STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155666		03/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE AND REHABILITATION CENTER	1751 WESLEY ROAD AUBURN, IN 46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March, 23, 24, 25, 26, and 27, 2015. Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Diane Nilson, RN, TC Rick Blain, RN Tim Long, RN Carol Miller, RN Census bed type: SNF/NF: 43 Total: 43 Census payor type: Medicare: 6 Medicaid: 23 Other: 14 Total: 43 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 31, 2015 by Randy Fry RN.	F 000	Plan of correction 2015: This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with those state allegations. Wesley Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facilities credible allegation of compliance. Wesley Healthcare requests paper compliance for F247, F282, F315, F329, F371 and F465. These were found to be low severity. There was no actual citation of harm to any of the residents.	

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

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

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F 247 SS=D Bldg. 00	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to notify 1 of 1 Residents (# 39) reviewed for notification of a roommate change. Findings include: On 3/24/15, at 8:53 A.M., an interview with Resident #39 indicated she had not been notified when she got a new roommate. An interview with the Social Service Director (SSD) on 3/26/15, at 1:33 P.M. indicated she does not record when a resident is getting a new roommate. The SSD indicated she usually notifies a resident before getting a new roommate but does not document the notification. The SSD did not have any documentation when Resident #39 got a new roommate. A progress note for the resident who moved into Resident #39's room, dated 3/13/15, noted on 3/12/15, the resident moved into Resident #39's room.	F 247	**F247 Right to notice before room/roommate change** **1. Corrective action taken:** Resident #39 was interviewed by SSD prior to getting a new roommate. SSD did not document when she spoke with resident #39. **2. Others having the potential to be affected:** All residents have the potential to be affected by the alleged deficient practice. **3. The following measures will be done to ensure the alleged deficient practices does not recur.** a) No resident shall be transferred to another room or given a roommate without advanced notice per facility policy.	04/10/2015

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	Review of an undated facility policy, provided by the Assistant Director of Nursing (ADN), on 3/26/15 at 2:15 P.M., Titled: "Room to Room Transfers", indicated under #4: "Roommates will be informed of any new transfer into their room. Such information will include why the transfer is being made and any information that will assist the roommate in accepting his or her new roommate." An interview with the ADN on 3/26/15 at 2:15 P.M., indicated the facility should have notified Resident #39 prior to getting a new roommate. **3.1-3 (v)(2)**		b) The SSD will give proper notification to residents and/or family members prior to room changes and/or new roommate. And document in residents chart. **4. The facility will monitor the corrective action to ensure the deficient practice does not recur.** All room changes/new admits will be discussed in the morning meeting. The administrator/designee will ensure that proper notification and documentation are completes with each room change x3 months, then randomly x3 months and report to QA quarterly. 5. **Date of compliance** – April 10, 2015.	
F 282 SS=E Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record reviews,	F 282		04/10/2015

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	and interviews, the facility failed to ensure medications were administered as ordered by the physician for 2 residents in a sample of 5 residents reviewed for unnecessary medications, Residents #31 and #51. The facility failed to ensure a nurse documented a resident's refusal of part of the resident's oral medications administered and observed during a medication pass. This affected 1 of 1 resident who refused to take all of the oral medications (Resident #4). In addition, the facility failed to follow their policy for flushing a Gastrostomy Tube(GT) for 1 of 1 residents observed during medication administration for GT medications, Resident #48. Findings include: 1. The record for Resident #31 was reviewed on 3/25/15, at 2:00 P.M. A physician's order, dated 3/5/15, indicated Heparin solution, 5000 unit/milliliter, administer 5000 units injection, every 8 hours. Review of the Medications Flowsheet for March, 2015, indicated the Heparin was given at 6:00 A.M., 1:00 P.M., and 9:00 P.M., on 3/6/15 through 3/24/15. The Director of Nursing Services was interviewed, on 3/26/15, at 10:25 A.M., and indicated the physician order		**F282 Services by qualified persons/per care plan** **1. Corrective action:** Resident #31 – the heparin times where corrected to ensure they were given every 8 hours, no negative outcomes identified by the alleged deficient practice. Resident #31 – the blood sugar sliding scale was reviewed no significant increase in blood sugars as a result of insulin not being given. Resident #4 – the medication list was reviewed by the doctor and some medications were discontinued after the resident stated she did not want them. Nurse #1 educated on documentation. No negative outcomes identified by the alleged deficient practice. Resident #48 – the proper flush orders where given to nurse #2 – no negative outcomes identified by the alleged deficient practice. Resident #51 – doctor clarified verbal order, ordered was written correctly, labs ordered, no negative outcome identified. **2. Others having the potential to be affected:** All residents who receive heparin; have a sliding scale with	

