of any falls or client to client events. Night staff report [client #74] sleeps well most nights. Night nurse states she uses a bed alarm at night for safety for times she does			

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	attempt to toilet self during the night. This writer spoke with PD (Program Director) and QDDP (Qualified Developmental Disabilities Professional) again, and PD reported that [client #74] holds a basket of flash cards between her legs as she is seated. QDDP and PD both agrees that this may be the cause of the light bruising...." The facility's follow-up report indicated "...Conclusion: The exact cause of the fading bruises has not been determined, however the team agrees they are most likely self-inflicted, but not intentionally. The discolorations continue to resolve at this time. [Client #74] displays no further sign of injury at this time. Staff will continue to monitor and report any further injuries. Staff will continue to follow guidelines of BSP as needed." -5/31/14 "While the CNA (Certified Nurse Aide) was doing an (sic) ADLs (adult daily living tasks) with [client #74], she noted a bruise on her left elbow. No edema or open areas. No complaints of pain. Investigation into cause of bruise will be investigated. The facility's 5/31/14 BIR indicated client #74 had injuries to her inner knee/thigh area and an injury/bruise to the front of her leg at the knee area.			

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	The facility's 6/6/14 follow-up report indicated "...Information from Nursing Notes, ...BIRs, Physician orders, ISP (Individual Support Plan), BSP, and Patterns & (and) Trends: [Client #74] remains medically stable at this time. She has no changes in medications. [Client #74] has a formal BSP which remains appropriate at this time. She is very active and tends to bruise easily. [Client #74] has no pattern of falls currently. She has no pattern of client to client events. [Client #74] has 3 previous unknown injuries documented this year. She had bruises to both forearms 5/6/14, a bruise to the left upper arm 2/17, and bruising to the leg 5/22/14. [Client #74] continues to display no signs of distress or discomfort." The facility's follow-up report and/or undated Injury/Fracture Investigation indicated Conclusion: Nursing notes bruising to [client #74's] elbow continues to resolve, and is very faint at this time. There are no further signs of injury at this time. The exact cause of the bruise has not been determined, however it is likely the result of [client #74] striking her arms on the wheelchair arms as she propels herself. Staff will monitor and educate [client #74] to use her feet as opposed to her entire body to propel herself. Staff will continue to monitor and report any			

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	further unknown injuries. Staff will also continue to monitor and document maladaptive behaviors, and follow guidelines of BSP." The facility's undated investigation indicated "...Nursing will continue to monitor for further signs of bruising or bleeding due to NSAID therapy....." The facility's above mentioned investigations failed to make recommendations which addressed client #74's pattern of injuries of unknown source. Client #74's record was reviewed on 6/18/14 at 12:28 PM. Client #74's 6/9/14 physician's order indicated "1) May use W/C (wheelchair) for ambulation (with) alarm alert pelvic stabilizer (sic)." Client #94's 4/25/14 physician's order indicated "PT (Physical Therapy) eval (evaluation) indicated for difficulty in walking." Another 4/25/14 physician's order indicated "eval completed. PT 3x (times)/wk (week) for wks for therex, gait tng (training)." A fax dated 5/22/14, to client #74's physician, indicated "FYI (for your information) Noted (with) several discolorations on left lower extremity: (L) (left) calf- 2 x (by) 2 cm (centimeter) bluish disc (discoloration). (L) knee 2 x 2 cm bluish disc.			

