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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/07/2016 |
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| NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256 |
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| F 0000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00195664, IN00195213, IN00194999, IN00194848, IN00193489, IN00192746, and IN00192640.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00197341.</p> <p>Complaint IN00195664 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00195213 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F441.</p> <p>Complaint IN00194999 - Substantiated. Federal/State deficiencies related to the allegations are cited at F465.</p> <p>Complaint IN00194848 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309.</p> <p>Complaint IN00193489 - Substantiated. Federal/State deficiencies related to the allegations are cited at F371 and F505.</p> <p>Complaint IN00192746 - Substantiated.</p> | F 0000 | <p>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 a Recertification and State Licensure Survey in conjunction with Complaints (IN0197341, IN00192650, IN00192746, IN00193489, IN00194848, IN00194999, IN00195213 and IN00195664) Survey on April 7, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.</p> | |

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

TITLE

(X6) DATE

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

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| | <p>Federal/State deficiencies related to the allegations are cited at F312 and F328.</p> <p>Complaint IN00192640 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: March 28, 29, 30, 31, April 1, 3, 4, 5, 6, and 7, 2016</p> <p>Facility number: 013019 Provider number: 155815 AIM number: 201251520</p> <p>Census bed type: SNF: 45 SNF/NF: 10 Residential: 23 Total: 78</p> <p>Census payor type: Medicare: 27 Medicaid: 10 Other: 18 Total: 55</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on April 14, 2016.</p> | | | |

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| F 0167 SS=C Bldg. 00 | <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation, interview, and record review, the facility failed to post a notice of availability and location of the most recent survey results. This had the potential to affect 55 of 55 residents in the facility.</p> <p>Findings include:</p> <p>An environmental tour of the facility was conducted with the Executive Director on 4/6/16 at 11:45 a.m. A binder containing the survey results was located at the receptionist desk. No posting of its' availability was observed.</p> <p>An interview was conducted with</p> | F 0167 | <p>F 167</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>A sign will be posted indicating the location of the most recent survey results. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>All residents have the potential to be affected by this alleged deficient practice. Measures put in place and</p> | 05/07/2016 |

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| F 0279 SS=D Bldg. 00 | <p>Resident #33 on 4/7/16 at 9:47 a.m. She indicated she didn't know where the state survey results were located, nor was she aware of a sign indicating the location of the survey results.</p> <p>An interview was conducted with the Clinical Support (CS) #14 on 4/6/16 at 2:40 p.m. She indicated she would expect a notice to be with survey binder indicating its' location. On 4/6/16 at 3:15 p.m., the CCS indicated there was no policy related to posting of survey results, but expected federal regulations to be followed.</p> <p>3.1-3(b)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain</p> | | <p>systemic changes made to ensure the alleged deficient practice does not recur: A sign will be posted indicating the location of the most recent survey results. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee monthly times 6 months to ensure compliance: Sign is posted indicating the location of the most recent survey results. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop an insomnia care plan and a care plan to address a resident's urinary incontinence for 2 of 26 residents reviewed for care plans (Resident #32 and #33).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #33 was reviewed on 4/4/16 at 11:00 a.m. The diagnoses for Resident #33 included, but were not limited to, malignant neoplasm of colon, malaise, depression, and diabetes mellitus.</p> <p>A Nurse Practitioner Note, dated 10/20/15, indicated, "...Impression: Insomnia..."</p> <p>A Nurse Practitioner Note, dated 10/21/15 indicated, "...She is c/o [complaining of] ongoing insomnia that has not improved with trazodone (anti-depressant used as sleep aid) or melatonin....Impression: Insomnia...."</p> | F 0279 | <p>F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #32 care plan was developed for insomnia. Resident #33 care plan was developed for urinary incontinence. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with a diagnosis of insomnia and consistent documentation of urinary incontinence to ensure a Care Plan is in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee on 5 residents 2 times per week times 8 weeks, then</p> | 05/07/2016 |

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| | <p>A Nurse Practitioner Note, dated 2/1/7/16, indicated, "...This resident has a long hx [history] of insomnia. She asked to speak with writer concerning her insomnia...Assessment: Insomnia....Plan: Increased [sic] trazodone to 100 mg [milligrams] qhs [at bedtime.]"</p> <p>A Physician's Progress Note, dated 2/18/16, indicated, "...Notes some issues with insomnia at [sic] medications were adjusted yesterday...Impression: Insomnia...continue sleeping aids qhs [at bedtime] as needed...."</p> <p>A Physician's Order, dated 2/17/16, indicated an order for trazodone 100 milligrams at bedtime daily.</p> <p>A careplan for insomnia was not located in the clinical record.</p> <p>During an interview with Clinical Support #14, on 4/6/16 at 9:19 a.m., Clinical Support #14 indicated the facility was not able to locate an insomnia careplan and a resident should have an insomnia careplan if they were being treated for it.</p> <p>2. The clinical record for Resident #32 was reviewed on 4/7/15 at 9:05 p.m.</p> <p>The 12/14/15 Admission MDS (minimum data set) assessment indicated</p> | | <p>monthly times 4 months to ensure compliance: resident Care Plans to ensure diagnosis of insomnia and consistent documentation of urinary incontinence are in place</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>Resident #32 was occasionally incontinent of urine. The 3/7/16 Quarterly MDS assessment indicated Resident #32 was frequently incontinent of urine.</p> <p>An interview was conducted with CRCA (Certified Resident Care Assistant) #14 and CRCA #8 on 4/7/16 at 9:12 a.m. CRCA #14 indicated Resident #32 was "check and change" every 2 hours due to her urinary incontinence. CRCA #8 agreed with CRCA #14 that Resident #32 was "check and change."</p> <p>No urinary incontinence care plan was found in the clinical record.</p> <p>An interview was conducted with the MDS Coordinator on 4/17/16 at 9:17 a.m. She indicated Resident #32 should have had a urinary incontinence care plan developed after her admission, when she was occasionally incontinent, and then updated after her quarterly assessment, when she was frequently incontinent.</p> <p>A policy titled, "Interdisciplinary Team Care Plan Guidelines, dated 6/2015, was received from Clinical Support #14, on 4/6/16 at 2:32 p.m. The policy indicated, "...d. Care plans to address acute problems are to be written on the appropriate Circumstance form.</p> | | | |

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| F 0282 SS=D Bldg. 00 | <p>Problems that become on-going or chronic, will then be addressed in the comprehensive care plan...."</p> <p>3-1.35(a)</p> <p>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 interview and record review, the facility failed to monitor/trend blood pressures as indicated by the Physician for 1 of 5 residents reviewed for unnecessary medications (Resident #33). Findings include: The clinical record for Resident #33 was reviewed on 4/4/16 at 11:00 a.m. The diagnoses for Resident #33 included, but were not limited to, malignant neoplasm of colon, malaise, depression, hypertension and diabetes mellitus. A Physician's Order, dated 9/23/15, indicated an order for Norvasc (blood</p> | F 0282 | <p>F 282</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #33 MD was contacted regarding BP monitoring for ordered medication.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all resident MD orders for past 14 days to ensure documentation is in place for any ordered blood pressure monitoring</p> | 05/07/2016 | |

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| F 0309 SS=D Bldg. 00 | <p>pressure medication) 5 milligrams daily.</p> <p>A Physician's Progress Note, dated 2/18/16, indicated, "...Plan/Discussion: Continue Norvasc. Trend BP [blood pressure]..."</p> <p>Blood Pressure trending after 2/18/16 was not located in the clinical record.</p> <p>During an interview with Clinical Support #14, on 4/4/16 at 4:05 p.m., Clinical Support #14 indicated blood pressure trending was not completed and was overlooked.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p> | | <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guideline: Medication Orders</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of Physician orders to ensure documentation is in place for any ordered blood pressure monitoring</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to administer anti-coagulation injections as ordered, notify the physician of out of range vital signs, and ensure a nurse obtained vital signs as part of an assessment prior to nebulizer treatments for 1 of 2 residents reviewed for death. (Resident #N)</p> <p>Findings include:</p> <p>The clinical record for Resident #N reviewed on 3/30/16 at 2:05 p.m. The diagnoses for Resident #N included, but were not limited to, edema, debility, congestive heart failure, and seizure disorder.</p> <p>A Short term Rehabilitation Careplan, dated 1/28/16, indicated an intervention of, "Provide me with nursing care and physician [sic] interventions according to my functional and healthcare needs."</p> <p>A Progress Note, dated 2/05/2016 at 5:40 p.m., indicated, "Resident presented with SOB [short of breath], O2 [oxygen] sat [saturation] of 88% and labored breathing. Aerosol treatment started; resident seen by NP [name of Nurse Practitioner #5]. Orders received for</p> | F 0309 | <p>F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #N has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents for the following for the past 14 days: 1). Medications administered as ordered for the past 7 days. 2). Physician notification is documented for vital signs out of range 3). Licensed Nurse obtained / documented vital signs as part of an assessment prior to nebulizer treatment. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and QMAs on the following guidelines: 1). Medication Orders 2). Medication Administration - General 3). Physician Notification 4). Respiratory / Inhalation Treatments How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or</p> | 05/07/2016 |

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| | <p>STAT labs and STAT chest x-ray as well as oxygen to keep sats 90% or above. Oxygen via nasal cannula applied with sats coming up to 91%; breathing regular and unlabored; resident more alert; less anxiety. Will continue to monitor."</p> <p>A Progress Note, dated 2/07/2016 at 8:10 p.m. indicated "Resident presented with rapid respirations and anxiety. BP 148/82, Pulse 99, Resp 60, O2 sats 95% on 2L oxygen. Resident given a PRN alprazolam at 5:04 pm. Respirations down to 28 with anxiety greatly decreased."</p> <p>A Nurse Practitioner Note, dated 2/10/16, indicated, "Noted increased lethargy and confusion. No c/o [complaints/of] voiced. Denies pain, sitting in wheelchair. Continues with loose stools, second Cdiff [type of bacteria] sample sent. VSS [vital signs stable]. No acute distress noted. Edema noted to RLE [right lower extremity]...Plan...U/s [ultrasound] RLE. Start Lovenox [medication for blood clots] 1mg/kg BID [milligram/kilogram twice a day]..."</p> <p>A Progress Note, dated 2/10/2016 at 4:40 p.m., indicated, "Writer received preliminary results of resident dopplar [sic] to Left leg, technician states that leg appears to be positive for DVT [deep</p> | | <p>observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>1). Medications administered as ordered 2). Physician notification is documented for vital signs out of range 3). Licensed Nurse obtained / documented vital signs as part of an assessment prior to nebulizer treatment. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>vein thrombosis-blood clot]. Notified NP who gave order to start Lovenox 1mg/kg BID...provided by staff. PCA, Resident and PT aware."</p> <p>A document, stamped as received 2/10/16 at 8:22 p.m., indicated, "Exam: Venous Doppler of Right Lower Extremity...Impression: Evidence of acute deep veins thrombosis in the common femoral, superficial femoral and popliteal veins of the right lower extremity...."</p> <p>A Progress Note, dated 2/11/2016 at 9:39 am., indicated "Resident vomitted [sic] after breakfast no distress noted. Contents dark green. Resident stated he felt ok will continue to monitor. MD notified."</p> <p>The February MAR (medication administration record) indicated Resident #N did not receive enoxaparin (Lovenox) until 2/11/16 at 10:00 p.m. The MAR also indicated QMA #4 entered the vitals on 2/11/16 at 4:00 p.m. and 8:00 p.m. The following were the vitals entered for the nebulizer treatment: 2/11/16 at 4:00 p.m.-heartrate=105, respiratory rate=55, oxygen saturation=91% 2/11/16 at 8:00 p.m.-heartrate=107, respiratory rate=49, oxygen saturation=90%.</p> | | | |

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| | <p>A Progress Note, dated 2/12/2016 at 1:04 a.m., indicated, "Called into resident's room to suction secretions from throat. Minimal mucous suctioned out. Resident asked for an anti-anxiety medication at this time. At 8:30 pm, QMA [name of QMA #4] administered xanax [anti-anxiety medication]; performed scheduled aerosol treatment [nebulizer treatment]; resident was conversing at this time. CRCA [name of crca/cna #40] entered resident's room at 10:15 pm; resident was awake and moving in the bed. Between 10:30-10:45 pm, QMA [name of QMA #4] came to me to say resident was not breathing. At this time writer went to [name of hallway] to acquire the code cart...Chest compressions started; 911 called. Continued chest compressions until paramedics and fire department arrived to take over the situation. At 11:20 pm life-saving measures were stopped per EMS staff; respirations ceased."</p> <p>The February MAR indicated QMA #4 administered alprazolam (anti-anxiety medication) to Resident #N at 10:24 p.m.</p> <p>During an interview with QMA #4, on 3/31/16 at 3:30 p.m., QMA #4 indicated she would take the vitals for the nurse and write out the vitals on a sheet of</p> | | | |

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| | <p>paper and place them and a vial for the nebulizer treatment on the medication cart for the nurse to review/administer the nebulizer treatment. QMA #4 indicated she told the nurse about the increased secretions she observed during the time she took a set of vitals and she indicated Resident #N was making small talk at the time, but QMA #4 was unsure what time this was. QMA #4 further indicated the nurse did not question or mention the vitals noted above at either time when QMA #4 placed the vitals on the medication cart. QMA #4 indicated she did not bring the vitals she obtained to the nurse's attention, because she was told Resident #N had a history of high respirations when she first started. QMA #4 also indicated she thought Resident #N requested an anti-anxiety medication from the nurse, not her. QMA #4 administered the anti-anxiety medication to him and continued with the rest of medication pass after the administration. She indicated she was unsure what time this was. QMA #4 indicated Resident #4 was sleeping when she went to see if the medication was effective and when she went in Resident #N's room later (she indicated she was unsure what time, but thought it was around 10:30 p.m. according to the above Progress Note) she noticed Resident #N was not moving or breathing so she told the nurse and the</p> | | | |

