

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/30/2012
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NAME OF PROVIDER OR SUPPLIER ALEXANDRIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 S PARK AVE ALEXANDRIA, IN 46001
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 23, 24, 25, 26, 27, and 30, 2012</p> <p>Facility number: 000518 Provider number: 155521 AIM number: 100266670</p> <p>Survey team: Donna M. Smith, RN, TC Toni Maley, BSW Gina Berkshire, RN Dorothy Watts, RN</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 4 Medicaid: 50 Other: 13 Total: 67</p> <p>Sample (Stage 2): 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/6/12</p>	F0000	<p>Submission of this Plan of Correction does not constitute an Admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and Submitted because of State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</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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	Cathy Emswiller RN			
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F0174 SS=E	<p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>Based on interview and record review, the facility failed to ensure residents who resided on the 300 hall Memory Care Unit/Dementia unit were provided a place to make private phone calls for 1 of 1 resident identified during a family interview who met the criteria for private phone use in a Stage 2 sample of 35. This had the potential to impact 20 of 20 residents residing on the Memory Care Unit. (Resident #69)</p> <p>Findings Include:</p> <p>Resident #69's clinical record was reviewed on 1/26/12 at 12:20 p.m.</p> <p>Resident #69's current diagnoses included, but were not limited to, Psychosis secondary to Alzheimer's disease and hypoxia. Resident #69 had a current 1/2012 physician's order to reside on the secured dementia unit.</p> <p>Resident #69 had a current 1/10/12, quarterly, Minimum Data Set assessment (MDS) which indicated the resident was severely cognitively impaired and rarely to never made</p>	F0174	<p>1. Resident #69 was provided assist with telephone use as requested. She had never requested a private area. Resident #69 will be offered a private area for telephone use and provided as requested. 2. All residents on the Memory Care/Dementia Unit have the potential to be affected. All residents requesting to make a telephone call will be offered a private area. A private area will be provided upon request. 3. All staff will be in-serviced on resident rights to include privacy during telephone use. The SSD or designee will monitor for privacy offered for telephone use on the Memory/Dementia care unit daily on regularly scheduled days for 1 month, then twice weekly for 1 months, then weekly for 1 months, then quarterly (Attachment A). 4. Any findings and subsequent disciplinary action will be reviewed by the SSD or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/20/2012			

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	<p>independent choices.</p> <p>Resident #69 had a current, 1/12/12, care plan problem/need, which originated 2/10/11, indicated her establishing her own goals for how to spend her time.</p> <p>During an 1/24/12, 10:04 a.m., interview, Resident #69's family member indicated the resident did not make phone calls in private. She made all her phone calls with staff assistance at the nursing station.</p> <p>During an 1/26/12, 2:38 p.m. during in an interview, CNA #8 indicated residents on the secured dementia unit made their phone calls at nurse's desk. She indicated there was nowhere to make a private call on the dementia unit.</p> <p>During an 1/26/12, 2:40 p.m., interview, LPN #7 indicated, Resident #69 liked to call her son. He indicated residents on the dementia unit use the phone at the nurse's desk. Additionally, there was no cordless phone on the hall. He had not considered the nursing station being a public area.</p> <p>During an 1/27/12, 7:51 a.m., interview, the Social Service Director</p>						

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	<p>indicated she was the Dementia Unit Director and presently had 20 residents on the unit. She indicated residents on the dementia unit made phone calls at the 300 nurse's station with staff assistance. Additionally, If a resident was up front (the area outside the secured area) for activities, the resident could use the private phone located in that area. She had never thought of the need for a private phone on the dementia unit. She additionally indicated, It could be difficult at times to escort a resident off the unit to make a phone call at the private phone area up front. She had never considered a cordless phone, which the resident could carry away from the station, to provide a private location.</p> <p>Review of a current, undated, facility policy titled "Your Rights As A Nursing Home Resident, which was provided by the Administrator on 1/27/12, 10:55 a.m., indicated the following: "You have the right to: ...Privacy during your visits or meetings, in making telephone calls..."</p> <p>3.1-3(f)</p>				

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F0241 SS=E	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure dependent residents received assistance to style their hair in a manner that promoted dignity for 2 of 5 residents reviewed for grooming assistance who met the criteria for services to promote dignity in the Stage 2 sample of 35 residents (Resident #61 and #68). The facility also failed to ensure residents who resided in the Memory Care Unit had tables cleared after meals in a manner to promote dignity when dining. This deficient practice had the potential to impact 19 of 19 residents who received meals in the Memory Care dining room.</p> <p>Findings Include:</p> <p>1.) Resident #61's clinical record was reviewed on 1/27/12 at 1:00 p.m.</p> <p>Resident #61's current diagnoses included, but were not limited to, anxiety, hypothyroidism and dementia with psychosis.</p> <p>Resident #61 had a current, 11/11/11, quarterly, Minimum Data Set</p>	F0241	<p>1. Resident #61 had hair damage prior to being admitted to the facility. This hair damage has caused a wiry appearance. The goal of resident #61's family was to allow her hair to grow then be evaluated by the beautician for further recommendations. She will be evaluated by the beautician and hair treatment will be provided as recommended. Resident #68's family, who provided hair care for her, had been ill and requested that her hair be washed in the shower. The family was in facility and set resident #68's hair upon illness being resolved. Upon notification the tables on the Memory Care/Dementia unit were cleared after meals in a manner that promotes dignity with dining.</p> <p>2. All residents with a permanent or damaged hair have the potential to be affected. All resident's hair was observed to ensure proper hair care is being provided to maintain dignity. All residents dining in the Memory Care/Dementia Unit have the potential to be affected. Tables are cleared on the Memory Care/Dementia Unit in a manner to provide dignity with dining.</p> <p>3. All nursing staff will be in-serviced on resident rights to include dignity and respect as</p>	02/20/2012			

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	<p>assessment (MDS) which indicated the resident was cognitively impaired and required staff assistance for decision making and required staff assistance for set up and cueing for activities of daily living (ADLs) which included dressing and grooming.</p> <p>Resident #61 had a current, 11/17/11, care plan problem/need, which originated 8/12/11, which indicated the resident needed extensive assistance with ADLs. The goal for this problem/need was "the resident will present neat clean & odor free appearance dly [daily]." An approach to this problem was "provide assistance with adls as resident requires."</p> <p>During an 1/23/12, 11:37 a.m., observation, Resident #61 had her hair brushed out in all directions all over her head resulting in a wiry appearance.</p> <p>During an 1/23/12, 3:00 p.m., observation, Resident #61 was in the dinning room making jewelry. Her hair was brushed out in all directions having an unkempt appearance.</p> <p>During an 1/24/12, 7:40 a.m., observation, Resident #61 was seated at the breakfast table. Her</p>		<p>well as proper hair care and clearing tables in a manner to provide dignity. The DON or designee will complete an audit to ensure hair care and the clearing of tables are provided in such a manner to provide dignity daily, on regularly scheduled days, for 1 months, then weekly for 1 month, then monthly for 2 months, then quarterly (Attachment B). 4. Any findings and subsequent disciplinary action will be reviewed by the DON or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. Addendum: The facility will clear off residents trays in the dish room and not visible to residents ensuring dignity.</p>	
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	<p>hair was brushed out in all directions having a wiry appearance.</p> <p>Observation of Resident #61's personal supply box on 1/26/12, 9:25 a.m., the resident had a wide toothed comb in her personal supplies.</p> <p>During an 1/26/12, 9:15 a.m., interview, CNA #2 indicated if a resident has a perm or old perm "maybe I should wet and scrunch to make it curly." She indicated she had instead brushed various residents hair out.</p> <p>2.) Resident #68's record was reviewed on 1/26/12 at 10:48 a.m.</p> <p>Resident #68's current diagnoses included, but were not limited to post stroke with right hand affected, Alzheimer's disease and anxiety with agitation.</p> <p>Resident #68 had a current, 1/5/12, Admission, Minimum Data Set assessment, which indicated the resident required extensive to total assistance of the staff for all activities of daily living.</p> <p>Resident #68 had a current, 1/15/12, care plan problem/need regarding the resident being dependent on staff for</p>			

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	<p>all activities of daily living. The goal for this problem/need was "the resident will present neat clean & odor free appearance dly [daily]." An approach to this problem was "provide assistance with adls as resident requires."</p> <p>During a 1/26/12, 8:25 a.m., observation and interview, Resident #68 stated "I really need to comb my hair." While making this statement, she ran her hands through her hair. CNA #2 Responded to Resident #68's statement, "I already combed your hair today, [Resident's name.]" Resident #68's hair was observed to be brushed out in all directions having a wiry appearance,</p> <p>During an observation on 1/26/12 at 8:30, Resident #68 propelled herself down the hallway and stated "I don't like my hair." Resident #68's hair was brushed out in all directions</p> <p>During a 1/26/12, 9:15 a.m., interview, CNA #2-indicated Resident #68 had an older perm and she had brushed out the resident's hair that morning. During an observation at this time, CNA #2 displayed a vent brush which had been used to brush Resident #68's hair. CNA #2 Indicated she did not know if Resident</p>			
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	<p>#68 had any style products or hair supplies for hair styling. She indicated she would have to check behind the desk in the resident's personal supply box to find out. She indicated she had not checked the supply box in the morning and had simply brushed out the resident's hair.</p> <p>During a 1/26/12, 9:25 a.m., observation of Resident #68's personal hygiene supply box revealed the resident had hair spray, a pick and a wide toothed comb.</p> <p>During an 1/26/12, 9:30 a.m., observation, Resident #68 was wheeling herself up and down the hall, her hair was brushed out in multiple directions having an unkempt appearance.</p> <p>During an 1/26/12, 10:25 a.m., observation, Resident #68 was in exercise. Her hair was brushed out in multiple directions</p> <p>During an 1/26/12 12:35 p.m., observation, Resident #68 was in the dining room talking with staff. Her hair was brushed out in multiple directions.</p> <p>During an 1/27/12, 2:35 p.m., interview the beautician indicated if a</p>				