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	post (L) thigh- 2, 1 cm round bluish disc's (sic) 0 (zero) edema to areas, 0 open areas noted. 0 s/s (signs/symptoms) pain." Client #74's Interdisciplinary Team (IDT) Meeting notes indicated the following: -5/15/14 "Team met to review [client #74's] unknown bruise to both her lower arms that were reported on May 6th 2014...The cause of the injury was not immediately known. [Client #74] had had no fall nor client to client physical altercation in the recent past. When asked how she sustained the injuries, [client #74] pointed to the grab bar on the wall between her bed and bathroom and denied being struck by anyone or having any fall. The previous night, on 05/5/14, night staff reported seeing [client #74] walk from bed to bathroom using grab bars. Staff interviews revealed that [client #74] will change multiple times a day. During temper tantrums, [client #74] does strike out at others and herself but no documented BIRs noted which would account for the bruises. Although the exact cause of the injuries were not determined, team agrees that most likely the injuries were inadvertently self inflicted. Staff will continue to monitor and report to nursing any continual bruising. Nursing staff will also continue			

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	to monitor for other adverse effects due to use of non-steroidal (sic)." -6/4/14 "The team met to review [client #74's] unknown bruise that was found on 5/22/14 (discoloration to left leg and inner left knee)...After speaking with staff, the exact cause of the injuries could not be determined. [Client #74] is noted to be very active in her wheelchair and will often get clothing out of her dresser to change. She is better about waiting for staff to assist her, but does have a clip alarm while in bed and an alarmed pelvic stabilizer for her wheelchair. [Client #74] also likes to hold her basket of flashcards in between her legs while pulling the cards out to look at them. She may have sustained two of the bruises from her basket of cards. The other bruise may have been from her bed as she was transferring to her wheelchair. The basket was replaced with a small plastic bucket to help prevent further injury as the weaving of the basket could be considered rough. Nursing will also continue to monitor [client #74] for further signs of bruising or bleeding due to NSAID therapy. The team has no further recommendations at this time." -6/9/14 "The team met to review [client #74's] unknown bruise that was found on 5/31/14. She was noted with a bluish			

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	fading discoloration to her left elbow. No edema to area noted and no open areas noted...After investigating, the exact cause of the bruise could not be determined, however, it is likely from [client #74] striking her arms on her wheelchair as she propels herself. Staff will continue to monitor and encourage [client #74] to use her feet to move herself in her wheelchair instead of her entire body to propel. The team has no further recommendations at this time." Client #74's IDT meeting notes and/or the client's 11/7/13 Individual Support Plan (ISP) indicated the facility failed to specifically address client #74's pattern of injuries of unknown source. Interview with administrative staff #1, the Director of Nursing, (DON), Quality Assurance (QA) staff #1 on 6/16/14 at 5:01 PM indicated client #74 had some recent injuries of unknown source. administrative staff #1 and QA staff #1 indicated the facility had conducted investigations in regard to the client's injuries. Interview with administrative staff #1 on 6/19/14 at 9:38 AM, by phone, stated "We looked at her pattern." Administrative staff #1 indicated it was felt client #74's injuries were due to the			

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	client opening her dresser drawers to attempt to get clothes out to change into. Administrative staff stated it was felt the client's "environment" was the cause of her injuries. Administrative staff #1 stated the client's IDT "was asked to come up with a plan or protocol to address her environment." Administrative staff #1 stated the above mentioned recommendation was made on 6/6/14 in the facility's "Pattern and Trends meeting." Administrative staff #1 indicated the recommendation was made before then as well. Administrative staff #1 indicated client #74's injuries of unknown source pattern should be addressed in the client's IDT meeting notes. Interview with QA staff #1 on 6/19/14 at 10:05 AM indicated client #74's bruising to her outer knee and a bruise above the client's right elbow was reported to QA on 617/14. QA staff #1 indicated the facility was in the process of conducting an investigation in regard to client #74's injury of unknown source. 2. On 6/16/14 at 1:45pm, on 6/17/14 at 6:25am, and on 6/18/14 at 6:45am, the facility's reportable incidents for client to client physical aggression were reviewed and indicated the following continued client to client physical aggressive			