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| | <p>nurse went to grab the crash cart."</p> <p>On 4/1/16 at 10:13 a.m., during an interview with Nurse Practitioner (NP) #5, she indicated she was following Resident #N for several issues near the time of his death. NP #5 indicated the resident was having issues with congestive heart failure, cardiomegaly, and possibly chronic obstructive pulmonary disease. NP #5 also indicated she had a concern about a possible blood clot, so she initiated the order for Lovenox and the ultrasound. NP #5 indicated when she wrote the order for Lovenox to be administered twice daily on the 2/10/16 Nurse Practitioner Note, she wanted the medication to be started that day. NP #5 indicated there were ways to get medications in the facility the same day, if the medication was not readily available. She also indicated if the Lovenox was not administered as ordered, she wanted to know. NP #5 indicated she "didn't know that" the Lovenox was not administered on 2/10/16 in the p.m. or 2/11/16 in the a.m., after she initiated the order on 2/10/16. During this time, NP #5 reviewed the history of Resident #N's vitals including, but not limited to, 2/5/16 with a heartrate (hr) of 114 and respiration rate (rr) of 24, 2/7/16-hr of 99, rr of 60, 2/8/16-hr of 97, rr of 47. NP #5 indicated if she was</p> | | | |

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| | <p>notified of the above vitals on 2/11/16 at 4:00 p.m. and 8:00 p.m., she would've had Resident #N sent out to the emergency room, due to both sets of vitals being increased, even though Resident #N had a history of elevated vitals at times.</p> <p>During an interview with NP #5, on 4/1/16 at 11:59 a.m., NP #5 indicated she will put the medication order in the system the day of her visit and the staff will need to go into the system to verify the orders or she will have the staff put the orders.</p> <p>At 12:10 p.m., on 4/1/16, Clinical Support #14 indicated the order for Lovenox was probably not put in the system correctly and that was why the doses were missed.</p> <p>On 4/1/16 at 3:30 p.m., Clinical Support #14 indicated nurses were supposed to take the vital signs as part of their assessment prior to nebulizer treatments.</p> <p>A policy titled, Medication Orders, dated 9/1/13, was received from Clinical Support #14 on 4/1/16 at 3:30 p.m. The policy indicated, "...The prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available.</p> | | | |

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| F 0312 SS=D Bldg. 00 | <p>A policy titled Preparation and General Guidelines, dated 2/1/10, was received from Clinical Support #14 on 4/4/16 at 12:11 p.m. The policy indicated, "...Administration...2.) Medications are administered in accordance with written orders of the attending physician...."</p> <p>A policy titled, Respiratory/Inhalation Treatments Guidelines dated 1/2006, was received from the Clinical Support #4 on 4/4/16 at 4:00 p.m. The policy indicated, "It is the policy [name of corporation] to administer aerosol breathing treatments, as ordered by the physician, by a licensed nurse...5. Prior to beginning the treatment a lung and heart rate assessment should be completed...."</p> <p>This Federal Tag relates to Complaint #IN00194848.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review,</p> | F 0312 | F 312 | 05/07/2016 |

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| | <p>the facility failed to provide showers two times a week for 1 of 3 residents reviewed for activities of daily living. (Resident #L) Findings include: The clinical record for Resident #L was reviewed on 4/1/16 at 11:30 a.m. The diagnoses for Resident #L included, but were not limited to: diabetes mellitus with diabetic neuropathy, and peripheral vascular disease. The Minimum Data Set (MDS) assessment dated, 11/4/15, indicated Resident #L needed physical help in part of bathing activity times 1 staff member. Resident #L's shower sheets were provided by the Clinical Support #14 on 4/5/16 at 1:00 p.m. It indicated Resident #L received partial bed baths from 10/31/15 thru 12/19/15 except for the following days Resident #L was bathed from head to toe: 11/13/15 - Shower 11/21/15 - Shower 11/28/15 - Shower 12/12/15 - Shower 12/14/15 - Complete Bed Bath An interview was conducted with the Clinical Support #14 on 4/5/16 at 1:15 p.m. She indicated partial bed baths included: bathing of face, underarms and privates. She indicated bathing is individualized by the resident's preference. The Clinical Support #14</p> | | <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #L has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents will be interviewed and / or observed to ensure their bathing / shower needs are being met per their preference. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing staff on the following: 1). Guidelines for Bathing Preference How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents will be interviewed and / or observed to ensure their bathing / shower needs are being met per their preference.</p> | |

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| | <p>indicated the facility does not have a system in placed to acquire preferences for bathing. The Clinical Support #14 indicated she also could not locate the weekly scheduled shower days for Resident #L.</p> <p>A bathing policy was provided on 4/6/16 at 2:27 p.m. It indicated "Guidelines for Bathing Preference Purpose: To establish a personal preference bathing routine. Procedure: 1. The resident will be advised of (name of facility)'s guidelines for resident's to self determine their plan of care and schedule during the stay in the campus. 2. The resident shall determine their preference for bathing upon admission. a. Day of the week. b. Time of day - morning or evening. c. Type of bathing - tub bath or shower...Resident preferences should be reviewed at the Resident First Meetings to determine if they would like any modifications made to their preference list...6. Bathing shall occur at least twice a week unless resident preferences states otherwise."</p> <p>This Federal tag relates to complaint IN00192746.</p> <p>3.1-38(a)(3)(A)(B)(C)(D)(E)</p> | | <p>The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p> | |

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| F 0314 SS=D Bldg. 00 | <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>Based on observation, interview, and record review, the failed to record weekly measurements of a pressure ulcer, provide a pressure ulcer intervention of wearing boots, and follow up with a Registered Dietician nutritional supplement timely to promote wound healing for 2 of 3 residents reviewed for pressure ulcers (Resident #144, #R).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #R was reviewed on 4/1/16 at 11:45 a.m. The diagnoses for Resident #R included, but were not limited to, stage 2 pressure ulcer, diabetes mellitus, dementia, dysphagia, and muscle weakness.</p> | F 0314 | <p>F 314</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #144 has been discharged. Resident #R has updated weekly measurements of a pressure ulcer documented, pressure ulcer interventions are in place and the Registered Dietician nutritional recommendations have been followed up on.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Review of all residents who</p> | 05/07/2016 |

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| | <p>A Progress Note, dated 12/16/15, indicated, "1.0 x 1.0 x 0 [measurement of left ankle pressure ulcer], area covered in yellow slough...declines to elevate feet while in w/c [wheelchair], wears [name of manufacturer] boots, cont. [continue] current treatment...."</p> <p>A Progress Note, dated 1/12/16, indicated "3 cm length x 0.9 mc [sic] width x unstageable depth d/t [due to] yellow slough...."</p> <p>No other measurements from 12/17/16-1/11/16 for the left ankle pressure ulcer were located in the clinical record.</p> <p>A Registered Dietician (RD) Progress Note, dated 10/30/15, indicated "...100# [pounds] 10/15, 106 [pounds] 9/15. down 5.6% [percent weight loss-significant weight loss]...wound to ankle continues. rec: [recommend] medpass [nutritional supplement] 60 ml BID [milliliters twice a day], MVI [multivitamin] with minerals qday [daily]...."</p> <p>A RD Progress Note, dated 11/25/15, indicated, "...re-rec [re-recommend]: MVI with min [minerals] qdays [sic], medpass 60 ml BID for wt/wound support...."</p> | | <p>currently have a pressure ulcer to ensure the following: weekly measurements of a pressure ulcer are documented, pressure ulcer interventions are in place and any Registered Dietician nutritional recommendations have been followed up on.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and CNAs on the following campus guidelines: 1). Pressure/Stasis/Diabetic Wound Condition 2). Pressure Prevention 3). Nutritional Recommendations</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: residents who currently have a pressure ulcer to ensure the following: weekly measurements of a pressure ulcer are documented, pressure ulcer interventions are in place and any Registered Dietician nutritional recommendations have been followed up on.</p> | |

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| | <p>A RD Progress Note dated 12/16/2015, indicated, "...SIG WT [significant weight] CHANGE NOTED x 30 days. large decline with wt/rapid...re-rec [re-recommend]: medpass 60 ml BID, MVI with min...."</p> <p>A RD Progress Note, dated 12/31/2015, indicated, "...medpass 60ml BId [sic] in place; re-rec: MVI with min..."</p> <p>The Physician Order's on the Medication Administration Record indicated Med Pass was initiated on 12/24/15 and the multi-vitamin was initiated on 1/19/16.</p> <p>During an interview, on 4/6/16 at 9:17 a.m., with the Registered Dietician (RD), the RD indicated a significant weight change over 30 days was 5% or higher and she recommended the med-pass and the multi-vitamin for weight loss and wound healing.</p> <p>On 4/6/16, at 2:30 p.m., Clinical Support #14 indicated the facility was not able to determine why the RD recommendations of med-pass and a multi-vitamin were not initiated in a timely manner</p> <p>A Physician's Order, dated 9/25/15, indicated, "Encourage and reposition heels floated while in the bed." A</p> | | The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |

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| | <p>Physician's Order, dated 3/17/16, indicated, "[name of manufacturer] boots to bilateral feet while in bed."</p> <p>A Skin Integrity Care Plan, dated 9/25/15 and remained current at the time of review, indicated the interventions, "Ensure that my heels are floated while I am in bed and encourage me to wear [name of manufacturer] boots. I often refuse the boots; Encourage and reposition heels floated while in the bed...."</p> <p>The following observations were made: 4/1/16 at 2:55 p.m. with CRCA/CNA#6=Resident #R was observed in bed without boots on and feet were crossed. Resident #R's feet were not floated while in bed at this time. 4/1/16 at 3:26 p.m.=Resident #R was in bed without boots on or feet floated. 4/4/16 at 2:34 p.m. with CRCA/CNA#7=Resident #R was covered in bed without boots on and feet were crossed. Float device was on top of blankets near edge of bed and boots were observed in closet. 4/5/16 at 10:50 p.m.=Resident #R was observed at table near Nurse's station with tennis shoes on. 4/5/16 at 12:56 p.m.=Resident #R was observed at dining room table with tennis shoes on.</p> | | | |

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| | <p>4/5/16 at 1:50 p.m. with CRCA/CNA #8=Resident #R was observed in bed without boots on or feet floated. The boots were observed next to Resident #R's bed.</p> <p>During an interview with CRCA/CNA #7, on 4/4/16 at 2:37 p.m., CRCA/CNA #7 indicated she had maybe seen Resident #R's boots on one time during her shift (2nd shift) this past month.</p> <p>No documentation was located in the clinical record that indicated Resident #R refused to have her boots on or her heels floated while in bed for the above observations.</p> <p>During an interview with Clinical Support #14, on 4/4/16 at 12:12 p.m., Clinical Support #14 indicated the facility was unable to locate pressure ulcer measurements for Resident #R from 12/17/15-1/11/16.</p> <p>On 4/6/16 at 10:30 a.m., Clinical Support #14 indicated the facility recently bought Resident #R slippers to wear while up in her wheelchair instead of tennis shoes. Clinical Support #14 further indicated Resident #R should've had boots on while in bed.</p> <p>A policy titled, Pressure/Stasis/Diabetic</p> | | | |

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| | <p>Wound Condition Guidelines, no date, was received from Clinical Support on 3/31/16 at 3:48 p.m. The policy indicated, "...To provide weekly documentation of wound measurements and condition...2. Document description of wound using: a. length...b. width...c. depth...4. Re-assessment/measurements weekly or with significant change in wound...."</p> <p>2.) The clinical record for Resident #144 was reviewed on 4/1/16 at 9:00 a.m. The diagnosis for Resident #144 included, but was not limited to: Cellulitis.</p> <p>A care plan dated, 3/28/16, indicated "I was admitted with multiple stage I pressure ulcers: L medial (middle) 3rd and 4th toes, 2 areas on my right lateral (side) foot, right heel, right 5th toe, right 4th toe medical (sic) and lateral...Approach...Avoid friction and shearing forces during transfers or position changes...Treatment per Md order."</p> <p>A physician order dated, 3/24/16, indicated Resident #144 was to wear prevalon boots to bilateral feet at all times.</p> <p>An observation was made on 4/4/16 at 2:34 p.m. Resident #144 was sitting on the side of the bed bare footed and his prevalon boots were sitting on the chest. Resident #144 did not have his prevalon boots on as ordered.</p> | | | |

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| F 0323 SS=D Bldg. 00 | <p>An observation was made on 4/5/16 at 9:23 a.m. Resident #144 was sitting in his wheelchair beside the nurse's medication cart with the nurse. Resident #144 was wearing slippers and not his prevalon boots.</p> <p>An observation was made on 4/5/16 at 10:50 a.m. Resident #144 was sitting at a table at the nurse's station. Resident #144 was wearing slippers and not his prevalon boots.</p> <p>An observation was made on 4/5/16 at 11:18 a.m. Resident #144 was in activities wearing slippers on his feet and not the prevalon boots as ordered.</p> <p>An observation was made on 4/5/16 at 12:30 p.m. Resident #144 was in the dining room eating lunch. Resident #144 was observed wearing slippers and not prevalon boots as ordered.</p> <p>An observation was made on 4/5/16 at 1:48 p.m. Resident #144 was observed propelling down the hallway in his wheelchair with slippers on and not his prevalon boots.</p> <p>This Federal tag is related to Complaint #IN00195213. 3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> | | | |

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| | <p>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 interview and record review, the facility failed to ensure a resident's geri-sleeves were properly positioned, prior to transferring her, for 1 of 3 residents reviewed for accidents. (Resident #Z)</p> <p>Findings include:</p> <p>The clinical record for Resident #Z was reviewed on 4/6/16 at 2:00 p.m. The diagnoses for Resident #Z included, but were not limited to: muscle weakness, venous insufficiency, muscle wasting and atrophy.</p> <p>The 1/21/16 Skin Integrity Event indicated Resident #Z incurred a skin tear to the lateral aspect of her left upper arm, measuring 3 x 3 (did not indicate centimeters or inches). It indicated Resident #Z was "laying in bed" at the time the skin tear occurred.</p> <p>The 1/22/16, 10:02 a.m., IDT (Interdisciplinary Team) note, attached to the 1/21/16 Skin Integrity Event, indicated, "IDT reviewed--staff educated on proper transfer technique. Keep geri sleeves on at all times."</p> | F 0323 | <p>F 323</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #Z has been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will observe all residents who wear skin protective sleeves and require assistance to ensure safe transfer.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following guideline: Gait Belt Use How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure</p> | 05/07/2016 |