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	<p>resident has a perm, even an old perm, the staff should pick the resident's dry hair or wet pick or scrunch the resident damp hair. They should not brush it out. She indicated there had been a problem with staff members brushing out perms leaving the hair looking unattractive.</p> <p>3.) During a 1/23/12, 12:05 p.m., observation, 20 residents resided on the Memory Care Unit and 19 residents ate meals served in the Memory Care Dining Room.</p> <p>During an 1/27/12, 7:51 a.m., interview, the Social Service Director indicated she was the Dementia Unit Director and presently had 20 residents on the unit.</p> <p>During a 1/27/12, 3:50 p.m. interview, QMA #16 indicated 19 residents ate in the Memory Care dining room.</p> <p>During a 1/23/12, 12:35 p.m., observation of lunch meal service on in the Memory Care dining room lunch. Employees scraped food off plates and poured drinks in a bucket in the food cart which was located on the hallway. The cart was visible to the residents and located about 3 to 4 feet from back of the closest resident. Standing 4 feet from the cart a person</p>						

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	<p>could hear liquids poured into bucket and see food dropping off plate into bucket. This same bucket was observed containing all of this meal's left over food and liquids scraped from the plates and poured from the cups.</p> <p>During an 1/24/12, 7:40 a.m., breakfast observation, and a 1/25/12, 12:40 p.m., lunch observation and a 1/27/12, 8:06 a.m., breakfast observation, employees scraped food off plates pour drinks in bucket in the food cart in hallway as described above.</p> <p>During an observation and interview with the Administrator on 1/27/12, 8:25 a.m., she indicated the food scraping bucket was not appetizing and should not be in sight of residents. She also indicated she had not considered the food scraping bucket as not homelike or appetizing.</p> <p>3.1-3(t)</p>				

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F0248 SS=D	<p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observations, interview, and record review, the facility failed to ensure cognitively impaired, physically dependent residents received individualized activities to meet their specific residents need for 1 of 3 residents reviewed for individualized activity programs in a Stage 2 census sample of 35. (Resident #40).</p> <p>Findings Include:</p> <p>1.) Resident #40's clinical record was reviewed on 1/25/12, 2:50 p.m.</p> <p>Resident #40's current diagnoses included, but were not limited to, degenerative back disorder, anxiety, seizure disorder and dementia with behavioral disturbances.</p> <p>Resident #40 had a current, 12/16/11, Significant Change, Minimum Data Set assessment (MDS) which indicated the resident rarely if ever understood others, had altered levels of consciousness, and rarely or never made independent decisions.</p>	F0248	<p>1. Resident #40's care plan and activity program were updated to include 1:1 activity 5 times per week for 10 minutes each visit, as well as meal times, for interaction with activity. 2. All residents that are cognitively impaired and physically dependant have the potential to be affected. All cognitively impaired and physically dependant residents will be reviewed to ensure they receive individualized activities to meet their specific needs. 3. Activities staff will be in-serviced on providing individualized activities to meet all resident specific needs. The Activities Director or designee will complete an audit to ensure residents are receiving individualized activities to meet their needs daily on regularly scheduled days for 1 month, then weekly for 1 month, then monthly for 2 months, then quarterly (Attachment C). 4. Any findings and subsequent disciplinary action will be reviewed by the Activity Director or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/20/2012			

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	<p>Resident #40 had a current 12/7/11, order to admit to Hospice due to advanced dementia.</p> <p>Resident #40 had a current 12/23/11 care plan problem/need, which originated 9/8/10, regarding the resident being a passive participant toward activities; attending some activities of her past interest; having confusion and delusions, and the resident being on a 1:1 (one to one) program. The one to one program statement was dated as added 12/23/11. The goal for this problem was to attend 2-3 activities per week and attend 2-3 sensory per month. Approaches to this problem were:</p> <ul style="list-style-type: none"> a.) remind the resident of activities b.) encourage attendance c.) provide small groups sensory activities d.) assist to and from activities e.) being read to or music played for 1 to 1. <p>The care plan goal did not address one to one programing. The plan of care did not indicate how often one to one activities should be offered or how long each program should last. The care plan did not address the need to have the resident available, when able, to attend before or after meal activities.</p>						

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	<p>Resident #40 had an, 1/11/12, Nursing Assessment which indicated "Able to communicate needs by other means, explain: discomfort by yelling loudly."</p> <p>2.) During an 1/25/12, 12:33 p.m., observation Resident #40 was in her room in a broda chair facing the TV, which was on. Resident #40's eyes were closed. She vocalized softly and did not appear to be watching TV.</p> <p>During an 1/25/12, 12:35 to 12:39 p.m., observation, Resident #40 was calling out "hey, hey hey." At 12:40 p.m. the resident was placed in bed and became quiet.</p> <p>During an 1/26/12, 8:35 a.m., observation, Resident #40 was in her room in a broda chair, facing the bed. Her TV was on behind her. She was snoring softly.</p> <p>During an 1/26/12, 10:20 a.m., observation, Resident #40 was in bed in a darkened room with her eyes closed.</p> <p>During an 1/26/12, 10:40 a.m. observation, Resident #40 was in bed calling out very loudly. At 10:42 a.m., the staff entered the residents room</p>			
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	<p>closed the door and provided care and services. The resident quieted after the provision of care.</p> <p>During an 1/26/12, 2:33 p.m., observation, Resident #40 was in bed, in a darkened room, with her eyes closed.</p> <p>During an 1/26/12, 9:15 a.m., observation, Resident #40 was in bed with her eyes closed.</p> <p>During an 1/26/12, 9:30 am , observation Resident #40 was in bed with her eyes closed and her T V on.</p> <p>During observations on 1/23/12 from 9:45 a.m. to 3:30 p.m., 1/24/12 from 7:45 a.m. to 3:00 p.m., 1/25/12 from 8:30 a.m. to 3:30 p.m. and 1/26/12 from 8:00 a.m. to 3:00 p.m., Resident #40 was only observed out of bed for meals.</p> <p>3.) During an 1/26/12, 12:55 p.m., interview, CNA #2 indicted Resident #40 went to bed after each meal. She was only up to eat because she was end stage in her disease.</p> <p>During a 1/24/12, 2:36 p.m., family interview, Resident #40's family indicated the resident was not encouraged or assisted to attend</p>			
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	<p>activities because she was now too ill.</p> <p>During an 1/26/12, 2:47 p.m., interview, the Activity Director indicated she did not assess Resident #40 when she was placed on hospice and one to one activity program. The Activity Director indicated she had continued the resident's previous plan of care. She had not developed a new plan. She had added the one to one program to the previous care plan. The Activity Director indicated she did not individualize the number of one to one activities each resident would have. She indicated she was "told everyone on one to ones gets visits two times weekly." The Activity Director reviewed the current care plan and indicated it was not appropriate because the resident rarely came out of her room for any event other than meals. The Activity Director indicated she had not worked with the nursing department to ensure Resident #40 could have activities when she was out of her room for meals, which was the only time the resident was out of bed.</p> <p>4.) Review of Resident #40's December 2011 and January 2012 (1/1/12 to 1/25/12) out of room activity attendance record indicated the resident had not attended any out of</p>			
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	<p>room activities in December 2011 or January 2012.</p> <p>Review of Resident #40's January 2012 and December 2011 one to one activities attendance record indicated the resident only received one to one activities two times each week for this two month period.</p> <p>3.1-33(a)</p>			
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F0250 SS=D	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident's specific request for caregivers was followed for 1 of 1 resident reviewed with the identified preference of caregivers in a Stage 2 sample of 35. (Resident #48)</p> <p>Findings include:</p> <p>1. Resident #48's record was reviewed on 1/25/12 at 9:54 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes. The annual Minimum Data Set assessment, dated 1/10/12, indicated the resident required extensive assistance of 1 to 2 persons for her activities of daily living (ADL).</p> <p>The "SOCIAL SERVICE ASSESSMENT," which was the annual and dated 1/11/12, noted refusing care on 12/01, 12/02, and 12/3/10 with interventions attempted; Manipulative behavior was indicated on 12/04/11 with interventions indicated as 1:1, place in bed; on 12/06/11 repetitive verbiage was indicated and the resident was "allow to vent." Prefers female staff was</p>	F0250	<p>1. Resident #48 and her POA were interviewed for their specific preference of care givers. It was noted that the resident had no preference and was fine with either a male or female care giver. Resident #48's care plan and ADL book were updated to reflect this. 2. All residents with a male or female care giver preference have the potential to be affected. All residents with a male or female care giver preference were reviewed to ensure their preference was care planned accordingly. 3. All nursing staff will be in-serviced on providing a care giver gender preference per the plan of care. The DON or designee will complete an audit to ensure all residents with a care giver gender preference is provided daily on regularly scheduled days for 1 month, then weekly for 1 month, then monthly for 2 months, then quarterly (Attachment D). 4. Any findings and subsequent disciplinary action will be reviewed by the DON or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. Addendum: The facility will conduct ongoing assessments of residents in regards to gender preference for their caregivers on a quarterly</p>	02/20/2012			

