

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 5, 6, 7, 10, and 12, 2014</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Survey team: Caitlyn Doyle, RN-TC Jennifer Redlin, RN Heather Hite, RN Julie Ferguson, RN (November 5, 6, 10, and 12, 2014)</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 9 Medicaid: 44 Other: 9 Total: 62</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies</p>	
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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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F000241 SS=D	<p>15, 2014, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure each residents' dignity was maintained related to, an uncovered indwelling urinary catheter bag for 1 of 3 residents reviewed for dignity out of 7 who met the criteria for dignity. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1 was observed on 11/5/14 at 12:32 p.m. sitting in the main dining room in her wheelchair. The resident's urinary catheter bag was under the wheelchair, uncovered and touching the floor with urine visible in the bag.</p> <p>Resident #1 was observed on 11/5/14 at 1:50 p.m. sitting in the front lobby in her wheelchair. The resident's urinary catheter bag was under the wheelchair uncovered and touching the floor with urine visible in the bag.</p>	F000241	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 catheter bag was changed on 11/6/2014. The dignity style bag provided has an overlay to prevent the urine from being visible in the bag. The catheter tubing was adjusted so it no longer touches the floor.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: An audit was completed on 11/6/2014 to ensure all current catheters have the dignity style bag in place and the catheter tubing is positioned properly to avoid contact with the floor. No further issues were identified via this audit.</p>	12/05/2014

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	<p>Resident #1 was observed on 11/6/14 at 1:58 p.m. laying in bed with the urinary catheter bag attached to the side of the bed. The urinary catheter bag was visible from the hallway. The urinary catheter bag was uncovered with urine visible in the bag. Interview with the resident at the time indicated her catheter bag is never covered and sometimes it bothers her roommate.</p> <p>Record review for Resident #1 was completed on 11/6/14 at 2:00 p.m. The residents diagnoses included, but were not limited to, urostomy (surgical opening in the abdominal wall through which urine passes), multiple sclerosis, depression, paraplegia, hemiplegia.</p> <p>The Annual Minimum Data Set (MDS) assessment completed on 10/14/14 indicated the resident was cognitively intact.</p> <p>Interview with the Director of Nursing (DON) on 11/6/14 at 2:45 p.m., indicated the catheter tubing and bag should be off the floor and covered with a dignity bag at all times.</p> <p>3.1-3(t)</p>		<p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Staff Development Coordinator will conduct in-service education with nursing staff on the continued use of dignity bags and proper catheter tubing placement by 12/02/14. Facility resident "Guardian Angels" were also be in-serviced on 11/26/14 on the above as an added layer of oversight when completing routine resident visits.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Director of Nursing / designee will audit 3 urinary catheters to ensure compliance with the use of dignity bag covers and proper catheter tubing placement. These audits will occur 3 days per week for 3 months and then once weekly for an additional 3 months. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as</p>	

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F000279 SS=D	<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 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 record review and interview, the facility failed to develop resident care plans, related to medications which can thin the blood, Aspirin, for 1 of 3 residents reviewed for non-pressure skin conditions of the 4 who met the criteria for non-pressure skin conditions and 1 of 5 residents reviewed for unnecessary medications. (Residents #15 and #39)</p> <p>Findings include:</p> <p>1. Resident #15's record was reviewed</p>	F000279	<p>deemed necessary</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The care plans for Residents #15 and #39 were amended on 11/17/14 to include care plan directives related to the risk for bruising secondary to the use of aspirin.</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	12/05/2014

