

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/01/2015
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NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00170228.</p> <p>Complaint IN00170228-Substantiated. Federal/State deficiencies related to the allegation are cited at F155 and F157.</p> <p>Survey dates: April 27, 28, 29, 30, and May 1, 2015.</p> <p>Facility number: 000108 Provider number: 155653 Aim number: 100267410</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type: Medicare: 8 Medicaid: 42 Other: 15 Total: 65</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>May 22, 2015 Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006 Dear Ms.Rhoades: Please reference the enclosed 2567L as "Plan of Correction" for the May 1, 2015 Recertification and State Licensure with Complaint (IN00170228) survey that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools May 22, 2015. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on May 22, 2015 serves as our allegation of compliance. The provider respectfully request a Desk review on or after May 27, 2015.</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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F 155 SS=D Bldg. 00	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on record review and interview, the facility failed to ensure a resident's rights were honored related to the administration of a medication after it was refused for 1 of 1 resident reviewed for the right to refuse treatment of the 1 resident who met the criteria for resident rights. (Resident #B)</p> <p>Finding includes: Interview with Resident #B on 4/30/2015</p>	F 155	<p>Should you have any question or concerns regarding the Plan of Corrections, please contact me. Respectfully, Neysa Stewart, HFA</p> <p>F 155 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #B no longer resides in the facility. 2.</p>	05/27/2015

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	<p>at 1:15 p.m., indicated he was prescribed an anti-anxiety medication after feeling short of breath. He further indicated his nurse thought he was having an anxiety attack, however, he did not feel as if he was having an anxiety attack, but suffered from Chronic Obstructive Pulmonary Disease (COPD). Continued interview indicated on 3/15/2015 he was given an initial dose of the anti-anxiety medication and it made him sleepy and he slept until noon and he told his nurse he no longer wanted to take the medication but staff continued to slip the pill in with his other medications. Resident #B further indicated on 3/20/2015 he was given the medication with his morning medications at 9:00 a.m. He also indicated he had the same symptoms of feeling sleepy and he called his sister to ask her to speak with the staff related to administering the medication after it was refused. The medication was then discontinued on 3/20/15.</p> <p>The closed record for Resident #B was reviewed on 4/30/2015 at 10:54 a.m. Diagnoses included, but were not limited to, COPD, diabetes, and anxiety.</p> <p>Review of the Physician Orders dated 3/15/2015 indicated Paxil 10 milligrams (mg) for anxiety daily.</p>		<p>The corrective action for those residents having the potential to be affected by the same deficient practice: All residents on Paxil are at risk for this alleged deficient practice. Their medical record was reviewed and their request to continue the med will be honored.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: ADON was educated by the DON concerning policy on MD notification with refusals. Nurses were re-educated By the DON 5/5 & 5/6 regarding Residents Rights.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will interview 5 residents weekly times 4 weeks. Then 3 residents weekly times 4 weeks. Then 2 residents weekly times 4 months to ensure that their rights are being honored. Any issues identified will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 5/27/15</p>	

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F 157 SS=D Bldg. 00	<p>Review of the Medication Administration Record (MAR) dated 3/2015 indicated the resident received Paxil 10 mg on 3/15/2015 and 3/20/2015. Further review of the MAR indicated the resident refused the medication on 3/16/2015 and 3/17/2015. Continued review indicated the medication was held on 3/18/2015 and 3/19/2015.</p> <p>Interview with the ADON on 5/1/2015 at 11:03 a.m., indicated a resident has the right to refuse treatment. She also indicated when a resident refuses a medication the Physician should be notified promptly.</p> <p>The current policy Refusal of Treatment received by the MDS Consultant on 4/30/2015 at 3:40 p.m. The policy indicated, "The resident is not forced to accept any medical treatment and may refuse specific treatment even though it is prescribed by a physician."</p> <p>This Federal tag relates to complaint IN00170228.</p> <p>3.1-4(d)(e)</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the</p>			

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	<p>resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to promptly notify the Physician after a resident refused treatment for 1 of 1 resident reviewed for notification of change of the 1 resident who met the criteria for notification of change. (Resident #B)</p>	F 157	<p>F 157 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the</p>	05/27/2015

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	<p>Finding includes:</p> <p>Interview with Resident #B on 4/30/2015 at 1:15 p.m., indicated he was prescribed an anti-anxiety medication after feeling short of breath. He further indicated his nurse thought he was having an anxiety attack, however, he did not feel as if he was having an anxiety attack, but suffered from Chronic Obstructive Pulmonary Disease (COPD). Continued interview indicated on 3/15/2015 he was given an initial dose of the anti-anxiety medication and it made him sleepy and he slept until noon and he told his nurse he no longer wanted to take the medication but staff continued to slip the pill in with his other medications. Resident #B further indicated on 3/20/2015 he was given the medication with his morning medications at 9:00 a.m. He also indicated he had the same symptoms of feeling sleepy and he called his sister to ask her to speak with the staff related to administering the medication after it was refused. The medication was then discontinued on 3/20/15.</p> <p>The closed record for Resident #B was reviewed on 4/30/2015 at 10:54 a.m. Diagnoses included, but were not limited to, COPD, diabetes, and anxiety.</p> <p>Review of the Physician Orders dated</p>		<p>resident found to have been affected by the deficient practice: Resident #B no longer resides in the facility.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents receiving Paxil/ medications are at risk for this alleged deficient practice. An audit was completed for all residents on Paxil and no further alleged deficiencies were identified.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Nursing staff were re-educated on 5/5/15 & 5/6/15 regarding "Honoring Residents Rights"/ MD notification of refusals.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor 5 residents weekly for four weeks. 3 residents weekly for 4 weeks. 2 residents weekly for 4 months to ensure that resident's rights are being honored. Any issues observed or identified will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when</p>	

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	<p>3/15/15 indicated Paxil 10 milligrams (mg) for anxiety daily.</p> <p>Review of the Medication Administration Record (MAR) dated 3/2015 indicated the resident received an initial dose of Paxil 10 mg on 3/15/2015 and refused the medication on 3/16/2015 and 3/17/2015. Continued review of the MAR indicated the medication was held on 3/18/2015 and 3/19/2015, and was again administered to the resident on 3/20/2015.</p> <p>Interview with the ADON on 5/1/2015 at 11:03 a.m., indicated a resident has the right to refuse treatment. She also indicated when a resident refuses a medication the Physician should be notified promptly and the resident's medication should have been discontinued on 3/15/2015 when he initially reported to his nurse that he no longer wanted to take the medication.</p> <p>The current policy Acute Condition Changes-Clinical protocol received by the MDS Consultant on 5/1/2015 at 10:30 a.m., indicated, "The staff will monitor and document a resident's progress and responses to treatment and the Physician will adjust treatment accordingly."</p>		<p><i>indicated.</i> 5. Completion date systemic changes will be completed: 5/27/15</p>				

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F 164 SS=D Bldg. 00	<p>This Federal tag relates to complaint IN00170228.</p> <p>3.1-5(b)(2)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution;</p>			

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	<p>law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure each resident's privacy was protected related to medication pass and leaving the Medication Administration Record open for 2 of 6 residents observed during medication pass. (Residents #87 & #25)</p> <p>Findings include:</p> <p>1. On 4/29/15 at 3:45 p.m., RN #1 was observed preparing medications for Resident #25 At that time, he was observed to be standing by the medication cart right in front of the Nurse's station. The RN prepared the resident for an accu-check to check the resident's blood sugar. He obtained the resident's blood and got the reading. He then left the medication cart and walked into the medication room to grab the basket of vials of Insulins. At that time, the Medication Administration Record (MAR) was left open and on top of the med cart in full view for all of the residents and visitors to see. The MAR was a list of all the resident's medications and had the resident's diagnoses listed. After returning to the med cart, RN #1 decided to walk into the dining room and wash his hands. He again left the MAR open on top of the cart.</p>	F 164	<p>F 164 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: DON closed MAR immediately. Resident #25 and Resident #87 were unaffected by this alleged deficient practice.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents that receive medications on that team are at risk for this alleged deficient practice. DON observed that there was no breach in confidentiality of these MARS.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: RN# 1 was immediately re-educated on ensuring the confidentiality of medical records. Nurses were re-educated on 5/5/& 5/6 regarding confidentiality.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will</p>	05/27/2015			