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	<p>also indicated. No information was indicated related to if care was being given by a male or female caregiver. Social Services progress note 1/04/12 - from MDS - "feeling down & tired." Discuss with family at care plan 1/12/12 concerning seeing (physician's name) for medication therapy for depression. Encourage attendance to group activities and 1:1's. Activities are declined majority of time.</p> <p>The current ADL book, originally dated 3/15/10, indicated no men were to do any of her ADL's. Also, in January/2012 the resident was indicated to have had a shower given by (male name) on 1/19/12 and 1/23/12.</p> <p>The care plan, dated 1/11/12, indicated the resident's daily preferences included, but were not limited to, prefers female caregivers.</p> <p>2. On 1/25/12 at 1:05 p.m. during an interview, the Director of Nursing (DON) indicated the resident was interviewable with confusion at times.</p> <p>On 1/25/12 at 1:30 p.m. during an interview, LPN #10 indicated the resident was given a shower by CNA #4 on 1/19/12.</p>		basis.	
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	<p>On 1/25/12 at 3:03 p.m. during an interview, CNA #2 indicated Resident #48 was very particular on several things when doing her care, for example, the seam of her chair pad had to be covered with a pillow case because she would get upset if not done her way. She indicated as long as you would follow her directions or knew her ways, she would be cooperative. She indicated Resident #48 did not mind some of the male CNA's except she does not like one male CNA (named) and would not let him do the bedtime task. She indicated this male CNA could take the resident into the bathroom, but she would not allow him to do her personal care.</p> <p>On 1/26/12 at 9:10 a.m. during an interview, CNA #4 indicated he had recently given Resident #48 showers and had done personal care for Resident #48. He also indicated he knew she was not to have male caregivers, but he indicated he would ask her first before initiating care. He indicated she was very particular in how she wanted things done.</p> <p>On 1/27/12 at 8:15 a.m. during an interview, LPN #5 indicated she had never seen Resident #48 have a</p>			
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	<p>behavior but knew some had been noted. She indicated she had seen male CNA's do care for her with no problems. She also indicated the resident was very particular.</p> <p>On 1/27/12 at 9:04 a.m. during an interview, Social Service #14 indicated the resident did allow male CNA's to care for her. She also indicated the resident had an understanding she may have to have male CNA's to do her care if needed although she preferred female caregivers.</p> <p>On 1/27/12 at 9:45 am. during an interview, Social services (SS) #14 indicated after checking the resident's record, she indicated Resident #48 was to have only female caregivers and added it was in the current ADL book to only have female caregivers.</p> <p>On 1/27/12 at 10:35 a.m. during an interview, SS #14 provided information for behaviors in 10/11, which indicated refusal of care due to back pain. She indicated in reference to the refusing care in 12/11, she had no further information but it was probably while she was in therapy.</p> <p>On 1/27/12 at 12:25 p.m. during an interview, the DON indicated she was aware male CNA's do take care of the</p>			
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	<p>resident on the day shift and maybe the care plan should be updated. She also said there was one male CNA (same name as CNA #2) on evening shift, who could not take care of her, and she wasn't sure if he knew it.</p> <p>3.1-34(a)</p>			
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F0253 SS=B	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observations and interviews, the facility failed to ensure a clean and sanitary environment related to floor tiles at the beginning of the hallway entry in 1 of 3 hallways (100 hallway) observed and the condition of floor tiles and bathrooms in resident's rooms observed for 4 of 6 resident rooms observed. This had the potential to impact 7 of 7 residents residing in the observed resident rooms (Room 113, 205, 307, and 312).</p> <p>Findings include:</p> <p>During the environmental tour on 1/26/12 at 1:15 p.m., the following was observed with the Maintenance Supervisor, Housekeeping Supervisor, and the Administrator:</p> <p>Room 205 - Upon entering the room, an area of pink colored 12 inch floor tiles was observed in front of the resident's recliner. Around this pink colored floor tile area a 1/8 inch gap was observed with a dark brown/black accumulation inside this gap. In this same area one of the corners of these floor tiles was observed with dents with a dark brown accumulation</p>	F0253	<p>1. No residents were harmed. Room 205 will have carpet installed. The tiles between rooms 101 and 103 will be replaced. The outside of the bathroom door in room 307 will be repaired. The faucet in room 312 was repaired, as well as the towel bar.2. All residents have the potential to be affected. An environmental tour of the facility was conducted to ensure all needed repairs are noted and scheduled for repair.3. All staff have been in-serviced on the process for maintenance request forms so that any noted repairs needed are reported to the Maintenance department for repair. The Administrator will monitor maintenance request forms and ensure repair are completed daily, on scheduled work days, for 1 month, then weekly for two months, then monthly (see attachment G). The Administrator will make environmental rounds weekly to ensure all needed repairs/maintenance have been identified (see attachment I).4 Any findings and subsequent disciplinary action will be reviewed by the Administrator Director or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/20/2012			

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	<p>also in these dents. At this same time during an interview, the Administrator indicated there were no plans presently for replacing any of the floors.</p> <p>In the 100 Hallway between rooms 101 and 103, 2 rows of 12 inch floor tiles the width of this hallway were observed with a row of irregular lines of dents and gouges in the floor tile. A dark brown accumulations was observed in these same dents/gouges.</p> <p>Room 113 - the wall call light to indicate it was turned on, was burned out; the arm brace over the toilet was very loose on the right side as one would sit on the toilet. At this same time during an interview, the Maintenance Supervisor indicated he would make rounds in the rooms weekly and would check them.</p> <p>Room 307 - upon entering the bathroom from this room, the outside bathroom door between the doorknob and the door latch, was observed broken up.</p> <p>Room 312 - in the bathroom the towel bar was missing the actual towel bar holder with 1 of the 2 brackets to hold the towel bar only partially mounted</p>				

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	<p>on the wall. Also, while checking the water temperature in this bathroom, the faucet sprayed in a manner allowing water to spill over onto the floor. At this same time during an interview, the Administrator indicated the faucet should be fixed as she was observed to wipe the water off of the floor with a paper towel.</p> <p>3.1-19(f)</p>			
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F0279 SS=D	<p>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 observation, interview and record review, the facility failed to ensure a resident, who had a change in condition requiring the revision/development of a new activity care plan, had a new individualized care plan revised and/or developed for 1 of 17 residents reviewed for care plan development in a Stage 2 sample of 35. (Resident #40).</p> <p>Findings Include:</p> <p>1.) Resident #40's clinical record was reviewed on 1/25/12, 2:50 p.m.</p> <p>Resident #40's current diagnoses</p>	F0279	<p>1. Resident #40's care plan and activity program were updated to include 1:1 activity 5 times per week for 10 minutes each visit, as well as meal times, for interaction with activity.2. All residents that have a change in condition have the potential to be affected. All residents that have exhibited a change in condition will be reviewed to ensure they receive individualized activities to meet their specific needs, with a care plan to reflect the current status.3. Activities staff will be in-serviced on providing individualized activities to meet all resident specific needs and care plan revision or development to reflect the current status. The Activities Director or designee will</p>	02/20/2012	

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	<p>included, but were not limited to, degenerative back disorder, anxiety, seizure disorder and dementia with behavioral disturbances.</p> <p>Resident #40 had a current, 12/16/11, Significant Change, Minimum Data Set assessment (MDS) which indicated the resident rarely if ever understood others, had altered levels of consciousness, and rarely or never made independent decisions.</p> <p>Resident #40 had a current 12/7/11, order to admit to Hospice due to advanced dementia.</p> <p>Resident #40 had a current 12/23/11 care plan problem/need, which originated 9/8/10, regarding the resident being a passive participant toward activities; attending some activities of her past interest; having confusion and delusions, and the resident being on a 1:1(one to one) program. The one to one program statement was dated as added 12/23/11. The goal for this problem was to attend 2-3 activities per week and attend 2-3 sensory per month.</p> <p>The care plan goal did not address one to one programing. The plan of care did not indicate how often one to one activities should be offered or</p>		<p>complete an audit to ensure all residents who have exhibited a change in condition have care plans that reflect the residents current status daily on regularly scheduled days for 1 month, then weekly for 1 month, then monthly for 2 months, then quarterly thereafter (see attachment #C).4. Any findings and subsequent disciplinary action will be reviewed by the Activity Director or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>		