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	<p>on 11/10/14 at 3: 49 p.m. The resident's diagnoses included, but were not limited to dementia, atrial fibrillation (irregular heart beat), congestive heart failure and hypertension (high blood pressure).</p> <p>The November 2014 Physician's Orders, indicated an order for Aspirin 81 mg (milligrams) give one chewable tablet, one time a day.</p> <p>Review of the Medication Administration Record (MAR) dated November 2014, indicated the Aspirin had been given as ordered.</p> <p>There was no care plan and/or interventions related to the aspirin usage and risk for bleeding and bruising for Resident #15.</p> <p>During an interview on 11/10/14 with the MDS (Minimum Data Set) Coordinator at 12:03 p.m., she indicated she does not do care plans for Aspirin.</p> <p>2. Resident # 39's record was reviewed on 11/10/14 at 8:47 a.m. The resident's diagnoses included, but were not limited to cardiac arterial disease, dementia, congestive heart failure, and hypertension (high blood pressure).</p> <p>The November 2014 Physician's Orders, indicated an order for Aspirin 81 mg</p>		<p>identified and what corrective action(s) will be taken: Full facility clinical audit was completed on 11/19/14 to identify any further residents requiring use of aspirin. Care plans for those identified were updated on 11/19/14 to include care plan directives related to the risk for bruising secondary to the administration of aspirin.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The MDS Coordinator was in-serviced on 11/13/14 by the Director of Nursing related to ensuring a care plan is evident for residents at risk for bruising secondary to use of aspirin. New physician orders for aspirin will be communicated to the MDS Coordinator so care plans can be amended and/or initiated as indicated.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Nursing / designee will audit the care plans of 5 residents requiring</p>	

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F000282 SS=D	<p>(milligrams) give one enteric-coated tablet, one time a day.</p> <p>Review of the Medication Administration Record (MAR) dated November 2014, indicated the Aspirin had been given as ordered.</p> <p>There was no care plan and/or interventions related to the aspirin usage and risk for bleeding and bruising for Resident #39.</p> <p>During an interview on 11/10/14 with the MDS (Minimum Data Set) Coordinator at 12:03 p.m., she indicated she does not do care plans for Aspirin.</p> <p>During an interview with the West Wing Unit Manager on 11/10/14 at 12:07 p.m., she indicated there was not a care plan for Aspirin.</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 observation, record review, and interview, the facility failed to ensure care plans were followed as written</p>			F000282	<p>the administration of aspirin on a weekly basis. This review will validate that the "at risk for bruising care plans" are in place for involved residents. This audit will be ongoing for 6 months. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by</p>		12/05/2014

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	<p>related to skin discolorations not assessed and monitored for 1 of 3 resident's reviewed for skin (non-pressure related), of the 4 who met the criteria for skin (non-pressure related). (Resident #1)</p> <p>Findings include:</p> <p>Resident #1 was observed on 11/5/14 at 3:17 p.m. laying in bed. She was observed to have green discolorations to her left outer forearm.</p> <p>The resident was observed on 11/6/14 at 1:58 p.m. laying in bed. She was observed to have green discoloration to her left outer forearm.</p> <p>The resident was observed on 11/7/14 at 9:12 a.m. sitting in her wheelchair in the hallway. She was observed to have green discolorations to left outer forearm.</p> <p>The resident was observed on 11/10/14 at 12:30 p.m., sitting in her wheelchair in the main dining room. She was observed to have green discolorations to her left outer forearm. Interview with the resident at the time indicated she was unaware on how she received the discolorations.</p> <p>Record review for Resident #1 was completed on 11/6/14 at 2:00 p.m. The</p>		<p>the deficient practice? Resident #1 was assessed by nurse and the area of discoloration was addressed with the physician on 11/10/14. Family was notified and corresponding facility documentation was completed in accordance with facility protocol.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: A full facility skin inspection audit was completed on 11/10-11/14 by Nursing Administration to identify any residents having skin related issues. Findings were immediately addressed per facility protocol and interventions implemented as indicated.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices do not recur: The Staff Development Coordinator will provide in-service education to the facility staff on adhering to the resident care plan directives with regard to reporting any</p>	