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	<p>2. On 4/29/15 at 4:25 p.m., RN #1 was observed preparing an Insulin injection for Resident #87. At that time, he walked away from the med cart. The MAR was open and viewable to all the residents standing by the med cart as well anyone else who came up to the second floor, as the med cart was right by the elevator. RN #1 left the med cart and wheeled Resident #87 to her room to administer the Insulin injection. He then came back to the med cart and threw away the syringe in the sharps container on the side of the cart. The RN walked into the dining room to wash his hands, again he was out of sight of the med cart and the MAR was still open and the resident's medications were listed.</p> <p>Interview with RN #1 at the time, indicated he should have probably closed the MAR when he left the med cart.</p> <p>Interview with the Director of Nursing on 4/29/15 at 5:00 p.m., indicated the Nurse should have closed the Medication Administration Record every time he was out of sight from the medication cart.</p> <p>3.1-3(p)(2)</p>		<p><i>monitor 3 nurses daily 5 times weekly for 4 weeks. 2 nurses daily 5 times weekly for 4 weeks. 5 nurses weekly for 4 months to ensure that the confidentiality of medical records is ensured. Any issues identified or observed will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</i></p>	

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F 226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow their Abuse Policy related to obtaining the results of criminal back ground checks completed by the State of Indiana for 1 of 10 employee files reviewed. (Employee #9)</p> <p>Finding includes:</p> <p>The facility employee files were reviewed on 5/1/15 at 12:00 p.m. Employee #9 was identified as a LPN hired on 12/15/14. A request for a Statewide Criminal Search was requested on 12/8/14. The "Result" section on the form indicated "waiting for reply." No completed criminal search was documented.</p> <p>When interviewed on 5/1/15 at 1:50 p.m., Social Service staff indicated they had no current record of the results of the above criminal history check. The Social Service staff indicated the facility had changed systems for the criminal history checks and at that time only the facility Administrator had access to the system to</p>	F 226	<p>F226 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. On 5/1/15 Employee #9 Background Check was completed.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected by the alleged deficient practice. No residents were identified as being adversely affected. An audit was completed on 5/4/15 of staff hired in the last 3 months to ensure background check were completed. Any issues will be addressed immediately.</p> <p>3The measures put into place and a systemic change made to</p>	05/27/2015

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F 241 SS=D Bldg. 00	<p>obtain the results.</p> <p>When interviewed on 5/1/15 at 2:15 p.m., the Director of Nursing indicated the results of the above employees criminal history check should have been obtained.</p> <p>The facility "Abuse Prevention Program Policy" was reviewed on 4/30/15 at 2:30 p.m. The Pre-Employment screening of potential employee section of the policy indicated pre-employment screening of employees was to be completed.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents</p>		<p>ensure the deficient practice not reoccur: Human Resource Coordinator and Social Service Director was re-inserviced by the Administrator on 5/4/15 on the facility abuse Policy regarding New Hire completed background checks. A new Background Check system has been implemented, requiring the hiring Department Manager or Administrator to review and initial all completed background checks prior to hiring. On 5/21/15 hiring Department Managers were in-serviced by the Human Resource Coordinator how to interpret the background checks.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Administrator / Designee will audit all new hire background checks prior to employment. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for four consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</p>		

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	<p>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, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to a Foley catheter bag being full of urine and facing the hallway for 1 of 1 resident reviewed for dignity of the 1 resident who met the criteria for dignity. (Resident #25)</p> <p>Finding includes:</p> <p>On 4/27/2015 at 8:40 a.m., during the initial tour of the facility Resident #25's Foley catheter bag was observed hanging from the bottom portion of the bed rail. The Foley catheter bag was full of yellow urine and facing the hallway.</p> <p>On 4/30/2015 at 9:30 a.m., Resident #25's Foley catheter bag was observed hanging from the bottom portion of the bed rail. The Foley catheter bag was half full of yellow urine and facing the hallway.</p> <p>The record for Resident #25 was reviewed on 4/29/2015 at 12:40 p.m. The resident's diagnoses included, but were limited to, pressure ulcers and Foley catheter.</p>	F 241	<p>F 241 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #25 Foley bag was changed to the "fig leaf" dignity bag on 4/30/15. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents with Foleys are at risk for this alleged deficient practice. An audit was completed on 4/30/15 and no further alleged deficiencies were indicated. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Nursing staff were re-educated on 5/5/15 & 5/6/15 regarding proper placement of Foley catheters. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor 5 residents with catheters weekly for four weeks. 3</p>	05/27/2015

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F 248 SS=D Bldg. 00	<p>Review of the Quarterly Minimum Data Set (MDS) dated 1/21/2015 indicated the resident was alert and oriented.</p> <p>Interview with the Director of Nursing (DON) on 5/1/2015 at 11:45 a.m., indicated the resident's Foley catheter bag should have been switched over to a Fig Leaf bag which provides privacy.</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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 observation, record review, and interview, the facility failed to provide ongoing activities in accordance with the resident's assessment for 1 of 1 resident reviewed for Hospice. (Resident #44)</p> <p>Finding includes:</p> <p>On 4/29/15 at 5:13 a.m., 8:39 a.m., 9:15 a.m., 10:10 a.m., 10:50 a.m., 12:25 p.m., 1:05 p.m., 1:54 p.m., and 5:17 p.m., Resident #44 was observed in bed. There</p>	F 248	<p><i>residents weekly for 4 weeks. 2 residents weekly for 4 months to ensure that dignity is maintained. Any issues identified or observed be corrected immediately The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5.</i></p> <p>Completion date systemic changes will be completed: 5/27/15</p> <p>F248 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #44's Television was turned on for her to watch. On 4/30/15 the activity</p>	05/27/2015			

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	<p>were no staff members or visitors in the resident's room. There was a television on top of the resident's bedside dresser. The television was off. No radio or tape players were in the resident's room.</p> <p>On 4/30/15 at 7:54 a.m., 9:00 a.m., 9:35 a.m., 10:25 a.m., and 10:53 a.m., the resident was observed in bed. There were no staff members or visitors in the resident's room. There was a television on top of the resident's bedside dresser. The television was off. No radio or tape players were in the resident's room.</p> <p>The record for Resident #44 was reviewed on 4/28/15 at 2:32 p.m. The resident's diagnoses included, but were not limited to, senile degeneration of the brain, stomach and lung cancer, acute kidney failure, and high blood pressure.</p> <p>The 3/5/15 Minimum Data Set (MDS) significant change assessment indicated the resident required extensive assistance of two staff members for bed mobility. The assessment also indicated the resident was dependent on two staff members for bathing, and the resident had not been transferred out of bed during the seven day reference period prior to the completion of the assessment. Listening to music was marked on the assessment as one of the resident's</p>		<p>director met with resident #44 to re-assessed her preference of ongoing activities. On 5/4/15 a radio was provide for Resident#44 for music listening.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All resident have the potential to be affected by the deficient practice. No residents were identified as being adversely affected. A full audit was conducted to insure that dependent / hospice residents are provided ongoing activities in accordance with the resident's assessment. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: On 4/30/15 all staff were in-serviced by the Activity Director on turning on the residents TV or radio when they are in the room. The Activity Director and Activity staff were in-serviced on 5/18/15 by the Administrator on providing ongoing activities in accordance with resident assessment preference. To ensure that ongoing program of activities designed to meet, in accordance with the comprehensive assessment. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Activity Director / Designee will conduct rounds to the dependent / hospice resident's rooms 5 days.</p>	

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	<p>preferences for her routine or activities.</p> <p>Review of the resident's current Care Plans indicated an Activities Care Plan was initiated on 3/19/15 related to a significant change in the resident's health status. The Care Plan goals were for the resident to receive one on one room visits and staff to create a relaxed environment. Interventions included for staff to provide audio, visual and tactile stimuli and to wheel the resident to the recreation area for special events.</p> <p>The "One-On-One Room Visits" log was reviewed. The resident received (9) one to one room visits for "music listening" from 4/1/15 through 4/30/15. No other types of visits were noted.</p> <p>When interviewed on 4/30/15 at 11:00 a.m. the Activity Director indicated the resident was on one to one activity visits. The Activity Director indicated for the one to one visits she would take a radio or tape player into the resident's room for approximately 15 minutes each visit. The Activity Director also indicated the resident had a television in her room. The Activity Director indicated she provided the one on one visits and the completed visits were logged on the room visit log and the resident received nine visits with music as per the log. The Activity</p>		<p>a week for 4 weeks and then 3 days a week for 3 months to ensure that assessment preferences are being met. A residents plan of care will be amended to honor new preferences or in the event of a change of status. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for <u>three</u> consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 05/27/2015</p>	