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	<p>how long each program should last. The care plan did not address the need to have the resident available, when able, to attend pre or post meal activities.</p> <p>Review of Resident #40's December 2011 and January 2012 (1/1/12 to 1/25/12) out of room activity attendance record indicated the resident had not attended any out of room activities in December 2011 or January 2012.</p> <p>Review of Resident #40's January 2012 and December 2011 one to one activities attendance record indicated the resident received one to one actives two times each week for this two month period.</p> <p>2.) During an 1/25/12, 12:33 p.m., observation Resident #40 was in her room in a broda chair facing the TV, which is on. Resident #40's eyes were closed. She vocalized softly and did not appear to be watching TV.</p> <p>During an 1/25/12, 12:35 to 12:39 p.m., observation, Resident #40 was calling out hey, hey hey. At 12:40 p.m. the resident was placed in bed and became quiet.</p> <p>During an 1/26/12, 8:35 a.m.,</p>						

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	<p>observation, Resident #40 was in her room in a broda chair, facing the bed. Her TV was on behind her. She was snoring softly.</p> <p>During an 1/26/12, 10:20 a.m., observation, Resident #40 was in bed in a darkened room with her eyes closed.</p> <p>During an 1/26/12, 10:40 a.m. observation, Resident #40 was in bed calling out very loudly. At 10:42 a.m., the staff entered the residents room closed the door and provided care and services. The resident quieted after the provision of care.</p> <p>During an 1/26/12, 2:33 p.m., observation, Resident #40 was in bed, in a darkened room, with her eyes closed.</p> <p>During an 1/26/12, 9:15 a.m., observation, Resident #40 was in bed with her eyes closed.</p> <p>During an 1/26/12, 9:30 am , observation Resident #40 was in bed with her eyes closed and her T V on.</p> <p>During observations on 1/23/12 from 9:45 a.m. to 3:30 p.m., 1/24/12 from 7:45 a.m. to 3:00 p.m., 1/25/12 from 8:30 a.m. to 3:30 p.m. and 1/26/12</p>						

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	<p>from 8:00 a.m. to 3:00 p.m., Resident #40 was only observed out of bed for meals.</p> <p>3.) During an 1/26/12, 12:55 p.m., interview, CNA #2 indicted Resident #40 went to bed after each meal. She was only up to eat because she was end stage in her disease.</p> <p>During a 1/24/12, 2:36 p.m., family interview, Resident #40's family indicated the resident was not encouraged or assisted to attend activities because she was now too ill.</p> <p>During an 1/26/12, 2:47 p.m., interview, the Activity Director indicated she did not assess Resident #40 when she was placed on hospice and one to one activity program. The activity director reviewed the current care plan and indicated it was not appropriate because the resident rarely came out of her room for any event other than meals.</p> <p>The Activity Director indicated she had continued the resident's previous plan of care. She had not developed a new plan. She had added the one to one program to the previous care plan. The Activity Director indicated she did not individualize the number of one to one activities each resident</p>						

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	would have. She indicated she was "told everyone on one to ones gets visits two times weekly." The Activity Director indicated she had not worked with the nursing department to ensure Resident #40 could have activities when she was out of her room for meals. 3.1-35(a)			
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F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review the facility failed to review, revise and update a residents plan of care related to wheelchair use and periods of rest in prevention of a pressure area and related to a change of condition or resident behavior warranted changes to address the resident's need for 3 of 17 residents reviewed for revision of care plans in a Stage 2 sample of 35. (Resident #10, #40 and #68)</p> <p>Findings include:</p> <p>1.) Resident #40's clinical record was reviewed on 1/25/12, 2:50 p.m.</p> <p>Resident #40's current diagnoses</p>	F0280	<p>1. Resident #40's care plan and activity program were updated to include 1:1 activity 5 times per week for 10 minutes each visit, as well as meal times, for interaction with activity. Resident #68 had new interventions implemented to address the root cause of her falls and the care plan was revised. On 1/1/12, a toileting schedule was implemented. She is now on a specific toileting schedule to meet her needs, as her infection is now resolved. On 1/6/12, a strap was placed to her wheel chair to hold her purse, as she was trying to get to her purse when she fell. On 1/11/12, one should note that the resident did not show any signs of hitting her face or head. She was just noted to be in the prone position and a low bed was implemented. A mat</p>	02/20/2012			

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	<p>included, but were not limited to, degenerative back disorder, anxiety, seizure disorder and dementia with behavioral disturbances.</p> <p>Resident #40 had a current, 12/16/11, Significant Change, Minimum Data Set assessment (MDS) which indicated the resident rarely if ever understood others, had altered levels of consciousness, and rarely or never made independent decisions.</p> <p>Resident #40 had a current 12/7/11, order to admit to Hospice due to advanced dementia.</p> <p>Resident #40 had a current 12/23/11 care plan problem/need, which originated 9/8/10, regarding the resident being a passive participant toward activities; attending some activities of her past interest; having confusion and delusions, and the resident being on a 1:1(one to one) program. The one to one program statement was dated as added 12/23/11. The goal for this problem was to attend 2-3 activities per week and attend 2-3 sensory per month.</p> <p>The care plan goal did not address one to one programing. The plan of care did not indicate how often one to one activities should be offered or</p>		<p>was not added as it could have potentially increased the risk for falls for not only this resident but others, as this is on a locked unit where resident wander. She had not hit her head on any previous falls. On 1/17/12, a follow up urinalysis was obtained as the resident had an infection previously. There was no indication that the resident hit her head. On 1/22/12, she had been restless in bed, so staff got her up in her chair with her lap buddy. An intervention was added to brush her dentures at bedtime as she stated she was getting up to brush her teeth. The lap buddy was continued as an intervention to help remind the resident not to get up unassisted. A low bed with a mattress next to the bed on the floor is in place as well to help reduce the risk for injury related to falls. Resident # 10 is alert and oriented and non-compliant with preventative care. Her care plan and assignment sheet were updated to include staff reminding resident to propel herself with her hands, rather than with her feet to reduce friction. 2. All residents that have a change in condition, pressure areas, or behaviors have the potential to be affected. All residents that have exhibited a change in condition, pressure areas, and behaviors will have their care plans reviewed to ensure they reflect the residents current needs. 3. Nursing staff and activities staff will be</p>		

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	<p>how long each program should last. The care plan did not address the need to have the resident available, when able, to attend pre or post meal activities.</p> <p>Review of Resident #40's December 2011 and January 2012 (1/1/12 to 1/25/12) out of room activity attendance record indicated the resident had not attended any out of room activities in December 2011 or January 2012.</p> <p>Review of Resident #40's January 2012 and December 2011 one to one activities attendance record indicated the resident received one to one activities two times each week for this two month period.</p> <p>During an 1/25/12, 12:33 p.m., observation Resident #40 was in her room in a broda chair facing the TV, which was on. Resident #40's eyes were closed. She vocalized softly and did not appear to be watching TV.</p> <p>During an 1/25/12, 12:35 to 12:39 p.m., observation, Resident #40 was calling out "hey, hey hey." At 12:40 p.m. the resident was placed in bed and became quiet.</p> <p>During an 1/26/12, 8:35 a.m.,</p>		<p>in-serviced on care plan revision and development to reflect the current status. The Activities Director/DON or designee will complete an audit to ensure all residents care plans and assignment sheets reflect the residents current status daily, on regularly scheduled days, for 1 month, then weekly for 2 months, then monthly for 2 months, then quarterly (see attachment E). 4. Any findings and subsequent disciplinary action will be reviewed by the Activity Director and Director of Nursing or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p> <p>1.Completion date February 20, 2012.</p>		

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	<p>observation, Resident #40 was in her room in a broda chair, facing the bed. Her TV was on behind her. She was snoring softly.</p> <p>During an 1/26/12, 10:20 a.m., observation, Resident #40 was in bed in a darkened room with her eyes closed.</p> <p>During an 1/26/12, 10:40 a.m. observation, Resident #40 was in bed calling out very loudly. At 10:42 a.m., the staff entered the residents room closed the door and provided care and services. The resident quieted after the provision of care.</p> <p>During an 1/26/12, 2:33 p.m., observation, Resident #40 was in bed, in a darkened room, with her eyes closed.</p> <p>During an 1/26/12, 9:15 a.m., observation, Resident #40 was in bed with her eyes closed.</p> <p>During an 1/26/12, 9:30 am , observation Resident #40 was in bed with her eyes closed and her T V on.</p> <p>During observations on 1/23/12 from 9:45 a.m. to 3:30 p.m., 1/24/12 from 7:45 a.m. to 3:00 p.m., 1/25/12 from 8:30 a.m. to 3:30 p.m. and 1/26/12</p>				