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	indicated the Heparin was to be given every 8 hours. She indicated one of the nurses had changed the times in March 2015 to 6:00 A.M., instead of 5:00 A.M., as the Medications Flowsheet had originally indicated. She indicated when the nurse had changed the 5:00 A.M. dose to 6:00 A.M., the nurse should have changed the other times so the medication would be given 8 hours apart as per the physician's order, but this had not been done. Physician orders for Resident #31 indicated Humalog insulin per sliding scale was to be given subcutaneously, every 6 hours as follows: If blood sugar was 121-150 - 2 units 151-200 - 4 units 201-250 - 6 units 251-300 - 8 units If blood sugar was greater than 300, the physician was to be called. Review of the Diabetic Flowsheet for March 2015 indicated the following: 3/6/15 at 6:00 P.M., the blood sugar was 122 - no insulin was given (the resident should have received 2 units of insulin). 3/10/15 at 12:00 A.M., the blood sugar was 120 - 2 units were given (no insulin should have been given) 3/20/15 at 6:00 A.M., the blood sugar		coverage; refuse any, part of or all of their medications; have peg tubes; and get verbal orders have the potential to be affected by the alleged practice. **3. The following measures will be done to ensure the alleged deficient practices does not recur.** a) All licensed nurses in-serviced on the policy and procedure for the following: importance of following doctor orders, giving meds at the right time, doing accu checks and ensuring they are being covered as ordered, documenting when residents refuse medications or don't take all meds and when receiving antipsychotics with interventions listed. b) A phone/verbal order form was implemented and put into place with all nurses and RT's trained on using them. The form was made by the medical director and approved by the other doctor in the building and the facility. **4. The facility will monitor the corrective action to ensure the deficient practice does not recur.** a)MARs/TARs will be monitored by DON/designee 3x week for 30 days, then then 2x week for 30 days then weekly for 30 days then randomly thereafter to ensure	

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	was 132 - no insulin was given (the resident should have received 2 units of insulin). 3/20/15 at 12:00 P.M., the blood sugar was 130- no insulin was given (the resident should have received 2 units of insulin). 3/25/15 at 12:00 P.M., the blood sugar was 121 - no insulin was given (the resident should have received 2 units of insulin). The current policy for Medication Administration, dated December 2013, was provided by the Director of Nursing Services on 3/26/15, at 1:35 P.M. The policy was reviewed, on 3/26/15, at 4:10 P.M., and indicated the following: All physician's orders must be accurately transcribed to the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) as needed. All medications must be administered to the resident in the manner and method prescribed by the physician. Documentation of medications given would be done in a consistent manner by the nurse placing her initials in the appropriate space on the MAR, and/or in facilities that used codes, placing the appropriate code in the appropriate space on the MAR. Documentation on the MAR would be done at the time of		meds are given at the right times and accu checks are being covered as ordered. b) Charting will be reviewed by DON/designee 3x week for 30 days then bi-weekly for 30 days then weekly for 60 days and then randomly thereafter to ensure documentation of all refusals are complete. c) Verbal order forms will be turned into the DON/designee daily, reviewed in morning meeting and checked to see if put on MARs/TARs and in the computer correctly. And report to QA with results. 5. **Date of compliance** – April 10, 2015.	

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	administration of the medication. The current policy for Insulin Administration, dated January 1, 2014, was provided by the Clinical Care Coordinator, on 3/26/15, at 4:30 P.M. The policy was reviewed, on 3/27/15, at 9:30 A.M., and indicated the following: The type of insulin, dosage requirements, strength, and method of administration must be verified to assure that it corresponded with the order on the medication sheet and the physician's order. Any discrepancies must be reported to the charge nurse and the attending physician. 2. During medication administration, on 3/25/15, at 8:50 A.M., LPN #1 was observed to crush Resident # 4's medications which included Tylenol, a multivitamin, Synthroid (a medication for low thyroid), and Pepcid, then mixed the crushed medications with applesauce. Then LPN #1 was observed to place 1 vitamin D-3 liquid pill on top of the applesauce. LPN #1 then gave Resident #4 a spoonful of the medications mixed with applesauce. The resident was observed to swallow 1 spoonful of the medication mixed with applesauce which included the vitamin D-3 pill. LPN #1 was observed to attempt to give the resident another spoonful of the			