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	<p>residents diagnoses included, but were not limited to, urostomy (surgical opening in the abdominal wall through which urine passes), multiple sclerosis, depression, paraplegic, hemiplegia.</p> <p>The Annual Minimum Data Set (MDS) assessment completed on 10/14/14 indicated the resident was cognitively intact.</p> <p>The November 2014 Physician Order Summary indicated the resident to have bi-weekly skin checks on Wednesday's and Saturday's.</p> <p>Review of the Weekly Skin Integrity Sheet for 11/1/14, 11/5/14, and 11/8/14 indicated the resident's skin was intact with no areas of discolorations observed.</p> <p>Review of the November Shower sheets for 11/4/14 and 11/7/14, indicated no new areas and skin intact.</p> <p>A care plan dated 10/15/14, indicated the resident has the potential for pressure ulcers. Nursing interventions included to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discolorations noted during bathing or daily care.</p> <p>Interview with LPN #2 on 11/10/14 at</p>		<p>new skin breakdown, redness, blisters, bruises or discolorations to the nurse for appropriate follow up in a timely manner. This education will be completed by 12/02/14. New skin related areas will be reported to the MDS Coordinator to ensure care plans are updated as indicated. CNA's will be utilizing the Interact Stop and Watch Tool to notify nursing of any identified skin related issue.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Nursing /designee will perform random skin inspection audits on 5 residents weekly for 12 weeks and then 5 residents monthly for an additional 3 months to ensure resident care plans are being followed related to the timely identification of new skin breakdown, redness, blisters, bruises or discolorations. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary.</p>	

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F000309 SS=D	<p>12:35 p.m., indicated she was unaware the resident had any discolorations to her forearm and the staff should have known about the areas by now.</p> <p>Interview with the East Wing Unit Manager on 11/10/14 at 12:38 p.m. indicated she was unaware the resident had discolorations to her left forearm and staff should have assessed and addressed them by now.</p> <p>A Nursing Note dated 11/10/14 at 2:52 p.m., indicated the nurse was informed of discolorations to the residents left forearm. The nurse assessed with findings of discolorations brownish green towards left wrist measuring 5 cm (centimeters) x 4 cm and towards the elbow measuring 2 cm x 3 cm.</p> <p>The resident's record indicated the discolorations to the left forearm had not been addressed or assessed until brought to the facility's attention.</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 practicable physical, mental, and</p>						

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 2 of 3 residents reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non pressure related skin conditions. (Resident's #1 and #15)</p> <p>Findings include:</p> <p>1. Resident #1 was observed on 11/5/14 at 3:17 p.m. laying in bed. She was observed to have green discolorations to her left outer forearm.</p> <p>The resident was observed on 11/6/14 at 1:58 p.m. laying in bed. She was observed to have green discoloration to her left outer forearm.</p> <p>The resident was observed on 11/7/14 at 9:12 a.m. sitting in her wheelchair in the hallway. She was observed to have green discolorations to left outer forearm.</p> <p>The resident was observed on 11/10/14 at 12:30 p.m., sitting in her wheelchair in the main dining room. She was observed</p>	F000309	<p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #1 and #15 were assessed by nurse and the skin discolorations were addressed with the physician on 11/10/14. Family was notified and corresponding facility documentation was completed in accordance with facility protocol.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>A full facility skin inspection audit was completed on 11/10-11/14 by Nursing Administration to identify any residents having skin related issues. Findings were immediately addressed per facility protocol and interventions were implemented as indicated.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Staff Development</p>	12/05/2014