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	<p>from 8:00 a.m. to 3:00 p.m., Resident #40 was only observed out of bed for meals.</p> <p>During an 1/26/12, 12:55 p.m., interview, CNA #2 indicated Resident #40 went to bed after each meal. She was only up to eat because she was end stage in her disease.</p> <p>During a 1/24/12, 2:36 p.m., family interview, Resident #40's family indicated the resident was not encouraged or assisted to attend activities because she was now too ill.</p> <p>During an 1/26/12, 2:47 p.m., interview, the Activity Director indicated she did not assess Resident #40 when she was placed on hospice and one to one activity program. The Activity Director reviewed the current care plan and indicated it was not appropriate because the resident rarely came out of her room for any event other than meals.</p> <p>The Activity Director indicated she had continued the resident's previous plan of care. She had not developed a new plan. She had added the one to one program to the previous care plan. The Activity Director indicated she did not individualize the number</p>			
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	<p>of one to one activities each resident would have. She indicated she was "told everyone on one to ones gets visits two times weekly." The Activity Director indicated she had not worked with the nursing department to ensure Resident #40 could have activities when she was out of her room for meals.</p> <p>2.) Resident #68's record was reviewed on 1/26/12 at 10:48 a.m.</p> <p>Resident #68's current diagnoses included, but were not limited to post stroke with right hand affected, Alzheimer's disease and anxiety with agitation.</p> <p>Resident #68 had a current, 1/5/12, Admission, Minimum Data Set assessment, which indicated the resident required extensive to total assistance of the staff for all activities of daily living. She had fallen at home prior to admission. She had fallen in the facility without injury. She had impaired balance and required balancing assistance when going from sit to stand, walking, turning around, transferring to the toilet and transferring from surface to surface.</p> <p>Resident #68 had a 12/29/11 Physical Therapy noted which indicated the</p>				

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	<p>resident had a decline in functional rehabilitation and difficulty in walking.</p> <p>Resident #68 had a 1/11/12, Physical Therapy Progress Report which indicated the resident had poor safety awareness and cognitive decline with difficulty concentrating on the task at hand.</p> <p>During an 1/27/12, 8:56 a.m., interview, the Director of Nursing (DON) indicated the following:</p> <p>a.) Following the 1/1/12, fall Resident #68 was placed on the facilities toileting plan. She was not placed on a toileting plan based upon the resident's assessed individual toileting pattern.</p> <p>b.) Following the 1/6/12, fall when the resident removed her lap buddy an approach to address lap buddy removal was not added to the care plan.</p> <p>c.) Following the 1/11/12-23 fall when Resident #68 was found face down on the floor beside her bed the resident was placed on a low bed. No cushioning was added to the floor to prevent head or facial injury.</p> <p>d.) Following the 1/17/12, fall when</p>			
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	<p>the resident was found on floor near the bed, no cushioning was added to the floor to prevent head or facial injury.</p> <p>e.) Following the 1/22/12 fall when the resident removed her lap buddy no approach to address lap buddy removal was added to the residents plan of care.</p> <p>f.) The removal of the lap buddy had been discussed at fall prevention meeting but not addressed in care plan approach changes. The lap buddy was in place "to slow her down a little bit."</p> <p>Review of Resident #68's "Mood and Behavior Communication Memo (s)" for 12/31/11 through 1/24/12 indicated the following concerns with removing her lap buddy, climbing out of bed, attempting to stand or standing or other potentially unsafe actions as follows:</p> <p>a.) 1/22/12-climbed out of bed, placed in wheelchair 2:30 a.m.-6 a.m. shift</p> <p>b.) 1/17/12-21:10 p.m.-tried to toilet self-toileted and placed in bed</p> <p>c.) 1/22/12- 3-4 a.m.-removed her lap</p>						

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	<p>buddy several times and fell in dining room</p> <p>d.) 1/22/12-3:30 p.m.-removed lap buddy two times</p> <p>f.) 1/13/12-6-2 p.m.-removing lap buddy</p> <p>g.) 1/10/12-3:30 p.m.- took off lap buddy several times this shift. One time stood and sat on floor. Staff had to run to sit her down.</p> <p>h.) 1/13/12-5:10 p.m.-took off her lap buddy in 304 and was attempting to stand. She did this again at 3:25 p.m.</p> <p>i.) 1/13/12-3:30 p.m.-took off lap buddy 3 times this shift.</p> <p>j.) 1/14/12-3:00 p.m. -removed alarm from wheelchair and brought it to me.</p> <p>k.) 1/6/12-15:50 p.m.-removed her lap buddy each shift.</p> <p>l.) 1/4/12-19:55 p.m.-standing, wanted to get her pants, placed back in bed and explained she had night gown on.</p> <p>m.) 1/1/12-2p-10p-removed lap buddy from wheelchair. She tried to stand almost falling three times.</p>			
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	<p>n.) 12/31/11-2p-8p-removed lap buddy numerous times. stood up from wheelchair and began to walk away from the chair.</p> <p>During a 1/27/12, 10:30 a.m. interview, the DoN indicated behaviors were summarized and reviewed in morning meetings. However, each event had not been read word for word. The DoN indicated she had not been aware of the frequency Resident #68 had been removing her lap buddy. She indicated she would expect staff members to monitor Resident #68 closely perhaps within arms reach when the resident was repeatedly removing her lap buddy. The DoN indicated there had not been an approach added to the resident's care plan to direct staff to monitor the resident frequently and closely when she was removing her lap buddy repeatedly.</p> <p>During an 1/26/12, 8:25 am, observation, Resident #68 was in the dining room in her wheelchair with a lap buddy. She was working at and manipulating her lap buddy. She had a large black, purple, yellow and green bruise circling her right eye up onto the temple.</p>						

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	<p>3. The clinical record of Resident # 10 was reviewed on 1/27/2012 at 3:15 p m. The physician's notes indicated Resident # 10 had a Stage 2 pressure ulcer on her left posterior dorsal thigh which had developed during a hospital stay.</p> <p>The physicians progress notes, dated 1/9/2012, indicated the majority of her problem still relates to her scooting in the wheelchair, with some constant rocking motion.</p> <p>Resident # 10's care plan problem/need was an open area to the left posterior dorsal thigh. The care plan was updated on 1/9/2012. The approaches included, but were not limited to, pillow case between legs at all times, pillow between legs when on side, activities as tolerated, encouragement to lie down between meals to relieve pressure, therapy to work with resident to use wheelchair wheels for propulsion rather than scooting in wheelchair.</p> <p>The Occupational Therapy Recertification form dated 1/17/2012, indicated to promote wound healing Resident #10 needed cues to walk feet while using arms to propel wheelchair instead of scooting self</p>	F0280	<p>1. Resident #40's care plan and activity program were updated to include 1:1 activity 5 times per week for 10 minutes each visit, as well as meal times, for interaction with activity. Resident #68 had new interventions implemented to address the root cause of her falls and the care plan was revised. On 1/1/12, a toileting schedule was implemented. She is now on a specific toileting schedule to meet her needs, as her infection is now resolved. On 1/6/12, a strap was placed to her wheel chair to hold her purse, as she was trying to get to her purse when she fell. On 1/11/12, one should note that the resident did not show any signs of hitting her face or head. She was just noted to be in the prone position and a low bed was implemented. A mat was not added as it could have potentially increased the risk for falls for not only this resident but others, as this is on a locked unit where resident wander. She had not hit her head on any previous falls. On 1/17/12, a follow up urinalysis was obtained as the resident had an infection previously. There was no indication that the resident hit her head. On 1/22/12, she had been restless in bed, so staff got her up in her chair with her lap buddy. An intervention was added to brush her dentures at bedtime as she stated she was getting up to brush her teeth. The lap buddy was continued as an intervention</p>	02/20/2012	

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	<p>forward and only using her feet.</p> <p>The Occupational Therapy Progress Report dated 1/14/2012 to 1/20/2012, the report indicated to continue with the current plan of care, focus on upper extremities strength and propelling in wheelchair. The Therapy Daily Progress Notes, dated 1/12/2011, indicated the resident needed cues not to scoot.</p> <p>On 1/27/2012 at 9:26 a.m. during interview, CNA # 13 indicated that when she sees Resident #10 using her feet and scooting in the wheelchair she will push her wheelchair down the hall. At this same time CNA #13 also indicated Resident #10 does not want to go to bed because she liked to do activities, but if she was tired she would let a CNA know.</p> <p>On 1/ 27/2012/ at 10:01 a.m. during interview, CNA # 12 indicated Resident #10 liked to go to activities and did not want to lay down after meals, unless she was tired. CNA #12 also indicated would she sees Resident #10 using her feet only she would push her to where she wanted to go.</p> <p>On 1/27/2012 at 3:00 p.m. during an</p>		<p>to help remind the resident not to get up unassisted. A low bed with a mattress next to the bed on the floor is in place as well to help reduce the risk for injury related to falls. Resident # 10 is alert and oriented and non-compliant with preventative care. Her care plan and assignment sheet were updated to include staff reminding resident to propel herself with her hands, rather than with her feet to reduce friction. 2. All residents that have a change in condition, pressure areas, or behaviors have the potential to be affected. All residents that have exhibited a change in condition, pressure areas, and behaviors will have their care plans reviewed to ensure they reflect the residents current needs. 3. Nursing staff and activities staff will be in-serviced on care plan revision and development to reflect the current status. The Activities Director/DON or designee will complete an audit to ensure all residents care plans and assignment sheets reflect the residents current status daily, on regularly scheduled days, for 1 month, then weekly for 2 months, then monthly for 2 months, then quarterly (see attachment E). 4. Any findings and subsequent disciplinary action will be reviewed by the Activity Director and Director of Nursing or designee in the facility's quarterly Quality Assurance meetings and the plan of</p>		

