

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2015
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00174705.</p> <p>Survey dates: June 11, 12, 15, 16, 17 and 18, 2015</p> <p>Facility number: 000222 Provider number: 155329 AIM number: 100274950</p> <p>Census bed type: SNF: 11 SNF/NF: 141 Total: 152</p> <p>Census payor type: Medicare: 36 Medicaid: 75 Other: 41 Total: 152</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after July 2nd , 2015.</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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F 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was showered as preferred for 1 of 3 residents reviewed for choices. (Resident #311)</p> <p>Findings include:</p> <p>Resident #311's record was reviewed on 6/15/15 at 10:12 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure (CHF), hypotension, arthritis, atrial fibrillation, neuropathy, bladder cancer, and had a colostomy. The record indicated Resident #311 admitted to the facility on 5/20/15.</p> <p>A 5/27/15 MDS assessment indicated Resident #311's BIMS (Brief Interview for Mental Status) score was "10" which indicated the resident did not have a severe cognitive impairment. The assessment also indicated it was "very important" to the resident to choose the</p>	F 0242	<p>F 242 Self Determination- Right to make choices</p> <p>It is the practice of this provider to ensure that all alleged violations involving self determination- right to make choices are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Resident #311 will be interviewed to determine bathing preference, and bathing will be provided according to preference.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p>	07/02/2015
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	<p>type of bathing care he received. A 6/1/15 MDS (Minimum Data Set) assessment indicated the resident required one person physical assistance from staff for bathing care.</p> <p>A 6/17/15 Social Service progress note indicated Resident #311 had a BIMS score of "12/15" which indicated the resident did not have a severe cognitive impairment.</p> <p>On 6/15/15 at 2:54 p.m., during an observation and interview, Resident #311 and his wife were in the resident's room. The resident was seated in a wheelchair visiting with his wife. He was alert and oriented to person, place, time, and situation. He indicated he had received 3 showers since his admission to the facility. He indicated he had never refused a shower offered by any staff member. During the same interview, his wife indicated they had told nursing staff the resident would like more showers during the week than he had been receiving.</p> <p>A document titled "Preferences for Daily Customary Routines" was received from the Medical Records LPN on 6/16/15 at 1:28 p.m. It indicated Resident #311 preferred to have a "shower every other day" between 7:00 a.m. and 8:00 a.m.</p>		<p>CEC/Designee will in-service all nursing staff on bathing according to residents preference by 7/2/15.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Unit managers/designee will complete daily audits to ensure that residents are receiving bathing per resident preference.</p> <p>Activity Director/Designee will update resident preferences for bathing upon admission, with significant change, quarterly, and per resident request.</p> <p>CEC/Designee will in-service all nursing staff on bathing according to residents preference by 7/2/15.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>An accommodation of needs CQI tool will be completed weekly x 4 weeks, monthly x 5 months, with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</p>	

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	<p>A facility ADL log indicated Resident #311 received a shower on the following dates: 5/21/15 (third shift), 5/22/15 (third shift), 5/23/15 (second shift), 5/29/15 (third shift), and 6/11/15 (first shift).</p> <p>On 6/16/15 at 9:52 a.m., during an interview, Resident #311 indicated he waited for "40 minutes outside the shower room" that morning but did not receive a shower. He indicated he mentioned to a CNA that he was waiting for a shower and she told him to "have a seat, they open up in a little bit." The resident also indicated he had never received a shower between 12:00 a.m. and 4:00 a.m. on any day during his stay at the facility as he "would remember someone waking me up for that." He also indicated not receiving any complete bed baths by facility staff and washing himself up when he is not able to get staff to help him take a shower.</p> <p>On 6/16/15 at 2:52 p.m., during an interview, Resident #311 indicated he did not receive a shower or a bed bath on 6/16/15. He indicated "I just washed myself up today." He indicated needing staff assistance to take a shower and to clean most parts of his body.</p> <p>On 6/17/15 at 8:18 a.m., during an</p>		<p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>Date of Compliance 7/2/15</p>	
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	<p>interview, the DNS (Director of Nursing Services) indicated resident showers were normally performed on "days and evening" shifts and not on third shift.</p> <p>On 6/17/15 at 8:53 a.m., during an interview, the Clinical Education Coordinator (CEC) indicated Resident #311 "probably did not get showered on third shift" on the dates listed above and it was not customary for facility residents to receive showers on third shift which she identified as between the hours of 9 p.m. and 5 a.m. She indicated the employees who documented the third shift showers for Resident #311 in the electronic record, "may need further training," on the facility's bathing process.</p> <p>On 6/17/15 at 9:18 a.m., during an interview, CNA #1 indicated Resident #311 asked for a shower on 6/16/15, but he was "not on the shower schedule" for the day. She indicated she told the resident she would attempt to get him showered but she had other residents scheduled for a shower already on 6/16/15.</p> <p>On 6/17/15 at 11:31 a.m., during an interview, the DNS (Director of Nursing Services) indicated she did not believe Resident #311 received showers on third</p>			