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	<p>to have green discolorations to her left outer forearm. Interview with the resident at the time indicated she was unaware on how she received the discolorations.</p> <p>Record review for Resident #1 was completed on 11/6/14 at 2:00 p.m. The residents diagnoses included, but were not limited to, urostomy (surgical opening in the abdominal wall through which urine passes), multiple sclerosis, depression, paraplegic, hemiplegia.</p> <p>The Annual Minimum Data Set (MDS) assessment completed on 10/14/14 indicated the resident was cognitively intact.</p> <p>The November 2014 Physician Order Summary indicated the resident to have bi-weekly skin checks on Wednesday's and Saturday's.</p> <p>Review of the Weekly Skin Integrity Sheet for 11/1/14, 11/5/14, and 11/8/14 indicated the resident's skin was intact with no areas of discolorations observed.</p> <p>Review of the November Shower sheets for 11/4/14 and 11/7/14, indicated no new areas and skin intact.</p> <p>A care plan dated 10/15/14, indicated the</p>		<p>Coordinator will provide in-service education to nursing staff regarding adherence to resident care plans in regards to reporting any new skin breakdown, redness, blisters, bruises or discolorations to nurse for follow up. This education will be completed by 12/02/14. New areas will be reported to MDS Coordinator during morning meeting or by Unit Managers to ensure care plans are updated as needed. CNA's will be using the Stop and Watch tool to notify nursing of any new skin issue.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: DON / designee will perform random skin inspection audits on 5 residents weekly for 12 weeks and then 5 residents monthly for an additional 3 months to ensure care plans are being followed related to identifying new skin breakdown, redness, blisters, bruises or discolorations. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as</p>		

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	<p>resident has the potential for pressure ulcers. Nursing interventions included to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discolorations noted during bathing or daily care.</p> <p>Interview with LPN #2 on 11/10/14 at 12:35 p.m., indicated she was unaware the resident had any discolorations to her forearm and the staff should have known about the areas by now.</p> <p>Interview with the East Wing Unit Manager on 11/10/14 at 12:38 p.m. indicated she was unaware the resident had discolorations to her left forearm and staff should have assessed and addressed them by now.</p> <p>A Nursing Note dated 11/10/14 at 2:52 p.m., indicated the nurse was informed of discolorations to the residents left forearm. The nurse assessed with findings of discolorations brownish green towards left wrist measuring 5 cm (centimeters) x 4 cm and towards the elbow measuring 2 cm x 3 cm.</p> <p>The resident's record indicated the discolorations to the left forearm had not been addressed or assessed until brought to the facility's attention.</p> <p>2. Resident #15 was observed on 11/5/14</p>		deemed necessary.	

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	<p>at 10:40 a.m. A medium, rectangular, purple/blue discoloration was observed on the back of the resident's right hand, by the wrist.</p> <p>Resident #15's record was reviewed on 11/10/14 at 3:49 p.m. The resident's diagnoses included, but were not limited to to dementia, atrial fibrillation (irregular heart beat), congestive heart failure and hypertension (high blood pressure).</p> <p>The Quarterly Minimum Data Set assessment, dated 8/8/14, indicated the resident was cognitively impaired and was an extensive two person assist with transfers, bed mobility, toilet use, and personal hygiene.</p> <p>The November 2014 Physician's Orders, indicated an order for Aspirin 81 mg (milligrams) give one chewable tablet, one time a day and Bi-weekly skin checks: Wednesday & Saturday on 3-11 shift.</p> <p>Review of the Medication Administration Record (MAR) dated November 2014, indicated the Aspirin had been given as ordered.</p> <p>The November Treatment Administration Record (TAR) indicated the resident's</p>			

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F000315 SS=D	<p>skin was assessed on 11/8/14 on the 3-11 shift by the nurse. The "Weekly Skin Sheet" indicated the last skin assessment was completed on 11/5/14.</p> <p>During an interview with the East Wing Unit Manager on 11/10/14 at 4:00 p.m., she indicated there was no documentation on the weekly skin sheet for the current observed bruise, and the last skin sheet was completed on 11/5/14. She further indicated, the assessments and the skin sheet were to be done biweekly.</p> <p>The resident's record indicated the discoloration had not been addressed or assessed until brought to the facility's attention.</p> <p>The policy titled, "Chapter 2: Pressure Ulcer Prevention," received from the East Wing Unit Manager as current on 11/10/14 at 12:38 p.m., indicated "...the results of the skin assessment are documented on the Weekly Skin Integrity Data collection form...."</p> <p>3.1-37(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a</p>			