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	<p>interview the Director of Nursing (DON) indicated Resident #10 had care plan interventions to help reduce her friction sheering that is caused by scooting in her wheelchair while propelling herself with her feet. The DON indicated the interventions included: When Resident #10 is observed by staff scooting back and forth while using her feet to propel the wheelchair; she is to be directed to use her hands instead.</p> <p>3.1-35(b)(2)</p>		<p>action adjusted accordingly. 1.Completion date February 20, 2012.</p>		

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observations, interview, and record review, the facility failed to ensure nursing staff followed the plan of care regarding wheelchair mobility and periods of rest as directed in the care plan for 1 of 2 residents who met the criteria for pressure ulcer in the stage 2 sample of 39. (Resident #10)</p> <p>Findings Included:</p> <p>On 1/26/2012 at 2:00 p.m. to 2:30 p.m., Resident # 10 was observed sitting in the lounge rocking back and forth. Resident # 10 was not redirected by staff.</p> <p>On 1/27/2012 at 2:25 p.m., Resident # 10 was observed using her feet to rock forwards and backwards to propel herself down the hall way. Resident #10 was not redirected by staff to use proper technique.</p> <p>On 1/27/2012 at 4:14 p.m., Resident #10 was observed in the 200 hall sitting in her wheelchair asleep.</p> <p>Resident #10's record was reviewed on 1/25/2012 at 3:00 p.m. The</p>	F0282	<p>1. Resident # 10 is alert and oriented and non-compliant with preventative care. Her care plan and assignment sheet were updated to include staff reminding resident to propel herself with her hands, rather than with her feet, to reduce friction. 2. All residents who self-propel in the wheelchair have the potential to be affected. All ADL care plans regarding mobility have been reviewed and revised as indicated. 3. Nursing and therapy staff in-serviced on care plan interventions and assignment sheets. The DON or designee will complete an audit to ensure the care planned interventions and assignment sheets are up to date and observe staff for implementing the interventions daily, on regularly scheduled days, for 1 month, then weekly for 2 months, then monthly for 2 months, then quarterly thereafter(Attachment E).4. Any findings and subsequent disciplinary action will be reviewed by the Director of Nursing or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/20/2012	

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	<p>resident's diagnoses included, but were not limited to, Diabetes Mellitus, Urinary Incontinence, Depression, and Parkinson Disease.</p> <p>The Admission Sheet dated 5/3/2011, indicated Resident #10 developed a pressure ulcer located on the left dorsal posterior thigh, during a hospital stay.</p> <p>Resident # 10's care plan problem/need was an open area to the left posterior dorsal thigh. The care plan was updated on 1/9/2012. The approaches included, but not limited to, encouragement to lie down between meals to relieve pressure, therapy to work with resident to use wheelchair wheels for propulsion rather than scooting in wheelchair.</p> <p>The Occupational Therapy Recertification form dated 1/17/2012, indicated to promote wound healing Resident #10 needed cues to walk feet while using arms to propel wheelchair instead of scooting self forward and only using her feet.</p> <p>The Occupational Therapy Progress Report dated 1/14/2012 to 1/20/2012, the report indicated to continue with the current plan of care, focus on upper extremities strength and</p>				

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	<p>propelling in wheelchair. The Therapy Daily Progress Notes, dated 1/12/2011, indicated the resident needed cues not to scoot.</p> <p>The physicians progress notes, dated 1/9/2012, indicated the majority of her problem still relates to her scooting in the wheelchair, with some constant rocking motion.</p> <p>On 1/27/2012 at 9:26 a.m. during interview, CNA # 13 indicated that when she sees Resident #10 using her feet and scooting in the wheelchair she will push her wheelchair down the hall. At this same time CNA #13 also indicated Resident #10 does not want to go to bed because she liked to do activities, but if she was tired she would let a CNA know.</p> <p>On 1/ 27/2012/ at 10:01 a.m. during interview, CNA # 12 indicated Resident #10 liked to go to activities and did not want to lay down after meals, unless she was tired. CNA #12 also indicated would she sees Resident #10 using her feet only she would push her to where she wanted to go.</p> <p>On 1/27/2012 at 3:00 p.m. during an interview the Director of Nursing</p>				

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	(DON) indicated Resident #10 had care plan interventions to help reduce her friction sheering that is caused by scooting in her wheelchair while propelling herself with her feet. The DON indicated the interventions included: When Resident #10 is observed by staff scooting back and forth while using her feet to propel the wheelchair; she is to be redirected to use her hands instead. 3.1-35(g)(2)			
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F0314 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record reviews, the facility failed to develop and implement specific interventions to promote healing of pressure ulcers for 1 of 2 residents who met the criteria for pressure ulcer in the stage 2 sample of 39. (Resident # 10)</p> <p>Findings Include:</p> <p>On 1/26/2012 at 12:45 p.m. during initial interview, LPN # 2 indicated Resident #10 had a healing stage 3 pressure ulcer.</p> <p>Resident #10's record was reviewed on 1/25/2012 at 3:00 p.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus, Urinary Incontinence, Depression, and Parkinson Disease.</p> <p>The Admission Sheet dated 5/3/2011, indicated Resident #10 developed a pressure ulcer located on the left dorsal posterior thigh, during a</p>	F0314	<p>1. Resident # 10 is alert and oriented and non-compliant with preventative care. Her care plan and assignment sheet were updated to include staff reminding resident to propel herself with her hands, rather than with her feet to reduce friction. A head to toe skin assessment is completed weekly and any areas are assessed and measured. She is currently being followed by the wound clinic with treatments applied as ordered by the physician. 2. All residents with pressure areas have the potential to be affected. All residents with pressure areas care plans were reviewed to ensure interventions to promote healing were in place. 3. Nursing staff were in-serviced on pressure ulcer prevention and treatment. The DON or designee will complete an audit to ensure the care plan and assignment sheets are up to date daily, on regularly scheduled days, for 1 month, then weekly for 2 months, then monthly for 2 months, then quarterly thereafter (Attachment E).4. Any findings and subsequent</p>	02/20/2012	

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	<p>hospital stay.</p> <p>On 6/27/2011 the physician order was to refer the resident to the wound care clinic for treatment of the left dorsal posterior thigh pressure ulcer. The wound clinics's progress notes indicated on 1/12/2012 the pressure ulcer was a stage 2. The wound clinic's progress notes, dated 1/23/2012, indicated the wound size as 2.8 cm X 2.8 cm X 1 cm.</p> <p>On 11/17/2011, the physician order was 1.) Occupational Therapy 3 times a week for 30 days for Activities of Daily Living and wheel chair management 2.) Patient needs assistance when getting up to prevent scooting across chair or bed to prevent sheering of wounds.</p> <p>The physicians progress notes, dated 1/9/2012, indicated the majority of her problem still relates to her scooting in the wheelchair, with some constant rocking motion.</p> <p>Resident # 10's care plan problem/need was an open area to the left posterior dorsal thigh. The care plan was updated on 1/9/2012. The approaches included , but not limited to, pillow case between legs at</p>		disciplinatory action will be reviewed by the Director of Nursing or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.				

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	<p>all times, pillow between legs when on side, activities as tolerated, encouragement to lie down between meals to relieve pressure, therapy to work with resident to use wheelchair wheels for propulsion rather than scooting in wheelchair.</p> <p>The Occupational Therapy Recertification form dated 1/17/2012, indicated to promote wound healing Resident #10 needed cues to walk feet while using arms to propel wheelchair instead of scooting self forward and only using her feet.</p> <p>The Occupational Therapy Progress Report dated 1/14/2012 to 1/20/2012, the report indicated to continue with the current plan of care, focus on upper extremities strength and propelling in wheelchair. The Therapy Daily Progress Notes, dated 1/12/2011, indicated the resident needed cues not to scoot.</p> <p>The current CNA Work Assignment Sheet was provided by CNA #12 on 1/30/2012 at 2:30 p.m. The care plan intervention to encourage Resident #10 to lay down after meals to relieve pressure from wound was not included on the CNA Assignment sheet.</p>						

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	<p>The quarterly Minimum Data Set (MDS) assessment, dated 1/7/2012, stated, " Rejection of Care-Presence and Frequency: Did the resident reject evaluation or care (blood work, taking medication, ADL assistance) that is necessary to achieve the resident ' s goal for health and well being. MDS indicates behavior not exhibited."</p> <p>On 1/25/2012 at 2:00 p.m. to 3:15 p.m. Resident #10 was observed sitting in her wheelchair in the hall.</p> <p>On 1/26/2012 at 9:20 a.m., Resident #10 was observed in the lounge shaking right knee up and down and rocking back and forth. Resident #10 was not redirected of instructed by staff.</p> <p>On 1/26/2012 at 10:18 a.m., observed LPN #1 change Residents #10's dressing. Pressure area appeared clean, no drainage noted. Treatment completed as ordered by wound clinic.</p> <p>On 1/26/2012 at 2:00 p.m. to 2:30 p.m., Resident # 10 was observed sitting in the lounge rocking back and forth. Resident # 10 was not redirected by staff.</p>			
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	<p>On 1/27/2012 at 2:25 p.m., Resident # 10 was observed using her feet to rock forwards and backwards to propel herself down the hall way. Resident #10 was not redirected by staff to use proper technique.</p> <p>On 1/27/2012 at 4:14 p.m., Resident #10 was observed in the 200 hall sitting in her wheelchair asleep.</p> <p>On 1/27/2012 at 9:26 a.m. during interview, CNA # 13 indicated that when she sees Resident #10 using her feet and scooting in the wheelchair she would push her wheelchair down the hall. At this same time CNA #13 also indicated Resident #10 did not want to go to bed because she liked to do activities, but if she was tired she would let a CNA know.</p> <p>On 1/ 27/2012/ at 10:01 a.m. during interview, CNA # 12 indicated Resident #10 liked to go to activities and did not want to lay down after meals unless she was tired. CNA #12 also indicated would she sees Resident #10 using her feet only she would push her to where she wanted to go.</p> <p>On 1/30/2012 at 10:50 a.m. during an interview with the DON, she indicated</p>						

