STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 / B. WING	06/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	1332 WATERFORD CIR GOSHEN, IN 46526

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 15, 16,17,18 19, 22 and 23, 2015 Facility number: 011150 Provider number: 155760 AIM number: 200831020 Census bed type: SNF: 19 SNF/NF: 49 Total: 68 Census payor type: Medicare: 21 Medicaid: 20 Other: 27 Total: 68 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on June 15-23, 2015. Please accept this Plan of Correction as The Maples at Waterford Crossing's credible allegation of compliance effective July 23, 2015. The Maples at Waterford Crossing respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES			

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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	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure the bathing preference regarding a shower was honored for 1 of 3 residents reviewed for choices. (Resident #147) Finding includes: On 6/16/15 at 10:55 A.M., during an interview, Resident # 147 indicated she had received one shower since her admission. The resident further indicated the staff just give her a sponge bath and she preferred a shower. The resident indicated she would feel cleaner if she could get a shower. On 6/22/15 at 2:27 P.M., a review of the clinical record for Resident #147 was conducted. The record indicated the resident was admitted on 5/26/15. The resident's diagnoses included, but were not limited to, protein malnutrition, anemia, weakness, colon cancer, dehydration and history of uterine cancer. The 24 hour report, dated 6/23/15,	F 0242	1) Resident #147 has been discharged. 2) All residents have the potential to be affected by this deficient practice. Resident bathing records are under review residents preferences are to be updated pending outcome 3) Director of Health Services or designee re-in serviced nursing staff on following resident bathing preferences and documentation. DHS/designee will review five residents bathing records per week for six months. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: July 23, 2015	07/23/2015

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	indicated the resident was to get her showers on Wednesday's and Saturday's during the day shift. A review of the Resident Bathing Type Chart indicated a shower did not occur on Saturdays (May 30th, June 13th and June 20th). A Life Enrichment Assessment Home Again form indicated the resident was interviewed for daily preferences. The resident's response indicated it was "very important" to the resident to choose between a tub bath, shower, bed bath or sponge bath. However a preference wasn't completed for the question - Do you prefer a tub bath, shower, bed bath, or sponge bath? A careplan for Activities of Daily Living (ADL's) indicated the resident would like to be showered at least two times a week and bathed on all other days. The Minimum Data Set (MDS) admission assessment, dated 6/2/15, under the Interview for Daily Preferences section, indicated it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. On 6/22/15 at 3:25 P.M., during an interview, the Assistant Director of			

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	Nursing (ADON) indicated she did not know why the resident did not receive a shower on some of her bathing days and was given a sponge/partial bath. On 6/22/15 at 3:40 P.M., the ADON provided a policy titled "Guidelines for Bathing Preference," undated, and indicated the policy was the one currently used by the facility. The policy indicated "... 2. The resident shall determine their preference for bathing upon admission...6. Bathing shall occur at least twice a week unless resident preference states otherwise...." 3.1-3(u)(1)			
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure	F 0248	1) Resident #91 activity care plan reviewed and updated to reflect	07/23/2015

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	activities were provided as care planned for 1 of 3 residents reviewed for activities. (Resident #91) Finding includes: The clinical record for Resident #91 was reviewed on 6/19/15 11:09 A.M. Resident #91 was admitted, on 08/31/14, with diagnoses, including but not limited to, dementia, chronic renal failure, gastro-esophageal reflux disease depression, hypertension, hyperlipidemia and history of left hip fracture. The initial MDS (Minimum Data Set) assessment, completed on 09/09/14, indicated Resident #91 was moderately cognitively impaired, demonstrated no mood issues or behavior issues, and it was very important for her to listen to the music she liked and participate in religious activities, was somewhat important to have books and magazines to read, animals visits, do her favorite activities and get outside for fresh air. An undated activity preferences form, indicated it was very important for her to listen to music she liked and participate in religious services and somewhat important for her to have books and magazines, to be around animals, to do favorite activities and get to go outside.		resident current preferences. 2) All residents have the potential to be affected by this deficient practice. Care plans reviewed and updated as appropriate for current residents within facility related to activities of interest. 3) Activity Director/designee re-inserviced activity and nursing staff on providing activities as care planned per resident preference. Activty Director or designee will observe/review three residents, three times per week to ensure activities are offered per care plan for four weeks then weekly times five months. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: July 23, 2015 -	

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	Another undated Resident Preferences and Activities Profile form, indicated the resident enjoyed games, gardening, and taking walks. She also enjoyed reading the Bible, did not have any favorite television show, and liked Christian music. An Activity interest form, completed on 09/02/14, indicated the resident enjoyed piano playing, exercising, studying health, and staying active, and reading the Bible. The form indicated the resident preferred participating in morning activities and preferred to do activities in her own room independently. The current activity care plan, initiated March 10, 2015, and reviewed on 06/09/15, indicated the goal was for the resident to attend one activity per week. The interventions were to remind her about religious activities, encourage her to attend group activities if sad, give a monthly calendar and encourage her to attend, and continues to enjoy news/trivia, exercise time, spiritual gatherings, television, radio, music to my ears, bird watching, entertainment at family night and theme dinners. An activity progress note, dated 03/09/15, indicated the resident was wheelchair			

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	dependent and dependent on staff for locomotion in her wheelchair. She was documented as enjoying news/trivia time, exercise time, spiritual gatherings, TV, radio, music to my ears, bird watching, and entertainment at family nights and theme dinners. She was also documented as receiving 1:1 activity visits once a week by life enrichment staff. An activity progress note, dated 06/09/15, indicated the resident continued to receive 1:1 activity visits per her needs. There was no documentation regarding any other activities provided for Resident #91 except the once weekly 1:1 visits. On 06/18/2015 at 10:51 A.M., Resident #91 was observed sleeping in her wheelchair in the 200 unit lounge during a church service. On 06/18/2015 at 2:13 P.M., Resident #91 was observed in her bed asleep. On 06/16/2015 at 11:07 A.M., Resident #91 was observed in her room, seated in her wheelchair sleeping. She had a baby doll on her lap and a stuffed animal was on the floor next to her wheelchair. On 06/19/2015 at 11:30 A.M., Resident #91 was observed seated in her high back wheelchair in the 300 unit lounge in front			

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	of the television. Interview with Resident #91 indicated she did not like television. On 06/22/2015 at 9:31 A.M., Resident #91 was observed seated in her wheelchair behind a row of wheelchairs in the 300 unit lounge in front of a television. The resident was awake but not looking at the television. On 06/22/2015 at 2:15 P.M., Resident #91 was observed lying in her bed asleep. No music was playing in her room. The roommates television was on but the volume was not audible. On 06/23/2015 at 9:20 A.M., Resident #91 was observed seated in her wheelchair in the crowded 300 unit lounge. She was placed sideways and behind a tall wheelchair so she could not view the television. On 6/22/15 at 9:57 A.M., ten residents were observed in the 200 unit lounge. The activity director, Employee #4 was talking to the resident's about Robert Frost poems. Three more resident's joined and they were talking about school memories. Resident #91 was dozing in her wheelchair behind another high back wheelchair in the 300 unit lounge in front of the television. A game show was on			

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	the television. On 06/22/2015 at 11:00 A.M., Resident #91 was observed seated in her wheelchair, on the 300 unit, in front of the television. The other resident in front of her had been moved and she was awake. During an interview, on 06/23/2015 at 9:55 A.M., Activity Director, Employee #4 indicated the resident refuses to leave the 300 unit lounge when staff try to get her to go to an activity. The activity director indicated she takes Resident #91 on strolls. She indicated the resident liked to listen to religious music and the nursing staff sometimes play the music in the 300 unit lounge. The activity participation logs for Resident #91 indicated she had been documented on 06/17/15 at 8:55 P.M. as having a family visit, on 06/18/15 at 9:27 A.M., 06/19/15 at 9:53 A.M. and 06/21/15 at 3:01 P.M. On 06/22/15 at 9:49 A.M. the log indicated the resident had visited with another resident in the facility. It was unclear with whom she visited and how long she visited. The resident was also documented as having participated in a Bible study the previous Thursday. The resident had a 1:1 visit on 06/17/15. She was not observed to be			

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	invited or physically assisted to any group activities except for the church service held on 06/18/15 in the morning. 3.1-33(a)			
F 0278 SS=E Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.			