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	incidents for client #121. -On 6/5/14 at 3:00pm, client #121 grabbed client #100 by her arms. -On 6/4/14 at 5:40pm, client #121 was physically aggressive and "slapped" client #117. -On 5/23/14 at 3:01pm, client #121 hit client #118 on their left shoulder. -On 5/19/14 at 12:30pm client #121 scratched client #92 on their back. -On 5/19/14 at 1:30pm, client #121 sat on the floor outside the soiled utility room and refused to allow other clients to exit the soiled utility room. When client #117 attempted to leave the soiled utility room client #121 "slapped" client #117 on her lower legs. -On 4/17/14 at 12:30pm, client #121 scratched client #116 on their arms. -On 3/3/14 at 3:08pm, client #121 hit client #112 on their arm. There report did not designate which arm. -On 3/3/14 at 3:08pm, client #121 was "physically aggressive" toward four (4) unidentified clients for no reason. The report indicated client #121 sat on the floor in the hallway and was hitting, scratching, and grabbing other clients. On 6/16/14 at 1:45pm, on 6/17/14 at 6:25am, and on 6/18/14 at 6:45am, the facility's "Client to Client" incident report investigations were reviewed for each			

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	incident and indicated client #121 "...Behaviors: [Client #121] has a BSP (Behavior Support Plan) which has been recently revised 3/28/14. Staff will continue to follow guidelines of BSP as well as encourage peers to give [client #121] personal space of an arm's length when passing by her. [Client #121's] BSP addresses Physical Aggression...and refusals to Respond to Redirection. [Client #121] has a history and patterns of inappropriately touching others...Documents reviewed: BIR's (sic), BSP's (sic), ISP's (sic), Nursing Notes, Physician's Orders, MARs (Medication Administration Records), and Patterns and Trends: [Client #121] has a pattern of striking and touching [clients #92, #100, #112, #116, #117, #118] and other peers (clients in the facility). There is rarely an injury associated with the contacts. [Client #121] continues to receive psychotropic medications to assist in maladaptive behaviors...." The reports indicated each client who was the target of client #121 did not have a "displayed" injury from client #121. On 6/18/14 at 6:45am, the facility's staff 4/21/14 and 4/22/14 "Inservice/Training" indicated client #121's BSP was reviewed with the facility staff. The training report indicated a "privacy screen should be			

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	used whenever [client #121] is sitting on the floor" and the screen should be moved "with" client #121 as client #121 moved her position to "give personal space." Client #121's 3/28/14 BSP was reviewed on 6/18/14 at 6:45am. Client #121's BSP indicated staff were "to encourage peers to give [client #121] personal space of an arm's length when passing by her." Client #121's BSP addressed targeted behaviors of "Physical Aggression...and refusals to Respond to Redirection. [Client #121] has a history and patterns of inappropriately touching others...." On 6/18/14 at 10:15am, an interview with PD (Program Director) #1 was conducted. PD #1 indicated client #121 was physically aggressive toward other clients and staff should make sure client #121's finger nails were trimmed to ensure the other clients were not injured. PD #1 indicated staff should use a privacy screen to ensure client #121 had personal space between her and other clients. When asked if this was effective when incidents of client #121's physical aggression continued toward other clients. PD #1 stated "I believe it is." PD #1 stated the other clients in the facility "had the right to be free" from client #121's physically aggressive incidents.			

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	PD #1 stated client #121 "will hit or scratch anyone." PD #1 indicated client #121 did sit on the floor outside the nursing office on the third floor and beside the soiled utility room. PD #1 indicated the elevator, soiled utility room, nursing office, and hallway access area were in this same area where client #121 sat and was physically aggressive toward other clients who lived on the third floor. 3. On 6/18/14 at 10:15am, client #7 and her wheelchair were observed with the Director of Nursing (D.O.N.). At 10:15am, the D.O.N. stated client #7's open skin area had been healed and "reopened" on 6/18/14 as the "result from" client #7's "wheelchair not being in good repair" and "caused" client #7's open sores to her skin. The D.O.N. pulled back a piece of sheep's skin (a protective soft coating pad) to expose client #7's molded frame seat which had cracks in the molded seat. The areas were a two inch (2") tear into the left shoulder area, a twelve inch (12") long tear into the seat. and a two inch (2") tear into the left hip area of client #7's wheelchair seat. The D.O.N. stated client #7's wheelchair molded seat had needed repair "over six (6) weeks" and the facility was waiting for the repair to be completed. On 6/18/14 at 10:15am, the D.O.N. indicated client #7's open skin			