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	<p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a urinary catheter received the necessary treatment and services to prevent urinary tract infections, related to the placement of the urinary catheter tubing and drainage bag for 1 of 1 residents reviewed for urinary catheters. (Resident #1).</p> <p>Findings include:</p> <p>Resident #1 was observed on 11/5/14 at 12:32 p.m. sitting in the main dining room in her wheelchair. The resident's urinary catheter bag was under the wheelchair, uncovered and touching the floor with urine visible in the bag.</p> <p>Resident #1 was observed on 11/5/14 at 1:50 p.m. sitting in the front lobby in her wheelchair. The resident's urinary catheter bag was under the wheelchair uncovered and touching the floor with urine visible in the bag.</p>	F000315	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #1 catheter bag was changed on 11/6/14. The dignity style bag provided has an overlay to prevent the urine from being visible in the bag. The catheter tubing was adjusted so it no longer touches the floor.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>An audit was completed on 11/6/14 to ensure all current catheters have the dignity style bag in place and the catheter tubing is positioned properly to avoid contact with the floor. No further issues were identified via this audit.</p> <p>What measure will be put into place or what systemic changes</p>	12/05/2014

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	<p>Resident #1 was observed on 11/6/14 at 1:58 p.m. laying in bed with the urinary catheter bag attached to the side of the bed. The urinary catheter bag was visible from the hallway. The urinary catheter bag was uncovered with urine visible in the bag. Interview with the resident at the time indicated her catheter bag is never covered and sometimes it bothers her roommate.</p> <p>Record review for Resident #1 was completed on 11/6/14 at 2:00 p.m. The residents diagnoses included, but were not limited to, urostomy (surgical opening in the abdominal wall through which urine passes), multiple sclerosis, depression, paraplegia, hemiplegia.</p> <p>The Annual Minimum Data Set (MDS) assessment completed on 10/14/14 indicated the resident was cognitively intact.</p> <p>Interview with the Director of Nursing (DON) on 11/6/14 at 2:45 p.m., indicated the catheter tubing and bag should be off the floor and covered with a dignity bag at all times.</p> <p>A policy titled Daily Catheter Care and received from the Director of Nursing (DON) on 11/6/14 at 2:45 p.m., indicated, "Procedure: ... 14. Make sure</p>		<p>will be made to ensure that the deficient practice does not recur:</p> <p>The Staff Development Coordinator will conduct in-service education with nursing staff on the continued use of dignity bags and proper catheter tubing placement by 12/02/14. Facility resident "Guardian Angels" were also in-serviced on 11/26/14 on the above as an added later of oversight when completing routine resident visits.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Director of Nursing / designee will audit 3 urinary catheters to ensure compliance with the use of dignity bag covers and proper catheter tubing placement. These audits will occur 3 days per week for 3 months and then once weekly for an additional 3 months. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary</p>		

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F000363 SS=E	<p>the catheter tubing and drainage bag are kept off the floor...."</p> <p>3.1-41(a)(2)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review and interview, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect 9 of 9 residents in the facility who received a puree diet.</p> <p>Findings include:</p> <p>On 11/10/14 at 10:31 a.m., Cook #2 was observed preparing pureed glazed carrots from the recipe for lunch.</p> <p>Cook #2 added 1/2 cup of water, and then added powdered food thickener from the can without measuring. The recipe did not indicate the use of water, and indicated to use 1/2 tablespoon of food thickener per serving.</p> <p>The "Glazed Baby Carrots" recipe for 50 servings ingredients and instructions</p>	F000363	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice :</p> <p>Involved dietary staff member was re- educated on 11/12/14 on following the facility recipe for preparation of pureed diets.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>Dietary staff were educated on 11/20/2014 by the Dietary Director on following the facility policy which outlines the recipe preparation of pureed diets.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Random audits of pureed diet preparation will occur on various</p>	12/05/2014