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| | <p>The 1/27/16 Skin Integrity Event indicated Resident #Z incurred a 3 cm skin tear to her right forearm. It indicated the activity at the time the skin tear occurred was "unknown."</p> <p>The Physician Order Report for Resident #Z indicated, "Geri sleeves on bil (bilateral) arms at all times" effective 1/22/16.</p> <p>The 1/28/16, 11:17 a.m., IDT note, attached to the 1/27/16 Skin Integrity Event, indicated, "IDT REVIEW-RE-EDUCATE STAFF ON IMPORTANCE OF STAFF CHECKING PLACEMENT OF GERI SLEEVES Q (every) SHIFT, USING GAIT BELT FOR ALL TRANSFERS." The IDT note was created by LPN #15.</p> <p>An interview was conducted with LPN #15 on 4/6/16 at 11:47 a.m. She indicated two aides were getting Resident #Z out of bed into her wheel chair to get her up for the morning. LPN #15 indicated Resident #Z liked to reach during transfers. She indicated Resident #Z was wearing her geri-sleeves during a transfer on 1/27/16, but they were "scrunched down", so when the aides got her out of bed the friction ripped her skin.</p> | | <p>compliance: Observe residents who wear skin protective sleeves and require assistance to ensure safe transfer.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| F 0325 SS=D Bldg. 00 | <p>This federal tag relates to Complaint #IN00192640.</p> <p>3.1-45(a)(2)</p> <p>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 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.</p> <p>Based on interview and record review, the facility failed to follow up with a Registered Dietician's recommendations and notify a Physician of a significant weight change for 1 of 3 residents reviewed for nutrition (Resident #R)</p> <p>Findings include:</p> <p>The clinical record for Resident #R was reviewed on 4/1/16 at 11:45 a.m. The diagnoses for Resident #R included, but were not limited to, stage 2 pressure</p> | F 0325 | <p>F 325 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #R - Registered Dietician's recommendations will be followed up on and MD notified of significant weight change. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with Registered</p> | 05/07/2016 |

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| | <p>ulcer, diabetes mellitus, dementia, dysphagia, and muscle weakness.</p> <p>The following were documented weights in the clinical record for Resident #R: 9/2015=106 10/9/15=100 11/5/15=101.6 11/20/15=93 12/10/15=88.4 1/15/16=85.6</p> <p>A Registered Dietician (RD) Progress Note, dated 10/30/15, indicated "...100# [pounds] 10/15, 106 [pounds] 9/15. down 5.6% [percent weight loss-significant weight loss]...rec: [recommend] medpass [nutritional supplement] 60 ml BID [milliliters twice a day], MVI [multivitamin] with minerals qday [daily]...."</p> <p>A RD Progress Note, dated 11/25/15, indicated, "...re-rec [re-recommend]: MVI with min [minerals] qdays [sic], medpass 60 ml BID...."</p> <p>A RD Progress Note dated 12/16/2015, indicated, "...SIG WT [significant weight] CHANGE NOTED x 30 days. large decline with wt/rapid...re-rec [re-recommend]: medpass 60 ml BID, MVI with min...."</p> | | <p>Dietician recommendations to ensure they have been followed up on and MD notified of any significant weight change.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1. Nutritional Recommendations 2. Weight Tracking</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Residents with Registered Dietician recommendations to ensure they have been followed up on 2). MD notified of any significant weight change. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation</p> | |

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| | <p>A RD Progress Note, dated 12/31/2015, indicated, "...medpass 60ml BId [sic] in place; re-rec: MVI with min..."</p> <p>The Physician Order's on the Medication Administration Record indicated Med Pass was initiated on 12/24/15 and the multi-vitamin was initiated on 1/19/16.</p> <p>During an interview with Clinical Support #14, on 4/1/16 at 3:30 p.m., Clinical Support #4 indicated the facility was not able to determine why the supplements were not ordered in a timely manner at this time, but she will continue to look into it.</p> <p>At 9:17 a.m., on 4/6/16, during an interview with the Registered Dietician (RD), the RD indicated a significant weight change over 30 days was 5% or higher and she recommended the med-pass and the multi-vitamin for weight loss and wound healing. The RD further indicated when she had a recommendation, she would fill out an individual recommendation sheet and would give it to the Director of Nursing and would give an entire summary of all residents reviewed for all management staff to review after her facility visit.</p> <p>On 4/6/16, at 2:30 p.m., Clinical Support #14 indicated the facility was not able to</p> | | | |

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| F 0328 SS=G Bldg. 00 | <p>determine if the Physician was notified of the significant weight change over 30 days from 9/15-10/15 as noted above. Clinical Support further indicated the facility was not able to determine why the RD recommendations of med-pass and a multi-vitamin were not initiated in a timely manner.</p> <p>A policy titled, Nutrition Recommendation Guideline, dated 2/16/13, was received from Clinical Support on 4/6/16 at 3:22 p.m. The policy indicated, "...4. Suggested discipline follows up on recommendation(s) in a timely manner...."</p> <p>3.1-46(a)(1)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;</p> | | | |

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| | <p>Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to ensure appropriate foot care was provided for a diabetic resident, resulting in an amputation of a toe and to ensure a resident who used oxygen had an order to do so, per facility policy, for 1 of 1 resident reviewed for foot care and 1 of 1 resident reviewed for respiratory care. (Resident #98 and #L)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #L was reviewed on 4/1/16 at 11:30 a.m. The diagnoses for Resident #L included, but were not limited to: diabetes mellitus with diabetic neuropathy, and peripheral vascular disease. Resident #L's BIMS (Brief Interview for Mental Status) score was 15 out of 15 which indicated the resident scored the highest possible for cognitive function. Resident #L's admission date was 10/28/15, and he was discharged on the evening of 12/19/15. The Minimum Data Set (MDS) assessment dated, 11/4/15, indicated Resident #L needed physical help in part of bathing activity times 1 staff member and extensive assist times 1 staff member for dressing. A physician order dated, 10/31/15,</p> | F 0328 | <p>F 328 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #98 and #L have been discharged from the campus. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review the following: 1). All residents to ensure an order is in place for weekly head to toe skin assessments and they are documented as complete 2). Observe the feet of all diabetic residents to ensure care is provided 3). Order in place for all residents who use oxygen Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guideline: 1). Weekly skin assessment 2). Administration of oxygen How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4</p> | 05/07/2016 |

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| | <p>indicated Resident #L was to be weighed daily.</p> <p>The physician orders and the Treatment Administration Records (TAR) did not include weekly skin assessments were to be done for Resident #L.</p> <p>An interview was conducted with the Clinical Support #14 on 4/4/16 at 12:11 p.m. She indicated there were no weekly skin assessments completed for Resident #L, and all residents in the facility should have a weekly head to toe skin assessment. The Clinical Support #14 indicated if a resident has had a fall in the facility a skin assessment is also completed.</p> <p>A progress note dated, 10/31/15, indicated Resident #L was found on the floor in his room with an abrasion to his right wrist.</p> <p>A progress note dated, 11/8/15, indicated Resident #L was found on the floor. There was no injuries noted.</p> <p>A progress note dated, 11/18/15, indicated Resident #L was found on the floor next to the bed. There was no injuries noted.</p> <p>A progress note dated, 12/8/15, indicated Resident #L was found sitting on the floor. There was no injuries noted.</p> <p>Resident #L's shower sheets were provided by the Clinical Support #14 on 4/5/16 at 1:00 p.m. It indicated Resident #L received partial bed baths from</p> | | <p>months to ensure compliance:</p> <p>1). Residents to ensure an order is in place for weekly head to toe skin assessments and they are documented as complete 2). Observe the feet of diabetic residents to ensure care is provided 3). Order in place for residents who use oxygen The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>10/31/15 thru 12/19/15 except for the following days Resident #L was bathed from head to toe: 11/13/15 - Shower 11/21/15 - Shower 11/28/15 - Shower 12/12/15 - Shower 12/14/15 - Complete Bed Bath</p> <p>An interview was conducted with the Clinical Support #14 on 4/5/16 at 1:15 p.m. She indicated partial bed baths included: bathing of the face, underarms and privates. She indicated bathing is individualized by the resident's preference. The Clinical Support #14 indicated the facility does not have a system in place to acquire preferences for bathing. The Clinical Support #14 indicated she also could not locate the weekly scheduled shower days for Resident #L.</p> <p>An interview was conducted with Resident #L's family member on 4/4/16 at 3:17 p.m. He indicated Resident #L was discharged from the facility on the evening of 12/19/15. Resident #L's family member indicated during discharge, he had assisted Resident #L with putting his shoes on and noticed a bad odor coming from Resident #L's foot that was covered with his sock. Resident #L's family member brought the odor to the attention of the staff and was ensured</p> | | | |

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| | <p>Resident #L was showered that day. The following morning, his mother removed the sock from Resident #L's foot and noticed his toenail was no longer attached to his toe. The toenail was found attached to the inside of the sock, and Resident #L's toe appeared to be black in color. Resident #L indicated to his wife at that time his toe had been bumped on the scales when he had been weighed a few weeks ago. The Certified Resident Care Assistant (CRCA) indicated at the time of the incident she would have notified the nurse and have his toe looked at. Resident #L's family member indicated nursing staff did not come to look at Resident #L's foot after the incident. Resident #L's family member indicated Resident #L had a hard time feeling his feet due to having diabetes. At the time of the incident Resident #L had indicated his toe had stung, but after the occurrence he did not experience any pain. Resident #L's family member indicated staffing changed frequently at the facility, and Resident #L could not determine who was the CRCA at the time of incident. Resident #L's family member indicated an appointment was made for Resident #L to be seen by a physician to look at his toe. Resident #L was seen on 12/22/15, and it was determined at that time the toe would need to be amputated. Resident #L's family member indicated Resident</p> | | | |

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| | <p>#L did not want to lose his entire toe, so a portion of the toe was removed on 12/23/15. Resident #L's toe could not be saved, and the remaining portion of the toe was amputated in January.</p> <p>An interview was conducted with Resident #L on 4/5/16 at 4:30 p.m. He indicated the staff at the facility had to weigh him every day. The CRCA wheeled him to the scales and did not shift the wheels on the wheelchair correctly and bumped his toe on the scales. The CRCA indicated she would notify the nurse, and the nurse would look at his toe. Resident #L indicated the nurse never came in to look at his toe. Resident #L indicated he went to the doctor after his toenail was found in his sock. The doctor indicated he had to have his toe amputated. Resident #L could not remember what day the incident occurred in the facility, or what staff member it was that was present at the time of the incident. He indicated he was a diabetic and his feet are numb. Resident #L indicated he does not usually feel pain on his feet. Resident #L indicated staff in the facility did not look at his injured toe nor was given any medication to treat his toe. The physician documentation was provided on 4/5/16 at 3:30 p.m. The podiatrist progress notes dated, 12/22/15, indicated "Integument lower extremities: Right distal (away from point of</p> | | | |

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| | <p>attachment) 2nd digit (toe) full thickness ulceration (1.5cm (centimeters) x 1.5 cm x 0.6 cm deep) which exposed bone of distal phalanx (toe bone) with overlying necrotic (dead) tissue and mild erythema (redness). Sausage toe appearance".</p> <p>"Assessment/Plan: Amputation right hallux and partial hallux amputation left hallux. Discussed the exposed bone 2nd digit right foot and the high likelihood of osteomyelitis due to visible necrosis of bone and the implications it has on healing and limb loss. I stressed the need to treat the problem aggressively. Recommended excision (removal) of the infected bone with culture and biopsy of the area..."</p> <p>The Surgery Center progress notes dated, 12/23/15, indicated "Preprocedure diagnosis: Osteomyelitis, second digit, right foot...Procedure performed: partial amputation, second digit, right foot..Indications: This patient..presented to my office yesterday with a distal second digit ulceration with exposed bone of distal phalanx. On x-ray there was no changed noted, however, the bone visualized was necrotic. I explained to the patient that he has osteomyelitis and needs a partial second digit amputation...</p> <p>The physician progress notes dated, 12/29/15, indicate "Subjective: (name of resident) Resident #L presents for first post-op exam...Objective: Examination</p> | | | |

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| | <p>of the surgery site reveals: Incision well coated with no gapping or drainage but with black ischemic (insufficient of blood supply) appearing edges. There is mild surrounding erythema. There is mild, localized edema. There is mild ecchymosis (bruising). Neurovascular status intact to all toes. Good position of the surgical site".</p> <p>The physician progress notes dated, 1/7/16, indicated "Subjective: (name of resident) Resident #L presents 2 week post-op exam...Objective: Examination of the surgery site reveals: Incision appears necrotic with malodor and fluctuance. I debrided skin and soft tissues down to necrotic appearing bone of proximal (near point of attachment) phalanx 2nd digit right foot. There is mild surrounding erythema. There is mild, localized edema. There is mild ecchymosis. Neurovascular status intact to all toes. Good position of the surgical site. Discussed the exposed bone through 2nd digit incision right foot and the high likelihood of osteomyelitis due to visible necrosis of bone and the implications it has on healing and the limb loss. I stressed the need to treat the problem aggressively. Recommended excision (removal) of the remaining 2nd digit. The Surgery Center dated, 1/13/16, indicated "Preprocedure diagnosis: Osteomyelitis, 2nd digit, right foot.</p> | | | |

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| | <p>Postprocedure diagnosis: Osteomyelitis, 2nd digit, right foot. Procedure performed: 2nd digit amputation, right foot...Indications: This patient is..who had a partial 2nd digit amputation approximately three weeks ago. The incision went on to necrose and dehisce and on his last visit the toe appeared necrotic. It was decided at that time to remove the rest of the digit.</p> <p>The Clinical Support #14 was interviewed on 4/6/16 at 1:00 p.m. She could not locate any documentation the incident regarding Resident #L's toe had occurred.</p> <p>A policy titled, "Weekly skin assessment guideline" was provided by the Clinical Support #14 on 3/31/16 at 3:48 p.m. It indicated "To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated. 1. A full body assessment shall be completed weekly by the licensed nurse. 2. Upon admission the admitting nurse shall include as part of the admission orders a weekly skin assessment. The order shall read: "Weekly skin assessment on (day of the week). 0 = no areas of skin impairment 1= new area of skin impairment 2= existing area of impairment (see wound sheet). 3. The date the assessment should</p> | | | |