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	Clinical disagreement does not constitute a material and false statement. Based on observation, record review and interviews, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected the physical and functional status of 4 of 4 residents reviewed for assessments. (Residents #9, #50, #57 and #108) Findings include: 1. The clinical record for Resident #57 was reviewed on 6/18/15 at 11:12 A.M. Resident #57 was admitted to the facility, on 07/18/14, with diagnoses, including but not limited, to right shoulder fracture, history of coronary artery disease, hypertension, history of urinary tract infection,dehydration, gastric esophageal reflux disease, hyperlipidemia, anxiety and history of deep vein thrombosis. The Quarterly Minimum Data Set (MDS) assessment completed, on 04/19/15, indicated the resident required supervision with one person physical assist for bed mobility and transfer needs and supervision with set up help only for ambulation and locomotion needs. Resident #57 required supervision, encouragement and cues from one person for toileting needs, was steady at all times	F 0278	1) Residents #9 and #108 are discharged. Significant Change in Status assessments have been open for residents #50 and #57. 2) All residents have the potential to be affected by this deficient practice. Most recent MDS assessments for current residents are being reviewed for accuracy of their physical and functional status. 3) Home Office Campus Support-Resident Assessments met with MDS coordinator and provided re-education of RAI guidelines and standards for Interviews, Assessments and Coding. DHS/designee will review three residents most current MDS for accuracy per week for six months. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: July 23, 2015	07/23/2015

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	when walking, and had not experienced any falls in the previous month. The care plan indicated the following intervention, initiated on 02/25/15: "One assist with transfers, extensive assist with toileting, not safe to walk alone, limited assist with ADL's [Activities of Daily Living] on bed and chair alarms." In addition, the care plan indicated on the resident had fallen 03/20/15. A 30 day MDS assessment, completed on 06/01/15, indicated the resident had fallen, on 05/14/15 an 05/15/15, and had experienced a fractured femur which was repaired. She returned to the facility, on 05/19/15, after having her fractured leg and hip repaired. During an interview, on 6/22/15 at 10:30 A.M., the MDS coordinator, RN #5 indicated he completed the MDS assessments based on a computerized report from the CNA charting. When asked why there was discrepancies between the care plan and the assessments he indicated both were accurate even though the care plan intervention did not match the required support needed for transfers and ambulation needs. 2. On 8/18/15 at 11:07 A.M., a review of the clinical record for Resident #50 was			

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	conducted. The record indicated the resident was admitted on 4/25/15. The resident's diagnoses included, but were not limited to, failure to thrive, dementia, hypertension, congestive heart failure and pubic fracture. A Skin Impairment Circumstance, Assessment and Intervention form, dated 5/4/15, indicated Stage I (Intact skin with nonblanchable redness of localized area, usually over a boney prominence) and Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed with slough) pressure ulcers were discovered on the resident's left buttock and coccyx. The form indicated the physician was contacted on 5/4/15 and new orders received. A family member was also notified on day of discovery. An intervention was added: Roho cushion (Pressure Sore Cushion). A Pressure Ulcer Assessment indicated on 5/4/15 two pressure ulcers were identified. A Stage ll pressure ulcer was located on resident's coccyx and measured 2 x 2 x 0.25 cm (centimeters). The wound bed was pink with no exudate. A Stage l pressure ulcer was located on the resident's left side of her upper buttock area and measured 4 x 2 x 0 cm and it had a red/purple color with			

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	no exudate. The 5/8/15 Pressure Ulcer Assessment indicated the coccyx area had a Stage ll pressure ulcer and measured 1.5 x 1.5 x 0.1 cm with no undermining. The Stage l pressure ulcer on the left side of the upper buttocks was changed to a Stage ll pressure ulcer and measured 3 x 2 x 0.1 cm. with no undermining. The treatment was to apply a duoderm to the areas, change weekly and as needed. The 14 day Minimum Data Set (MDS) Assessment, dated 5/9/15, indicated the resident's BIMS (Brief Interview Mental Status) score was 3 (score 0-7 indicates severe dementia). The Skin Condition section of the MDS assessment indicated the resident was at risk for a pressure ulcer and the Skin and Ulcer treatment section indicated nutrition/hydration, pressure reducing device for bed/chair, and application of ointments were checked as treatments to prevent a pressure ulcer. The MDS assessment did not indicate the resident had a Stage l or Stage ll pressure ulcers. A Weight form indicated the Resident #50's admission weight was 99 pounds. On 5/5/15 the resident's weight was 93 pounds a 6 percent loss.			

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	On 5/6/15 a physician's order indicated to add "failure to thrive" to the diagnoses. A careplan titled "Alteration in Skin Integrity," dated 5/4/15, indicated the resident had a pressure ulcer related to immobility, incontinence bowel/bladder, and nutritional status (failure to thrive). The interventions included, but were not limited to: provide peri care after incontinence episode, turn reposition every 2 hours, pressure reducing mattress/chair, nutritional risk assessments per RD (Registered Dietician), provide supplements as ordered and Santyl (ointment) daily. On 6/19/15 at 9:35 A.M., an observation of Resident #50's coccyx wound was completed with LPN #25 the Wound Care Nurse. LPN #25 removed the resident's brief and the old dressing from the coccyx area. A small amount of pink drainage was on the old dressing. The Stage lll (Full thickness tissue loss)pressure ulcer measured 1.0 x 1.5 x 1.0 cm with tunneling at 11:00 o'clock to 1:00 o'clock (1 cm) and tunneling at 3 o'clock (0.5 cm). The area was cleansed with soap and water, Santyl ointment was applied into wound area, and wound area was covered with gauze and a folded ABD (abdominal bandage) secured with tape. The resident tolerated the procedure			

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	155760		06/23/2015

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	and indicated the pressure ulcer was not painful. During an interview, on 6/19/15 at 11:05 A.M. the MDS Coordinator indicated he was unaware the resident had a Stage 1 pressure ulcer on her left upper buttock and a Stage ll pressure ulcer on her coccyx when he did the 5/9/15 MDS assessment even though the ulcers were discovered on 5/4/15. When asked if he had done a significant change MDS assessment for the current Stage lll pressure ulcer and/or for the diagnosis of failure to thrive. The MDS Coordinator indicated he would address those issues on the next quarterly assessment. On 6/19/15 at 2:15 P.M., a current policy titled "MDS and Wound Care Area Assessment Module, undated, was received from the Nurse Consultant. The policy indicated "...2. Wound documentation should be reviewed for inclusion in the proper sections of the MDS. 3. The RN Assessment Coordinator shall review the MDS for accurate completion prior to submission...." On 6/22/15 at 11:15 A.M., a MDS 3.0 RAI (Resident Assessment Instrument) Manual from the facility, dated 2014, indicated guidelines for determining a			

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	significant change in a resident's status included but were not limited to: Emergence of unplanned weight loss problem, and emergence of new pressure ulcer at Stage ll or higher or worsening in pressure status. 3. On 6/18/15 at 10:59 A.M., record review indicated Resident #9 was admitted to the facility on 5/5/15, and discharged to home on 6/12/15, with diagnoses including, but were not limited to, "...congestive heart failure, anemia, Stage III kidney failure, atrial fibrillation and diabetes mellitus...." A patient transfer form, dated 5/5/15, indicated the resident had a skin tear on the left forearm and (2) Stage II ulcers on the coccyx. A nursing admission assessment, dated 5/5/15, indicated the resident has a Stage I wound or greater and to see the skin sheets. A form titled "Assessment Review and Considerations," dated 5/5/15, indicated skin breakdown risk potential: this resident has the following risk factors that may contribute to skin breakdown: mobility impairment, past history and has current pressure ulcers.			