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F 272 SS=D Bldg. 00	<p>Director also indicated there was a television in the residents room only and the television could have also been turned on for stimulation for the resident. The Activity Director indicated there was no radio or tape player left in the resident's room.</p> <p>3.1-33(b)(8)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;</p>			

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	<p>Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a bladder assessment was complete and accurate for a resident who had an indwelling Foley catheter for 1 of 3 residents reviewed for Foley catheters of the 18 residents who met the criteria for Foley catheters. (Resident #64)</p> <p>Finding includes:</p> <p>On 4/29/15 at 8:33 a.m., Resident #64 was observed in bed eating breakfast. At that time, the resident was observed with an indwelling Foley catheter hanging on the side of the bed</p> <p>The record for Resident #64 was reviewed on 4/30/15 at 12:50 p.m. The resident ' s diagnoses included but were not limited to pain, Foley catheter, and end stage renal disease.</p> <p>Physician Orders on the current 4/2015 recap indicated catheter care every shift and catheter Foley size 16 French for Stage 4 pressure ulcer due to medical</p>	F 272	<p>F 272 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #64 was reassessed on 5/20/15. Her bladder observation assessment was updated at that time. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: An audit was completed on 5/20/15 and all residents with indwelling foley catheters was completed and updated. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Restorative nurse was re-educated on 5/21/15 regarding proper completion of bladder observation assessment. 4. To ensure the deficient practice does not reoccur, the</p>	05/27/2015

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	<p>necessity.</p> <p>The bladder assessment dated 1/15/15 indicated the indication evaluation for residents with indwelling catheters was blank with no reason for the catheter.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 4/20/15 indicated the resident had a Foley catheter.</p> <p>The care plan dated 3/14/13 indicated resident was at risk for urinary tract infection. Resident had a Foley catheter. Resident will be free of Urinary Tract Infection</p> <p>The Skin Integrity sheet dated 11/19/14 indicated the resident was admitted with a right inferior lower back Stage 4 pressure ulcer on 3/14/13. The pressure ulcer was resolved 100% and the treatment was discontinued.</p> <p>Nursing progress notes dated 1/2/15 at 3:26 p.m., documented by the Director of Nursing (DON) indicated this writer had conversation with resident concerning her catheter. Even after educating concerning the risk the resident was hesitant and was refusing to have the catheter d/c.</p> <p>Interview with the DON on 4/30/15 at</p>		<p>monitoring system established is to: MDS Nurse / Designee will monitor 2 residents weekly X 4 weeks. MDS Nurse/ Designee will monitor 3 residents weekly X 3 months. To ensure accurate bladder observations are being completed. Any Issues identified will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5.</p> <p>Completion date systemic changes will be completed: 5/27/15</p>	

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F 278 SS=E Bldg. 00	<p>2:00 p.m., indicated the resident wants the Foley catheter and refuses for it to be removed. She further indicated the bladder assessment should have reflected the resident's choice to have the Foley catheter.</p> <p>3.1-31(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p>			

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	<p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded related to antidepressant medications and insulin injections for 2 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure the MDS was coded accurately related to vision status for 2 of 3 residents reviewed for vision of the 17 residents who met the criteria for vision. (Residents #5, #26, #29, #44, and #74)</p> <p>Findings include:</p> <p>1. The record for Resident #29 was reviewed on 4/29/15 at 9:57 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.</p> <p>A Physician's order dated 1/26/15, indicated the resident was to have her blood sugar tested twice a day and she was to receive a Novolog insulin injection based on a sliding scale.</p> <p>A Physician's order dated 3/3/15, indicated the resident was to receive 10 units of Levemir insulin subcutaneous at bedtime.</p>	F 278	<p>F 278 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: · Resident #29 MDS section N was modified on 5/21/15. · Resident #5 MDS section N was modified on 4/29/15. · Resident #26 vision was reassessed on 5/15/15 and section B1000 reflects use of glasses. · Resident #74 vision was reassessed on 5/22/15 for section B1000 & B1200. He refuses to wear glasses and his plan of care was updated. · Resident #44 MDS section N4 was modified on 4/29/15.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: An audit was completed on 5/21/15 of section N on these residents most recent MDS for all residents receiving antidepressants, antipsychotics, and insulin injections. An audit was completed on 5/21/15 to ensure proper MDS coding for all</p>	05/27/2015

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	<p>The 4/16/15 Quarterly Minimum Data Set (MDS) assessment was reviewed. Review of Section N. Medications on the MDS, indicated the injection section was coded as "0". Insulin injections were also coded as "0" indicating the resident had not received an insulin injection in the past 7 days.</p> <p>Interview with the MDS Consultant on 5/1/15 at 11:00 a.m., indicated the insulin injections should have been coded on the Quarterly MDS.</p> <p>2. The record for Resident #5 was reviewed on 4/30/15 at 3:34 p.m. The resident's diagnoses included, but were not limited to, schizophrenia and depressive disorder.</p> <p>Physician Orders on the current 4/2015 and an original date of 10/2007 indicated Zyprexa (an antipsychotic medication) 10 milligrams (mg) at night time.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 3/31/15 under the medications section indicated the resident received an antidepressant 7 days and an antipsychotic 0 days.</p> <p>Interview with the MDS Nurse Consultant on 5/01/15 at 9:49 a.m., indicated Zyprexa should have been coded as an antipsychotic on the MDS.</p>		<p><i>residents wearing glasses.</i></p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: <i>MDS nurse and restorative nurse were re-educated on 5/21/15 regarding proper MDS coding according to the RAI manual.</i> 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: <i>MDS Nurse / Designee will monitor 5 residents weekly X 4 weeks. MDS Nurse/ Designee will monitor 3 residents weekly X 3 months. To ensure proper coding related to vision, injections, antidepressants and antipsychotics. Any issues identified will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.</i> 5. Completion date systemic changes will be completed: <i>5/27/15</i></p>	

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	<p>3. On 4/29/15 at 8:34 a.m., Resident #26 was observed in bed. She was also observed wearing a pair of glasses. Interview with the resident at that time, indicated she needs them to see the television because she cannot see far away.</p> <p>The record for Resident #26 was reviewed on 4/30/15 at 9:00 a.m.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/28/15 indicated the resident's vision was impaired and no corrective lens were used. The Brief Interview for Mental Status (BIMS) score was a 15 indicating she was alert and oriented</p> <p>The Care Area Assessment Summary (CAAS) dated 5/14/14 indicated resident had some vision impairment. The resident was able to see staff faces and objects. The resident was able to propel self at times and she was able to feed self after some setup.</p> <p>The Optometrist eye exam was dated 12/22/14 which indicated glasses plan: no new glasses, will not improve vision. The Optometrist indicated the resident had a prescription for glasses and there was no change in her prescription.</p>			

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	<p>Interview with the Restorative Nurse on 4/30/15 at 1:30 p.m., indicated at the time of the vision exam the resident was not wearing her glasses. She indicated she was under the impression if they were not wearing their glasses at that time, she would code them as no corrective lens. During the Interview, the Restorative Nurse reviewed the RAI manual which indicated during the corrective lens assessment it was okay to ask the resident if they wear their glasses, if resident was not able to communicate it was ok to ask their family members if corrective lens were worn and to code accordingly.</p> <p>4. On 5/1/15 at 11:05 a.m., Resident #74 was observed in bed. There was a pair of glasses on top of the television at the foot of his bed. The resident indicated they were his glasses.</p> <p>The record for Resident #74 was reviewed on 4/29/15 at 10:58 a.m. The resident's diagnoses included, but were not limited to, left eye legal blindness, congestive heart failure, and joint contractures.</p> <p>Review of the 3/7/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (12). A score of (12) indicated the residents cognitive</p>			

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	<p>patterns were moderately impaired. The assessment also indicated the resident's vision was moderately impaired and he was not able to see newspaper headlines but could identify objects. The assessment also indicated the resident did not have corrective lens such as contact lens, glasses, or a magnifying lens.</p> <p>When interviewed on 5/1/15 at 11:00 a.m., the Restorative Nurse indicated she had completed the vision section on the above 3/7/15 MDS assessment. The Restorative Nurse indicated the resident did not have glasses on at the time she completed her assessment. The Restorative Nurse also indicated the assessment should have been completed with the resident wearing his eye glasses.</p> <p>5. On 4/29/15 at 5:13 a.m. Resident #44 was observed in bed. The resident was receiving tube feeding via a gastrostomy tube (a tube placed in the resident's abdomen or provide nutrition through).</p> <p>The record for Resident #44 was reviewed on 4/28/15 at 2:32 p.m. The resident's diagnoses included, but were not limited to, gastrostomy tube, senile degeneration of the brain and, high blood pressure.</p> <p>Review of the current Physician orders</p>			