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	areas were the result of her damaged wheelchair. Observation of client #7's left shoulder was conducted on 6/18/14 at 1:38 P.M. Client #7 had a dime sized open area with a red center. It was covered by a standard sized band aid. The band aid had non-colored moisture on the pad. There were numerous scars in the shoulder area. Client #7 had scoliosis with advanced curvature and bony protuberances at joints and along her spine. On 6/16/14 at 1:45pm, on 6/17/14 at 6:25am, and on 6/18/14 at 6:45am, the facility's reportable incidents were reviewed. The facility's 5/5/14 reportable incident for 5/4/14 at 7:00pm, indicated client #7 had an open skin area on her left hip and the cause of the injury was not determined. Client #7's record was reviewed on 6/18/14 at 3:02 P.M. Client #7's record indicated she had a history of pressure ulcers, with the most recent ulcers having healed on 6/11/14. Nursing notes for client #7 dated 6/18/14 at 13:14 indicated "DCS showed nurse that area to client's Lt. (left) shoulder had re-opened. Client had an open area at the same location that had healed. Area is 1cm (centimeter) in diameter, red center to Lt shoulder on the			

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	shoulder blade. New order for Bacitracin (antibiotic topical) and band-aid applied. Hospice nurse, doctor, executive director and director of nursing services aware." Client #7's Physical Therapy evaluation dated 4/28/14 indicated "Referred by nursing due to open area on left posterior thoracic area possibly resulting from scoliosis and abnormal seating posture in her custom wheelchair. She was molded for a custom wheelchair...seat cushion (current chair) has a major crack in the center with 2 minor cracks...patient will likely fare better with new custom molded wheelchair seating surface...." A physician's order dated 5/7/14 indicated client #7 was to have "posey pants for hip padding, elbow pads for protection, low air loss mattress with rails for policy and procedures, bed rest with positioning as screened per patient." Client #7's skin integrity plan dated 6/13/14 indicated "...CNA's (certified nursing assistants) will continue to reposition [client #7] as trained...staff will get her up in her wheelchair for meals and leave her up for a total of 2 hours...." Staff in-service training dated 5/5/14 indicated "2-hr (hour) positioning in bed. 1st preferred left side lying. Body pillow placed behind her (client #7's) back to hold her side lying position. Another pillow placed b/n (beneath) knees. Positioning to be changed every 2 hrs. (hours). 2nd			

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	preferred is supine (one back) with pillow under both knees...." Observations were conducted on 2 North on 6/17/14 from 7:19 A.M. through 9:28 A.M. At 7:19 A.M. client #7 was up in her wheelchair. At 8:25 A.M. client #7 was wheeled into the dining room in her wheelchair and ate her breakfast. At 9:28 A.M. client #7 was seated in her wheelchair in the program room. Observations were again conducted on 2 North on 6/17/14 from 10:57 A.M. through 11:45 A.M. Client #7 was seated in her wheelchair. She was located in the program room. Direct Care Staff (DCS) #64 stated at 11:20 A.M. on 6/17/14, "Yes, she (client #7) has been up in her wheelchair all morning today." An interview was conducted with QIDP #3 on 6/18/14 at 6:08 P.M. QIDP #3 stated, "She (client #7) has a long history of skin breakdowns. Not sure what caused it to re-open this morning. She is to be up a total of 2 hours around meals. No where is it tracked how long she was up yesterday in her wheelchair or when staff reposition her. No, it wouldn't have been following her plan for her to be up all morning." The QIDP indicated she was unaware of any further nursing measures being taken to protect client #7 while she was up in her wheelchair other			