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	<p>shift as documented by CNA #2. She indicated third shift CNA #2, who documented showers were provided to Resident #311 on third shift on 5/21/15 (1:14 a.m.), 5/22/15 (1:10 a.m.), 5/29/15 (12:37 a.m.), was no longer an employee of the facility.</p> <p>A self care deficit care plan, dated 5/21/15, indicated Resident #311 required staff assistance with personal hygiene. Interventions on the care plan included, but were not limited to, "...Provide shower every other day..." and "...Encourage resident (#311) to make choices in care such as clothing, shower time preference..." The same care plan indicated for nursing staff to provide 1 person assistance with ADL's for the resident.</p> <p>A facility "North Shower Schedule", undated, indicated Resident #311 was scheduled for showers on "Wednesday/Saturday-Days".</p> <p>A facility policy, dated "11/2011" and titled "Preferences for Daily Routines" indicated a preference worksheet was completed " ...upon admission of a new resident ... " and " ...the information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's</p>			

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F 0312 SS=D Bldg. 00	<p>preferences ... "</p> <p>3.1-3(u)(1)</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.</p> <p>Based on interview and record review, the facility failed to ensure a resident was provided bathing care for 1 of 3 residents reviewed for ADL's. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 6/15/15 at 10:50 a.m. The resident's diagnoses included, but were not limited to, motor vehicle accident, ischemic heart disease, multiple rib fractures, and other bone fracture.</p> <p>A 5/7/15 MDS (Minimum Data Set) assessment indicated Resident #B had a BIMS score of "13" which indicated the resident did not have a severe cognitive impairment. The assessment also indicated the resident required "Two+persons physical assist" from staff for bathing care.</p>	F 0312	<p>F 312 ADL care provided for dependent residents</p> <p>It is the practice of this provider to ensure that all alleged violations involving ADL care provided for dependent residents are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Resident #B no longer resides at the facility.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p>	07/02/2015

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	<p>A 5/1/15 ADL care plan for Resident #B, indicated "...Resident requires staff assist to complete daily bathing, dressing, grooming, personal hygiene..." One of the interventions on the care plan, dated 5/1/15, indicated for the resident to receive two showers per week with partial baths in between.</p> <p>A document titled "Preferences for Daily Customary Routines" (for Resident #B), dated 5/4/15, was received from Medical Records on 6/16/15 at 1:28 p.m. It indicated the resident preferred to take a shower 2 times weekly between 8:00 a.m. and 9:00 a.m.</p> <p>ADL records for Resident #B indicated he received a shower on 5/1/15 (third shift), 5/2/15 (third shift), 5/6/15 (third shift), 5/8/15 (third shift), 5/10/15 (third shift), 5/15/15 (third shift), 5/20/15 (first shift), 5/21/15 (first shift), 5/22/15 (third shift), 5/25/15 (third shift), 5/27/15 (one shower documented on third shift and one on first shift) and 5/29/15 (two showers documented on third shift). The same records indicated the resident received a "Partial Bed Bath" on the following dates: 5/1/15 (2), 5/3/15, 5/4/15, 5/5/15, 5/6/15, 5/7/15, 5/9/15, 5/11/15, 5/13/15, 5/14/15 (2), 5/14/15 (2), 5/15/15 (2), 5/16/15, 5/17/15,</p>		<p>CEC/designee will in-service all nursing staff on bathing according to residents preference and how to properly document bathing in Matrix/POC by 7/2/15.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Unit managers/designee will complete daily audits to ensure that residents are receiving bathing per resident preference.</p> <p>DNS/designee will review bathing documentation in POC/Matrix daily to ensure bathing was performed and appropriate documentation occurred per plan of care.</p> <p>CEC/designee will in-service all nursing staff on bathing according to residents preference and how to properly document bathing in Matrix/POC by 7/2/15.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>An accommodation of needs CQI tool will be completed weekly x 4 weeks, monthly x 5 months with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved,</p>	