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| | <p>be completed shall be assigned by the DHS or designee and indicated by the corresponding date on the treatment administration record (TAR). 4. The nurse completing the weekly skin check shall indicate the appropriate number (0,1,2) medication note. 5. Initiate applicable Wound Event if a new area of impairment is identified. (Pressure/Stasis/Arterial/Diabetic or Other). This may not include incidental bruises, hemosiderin staining, petechiae, and senile purpura. 6. In addition to the Weekly Assessment by the license nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified."</p> <p>2. The clinical record for Resident #98 was reviewed on 3/30/16 at 9:28 a.m. The diagnoses for Resident #98 included, but were not limited to: chronic respiratory failure, sleep apnea, and morbid obesity. She was admitted to the facility on 10/19/15.</p> <p>The 10/19/15 Discharge Continuity of Care forms from Resident #98's previous facility indicated she used 5 liters of oxygen per nasal cannula.</p> <p>The Vitals Report for Resident #98 indicated oxygen was in use on the following dates:</p> | | | |

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| | <p>10/20/15 10/22/15 10/28/15 10/29/15 10/30/15 10/31/15 11/1/15 11/3/15 11/4/15</p> <p>The 11/5/16, 1:06 p.m., nurses note indicated, "Resident began experiencing difficulty breathing at approx (approximately) 1130pm. Oxygen concentrator checked and was noted to have low air flow. Oxygen concentrator switched, resident continued to c/o (complain of) not getting any air. Nasal cannula checked and was functioning. Oxygen turned up to 5 liters per resident request. O2 (oxygen) sat (saturation) at this time 67%. Albuterol neb (nebulizer) treatment given and on call NP (nurse practitioner) called. After neb treatment complete, O2 sat 71-75%. Per NP, (name of nurse practitioner), resident to be sent to ER (emergency room). Writer told resident that she was going to ER, resident stated she would be fine and did not want to go out. O2 sat remained in low 70s with oxygen at 6 liters on portable oxygen tank via face mask. Resident agreed to be transported to ER</p> | | | |

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| | <p>at approx. 12am. (Name of ambulance company) called to transport. Writer in room waiting with resident. Mottling noted to bilateral upper and lower extremities. Oxygen remains in place at 6 liters via face mask. Writer exited room to open door for EMTs (emergency medical technicians) and returned, resident noted to be unresponsive, with no pulse and no respirations. Remained unresponsive after sternal rub preformed. CPR (cardio pulmonary resuscitation) started. ON call paged due to resident being own responsible party, order given to stop CPR. Time of death called at 1224am. Emergency contacts called."</p> <p>There was no information in the clinical record to indicate Resident #98 had an order for continuous or prn (as needed) oxygen.</p> <p>An interview was conducted with LPN #18 on 4/7/16 at 11:07 a.m. She indicated it didn't look like Resident #98 had an order for her oxygen use.</p> <p>An interview was conducted with Clinical Support #14 on 4/7/16 at 12:38 p.m. She indicated Resident #98 did not have orders for oxygen, but acknowledged Resident #98's use of oxygen while in the facility. Clinical Support #14 indicated, typically, there</p> | | | |

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| | <p>would be an order to keep saturations above 90%, perhaps a titration order, but an order of some sort. She indicated the facility could do a 24 hour order for oxygen in the case of emergencies, but afterwards, would need an order.</p> <p>Clinical Support #14 indicated her transfer paperwork from her previous facility indicated Resident #98 was on 5 liters of oxygen per nasal cannula, but the information was never transferred to their orders, nor was it clarified. Clinical Support #14 indicated if Resident #98's saturations were low, staff "probably bumped it up" until it was above 90.</p> <p>The Guidelines for Administration of Oxygen policy was provided by the Clinical Support #14 on 4/7/16 at 2:50 p.m. It indicated the purpose of the policy was, "To provide guidelines for safe oxygen administration when insufficient oxygen is being carried by the blood to the tissues." The policy indicated, "Verify physician's order for the procedure."</p> <p>This Federal tag relates to complaint IN00192746.</p> <p>3.1-47 (a)(6) 3.1-47(a)(7)</p> | | | |

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| F 0329 SS=E Bldg. 00 | <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to monitor potential side effects for use of antidepressant and antipsychotic medications, to ensure a resident that was not ordered stimulant medication did not receive stimulant medication, to ensure supporting physician documentation for the continued use of an anti-psychotic medication was located in the clinical record, and to ensure an increase of an</p> | F 0329 | <p>F 329</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #33 and #1 - monitoring for potential side effects of ordered psychoactive medications is in place. Resident #R - no further medication errors made. Resident #62 - supporting physician documentation is in place for continued use of</p> | 05/07/2016 |

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| | <p>anti-psychotic medication was not initiated after the resident was re-directable after behaviors for 4 of 5 residents reviewed for unnecessary medications. (Resident #R, #1, #33, and #62)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #62 was reviewed on 4/4/16 at 11:30 a.m. The diagnoses for Resident #62 included, but were not limited to, persistent mental disorder, depression, debility, hypertension, and anemia. Resident #62's admit date was 1/15/15.</p> <p>A Physician's Order, dated 3/7/16, indicated an order for risperdal (anti-psychotic medication) 0.5 mg (milligrams) daily.</p> <p>A Social Services Progress Note, dated 1/22/15, indicated, "...Admit Note: Resident was admitted 1/15/15 from home [symbol for with] primary diagnosis of dementia among others...Resident is on citalopram [anti-depressant medication-Celexa] 20 mg for depression and risperdone 0.5 mg for psychotic disorder...."</p> <p>A Physician's Note, dated 2/13/15, indicated, "Patient [symbol for without]</p> | | <p>psychoactive medication and no increase in psychoactive medication has been made after a behavior that the resident was re-directed from.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review residents with behaviors and / or psychoactive medications and ensure the following: 1). Monitoring for potential side effects of ordered psychoactive medications is in place. 2). No medication errors have been made 3). Supporting physician documentation is in place for continued use of psychoactive medication 4). No increase in psychoactive medication has been made after a behavior that the resident was re-directed from.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following: 1). Medication monitoring and management guideline 2). Medication preparation and general guideline</p> | |

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| | <p>complaints...2. Depression-Celexa, risperdal...."</p> <p>A Physician's Note, dated 3/13/15, indicated, "Patient doing well...2. Depression-Celexa, risperdal...."</p> <p>A Nurse Practitioner Note, dated 5/18/15, indicated, "Patient [symbol for without] complaints...3. Depression-Celexa, risperdal..."</p> <p>A Note to Attending Physician/Prescriber, printed 7/7/15, indicated, "Resident as [sic] the following psychotropic medications which are due for dosage reduction evaluations...risperdone 0.5 mg for psychotic disorder...if reduction is not appropriate, please document risk v [versus] benefit..." Prescriber response indicated no changes, with no further documentation.</p> <p>A Physician Note, dated 7/17/15, indicated, "Patient doing well today. She has no complaints...1. depression-cont. [continue] Celexa and risperdal...."</p> <p>A Nurse Practitioner Note, dated 10/6/15, indicated, "...Impression...dementia...cont. with current meds and treatments...Psych:Mood and affect</p> | | <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Monitoring for potential side effects of ordered psychoactive medications is in place. 2). No medication errors have been made 3). Supporting physician documentation is in place for continued use of psychoactive medication 4). No increase in psychoactive medication has been made after a behavior that the resident was re-directed from.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>normal...."</p> <p>A Note to Attending Physician/Prescriber, signed by prescriber 1/8/16, indicated, "...Resident has the following orders which are due for dosage reduction evaluations...risperdal 0.5 mg (milligrams) since a psych diagnosis is not listed for this resident please consider trial reduction of risperdal to 0.25 mg qhs (at bedtime) with goal to taper and discontinue...."</p> <p>The Physician/Prescriber Response was marked agreed.</p> <p>A Nurse Practitioner Note, dated 1/19/16, indicated, "...Psychiatric: No change in cognition...Psychiatric: awake, alert to self...continue with current meds and treatments...."</p> <p>A Progress Note, dated 2/15/16, indicated, "Pharmacist recommendation accepted for dose reduction of risperdal 0.5 mg qhs [at bedtime] and dose changed to risperdal 0.25 mg qhs..."</p> <p>A Progress Note, dated 2/17/16, indicated, "No adverse reactions observed from Resperidol [sic] reduction. Resdident [sic] continues to follow typical routine and socializes with staff and peers. No behaviors or distressed [sic] reported. This writer will continue</p> | | | |

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| | <p>to observe for changes and provide support as needed." The note was signed by the Social Services Director.</p> <p>A Physician Note, dated 2/28/16, indicated, "PMH [patient medical history] dementia, depression, deconditioning, osteoporosis, hearing impairment...continue antidepressants. Mood is stable...."</p> <p>No other documentation by a Physician/Nurse Practitioner related to the use of risperdal was located in the clinical record.</p> <p>A Progress Note, dated 2/29/2016 at 12:00 p.m., indicated, "This writer found resident in another residents bed. This writer informed resident that she was in the wrong room and that I would help her back to her own room. This resident yelled that I was wrong and she was going to stay "in her room and watch TV" I pulled back the covers of the bed and she said I was rude and to leave her room. After several minutes of redirecting, resident got out of bed and sat in her W/C [wheelchair]. This writer then assisted [sic] resident to appropriate room. Will continue to monitor for increased agitation."</p> <p>A Progress Note, dated 2/29/2016 at</p> | | | |

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| | <p>11:16 p.m., indicated "Resident with increased agitation this shift, impulsive with staff, when staff would do something she asked [sic] she would get upset and yell."</p> <p>A Progress Note, dated 3/08/2016 at 6:08 p.m., indicated, "Resident had outburst this shift, resident came from dining room [sic] she ate dinner. She was sitting at nurses station yelling at nurse "are you going to take me to the dining room?" The nurse explained that she had already ate dinner. The resident kept yelling at the nurse. This writer tried to redirect resident when she started to yell and tried to hit this writer. Nurse attempted to explain that she cannot hit at people. Crca's [CNAs-certified nursing assistant] took resident to be bed at this time per her request."</p> <p>No other behaviors were located in the clinical record.</p> <p>During an interview with Clinical Support #14 on 4/4/16 at 12:04 p.m., Clinical Support #14 indicated the facility charted behaviors by exception and the behaviors would be documented in the clinical record.</p> <p>On 4/6/16 at 9:17 a.m., Clinical Support #14 indicated Resident #62 had not been</p> | | | |

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| | <p>seen by an outside psychiatric service and her Primary Physician/Nurse Practitioner were managing her risperdal.</p> <p>At 9:44 a.m., on 4/6/16, Clinical Support #14 indicated when a resident was admitted on an anti-psychotic medication, the facility's interdisciplinary team should review the rationale for the medication. Clinical Support #14 further indicated if there was no supporting documentation with the admitting paperwork, the facility should determine where the original order came from and determine if the diagnosis/reason for the continued use was appropriate. If there was no supporting documentation/diagnosis for the medication, the facility should have the Physician initiate a reduction.</p> <p>During an interview with Clinical Support #14, on 4/6/16 at 11:42 p.m., Clinical Support #14 indicated the facility was not able to determine if Resident #62 had any behaviors prior to 2/29/16 and was redirectable in the behaviors listed above in the progress notes. Clinical Support #14 further indicated the facility was not able to locate any further Physician documentation related to the use of risperdal.</p> | | | |

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| | <p>On 4/6/16 at 2:34 p.m., Clinical Support #14 indicated the above behaviors listed in the progress notes were not an acceptable reason to restart Resident #62 on a higher dose of the risperdal due to her ability to be redirected.</p> <p>During an interview with Resident #62's Nurse Practitioner #5 (NP), on 4/7/16 at 1:32 p.m., NP #5 indicated Resident #62 was on risperdal for dementia with behaviors and she thought Resident #62 saw an outside psychiatric service for the continued use of risperdal. She further indicated she relies heavily on facility staff to provide her with relevant information about Resident #62, since the staff were around her daily. NP #5 indicated she was told by the charge nurse that Resident #62 was not doing well behaviorally after the reduction of the risperdal and she did not know that Resident #62 was redirectable after the behaviors listed above. NP #5 also indicated she was not aware that Resident #62 had no prior behaviors to 2/29/16. NP #5 also indicated she was not part of the behavior meetings and does not receive the information from the behavior meetings. NP #5 additionally indicated Resident #62 should be evaluated to determine if risperdal should be continued.</p> | | | |

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| | <p>A policy titled, Medication Monitoring and Management was received from Clinical Support, on 4/5/16 at 12:31 p.m. The policy indicated, ".8) The medication regimen is re-evaluated periodically to determine whether prolonged or indefinite use of a medication is indicated. a. Prescribers, facility staff, and consultants document progress towards, maintenance of, or regression from therapeutic goals...If the prescriber deems the medication necessary, a documented clinical rationale for the benefit of, or necessity for, the medication is documented in the resident's active record...."</p> <p>2. The clinical record for Resident #R was reviewed on 4/1/16 at 11:45 a.m. The diagnoses for Resident #R included, but were not limited to, stage 2 pressure ulcer, diabetes mellitus, dementia, dysphagia, and muscle weakness.</p> <p>The Current Physician's Orders indicated an order for tramadol (pain reliever) 50 mg (milligrams) every 8 hours.</p> <p>A document titled, Safety Events-[name of corporation] Medication Error Circumstance, was recorded 2/21/16 at 6:58 a.m.. The document indicated Resident #R had an order for Tramadol (narcotic pain reliever) 50 mg. The</p> | | | |

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| | <p>document further indicated,"...Describe the Error[:] was given modafinil (stimulant to treat sleep disorder/narcolepsy) 100 mg... Type of Error[:] Incorrect Medication... Interventions...monitor for adverse reaction... Notification...Attending faxed: No Physician Notified: No...Family Notified: No Care Plan Reviewed: No... Note: dated 2/23/16-Presently sleeping in bed with call light in reach. Denied pain or discomfort when asked. Alert and talkative to this writer when vitals signs were assessed. No adverse reaction or change in condition noted this shift... Evaluation Notes: IDT closed."</p> <p>There was no further information including Physician/Family notification of the medication error described above located in the clinical record.</p> <p>Resident #R did not have a Physician's Order for modafinil 100 mg.</p> <p>During an interview with Clinical Support #14, on 4/4/16 at 4:25 p.m., she indicated she was not aware of the medication error. The facility would've started an investigation into why the wrong medication was administered and taken appropriate steps to inservice staff as needed. Clinical Support #14 further</p> | | | |