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	<p>indicated an order was written on 3/18/15 for the resident to be NPO (to receive nothing by mouth). Another order was written on 4/9/15 for the resident to receive Glucerna tube feeding via a gastrostomy tube for 20 hours a day. There was also a Physician's order written on 3/11/15 for the resident to receive Mirtazapine (an anti-depressant medication) 7.5 milligrams at bedtime daily.</p> <p>The March 2015 and April 2015 Medication Administration Records indicated the resident received the Mirtazapine 7.5 milligrams daily from 3/12/15 through 4/27/15.</p> <p>The 3/18/15 Minimum Data Set (MDS) significant change assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident had no signs of feeling down or depressed and no behaviors. The Medication section on the assessment was not coded to indicate the resident had received an anti depressant medication (7) of the (7) days in the assessment reference period.</p> <p>When interviewed on 4/29/15 at 9:31 a.m. the Director of Nursing indicated the staff should have coded the anti</p>			

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F 282 SS=D Bldg. 00	<p>depressant medication on the above MDS assessment.</p> <p>3.1-31(g)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to scheduling a follow up Neurosurgeon appointment for 1 of 3 residents reviewed for hospitalization of the 6 residents who met the criteria for hospitalization. The facility also failed to ensure vital signs were monitored daily for 1 of 1 residents reviewed for dialysis. (Residents #74 and #83)</p> <p>Findings include:</p> <p>1. The record for Resident #83 was reviewed on 4/30/15 at 1:47 p.m. The resident's diagnoses included, but were not limited to, metastatic brain and spinal cord neoplasm and status post craniotomy.</p>	F 282	<p>F 282 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #83 has since been discharged. Resident #74 orders were clarified. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents admitted in January & February charts were reviewed for any missed appointment. No further deficiencies were indicated. All residents that receive dialysis orders were clarified. 3. The measures put into place and a</p>	05/27/2015

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	<p>A Physician's order dated 1/12/15, indicated the resident was to have a follow up appointment with the Neurosurgeon in one week. There was no documentation in the resident's record to indicate if she had seen the Neurosurgeon or if an appointment had been scheduled.</p> <p>Interview with the Director of Nursing on 5/1/15 at 10:20 a.m., indicated based on the documentation in the Unit calendar, it appeared a follow up appointment with the neurosurgeon was not made.</p> <p>2. The record for Resident #74 was reviewed on 4/29/15 at 10:58 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, dialysis, high blood pressure, and congestive heart failure.</p> <p>The current Physician orders were reviewed. There was an order written on 6/2/14 for the resident to receive hemodialysis on Tuesdays, Thursdays, and Saturdays.</p> <p>Review of the 4/2015 Medication Administration and Treatment Administration Records did not indicated vital signs were being taken daily. Vital sign readings were recorded in the 4/2015 Nursing Progress Notes on the following dates/times: 4/03/14 at 7:16 p.m.</p>		<p>systemic change made to ensure the deficient practice not reoccur: Nurses were re-educated on follow up on MD orders for outside MD appointments. Nurses were re-educated on policy for vitals monitoring for all dialysis residents. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor 100% MD orders for appointments & those on dialysis for vitals 5 days per week for four weeks. 5 residents weekly for 4 weeks. 2 residents weekly for 4 months to ensure that resident's vitals are being monitored daily and MD orders for appointments are being followed. Any issues identified and observed will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</p>	

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F 309 SS=D Bldg. 00	<p>4/10/15 at 7:17 p.m. 4/11/15 at 9:36 a.m. 4/12/15 at 2:55 p.m. 4/24/15 at 8:01 p.m.</p> <p>When interviewed on 4/30/15 at 8:05 a.m., the Director of Nursing indicated the resident's blood pressure had not been taken daily as per the policy.</p> <p>The facility titled "Post Dialysis Monitoring and Observation Implanted A-V Shunt" was reviewed on 4/29/15 at 1:42 p.m. There as no date on the policy. The Director of Nursing provided the policy and indicated the policy was current.</p> <p>The policy indicated at least a daily check of blood pressures and vital signs were to be documented.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview,</p>	F 309	F 309 PLAN OF CORRECTION Please accept	05/27/2015	

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	<p>the facility failed to assess a resident who had a change in condition for 1 of 2 residents reviewed for change in condition of the 2 residents who met the criteria for change in condition. (Resident #23)</p> <p>Finding includes:</p> <p>The closed record for Resident #23 was reviewed on 4/28/15 at 3:05 p.m. The resident's diagnoses included, but were not limited to, colon cancer, colostomy, and congestive heart failure.</p> <p>Review of the Transfer Discharge form dated 1/14/15 indicated the resident was being sent to the Emergency Room (ER) due to abnormal labs.</p> <p>Review of the Prompt Patient Care Report dated 1/14/15 at 7:52 a.m., the resident was unconscious or lethargic, blood pressure 78/52, pulse rate 114, respirations 32 and labored, and his O2 saturation was 71% on room air.</p> <p>Review of the nursing notes indicated no documentation related to the resident's status before he left the facility.</p> <p>Interview with LPN #2 on 5/1/15 at 9:43 a.m., indicated she was the midnight nurse caring for the resident on 1/14/15.</p>		<p>the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #23 has since been discharged from the facility. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: Any residents that has a change in condition is at risk for this alleged deficient practice. Charting was reviewed for all residents that were discharged or had a change in condition during the week of January 12-18th to ensure that residents were assessed post change in condition. No further alleged deficiencies were identified. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Nurses were reeducated on 5/5/15 & 5/6/15 on charting to be completed post change in condition. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor 100% of charting 5 days / weekly for four weeks. 75% of charting 4-5 days</p>	

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F 323 SS=E Bldg. 00	<p>She had received a call from the Physician that morning at 7:00 a.m., with new orders to transfer the resident to the ER due to abnormal labs. She further indicated the resident had a change in condition during the night; however, she did not chart the change in condition. She indicated the resident had a low blood pressure and she kept a close eye on the resident throughout the night.</p> <p>Interview with the MDS Consultant on 5/01/2015 at 10:23 a.m., indicated nurses should complete an event form when there was a change in condition.</p> <p>The current Acute Condition Changes policy received by the MDS Consultant on 5/1/2015 at 10:30 a.m. The policy indicated, "The staff will monitor and document the resident's progress and responses to treatment, and the Physician will adjust treatment accordingly.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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><i>weekly for 5 months to ensure that proper documentation is completed post change in condition. Any issues identified will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</i></p>	

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	<p>Based on observation and interview, the facility failed to ensure the environment remained free from accident hazards related to elevated water temperatures on 2 of 2 floors throughout the facility. (The First and Second floors)</p> <p>Findings include:</p> <p>1. On 4/27/15 at 10:48 a.m., the following hot water temperatures were noted on the First floor:</p> <p>a. Room 102-134 degrees Fahrenheit. One resident resided in this room.</p> <p>b. Room 106-134 degrees Fahrenheit. Two residents resided in this room.</p> <p>c. Room 111-134 degrees Fahrenheit. Two residents resided in this room.</p> <p>2. On 4/27/15 at 11:00 a.m., the following hot water temperatures were noted on the Second floor:</p> <p>a. Room 202-133 degrees Fahrenheit. Two residents resided in this room.</p> <p>b. Room 203-132 degrees Fahrenheit. One resident resided in this room.</p> <p>All of the above water temperatures were tested by the Maintenance Supervisor.</p>	F 323	<p>F323 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were identified as being adversely affected.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All resident have the potential to be affected by the deficient practice. No residents were identified as being adversely affected.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: The Maintenance Director and maintenance staff were in-service by the Administrator on 5/18/15 regarding monitoring the water temperatures in the resident's rooms at the beginning of their shift and properly maintaining an accident and hazard free environment. Seco Refrigeration, Inc was called out on 4/28/15 to check the water mixing valve, needed repairs were made. On 5/8/15 Seco Refrigeration, Inc replaced the water mixing valve.</p>	05/27/2015