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	medications mixed with applesauce which the resident refused. Resident #4 then refused the rest of the medication mixed with the applesauce. LPN #1 was observed to dispose of the rest of the resident's medication mixed with applesauce. An interview with LPN #1 indicated the resident did not always take all of her medications. On 3/26/15 at 9:00 A.M., during observation with the Assistant Director Of Nursing, there was no documentation on the Medication Administration Record (MAR) that indicated Resident #4 did not take all of her medications on 3/25/15 at 8:50 A.M. On 3/26/15 at 1:30 P.M., an interview with the Director Of Nursing (DON) indicated Resident #4 liked to have her medications crushed and mixed with applesauce, but indicated the resident would only take 1 bite of the medications mixed with the applesauce. The DON further indicated LPN #1 should have mixed the crushed medications with just enough applesauce to make 1 bite of the crushed medications. The DON indicated LPN #1 should have then documented on the resident's MAR or in the Progress Notes the resident's refusal to take all of the crushed medications in applesauce.			

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	The current policy for "Medication Administration", dated as revised on 12/2013, was reviewed, on 3/26/15 at 1:35 P.M. Number 7 on the policy indicated, " In the event a medication cannot be given, the reason must be documented in the Nurses Medication Notes on the MAR or Progress Notes, and the time frame circled on the MAR..." 3. During medication administration on 3/25/15 at 12:00 P.M., RN #2 was observed to check Resident #48's Gastrostomy tube (Enteral tube placed in the stomach) for placement and for residual and then RN #2 flushed the Gastrostomy tube with 60 milliliters (ml) of water. RN #2 administered the medication Cholestyramine through the Gastrostomy tube and then flushed the resident's Gastrostomy tube with 60 ml of water. On 3/25/15 at 1:00 P.M., the DON provided the current "Policy for Prior to Administering Medication for G-Tube (Gastrostomy tube)", dated January 1, 2014. The policy was reviewed at this time and indicated the following: "...Check for patency by flushing the tube with 30 ml (milliliters) of warm water...End medication administration			

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	with 30 ml ... water flush." On 3/25/15 at 1:15 P.M., an interview with RN #2 indicated she should have flushed Resident #48's gastrostomy tube with 30 cc of water instead of 60 cc before the medication was given and after the medication was administered through the gastrostomy tube. 4. The record for Resident #51 was reviewed on 3/25/2015 at 2:30 P.M. Diagnoses included, but were not limited to, hypertension (high blood pressure). A Physician's Order, dated 2/2/2015, indicated Resident #51 was prescribed Furosemide (a medication used to reduce excess fluid) 40 mg (milligrams) twice daily at 8:00 A.M. and 12:00 P.M. A physician's progress note, dated 03/18/2015, indicated "(Resident #51's) CXR (chest x-ray) actually showed some volume overload/pulmonary edema, but no consolidation. He is still complaining of the band-like tightness around his chest." The note further indicated "(Resident #51) is already getting Lasix (brand name for Furosemide) 40 bid (twice daily); will increase am (morning) Lasix to 80 mg x (times) 3 days to see if symptoms improve."			

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	The Medication Administration Record (MAR) for March 2015 for Resident #51 indicated the morning dose of the Furosemide had been increased to 80 mg on 3/19/2015 per the physician's orders. The MAR indicated the morning dose of the Furosemide had remained at 80 mg from 3/19/2015 through 3/26/2015. The facility Assistant Director of Nursing (ADON) was interviewed on 3/26/15 at 11:00 AM. During the interview, the ADON indicated the nurse who took the order from the physician to increase Resident #51's morning dose of Furosemide had indicated she had not heard the physician state the increase was only for three days. The ADON further indicated she had just called the physician and the physician indicated she had only wanted the Furosemide increased to 80 mg in the morning for three days. The ADON indicated nurses taking verbal orders from physicians should repeat the orders back to the physician to ensure accuracy. 3.1-35(g)(2)			
F 315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive			