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F000366 SS=D	<p>were "...Portions: 31 #8 scoop, Glazed Baby Carrots: 50 1/2 cup, 1. Prepare according to regular recipe, Food Thickener: 2. Process until smooth using 1/2 TBSP (Tablespoon) food thickener per serving...."</p> <p>During an interview with Cook #2 while she prepared the pureed carrots, she indicated that she used the water to thin the recipe and she estimates the amount of food thickener because the recipe calls for 50 servings which equals 1/2 cup of carrots.</p> <p>A facility policy titled, "Puree Diet," received from the Director of Nutrition as current on 11/10/14 at 10:58 a.m., indicated "...Effort is made to prepare the pureed food without the addition of a thickening agent...All items must be measured according to the recipe...."</p> <p>3.1-20(i)(4)</p> <p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. Based on observation and interview, the facility failed to provide substitutes of a similar nutritive value to a resident who</p>	F000366	<p>days and will include weekends and will also include observation at different meal times. (Breakfast, Lunch, Dinner) by the Director of dietary/designee 3 times weekly. Dietary staff received inservice education on 11/20/14 by the Dietary Director regarding adherence to facility policy for preparation of pureed food items. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary Director will observe food preparation for the pureed diet 3 times weekly for 6 months to ensure proper preparation of pureed food items. Observation results and system components will be reviewed monthly by QA for 6 months with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by</p>	12/05/2014

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	<p>refused to eat the original meal provided. (Resident #59)</p> <p>Findings include:</p> <p>During an observation on 11/05/2014 at 12:04 p.m., in the East Wing Dining Room, the staff were serving the lunch meal. There were six staff initially passing out trays, four of which then provided direct feeding assistance to residents with Speech Therapist #1 and LPN #1 observing.</p> <p>At 12:20 p.m., Resident #59 remained sitting at the end of the table not eating and with no staff interaction at all. At 12:25 p.m., the CNA sitting across the table from the resident asked if she wanted to eat. Resident #59 indicated, "I don't want puree" and refused her tray. Speech Therapist #1 was present and observed the interaction, then spoke with LPN #1 regarding Resident #59 and left without any further interaction with the resident. Resident #59 continued to verbalize, "I won't eat puree."</p> <p>At 12:46 p.m., the West Wing Unit Manager (UM) arrived to check on dining. At that time, she indicated for LPN #1 to help Resident #59. LPN #1 indicated the resident refused her puree meal and the mashed potatoes offered at</p>		<p>the deficient practice? Resident #59 was offered an alternative to the meal and she accepted. Speech therapy provided treatment to this resident from 11/06-24/14. A diet upgrade was not indicated at that time.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Per discussion with interviewable residents it was evident that they understand that they can request an alternate food choice when the original choice is not desired as long as it is of comparable nutritional value. In the event a non-interviewable resident is not eating their meal, staff will offer a substitute in the same manner as above.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Staff Development Coordinator will in-service facility staff by 12/ 02/14 on providing appropriate meal substitutes to residents who are</p>	

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F000371 SS=E	<p>the beginning of lunch and Speech Therapist #1 was aware. She further indicated nothing else had been offered to Resident #59. The West Wing UM gave a few other suggestions to LPN #1 to offer Resident #59 and the resident agreed to eat eggs. At 12:53 p.m., the West Wing UM brought eggs and juice to Resident #59 and she immediately began to eat without assistance.</p> <p>During an interview with the West Wing UM at the time of the observation, she indicated the staff present in the East Wing Dining Room should have offered other alternatives to Resident #59.</p> <p>3.1-21(a)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or</p>		<p>refusing to eat the original meal provided in a timely manner. Episodes of continued refusals without acceptance of a food substitute will be communicated to the physician and additional interventions implemented as deemed necessary.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Nursing / Designee will audit meal delivery services once daily for 8 weeks; weekly for additional 4 weeks and then monthly for 3 months to ensure residents who refuse the original meal are offered an appropriate substitute of similar nutritional value. Observation will occur at various meal times and alternate dining rooms. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure food was stored under sanitary conditions related to dirt and grime under the dishwasher and the puree blender not properly sanitized for 1 of 1 kitchens observed. (The Main Kitchen)</p> <p>Findings Include:</p> <p>1. During the Brief Kitchen Sanitation Tour with the Director of Nutrition on 11/5/14 9:10 a.m. the following was observed:</p> <p>Under the dishwasher, by the drainage pipe, a build up of dirt and grime was observed. During an interview with Director of Nutrition during the observation, she indicated the floors are cleaned after each shift.</p> <p>On 11/5/14 at 2:50 p.m., the dirt and grime was still observed under the dishwasher.</p> <p>During the Final Kitchen Sanitation Tour on 11/12/14 from 8:50 a.m. until 9:00 a.m., with the Director of Nutrition the following was observed:</p>	F000371	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice :</p> <p>Dietary staff member educated on 11/12/14 on proper use of the 3 compartment sink sanitizer (multi quat sanitizer) and proper time for equipment, ware and utensils.</p> <p>On 11/12/2014 the floor beneath the dish machine by the pipes was immediately cleaned with quat 146 floor cleaner. All grime and build up was removed at that time.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>Dietary staff were educated on 11/20/2014 by the Dietary Director on proper use of the 3 compartment sink sanitizer (multi quat sanitizer) and proper time for equipment, ware and utensils.</p> <p>Dietary staff were educated 11/20/2014 by the Dietary Director on proper sanitation of kitchen floors and adherence to the daily cleaning schedule.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>A random audit of the 3</p>	12/05/2014