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	A form titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment," dated 5/5/15, indicated a Stage II ulcer located at the right and superior coccyx area that was present on admission and an unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough and or eschar) pressure ulcer was present on admission on the right heel. The care plan, dated 5/5/15, indicated the problem: alteration in skin integrity pressure ulcer to rt (right) buttock, coccyx and rt heel, related to insufficient circulation and immobility. Interventions included but were not limited to "...pressure/wound assessment per schedule, examine skin daily...turn and reposition every 2 hours and as needed...pressure reducing mattress on bed, pressure reducing cushion on chair...skin assessment with shows, notify physician and responsible party of changes in skin status...." A form titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment," dated 5/11/15, indicated Resident #9 developed a Stage II pressure ulcer on his L (left) buttock on 5/11/15. The admission MDS (Minimum Data Set) assessment, completed on 5/12/15,			

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	indicated Resident #9 was not at risk for developing pressure ulcers and did not have any unhealed pressure ulcers at Stage I or higher. The 14 day MDS assessment, dated 5/19/15, indicated Resident #9 was at risk for developing pressure ulcers and that the resident did not have any unhealed pressure ulcers a Stage I or higher. During an interview, on 6/19/15 at 10:15 A.M., the MDS Coordinator indicated before he fills out the MDS assessment he checks to see if the skin sheets are available in he skin book, he then talks to the nursing assistants and nurses to compile his information. He further indicated the assessment should have indicated that the resident had 3 pressure ulcers upon admission and developed a Stage II ulcer on 5/11/15. 4. On 6/18/15 at 2:40 P.M., record review indicated Resident # 108 was admitted to the facility on 1/12/15, and discharged to home on 3/3/15, with diagnoses including, but not limited to, "...femoral neck fracture, hypoxia, atrial fibrillation, Guillian Barre syndrome and Parkinson's disease...." A nursing admission assessment, dated 1/12/15, indicated the resident did not			

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	have a Stage I wound or greater upon admission. A form titled "Assessment Review and Considerations," dated 1/12/15, indicated skin breakdown risk potential: this resident has the following risk factors that may contribute to skin breakdown: mobility impairment. A form titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment," dated 1/2615, indicated the resident developed a Stage II pressure ulcer to his left heel on 1/26/15. A review of an undated care plan, indicated the problem: Alteration in skin integrity, pressure ulcer related to insufficient circulation and immobility. The interventions section of the care plan was blank nothing was marked. The 14 day MDS assessment, dated 1/26/15, indicated the resident was at risk for developing pressure ulcers and he did not have one or more unhealed pressure ulcers at stage I or higher. The 30 day MDS assessment, dated 2/9/15, indicated the resident did not have one or more unhealed pressure ulcers at stage I or higher.			

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	During an interview, on 6/19/15 at 10:27 A.M., the MDS Coordinator indicated he should have marked on the 30 day assessment that the resident developed a Stage II pressure ulcer to his left heel. 3.1-31(d)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews the facility failed to ensure a plan of care regarding the need for increased and/or 1:1 supervision was provided for 1 of 3 residents reviewed for accident/falls. (Resident #57) Finding includes: The clinical record for Resident #57 was reviewed on 06/18/2015 at 11:12 A.M. Resident #57 was admitted to the facility on 07/18/14 with diagnoses, including but not limited to right shoulder fracture, history of coronary artery disease, hypertension, history of urinary tract infection and dehydration, gastric esophageal reflux disease, hyperlipidemia, anxiety and history of	F 0282	1) Resident #57 care plan reviewed and updated to include appropriate interventions for fall risk. 2) All residents have the potential to be affected by this deficient practice. Care plans are under review and will beupdated as appropriate for current residents within facility related to falls. 3) Nursing staff to be re-inserviced to complete the initial careplan on admission/readmission for fall risk and following interventions reflected in care plan. DHS/designee will observe/review three residents with falls, three times per week during care to ensure compliance with care plan intervention for four weeks then weekly times five months.	07/23/2015

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	deep vein thrombosis. A fall risk assessment, completed on 07/18/14, indicated the resident had impaired mobility as a fall risk factor and had an individualized care plan initiated to address the risk factors. The care plan, dated 2/14/15, indicated she needed assistance with transfers and ambulation and was not to walk alone. On 02/21/15, the wheelchair was to be utilized due to poor balance, she was to be assisted for dressing and moving furniture, she was to receive assist with transfers, extensive assist with toileting as she was not safe to walk alone. The Quarterly Minimum Data Set (MDS) assessment, on 04/17/15, indicated the resident's BIMS (Brief Interview Mental Status) score was a 5 (severe dementia) and required supervision from one person for transfers and locomotion. She was set up and supervision only for ambulation. She was unsteady but able to regain her balance without assistance. The care plans for Resident #57, on 04/17/15, indicated the resident's bed was to be at a proper height to facilitate safe transfers, her call light and frequently used items were to be in easy reach, the		4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: July 23, 2015	

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	pathways in her environment were to be free of clutter, she was to have a personal alarm on her bed and chair, she was educated on locking her wheelchair brakes before transferring, she was to ask for assistance to remove her socks, nursing staff was to leave a night light on at night, her trash can was to be placed out of the walkway to the bathroom. The intervention implemented after the 04/24/15 fall was for the resident to request assistance with dressing. A Fall Circumstance, Assessment and Intervention Form indicated Resident #57 was found on the floor on 05/14/15 at 4:00 A.M. She complained of left hip pain and was sent to the emergency room. The form indicated the call light was out of reach and her room lighting was inadequate. The resident had improper footwear on, and was apparently attempting to ambulate. The intervention was to leave the bathroom light on at night. The fall risk re-assessment indicated the resident did not require assistance to ambulate. The Root Cause indicated "Balance issues, unstable." A Fall Circumstance, Assessment and Intervention Form indicated on 05/15/15 a 7:50 A.M., Resident #57 found on the			

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	floor in her room. The resident had been attempting to transfer herself, an assistive device was not being utilized, frequently used items were out of reach and her wheelchair brakes were not locked. The Fall Risk Re-assessment indicated the resident at times needed assistance with transfers and needed assistance with ambulation needs. A nursing note, dated 05/15/15 at 8:00 P.M., indicated the resident was admitted to an acute care facility due to the results of the X-ray. The resident was readmitted to the facility, on 05/19/15, after having her fractured femur and left hip repaired. A new fall risk assessment, completed on 05/18/15 (sic), indicated the resident's fall risk factors included: cognitive impairment, mobility impairment, incontinence, medications, and medical condition/diagnosis. The assessment indicated the resident's fall risk care plan addressed the risk factors. The care plan related to her fall risk remained unchanged for Resident #57 after her fall with a hip fracture. A Fall Circumstance, Assessment, and Intervention form, dated 06/11/15 at 2:20 P.M., indicated the resident had an unwitnessed fall in her room. The			

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	resident complained of pain in her right leg and hip and was sent to the emergency room for an evaluation. The resident had been transferring herself, had improper foot wear, and had been documented as having been recently agitated. The intervention implemented was to "teach/encourage call light use." This intervention had been attempted several times unsuccessfully in the past. A Social Service Progress Note, dated 06/15/15, indicated Resident #57's daughter had been notified regarding the resident's increased behaviors of wandering, resisting care, agitation, and confusion. The note indicated the social worker wanted to transfer the resident to an inpatient psychiatric facility but the resident's daughter was resistive. The Social Service Director documented "...I assured dtr [daughter] we were not "duping" [sic] res [resident] out of facility but we can not provided 1:1 care which is what res [resident] is needing....' A Fall Circumstance, Assessment and Intervention form, dated 06/16/15 at 11:00 A.M., indicated the resident had an unwitnessed fall in her room. The resident was attempting to transfer herself. It was unclear if she was transferring herself from the bed or from her wheelchair or recliner. The			

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	Environmental and Personal Inspection of the form was left blank. The intervention implemented after the fall was to send a urinalysis to see if the resident had a urinary tract infection. On 6/16/15 at 2:30 P.M., Resident #57 was observed seated in her room, in a recliner with the door almost all the way closed. A Fall Circumstance, Assessment and Intervention form, dated 06/16/15 at 5:45 P.M., indicated the resident had an unwitnessed fall in her room, had hit and lacerated the right side of her head. The form indicated the door to the room was shut, the alarms were not plugged in and her boyfriend had left. The resident was attempting to ambulate when she fell. The intervention was for the resident's room door to remain open. The resident was sent to an acute care facility and received 7 staples to repair the laceration to her head. On 6/18/15 at 8:45 A.M., Resident #57 was observed seated in her room, alone in her recliner awake. There were no home health agency staff or facility staff in the room, visible in the hallway or at the nurse's station. On 06/18/2015 at 9:00 A.M., Resident			

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	#57 was observed seated in her wheelchair in her room and RN #3, the facility corporate nursing consultant was observed standing in the doorway to the room, looking up and down the hallway. She indicated she was looking for some staff that might know what was going on with Resident #57. When she was queried as to the need for 1:1 supervision, she replied "No comment." On 6/18/15 at 8:47 A.M., Resident #57 was observed seated in her recliner by herself, no staff in the room. There was a motion seat alarm noted. The resident was calm and awake and indicated she did not feel very well. On 6/19/15 at 9:18 A.M., Resident #57 was observed lying in her bed awake. Her boyfriend was in the room and two "sitters" from a home health agency were in the room. The middle side rails were elevated on both sides of her bed. Resident #57 was observed on 6/19/2015 at 11:51 A.M. in the 200 unit lounge sitting in her wheelchair. She was awake, dressed, and alert. Her daughter and boyfriend were sitting with her. During an interview, on 6/22/15 at 9:10 A.M., RN #2 indicated before the resident's fall, with the leg fracture,			

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	Resident #57 was ambulatory independently with supervision but after her fall she became wheelchair dependent and was an extensive assist of one staff for transfers and ambulation needs. On 6/22/15 at 9:49 A.M., Resident #57 was observed in her room by herself sleeping in her recliner with alarms attached and the door open. The nurse was at the nurse's station and there were no other staff noted in the hallway within visualization of the resident. At 10:20 A.M., the resident was still sleeping and her boyfriend was now in the room sitting beside her. On 6/22/15 at 1:50 P.M., Resident #57 was observed alone, sleeping in her recliner in her room. Her door was open but there were no staff in the hallway able to visualize the resident. RN #2 was observed to exit a room down the hallway, obtain some medication from the cart and go into another room to administer the medication. A CNA on the hall was noted to be in the kitchen getting some thickened water for another resident. On 6/22/15 at 2:13 P.M., Resident #57 was observed awake, her feet were between the recliner chair and elevated footrest. The resident was trying to			

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	refold her blanket. No staff were in the hallway, a CNA was sitting at the nurse's station and no one was visualizing the resident. She was alone in the room. During an interview, on 6/22/15 at 11:28 A.M., RN #3, the nursing consultant indicated the facility did not implement the one to one supervision for Resident #57 but had placed her on increased supervision. She indicated increased supervision meant as much as the staff was able they would keep her in our sight. They indicated they did not implemented 1:1 supervision. 3.1-35(g)(2)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interviews the facility failed to	F 0314	1) Resident #108 discharged from facility.	07/23/2015

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	implement interventions to prevent a new pressure ulcers from developing on 1 of 3 residents reviewed for pressure ulcer development. (Resident #108) Finding includes: On 6/18/15 at 2:40 P.M., record review indicated Resident # 108 was admitted to the facility on 1/12/15, and discharged to home on 3/3/15, with diagnoses including, but were not limited to, "...femoral neck fracture, hypoxia, atrial fibrillation, Guillian Barre syndrome and Parkinson's disease...." A nursing admission assessment, dated 1/12/15, indicated the resident did not have a Stage I wound or greater upon admission. The section titled "Skin Plan of Care" was all blank except in chair and to bed was circled. A form titled "Assessment Review and Considerations," dated 1/12/15, indicated skin breakdown risk potential: this resident has the following risk factors that may contribute to skin breakdown: mobility impairment. An individualized care plan has been initiated to address the above risk factors and minimize the risk for skin breakdown. A care plan, dated 1/13/15, indicated the		2) All residents have the potential to be affected by this deficient practice. Current residents are being reviewed for skin breakdown and preventative measures to be careplanned/updated as needed to reflect resident current needs 3) Nursing staff to be re-inserviced regarding preventative guidelines for skin integrity. DHS/designee will observe/review five residents and their care plans for skin breakdown / interventions per week for six months. 4) Per campus guidelines, Nursing Leadership Team & IDT will hold CAR (Clinically At Risk) meeting weekly, in which residents with pressure sores will be reviewed & updated to ensure proper intervention, prevention of further skin breakdown are in place 5) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: July 23, 2015	

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	155760		06/23/2015

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	problem: Potential for alteration in skin integrity related to: immobility and incontinence. Interventions included but were not limited to "...assess/record changes in skin status. Report pertinent changes in skin status to physician...Educate resident about primary risk factors. Monitor lab results as ordered...Administer/monitor effectiveness of/response to preventative treatment...Provide diet as ordered and monitor nutritional status and dietary needs. Turn and reposition every two hours. Provide/monitor effectiveness of pressure relieving or reduction device(s)...." The admission MDS (Minimum Data Set) assessment, dated 1/19/15, indicated the resident required extensive assistance in bed mobility and transfers. A form titled "Skin Impairment Circumstance, Assessment and Intervention," dated 1/26/15, indicated a Stage II ulcer was located on the residents left heel, the physician was notified and Mepilex change every three days was ordered. Environmental and Equipment Inspection: Does the resident have pressure reducing devices? NO was circled. The Prevention Update indicated to float resident's heels off the bed.			

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	A form titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment," dated 1/2615, indicated the resident developed a Stage II pressure ulcer to his left heel on 1/26/15. The length of the ulcer was 3.0 cm (centimeters) the width was 3.0 cm and the depth was 0.1 cm. A treatment of Mepilex was ordered to change every three days. On 1/30/15, the length of the pressure ulcer was 2.5 cm, the width was 2.0 cm and the depth was 0.1 cm. The treatment comment was Mepilex change every three days and prn (as needed), elevate heels and no shoes. On 2/6/15, the length of the pressure ulcer was 2.0 cm, the width was 2.0 cm and the depth was 0.1 cm. The treatment comment was Medihoney change every three days, no shoes, elevate heels and zflow (positioning device) pillow. On 2/13/15, the length of the pressure ulcer was 2.0 cm, the width was 2.0 cm and the depth was 0.1 cm. The treatment comment was Puracol daily with gauze and ace wrap, elevate heels and zflow. On 2/27/15 the length of the ulcer was 2.0 cm, the width was 1.8 cm and the depth was 0.1 cm. The undated care plan, indicated the problem: Alteration in skin integrity, pressure ulcer related to insufficient circulation and immobility. The			

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	interventions section of the care plan was blank. The 30 day MDS assessment, dated 2/9/15, indicated the resident did not have one or more unhealed pressure ulcers at stage I or higher. Forms titled "Skilled Charting Evaluation", dated 1/26/15 to 2/13/15, under the pressure ulcer section was marked as none, n/a (not applicable) or a line was marked across this section. On 2/14/15, under the pressure ulcer section: location: L (left) heel, drainage none was marked. A form titled "Resident First Conference Notes," dated 2/12/15, indicated under the skin section: Pressure area: YES. Pressure reduction devices: mattress, w/c(wheelchair) cushion, zflow. Care giver comments: Res (resident) left heel continues to cause some pain when walking. During an interview on 6/19/15 at 10:56 A.M., the DON (Director of Nursing) indicated the nursing admission assessment indicated a pressure relieving device was on the residents bed and chair. The DON further indicated the care plan that was initiated for potential alteration in skin integrity should have			

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	been more specific as to what pressure relieving devices were in place, she was able to find a form titled first conference notes that indicated zflow boots were applied to the residents heels, she indicated that the zflow boots were probably initiated on 2/12/15, the date on the form. There was no indication specific interventions to protect the resident's heel were in place prior to the development of his heel pressure ulcer. During an interview on 6/22/15 at 10:51 A.M., Employee #15 indicated the resident progressed slowly in his physical therapy due to developing a pressure on his left heel, it caused him a lot of pain and made it hard for him to bear weight and walk. O 6/22/15 at 10:00 A.M., a current policy titled "Wound Plan of Care Guidelines," was received from the MDS Coordinator indicated "...To provide individualized care interventions to treat areas of skin impairment and contributory causes...4. Resident's plan of care should also include goals, approaches and interventions for contributor causes to wound development and prevention...." 3.1-40(a)(1)			

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F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interviews, the facility failed to ensure there were effective interventions implemented and adequate supervision to prevent falls for 2 of 3 residents reviewed for falls. (Resident #52 and #57) This deficient practice results in repeated falls and a head injury requiring 7 staples for 1 of 3 residents reviewed for accidents/falls. (Resident #57) In addition, the facility failed to ensure hazardous chemicals were not accessible in 1 of 35 resident rooms. (Resident #57) Findings include: 1. The clinical record for Resident #57 was reviewed on 6/18/15 at 11:12 A.M. Resident #57 was admitted to the facility, on 07/18/14, with diagnoses, including but not limited to, right shoulder fracture, history of coronary artery disease, hypertension, history of urinary tract infection and dehydration, gastric esophageal reflux disease, hyperlipidemia, anxiety and history of deep vein thrombosis.	F 0323	1) Resident #57 fall careplan has been reviewed and updated, all hazaderous chemicals were removed from room. Resident #52 has been discharged. 2) All residents have the potential to be affected by this deficient practice. Current residents that have had falls past 30 days are in the process of being reviewed for interventions /update of plan of care to ensure interventions are reflective of resident current needs. All resident rooms have been audited for hazardous chemicals. 3) Nursing staff to be re- inserviced on fall prevention, guidelines of immediate and on-going interventions. DHS/designee to re-inservice nursing & housekeeping staff on rounding and removal of hazaderous items/chemicals. DHS/designee will review resident care plan / interventions for residents who sustain fall within 72 hours and during weekly CAR meeting. DHS/designee will observe five resident transfers per week for six months to ensure staff following transfer care plan. DHS/designee will audit five resident rooms per week for six	07/23/2015

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	The admission nursing assessment, completed on 07/18/14, indicated the resident had a right humerus fracture, needed half bedrails one both sides, a wheelchair for safety, and had experienced a fall prior to admission. The assessment further indicated the resident required staff assistance of one for grooming, transferring, wheelchair use, ambulation, bathing, dressing, bed mobility, eating, oral care, and toileting. The assessment also indicated she was illogical with her speech, confused at times, and easily distracted. The resident was to have staff assistance, of one person, for transfers and ADL's (activities of daily living). A fall risk assessment, completed on 07/18/14, indicated the resident had impaired mobility as a fall risk factor and had an individualized care plan initiated to address the risk factors. The care plans for Resident #57 on 7/19/14 indicated the resident's bed was to be at a proper height to facilitate safe transfers, her call light and frequently used items were to be in easy reach, the pathways in her environment were to be free of clutter, she was to have a personal alarm on her bed and chair, she was educated on locking her wheelchair		months to ensure rooms free of hazaderous chemicals. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: July 23, 2015	

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	brakes before transferring, she was to ask for assistance to remove her socks, nursing staff was to leave a night light on at night, her trash can was to be placed out of the walkway to the bathroom. An updated care plan dated, 2/21/15, indicated the wheelchair was to be utilized due to poor balance, she was to be assisted for dressing and moving furniture, she was to receive assist with transfers, extensive assist with toileting as she was not safe to walk alone. A review of the Profile History Report for Resident #57 indicated she had fallen on 01/13/15 while reaching for her phone. The intervention was to put frequently used items close by her including her phone. She fell again on 01/22/15 while she was up walking alone in her dark room. The intervention was to place a night light in her room. She fell again on 02/07/15 when she tripped on a trash can on her way to the bathroom. The intervention was to make sure the trash can was not on her walking pathway to the bathroom. She fell again on 02/21/15, caught her arm in a door handle and injured her arm. The intervention was to put safety alarms on her bed and chair and have her start using a wheelchair. She fell again on 03/02/15 as she had turned off her alarms. The intervention was because the alarms were			

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	upsetting her they were discontinued. She fell again on 03/20/15 as she forgot to put the brakes on her wheeled walker. She and her boyfriend were educated on using the brakes. The Quarterly Minimum Data Set (MDS) assessment, completed on 04/17/15, indicated the resident's BIMS (Brief Interview Mental Status) score was a 5 (severe dementia) and required supervision of one person for transfers and locomotion. She was set up and supervision only for ambulation. She was unsteady but able to regain her balance without assistance. A Fall Circumstance, Assessment and Intervention form, dated 4/24/15 at 5:00 P.M., indicated Resident #57 had a witnessed fall in her room (the report did not say who witnessed the fall) The resident was evidently changing her clothes and moving furniture. The fall risk re-assessment indicated the resident had cognitive and judgement impairment that affects her safety, had difficulty understanding instructions and following directions, had a history of recent falls, occasionally required assistance with transfers, used a rollator (walker), often forgot her assertive device, was taking either psychoactive, diuretic, narcotic, analgesic, cardiovascular or			

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	anticonvulsive medications. The intervention implemented after the 04/24/15 fall was for the resident to request assistance with dressing. This intervention was implemented even though the resident was cognitively impaired and had just been assessed to have problems understanding and following instructions. In addition, on 09/24/14 and again on 02/24/15 the care plan had already been updated with instructions to provide assistance for the resident anytime she was walking, extensive assistance with toileting and assistance with ADL's (activities of daily living). A Fall Circumstance, Assessment and Intervention form indicated Resident #57 was found on the floor on 5/14/15 at 4:00 A.M. She complained of left hip pain and was sent to the emergency room. The form indicated the call light was out of reach and her room lighting was inadequate. The resident had improper footwear on, and was attempting to ambulate. The intervention was to leave the bathroom light on at night. The fall risk re-assessment indicated the resident did not require assistance to transfer or ambulate. The Root Cause indicated "Balance issues, unstable."			

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	Nursing note, on 5/15/15 at 8:00 P.M., indicated the resident was admitted to an acute care facility due to the results of the x-ray. The resident was readmitted to the facility, on 05/19/15, after having her fractured femur and left hip repaired. A new fall risk assessment, completed on 05/18/15 (sic) indicated the resident's fall risk factors now included: cognitive impairment, mobility impairment, incontinence, medications, and medical condition/diagnosis. The assessment indicated the resident's fall risk care plan addressed the risk factors. The care plan related to her fall risk remained unchanged for Resident #57 after her fall with a hip fracture. A Fall Circumstance, Assessment, and Intervention form, dated 05/31/15 at 7:15 A.M., indicated the resident had an unwitnessed fall in her room. The form indicated the resident was reaching for her shoes while sitting in her unlocked wheelchair and fell. The Fall Risk Re-Assessment indicated the resident required assistance to transfer, ambulate, and was unable to maintain her balance. The form further indicated she fell because her shoes had fallen off of her feet and she wanted to pick them up. The intervention was to make sure her shoes			

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	had backs on them and to put anti-tip back bars on her wheelchair. A Fall Circumstance, Assessment, and Intervention form, dated 06/03/15 at 9:00 A.M., indicated the resident had an unwitnessed fall in her room while attempting to transfer herself. The resident was documented as having been recently agitated. There were no additional interventions implemented after her 06/03/15 fall. A Fall Circumstance, Assessment, and Intervention form, dated 06/11/15 at 12:20 P.M., indicated the resident had an unwitnessed fall in her room. The resident complained of pain in her right leg and hip and was sent to the emergency room for an evaluation. The resident had been transferring herself, had improper foot wear, and had been documented as having been recently agitated. The intervention implemented was to "teach/encourage call light use." This intervention had been attempted several times unsuccessfully in the past. A Social Service Progress Note, dated 06/15/15, indicated Resident #57's daughter had been notified regarding the resident's increased behaviors of wandering, resisting care, agitation, and confusion. The note indicated the social			

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	worker wanted to transfer the resident to an inpatient psychiatric facility but the resident's daughter was resistive. The Social Service Director documented "I assured dtr [daughter] we were not "duping" [sic] res [resident] out of facility but we can not provided 1:1 care which is what res is needing....' There were no interventions added to the resident's care plan regarding provided increased and/or 1:1 supervision. A Fall Circumstance, Assessment, and Intervention form, dated 06/16/15 at 11:00 A.M., indicated the resident had an unwitnessed fall in her room. The resident was attempting to transfer herself. It was unclear if she was transferring herself from the bed or from her wheelchair or recliner. The Environmental and Personal Inspection of the form was left blank. The intervention implemented after the fall was to send a urinalysis to see if the resident had a urinary tract infection. On 06/16/15 at 2:30 P.M., Resident #57 was observed seated in her room in a recliner with the door almost all the way closed. The resident's room was around the corner from the nurse's station and 2/3 down the length of the hall.			

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	A Fall Circumstance, Assessment, and Intervention form, dated 06/16/15 at 5:45 P.M., indicated the resident had an unwitnessed fall in her room, had hit and lacerated the right side of her head. The form indicated the door to the room was shut, the alarms were not plugged in and her boyfriend had left. The resident was attempting to ambulate when she fell. The intervention was for the resident's room door to remain open. The resident was sent to an acute care facility and received 7 staples to repair the laceration to her head. On 06/18/2015 at 8:47 A.M., Resident #57 was observed seated in her recliner by herself, no staff were in the room. There was a motion seat alarm noted. The resident was calm and awake and indicated she did not feel very well. On 06/19/2015 at 8:45 A.M., Resident #57 was observed seated in her room, alone in her recliner awake. There were no visitors in the room and no facility staff in the room, no staff were visible in the hallway, or at the nurse's station. On 06/19/15 at 9:00 A.M., Resident #57 was observed seated in her wheelchair in her room and RN #3, the facility corporate nursing consultant, was observed standing in the doorway to the			

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	room, looking up and down the hallway. She indicated she was looking for some staff that might know what was going on with Resident #57. When she was queried as to the need for 1:1 supervision, she replied "No comment." Resident #57 was observed, on 06/19/2015 at 9:18 A.M., lying in her bed awake. Her boyfriend was in the room and two home health agency were in the room. The middle side rails were elevated on both sides of her bed. On 6/19/2015 at 11:51 A.M., Resident #57 was observed in the 200 unit lounge sitting in her wheelchair. She was awake, dressed, and alert. Her daughter and boyfriend were sitting with her. On 6/22/2015 at 8:52 A.M., Resident #57 was observed seated in her wheelchair beside the 200 unit nurse's station. There were two staff members at the nurse's station in view of the resident. Resident #57 was alert, dressed, and conversing. She was calmly sitting in her wheelchair and a motion alarm was noted connected to her wheelchair. During an interview, on 06/22/15 at 9:10 A.M., RN #2 indicated before her fall with the leg fracture Resident #57 was ambulatory independently with			

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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
	supervision but after her fall she became wheelchair dependent and was an extensive assist of one staff for transfers and ambulation needs. RN #2 was getting something out of the medication cart, on 06/22/15 at 9:13 A.M., when Resident #57 stood up utilizing the handrail and set off her motion alarm. Her wheelchair was held by a visitor so it did not roll backwards and she then sat back down and the nurse got to her and handed her a banana She peeled the banana ate a bite and then wheeled her wheelchair a few more feet, put her banana back in the fruit bowl and stood up again, setting off her alarm once again. The nurse got to her and assisted her to sit back down and then asked her what she wanted to do. The resident kept showing her hands and asking "what should I do with these?" Nurse indicated "Lets go for a walk" and pushed the resident's wheelchair down the hallway. On 06/22/2015 at 9:28 A.M., Resident #57 was observed sitting with RN #2 in the 200 unit lounge. The Resident then stated if she had a room to go to she wanted to go back to her room. The nurse gave her a baby doll per her request to hold and pushed her back to her room, which was located approximately 1/2 way down the hallway.			

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	On 06/22/2015 at 9:49 A.M., Resident #57 was observed in her room by herself sleeping in her recliner with alarms attached and the door open. The nurse was at the nurse's station and there were no other staff noted in the hallway within visualization of the resident. At 10:20 A.M., the resident was still sleeping and her boyfriend was now in the room sitting beside her. On, 6/22/15 at 1:50 P.M., Resident #57 was observed sleeping in her recliner in her room, alone. Her door was open but there were no staff in the hallway to visualize the resident. RN #2 was observed to exit a room down the hallway, obtain some medication from the cart and go into another room to administer the medication. A CNA on the hall was noted to be in the kitchen getting some thickened water for another resident. No staff were on the hallway supervising the resident. On 6/22/15 at 2:13 P.M., Resident #57 was observed awake, her feet were between the recliner chair and elevated footrest. The resident was trying to refold her blanket. No staff were in the hallway, a CNA was sitting at the nurse's station and no one was visualizing the resident. She was alone in the room.			

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	During an interview, on 06/22/15 at 10:30 A.M., the MDS coordinator, RN #5 indicated the one to one intervention was going to be added (to the care plan) by the end of today. He further indicated the CNAs used the acute care plan to provide the up to date accurate fall interventions for the resident. During an interview, on 6/22/15 at 11:28 A.M., RN #3, the nursing consultant indicated the facility did not implement on one to one supervision for Resident #57 but had placed her on increased supervision. She indicated increased supervision meant as much as the staff was able we would keep her in our sight. They indicated they did not implemented 1:1 supervision. 2. On 6/19/15 at 8:47 A.M., a review of the clinical record for Resident #52 was conducted. The record indicated the resident was admitted on 5/1/15. The resident's diagnoses included, but were not limited to, hyperkalemia, congestive heart failure, hypertension, hypothyroidism, diabetes, cerebral vascular accident (CVA) and osteoarthritis. A Fall Circumstance, Assessment and Intervention form, dated 6/3/15, indicated			

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	the resident had a fall. The form indicated the resident fell while a Certified Nursing Assistant (CNA) was helping the resident off the toilet. The report indicated the resident leaned to the left and fell to the floor. The CNA tried to catch the resident, however the resident slid to floor. The resident received no injuries related to the fall. The form further indicated the resident was educated to keep both hands on the bar to help assist her until CNA indicated to the resident it was ok to sit. The careplan for ADL's (Activities of Daily Living), undated, indicated the resident was an "...extensive assist of two with bed mobility, transfers and toileting. Extensive assist of one with all other ADLs...." An admission care plan indicated the resident was at risk for falls related to right sided weakness, post CVA. During an interview, on 6/22/15 at 10:15 A.M., CNA #26 indicated the Care Tracker would indicate what assistance a resident would need with transfers. CNA #26 was observed going to a Care Tracker and bringing up the Resident #52's ADL section on the Care Tracker screen. CNA #26 referred to the transfer and toileting section which indicated the resident was an extensive assist of two			

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	persons with bed mobility, transfers, and toileting. During an interview, on 6/22/15 at 10:33 A.M., the ADON indicated the careplan was current and the resident required a two person assist with transfers on and off the toilet. 3. On 6/16/15 at 10:15 A.M., an observation of Resident #57's room indicated there was a half full spray bottle of [store brand name] 91% Isopropyl alcohol on the bedside stand. Resident #57 who resides in room 207 was observed resting in her bed at that time. On 6/17/15 at 3:21 P.M., an observation of the room indicated there was a half full spray bottle of 91% Isopropyl alcohol on the bedside stand. Resident #57 was resting in her recliner with the bedside stand beside her. On 6/22/15 at 10:09 A.M., an observation of the room indicated resident #57 was resting in her recliner with her eyes closed, an observation of the bathroom indicated there was a full bottle of hand sanitizer and a half full spray bottle of 91% Isopropyl alcohol on top of a Rubbermaid container. An interview at that time with the Director of Nursing indicated there should not be any			

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	hazardous chemicals in the resident's rooms. On 6/22/15 at 10:36 A.M., record review indicated Resident #57's diagnoses included but were not limited to "...anxiety, severe dementia, right shoulder fracture and a recent femur fracture...." A quarterly MDS (Minimum Data Set) assessment, dated 4/19/15, indicated the resident required supervision only for locomotion on and off the nursing unit, and the resident scored a 5 on the BIMS (Brief Interview for Mental Status) assessment which indicates the resident had severe dementia. During an interview, on 6/22/15 at 1:42 P.M., RN #11 indicated there is currently no policy regarding hazardous chemicals in resident rooms. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of			

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	nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review the facility failed to ensure Resident #146 received the required therapeutic diet needed to address his protein needs for 1 of 1 residents reviewed for dialysis. Finding includes: On 6/23/15 at 9:24 A.M., a review of the clinical record for Resident #146 was conducted. The record indicated the resident was admitted on 5/30/15. The resident's diagnoses included but were not limited to, renal failure, chronic kidney disease, severe venous status, morbid obesity, diabetes, respiratory distress, acute pancreatitis, congestive heart failure and chronic edema with episodes of recurrent cellulitis. A Skilled Charting Evaluation, dated 5/31/15 thru 6/21/15, indicated the resident was being evaluated due to an infection-cellulitis of bilateral lower extremities. A Nutritional Assessment and Data Collection form, dated 6/3/15, indicated	F 0325	) Resident #146 discharged from facility. 2) All residents have the potential to be affected by this deficient practice. All current dietary recommendations reviewed and sent to physician. Met with Dietitican and all recommendations will now be sent to the DHS/ADHS via email following her visit. DHS or designee will review, forward to physician and follow up with Dietician upon next return visit. 3) DHS/designee will continue to review dietary recommendations upon receipt and review with Dietitican upon next visit. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.	07/23/2015

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	estimated Kcal needs were 2655 Kcal per day, protein needs were 141 grams per day, and fluid needs were 2655 milliliters per day. The nutritional assessment indicated the resident does not meet nutritional needs. The dietician's assessment indicated the resident had increased protein needs related to hemodialysis, the resident's protein needs were greater than the standard menu. The dietician recommended double protein at meals. A Meal/Snack/Fluids careplan, undated, indicated the resident had increased nutritional needs due to being on hemodialysis and the resident's protein needs were greater than the standard menu. The interventions included but were not limited to: provide diet as ordered, offer/encourage fluids, offer alternate food/beverage items if resident dislikes what is offered, monitor labs, provide snacks between meals or as needed, and administer medication/supplements as ordered. A Diet Order & Communication form, dated 5/30/15, indicated the resident was on a no added salt with controlled carbohydrate diet. A diet ticket, dated 6/23/15, indicated the resident's diet remained the same as			

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	ordered on 5/30/15, and was confirmed by the Director of Food Services. On 6/23/15 at 11:10 A.M., the resident was observed lying across his bed. He indicated he was still experiencing weakness and was having some dizziness that morning. The resident further indicated he would need to get moving soon because a therapist would work with him before lunch. During an interview, on 6/23/15 at 11:31 A.M., the Assistant Director of Nursing (ADON) indicated she would receive any recommendations from the dietician and inquire the physician regarding those recommendations. She further indicated the regular dietician, for the facility, did not see the resident and her recommendations on 6/2/15 were not received by the ADON until 6/19/15. The ADON further indicated the physician had not been notified of the recommendation of double protein meals for Resident #146. On 6/23/15 at 2:49 P.M., the ADON provided the current Nutritional Recommendation Guidelines for the facility, dated 2/16/13. The guideline indicated the Clinical Nutrition Support reviews the recommendations with the Director of Nursing or designee, and			

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	Director of Food Services, if possible. The guidelines further indicated "...4. Suggested discipline follows up on recommendation (s) in a timely manner...." 3.1-46(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and	F 0329	1) Resident #57 medication	07/23/2015

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	interviews, the facility failed to ensure there was adequate indications to support an increase in anti-anxiety medication and the use of a sleep aid for 2 of 5 residents reviewed for unnecessary medication use (Resident #57 and Resident #52). In addition, the facility failed to ensure there was adequate monitoring of medications including monitoring laboratory values in respect to medication use for 1 of 5 residents reviewed for unnecessary medications. (Resident #91) Findings include: 1. The clinical record for Resident #57 was reviewed on 06/18/2015 11:12:59 AM . Resident #57 was admitted to the facility on 07/18/14 with diagnoses, including but not limited to right shoulder fracture, history of coronary artery disease, hypertension, , history of urinary tract infection and dehydration, gastro-esophageal reflux disease, hyperlipidemia, anxiety and history of deep vein thrombosis. On 05/15/15 the resident had been admitted to an acute care facility due to a fractured femur. She was readmitted to the facility on 05/19/15 after having her hip fracture repaired surgically.		adjusted. Resident #52 has been discharged. Resident #91 has had labs obtained. 2) All residents have the potential to be affected by this deficient practice. Current residents have been reviewed by consulting pharmacist to ensure medications requiring lab monitoring have labs ordered. Residents with psychotropic medications reviewed for documentation for appropriateness. 3) Consultant pharmacist to audit residents on medications requiring labs and provide recommendations monthly. DHS/designee to review MAR for five residents per week to identify medications requiring lab follow up for six months DHS/designee will review five residents per week to identify psychotropic medication changes and documentation 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.	

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	The physician's order for medications on admission, on 07/18/14 indicated the resident was not receiving any antidepressant, anti-anxiety, mood stabilizing or antipsychotic medications. The current medication orders for Resident #57 included: -Ativan (an anti-anxiety medication) 0.5 mg (milligrams) TID (three times a day) prn (as needed) -Haldol (an antipsychotic medication used to treat behaviors) I ml (milliliter) intramuscularly BID (twice a day) prn for anxiety. The Ativan medication was originally ordered on 07/21/14. However, on 06/10/15 the Ativan medication order was changed and increased to reflex .5 mg TID routinely. A nurse's note, dated 06/04/15, indicated the physician had been faxed regarding "med (medication) admin needs for review, in regards to falls and behaviors outside of her room." The PRN Medication Tracking form for Resident #57 for May 2015 and June 2015 indicated the resident had been administered Ativan twice on 05/24/15 and twice on 05/30/15 and once on 06/03/15. In addition she had been given pain medication of either Tramadol or Norco at the same times. The Ativan was			

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	documented as having been effective on all but one of the times it had been administered and there was no documentation regarding effectiveness on that occasion. The electronic Behavior Detail Report indicated, from 05/24/15 - 06/03/15, there was only one documented behavior of wandering on 05/29/15. The nursing notes from 06/03/15 - 06/10/15 indicated on 06/10/15 at 6:00 A.M. the resident had been awake during the night had when placed in her wheelchair was wandering up and down the hall yelling for "whisky." She was given pain medication and eventually went to sleep. There was no documentation to support the increase in Ativan from PRN to routine. In addition, on 06/11/15 the resident fell out of bed and a physician's order, dated 06/13/15 changed the Ativan medication back to the original PRN frequency and also included an order to restart therapy once the resident's sedation lifted. 2. The clinical record for Resident #91 was reviewed on 06/19/2015 11:09:49 AM . Resident #91 was admitted on 08/31/14 with diagnoses, including but			

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	not limited to dementia, chronic renal failure, depression, hypertension, hyperlipidemia and history of left hip fracture. The current medication orders for Resident #91 included the following: -Depakote 125 milligrams (mg) twice a day (BID) (an anticonvulsant) -Zocor 20 mg one tablet daily (an antilipemic) There were no laboratory studies to check for adverse side effects and therapeutic levels for any of the medications. During an interview, on 06/19/2015 at 2:15 P.M. with ADON indicated they did not locate any labs completed at all for Resident #91. No policy was provided in regards to medications and serum level monitoring with lab tests. 3. On 6/19/15 at 8:47 A.M., a review of the clinical record for Resident #52 was conducted. The record indicated the resident was admitted on 5/1/15. The resident's diagnoses included, but were not limited to, hyperkalemia, hypothyroidism, cerebral vascular accident, expressive aphasis, diabetes, breast cancer and osteoarthritis. The Medication Administration Record			

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	(MAR) indicated the resident currently was administered the following medication: Remeron 7.5 milligrams (mg) at bedtime. Review of the office notes, from a local neuro clinic, dated 6/8/15, indicated the resident was having significant problems with sleep and anxiety. The physician ordered Remeron 7.5 milligrams at bedtime for the insomnia. A Mental Health Wellness Circumstance, Assessment, dated 6/9/15, indicated the resident was clinging to others, using repetitive verbalizations and yelling out. The assessment indicated the resident was on remeron, however the resident was restless, and unable to rest last night. On 6/22/15 at 1:25 P.M., Social Service Director indicated the remeron was given to the resident for insomnia and there was no plan of care to address insomnia. She further indicated the Mood Report had one incident of resident having a "sleep issue" on 6/10/15. On 6/22/15 at 2:00 P.M., the Nurse Consultant provided a policy titled "Guidelines for Care Plan Development", dated June 2013, and indicated the policy was the one currently used by the facility. The policy indicated "...7. The care plan			

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	shall be updated as preferences and needs change...." 3.1-48(a)(6)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to ensure food was prepared, distributed and served under sanitary conditions related to proper hand washing. This deficiency had the potential to affect 67 of 67 residents who receive food from 1 of 1 kitchen, and 50 of 50 residents who eat in 2 of 2 dining rooms. Findings include: On 6/15/15 from 11:50 A.M. to 12:45 P.M. during the noon meal food prep and dining service the following was observed: At 11:50 A.M. Cook #12 was observed frying french fries in a deep fryer. Cook #12 removed the metal basket from the	F 0371	) No specific residents listed. 2) All residents have the potential to be affected by this deficient practice. Staff serving in dining room expected to wash their hands frequently and appropriately. No adverse effects noted. 3) DHS & Director of Food Services or designee will re-inservice nursing & kitchen staff on proper handwashing & handling of glassware. DFS or designee will observe handwashing/handling of glassware in kitchen & dining room five times per week for three months then three times per week for three months. 4) QAA will monitor findings	07/23/2015

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	155760		06/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	1332 WATERFORD CIR GOSHEN, IN 46526

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	oil and allowed the french fries to drain and cool, he then proceeded to remove a french fry from the metal basket and eat it with his bare hands he did not wash his hands afterwards. Cook #12 removed a pair of thongs from a hanging metal rack by grabbing the end of the thongs with his bare hands, he then used the thongs to remove frozen french fries from a paper bag and placed the fries into the metal basket to fry in the oil. At 12:00 P.M., Cook #12 walked over to the sink in the kitchen and washed his hands for 10 seconds he then turned the faucet handles off with his bare hands. At 12:05 P.M., Cook #12 transported large metal pans with food inside that were covered with aluminum foil to the steam table located in the main dining room. He removed the aluminum foil from the top of the metal pans which caused his glasses to steam over, Cook #12 was then observed to take his bare fingers and wipe the steam from his glasses, he did not wash his hands and then started to temp the food on the steam table. At 12:15 P.M., Cook #12 was serving food from the steam table he was observed to use his bare hand and scratch his hair underneath his hat covering his		monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: July 23, 2015	

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	hair, he then without washing his hands continued to serve food onto individual plates. At 12:30 P.M., Cook #12 was observed removing french fries from a metal pan with a pair of thongs, a french fry fell off of the plate, it landed on the edge of the steam table he picked the fry up with the thongs and placed it back on the plate to be served. At 12:45 P.M., Cook #12 was observed to rub his mouth with his left hand, he did not wash his hands and continued to serve food from the steam table. On 6/18/15 from 12:04 P.M. to 12:30 P.M., during the dining service in the restorative dining room the following was observed: At 12:05 P.M., CNA #13 was observed serving an unidentified resident his lunch, when CNA #13 placed a small plastic cup on the table that had 3 pickle slices in it the plastic cup fell over, she was observed to place the pickle slices back in the cup with her bare hands, she did not wash her hands and continued to serve other residents. From 12:15 P.M. to 12:30 P.M. CNA #13 and RN #14 was observed serving			

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	residents their drinks by placing their fingers around the rim of the drinking glasses. CNA #13 and RN #14 was not observed to wash their hands during the meal service. On 6/22/15 at 1:50 P.M. record review of the current policy titled "Guidelines For Handwashing" received from the Administrator indicated "...All health care workers shall wash their hands frequently and appropriately...3. Health care workers shall wash hands at times such as: a. on reporting to work; before/after eating;...toileting, blowing nose, coughing, sneezing, handling hair, etc. b. before/after preparing/serving meals, drinks...c. before/after having direct physical contact with residents...." 3.1-21(i)(2)			
F 0428 SS=D Bldg. 00	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on observation, record review and	F 0428		07/23/2015

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	interviews, the facility failed to ensure a pharmacists recommendation, approved by the physician, was implemented for 1 of 5 residents reviewed for unnecessary medications. (Resident #27) Finding includes: The clinical record for Resident #27 was reviewed on 06/19/15 at 2:30 P.M. Resident #27 was admitted to the facility, on 02/04/15, with diagnoses, including but not limited to status post cerebral vascular accident, hypertension, chronic obstructive pulmonary disease, depression, anxiety, status post pulmonary embolism, chronic renal failure, spinal fusion, and bilateral foot deformities, history of falls, hypocalemia, gastritis, pain and hyperlipidemia. According to the physician orders section of the clinical record and the June Medication Administration Record, the current physician orders for medications, included but were not limited to: Spiriva (a bronchodliator medication) 18 mcg (micrograms) one capsule inhaled daily for shortness of breath. A Pharmacy recommendation, completed on 2/27/15, and responded to by the physician on 03/04/15 indicated to reduce the Allegra to 180 milligrams (mg) once		1) Resident #27 record reviewed and clarification requested from physician 2) All residents have the potential to be affected by this deficient practice. Licensed nurses to be re-inserviced related to new admission medication regimen review process. 3) DHS/designee will review pharmacy recommendations as received and insure follow up with physician. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion date: July 23, 2015	

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	a day the physician ordered it to be given "QD (once a day) and in response to the pharmacy recommendation to "make sure only one capsule was used a day for the Spiriva, the physician responded to "D/C (discontinue) Spiriva." A Pharmacy recommendation completed on 05/12/15, included the following recommendations: "Allegra 180 mg twice a day (BID) is usually only for uticaria (a skin rash triggered by an allergic response and characterized by hives)." The Pharmacist further recommended the Spiriva is not usually administered as needed. The Physician responded to change the Allegra and Spiriva to be administered to the resident once a day. The physician response orders for February or May were not initiated. During an interview, on 06/23/2015 at 11:54 A.M., the ADON (Assistant Director of Nursing) indicated the nurses on the floor for the day were responsible for transcribing the orders given as a result of the pharmacy recommendations. She indicated there was a separate audit system for the Consultant Pharmacists report and recommendations, however the pharmacy recommendations came directly from the pharmacy for Resident #27.			

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	3.1-25(i)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package			

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	drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interviews, the facility failed to ensure the medication stored in the medication refrigerators in 2 of 3 medication rooms were not expired. (100 and 200 unit) Finding includes: During an observation of the medication room on the 100 unit, conducted on 06/22/15 at 4:15 P.M., two opened vials of Tubersol (a serum used to administered Mantoux tuberculin skin tests for residents and staff) were expired. One of the vials was marked as expired on 05/17/15 and another vial was marked as expired on 05/20/15. RN #1, who was working on the 100 unit, confirmed both vials were expired and removed them from the medication room. During an observation of the medication room on the 200 unit, conducted on 06/22/15 at 4:30 P.M., one opened vial of Tubersol was expired. The opened vial indicated the medication expired on 05/19/15. RN #2, who was working on the 200 unit confirmed the medication was expired. The Medication Storage in the Facility	F 0431	1) No specific residents listed and no adverse outcome noted. Expired medications removed from both medication rooms immediately. 2) All residents have the potential to be affected by this deficient practice. All three medication rooms have been checked for expired medication. 3) DHS/designee to re-inservice nursing staff on removal of expired medication immediately in medication rooms. DHS/designee will audit medication rooms for expired medication three times per week for six months. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion date: July 23, 2015	07/23/2015

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	policy and procedure, dated 09/01/2013, provided by the facility nursing consultant RN #3 included the following: "...l. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock...." 3.1-25(o)			
F 0441 SS=D Bldg. 00	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			

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	must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and interviews, the facility failed to ensure 1 of 3 nurses observed administering medication changed gloves and washed her hands appropriately while administering intravenous medication to 1 resident. (Resident #135) Finding includes: During a medication pass observation, conducted on 06/19/2015 at 10:29 A.M., RN #1 was observed hanging intravenous antibiotic and changing the tubing for Resident #135. The nurse had washed her hands and donned a pair of disposable gloves. She handled the tape around the resident's peripherally inserted central catheter (PICC) line, handled the packaged tubing, and then grabbed the trash can with her gloved hand. She then spent time priming the tubing with her	F 0441	1) Resident #135 was assessed and shows no signs or symptoms of infection. RN was re-educated on changing of gloves during the process of administering intravenous medication. 2) All residents receiving intravenous medication have the potential to be affected by this deficient practice. 3) DHS/designee will re-educate nursing staff on appropriate glove use during process of administering intravenous medication. DHS/designee will observe intravenous medication glove usage three times per week for six months if IV in use. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion date: July 23, 2015	07/23/2015

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	contaminated gloved hands. She then opened a 10 milliliter (ml) tubex of normal saline fluid and pushed 5 ml (approximately 1/2 of the tubex) into the resident's PICC line after she had cleaned the end of the tubing twice, handling the resident's PICC line with both of her hands and an alcohol pad. She then connected the primed tubing, connected to the antibiotic to the resident's PICC line and after allowing gravity to prime the tubing, she then connected the tubing to the Intravenous pump machine and set the machine to run at 100 ml/hr for the 50 ml bag of antibiotic fluid. She removed her gloves and washed her hands prior to leaving the room. During an interview, on 06/23/15 at 3:00 P.M., with the Regional Nurse Consultant, she indicated the facility did not have a specific policy regarding when to change gloves during the process of administering intravenous medication but it was just "Nursing 101" and expected staff know to change their gloves and wash their hands after handling a trash can. 3.1-18(b)(1)(A)			