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	<p>5/18/15 (2), 5/19/15, 5/21/15, 5/22/15, 5/23/15, 5/24/15 (2), 5/26/15, and 5/30/15. The record also indicated the resident received a "Complete Bed Bath" on the following dates: 5/2/15, 5/5/15 (one on third shift and one on first shift), 5/7/15 (third shift), 5/9/15, 5/10/15, 5/13/15, and 5/28/15 (one on first shift and one on third shift).</p> <p>The record indicated CNA #2 documented showers were provided for Resident #B on the following dates: May of 2015: 5/1/15 (1:34 a.m.), 5/2/15 (1:02 a.m.), 5/6/15 (12:27 a.m.), 5/8/15 (2:40 a.m.), 5/10/15 (12:11 a.m.), 5/15/15 (2:48 a.m.), 5/25/15 (12:07 a.m.), 5/27/15 (4:48 a.m.), 5/29/15 (12:46 a.m.) 5/29/15 (9:54 p.m.).</p> <p>Facility "Shower Report"(s) for Resident #B were provided by the DNS (Director of Nursing Services) on 6/15/15 at 3:02 p.m. The sheets indicated the resident refused a shower on 5/6/15 and 5/13/15 (refused shower but received bed bath). The sheets indicated the resident received a shower on 5/7/15, 5/9/15, 5/16/15, 5/20/15, and 5/23/15.</p> <p>On 6/15/15 at 12:50 p.m., On 6/15/15 at 12:50 p.m., during an interview with the complainant, she indicated Resident #B was not provided a shower or complete</p>		<p>an action plan will be developed to ensure compliance.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>Date of Compliance 7/2/15</p>	

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	<p>bed bath between 4/30/15 and 5/18/15.</p> <p>On 6/17/15 at 8:19 a.m., during an interview, the DNS indicated CNA's (Certified Nursing Assistants) "do not give showers on third shift usually." She indicated shower sheets are "not part of the resident's clinical record", but indicated the ADL (Activities of Daily Living) bathing record in the electronic record reflects the actual number of times a resident received bathing care.</p> <p>On 6/16/15 at 9:42 a.m., during an interview, Unit Manager #4 indicated "We don't do showers on night shift." She indicated the facility routine was to attempt to balance showers between days and evening shift and to accommodate resident preferences as much as possible. She also indicated the staff was guided by nursing management not to get people out of bed before 5 a.m. to allow the residents to get as much rest as possible.</p> <p>On 6/17/15 at 8:53 a.m., during an interview, the Clinical Education Coordinator (CEC) indicated Resident #B "probably did not get showered on third shift" on the dates listed above and it was not customary for facility residents to receive showers on third shift which she identified as between the hours of 9 p.m. and 5 a.m. She indicated the</p>			

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	<p>employees who documented the third shift showers for Resident #B in the electronic record, "may need further training" on the bathing process.</p> <p>On 6/17/15 at 11:31 a.m., during an interview, the DNS (Director of Nursing Services) indicated she did not believe Resident #B received showers on third shift as documented by CNA #2. She indicated third shift CNA #2, who documented the third shift showers provided to Resident #B, was no longer an employee of the facility. She indicated showers are not normally done on third shift and are scheduled throughout the days and evening shifts except by individual resident preference or as some other unique circumstance would warrant a third shift shower.</p> <p>On 6/17/15 at 1:13 p.m., during a telephone interview, Resident #B indicated he only received one shower during his time at the facility and had never received a complete bed bath at any time during his stay at the facility. He indicated the one shower he received was on the day shift and he was assisted by therapy staff to the shower where he was able to complete the shower mostly by himself. He also indicated having never refused a shower or bed bath while a resident of the facility.</p>			