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	<p>she could make Resident #10's care plan more specific as to when she should lie down.</p> <p>3.1-40(a)(2)</p>			
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F0323 SS=D	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to develop interventions to prevent falls and possible injury for a cognitively impaired resident who was displaying unsafe behaviors resulting in falls for 1 of 6 residents reviewed for fall prevention in the Stage 2 sample of 35. (Resident #68)</p> <p>Findings Include:</p> <p>During an 1/26/12, 8:25 am, observation, Resident #68 was in the dining room in her wheelchair with a lap buddy. She was working at and manipulating her lap buddy. She had a large black, purple, yellow and green bruise circling her right eye up onto the temple.</p> <p>Resident #68's record was reviewed on 1/26/12 at 10:48 a.m.</p> <p>Resident #68's current diagnoses included, but were not limited to post stroke with right hand affected, Alzheimer's disease and anxiety with agitation.</p>	F0323	<p>1. Resident #68 had new interventions implemented to address the root cause of her falls and the care plan was updated accordingly. On 1/1/12, a toileting schedule was implemented. She is now on a specific toileting schedule to meet her needs as her infection is now resolved. On 1/6/12, a strap was placed to her wheel chair to hold her purse as she was trying to get to her purse when she fell. On 1/11/12, one should note that the resident did not show any signs of hitting her face or head. She was just noted to be in the prone position and a low bed was implemented. A mat was not added as it could have potentially increased her risk for falls and the risk of falls for others, as this is a locked unit with wandering residents. She had not hit her head on any previous falls. On 1/17/12, a follow up urinalysis was obtained as the resident had an infection previously. There was no indication that the resident hit her head. On 1/22/12, she had been restless in bed, so staff got her up in her chair with her lap buddy. An intervention was added to brush her dentures at bedtime as she stated she was getting up to brush her teeth. The lap buddy was continued as an</p>	02/20/2012			

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	<p>Resident #68 had a current, 1/5/12, Admission, Minimum Data Set assessment, which indicated the resident required extensive to total assistance of the staff for all activities of daily living. She had fallen at home prior to admission. She had fallen in the facility without injury. She had impaired balance and required balancing assistance when going from sit to stand, walking, turning around, transferring to the toilet and transferring from surface to surface.</p> <p>Resident #68 had a 12/29/11 Physical Therapy noted which indicated the resident had a decline in functional rehabilitation and difficulty in walking.</p> <p>Resident #68 had a 1/11/12, Physical Therapy Progress Report which indicated the resident had poor safety awareness and cognitive decline with difficulty concentrating on the task at hand.</p> <p>Review of nursing notes indicated Resident #68 fell, got out of bed, removed her lap buddy, attempted to stand or stood as follows:</p> <p>a.) 12/30/11, late entry, 11:30 a.m. -Resident #68 fell in the clean utility room sitting on floor. Her lap buddy and personal alarm were found on the</p>		<p>intervention to help remind the resident not to get up unassisted. A low bed with a mattress next to the bed on the floor is in place as well to help reduce the risk for injury related to falls.2. All residents at risk for falls have the potential to be affected. All fall risk care plans reviewed to ensure appropriate interventions are in place to decrease the risk for injury related to falls.3. All nursing staff will be in-serviced on fall prevention and dealing with behaviors. The DON or designee will be notified immediately of any incidents to ensure a new intervention to address the root cause of the fall is implemented. All incidents will then be reviewed in the morning meeting to ensure all disciplines are aware of incident and the IDT can review interventions. The assignment sheet and care plan will be updated to include new interventions. The DON or designee will complete an audit to ensure new fall interventions are care planned and implemented as such daily, on regularly scheduled days, for 1 months, then weekly thereafter (Attachment E).4. Any findings and subsequent disciplinary action will be reviewed by the Director of Nursing or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>		

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	<p>floor near the resident.</p> <p>b.) 12/31/11-11:00 a.m.-Resident # 68 took off her lap buddy and was trying to transfer self.</p> <p>c.) 1/1/12, 6:50 p.m. Resident #68 was on floor found by QMA. The resident said she had to go to the restroom.</p> <p>d.) 1/2/12, 9:00 p.m.-"less anxious has only removed lap buddy a few times..."</p> <p>e.) 1/4/12, 3:30 a.m.-bed alarm sounded, resident had gotten out of bed.</p> <p>f.) 1/6/12, 3:50 p.m., sitting on floor in room, resident had removed her lap buddy.</p> <p>g.) 1/11/12-11:10 p.m.-bed alarm sounded, resident found face down on floor beside her bed.</p> <p>h.) 1/15/11-9:00 p.m.- resident restless and agitated most shift, alarm sounded, found standing at bedside.</p> <p>i.) 1/17/12, 2:30 a.m., found on floor beside bed, bed alarm sounding.</p> <p>j.) 1/22/12 6 a.m.-removed lap buddy</p>						

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	<p>k.) 1/24/12, 3:15 a.m.-Summoned to unit per CNA. Found resident lying on her abdomen on the floor beside her bed. No inward/outward rotation noted to any extremity. Resident had a half dollar sized hematoma on her right brow. Ice pack applied to area.</p> <p>During an 1/27/12, 8:56 a.m., interview the Director of Nursing (DON) indicated the following:</p> <p>a.) Following the 1/1/12, fall Resident #68 was placed on the facilities toileting plan. She was not placed on a toileting plan based upon the resident's assessed individual toileting pattern.</p> <p>b.) Following the 1/6/12, fall when the resident removed her lap buddy an approach to address lap buddy removal was not added to the care plan.</p> <p>c.) Following the 1/11/12-23 fall when Resident #68 was found face down on the floor beside her bed the resident was placed on a low bed. No cushioning was added to the floor to prevent head or facial injury.</p> <p>d.) Following the 1/17/12, fall when the resident was found on floor near</p>			
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	<p>the bed, no cushioning was added to the floor to prevent head or facial injury.</p> <p>e.) Following the 1/22/12 fall when the resident removed her lap buddy no approach to address lap buddy removal was added to the residents plan of care.</p> <p>f.) The removal of the lap buddy had been discussed at fall prevention meeting but not addressed in care plan approach changes. The lap buddy was in place "to slow her down a little bit."</p> <p>Review of Resident #68's "Mood and Behavior Communication Memo (s)" for 12/31/11 through 1/24/12 indicated the following concerns with removing her lap buddy, climbing out of bed, attempting to stand or standing or other potentially unsafe actions as follows:</p> <p>a.) 1/22/12-climbed out of bed, placed in wheelchair 2:30 a.m.-6 a.m. shift</p> <p>b.) 1/17/12-21:10 p.m.-tried to toilet self-toileted and placed in bed</p> <p>c.) 1/22/12- 3-4 a.m.-removed her lap buddy several times and fell in dining</p>			
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	<p>room</p> <p>d.) 1/22/12-3:30 p.m.-removed lap buddy two times</p> <p>f.) 1/13/12-6-2 p.m.-removing lap buddy</p> <p>g.) 1/10/12-3:30 p.m.- took off lap buddy several times this shift. One time stood and sat on floor. Staff had to run to sit her down.</p> <p>h.) 1/13/12-5:10 p.m.-took off her lap buddy in 304 and was attempting to stand. She did this again at 3:25 p.m.</p> <p>i.) 1/13/12-3:30 p.m.-took off lap buddy 3 times this shift.</p> <p>j.) 1/14/12-3:00 p.m. -removed alarm from wheelchair and brought it to me.</p> <p>k.) 1/6/12-15:50 p.m.-removed her lap buddy each shift.</p> <p>l.) 1/4/12-19:55 p.m.-standing, wanted to get her pants, placed back in bed and explained she had night gown on.</p> <p>m.) 1/1/12-2p-10p-removed lap buddy from wheelchair. She tried to stand almost falling three times.</p>			
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	<p>n.) 12/31/11-2p-8p-removed lap buddy numerous times. stood up from wheelchair and began to walk away from the chair.</p> <p>During a 1/27/12, 10:30 a.m. interview, the DON indicated behaviors were summarized and reviewed in morning meetings. However, each event had not been read word for word. The DON indicated she had not been aware of the frequency Resident #68 had been removing her lap buddy. She indicated she would expect staff members to monitor Resident #68 closely perhaps within arms reach when the resident was repeatedly removing her lap buddy. The DON indicated there had not been an approach added to the resident's care plan to direct staff to monitor the resident frequently and closely when she was removing her lap buddy repeatedly.</p> <p>3.1-45(a)(1)</p>				