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| | <p>indicated the Physician and Family was not notified of the medication error and the document was laid out to assist in providing the notification.</p> <p>A policy titled Preparation and General Guidelines, dated 2/1/10, was received from Clinical Support #14 on 4/4/16 at 12:11 p.m. The policy indicated, "...Preparation...3.) Prior to administration the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and MAR are different...the physician's orders are checked for the correct dosage schedule...Administration...2.) Medications are administered in accordance with written orders of the attending physician.</p> <p>3. The clinical record for Resident #33 was reviewed on 4/4/16 at 11:00 a.m. The diagnoses for Resident #33 included, but were not limited to, malignant neoplasm of colon, malaise, depression, anxiety, and diabetes mellitus.</p> <p>A Physician's Order, dated 10/12/15, indicated an order for lorazepam (psychotropic/anti-anxiety medication) 0.5 mg (milligrams) at bedtime daily.</p> | | | |

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| | <p>An Anxiety Careplan did not indicate to monitor for potential side effects from the anti-anxiety medication.</p> <p>There was no indication Resident #33 was being monitored for side effects from the anti-anxiety medication in the clinical record.</p> <p>During an interview with Clinical Support #14, on 4/6/16 at 9:19 a.m., Clinical Support #14 indicated there was no indication that Resident #33 was being monitored for possible side effects related to the anti-anxiety medication in the clinical record.</p> <p>On 4/6/16 at 12:20 p.m., during an interview with LPN #9 (Resident #33's nurse that day), LPN #9 indicated if a resident was having potential side effects from an anti-anxiety medication, the resident would display depression or outbursts.</p> <p>The Nursing 2014 Drug Handbook, Lippincott Williams & Wilkins, copyright 2014, indicated lorazepam adverse reactions included but were not limited to, "drowsiness, sedation, amnesia, insomnia...."</p> <p>A policy titled, Medication Monitoring and Management, dated 2/1/10, was</p> | | | |

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| | <p>received from Clinical Support #14 on 4/5/16 at 12:31 p.m. The policy indicated, "In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use...A. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an on-going basis...."</p> <p>4. The clinical record for Resident #1 was reviewed on 3/29/16 at 11:39 a.m. The diagnoses for Resident #1 included, but were not limited to, major depressive disorder.</p> <p>The Physician's Orders for Resident #1 indicated she duloxetine (antidepressant medication) daily effective 9/16/15 and quetiapine (antipsychotic medication) daily effective 9/16/15.</p> <p>There was no verification in the clinical record to indicate the facility was monitoring for side effects of Resident #1's antidepressant and antipsychotic medication use.</p> <p>An interview was conducted with Clinical Support #14 on 4/5/16 at 9:43</p> | | | |

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| | <p>a.m. She indicated the facility should have an order to monitor side effects of Resident #1's antidepressant and antipsychotic medication use. She indicated the facility's system to monitor side effects was to add an order for monitoring every shift for each resident who was taking an antidepressant or antipsychotic. CS #14 indicated that was not done for Resident #1 for either of her medications.</p> <p>An interview was conducted with LPN #15 and LPN #2 on 4/5/16 at 11:02 a.m. LPN #15 indicated she was monitoring for side effects/adverse reactions of Resident #1's antidepressant use by looking for a change in condition, agitation, tearfulness, withdrawal, and any behavior episodes. LPN #15 indicated she was monitoring for side effects of Resident #1's antipsychotic use by looking for behaviors like refusing treatment, becoming combative, and talking about dying. LPN #15 indicated there was typically an order associated with use of antipsychotic and antidepressant medications. After looking in Resident #1's clinical record, LPN #15 indicated Resident #1 had no such order for either medication. LPN #2 indicated she was monitoring for side effects of Resident #1's antidepressant use by looking for altered mental status</p> | | | |

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| | <p>and mood swings. LPN #2 indicated the only side effects she knew to be associated with antipsychotic use were hallucinations and mood swings.</p> <p>The Nursing 2014 Drug Handbook, Lippincott Williams & Wilkins, copyright 2014, indicated adverse reactions to duloxetine were dizziness, headache, fatigue, insomnia, somnolence, suicidal thoughts, fever, hyposthesida, irritability, lethargy, nervousness, nightmares, restlessness, sleep disorder anxiety, asthenia, tremor, hot flashes, hypertension, increased heart rate, blurred vision, nasopharyngitis, pharyngolaryngeal pain, constipation diarrhea, dry mouth, nausea, dyspepsia, gastritis, vomiting, abnormally increased frequency of urinating, dysuria, urinary hesitation, decreased appetite, hypoglycemia, increased appetite, weight gain or loss, hyponatremia, muscle cramps, myalgia, cough increased sweating, night sweats, pruritus, rash, and rigors. It indicated adverse reactions to quetiapine were dizziness, headache, somnolence, neuroleptic malignant syndrome, seizures, hypertonia, dysarthria, asthenia, agitation orthostatic hypotension, tachycardia, palpitations, peripheral edema, ear pain, pharyngitis, rhinitis, dry mouth, dysepsia, abdominal pain, constipation, anorexia, vomiting,</p> | | | |

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| F 0371 SS=F Bldg. 00 | <p>leukopenia, weight gain, hyperglycemia, back pain, increased cough, dyspnea, rash, diaphoresis, and flulike syndrome.</p> <p>3.1-48(a)(6)</p> <p>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 interview, the facility failed to use proper unthawing methods with frozen poultry and dating refrigeration prepared food items. This had a potential to effect 53 out of 55 residents that consume food out of this kitchen.</p> <p>Findings Include:</p> <p>An observation was made of the kitchen with the Dietary Food Supervisor (DFS) on 3/28/16 at 12:12 p.m. During the tour, an observation of a walk in refrigerator was made. A server cart that included racks of trays was observed in the refrigerator. The following prepared food</p> | F 0371 | <p>F 371</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Audit / observation of kitchen to ensure frozen foods are not defrosted at room temperature. 2). Audit / observation of refrigerated storage to ensure food is covered and dated</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be</p> | 05/07/2016 |

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| | <p>items were on the stacked racks on the server cart were not dated: pineapple chunks in bowls, a full sheet of blueberry cheesecake, oranges in bowls, slices of carrot cake on plates, sliced peanut butter pudding bars in bowls, slices of boston cream pie on plates and slices of strawberry short cake with strawberries on top were on plates. The strawberries looked dry and shriveled, and the cake appeared to be dry in appearance. The DNS indicated at that time, the oranges were from breakfast and the strawberry short cake was served last Friday. DNS indicated she was throwing out the strawberry desert, because it did not look edible. An observation was made of a second refrigerator in the kitchen. This included two closed containers of prepared food items. There were no dates on either of these containers. The DNS opened the containers and indicated the one container was coleslaw and the other was chicken salad. At that time, the DNS indicated the staff should have dated the containers and pulled both containers out of the refrigerator to discard food items.</p> <p>During the kitchen tour, an observation was made of pieces of white meat sitting in the bottom of a sink of water. The DNS indicated the white meat was chicken and was unthawing for dinner that night. She at that time took the</p> | | <p>affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: 1). Food Production - Sanitation and Safety 2). Storage Procedures How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Audit / observation of kitchen to ensure frozen foods are not defrosted at room temperature. 2). Audit / observation of refrigerated storage to ensure food is covered and dated</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>temperature of the water in the sink. The temperature of the water was 48.6 degrees Fahrenheit. She than picked up a piece of chicken and brought it to the surface of the water. DNS indicated the meat was still frozen and placed it back in the water.</p> <p>An observation was made of the kitchen with the DNS on 3/28/16 at 1:15 p.m. A sink was observed with pieces of chicken sitting on the bottom and submerged in water. The surface of the water had white bubbly film patches floating on top of the water. There were no observation made of water continuously running or water agitation. Dietary staff member indicated he had changed the water twice since he came in. Dietary staff member indicated he had arrived at 11:00 a.m. and placed the chicken in the water around 11:30 a.m. - 12:00 p.m. At that time, water had been changed out twice. DNS indicated she had always used this method to "quick unthaw".</p> <p>An interview was conducted with the Clinical Support #14 on 3/28/16 at 3:07 p.m. She indicated the chicken should be under running water to unthaw. She indicated the chicken would be discarded and not served for dinner.</p> <p>A policy titled, "Food Production</p> | | | |

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| | <p>"Guidelines-Sanitation and Safety" was provided by the Clinical Support #14 on 3/28/16 at 3:05 p.m. It indicated, "Guideline: Safe and sanitary handling of food will be employed during food production. Procedure:...10. Frozen foods are defrosted in the refrigerator - not at room temperature. In an emergency, they may be thawed under cool running water."</p> <p>A policy titled, "Storage Procedures" was provided by the Clinical Support #14 on 3/38/16 at 3:06 p.m. It indicated, "Guideline: Food and supplies stored to keep foods safe and preserve flavor, nutritive value, and appearance. Procedure:...Refrigerated Storage..5. Food is covered, dated and stored loosely to permit air circulation..7. Prepared perishables such as salads, puddings, milk, etc., are stored in a refrigerator and covered, labeled, and dated until used...9. Food items are arranged so that older items will be used first.</p> <p>This Federal tag relates to complaint IN00193489.</p> <p>3.1-21(i)(1)(3)</p> | | | |

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| F 0425 SS=D Bldg. 00 | <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to dispose of expired insulin prior to administration for 1 of 4 residents that received insulin from the medication cart (Resident #27).</p> <p>Findings include:</p> <p>During an observation with LPN #13, on 4/7/16 at 10:50 a.m., a Humalog (insulin) flexpen and a Lantus (insulin) flexpen were both observed with open dates of 3/7/16. The flexpens were for Resident</p> | F 0425 | <p>F 425</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #27 Humalog and Lantus Flexpens were destroyed.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All medication carts will be audited to ensure there is no expired insulin</p> | 05/07/2016 |

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| | <p>#27.</p> <p>During an interview with LPN #13, on 4/7/16 at 10:51 a.m., LPN #13 indicated she initially thought insulin flexpens were not expired until after 30 days. LPN #13 indicated there were no other Humalog or Lantus flexpens in the medication cart for Resident #27 and she will retrieve new flexpens out of the facility medication storage.</p> <p>Physician's Orders, dated 2/16/16, indicated a sliding scale for Humalog before meals and 8 units of Lantus to be administered at bedtime for Resident #27.</p> <p>The April MAR (medication administration record) indicated Resident #27 received 2 units of Humalog on 4/6/16 between 10:00 a.m. to 12:30 p.m. and 8 units of Lantus on 4/6/16 at bedtime.</p> <p>A policy titled, Expiration Dates, dated 2/2016, was received from Clinical Support on 4/7/16 at 12:33 p.m. The policy indicated, Humalog and Lantus Flexpens expire after 28 days after opening.</p> <p>3.1-25(o)</p> | | <p>in use.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Expiration days for insulin vials and pens How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of each medication cart will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Audit to ensure there is no expired insulin in use.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | | |

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| F 0428 SS=D Bldg. 00 | <p>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.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, interview, and record review, the facility failed to act and act timely on pharmacy recommendations for 3 of 5 residents reviewed for unnecessary medications. (Resident #1, #33, and #62)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1 was reviewed on 3/29/16 at 11:39 a.m. The diagnoses for Resident #1 included, but were not limited to, major depressive disorder.</p> <p>The 2/5/16 pharmacy Note to Attending Physician/Prescriber indicated, "Resident is on the following psychotropic medications which are due for dosage reduction evaluations: Duloxetine 120 mg QD (everyday) for depressive disorder, Seroquel 25 mg QHS (every night) for depressive disorder....If</p> | F 0428 | <p>F 428</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The current pharmacy recommendations for residents #1, #33 and #62 have been followed up on.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: The current pharmacy review recommendations for April 2016 will be reviewed and followed upon timely.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: 1). Clinical Support Nurse will</p> | 05/07/2016 |

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| | <p>Seroquel is being used for symptoms other than depression, please document. Also if resident should continue on current doses, please document risk v. (versus) benefit." The response from the nurse practitioner was signed on 2/15/16 and indicated to continue the medications at the same doses.</p> <p>There was no information in the clinical record to indicate the recommendation to document risk v. benefit was acted upon.</p> <p>An interview was conducted with the SSD (Social Services Director) on 4/5/16 at 10:37 a.m. She indicated she did not see any documentation regarding symptoms other than depression or any documentation of risk versus benefit for continuing Cymbalta and Seroquel at current doses.</p> <p>The Consultant Pharmacist Reports policy was provided by the SSD on 4/5/16 at 11:30 a.m. It indicated, "Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her within a reasonable time frame the Director of Nursing and/or the consultant pharmacist may contact the Medical Director."</p> <p>2. The clinical record for Resident #62</p> | | <p>educate the DHS (Director of Health Services) and ADHS (Assistant Director of Health Services) on the following campus guideline: 1). Consultant Pharmacist Report 2). Medication Monitoring and Management</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: 1). The following audits will be conducted by the Clinical Support Nurse 1 time per month times 6 months to ensure compliance: review of the monthly pharmacy review reports to ensure it has been reviewed by DHS or designee and action items have been followed up on timely.</p> | |

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| | <p>was reviewed on 4/4/16 at 11:30 a.m. The diagnoses for Resident #62 included, but were not limited to, persistent mental disorder, depression, debility, hypertension, and anemia.</p> <p>A Note to Attending Physician/Prescriber, signed by prescriber 1/8/16, indicated, "...Resident has the following orders which are due for dosage reduction evaluations...risperdal 0.5 mg (milligrams) since a psych diagnosis is not listed for this resident please consider trial reduction of risperdal to 0.25 mg qhs (at bedtime) with goal to taper and discontinue...." The Physician/Prescriber Response was marked agreed.</p> <p>A Progress Note, dated 2/15/16, indicated, "Pharmacist recommendation accepted for dose reduction of risperdal 0.5 mg qhs and dose changed to risperdal 0.25 mg qhs..."</p> <p>There was no indication in the clinical record to indicate why there was a delay in initiating the reduction of the risperdal for Resident #62.</p> <p>During an interview with Clinical Support #14, on 4/4/16 at 4:03 p.m., Clinical Support #14 indicated the reduction was overlooked and was not</p> | | | |