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	assessment, the facility must ensure that a 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. Based observation, record review, and interview the facility failed to ensure urinary catheter tubing and a urine collection bag were not touching the floor for 2 residents (Resident #23 and Resident #11) in a sample of 4 residents reviewed for indwelling catheters. Findings include 1. The record for Resident #23 was reviewed on 3/26/2015 at 11:30 A.M. Diagnoses included, but were not limited to, neurogenic bladder (dysfunction of the urinary bladder due to disease of the nerves involved in bladder control) and urine retention. A care plan for Resident #23, with a start date of 2/18/2015, indicated resident #23 had an indwelling urinary catheter. The care plan indicated "Do not allow tubing or any part of drainage system to touch the floor." On 3/23/15 at 10:15 AM, Resident #23	F 315	**F315 no catheter, prevent UTI, restore bladder** **1. Corrective action taken:** Resident #23 and #11 foley catheter bags and tubing placed in dignity bags and hooked to chairs to ensure they do not touch the floor. 2. **Others having the potential to be affected:** All residents who have foley catheters in geri chairs have the potential to be affected by the alleged deficient practice. **3. The following measures will be done to ensure the alleged deficient practices does not recur.** a) All staff in-serviced on the importance of keeping catheter bags and tubing off the floor. b) All licensed staff also	04/10/2015

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	was observed in her room in a geriatric chair (a recliner on wheels). Drainage tubing from a Foley catheter (indwelling urinary catheter) was observed to be running from beneath Resident #23's clothing into a urine collection bag. The urine collection bag was observed to be in a privacy cover and was laying on the floor beneath the geriatric chair. The drainage tubing was also observed to be laying on the floor. On 3/23/15 at 12:15 P.M., Resident #23 was observed in her room in a geriatric chair (a recliner on wheels). Drainage tubing from a Foley catheter (indwelling urinary catheter) was observed to be running from beneath Resident #23's clothing into a urine collection bag. The urine collection bag was observed to be in a privacy cover and was laying on the floor beneath the geriatric chair. The drainage tubing was also observed to be laying on the floor. On 3/23/15 at 1:35 PM., Resident #23 was observed in her room in a geriatric chair (a recliner on wheels). Drainage tubing from a Foley catheter (indwelling urinary catheter) was observed to be running from beneath Resident #23's clothing into a urine collection bag. The urine collection bag was observed to be in a privacy cover and was laying on the		in-serviced on infection control with catheters touch the floor. c) All geri chairs will have a special hook in place for catheter bags to ensure they do not touch the floor. **4. The facility will monitor the corrective action to ensure the deficient practice does not recur.** The DON/designee will conduct audits to ensure no catheter bags or tubing touch the floor 3x week for 30 days then 2x week for 30 days then weekly for 30 days then randomly thereafter. And report findings to QA. 5. **Date of compliance** – April 10, 2015.	

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	floor beneath the geriatric chair. The drainage tubing was also observed to be laying on the floor. The facility DON (Director of Nursing) was interviewed on 3/26/2015 at 1:45 P.M. During the interview, the DON indicated urine collection bags for catheters and catheter drainage tubing should not touch the floor. The DON indicated the collection bag and tubing should be hung on the side of the resident's bed or chair to prevent contact with the floor. 2. On 3/26/15, at 10:30 A.M., Resident #11 was observed in his room in a reclining rolling chair with his indwelling urinary catheter bag touching the floor. On 3/26/15, at 10:45 A.M., Resident #11 was observed in his room in a reclining rolling chair with his indwelling urinary catheter bag touching the floor. On 3/26/15, at 11:00 A.M., Resident #11 was observed in a rolling chair, being pushed by a CNA. As the resident reached the hallway, the Activity Director was observed moving the indwelling urinary catheter bag off the floor and secured it properly to the chair. Review of Resident #11's care plan for a indwelling urinary catheter, dated			

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	11/05/14, indicated under approaches: "do not allow tubing or any part of the drainage system to touch the floor." A current facility policy entitled "Catheter Care", dated 3/2007 and provided by the DON on 3/36/2015 at 1:40 P.M., did not address keeping the urine collection bags or drainage tubing off of the floor. 3.1-41(a)(2)			
F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically			