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F 325 SS=D Bldg. 00	<p>When interviewed on 4/27/15 at 11:15 a.m., the Maintenance Supervisor indicated he checked water temperatures in five rooms per day. The five rooms were a combination of the First and Second floors. The Maintenance Supervisor also indicated there had been no recent problems with the temperatures being over 120 degrees Fahrenheit as required.</p> <p>The last documented entry in the water temperature log was on 4/24/15, which indicated all five rooms tested were below 120 degrees Fahrenheit.</p> <p>During the Environmental tour on 5/1/15 at 1:00 p.m., with the Maintenance and Housekeeping Supervisors, the following water temperatures were noted:</p> <p>Room 102-113 degrees Fahrenheit. Room 106-105 degrees Fahrenheit. Room 111-108 degrees Fahrenheit.</p> <p>3.1-19(r)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a</p>		<p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Maintenance Director / Designee will monitor <u>10 resident rooms on each floor 5 days a week for 4 weeks</u> and <u>then 5 resident's rooms on each floor 5 days a week for 4 months</u> to insure the deficient practice does not reoccur. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for <u>three</u> consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 05/27/2015</p>	

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	<p>resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident was reviewed in the Nutrition at Risk committee meetings related to a recent weight loss after a hospitalization for 1 of 3 residents reviewed for nutrition of the 23 who met the criteria for nutrition. (Resident #12)</p> <p>Finding includes:</p> <p>On 4/29/15 at 12:33 p.m., Resident #12 was observed being fed his lunch. The resident received a hamburger with cheese, bun, carrots, a mini chef salad with hard boiled egg, lettuce, cheese, ham and salad dressing. The resident also received pudding, ice cream, milk and juice.</p> <p>The record for Resident #12 was reviewed on 4/29/15 at 3:12 p.m. The residents's diagnoses included but were not limited to, quadriplegic, anxiety, pressure ulcer, and depressive disorder.</p> <p>The Quarterly Minimum Data Set (MDS)</p>	F 325	<p>F 325 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: <i>Resident #12 has had no further significant weight loss.</i> 2. The corrective action for those residents having the potential to be affected by the same deficient practice: <i>An audit was completed on 5/20/15 of all residents that were admitted /readmitted during the months of April & May 2015 to ensure all residents were discussed in the weekly NAR's meeting. No further deficiencies were noted.</i> 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: <i>Current system was reviewed. An improved system for communicating the residents that</i></p>	05/27/2015

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	<p>assessment dated 4/20/15, indicated the resident's Brief Interview for Mental Status (BIMS) score was a 15 indicating he was alert and oriented. The resident had no oral problems and weighed 140 pounds. Weight loss was noted and the resident was totally dependent with 1 person physical assist for eating.</p> <p>The resident was admitted to the hospital on 1/14/15 and returned back to the facility 2/2/15.</p> <p>Review of the weight record indicated the resident was not weighed until 2/10/15 after his return in which he weighed 148 pounds. The previous weight obtained on 1/14/15 indicated he weighed 156 pounds.</p> <p>The Registered Dietitian (RD) Progress Note dated 2/3/15 indicated the resident had just returned from the hospital. The RD used the 1/14/15 weight of 156 pounds for the review. The RD had recommended the resident to receive Ensure (a nutritional supplement) three times a day for added calories.</p> <p>The next RD Progress Note was dated 2/18/15 which indicated the resident's weight was 148 pounds and that was a 5% weight loss times one month. The RD indicated the suspected weight loss</p>		<p><i>will be followed in NAR's was implemented. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON/ Designee will monitor 100% of residents weekly X 4 for weights and documentation related to NAR's. DON/ Designee will monitor 7 residents weekly X 4 weeks. Then 5 residents weekly X 4 months. Any issues identified will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</i></p>	

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	<p>was due to the recent hospitalization.</p> <p>Review of the weight record indicated the next documented weight after 2/10/15 was on 2/25/15 and was 146 pounds. His weight was obtained on 3/4/15 which was 152 pounds. The resident was then admitted to the hospital on 3/18/15 and returned back to the facility on 3/26/15. The next documented weight was on 3/31/15 which was 146 pounds. The resident was weighed weekly up until 4/28/15 and that was the latest weight which was 140 pounds.</p> <p>The Nutrition at Risk (NAR) notes were reviewed. The first documented NAR was on 2/11/15. The resident was then reviewed in NAR on 2/18, and 2/25, and then not again until 4/1/15. There were no NAR notes for review on 3/4 and 3/11/15.</p> <p>The current 3/5/13 Guidelines for Nutrition at Risk Committee review of high priority cases provided by the Nurse Consultant indicated Re-admissions should be weighed weekly for four weeks and therefore the weight recorded for the first week after return to the facility should suggest those residents requiring committee evaluation. Any weight loss that meets one or more of the following conditions-Unplanned weight loss of 5%</p>			

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F 329 SS=E Bldg. 00	<p>or more in 30 days.</p> <p>Interview with the Restorative Nurse on 4/30/15 at 1:30 p.m., indicated the resident should have been weighed upon return from the hospital on 2/2/15. She indicated she was unclear why he was not weighed when he returned. She further indicated when a resident comes back from the hospital they should be weighed weekly for 4 weeks. She also indicated she was unaware the resident was not reviewed NAR on 3/4/15 and 3/11/15.</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless</p>			

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	<p>antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary medications related to an indication for the increase of an anti-psychotic medication, the use of an anti-depressant for excessive duration, lack of an attempted gradual dose reduction for an anti-psychotic medication and lack of blood pressure monitoring for a resident receiving an anti-hypertensive medication for 4 of 5 residents reviewed for unnecessary medications. (Residents #5, #8, #29, and #44)</p> <p>Findings include:</p> <p>1. The record for Resident #29 was reviewed on 4/29/15 at 9:57 a.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance and atypical nonorganic psychosis.</p> <p>A Physician's order dated 3/26/15, indicated the resident's Risperdal (an</p>	F 329	<p>F 329 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #29 meds were reviewed on 5/11/15 by Psychiatrist and she is on the lowest dose needed at this time. Another med reduction will be attempted when appropriate. She has had successful reductions in the past. Her most recent AIMS shows no ill effects from the medication. Resident #5 has had Schizophrenia for years and her medication regimen has been effective. Her most recent AIMS assessment that shows she is not having any negative effects. MD has been informed of the need to document her plan of care supportively. Resident #8 has had no negative effects from this alleged deficient practice. Orders were placed under the "general category" instead of under</p>	05/27/2015

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	<p>antipsychotic medication) was being decreased to 0.5 milligrams (mg) daily.</p> <p>A Physician's order dated 4/15/15, indicated the resident's Risperdal was increased to 0.5 mg twice a day.</p> <p>A 4/15/15 Psychiatric progress note, indicated the Nurse reported the resident had been refusing her medications and spitting them out. The behavior had been escalating since the reduction of the Risperdal. Will increase the dosage back to Risperdal 0.5 mg twice a day.</p> <p>The April 2015 Medication Administration Record (MAR), indicated the resident had not refused any oral medications 4/1/15-4/15/15. The resident did refuse some nebulizer treatments on 4/6, 4/8, 4/9, 4/10, and 4/11/15. The Director of Nursing indicated on 5/1/15 at 11:00 a.m., the frequency of the resident's nebulizer treatments had been changed.</p> <p>There was no documentation in the Nursing progress notes for the month of April 2015 related to medication refusals and increased behaviors. There also were no behavior monitoring sheets completed for 4/1-4/15/15.</p> <p>The Quarterly Minimum Data Set (MDS)</p>		<p><i>medication so it never printed on the MAR. This was corrected immediately. Resident #44 Remeron was discontinued on 4/29/15. She has had no negative effects from medication.</i></p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: <i>All residents on Risperdal are at risk for this alleged deficient practice. An audit was completed during survey of all Residents with an increase in Risperdal for the month of April 2015 and no further alleged deficiencies were identified. All residents on Antipsychotic meds are at risk for this alleged deficient practice. Their medication regimen and MD charting was reviewed to ensure that there is proper documentation to support medication use. All residents with orders for blood pressure monitoring are at risk for this alleged deficient practice. Their orders were reviewed and clarified as needed. All residents that are NPO are at risk for this alleged deficient practice. Their charts were reviewed and no further alleged deficiencies were identified.</i></p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: <i>Nurses were reeducated on 5/5/15& 5/6/15 concerning unnecessary meds</i></p>	