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	than the fleece lining the seat of her wheelchair cushions. The facility's policy and procedures were reviewed on 6/16/14 at 3:20 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated "...It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source...." The facility's policy defined "...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...." The facility's policy defined "...Neglect (as) means failure to provide goods and services necessary to avoid physical harm...." This deficiency was cited on 4/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and	W000331	W331 I Nurse for residents sited completed retraining regarding G	07/31/2014

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	interview for 4 of 14 sampled clients (#4, #6, #7 and #14) and for 1 additional client (#71), the facility's nursing services failed to ensure the staff repositioned and provided incontinence care as indicated in the clients' plans, and to ensure all bottles of Jevity (tube feeding) were labeled with the clients' name, date, time hung and rate of infusion for clients #6 and #71. Findings include: 1. Observations were conducted on the west hall of the second floor of the facility on 6/16/14 between 2 PM and 6:30 PM. __At 2 PM client #4 was lying in her bed with her left leg elevated on a pillow and a soft cast/splint to her left lower leg. From 2 PM until 4:33 PM client #4 remained in her bed, eyes closed and dozing periodically. At 4:33 PM staff #5 and staff #8 got client #4 up into a wheel chair using a mechanical lift. Client #4 was wheeled into the dining room for her evening meal and was returned to her bedroom at 5:35 PM where she sat in her wheelchair through the remainder of the observation. During this observation period the staff did not reposition and/or toilet client #4 every two hours. __At 2 PM client #6 lay in her bed on her back, slightly to her left side. The head of		tube label and date procedure. Nurse for sited residents retrained on Risk Identification and Prevention of skin integrity and North Willow pressure relief changes. Nurse for sited resident retrained in Incontinence Care. II All residents may be at risk of this deficient practice. III Nurses completed retraining regarding G tube label and date procedure. Incontinent care. Nurses retrained on Risk Identification and Prevention of skin integrity and North Willow pressure relief changes. Nurses retrained in Incontinence Care. IV Audit of proper G tube label and date completed five times a week for two weeks, three times a week for two months and then as part of monthly audit process. QMRP completes Active Treatment audits five times each week for one month, three times a week for two months and then and then 2 times per week thereafter. Program Directors complete Active Treatment audits weekly and review outcomes of audits completed by QMRPs. Positioning is checked as part of the Active Treatment audit process by QMRPs and PDs. Nursing assures positioning, incontinence care and skin care as part of their rounds on their assigned area during their shift. Director of Clinical Education completes Nursing Competencies	

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	client #6's bed was elevated approximately 30 degrees and client #6 was slumped down in her bed. Client #6 lay in her bed in this position throughout this observation period. During this observation period the staff did not reposition client #6 every two hours. __ At 2 PM client #14 was sitting in his wheelchair a few feet away from his bed in his bedroom, his head on his chest and his eyes closed. From 2 PM until 4:45 PM client #14 remained sitting in his bedroom. At 4:45 PM client #14 was wheeled to the dining room for his evening meal. Client #14 sat with his head down to his chest, eyes closed, leaning to his left side and dozing while in the dining room. Staff #5 picked up client #14's garlic bread with one hand and touched client #14 on the shoulder with her other hand and stated, "Come on [client #14] wake up so you can eat." Staff #5 put a slice of bread into client #14's hand and prompted client #14 to eat. Client #14 took a few bites of his bread and a bite of his pizza. After a few minutes, client #14's head drifted down to his chest and his eyes closed. At 5:30 PM client #14 was wheeled out of the dining room and to the classroom on the west hallway. At 6:05 PM LPN #2 instructed the staff to take client #14 back to his bedroom so she could give him his PM medications. During this observation		annually which includes Skin Integrity, Observation, Assessment and Documentation and Medication Administration as part of core competencies.	