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	contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted prior to administering psychopharmacological medications to 2 residents (Resident #51 and Resident #39) in a sample of 5 residents reviewed for unnecessary medications. Findings include: 1. The clinical record of Resident #39 was reviewed on 3/25/15 at 10:15 A.M. Diagnoses included, but were not limited to, anxiety. The March 2015 Medication Administration Record (MAR) indicated the resident had received Ativan (used to treat anxiety) 0.5 milligrams (mg) by mouth on 3/14/15 at 12:00 A.M. and 6:00 P.M. There was no documentation on the resident's MAR or in the Progress Notes to indicate any interventions were tried prior to the administration of the Ativan on 3/14/15 at 12:00 A.M. and 6:00 P.M. The Physician's Order dated 8/28/14 indicated Ativan 0.5 milligrams by mouth every 8 hours as needed. The Care Plan for anxiety dated 8/27/14	F 329	**F329 Drug regimen is free from unnecessary drugs** **1. Corrective action taken:** Resident #39 no longer resides at facility. Resident #51 was re-evaluated by psych NP. With no changes in his Ativan order. No negative outcomes identified by the alleged deficient practice. 2. **Others having the potential to be affected:** All residents who take PRN antipsychotics have the potential to be affected by the alleged deficient practice. 3. **The following measures will be done to ensure the alleged deficient practices does not recur:** Nurses will be re-educated on non-pharmacological interventions prior to the usage of PRN medications. Extra reminders of interventions, resident specific, will be place in MARs. **4. The facility will monitor the corrective action to ensure the**	04/10/2015

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	and evaluated on 3/6/15 for Resident #39 indicated "...Alter the cause of anxiety if able...Attempt to find out the reason or cause of anxiety...." 2. The record for Resident #51 was reviewed on 3/25/2015 at 2:30 P.M. Diagnoses included, but were not limited to, anxiety. A Physician's Order, dated 1/13/2015, indicated Resident #51 was prescribed Ativan (a medication used to treat anxiety) 1 mg (milligram) by mouth every six hours as needed for anxiety. The March 2015 Medication Administration Record (MAR) for Resident #51 indicated the resident had been administered Ativan 1 mg by mouth on the following dates and times: 3/1/2015 at 10:00 P.M. 3/2/2015 at 9:00 P.M. 3/4/2015 at 10:00 P.M. 3/5/2015 at 9:00 P.M. 3/6/2015 at 9:00 P.M. 3/7/2015 at 9:00 P.M. 3/8/2015 at 9:00 P.M. 3/9/2015 at 9:00 P.M. 3/10/2015 at 9:00 P.M. 3/11/2015 at 9:00 P.M. 3/12/2015 at 9:00 P.M. 3/14/2015 at 9:00 P.M. 3/16/2015 at 9:00 P.M.		**deficient practice does not recur.** DON/designee will audit to ensure continued compliance with the use of PRN psychotropics and documentation of interventions. These audits will be conducted weekly for one month then bi weekly for 3 months then randomly thereafter. The report will be shared with QA. 5. **Date of compliance** – April 10, 2015.	

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	3/17/2015 at 8:00 A.M. and 9:00 P.M. 3/18/2015 at 8:00 P.M. 3/19/2015 at 8:00 P.M. 3/20/2015 at 8:00 P.M. 3/21/2015 at 9:00 P.M. 3/25/2015 at 8:00 P.M. A care plan for Resident #51, with a start date of 10/22/2014 and edited by the Social Service Director on 1/9/2015, indicated the resident had a diagnosis of anxiety. The care plan indicated approaches staff were to use when the resident experienced anxiety included, but were not limited to, attempting to alter the cause of the anxiety if able, attempting to find out the reason or cause of the anxiety, and encouraging activities of the resident's choice. The facility Social Service Director (SSD) was interviewed on 3/26/2015 at 1:35 P.M. During the interview, the SSD indicated she had developed the care plan to address Resident #51's anxiety. The SSD further indicated staff were to attempt the non-pharmacological interventions prior to administering the Ativan. The facility Director of Nursing (DON) was interviewed on 3/26/2015 at 1:50 P.M. During the interview, the DON indicated nursing staff were to attempt			