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	<p>assessment dated 4/16/15, indicated the resident had no mood or behavior problems during the assessment reference period.</p> <p>Interview with the Director of Nursing (DON) on 5/1/15 at 10:20 a.m., indicated the resident was refusing her nebulizer treatments and that was why her Risperdal was increased. The DON indicated she would check with Social Services to see if any behavior sheets had been completed.</p> <p>Interview with the MDS Consultant on 5/1/15 at 11:45 a.m., indicated the resident had no current behavior sheets.</p> <p>2. The record for Resident #5 was reviewed on 4/30/15 at 3:34 p.m. The resident's diagnoses included, but were not limited to, altered mental status, schizophrenia, and depressive disorder.</p> <p>Physician Orders dated 6/17/14 and on the current recap indicated Lexapro (an anti-depressant) 10 milligrams (mg) daily. The resident was also receiving Zyprexa (an anti-psychotic medication) 10 mg at bed time. This medication had an order dated of 6/17/14.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 3/31/15 indicated the resident had a Brief Interview for Mental</p>		<p><i>related to supportive documentation for Remeron and Antipsychotics. They were also reeducated on correct way to put in blood pressure orders in Matrix so they reflect on MAR. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor 100% of residents with any increase in Antipsychotic meds 5 days per week for 4 weeks. 50% for 4 weeks, 25 % for 4 months. DON / Designee will monitor 100% GDR (that MD declines) 5 times per week for 4 weeks to ensure that documentation adequately supports the medication use. Then 50% for 5 months. DON / Designee will monitor 3 residents daily with B/P monitoring orders 5 times per week times 4 weeks. Then 7 residents weekly for 4 weeks. Then 5 residents weekly for 4 months. DON / Designee will monitor 100% residents with NPO orders and any new appetite stimulant orders weekly for 4 weeks. 50% times 4 weeks. 25% for 4 months. Any issues will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5. Completion</i></p>	

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	<p>Status (BIMS) score of 10 indicating the resident was moderately impaired for decision making. The resident was coded as having no behaviors or mood problems.</p> <p>The Pharmacist consultation dated 3/1/15 through 3/31/15 indicated the resident had received Zyprexa 10 mg since 10/2007 along with Lexapro 10 mg since 10/2010 daily for depression and schizophrenia. Please evaluate current regime to ensure resident was receiving the lowest effective dose for her condition, if a Gradual Dose Reduction (GDR) was needed please jot down any new orders on the lines below.</p> <p>Continued review of the Pharmacist consultation indicated the Physician's response dated 4/1/15 by a facility LPN indicated "(Physician's name) declines request from consultation...."</p> <p>The Physician Progress Notes dated dated 3/12/15, 2/10/15, and 1/14/15, indicated the resident was medically stable and vital signs were adequate. Will continue current plan of care.</p> <p>A Social Service Progress Note dated 9/15/14 indicated there was no documentation regarding any behaviors or signs of depression. This was the most</p>		<p>date systemic changes will be completed: 5/27/15</p>	

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	<p>current Social Service Progress Note.</p> <p>Interview with the DoN on 5/01/15 at 9:48:28 a.m., indicated the Physician had not provided adequate written documentation of why the resident should not have a Gradual Dose Reduction.</p> <p>3. The record for Resident #8 was reviewed on 4/30/15 at 3:13 p.m. The resident's diagnoses included, but were not limited to, fracture facial bone and right ankle, stroke, hemiplegia, high blood pressure, and hyperlipidemia.</p> <p>Physician Orders dated 3/4/15 indicated the resident was to receive Metoprolol Tartrate (a medication used to lower blood pressure) 50 milligrams (mg) twice a day and Isosorbide Mononitrate (a medication used to lower blood pressure) extended release 60 mg daily. Another Physician Order dated 3/4/15 indicated to monitor blood pressure twice a day and record.</p> <p>The Medication Administration Records for March and April 2015 were reviewed. There was no documentation of any blood pressures recorded twice a day as ordered.</p> <p>The vital signs were reviewed in the</p>			

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	<p>clinical record. The resident's blood pressure were recorded on 3/24, 3/23, 3/17, and 3/3/15.</p> <p>Interview with the DoN on 5/01/15 at 9:47 a.m., indicated the blood pressures were not completed as ordered by the Physician twice a day.</p> <p>4. On 4/29/15 at 5:13 a.m., Resident #44 was observed in bed. The resident was receiving tube feeding through a gastrsotomy tube.</p> <p>The record for Resident #44 was reviewed on 4/28/15 at 2:32 p.m. The resident's diagnoses included, but were not limited to, senile degeneration of the brain, lung and stomach cancer, high blood pressure, and pressure ulcer.</p> <p>The current Physician orders were reviewed. An order was written on 3/11/14 for the resident to receive Mirtazapine 7.5 milligrams once a day. An order was written on 3/18/15 for the resident to be NPO (to receive nothing by mouth).</p> <p>Review of the 3/15 and 4/15 Medication Administration Records indicated the resident received the Mirtazapine medication daily.</p> <p>When interviewed on 4/29/15 at 9:31</p>			

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F 371 SS=E Bldg. 00	<p>a.m., the Director of Nursing indicated the resident had a weight loss and the Mirtazapine medication had been being used as an appetite stimulant for the resident. The Director of Nursing also indicated a Physician's order was written on 3/18/15 for the resident to be NPO and Mirtazapine medication continued while the resident could not be given any oral intake.</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to an accumulation of dirt, dust, and debris on counters, floor, shelves, food preparation equipment, and cabinets, and food items note dated in 1 of 1 Kitchens and 1 of 2 Units. (The Main Kitchen and the First Floor Unit)</p>	F 371	F371 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The corrective action taken for the resident found to have been affected by the deficient	05/27/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. The following was observed during the Kitchen Sanitation Tour on 4/27/15 at 7:35 a.m. <ol style="list-style-type: none"> a. There was an accumulation of dust and grease on oven hood slots above the oven and stove areas. b. There were crumbs and debris on the floors under the food prep counter. c. There was an accumulation of dust and grease on the (14) spice jars and lids. All of the bottles had been opened. Thirteen of the opened jars were not labeled with the date they had first been opened. d. There was an accumulation of crumbs on the bottom of two drawers under the food prep counter. These drawers had clean scoops, ladles, or tongs in them . e. There were two white tub containers of chicken and beef stock on the floor. There was an accumulation of dust and dirt on the containers. f. There was an accumulation of dust on crumbs on the shelves below the steam table. 		<p>practice: 1. All areas cited during Dietary Sanitation Tour were addressed immediately. Phoenix Industrial Cleaning is schedule on 5/22/15 @ 7:30 pm to clean Oven hood / hood slots of dust and grease. On 4/27/15 the kitchen was deep cleaned. All spice jars were cleaned and dated. The crumbs and debris on the floor, under the food prep counter, food prep counter drawers, scoops, ladles and tongs were cleaned. The two white tubs were cleaned of dust and dirt and stored on the bottom rack. The shelves below the steam table were cleaned of dust and crumbs. The portable fan was cleaned of grease and dust, it was removed from the kitchen area. The walk in cooler floor was cleaned of spillage and debris. The accumulation of dust on the fan in the walk in cooler was cleaned. The fan blades and stand located in the dish room were cleaned of dust debris. The dishwasher room shelve liners were sent through the dish machine for cleaning. All pitchers and bowls on the metal rack in the dishwasher room were sent through the dishwasher for cleaning. On 5/4/15 the ceiling in the dishwasher area was repaired and painted. All undated items were disposed of (cookie dough pieces, mixed vegetables and chueros) on 4/30/15. The refrigerator in the first floor Nursing Station bottom shelve</p>	

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	<p>g. There was an accumulation of dust on the blades of a portable fan on the juice counter. There were severe boxed of packed just dispenser on the counter with the fan.</p> <p>h. There was spillage and debris on the floor of the walk in cooler.</p> <p>i. There was an accumulation of dust on the fan in the walk in cooler.</p> <p>j. There was a accumulation of dust and debris one fan, fan blades and fan stand in the dish washing area. The fan was next to metal tiered rack of clean pitchers and bowls stored on the rack. There were crumbs and food debris on the liner of one of the shelves.</p> <p>k. White paint was peeling off the ceiling in the corner of the dishwashing area. There was a tiered metal rack with clean pitches and bowls under the area of the peeling paint.</p> <p>2. During continuation of the Kitchen Sanitation Tour on 4/30/15 at 9:50 a.m. there were opened bags of cookie dough pieces, mixed vegetables, and chueros on the shelves. There were no dates written on labeled on the bags to indicated the date they had been opened.</p>		<p>was cleaned of sticky spillage and all undated items disposed of on 4/30/15. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents that reside in this building and eat meals prepared in the facilities kitchen are at risk for this alleged deficient practice. No residents were identified as being affected from this alleged deficient practice. 3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Dietary staff were re-inserviced concerning kitchen sanitation and areas cited on 5/04/15. Dietary Cleaning Schedule was revised and staff were in-serviced regarding this also on 5/18/15. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Dietary Manager will audit cleaning schedules for completion 5 days a week for four weeks and then 3 days a week for 3 months. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be</p>	