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	period the staff did not reposition client #14 every two hours. Observations were conducted on the west hall of the second floor of the facility on 6/17/14 between 6:30 AM and 9 AM. At 6:30 AM client #4 was in her bed lying on her back with the head of her bed slightly elevated, her eyes closed. At 7 AM two staff got client #4 out of bed using a mechanical lift and wheeled her to the dining room for her AM meal. At 8:25 AM client #4 was wheeled back to her bedroom where she remained sitting in her wheelchair the remainder of the observation. __At 6:30 AM client #14 was sitting up in his wheelchair in his bedroom. At 7:30 AM client #14 was wheeled to the dining room for his AM meal. After eating, at 8:25 AM, client #14 was wheeled to the classroom on the west hall where client #14 stayed through the remainder of this observation period. Client #14 was not repositioned and/or toileted during this observation. Review of the undated West Hall Assignment Sheet on 6/17/14 at 3 PM indicated (not all inclusive): __Client #4 utilized a wheelchair for mobility, used a "white pull up" and the staff were to reposition client #4 every			

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	two hours. __Client #6 utilized a wheelchair for mobility, was to have the head of her bed elevated and wore yellow briefs. __Client #14 utilized a wheelchair for mobility, had no vision and was diabetic. The Assignment Sheet did not indicate client #6's and #14's positioning schedule. The sheet indicated no toileting schedule for clients #4, #6 and #14. Client #4's record was reviewed on 6/17/14 at 1 PM. Client #4's record indicated client #4 was blind in both eyes and had diagnoses of, but not limited to, recent fracture of left lower leg, Recurrent dislocation of shoulder joint, Osteoporosis, Peripheral Neuropathy (damage to nerves causing impaired sensation, movement, organ function and/or other aspects of health) and PVD (Peripheral Vascular Disease - disease of the blood vessels located outside the heart and the brain). __Client #4's physician's orders dated 5/27/14 indicated "Use Maxi Move (mechanical lift) for all transfers. Up in w/c (wheelchair) for meals. Keep leg elevated. Use pillow between leg and cast with turning/repositioning. Observe skin at cast site for redness and rubbing." __Client #4's 11/4/13 revised Risk Plan for "poor response to environment" indicated client #4 was not aware of her			

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	surroundings, had limited ability to communicate and limited ability to react. __Client #4's 7/17/13 revised Risk Plan for skin integrity indicated client #4 was at risk for "pressure ulcers." The risk plan indicated "Turning and repositioning when in bed to prevent further redness to bony prominence. Monitor skin for breakdown." __Client #4's 5/23/14 Risk plan for "Potential fracture r/t (due to) weakening bones and decreased bone matrix and Osteoporosis." The risk plan indicated "...complete bedrest.... Staff to avoid twisting client's limbs when repositioning in the bed. Client to continue with cast on left leg. Monitor skin under cast for breakdown." __Client #4's "24 Hour Flow Sheets" for March, April, May and June 2014 indicated client #4 was to be repositioned every two hours and provided incontinence care. The flow sheets indicated client #4 was not repositioned every two hours and not provided incontinence care as indicated on the flow sheets with inconsistent and missing documentation from the staff of the care given. __Client #4's Repositioning records for March through June 2014 indicated client #4 was to be repositioned every two hours. The records indicated no documentation and/or the client was not			

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	repositioned every two hours on: __June 4, 5, 9, 10, 11, 12, 13, 14, 15 and 16, 2014. __May 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 17, 18, 19, 20, 21, 23, 24, 25, 26, 27, 29, 30 and 31, 2014. __April 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2014. __March 1, 2, 3, 4, 5, 11, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 28 and 29, 2014. Client #6's record was reviewed on 6/17/14 at 1 PM. Client #6's record indicated client #6 had diagnoses of, but not limited to, Kyphoscoliosis (an abnormal curvature of the spine), Constipation, Transient Cerebral Ischemia (TIA - a disruption of blood flow to the brain causing a mini-stroke), Dysphagia (difficulty swallowing), Cerebral Palsy (a disorder of posture, muscle tone and movement resulting from brain damage). __Client #6's revised 12/15/13 Risk Plan for Altered Skin Integrity indicated "Provide thorough skin care after incontinent episodes and apply barrier cream. Skin assessment to be completed per Living Center Policy. Encourage/assist client to turn and reposition to relieve pressure points." __Client #6's revised "Pressure Ulcer" Risk Plan if 12/15/13 indicated client #6			