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	<p>The same dirt and grime was still present under the dishwasher by the pipes. Interview with the Director of Nutrition at the time of the tour indicated that the floor was in need of cleaning.</p> <p>2. On 11/10/14 following the puree of the glazed carrots, Cook #2, was observed to wash the puree blender in the 3 compartment sink in compartment #1. Cook #2 then rinsed the blender in compartment #2 and sanitized the blender for 10 seconds in compartment #3. Cook #2 was then observed dishing the tuna casserole into the puree blender. During an interview with Cook #2, she indicated that she normally would soak the blender in the sanitizer anywhere from 10 seconds to 1 minute, but was reusing it right away.</p> <p>"Scout Pot & Pan Wash Procedure" received on 11/10/14 at 10:58 a.m. from the Director of Nutrition, indicated "...Submerge in sanitizer sink for one minute"</p> <p>A facility policy titled, "Cleaning Schedule," received on 11/12/14 at 9:42 a.m. from the Director of Nutrition as current, indicated "...to ensure that the Food and Nutrition Services department remains clean and sanitary at all times...the Director of Food and Nutrition</p>		<p>compartment sink will be done 3 times weekly by the Dietary Director or designee to ensure that equipment, wares and utensils are being submerged in the multi quat sanitizer for the appropriate amount of time per the recommendations of the multi quant sanitizer. Dietary staff were educated 11/20/2014 by the Dietary Director on proper sanitation of kitchen floors and adherence to the daily cleaning schedule. A sanitation audit will be conducted 3 times weekly by Dietary Director /designee of the kitchen floors to ensure floors are clean and free from grime and build up. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary Director/designee will audit the use of the multi quat sanitizer, in the 3 compartment sink, 3 times weekly and the floor sanitation 3 times weekly for 6 months to ensure proper use of the 3 compartment sink, multi quat sanitizer and floor sanitation is completed per facility protocol.. Observation results and system components will be reviewed monthly by QA for 6 months with subsequent plans of correction developed and implemented as deemed necessary.</p>	