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	<p>3. The food refrigerator in the First floor Nursing Station was observed on 4/30/15 at 11:50 a.m. There was an opened plastic bag of green spinach lettuce in the refrigerator. There were also two opened bottles of salad dressing and an uncovered cup of shredded cheese in the refrigerator. No names or dates were labeled or written on any of the above items. The bottom shelf and the door shelves were sticky to touch.</p> <p>When interviewed on 4/30/15 at 11:50 a.m., RN #1 indicated residents were allowed to store food in the refrigerator and the food items were to be labeled with the resident's name and the date.</p> <p>When interviewed on 4/27/15 at 7:35 a.m. and 4/30/15 at 9:50 a.m., the Dietary Manager indicated the above areas were in need of cleaning and food items were to dated when they were first opened.</p> <p>The policy titled " Refrigerator Management " was reviewed on 4/30/15 at 2:02 p.m. The Director of Nursing provided the policy. The policy indicated refrigerators were to be cleaned once a month or more often is needed. The policy also indicated all opened and unsealed food items were to be labeled and dated.</p>		<p>amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</p>				

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F 441 SS=E Bldg. 00	<p>The Dietary cleaning schedules were reviewed on 4/30/15 at 1:30 p.m. The Dietary Manager provided the schedules. The schedules indicated all cooks were responsible for cleaning of the stove top, microwave and walls along side of the stove on a daily basis. Daily date everything that had been opened, and daily sweep and mop kitchen, dish room and storage room floors. Sweeping and mopping was required after every meal.</p> <p>3.1-21(i)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p>			

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	<p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure urinals and wash basins were stored properly on 2 of 2 floors throughout the facility. The facility also failed to ensure handwashing was completed after direct resident contact as well as washing hands after glove removal and ensuring gloves were worn while administering an insulin injection for 2 of 6 residents observed during medication administration. (The First and Second floors and Residents #25 and #87)</p> <p>Findings include:</p> <p>1. On 4/27/15 at 11:44 a.m., a pink disposable bed pan was observed on top of the bed side cabinet for bed 1 in Room</p>	F 441	<p>F 441 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: <i>On 4/27 the bed pan in 103 & urinal in 111 & bath basin in room 222 & the 'nuns cap' in the 117/118 restroom was disposed of & the urinal in room was disposed of. All new equipment were distributed and placed in proper storage. On 5/1 111-2 urinal and wash basin in 222 was replaced and stored properly. On 4/28 the bath basin was disposed of that was in the</i></p>	05/27/2015

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	<p>103. The bed pan was not covered at this time. Two residents resided in this room.</p> <p>2. On 4/27/15 at 10:18 a.m., a plastic urinal was observed in the garbage can in Room 111. The urinal was not covered. Two resident's resided in this room.</p> <p>On 5/1/15 at 1:25 p.m., a urinal containing urine was observed on the bed side stand for bed 2 in Room 111. There was no lid on the urinal at the time. Two residents resided in this room.</p> <p>3. On 4/27/15 at 1:43 p.m., a white plastic device used to collect urine specimens was observed on the back of the toilet in the shared bathroom for Rooms 117 and 118. Three residents used this bathroom.</p> <p>4. On 4/28/15 at 9:42 a.m., a plastic urinal was observed on the bedside stand for bed 1 in Room 120. The urinal was not covered at this time. Two residents resided in this room.</p> <p>5. On 4/28/15 at 11:14 a.m., a wash basin was observed on the back of the toilet in the shared bathroom for Rooms 205 and 206. The was basin was not covered in plastic. Two residents shared this bathroom.</p>		<p>205/206 bathroom & the urinal for 120-1 was disposed of and new ones placed in proper storage. On 4/29 RN #1 was reeducated immediately on proper hand washing and glove use. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: On 5/1 All residents requiring a urinal, and bath basins, nuns caps equipment was checked and replaced as necessary. All residents that receive injections are at risk for this alleged deficient practice. There was no negative outcome related to nurse wearing gloves/ and hand washing. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Nursing staff were reeducated concerning hand washing and glove use along with storage of nursing equipment on 5/5/15 & 5/6/15. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON/ Designee will monitor 2 staff daily 5 days per week for four weeks. 2 staff 3 days per week for 4 weeks. 3 staff weekly for 4 months. DON/ Designee will monitor 7 rooms daily 5 days per week for 4 weeks Then 5 rooms daily 5 days per week for 4 weeks. Then 2 rooms daily 5 days per week for 4 months ,for</p>	

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	<p>6. On 4/27/15 at 10:29 a.m., a pink wash basin was observed on the closet floor in Room 222. The wash basin was not covered in plastic.</p> <p>On 5/1/15 at 1:30 p.m., pink and gray wash basins were observed on the floor in Room 222. The wash basins were not contained in plastic. Two residents resided in this room.</p> <p>Interview with the Minimum Data Set (MDS) Consultant on 5/1/15 at 3:36 p.m., indicated the wash basins and urinals should have been contained in plastic and stored appropriately.</p> <p>7. On 4/29/15 at 3:58 p.m. RN #1 donned clean gloves to both of his hands to do a glucometer for Resident #25. The RN did not wash his hands first with soap and water or use alcohol gel prior to donning the gloves. At that time, the nurse was observed gathering supplies with his gloved hands, the telephone then rang. The nurse walked over to the phone and answered it still wearing his gloves. He then hung up the phone and walked back to the medication cart. He unlocked the cart and removed a lancet for the accucheck. He pricked the resident's finger with the lancet, obtained the blood and placed the strip in the glucometer. The nurse threw the lancet in the sharps container on the side of the</p>		<p><i>proper storage of bath basins and urinals and nuns caps. Any issues identified will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</i></p>	

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	<p>cart and removed his gloves and threw them away in the garbage can on the side of the cart. He walked away from the cart and went into the medication room to get the resident's Insulin. He had not washed his hands with soap and water or used alcohol gel after the removal of his gloves. RN #1 opened a germicidal wipe and wiped down the glucometer using his bare hands. He was then observed to pull up his pants. At that time, the telephone rang again, so he left the cart and answered the phone. After the phone call, he walked into the dining room and washed his hands with soap and water.</p> <p>Interview with RN #1 at that time, indicated he should have washed his hands after removing his gloves after obtaining the accucheck.</p> <p>8. On 4/29/15 at 4:25 p.m., RN #1 was observed preparing an Insulin injection for Resident #87. He asked the resident to wheel herself to her room to administer the injection. The RN used an alcohol pad and wiped the resident's left upper arm and administered the insulin with his bare hands. The RN had not donned clean gloves to administer the injection. He walked out of the room with the syringe in his hand and disposed of it in the sharps container on the side of the med cart. At that time, RN #1 was</p>			

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F 465 SS=E Bldg. 00	<p>observed to open the medication cart and the medication book. He had not washed his hands with soap and water or used alcohol gel after the Insulin injection.</p> <p>Interview with RN #1 at that time, indicated he probably should have worn gloves while giving the Insulin injection.</p> <p>The 6/2005 current Personal Protective Equipment provided by the Nurse Consultant indicated the purpose of gloves was to protect hands from potentially infectious material. Hands should be washed after removing gloves. Gloves should be worn when touching excretions, secretions, blood, body fluids, mucous membranes or non intact skin.</p> <p>Interview with the Director of Nursing at that time, indicated the Nurse should have washed his hands after glove removal and worn gloves while giving the insulin injection.</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p>			

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	<p>Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained related to marred walls, doors, and closet doors. Loose heat register covers, loose base boards, dusty ceiling vents, dust and dirt on pipes underneath cabinets and electric cords and outlets on 2 of 2 floors throughout the facility and 1 of 1 kitchen areas throughout the facility. (The First and Second floors and the Main kitchen)</p> <p>Findings include:</p> <p>1. During the Environmental tour on 5/1/15 at 1:05 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>First floor</p> <p>a. In Room 102, the air conditioning cover had an accumulation of dried liquid spillage. The wall behind the head of bed 2 was paint chipped and marred. The foot board for bed 2 was scratched and marred. One resident resided in this room.</p> <p>b. Dried food spillage and dust was observed on the wheelchair for bed 1 in Room 103. Two residents resided in this room.</p>	F 465	<p>F 465 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. On 5/1/15 all the environmental concerns identified during the survey were immediately addressed and / or resolved. The dried liquid spillage in room 102 air conditioner cover was cleaned. The chipped paint and marred walls in room (102-2, 110,111,112.113, 114), (bathrooms in 123, 206 and 211) were painted. The scratched and marred foot board in room 102-2 was replaced. The wheelchair in room 103-1 was cleaned of dried food and dust. The missing floor register covers in rooms (104 and 106) were installed. The floor mat in room 104-2 was replaced. The window curtain in room 104 was cleaned of brown stains. Room 106 base board corner of bathroom door was repaired. Over bed table base was repaired of chipped paint and marred in room 106. Floor tile in room111-2 was replaced. Closet doors in room 112 were painted. Bathroom ceiling vent in room</p>	05/27/2015