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	was at risk for a pressure ulcer. The plan indicated "Monitor skin under Hoyer (a mechanical lift) sling. Turning and repositioning schedule per assessment." __Client #6's "24 Hour Flow Sheets" for March, April, May and June 2014 indicated client #6 was to be provided incontinence care and repositioned every two hours. The flow sheets indicated client #6 was not repositioned every two hours and provided incontinence care as indicated on the flow sheets with inconsistent and missing documentation from the staff of the care given. __Client #6's Repositioning records for March through June 2014 indicated client #6 was to be repositioned every two hours. The records indicated no documentation and/or the client was not repositioned every two hours on: __June 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16, 2014 __May 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2014. __April 1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2014. __March 4, 7, 11, 12, 13, 18, 19, 23, 24, 25, 29 and 30, 2014. Client #14's record was reviewed on 6/18/14 at 10 AM. Client #14's record			

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	indicated client #14 was blind in both eyes and had diagnoses of, but not limited to, Aphasia (impaired ability to communicate), Constipation, Joint pain, Osteoporosis (porous bones causing reduced bone strength and a higher risk of fractures), Quadriplegia (paralysis affecting all four limbs), Quadriparesis (weakness in the arms and legs) and hearing loss. Client #14's ISP of 3/6/14 indicated client #14 required a wheelchair for ambulation and staff assistance for transfers to and from the bed. __Client #14's 2/27/14 revised Risk Plan for "poor response to environment" indicated client #14 was not aware of his surroundings, had limited ability to communicate and limited ability to react. __Client #14's "24 Hour Flow Sheets" for March, April, May and June 2014 indicated client #14 was to be provided incontinence care and repositioned every two hours. The flow sheets indicated client #14 was not repositioned every two hours and provided incontinence care as indicated on the flow sheets with inconsistent and missing documentation from the staff of the care given. __Client #14's Repositioning records for March through June 2014 indicated client #14 was to be repositioned every two hours. The records indicated no documentation and/or the client was not			

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	repositioned every two hours on: __June 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16, 2014. __May 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2014. __April 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2014. __March 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2014. Interview with staff #3 on 6/17/14 at 10 AM indicated clients #4 and #6 were to be repositioned every two hours. Staff #3 stated, "give or take. We try to but sometimes we get busy and things happen and it might be a little later." Staff #3 indicated the staff were to document the care given to the clients on the 24 hour flow sheets. Interview with LPN #2 on 6/16/14 at 6:30 PM indicated clients #4, #6 and #14 were to be repositioned every two hours. The LPN stated client #14 could reposition himself "somewhat" but needed prompting and assistance from the staff. LPN #2 stated client #4 had recently fractured her leg and "is really fragile." The LPN stated clients #4 and #6 were "completely dependent" on the staff for all toileting and repositioning			

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	needs/care. The LPN indicated the staff were to document on the clients' 24 Hour Flow Sheets and Repositioning records when they repositioned the clients, the position the client was placed in and the clients' incontinence care provided. Interview with the DON (Director of Nursing) on 6/18/14 at 4 PM indicated the staff were to ensure the clients were turned/repositioned and provided incontinence care as indicated on the staff assignment sheets and were to document the care given on the clients' 24 Hour Flow Sheets and Repositioning records. 2. Observations were conducted on the west hall of the second floor of the facility on 6/16/14 at 1:30 PM. Clients #6 and #71 were in their bedroom and in bed. There were two IV (Intravenous) stands in the room. From each IV stand hung a bottle of Jevity, one with 450 cc (cubic centimeters) and the other with 500 cc. Both bottles had tubing extending from them and were connected to infusion pumps. Both bottles of Jevity indicated no name, date/time hung and/or the rate the clients were to be receiving their feeding. Interview with LPN #1 on 6/16/14 at 2:30 PM indicated bottles of Jevity were to be labeled with the clients' names, the			