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F 0371 SS=E Bldg. 00	<p>On 6/18/15 at 12:43 p.m., during an interview, CNA #3 indicated she was familiar with Resident #B ' s care needs. She indicated he was not resistive to care with bathing. She did not recall how often he was bathed.</p> <p>On 6/17/15 at 1:58 p.m., the DNS provided 2 documents, dated "2/2010" and titled "HS CARE" and "AM CARE". She identified the documents as "basically the policy" on how CNA staff should provide care for residents to maintain a resident's highest functional level regarding ADL's. The documents indicated for CNA's to provide assistance to resident's for toileting, perineal care, washing, shaving, and other grooming and ADL routines.</p> <p>This Federal Tag relates to Complaint # IN00174705.</p> <p>3.1-38(b)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>			

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	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to store raw meat below ready to eat foods in the refrigerator. This had the potential to affect 150 residents who eat food from the kitchen.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted on 6/11/15 at 10:20 a.m. The multi-rack, mobile food storage cart was observed with foods stacked in the following order, from top to bottom:</p> <p>ready to eat individual bowls of pudding raw ground sausage diced ham roast beef and turkey ready to eat individual bowls of pudding ready to eat individual bowls of pudding roast beef raw pork roast raw ground beef raw ground beef</p> <p>A sign was posted on the wall in the refrigerator. It indicated, "Raw poultry and meats must be store (sic) separately</p>	F 0371	<p>Facility requests face to face IDR hearing for this citation.</p> <p>F371 Food procure, store, prepare, serve- sanitary</p> <p>It is the practice of this provider to ensure that all alleged violations involving procurement, storage, preparing, and preserving of food are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>All improperly stored food was disposed of prior to serving, thereby no residents were affected due to this alleged deficient practice.</p> <p>All food is properly stored according to the food storage policy.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents that would have consumed the potentially contaminated food had the potential</p>	07/02/2015

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	<p>or below ready to eat, cooked foods to avoid cross contamination and potential foodborne illness. Whenever possible segregate food items. The order of foods is based upon the required minimum internal cooking temperature of each food, as per the 2005 FDA (Food and Drug Administration) Food Code."</p> <p>An interview was conducted with the Dietary Manager on 6/11/15 at 10:35 a.m. She indicated all the pudding should have "absolutely" been on the top racks, above the uncooked meats.</p> <p>An interview was conducted with the Dietician on 6/12/15 at 1:45 p.m. She indicated the diced ham and the turkey were cooked meats.</p> <p>The Food Storage Policy was provided by the Dietician on 6/12/15 at 1:45 p.m. It indicated, "Food is stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination....Cooked foods must be stored above raw foods to prevent contamination."</p> <p>3.1-21(i)(3)</p>		<p>to be affected by the alleged deficient practice.</p> <p>All dietary staff will be inserviced on the food storage policy by the dietary manager/designee by 7/2/15.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Dietary manager or designee will check daily after each meal service to ensure all food items, including raw poultry and meats, are stored according to food storage policy using the short sanitation tool.</p> <p>-</p> <p>All dietary staff will be inserviced on the food storage policy by the dietary manager/designee by 7/2/15.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>A kitchen sanitation/environmental review tool will be completed by the dietary manager or designee after each meal service weekly x 4 weeks, monthly x 5 months with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an</p>	

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F 0508 SS=D Bldg. 00	<p>483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to obtain an EKG (electrocardiogram), as ordered, for 1 of 5 residents reviewed for unnecessary medication. (Resident #147)</p> <p>Findings include:</p> <p>The clinical record for Resident #147 was reviewed on 6/16/15 at 11:00 a.m. The diagnoses for Resident #147 included, but were not limited to: atrial fibrillation.</p>	F 0508	<p>action plan will be developed to ensure compliance.</p> <p>RD/designee will complete kitchen sanitation review monthly. If threshold is less than 95% an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>Date of Compliance 7/2/15.</p> <p>F 508 Provide/Obtain Radiology/Diagnostic Services</p> <p>It is the practice of this provider to ensure that all alleged violations involving providing and obtaining radiology and diagnostic services are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>An EKG was ordered and performed</p>	07/02/2015