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F0332 SS=D	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observations, record reviews, and interview, the facility failed to ensure it was free of a medication error rate of 5% or greater for 3 of 53 opportunities during 2 of 6 nursing staff observed and for 2 of 17 residents observed during medication pass. The medication error rate was 5.66 %.</p> <p>(Resident #15 and #61) (LPN #17 and RN #3)</p> <p>Findings include:</p> <p>1. On 1/27/12 at 3:00 p.m., medication pass was observed. As LPN #17 prepared the Resident #61's Advair diskus (bronchodilator), the open date of this medication was 12/19/11. LPN #17 was observed to administer this medication to the resident. During an interview at this same time, LPN #17 indicated the Advair diskus was good until the last dose of the same diskus was given.</p> <p>On 1/27/12 at 3:15 p.m., the "Nursing 2011 Drug Handbook" was provided by QMA #16 as the source for medication information. The following information was indicated: Advair Diskus - Patient teaching - "...Patient should discard device 1 month</p>	F0332	<p>1. Resident #61 was not harmed and had a new Advair diskus ordered. LPN #17 was re-educated on Advair expiration dates. Resident # 15 was not harmed and insulin dose was administered as ordered. RN #3 was re-educated on appropriate time to administer insulin.2. All residents receiving medications have the potential to be affected. See below for corrective measures.3. The facility's medication administration policy was reviewed with no revisions indicated. All nurses will be in-serviced on the medication administration procedure and expired medications. The DON or designee will complete medication pass observations daily, on regularly scheduled days, for 1 month, then weekly for 2 months, then monthly for 2 months, then quarterly (Attachment F).4. Any findings and subsequent disciplinary action will be reviewed by the Director of Nursing or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. Addendum: The DON or designee will complete medication pass observations at random medication pass times to include all shifts.</p>	02/20/2012			

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	<p>after removal from the moisture-protective over wrap pouch or after every blister had been used, whichever comes first...."</p> <p>Resident #61's record was reviewed on 1/27/12 at 3:10 p.m. The physician's orders included, but were not limited to, Advair 250-50 Diskus, dated 8/05/11, to use 1 puff by mouth 2 times a day for chronic obstructive pulmonary disease.</p> <p>2. On 1/27/12 at 4:20 p.m., RN #3 completed Resident #15's accucheck (to determine blood sugar) with a resultant blood sugar of 152. At this same time RN #3 indicated with a blood sugar of 152, the resident would not require any insulin coverage, but she indicated the resident did receive a dose of insulin with meals. RN #3 was then observed to prepare the 12 units of Novolog insulin (to decrease blood sugars). As she was leaving the nurse's station to give the resident his insulin, she was again questioned concerning the blood sugar of 152. After rechecking the medication administration record, she indicated the resident should receive 2 additional units of insulin to cover the blood sugar of 152, which was then added to the amount to equal 14 units. This insulin was observed given at 4:25 p.m. with the resident returned from his room into the TV lounge. At this</p>						

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	<p>same time during an interview, QMA #16 indicated dinner would be served between 5:15 p.m. to 5:30 p.m.</p> <p>On 1/27/12 at 4:50 p.m., Resident #15 remained in the TV lounge with no food/meal observed.</p> <p>On 1/27/12 at 5:00 p.m. during an interview, the Dietary Supervisor indicated the Memory Unit (Resident #15's residence) would not be served dinner until around 5:25 p.m. today.</p> <p>Resident #15's record was reviewed on 1/27/12 at 4:35 p.m. The physician's orders included, but were not limited to, the following: Novolog 100 units (u) per milliliter (ml), dated 12/29/11, was to give 12 u with the sliding scale with each meal; Humalog 100u per ml sliding scale with no coverage for a blood sugar (BS) less than 150; BS -151 to 200 = 2u; BS - 201 - 250=4u; BS - 251 - 300 = 8u; BS 301 -350 12u; BS 351 - 400 = 16u; Accuchecks 4 times a day.</p> <p>The "Nursing 2011 Drug Handbook" indicated the following information: Novolog Insulin - Administration: Give Novolog 5 to 10 minutes before start of meal; Patient teaching - Teach patient...and importance of timing dose to</p>			

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	<p>meals and adhering to meal times.</p> <p>The "MEDICATION ADMINISTRATION POLICY AND PROCEDURE" policy was provided by the Administrator on 1/30/12 at 8:55 a.m. This current policy indicated the following:</p> <p>"PURPOSE: To administer medications according to the guidelines set forth by the State and Federal regulations.</p> <p>PROCEDURE: ...11. Medications will be given with food or antacids if ordered....."</p> <p>3.1-48(c)(1)</p>			
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F0463 SS=E	<p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation, record review, and interview, the facility failed to ensure bathroom call lights were functional in 2 of 4 rooms (Room 305 and 307) observed for 4 of 4 resident residing in these rooms in the Memory Unit, [Residents' # 66, # 63, # 20 and # 19] on 1 of 3 hallways observed.</p> <p>Finding include:</p> <p>On 1/26/12 at 2:20 p.m., the bathroom call light strings were observed missing in Room 307 and Room 305 resulting in no method available to turn the bathroom call light on.</p> <p>On 1/26/12 at 2:40 p.m. during an interview, the Maintenance Supervisor indicated he was unaware of the missing call light strings and indicated the strings do get pulled out in the Memory unit at times.</p> <p>The "Indiana State Department of Health DIVISION OF LONG TERM CARE NURSE AIDE TRAINING PROGRAM JULY 1998" indicated the following:</p>	F0463	<p>1. The call light string for the bathroom between rooms 305 & 307 was repaired immediately.2. All residents have the potential to be affected. All call lights checked to ensure all were in working order.3. Maintenance will check all lights for function daily, on regularly scheduled days, for 1 months, then weekly thereafter (see attachment #H).4. Any findings and subsequent disciplinary action will be reviewed by the Maintenance supervisor or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/20/2012			

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	<p>"...TOPIC 8: EMERGENCIES</p> <p>1. An emergence is a sudden, unexpected severe problem that endangers people. Emergencies can occur anywhere at anytime....</p> <p>3. Resident emergencies such as choking, falls, shock, burns, seizures, fainting, hemorrhage or cardiac arrest require immediate action:</p> <p>...b. Call for assistance immediately.</p> <p>...6. CNA's Role:</p> <p>...e. Call for help as soon as you notice an emergency....."</p> <p>3.1-19(u)(2)</p>			
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F0465 SS=C	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observations and interviews, the facility failed to ensure service areas were sanitary and in good repair related to a leaking washing machine for 1 of 2 washing machines observed, the condition of the floors for 1 of 1 laundry room and 2 of 2 soiled utility rooms observed. This had the potential to impact 67 of 67 residents residing in the facility. (laundry room, 200 soiled utility room, and Memory Unit soiled utility room)</p> <p>Findings include:</p> <p>1. On 1/26/12 at 1:15 p.m. during the environmental tour, the following was observed:</p> <p>Laundry room - in the soiled side of the laundry room, the smaller washing machine was observed to completed a load of laundry. A puddle of water was observed next to the washer. At this same time during an interview, the Administrator indicated she was not sure where the water had come from and instructed the Maintenance Supervisor to check on it. At this same time during an interview, the Administrator indicated all residents received laundry from the facility.</p>	F0465	<p>1. No residents were harmed. The leaking washing machine was repaired. The floor tiles, dry wall and cove base will be repaired. 200 hall soiled utility room caulking will be placed and area cleaned. The Memory care soiled utility room was cleaned and tiles and caulking will be repaired.2. All residents have the potential to be affected. An environmental tour of the facility was conducted to ensure all needed repairs are noted and scheduled for repair.3. All staff in-serviced on the process for maintenance request forms so that any noted repairs needed are reported to the Maintenance department for repair. The Administrator will monitor maintenance request forms and ensure repair are completed daily, on schedule work days, for 1 month, then weekly for 2 months, then monthly (see attachment G). The Administrator will complete environmental rounds weekly to ensure all needed repairs are identified (see attachment I).4. Any findings and subsequent disciplinary action will be reviewed by the Administrator Director or designee in the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/30/2012	
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	<p>The larger washing machine was observed on a raised area. Around this raised area and in front of the smaller washing machine, the 12 inch floor tiles were observed discolored with cracks and missing pieces throughout the floor. The patched areas of pink colored floor tiles were observed with gapping seams with a dark brown accumulation observed in these gaps. Along the back wall of this side of the laundry room, no cove base was in place with irregular pieces of dry wall missing from the bottom of the wall and gapped areas between the floor and wall.</p> <p>200 Hall soiled utility room - on the one side of the raised area where the hopper was located next to the sink, no caulking was present leaving a gap with dark brown accumulated substance in this gapped area.</p> <p>Memory Care soiled utility room - The base the hopper was sitting on was observed with a gap containing a dark brown accumulation along the one side located between this base and the sink. The 12 inch floor tiles were observed with dents and broken corners around this same base of the hopper and scattered areas of the discolored floor</p> <p>2. On 1/30/12 at 8:15 a.m. during an</p>						

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	<p>interview, the Maintenance Supervisor indicated a broken seal in the washing machine was causing the water leakage and was to be fixed.</p> <p>3.1-19(f)</p>			
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