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	date/time hung and the rate of infusion the client was to receive their feeding. The LPN indicated the bottles of Jevity hanging in client #6's and #71's bedroom were not labeled properly and had been replaced. Interview with LPN #2 on 6/16/14 at 5:30 PM indicated continuous feed bottles of Jevity were to be timed and dated when they were hung and labeled with the client's name. 3. Observation of client #7's left shoulder was conducted on 6/18/14 at 1:38 P.M. Client #7 had an open area dime sized with a red center. It was covered by a standard sized band aid. The band aid had non-colored moisture on the pad. There were no signs or symptoms of infection, no drainage, bleeding or odor. There were numerous scars in the shoulder area. Client #7 had scoliosis with advanced curvature and bony protuberances at joints and along her spine. Client #7's record was reviewed on 6/18/14 at 3:02 P.M. Client #7's record indicated she had a history of pressure ulcers, with the most recent ulcers having healed on 6/11/14. Nursing notes for client #7 dated 6/18/14 at 13:14 indicated "DCS showed nurse that area to client's			

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	Lt. (left) shoulder had re-opened. Client had an open area at the same location that had healed. Area is 1cm (centimeter) in diameter, red center to Lt shoulder on the shoulder blade. New order for Bacitracin (antibiotic topical) and band-aid applied. Hospice nurse, doctor, executive director and director of nursing services aware." Client #7's Physical Therapy evaluation dated 4/28/14 indicated "Referred by nursing due to open area on left posterior thoracic area possibly resulting from scoliosis and abnormal seating posture in her custom wheelchair. She was molded for a custom wheelchair...seat cushion (current chair) has a major crack in the center with 2 minor cracks...patient will likely fare better with new custom molded wheelchair seating surface...." A physician's order dated 5/7/14 indicated client #7 was to have "posey pants for hip padding, elbow pads for protection, low air loss mattress with rails for policy and procedures, bed rest with positioning as screened per patient." Client #7's skin integrity plan dated 6/13/14 indicated "...CNA's (certified nursing assistants) will continue to reposition [client #7] as trained...staff will get her up in her wheelchair for meals and leave her up for a total of 2 hours...." Staff in-service training dated 5/5/14 indicated " 2-hr (hour) positioning in bed. 1st preferred left side lying. Body pillow placed behind			

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	her (client #7's) back to hold her side lying position. Another pillow placed b/n (beneath) knees. Positioning to be changed every 2 hrs. (hours). 2nd preferred is supine (one back) with pillow under both knees...." Observations were conducted on 2 North on 6/17/14 from 7:19 A.M. through 9:28 A.M. At 7:19 A.M. client #7 was up in her wheelchair. At 8:25 A.M. client #7 was wheeled into the dining room in her wheelchair and ate her breakfast. At 9:28 A.M. client #7 was seated in her wheelchair in the program room. Observations were again conducted on 2 North on 6/17/14 from 10:57 A.M. through 11:45 A.M. Client #7 was seated in her wheelchair. She was located in the program room. Direct Care Staff (DCS) #64 stated at 11:20 A.M. on 6/17/14, "Yes, she (client #7) has been up in her wheelchair all morning today." An interview was conducted with QIDP #3 on 6/18/14 at 6:08 P.M. QIDP #3 stated, "She (client #7) has a long history of skin breakdowns. Not sure what caused it to re-open this morning. She is to be up a total of 2 hours around meals. Nowhere is it tracked how long she was up yesterday in her wheelchair or when staff reposition her. No, it wouldn't have been following her plan for her to be up			

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	all morning." The QIDP indicated she was unaware of any further nursing measures being taking to protect client #7 while she was up in her wheelchair other than the fleece lining the seat of her wheelchair cushions. This deficiency was cited on 4/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-17(a)			