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	non-pharmacological interventions as indicated on the care plan in an attempt to reduce anxiety prior to administering a PRN (as needed) psychiatric medication. The DON further indicated nursing staff were to document which interventions had been attempted and the effectiveness of the interventions. The DON indicated the documentation should be completed in the resident's progress notes. A review of Resident #51's progress notes for March 2015 did not indicate any non-pharmacological interventions had been attempted by staff prior to administering the Ativan. A facility policy entitled "Medication Administration", dated 12/2013 and provided by the DON on 3/26/2015 at 3:00 P.M., indicated "PRN medication should be given only after the resident is encourage (sic) to use other symptom management techniques, such as stress management, etc. according to the resident's individual care plan. 3.1-48(a)(4)			
F 371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -			

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	(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, interview and record review, the facility failed to ensure food was stored correctly on 1 of 1 observations. This had the potential to affect 34 residents who received meals from the facility kitchen. Findings include: During a kitchen inspection on 3/23/15, at 9:35 A.M., a plastic wrapped package of ground beef was noted with a date of 3/5/2015 in a refrigerator. An interview with Cook #3 on 3/23/15, at 9:45 A.M. indicated the ground beef was set out to thaw the day before and was to be used on 3/23/15 for lunch. During inspection of the dry food storage area on 3/23/15 at 9:40 A.M., a bin of rice was observed to be uncovered with the lid approximately 3 inches off the container. An interview with the Dietary Manager (DM) on 3/23/15 at 9:41 A.M. indicated the rice should have been covered and she directed Cook #3 to discard the rice in the bin.	F 371	**F371 food procure, store/prepare/serve – sanitary** **1. Corrective action taken:** The facility will store and thaw food under sanitary conditions. The rice and container and the ground beef where thrown away at the time it was found. All non-compliant storage containers have been disposed of. All items requiring labeling have been appropriately labeled. 2. **Others having the potential to be affected:** All residents that are served meals from the kitchen have the potential to be affected by the alleged deficient practice. **3. The following measures will be done to ensure the alleged deficient practices does not recur.** a) Dietary staff was in-serviced on proper methods of thawing meats and labeling and storing dry goods in proper containers. 4. **The facility will monitor the**	04/10/2015

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	Review of the current policy provided by the DM on 3/27/15 at 9:10 A.M., titled Food Storage, dated 2010, under Procedure, section 4 stated: "Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods."; In addition, Section 15, c. Frozen Foods stated: "Frozen meat, poultry, and fish should be defrosted in a refrigerator for 24-48 hours, and should be used immediately after thawing; d. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded." 3.1-21(i)(1)		**corrective action to ensure the deficient practice does not recur.** The administrator/dietary manager will monitor for proper labeling and food storage 3x week for 30 days then 2 x weeks for 30 days then weekly for 3 months then randomly thereafter. And report to QA with findings. 5. **Date of compliance** – April 10, 2015.	
F 465 SS=D Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations, and interviews, the facility failed to ensure the cove base in resident #38's bathroom was clean. This deficiency affected 1 of 1 resident whose cove base in the bathroom was not completely clean (Resident #38) .	F 465	**F465** **safe/functional/sanitary/comfortable environment** **1. Corrective action taken:**	04/10/2015

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	Findings include: On 3/23/15 at 11:05 A.M. in Resident #38's bathroom the cove base was observed to be dirty. On 3/23/15 at 11:59 A.M. an interview with Resident #38 indicated " They don't always clean good, sometimes the bathroom is dirty ...along the walls." On 3/27/15 at 8:10 A.M. with the Administrator, the Maintenance Director, and the Environmental Director an observation of Resident #38's bathroom indicated the cove base was dirty. On 3/27/15 at 8:00 A.M. an interview with the Environmental Director indicated the resident's bathrooms were cleaned every day. The Environmental Director indicated the cove base in Resident #38's bathroom had an accumulation of some dried wax and when the bathroom floor was mopped the dirt that was on the mop was pushed onto the cove base by the mop where the wax and dirt from the floor dried on the cove base. 3.1-19(f)		The cove base in resident #38's bathroom was cleaned of all dried wax. No negative outcomes identified by the alleged deficient practice. 2. **Others having the potential to be affected:** All bathroom floors can potentially be affected. **3. The following measures will be done to ensure the alleged deficient practices does not recur.** a) All housekeepers in-serviced on daily room cleaning with specific things to look for including but not limited to wax build up on the cove bases. 4. **The facility will monitor the corrective action to ensure the deficient practice does not recur.** Environmental director /designee will monitor 2xweek for 30 days then weekly for 30 days then monthly x 3 months. And report to QA with findings. 5. **Date of compliance** – April 10, 2015.	

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