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	<p>The June, 2015 Physician's Orders for Resident #147 indicated an EKG to be done once a day on the last Tuesday of every 3rd month, effective 5/8/14. The actual months for EKG's to be done were not listed on the orders. No EKG results were found in the clinical record.</p> <p>An interview was conducted with the DON (Director of Nursing) on 6/16/15 at 1:30 p.m. She indicated the last EKG for Resident #147 was completed in March of 2014 and provided a copy at this time. It was dated 3/25/15. She indicated the EKG order was written for every 3rd month instead of listing the actual months, so it wasn't caught.</p> <p>3.1-49(g)</p>		<p>for resident #147</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who have radiology and diagnostic testing ordered by physician have the potential to be affected by this alleged deficient practice.</p> <p>CEC/designee will in-service all nurses on how to properly transcribe lab and radiology orders by 7/2/15.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Medicals Records Nurse/Designee will check all diagnostic and radiology orders daily to ensure orders have been transcribed correctly.</p> <p>Diagnostic and radiology testing will be checked daily by Unit Managers/Designee to ensure they were completed.</p> <p>CEC/designee will in-service all nurses on how to properly transcribe lab and radiology orders by 7/2/15.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>	

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F 9999 Bldg. 00	<p>3.1-14 Personnel</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>(5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review,</p>	F 9999	<p>i.e. what quality assurance program will be put into place?</p> <p>Lab and Diagnostic CQI tool will be completed weekly x 4 weeks, monthly x 5 months, with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>Date of Compliance 7/2/15</p> <p>F9999 Final Observations</p> <p>It is the practice of this provider to ensure that all alleged violations involving recertification of licensure are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>CNA #10 has current nursing assistant certification. CNA # 11 no longer employed at this facility.</p>	07/02/2015	

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	<p>the facility failed to maintain current certified nursing assistant licensure for 2 of 60 certified nursing assistants reviewed for professional licensure (CNA #10 & CNA #11).</p> <p>Findings include:</p> <p>The Employee Records form was reviewed on 6/18/15 at 12:15 p.m. The Employee Records form indicated a start date of 7/23/14 for CNA #10 and start date of 4/17/15 for CNA #11. CNA #10's certified nursing assistant license indicated an expiration date of 6/7/15. CNA #11's certified nursing assistant out of state license indicated an expiration date of 5/31/15.</p> <p>During an interview with the Clinical Education Coordinator (CEC), on 6/18/15 at 1:45 p.m., the CEC indicated she renewed CNA #10's license today because she overlooked the expiration date of his license. The CEC also indicated she noted the expiration date on CNA #11's out of state license when CNA #11 was hired. The CEC further indicated she thought the facility/CNA #11 had 120 days to acquire an in-state license after CNA #11 started working at the facility, whether the out of state license was expired or not.</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>All personnel files will be audited by CEC/designee to ensure that all licensure/certifications are current.</p> <p>CEC will be in-serviced by DNS on licensure certification tracking and regulations by 7/2/15.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>CEC/designee will complete weekly audit X 4 weeks, and monthly X 5 months to ensure licensure/certification is active and will verify that licensure/certification is current upon hire.</p> <p>CEC will be in-serviced by DNS on licensure certification tracking and regulations by 7/2/15</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p>				

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	<p>CNA #10's worked schedule provided by the CEC, on 6/18/15 at 2:25 p.m., indicated CNA #10 worked on 6/10/15, 6/13/15, and 6/14/15 after his license was expired.</p> <p>CNA #11 worked schedule provided by the CEC, on 6/18/15 at 2:55 p.m., indicated CNA #11 worked on 6/2/15, 6/4/15, 6/13/15, & 6/15/15 after her license expired after 5/31/15.</p>		<p>ED/designee will complete monthly audit for 6 months of employee files to ensure certification and licensure is current.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>Date of Compliance 7/2/15</p>		