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	<p>c. In Room 104, the floor register was missing a cover, there were scuff marks on the floor mat next to bed 2, and there were brown stains on the window curtain. One resident resided in this room.</p> <p>d. The floor register in Room 106 was missing a cover and the base board was peeling away by the corner of the bathroom door. The base of the over bed table was also paint chipped and marred. Two residents resided in this room.</p> <p>e. The wall across the foot of the bed in Room 110 had areas of chipped paint above the base board. One resident resided in this room.</p> <p>f. The floor tile next to bed 2 in Room 111 had an area of black discoloration. The corner of the wall located next to the closet door was marred. Two residents resided in this room.</p> <p>g. The closet doors in Room 112 was paint chipped and marred. The entrance door to the room was also scratched and marred. Two residents resided in this room.</p> <p>h. Areas of steel trim were observed to be lifting away from the cover of the floor register in Room 113. The wall behind the head of bed 2 was paint</p>		<p>117/118 was cleaned of dust. Base boards in rooms (117 and 118 bathroom across from toilet) was repaired. The bathroom ceiling in room 117/118 plastered and painted. The heat register in room 119 was repaired, the window sill painted. The plaster around the blind hardware was repaired and painted in room 119. The closet door in room 119 was put back on track and painted. Room 211 bathroom above the sink was painted. The wall in room 202-2 was plastered and painted. The electrical face plate outlet in room 213-2 was attached back to the wall. Room 218 the cracked plaster underneath the air conditioner was repaired and painted. The marred walls and bathroom door were painted in room 218. The discolored caulk at the base of the toilet in room 221 repaired. The wall behind bed 2 in room 226 and closet doors was repaired and painted. The base boards by the closet in room 226 were repaired. The bathroom sink drain was replaced in room 226. The dust underneath the white plastic pipes under the dishwasher and 3 compartment sink in the dishwasher area were cleaned. The electrical outlet plate and cords plugged into the outlets behind the juice counter were cleaned of dust and dirt. Emergency call light string in room 119 replaced. 2. The corrective action for those</p>	

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	<p>chipped and marred. The lift seat for the toilet was missing a plastic handle cover on the left side and the left handrail was uneven. The back of the toilet riser was also paint chipped and marred. Two residents resided in this room.</p> <p>i. The wall behind the head of bed 1 in Room 114 was paint chipped and marred. The cover of the floor heat register was not attached and positioned on the floor. Two residents resided in this room.</p> <p>j. The shared bathroom for Rooms 117 and 118 was observed to have peeling paint on the ceiling. There was also an accumulation of dust on the ceiling vent in the bathroom and an area of baseboard across from the toilet was loose. Three residents shared this bathroom.</p> <p>k. The floor heat register in Room 119 was observed to be peeling away from the wall. Peeling paint was observed around the window sill and there was cracked plaster around the window blind hardware. The closet doors were paint chipped and marred as well as off track. There was a dusty ceiling vent in the bathroom and there was no pull cord for the emergency call light. Two residents resided in this room.</p> <p>l. The bathroom wall in Room 123 was</p>		<p>residents having the potential to be affected by the same deficient practice: All residents that reside in this building are at risk with this alleged deficient practice. No residents were identified as being adversely affected. F 465 3.</p> <p>The measures put into place and a systemic change made to ensure the deficient practice not reoccur: On 5/04 /15 housekeeping and maintenance staff were re-inserviced regarding repairs and proper cleaning, missing emergency call light strings, marred walls, marketed floor tile, stained window curtains and dirty ceiling vents. Housekeeping cleaning schedule has been revised and "Housekeeping / Maintenance audit tools" have been implemented. On 5/20/15 all Department Heads were re-inserviced by the Administrator/ Housekeeping Director on what to look for during Guardian Angel rounds and how use the maintenance request forms. On 5/18/15- 5/21/15 staff was educated on the use of "maintenance request forms" and areas facility was cited during annual survey by the Housekeeping Director.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Housekeeping / Maintenance Director will monitor <u>5</u> rooms daily on each floor for <u>5</u></p>	

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	<p>scratched and marred. Two residents resided in this room.</p> <p>Second floor</p> <p>a. In room 202, the paint was peeling on the wall next to bed 2. Two residents resided in this room.</p> <p>b. In Room 206, the wall was marred by the window and chipped paint was observed on the bathroom wall. One resident resided in this room.</p> <p>c. In the bathroom of Room 211, the paint was stained above the sink and the walls were marred. One resident resided in this room.</p> <p>d. In Room 213, the face plate on the electrical outlet next to bed 2, was loose and detached from the wall. One resident resided in this room.</p> <p>e. In Room 218, the wall was marred next to the dresser. There was also an area of cracked plaster along the wall underneath the air conditioner. The door to the bathroom was also scratched and marred. One resident resided in this room.</p> <p>f. The caulk at the base of the toilet in Room 221 was discolored and cracked.</p>		<p>days a week for four weeks. Then <u>5</u> rooms weekly on each floor for <u>4</u> months. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. All issues found will be addressed immediately. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</p>	

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F 469 SS=E Bldg. 00	<p>One resident resided in this room.</p> <p>g. The wall behind bed 2 in Room 226 was chipped and gouged. The closet door was paint chipped and the base board was pulling away from the wall by the closet door. The sink drain in the bathroom also had an accumulation of rust. One resident resided in this room.</p> <p>Interview with the Maintenance and Housekeeping Supervisors at the time, indicated all of the above were in need of cleaning and/or repair.</p> <p>2. During the Kitchen Sanitation Tour on 4/27/15 at 7:35 a.m., the following was observed:</p> <p>a. There was an accumulation of dust and dirt on the white plastic pipes under the dishwasher and the three compartment sink in the dish wash area.</p> <p>b. There was an accumulation of dust and dirt on the electrical outlet plates behind the juice counter. The cords plugged into the outlet were also dirty.</p> <p>3.1-19(f)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation and interview, the facility failed to ensure an effective pest control program was maintained related to gnats being observed in resident rooms on the first floor as well as in the hallway on the first floor and in the Director of Nursing's office. (Rooms #111 and #123)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 4/28/15 at 8:31 a.m., gnats were observed flying around in Room 123. Interview with Resident #12, who resided in this room, at the time, indicated there was a big gnat problem in the facility. On 4/27/15 at 10:18 a.m., gnats were observed flying around in Room 111. On 4/29/15 at 5:41 a.m., there were seven gnats on the ground and flying around in the hallway outside of Room 111. On 5/1/15 at 11:00 a.m., gnats were observed flying around in the Director of Nursing's office. <p>Interview with the Director of Nursing at the time, indicated the gnats were a</p>	F 469	<p>F469 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <ol style="list-style-type: none"> The corrective action taken for the resident found to have been affected by the deficient practice: Resident #12 room was deep cleaned and sticky strip was placed in his room. Rooms 111 and the Director of Nursing Office were also deep cleaned and sticky strip was placed on 5/15/15. Monroe Pest Control came out to exterminate on 5/5/15 and 5/19/15. On 5/20/15 Gatlin Plumbing came out to look at the facility drains. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately. The measures put into place and systemic change made to ensure the deficient practice does not reoccur: Housekeeping and Maintenance was In-serviced by the Environmental Director on 5/4/15 	05/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/01/2015
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	<p>problem and the pest control company had been called.</p> <p>3.1-19(f)(4)</p>		<p>and staff 5/18/15-5/21/15 regarding monitoring resident's room for gnats and uncovered snacks in resident's room/ any items that would attract gnat. A new deep Cleaning schedule was implemented. Monroe Pest Control will continue to service the facility weekly for four weeks and there after biweekly for gnats/ pest control. 4. To ensure the deficient practice does not reoccur, the monitoring system established is: The Maintenance Manager / Designee will monitor for gnats 10 rooms five days a week for four weeks, then 5 rooms 5 days a week for 3 months. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 5/27/15</p>	