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| | <p>started in a timely manner.</p> <p>A policy titled, Medication Monitoring and Management, dated 2/1/10, was received from Clinical Support #14 on 4/5/16 at 12:31 p.m. The policy indicated, "In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use...A. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an on-going basis...."</p> <p>3. The clinical record for Resident #33 was reviewed on 4/4/16 at 11:00 a.m. The diagnoses for Resident #33 included, but were not limited to, malignant neoplasm of colon, malaise, depression, anxiety, and diabetes mellitus.</p> <p>A Physician's Order, dated 10/12/15, indicated an order for lorazepam 0.5 mg at bedtime.</p> <p>A Pharmacy Recommendation, signed by the Prescriber on 2/10/16, indicated, "...This resident is currently receiving the following psychotropic medication which</p> | | | |

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| | <p>are due to dosage reductions evaluations:...lorazepam 0.5 milligrams. Please evaluate s/sx [signs/symptoms] of depression and anxiety and determine if trial reduction of one of the orders may be appropriate at this time. If resident is to continue current order, please document risk v. [versus] benefit...."</p> <p>Nurse Practitioner Notes, dated 2/10/16 and 2/17/16 or Physician Progress Note, dated 2/18/16, did not include any risk v. benefit documentation for the continued use of the lorazepam.</p> <p>There was no other risks versus benefit documentation located in the resident's clinical record.</p> <p>During an interview with Clinical Support #14, on 4/6/16 at 3:24 p.m., Clinical Support #14 indicated the facility was unable to locate any documentation related to the risks versus benefit for the continued use of lorazepam.</p> <p>A policy titled, Medication Monitoring and Management, dated 2/1/10, was received from Clinical Support #14 on 4/5/16 at 12:31 p.m. The policy indicated, "...If the prescriber deems the medication necessary, a documented clinical rationale for the benefit of or</p> | | | |

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| F 0441 SS=D Bldg. 00 | <p>necessity for, the medication is documented in the resident's active record...."</p> <p>3.1-25(b)(2) 3.1-25(i) 3.1-25(j)</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with</p> | | | |

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| | <p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure a glucometer (a machine that test blood sugars) was disinfected as recommended by the manufacturer's instructions for 1 of 2 random medication administration observations. This had the potential to affect 2 residents that received blood sugar checks on 1 of 2 medications carts on the Tinsley Hall. The facility also failed to use hand hygiene during a random observation for a wound dressing change with a resident in contact isolation for 1 of 3 residents reviewed for pressure ulcers. (Resident #B, Resident #137, and Resident #143)</p> <p>Findings include:</p> <p>1.) A random observation was made with the cleaning of a glucometer with License practical nurse (LPN) #1 on 3/31/16 at 12:38 p.m. After the completion of a</p> | F 0441 | <p>F 441</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B, #137, #143 all have been discharged from the campus.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). DHS or designee will clean all glucometers with Germicidal Wipe per manufacture instructions. 2). Observe dressing change for all resident reviewed for pressure ulcers to ensure appropriate hand hygiene and handling of linens is demonstrated.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient</p> | 05/07/2016 |

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| | <p>blood sugar check LPN #1 returned to her medication cart and pulled out the cleaning product to use to clean the glucometer. The cleaning product titled, "Sani-Cloth Bleach" indicated the disinfected time was 4 minutes. LPN #1 wiped the front and then the back of the glucometer with the sani-cloth. She then placed the glucometer on a paper towel. The glucometer remained wet for 2 minutes and then was placed by LPN #1 in a drawer inside of the medication cart. At that time, LPN #1 indicated she wipes the front and back of the glucometer and then places it on a paper towel to dry. LPN #1 indicated after the glucometer is dry she places it in the drawer. She indicated she was unaware the glucometer has to remain wet for 4 minutes. LPN #1 indicated she only had 2 blood sugars that are checked with the glucometer, and the other resident is not in the building at that time.</p> <p>An interview was conducted with the Clinical Support #14 on 3/31/16 at 2:15 p.m. She indicated Sani-Cloth Germicidal disposable wipes are the wipes that are used to clean the glucometers. She indicated the wrong wipes were used by LPN #1 to clean the glucometer.</p> <p>A policy titled, "Glucometer Cleaning</p> | | <p>practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following: 1). Glucometer Cleaning Guideline 2). Germicidal Wipe package instructions 3). General Guideline for Dressing Changes 4). Guidelines for Handling Linen</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following observations for 5 residents, random shifts will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Observe accu check to ensure glucometer machine is disinfected appropriately with a Germicidal Wipe per package instructions. 2).). Observe dressing change for pressure ulcers to ensure appropriate hand hygiene and handling of linens is demonstrated.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>Guidelines" were provided by the Clinical Support #14 on 4/1/16 at 3:30 p.m. It indicated, "...Recommendations:...3. After cleaning visible blood or bloody fluids or if no visible organic material is present, disinfect after each use the exterior surfaces following the manufacture's directions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal or HBD/HIB label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration.</p> <p>2.) A random observation was made of a wound dressing change with LPN #2 and LPN #1 on 4/4/16 at 11:00 a.m. Resident #B was in contact isolation for Clostridium difficile (an infection that affects the colon). LPN #1 and #2 were observed wearing gowns and gloves during wound dressing change. LPN #2 indicated she had completed all the other wounds expect dressing changes to Resident #B's right and center buttocks and his back. LPN #2 was in the process of using wet gauze and packed the right buttocks wound using her gloved hands. The wound on Resident #B was the size of a base ball. The skin surrounding the outside perimeter of the wound was red. LPN #2 used skin prep and wiped around the wound bed of the right buttocks. She</p> | | | |

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| | <p>than placed an abdominal pad over the wound and tape was used to hold the dressing. At that time, LPN #2 and LPN #1 turned Resident #B. LPN #2 touched with her gloved hands Resident #B's bedside table and the bed. LPN #2 did remove and donned new set of gloves nor washed her hands.</p> <p>LPN #2 then removed the old dressing from Resident #B's back. LPN #2 was not observed removing her gloves nor washing her hands. She then cleaned Resident #B's wound on his back with a wound cleaner and patted using a dry towel. LPN #2 after drying the wound on his back went directly to a supply cabinet in the room and removed wound supplies for Resident #B's back. LPN #2 did not remove gloves or wash her hands prior or after she touched the handle on the cabinet. LPN #2 used scissors to cut the wound dressing and immediately packed the inside of the wound bed using her gloved hands. Resident #B's wound on his back was the size of a base ball. LPN #2 then placed a dry dressing on top of the wound and taped the dressing. LPN #2 was not observed removing gloves nor washing her hands. LPN #2 immediately moved the bedside table and the bed using gloved hands.</p> <p>LPN #2 was observed removing dressing</p> | | | |

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| | <p>on middle of Resident #B's buttocks. She than cleaned the wound. It was also the size of a base ball. After she cleaned the wound, LPN #2 packed with wet gauze in the open wound using her gloved hands. She than cleaned the area around the wound using skin prep. An abdominal pad was applied over the wound and tape was used to hold the dressing. There was no observation of LPN #2 removing her gloves or washing her hands. After the completion of the dressing on the wound, Resident #B had a bowel movement with loose stool. LPN #2 using her gloved hands wiped Resident #B's buttocks with a cleaning wipes. LPN #2 after wiping Resident #B stuffed the soiled brief under Resident #B and turned the resident. LPN #2 touched the bed and the side table during that time. LPN #2 grabbed more cleaning wipes and continued to provide incontinent care. LPN #2 was not observed removing her gloved hands nor washing her hands after incontinent care. LPN #2 removed Resident #B's right buttocks soiled dressing. There was no observation of removal of LPN #2's gloves or washing her hands. LPN #2 wiped gloved hands using cleaning wipes and indicated at that time, "I should have brought more gloves". LPN #2 threw the soiled cleaning wipes in a trash bag and begun dressing change with no observation of removing gloves or</p> | | | |

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| | <p>washing hands.</p> <p>LPN #2 repeated the dressing change on Resident #B's right buttocks at that time due to incontinent soilage. Resident #B's soiled gown and sheets were removed from Resident #B. There was no observation of LPN #2 removing of her gloves nor washing her hands. LPN #2 was observed touching Resident #B's feeding pump, feeding bag, bed side table, and raising his bed with gloved hands. She than placed a clean brief, gown and new sheets on Resident #B. She than pulled up Resident #B on the bed and placed a blanket on him. LPN #2 placed the dirty linen on the floor. Using her gloved hands, LPN #2 grabbed new feeding and flush bag for Resident #B. LPN #2 removed old gloves and donned new set of gloves. Then she turned on the water in the bathroom and put water into the flush bag. She placed the flush bag on Resident #B's pole.</p> <p>An interview was conducted with LPN #2 on 4/4/16 at 11:45 a.m. She indicated she would have normally changed out her gloves inbetween dressing changes, but gloves were not in her reach. She also indicated LPN #1 was suppose to bring her back a trash bag, and she must have forgotten. She indicated she did not have a trash bag in the room to place the soiled</p> | | | |

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| | <p>linen in, so she placed them on the floor. LPN #2 indicated she would remove the soiled linen when she gets a trash bag and leaves the room.</p> <p>An interview was conducted with the Clinical Support #14 on 4/4/16 at 12:26 p.m. She indicated the changing of gloves and hand washing should be done after the removal of the old dressing, changing wound sites, and before/after incontinent care. She indicated soiled linen should not be placed on the floor.</p> <p>A policy titled, "General Guidelines for Dressing Changes" was provided by the Clinical Support #14 at 3:54 p.m. It indicated, "Purpose: To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination. Procedure: 1. Place plastic bag near to dispose the soiled dressing. 2. Create a clean field with a towel or towelette drape...4. Open dressing pack. 5. Wash hands with soap and water. 6. Put on first pair of disposable gloves. 7. Remove soiled dressing and discard in plastic bag. 8. Dispose of gloves in plastic bag. 9. Wash hands with soap and water. 10. Put on second pair of disposable gloves..13. If using scissors, make sure it is clean with antiseptic after contact with soiled</p> | | | |

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| F 0465 SS=D Bldg. 00 | <p>dressings. 14. Remove gloves and discard with all unused supplies in plastic bag. 15. Wash hands with soap and water...17. Discard soiled dressings per protocol."</p> <p>A policy titled, "Guidelines for Handling Linen" was provided by the Clinical Support #14 on 4/4/16 at 3:54 p.m. It indicated, " Purpose: To provide clean, fresh linen to each resident. To prevent contamination of clean linen. Procedure:...Dirty Linen..2. Place soiled linens in a plastic bag if wet or soiled with feces...3. Discard soiled linen in soiled linen containers. 4. Do not place soiled linen on furniture or floor..."</p> <p>This Federal tag relates to complaint IN00195213.</p> <p>3.1-18((1) 3.1-19(g)(1)(2)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to</p> | F 0465 | F 465 | 05/07/2016 |

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| | <p>provide a safe environment at the front door/lobby area for 2 of 3 residents reviewed for accidents. (Resident #X and #69)</p> <p>Findings include:</p> <p>1. The clinical Record for Resident #X was reviewed on 3/31/16 at 10:00 a.m. The diagnoses for Resident #X included, but were not limited to, dementia.</p> <p>The 10/29/15 Admission MDS (minimum data set) assessment indicated Resident #X had a BIMS (brief interview for mental status) score of 3, indicating she was cognitively impaired.</p> <p>The 11/10/15 care plan for Resident #X indicated, "I have dementia and associated short term memory impairment and risks for confusion, disorientation, altered mood and/or impaired reduced safety awareness."</p> <p>The 12/13/15 Exit Seeking Circumstance for Resident #X indicated, on Sunday,12/13/15, " Resident went to an activity at approximately 4pm. At approximately 4:30 pm the family member of another resident found (Name of Resident #X) on the sidewalk outside. Resident was brought back in and write (sic) performed an assessment of resident. Resident's skin appears to be</p> | | <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #X and #69 have been discharged from the campus.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Contracted vendor installed additional equipment at the front door/lobby area to provide a safe environment by requiring a code to exit these sets of doors.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Contracted vendor installed additional equipment at the front door/lobby area to provide a safe environment by requiring a code to exit these sets of doors.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following inspections for the front door/lobby area will be conducted by the Director of Plant Operations or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: The code to exit the front door / lobby area is</p> | |

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| | <p>intact with no evidence of redness, bruising, or otherwise. Residents vital signs as follows: BP (blood pressure):126/64,P (pulse): 72 RR:16, T (temperature): 98.1 02 (oxygen): 98%. Resident shows no signs of distress. Resident is confused, expresses no interest in leaving the facility or going outside. Wonder Guard placed on right ankle for patient safety. Order to check placement every shift put in system. Will continue to monitor resident." The Exit Seeking Circumstance was created by RN #13.</p> <p>An interview was conducted with RN #13 on 3/31/16 at 10:56 a.m. She indicated Resident #X went to an activity in the community room. Resident #X was assisted by staff to the community room. A family member of another resident saw her outside on the sidewalk out front, helped her back inside, and told the first staff member they saw. Resident #X was brought back to the unit, where she, RN #13, did an assessment. RN #13 indicated Resident #X informed her she wasn't trying to leave the facility, and was "just confused."</p> <p>On 3/31/16 at 12:01 a.m., a telephone interview was conducted with Family Member #17, the family member who assisted Resident #X inside on 12/13/15. He indicated there was an older lady outside in her wheel chair one day on his</p> | | <p>functioning.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>way into the facility. He indicated if he hadn't gotten there, in another 2 seconds, Resident #X would have fallen. He indicated Resident #X was propelling herself in her wheelchair. He indicated he saw the chair on the curb of the sidewalk, and if he hadn't gotten there, she would have fallen, and hit her head. He indicated he asked her where she was going and she said she wasn't sure. He indicated Resident #X was at least 20 feet from the door, on the sidewalk to the left. He indicated her front and rear tire were on the curb. He indicated he had to grab the chair just right so she wouldn't fall. He indicated he did not see any staff members outside. He indicated he pushed her back inside. He indicated he did not see an activity going on when he entered the facility with Resident #X. He indicated this occurred on a Sunday, about 5:00 p.m. He indicated he could have minded his own business and let her fall.</p> <p>An observation of the front exit doorway and sidewalk was made during the above telephone conversation on 3/31/16 at 12:10 p.m. The front sidewalk ran left and right. The sidewalk is level with the parking lot until approximately 20 feet from the doorway, then the curb of the sidewalk is 3 to 4 inches from the pavement.</p> <p>The 12/16/15, 11:38 a.m. Social Services</p> | | | |