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F000464 SS=E	<p>Services monitors the cleaning schedule to ensure the tasks are completed timely and appropriately."</p> <p>3.1-21(i)(3)</p> <p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation and interview, the facility failed to provide sufficient space in the East Wing Dining Room for meal times, related to residents being moved during meal time to allow other residents in and out of the dining room freely during 1 of 1 meals observed. This had the potential to effect 13 residents who eat meals in the East Wing Dining Room. (Resident #60)</p> <p>Findings include:</p> <p>During a dining observation on 11/05/2014 at 12:04 p.m., in the East Wing Dining Room, the staff were serving the lunch meal. During the meal, at 12:08 p.m., Resident #60 indicated she was not feeling well and wanted to go</p>	F000464	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The East Wing Dining Room furniture was rearranged on 11-13-2014 in order to allow ample entry and exit for residents.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>No further issues have been identified following re-arrangement of the East Wing Dining Room.</p> <p>What measure will be put into place or what systemic changes</p>	12/05/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F009999	<p>back to her room. She could not exit the dining room independently due to the crowding of the dining room. The staff had to move two other residents out of the path so Resident #60 could leave the dining room.</p> <p>During an interview with the Administrator, on 11/12/14 at 1:40 p.m. during the Environmental tour, she indicated the family style seating arrangement for the East Wing Dining Room was new and the facility would have to review the procedure to ensure all residents were able to move freely in the dining space.</p> <p>3.1-19(w)</p>	F009999	<p>will be made to ensure that the deficient practice does not recur:</p> <p>The Staff Development Coordinator will conduct in-service education with facility staff on the importance of ensuring sufficient space for residents in the dining rooms by 12/02/14.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The Director of Nursing / designee will provide oversight in facility dining rooms 3 times per week for 8 weeks and then once weekly for additional 4 months to ensure sufficient space is maintained. Audits will include observation at different meal service delivery times to validate compliance. Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary.</p>	12/05/2014
	3.1-14 PERSONNEL		What corrective action(s) will be accomplished for those residents found to have been affected by	

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	<p>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure staff personnel records for employees were current and accurate for 8 of 10 employees reviewed related to not completing physical exam timely (Activities Assistant #1, Cook #1, RN #1, CNA #1, RN #2, Dietary Aide #1, CNA #2, CNA #3)</p> <p>Findings include:</p> <p>1. Review of Activities Assistant #1's personnel record on 11/12/14 at 10:00</p>		<p>the deficient practice? No residents were affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Effective 11/12/14 new hires/associates to the facility will have a pre-employment physical completed prior to their first day of employment. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Staff Development Coordinator received in-serviced education by the Executive Director on 11/25/14 in regards to ensuring that all new associates have physical examinations completed prior to first day of employment. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Executive Director/designee will audit personnel files to ensure timely completion of physical examinations on each new associate for 6 months.</p>	

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	<p>a.m., indicated the employee was hired on 3/17/14. The record indicated a physical exam had been completed but no date was provided.</p> <p>2. Review of Cook #1's personnel record on 11/12/14 at 10:10 a.m., indicated the employee was hired on 4/18/14. The record indicated a physical exam had been completed but no date was provided.</p> <p>3. Review of RN #1's personnel record on 11/12/14 at 10:20 a.m., indicated the employee was hired on 8/21/14. The record indicated a physical exam had been completed but no date was provided.</p> <p>4. Review of CNA #1's personnel record on 11/12/14 at 10:30 a.m., indicated the employee was hired on 8/29/14. The record indicated a physical exam had been completed but no date was provided.</p> <p>5. Review of RN #2's personnel record on 11/12/14 at 10:40 a.m., indicated the employee was hired on 2/18/14. The record indicated a physical exam had been completed on 2/20/14, after employment.</p> <p>6. Review of Dietary Aide #1's personnel</p>		<p>Audit results and system components will be reviewed monthly by the QA Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>record on 11/12/14 at 10:50 a.m., indicated the employee was hired on 7/29/14. The record indicated a physical exam had been completed on 9/12/14, after employment.</p> <p>7. Review of CNA #2's personnel record on 11/12/14 at 11:00 a.m., indicated the employee was hired on 10/17/14. The record indicated a physical exam had been completed but was not signed by a physician and no date was provided.</p> <p>8. Review of CNA #3's personnel record on 11/12/14 at 11:10 a.m., indicated the employee was hired on 10/17/14. The record indicated a physical exam had been completed but was not signed by a physician and no date was provided.</p> <p>Interview with the Staff Development Coordinator on 11/12/14 at 2:30 p.m., indicated she was not aware a physical exam had to be completed prior to employment. She indicated she had not noticed some of the exams were not dated or signed by the physician.</p> <p>3.1-14(t)</p>				