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| | <p>note, attached to the 12/13/15 Exit Seeking Circumstance, indicated, "Staff reports to this writer resident was outside of the facility around 4:30 PM on 12-13-15. Per investigative review resident was witnessed leaving the front doors of this facility. Staff reports resident was brought back into the campus by a family member coming into the facility. Staff states they assessed resident and n (sic) signs of injury found, and resident appeared to be in no distress. Wandergaurd put on residents ankle. This writer met with resident today and she appears to be in good spirits. Resident has not attempted to leave this facility and states no desire to leave today. Social services will continue to observe for changes and provide support as needed. Care plan updated." This note was created by the SSD (Social Services Director).</p> <p>An interview was conducted with the Clinical Support on 3/31/16 at 10:26 a.m. She indicated the facility had no investigative file for Resident #X's 12/13/15 exit seeking circumstance. She indicated the facility always secured the front doors, but to her knowledge, that was around 8:00 p.m. She acknowledged Resident #X was found outside by a visitor on a Sunday at 4:30 p.m.</p> <p>An observation of the facility video surveillance was made on 4/1/16 at</p> | | | |

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| | <p>10:22 a.m. It showed Resident #X exiting the front door on 12/13/16 at 4:28 p.m. No staff member was with Resident #X. The video showed Resident #X being brought back in by a visitor at 4:31 p.m. No observation could be made of Resident #Z while outside, as the video only viewed the front doorway. Several visitors were observed going in and out of the facility on the video during this time.</p> <p>2. The clinical record for Resident #69 was reviewed on 4/1/16 at 2:00 p.m. The diagnoses for Resident #69 included, but were not limited to, dementia.</p> <p>The 11/16/15 Admission Assessment for Resident #69 indicated she was at risk of getting to a dangerous place. It indicated her BIMS score was 13, indicating she was cognitively in tact.</p> <p>The 11/15/15, Exit Seeking Circumstance for Resident #69 indicated, on Sunday at 5:07 p.m., she was found outside attempting to transfer into one of the benches. It indicated she exhibited combativeness and exit seeking successes in the past, prior to this exit seeking event.</p> <p>The 11/15/15, 5:27 p.m. Nursing Note, attached to the 11/15/15 Exit Seeking</p> | | | |

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| | <p>Circumstance indicated, "Resident asked this writer for codes to both exit doors this shift. Resident was told that the exit doors on the ends of both halls were emergency exits and the alarm would sound upon exit. The resident expressed wanting to go outside and find something in her car. This writer then told the resident that no staff was available to accompany her at the time but if she would wait a few minutes that a staff member would sit outside with her. The resident became agitated stating, "I don't need an escort to go outside!" At approximately 1645 (4:45 p.m.) the resident was observed outside of the front door on porch area attempting to transfer into one of the benches. The resident was unaccompanied by staff. A staff member tried sitting with the resident and the resident became agitated stating, "I don't need a babysitter!" When the staff tried to bring the resident into the building the resident threw a hot cup of coffee on the staff member. The staff member did not have any injuries. On call Nurse Practitioner (name of nurse practitioner) (name of doctor's office) notified. New order for a wander guard to be worn at all time and a UA/C&S (urinalysis/culture & sensitivity). Message also left with durable POA (power of attorney)."</p> <p>3. An observation of the front lobby area</p> | | | |

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| | <p>and front doors was made on Sunday, 4/3/16, at 4:02 p.m.. After entering the front doors, no staff was observed at the receptionist front desk or any of the front offices, including the conference room, work room, Social Services office, Medical Records office, Executive Director office, Community Services Representative office, and B195 office. Two residents were observed in the lobby area. One of the residents observed was Resident #138. Resident #138 indicated no staff was at the front or in any of the front offices. She indicated she thought there should be staff at the front on the weekends. She indicated she'd had a conversation with her son about how anyone could just walk in the facility and harm people. Several visitors were observed to enter and exit the front doors freely. No code was required to enter or exit.</p> <p>On Sunday, 4/3/16, at 4:20 p.m., an observation of the right hall nurse's desk camera was made. It included a view of the front door in the top left corner of the screen. A red dot appeared on the screen when movement occurred, but no sound was indicated with movement. No staff member was observed consistently monitoring this camera, as all staff were busy assisting residents.</p> | | | |

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| | <p>On Sunday, 4/3/16, at 4:28 p.m., an observation of the left hall nurses station was made. There was no camera observed at this station.</p> <p>On 4/4/16 at 9:44 a.m., a sign was observed at the front doorway. It indicated, "Doors will be locked between 6:00 PM - 7:00 AM. Please enter code on key pad on automatic door opener or press silver button on air phone for immediate assistance entering building. Thank-you!"</p> <p>An interview was conducted with the ED (Executive Director) and CS (Clinical Support) on 4/4/16 at 10:00 a.m. Both indicated they did not recognize that Resident #X and Resident #69 left the facility unattended on Sunday afternoons around the same time. The ED indicated the doors were locked between 6 p.m. and 7 a.m. as routine safety. The ED indicated they were interviewing for someone to sit at the front desk on the weekends, to greet people and keep an eye on things. The CS indicated the front door times were discussed when some pre exit seeking behaviors were noticed.</p> <p>An interview was conducted with the CS on 4/4/16 at 10:41 a.m. She indicated the facility did not have a policy on locking the front doors or in regards to</p> | | | |

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| | <p>general safety.</p> <p>4. An interview was conducted with Resident #33 on 4/7/16 at 10:03 a.m. She indicated the resident who lived in the room next to her, Resident #86, had dementia that seemed to be progressing lately. Resident #33 indicated she was concerned Resident #86 could get out of the building and stated, "I just don't want to see anything happen to her." Resident #33 indicated Resident #86 was wandering inside of the facility and was worried Resident #86 will get outside through the front doors. Resident #33 indicated, "The nurses and aides can't be everywhere." Resident #33 indicated someone was at the front on the weekends "sometimes, but not all day." Resident #33 indicated, "I'd hate to see her fall or wander away." Resident #33 indicated it might be a good thing to have a code for the front doors at all times of the day, for the safety of the residents.</p> <p>This federal tag relates to Complaint IN00194999.</p> <p>3.1-19(f)</p> | | | |

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| F 0496 SS=D Bldg. 00 | <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 33 actively employed CNAs (certified</p> | F 0496 | <p>F 496</p> <p>Corrective actions accomplished for those</p> | 05/07/2016 |

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| | <p>nursing assistant) had an active license when worked. (CNA #10).</p> <p>Findings include:</p> <p>The Employee Records form and 33 CNA licenses were reviewed on 4/7/16 at 11:00 a.m. The Employee Records form indicated the following start date for CRCA/CNA #10 was 11/4/14.</p> <p>CRCA/CNA #10's license indicated her license expired on 3/5/15.</p> <p>A document provided by Clinical Support #14, on 4/7/16 at 3:00 p.m., indicated CRCA/CNA #10 transferred to the facility on 11/15/15 an worked 548 hours from 11/15/15 to 4/3/16.</p> <p>During an interview with Clinical Support #14, on 4/7/16 at 12:00 p.m., Clinical Support #14 indicated CRCA/CNA #10 worked full time and the expectation was that staff have active licenses when they worked.</p> <p>A policy titled, General Employment Policies, no date, was received from Clinical Support #14, on 4/7/16 at 1:30 p.m. The policy indicated, "...Employees, whose position requires that they be licensed or certificated, must furnish evidence of licensure or</p> | | <p>residents found to be affected by the alleged deficient practice: CRCA #10 has a current certification on file.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all employed CRCA's to ensure they have a current certification on file.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing Leadership team on the following: General Employment Policies</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 CRCAs will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Review certification on file to ensure it is current.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further</p> | |

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| F 0502 SS=D Bldg. 00 | <p>certification upon hire. It is your responsibility to maintain ongoing licenses/certification in good standing with the issuing authority and provide the Company with a copy of renewals as they occur...."</p> <p>3.1-14(q)(5)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to ensure labs were drawn, as ordered, for 1 of 5 residents reviewed for unnecessary medications. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record for Resident #1 was reviewed on 3/29/16 at 11:39 a.m. The diagnoses for Resident #1 included, but were not limited to, major depressive disorder and type 2 diabetes.</p> <p>The Physician's Orders for Resident #1 indicated an Hgb A1C lab to be drawn</p> | F 0502 | <p>recommendation.</p> <p>F 502 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #1 labs have been drawn as ordered. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee review all resident current lab orders to ensure the labs were drawn as ordered. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate</p> | 05/07/2016 |

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| F 0505 SS=D Bldg. 00 | <p>every 6 months on the 16th of February and August, with a start date of 2/15/16. They indicated a TSH (thyroid stimulating hormone) lab to be drawn annually on the 16th of February, with a start date of 2/15/16.</p> <p>There was no information in the clinical record to indicate the Hgb A1C or TSH labs were drawn on 2/16/16, as ordered.</p> <p>An interview was conducted with Clinical Support #14 on 4/5/16 at 12:51 p.m. She indicated the TSH and Hgb A1c labs were not drawn, as ordered, so they got a new order to have them drawn on this date (4/5/16).</p> <p>3.1-49(a)</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on interview and record review, the facility failed to promptly address a critical lab for 1 of 1 residents reviewed for hospitalization. (Resident #U)</p> <p>Findings include:</p> | F 0505 | <p>the Licensed Nurses on the following campus guidelines: Lab Tracking How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: resident current lab orders to ensure the labs were drawn as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>F 505 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident U has been discharged from the campus. Identification of other residents</p> | 05/07/2016 |

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| | <p>The clinical record for Resident #U was reviewed on 3/31/16 at 10:41 a.m. The diagnoses for Resident #U included, but was not limited to: Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria.</p> <p>A physician order dated, 12/24/15, indicated a Hematocrit and Hemoglobin (H and H) lab draw was to be drawn one time.</p> <p>A document titled, (name of lab company) "STAT" (as soon as possible) dated, 12/24/15 at 2:37 p.m., indicated the lab was ordered, and the H and H was collected and sent to the hospital to be tested for Resident #U.</p> <p>A document titled, (name of lab company), dated 12/24/15 at 7:24 p.m., indicated Resident #U's lab results were the following: hemoglobin was 6.0 L (low) reference range 11.6 - 12.2 grams/deciliter and Hematocrit was 19.3 L (low) 34.4 - 45.6 %.</p> <p>A progress note dated, 12/24/15 at 2:47 p.m., indicated, "notices that resident (Resident #U) looks pale. Resident states that she does not feel well. States that she has a headache and abdominal pain. Nurse informed that resident had black</p> | | <p>having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee review all resident current lab orders to ensure the nursing staff promptly notified the MD of lab test results, including critical results. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Physician Notification. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: resident current lab orders to ensure the nursing staff notified the MD of lab test results, including critical results. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>stool this AM. Resident not currently on an iron supplement. Vitals as follows Bp (Blood pressure)108/81, Pulse 56, O2 87, Resp (respirations) 16. Stat hemoglobin and hematocrit ordered. 2L (liter) O2 (oxygen) applied via (through) nasal cannula. O2 up to 98%. Responsible party (name of party) notified of current situation..."</p> <p>A progress note dated, 12/25/2015 6:22 p.m., indicated "Resident (Resident #U) was sent to the ER (emergency room) per NP (nurse practitioner) orders due to a Hemoglobin reading of 6.0 and a hematocrit 19.3. Resident was sent to (name of hospital) ER. POA (power of attorney) notified."</p> <p>An interview was conducted with the Clinical Support #14 on 3/31/16 at 3:05 p.m. She indicated she does not know why there was a delay with notifying the medical provider with the H and H lab results for Resident #U.</p> <p>An interview was conducted with the Clinical Support on 4/1/16 at 12:10 p.m. She indicate the progress note entered on 12/24/15 for Resident #U was considered a change of condition, and Resident #U should have been monitored. She could not locate any documentation Resident #U was monitored since the change of condition.</p> | | | |

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| | <p>Resident #U's hospital records were provided on 4/1/16 at 9:00 a.m. History..."Per the triage nurse, EMS (emergency medical services) had reported that the ECF (extended care facility) staff reported that the pt (patient)'s hgb (hemoglobin) was 6.0. At the time of the exam, the pt sts (sic) that she feels cold. Her fingers have slightly notable cyanosis (blue). She denies any pain, as she sts (sic) that she has done nothing today..."</p> <p>ED (emergency department) notes indicated "rectal exam: hemocult (test for blood in stool) positive stool, dark melena (bloody stool)...ED lab results: Hemoglobin 5.6 and Hematocrit 17.9..."</p> <p>Clinical Impressions: "1. Gastrointestinal hemorrhage with melena. 2. Anemia.."</p> <p>"History of Present Illness:...Pt (patient) had been feeling extremely weak and tired for some time. She is unable to describe exact duration of her Sx (symptoms). She was noted to be extremely anemic yesterday and was then admitted. She initially reported she has been having black stools for some time.."</p> <p>"Hospital Course: Heme + stool in ED with hgb of 5.6. Patient (Resident #U)</p> | | | |

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| | <p>was admitted with GI (gastrointestinal bleed) and acute blood loss anemia. GI was consulted and patient was transfused PRBC (pack red blood cells)...Cardiology was consulted, NSTEMI (heart attack) likely secondary to GI blood loss and severe anemia...AKI (acute kidney injury) related to pre-renal dehydration and blood loss..."</p> <p>An interview was conducted with nurse practitioner (NP) on 4/1/16 at 10:12 a.m. She indicated she considered a hemoglobin of 6.0 a critical lab result and would like to be made aware of the results immediately. The NP indicated if a resident had a hemoglobin of 6.0 he or she would be sent out to the hospital. She indicated she could not say if Resident #U's cardiac and kidney concerns could have been avoided if she had been sent to the hospital earlier.</p> <p>A policy titled, "Physician Notification Guidelines" was provided by the Clinical Support #14 on 4/1/16 at 12:12 p.m. It indicated, "Purpose: To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure:...2. The physician should be notified of critical lab results or an</p> | | | |

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| F 9999 Bldg. 00 | <p>immediate need by phone as soon as the results are known with a response received before the call is completed when possible. If the physician must be paged a call back is expected within 15 minutes to one hour depending on severity of the concern...10. Attempts to notify the physician and their response should be documented in the resident record. 11. The 24 hour report shall be utilized for nurse to nurse communication regarding the status of notification and response back..."</p> <p>This Federal tag relates to complaint IN00193489.</p> <p>3.1-49 (f)(2)</p> <p>3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights.</p> | F 9999 | F 9999 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: All staff have current TB test on file and staff who have regular contact with residents shall have a minimum of 6 hours | 05/07/2016 |

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| NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256 |
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| | <p>(2) Prevention and control of infection.</p> <p>(3) Fire prevention.</p> <p>(4) Safety and accident prevention.</p> <p>(5) Needs of specialized populations served.</p> <p>(6) Care of cognitively impaired residents.</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel.</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method.</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1)</p> | | <p>of dementia specific training within 6 months of initial employment and 3 hours annually thereafter to meet the needs or preferences of cognitively impaired residents. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All staff have current TB test on file and staff who have regular contact with residents shall have a minimum of 6 hours of dementia specific training within 6 months of initial employment and 3 hours annually thereafter to meet the needs or preferences of cognitively impaired residents.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus leaders involved in the hiring process on the following state regulations: 1). Screening for tuberculosis 2). Dementia specific training How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). staff have current TB test on file 2) staff who have regular contact with residents shall have a minimum of 6 hours of</p> | |

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| | <p>to three (3) weeks after the first step.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide staff members a tuberculin skin test for 3 of 10 employee personal files reviewed and also failed to provide annual dementia in-service training for 1 of 10 employee personal files reviewed. Certified Resident Care Aide (CRCA) #15, CRCA #16 CRCA #20, and CRCA #21)</p> <p>Findings include:</p> <p>The Employee Records form was reviewed on 4/7/16 at 3:00 p.m. The record indicated CRCA #21's start date was 8/30/11. CRCA #21's file was missing an annual Tuberculosis (TB) screening and the annual dementia in-service training.</p> <p>The Employee Personnel File for CRCA #15's start date was 2/3/15. CRCA #15 was missing an annual TB screening and the annual dementia in-service training.</p> <p>The Employee Personnel File for CRCA #16's start date was 11/11/14. CRCA #16 was missing an annual TB screening and the annual dementia in-service training.</p> | | <p>dementia specific training within 6 months of initial employment and 3 hours annually thereafter to meet the needs or preferences of cognitively impaired residents. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>The Employee Personnel File for CRCA #20's start date was 3/25/15. CRCA #20 was missing the annual dementia in-service training.</p> <p>An interview was conducted with the Clinical Support #14 on 4/7/16 at 3:35 p.m. She indicated she could not provide the missing documentation for the TB screenings nor the annual dementia in-service training.</p> <p>A document was provided by the Clinical Support on 4/7/16 at 4:30 p.m. It indicated the work hours for the following employees:</p> <p>CRCA #21 - full time employee and works 32-40 hours a week CRCA #15 - as needed employee and works 0-10 hours week CRCA #16 - part-time employee and works 15-30 hours week CRCA #20 -part- time employee and works 15-30 hours week</p> | | | |

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| R 0000 Bldg. 00 | These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. | R 0000 | 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 a Recertification and State Licensure Survey in conjunction with Complaints (IN0197341, IN00192650, IN00192746, IN00193489, IN00194848, IN00194999, IN00195213 and IN00195664) Survey on April 7, 2016. Please accept this plan of correction as the provider's credible allegation of | |

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| R 0042 Bldg. 00 | <p>410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.</p> <p>Based on observation and interview, the facility failed to provide a posting of the location to review the state survey observed during an environmental tour. This had a potential to effect 23 of 23 residents living in the assisted living.</p> <p>Findings include:</p> <p>An environmental tour was conducted with the Executive Director on 4/6/16 at 11:45 a.m. There were no observations of the posting where the state survey was located. During the tour the survey binder was located at the receptionist desk on the first floor. There was no posting observed its location.</p> <p>An interview was conducted with the Clinical Support #14 on 4/6/16 at 2:40 p.m. She indicated she would have expected a posting to be with the survey book indicating the location. The Clinical Support #14 indicated there was no policy related to posting of the survey results.</p> | R 0042 | <p>compliance.</p> <p>R 0042 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: A sign will be posted indicating the location of the most recent survey results. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: A sign will be posted indicating the location of the most recent survey results. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee monthly times 6 months to ensure compliance: Sign is posted indicating the location of the most recent survey results. The results</p> | 05/07/2016 |

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| R 0120 Bldg. 00 | <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance</p> <p>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor.</p> | | of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |

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| | <p>(C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to provide staff members annual dementia in-service training for 3 of 5 employee personal files reviewed. Certified Resident Care Aide (CRCA) #17, CRCA #18 and CRCA #19)</p> <p>Findings include:</p> <p>The Employee Records form was reviewed on 4/7/16 at 3:00 p.m. The record indicated CRCA #19's start date was 1/20/14. CRCA #14's file was missing the annual dementia in-service training.</p> <p>The Employee Personnel File for CRCA #17's start date was 11/24/14. CRCA #17 was missing the annual dementia in-service training.</p> <p>The Employee Personnel File for CRCA #18's start date was 10/18/15. CRCA #18 was missing the annual dementia in-service training.</p> <p>An interview was conducted with the Clinical Support #14 on 4/7/16 at 3:35 p.m. She indicated she could not provide</p> | R 0120 | <p>R 0120 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Staff who have regular contact with residents shall have a minimum of 6 hours of dementia specific training within 6 months of initial employment and 3 hours annually thereafter to meet the needs or preferences of cognitively impaired residents.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Staff who have regular contact with residents shall have a minimum of 6 hours of dementia specific training within 6 months of initial employment and 3 hours annually thereafter to meet the needs or preferences of cognitively impaired residents. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus leaders involved in the hiring process on the following state regulations: Dementia specific training How the corrective measures will be monitored to ensure the alleged deficient practice does</p> | 05/07/2016 |

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| R 0121 Bldg. 00 | <p>the missing documentation for the annual dementia in-service training.</p> <p>A document was provided by the Clinical Support on 4/7/16 at 4:30 p.m. It indicated the work hours for the following employees:</p> <p>CRCA #19 - full time employee and works 32-40 hours a week CRCA #18 - full time employee and works 40 hours week CRCA #17 - PRN (as needed) employee and works 0-10 hours week</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test</p> | | <p>not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: staff who have regular contact with residents shall have a minimum of 6 hours of dementia specific training within 6 months of initial employment and 3 hours annually thereafter to meet the needs or preferences of cognitively impaired residents. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to provide a staff member a tuberculin skin test for 1 of 5 employee personal files reviewed. (Certified Resident Care Aide (CRCA) #17)</p> <p>Findings include:</p> <p>The Employee Records form was reviewed on 4/7/16 at 3:00 p.m. The record indicated CRCA #17's start date was 11/24/14. CRCA #17's file was missing an annual Tuberculosis (TB)</p> | R 0121 | <p>R 0121 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: All staff have current TB test on file Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All staff have current TB test on file Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus leaders involved in the</p> | 05/07/2016 |

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| R 0273 Bldg. 00 | <p>screening.</p> <p>An interview was conducted with the Clinical Support #14 on 4/7/16 at 3:35 p.m. She indicated she could not provide the missing documentation for the TB screening.</p> <p>A document was provided by the Clinical Support on 4/7/16 at 4:30 p.m. It indicated the work hours for CRCA #17. CRCA #17 was a PRN (as needed) employee and she works 0-10 hours week.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to use proper unthawing methods with poultry and dating refrigeration prepared food items. This had a potential to effect 23 out of 23 residents that eat food out of this kitchen.</p> <p>Findings include:</p> | R 0273 | <p>hiring process on the following state regulations: Screening for tuberculosis How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: staff have current TB test on file The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>R 273 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Audit / observation of kitchen to ensure frozen foods are not defrosted at room temperature. 2). Audit / observation of refrigerated storage to ensure food is covered and dated Identification of other</p> | 05/07/2016 |

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| | An observation was made of the kitchen with the Dietary Food Supervisor (DFS) on 3/28/16 at 12:12 p.m. During the tour, an observation of a walk in refrigerator was made. A server cart that included racks of trays was observed in the refrigerator. The following prepared food items were on the stacked racks on the server cart were not dated: pineapple chunks in bowls, a full sheet of blueberry cheesecake, oranges in bowls, slices of carrot cake on plates, sliced peanut butter pudding bars in bowls, slices of boston cream pie on plates and slices of strawberry short cake with strawberries on top were on plates. The strawberries looked dry and shriveled, and the cake appeared to be dry in appearance. The DNS indicated at that time, the oranges were from breakfast and the strawberry short cake was served last Friday. DNS indicated she was throwing out the strawberry desert, because it did not look edible. An observation was made of a second refrigerator in the kitchen. This included two closed containers of prepared food items. There were no dates on either of these containers. The DNS opened the containers and indicated the one container was coleslaw and the other was chicken salad. At that time, the DNS indicated the staff should have dated the containers and pulled both containers out of the refrigerator to discard food items. | | residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: 1). Food Production - Sanitation and Safety 2). Storage Procedures How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Audit / observation of kitchen to ensure frozen foods are not defrosted at room temperature. 2). Audit / observation of refrigerated storage to ensure food is covered and dated The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/07/2016 |
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| NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256 |
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| | <p>During the kitchen tour, an observation was made of pieces of white meat sitting in the bottom of a sink of water. At that time, the DNS indicated the white meat was chicken and was unthawing for dinner. She took the temperature of the water in the sink. The temperature of the water was 48.6 degrees Fahrenheit. She then picked up a piece of chicken and brought it to the surface of the water. DNS indicated at that time the meat was still frozen and placed back in the water.</p> <p>An observation was made of the kitchen with the DNS on 3/28/16 at 1:15 p.m. A sink was observed with pieces of chicken sitting on the bottom submerged in water. The surface of the water had white bubbly film patches floating on top of the water. There were no observation made of water continuously running or water agitation. Dietary staff member indicated he had changed the water twice since he came in. Dietary staff member indicated he arrived at 11:00 a.m. and placed the chicken in water around 11:30 a.m. - 12:00 p.m. At that time, water had been changed out twice. DNS indicated she had always used this method to "quick unthaw".</p> <p>An interview was conducted with the Clinical Support #14 on 3/28/16 at 3:07</p> | | | |

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| | <p>p.m. She indicated the chicken should be under running water to unthaw. She indicated the chicken would be discarded and not served for dinner.</p> <p>A policy titled, "Food Production Guidelines-Sanitation and Safety" was provided by the Clinical Support #14 on 3/28/16 at 3:05 p.m. It indicated, "Guideline: Safe and sanitary handling of food will be employed during food production. Procedure:...10. Frozen foods are defrosted in the refrigerator - not at room temperature. In an emergency, they may be thawed under cool running water."</p> <p>A policy titled, "Storage Procedures" was provided by the Clinical Support #14 on 3/38/16 at 3:06 p.m. It indicated, " Guideline: Food and supplies stored to keep foods safe and preserve flavor, nutritive value, and appearance. Procedure:...Refrigerated Storage..5. Food is covered, dated and stored loosely to permit air circulation..7. Prepared perishables such as salads, puddings, milk, etc., are stored in a refrigerator and covered, labeled, and dated until used...9. Food items are arranged so that older items will be used first.</p> | | | |

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| R 0408 Bldg. 00 | <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission.</p> <p>Based on interview and record review the facility failed to obtain documentation of chest radiograph (x-ray) within 6 months of admission for 2 of 5 residents reviewed for admission documentation. (Resident #8 and Resident #9) Findings include: 1. On 4/6/16 at 9:30 a.m., clinical record was reviewed for Resident #9 indicating there was no chest x-ray completed prior to being admitted to AL (Assisted Living) facility on 12/10/15. On 4/6/16 at 11:20 a.m., Clinical Support #11 indicated the chest x-ray should have been completed within six months of being admitted to facility. On 4/7/16 at 11:30 a.m., Clinical Support #14 indicated a chest x-ray was not done prior to admission to facility.</p> <p>2. On 4/6/16 at 11:15 a.m., clinical record was reviewed for Resident #8 indicating a chest x-ray was completed on 7/14/14 prior to admission to AL facility on 6/13/15.</p> | R 0408 | <p>R 408</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #8 and #9 have a documented negative (0mm) Mantoux test</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee review all potential admissions to ensure documentation is obtained of a chest x-ray within 6 months of admission</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Assisted Living Guideline Chest X-Ray and</p> | 05/07/2016 |

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| | <p>On 4/6/16 at 11:22 a.m., Clinical Support #11, indicated the chest x-ray should have been completed within six months of being admitted to facility.</p> <p>On 4/6/16 at 3:15 p.m., UM #12 indicated Resident #8 will be receiving a chest x-ray either on 4/6/16 or 4/7/16 due to Resident #8 being at a doctor ' s appointment at this time.</p> <p>On 4/7/16 at 9:20 a.m., UM #12 provided documentation that indicated an order was placed for a chest x-ray for Resident #8 dated for 4/7/16.</p> <p>A " Guidelines for TB Results Summary Documentation: Residents " policy was provided by Clinical Support #14 on 4/7/16 at 9:30 a.m. It indicated the following:.. " Procedure: 3. Should the resident be a known converter a CXR (chest x-ray) shall be completed to ensure the resident is TB free. "</p> <p>A " Health Facilities; Licensing and Operational Standards " document was provided by Clinical Support #14 on 4/7/16 at 9:30 a.m. It indicated the following:.. " Infection control... Sec. 12... (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. "</p> | | <p>Mantoux Testing</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 new admission residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review new admission residents to ensure documentation is obtained of a chest x-ray within 6 months of admission</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |