

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714
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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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00178444.</p> <p>Survey dates: July 15, 16, 17, 20, 21 & 22, 2015</p> <p>Facility number: 000465 Provider number: 155501 AIM number: 100273870</p> <p>Census bed type: SNF/NF: 49 Total: 49</p> <p>Census payor type: Medicare: 9 Medicaid: 35 Other: 5 Total: 49</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>F 000</p> <p>The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because of federal and state law. The facility also respectfully requests a desk review of this plan of correction.</p>	
F 0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF			

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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Bldg. 00	<p>EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure planned, structured activities were provided for residents on Sundays for 2 of 3 residents reviewed for activities. (Resident #18, Resident #39)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #18 was reviewed on 7/20/15 at 11 a.m. Diagnose's included, but were not limited to, the following: Dementia and Depression. The MDS (minimum data set assessment) dated 5/19/15 indicated the following: independent cognition. (alert and oriented)</p> <p>A Quality of Life Lifestyle Review, dated 3/13/15, indicated which activities/hobbies the resident enjoyed.</p> <p>A social service review, dated 5/19/15, included but was not limited to, the following: "...Res (resident) family lives out of state, however visits a couple times a year. She...has occasional visits from past friends..."</p>	F 0248	<p>F 248 - D</p> <p>It is the Policy of the facility to 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>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident's #18 and #39 Quality of Life Assessments have been reviewed by Quality of Life Director on July 24, 2015.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>CEO will meet with the Resident council to discuss ideas for evening and weekend activities by August 12, 2015 and will review the proposed Activity calendar with them. Revised calendar will be redistributed with evening and weekend activities highlighted.</p>	08/21/2015			

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	<p>An Activity Progress note, dated 5/19/15, included but was not limited to, the following: "...enjoys group activities...enjoys conversing..."</p> <p>A plan of care, dated 6/10/15, addressed the problem of "Resident is at risk for experiencing depression/mood state..." Approaches included, but were not limited to, the following: encourage resident to participate in facility activities; encourage socialization, verbalization of self-issues as needed.</p> <p>A plan of care, dated 6/10/15, addressed the problem of "...participating in...group activities..." Approaches included, but were not limited to, the following: "...will be invited to group activities that might interest her, will socialize with peers as she desires..."</p> <p>On 7/20/15 at 9:30 am., Resident # 18 was interviewed. She indicated her son lived in a state out west as well as her grandson and she doesn't have any family around here. She indicated she would really like activities to do on Sundays as they "don't really have anything to do then."</p> <p>On 7/21/15 at 9 a.m., the Activity</p>		<p>2.Whatmeasures will be put into place or what systematic changes will be made toensure that the deficient practice will not reoccur:</p> <p>Our Activity Director (Quality of Life) hasexited Signature of Bluffton's employment. Our Social Services Designee is credentialed from the state of Indianaas an Activity Director. She willassume Administrative responsibilities to include, Calendar development,Assessments and record reviews per Policy. Additional Activity (Quality of Life) assistants have been added foradditional activities to include evenings and weekends.</p> <p>Our Administrator and Activity Director orDesignee will review attendance records to determine preferences / trends oflikes or dislikes.</p> <p>3.How the corrective action(s) will bemonitored to ensure the deficient practice will not reoccur:</p> <p>Our Administrator and Activity Director orDesignee will review attendance records to determine preferences / trends oflikes or dislikes on a monthly basis with Resident council.</p> <p>Signature of Bluffton utilizes the AbaqisQuality Assurance Process Improvement (QAPI) tools, specifically, resident andfamily interviews for customer satisfaction. CEO/ SSD/ Designee will conduct activity</p>		

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	<p>Directory was interviewed. She indicated she does the activity calendar for the residents. She indicated she had a volunteer come in to do activities on Sundays but "they stopped showing up." She indicated it was hard to get residents to do activities on Sundays. She indicated they had some activities on Sundays last month but didn't have a good turn out. She said they would have 1 resident at times.</p> <p>On 7/21/15 at 9:49 a.m., the Activity Assistant was interviewed. She indicated "the documentation was my fault." She indicated she assumed if a resident watched television (TV) when she observed them, that they also did when she wasn't in the facility. She indicated this was why the resident's Daily participation log for activities had "TV" marked every day.</p> <p>On 7/21/15 at 4:35 p.m., the Administrator provided copies of the activity calendars for May, June and July 2015. The May and June calendars were observed to have the following on Sundays: a church service scheduled at 10 a.m. and an additional activity at 1 p.m. The July calendar had only a church service at 10:00 a.m. on Sundays.</p> <p>On 7/22/15 at 12:45 p.m., the Activity</p>		<p>preference interviews with 5 residents per week x4 weeks; then 5 interviews monthly x3. Abaqis QAPI will continue every quarter per policy. The Administrator (CEO) will share results of weekly interviews during the monthly QAPI meeting to ensure compliance.</p> <p style="text-align: center;">Compliance date of August 21, 2015</p>				

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	<p>Director was interviewed. She indicated she works Monday through Friday and Volunteers staff her activities scheduled on the weekends. She indicated they have tried everything to get more volunteers as some of the ones she did have, quit or don't show up. She indicated some of her weekend volunteers stopped coming in June and that was why none of the activities scheduled on Sundays at 1:00 p.m. were completed. She indicated she prepared her activity calendar a month in advance and this was why there were no afternoon activities scheduled for July. She also indicated the facility didn't have a good turnout of residents for Sunday activities as "that's when a lot of families visit." She indicated she was aware Resident #18 didn't have local family to visit.</p> <p>On 7/22/15 at 12:47 p.m., the Activity Assistant was interviewed. She indicated she used to come to the facility on Sundays but wouldn't really have a good turnout. She indicated sometimes she would only have one resident attend activities on Sunday.</p> <p>On 7/22/15 at 2:44 p.m., the Activity Director was interviewed and the resident's Daily Participation Log for July 2015 activities was reviewed. The Activity Director indicated the following</p>			

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	<p>regarding the definition of the activities: Cognitive activities included things they do daily, like get up and brush their teeth, watch TV, etc. Independent activities included things they do in their room, TV, word search, read. Peer/friend/family visits included interaction with staff, friends and family. Socials included parties, morning coffee, chats, anytime they get together to chat. Task related diversions included: TV/radio, read the paper. Self directed activities included: TV/radio, things resident's do themselves and in the activity room. Walk/wheelchair rides: when the resident is up walking in the halls and/or just propelling throughout the facility. The Activity Director indicated she was taught to document anything they do. She was taught the above categories were "considered activities." She indicated it was not appropriate to document activities as having been completed when they were not actually observed.</p> <p>2. On 7/21/15 at 4 p.m., the clinical record of Resident # 39 was reviewed. Diagnoses included, but were not limited to, the following: Bipolar depression. The MDS dated 6/23/15 indicated the resident was of independent cognition.</p>			

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	<p>A plan of care, dated 7/1/2015, indicated the resident "enjoys animals...doing things with groups of people, favorite activities, going on outings and music." Approaches included but were not limited to, the following: "...offered pet visits...invited by staff to group activities...invited by staff to participate in music events."</p> <p>A plan of care, dated 5/28/15 addressed problem of "Alteration in Mood...r/t (related to) H/O (history of) depression."</p> <p>On 7/22/15 at 3 p.m., the resident's Daily Participation Log for activities was reviewed for July 2015. This form indicated the resident had daily participation in the following activities: cognitive activities, independent activities, peer/family/friend visits, socials, task related/diversion, TV/radio, and walk/wheelchair rides. Documentation was lacking on the log of the resident having attended or refused any activities on the Sundays in July, 7/5, 7/12 and 7/19.</p> <p>The following anonymous family interview statement was obtained during a family interview: "never see mom doing anything." The following resident comments were obtained during resident interviews: "not a lot to do on the</p>			

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F 0318 SS=D Bldg. 00	<p>weekends; sometimes it's a long weekend; could be more in the evenings and weekends; not a lot to do on the weekends."</p> <p>On 7/21/15 at 10:14 a.m., the DON (Director of Nursing) provided a copy of the current facility policy and procedure for "Activity Program", dated 1/2009. The policy included, but was not limited to, the following: "It is the intent of this policy that an ongoing program of activities is designed to meet the needs, interest and promote the physical mental and psychosocial well being of each resident...Activities are scheduled daily and residents are given an opportunity to contribute to the planning...and critique the program...are offered at hours convenient to the residents, including...and weekends...Activities will be scheduled..seven days a week...."</p> <p>3.1-33(a)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p>			
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	<p>Based on observation, interview and record review, the facility failed to provide splinting and stretching exercises for contractures for 1 of 2 residents reviewed who met the criteria for contractures without range of motion exercises. (Resident #33)</p> <p>Findings include:</p> <p>A review of Resident #33's clinical record began on 7/20/15 at 3:30 p.m. The resident's clinical record indicated diagnoses included, but were not limited to, CVA (cerebrovascular accident, stroke) with hemiparesis (paralyzed on one side), contracture of forearm joint, CAD (coronary artery disease), hypertension, seizure disorder, diabetes mellitus, depression.</p> <p>On 7/20/15 at 4:00 p.m., a review of the MDS (Minimum Data Set) Assessment, dated 4/24/15, for Resident #33 indicated his BIMS (Brief Interview for Mental Status) Score was 15/15 which indicated the resident was cognitively intact. The MDS also indicated Resident #33's Functional Limitation in Range of Motion of upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) had impairment on one side. Resident #33 required extensive assistance of one person</p>	F 0318	<p>F318 – D It is the intent of the facility to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #33 is receiving Occupational therapy for evaluation and treatment.</p> <p>1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All other residents have the potential to be affected, therefore the clinical team (DON, Unit Manager, CEO and RSM) will identify all residents within the facility that have contractures and/or the need for splinting and referrals made to the therapy department as appropriate and with physician orders.</p> <p>1. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur: Systematic changes will include education with the clinical team by the RSM (rehab services manager) regarding process for referrals to therapy. Will be made as clinical team</p>	08/21/2015

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	<p>physical assist for bed mobility, dressing, toileting, personal hygiene and bathing. The MDS further indicated Resident #33 was receiving Occupational Therapy Services and Physical Therapy Services.</p> <p>On 7/20/15 at 4:15 p.m., a review of the Care Plan Conference Summary dated 5/13/15 indicated, "...OT (Occupational Therapy)-L(left) elbow ext. (extension) L hand splint RNP (Restorative Nursing Program)...."</p> <p>During an observation and interview with Resident #33 on 7/16/15 at 12:00 p.m., a contracture was observed of his left hand.</p> <p>During an interview with Resident #33 on 7/16/15 at 12:00 p.m., he indicated he had a stroke and his left arm and left leg were paralyzed and he had a contracture of his left arm. The resident indicated he had a splint for his arm in his closet but the splint had not been used in a long time. He also indicated the staff was supposed to be taught how to put the splint on him but the splint had not been put on him by the staff.</p> <p>During an interview with OT #2 on 7/21/15 at 12:00 p.m., he indicated Resident #33 had been seen by OT for therapeutic exercises and splinting of his left arm and hand. OT #2 indicated the</p>		<p>deems appropriate, using the "Referral to Therapy" form. Therapy will evaluate and treat residents as ordered by the attending physician. Rehab team will complete a Therapy Discharge Notice prior to discharge and will recommend restorative programs (i.e. Splinting and ROM) to be initiated by nursing, in collaboration with therapy stop date and training. This notice form will allow the RSM to ensure proper physician orders are obtained, training with nursing staff is accomplished, and resident/ family notification.</p> <p>1. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur: Monitoring of this systematic change will be done utilizing the "Discharge Tracking Log" by the RSM. This log will be reviewed in the QAPI meeting monthly x 3 and quarterly x3 or until the team is confident that continued compliance is achieved. CEO and RSM are responsible to ensure compliance by 8-21-2015.</p> <p>Resident Name</p> <p>Discharge Date</p> <p>Discipline</p> <p>Order Complete</p>	

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	<p>resident was discharged from OT services in June 2015 and indicated 4 CNAs (Certified Nursing Assistant) were taught how to apply and remove the splint. OT#2 further indicated Resident #33 had a Restorative Nursing Program (RNP) for stretching exercises, donning and removing the splint.</p> <p>A review of the OT Discharge Summary for Resident #33, dated 6/12/15, provided by OT #2 on 7/21/15 at 12:10 p.m., indicated the following: "...Discharge Status and Recommendations. Prognosis...Good with consistent staff follow-through...Discharge recommendations: FMP (Functional Maintenance Program)/RNP (Restorative Nursing Program)...Staff educated on donning/doffing of L (left) elbow extension and L resting hand splint as well as on stretching techniques prior to splint application...."</p> <p>An interview with the DON (Director of Nursing) on 7/21/15 at 4:15 p.m., indicated Resident #33 had not received RNP for splinting of left arm contractures. The DON indicated Resident #33 did not have a physician's order for RNP and indicated the Occupational Therapist should have written a physician's order for the OT recommendations for RNP and splinting</p>		<p>Family Notified</p> <p>Staff Training</p> <p>Comments</p>	

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	<p>of left arm contractures. She further indicated the occupational therapist forgot to write the orders for RNP and splinting the left arm contractures.</p> <p>An interview with OT #2 on 7/22/15 at 10:55 a.m., indicated he was not aware until yesterday, Resident #33 had not been receiving RNP for splinting. OT #2 indicated it was his responsibility and he had forgotten to write the Physician's order for the splinting of Resident #33's left arm contractures.</p> <p>An interview with the DON on 7/22/15 at 2:15 p.m., indicated Resident #33 was currently receiving Physical Therapy (PT) services and the RNP services could not start until PT services were finished. She further indicated Resident #33 should have received the needed splinting of his contractures done by the nursing staff as recommended by OT while he received PT services.</p> <p>A review of the current facility policy provided by the Corporate Nurse on 7/22/15 at 1:45 p.m., titled, Restorative Nursing Policy and Procedure Manual, dated, July 2010, indicated the following: "...Restorative Nursing is a collection of interventions designed to promote resident independence and safety....The most successful Restorative Nursing</p>			

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	<p>programs are evidenced by the presence of a solid nursing/therapy team. This provides the foundation for superior resident care delivery and seamless transition through the rehabilitation and restoration continuum....Splinting can be utilized to assist in counteracting contractures formation, joint stiffness, pain, swelling, to increase more independent use of the upper or lower extremity, to provide support and to prevent skin breakdown or injury....Normal movement is an essential part of healthful living. Some individuals become incapable of moving their arms and legs without assistance. If range of motion exercises are performed with people who cannot move, joint movement capabilities can be maintained. This prevents the occurrence of painful, unsightly deformities...."</p> <p>3.1-42(a)(2)</p>			

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F 0328 SS=D Bldg. 00	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure a means to maintain the resident's tracheostomy patency in the event of an airway obstruction emergency for 1 of 2 resident's reviewed with a tracheostomy. (Resident # 24)</p> <p>Findings include:</p>	F 0328	<p>F 328- D It is the intent of the facility to ensure that residents receive proper treatment and care for the following special services: Injections, Parenteral and enteral fluids, Colostomy, ureterostomy and/ or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care and prosthesis.</p> <p>1. What corrective action(s) will be accomplished for those</p>	08/21/2015

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	<p>On 7/21/15 at 11 a.m., the clinical record of Resident #24 was reviewed. Diagnoses included but were not limited to, the following: Pneumonia, COPD (Chronic Obstructive Pulmonary Disease) and Tracheostomy (an opening surgically created through the front of the neck into the windpipe with a tube placed in this opening to provide an airway and remove secretions from the lungs). A MDS (Minimum Data Set) assessment, dated 6/9/15, indicated the resident was of independent cognition. (alert and oriented)</p> <p>On 7/21/15 at 8:25 a.m., LPN #4 was interviewed. She indicated she was providing care for Resident #24 today. He was observed to have a suction canister with a suction machine at his bedside with at least 300 ml (milliliters) of cloudy liquid in it. Resident #24 was also observed to have a tracheostomy in place.</p> <p>At 8:27 a.m., Resident #24 was interviewed. He indicated he was suctioned "about every 4 hours." He also indicated about a week ago, he "had a mucus plug and passed out." He indicated "the night nurse got me back." Resident #24 also indicated he had a tracheostomy in place for about a year</p>		<p>residents found to have been affected by the deficient practice: Resident#24 did go on facility outing on 7/21/ 2015 and had no difficulties and enjoyedthe day, with his wife. Accompanying the residents on this outing were 3Registered Nurses, a Physical Therapy aide, and a first responder from thelocal fire department, all CPR certified. Suction machine, respiratory equipment and oxygen were also taken to theouting sight. Resident #24 had aphysician's order dated July 12, 2015 to go and he is alert, oriented andcognitively intact (BIMS score of 15/15) making him competent to choose risksbased on quality of life choices. Facility respectfully asserts that at no time was the resident's safetycompromised and that staff were fully prepared to execute emergency measures.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential tobe affected. There is one other residentresiding in facility with a tracheostomy. Interventions are in place to maintain airwaypatency, care planned and on C.N.A Care guides.</p> <p>1.What measures will be put into place or what systematic</p>	

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	<p>and a half. LPN #4 was observed to have performed tracheostomy care on Resident #24 in his room. At 8:35 a.m., LPN #4 requested the assistance of the Director of Nursing (DON) for the resident's tracheostomy care. During the resident's tracheostomy care, the DON indicated to the resident she was aware Resident #24 was going out of the facility on an activity later in the morning. She indicated the resident was going on a facility activity of a cookout at a nearby campground at 10:00 a.m.</p> <p>On 7/21/15 at 9:40 a.m., the resident was observed in the lobby of the facility with his rolling walker. He was observed to have a portable oxygen tank in his rolling walker.</p> <p>On 7/21/15 at 9:50 a.m., the resident was in the lobby with the portable oxygen in his rolling walker. At this time, the local community transport vehicle, was observed to arrive at the facility. Residents were being assisted onto the community transport vehicle. The Activity Director was interviewed and indicated the following staff members were going on the out of facility activity: Dietary Manager, Activity Director, RN consultant, RN from the dementia unit, Social Service Director and the Administrator. She indicated she would</p>		<p>changes will be made to ensure that the deficient practice will not reoccur: Systematic changes have been put intoplace to ensure that precautions are taken to every resident who may have aspecial need including the following: ·CEOhas obtained 2 battery operated suction machines that will be reserved for outthe facility activities; along with an Ambu bag. ·Qualityof Life / SSD manager will review list of those desiring participation inoutside activities with the clinical team in order to assess care needs;including equipment or staffing needs, will ensure physician's order, appropriate consents in place, proper clothingfor the weather, meal and medication consideration and therapy schedule. Oncelist of participants have been established, the QOL/ SSD will review finalizedlist with DON/ designee and CEO. Check list will be completed to ensure allpreparations are in place including special equipment, precautions and staffdeployment. ·CEOeducated Department head team July 28, 2015 regarding special needs protocol.DON/designee will educate Nursing Staff by August 14th, 2015.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficientpractice will not reoccur: CEO will review</p>				

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	<p>expect to be informed by the staff nurse, caring for the resident, of any special needs of the residents who were going on an out of facility activity.</p> <p>On 7/21/15 at 9:55 a.m., LPN #4 was interviewed. She indicated the only equipment which was being taken for Resident #24 was portable oxygen. She was interviewed regarding any additional emergency supplies or equipment to be taken along for the resident and she indicated, "I'll ask (name of DON)." LPN # 4 then walked down the hall and talked to the DON. LPN #4 was observed to go into the resident's room and she returned to the hall with a satchel type bag. She indicated she had placed an ambu bag and spare tracheostomy supplies in the bag, which included an extra inner cannula and a complete tracheostomy pack. The supplies in the bag were observed and did not include any device to suction the tracheostomy. LPN #4 was questioned what would be done in the event the resident needed to be suctioned. She indicated if the resident needed to be suctioned, he would have to be brought back to the facility. She was unaware if the campground had electrical hook ups available. She indicated she would ask the DON if they should send suction equipment with the resident. At 10:00 a.m., LPN #4 was</p>		<p>outing procedure with the Medical Director in Ad Hoc QAcommittee meeting August 19, 2015 and will reviewfuture outings participation as a part of the QAPI meeting monthly x 3 and thenquarterly thereafter to ensure system integrity. Compliance by August 21, 2015.</p> <p>Resident</p> <p>Indicated Need</p> <p>MD order</p> <p>Consent</p> <p>Proper Attire</p> <p>Meal Need</p> <p>Med Need</p> <p>Therapy Aware</p> <p>Staff Need</p>	

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	<p>observed to talk to the DON and then she spoke to the RN Consultant. At 10:01 a.m. the RN consultant was interviewed. She indicated she wasn't aware a resident with a tracheostomy was going on the outing. She indicated, "I'm going to take something but I'm not sure if they (the campground) have electricity or not but I have my phone." At this time, a suction machine was removed from the oxygen storage room to take with the resident.</p> <p>On 7/21/15 at 10:20 a.m., the DON (Director of Nursing) was interviewed. She indicated it was the facility's responsibility to make sure the resident was kept safe. She indicated the reason the resident was sent to the hospital on 7/13/15 was due to a mucus plug resulting in an airway obstruction and the resident becoming unresponsive.</p> <p>On 7/21/15 at 11:00 a.m. the resident's clinical record was reviewed. Nurses notes dated 7/13/15 at 10:00 p.m., included, but were not limited to, the following: "Notified by CNA (certified nursing assistant) that resident was in distress...resident was a full code...resident was extremely pale and lips were blue...resident was not responding. Writer slightly shook resident shoulder and called his name. Writer rubbed resident's chest and kept</p>			

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	<p>talking with resident. Resident was breathing but experienced short episodes of apnea... ambulance arrived. Resident was still breathing on own but still was not responding to writer...." A "Radiology Department" form, dated 7/13/15, included, but was not limited to, the following: "...current history: difficulty breathing, recent history of pneumonia...Impression: low lung volumes..."</p> <p>A plan of care with an initiation date of 5/22/15, identified the following problem: "Resident has pulmonary condition/DX (diagnosis and has potential for difficulty breathing with COPD (Chronic Obstructive Pulmonary Disease)...exacerbations. Also has a permanent tracheostomy due to stenosis of trachea. Each of the interventions had a date of 5/22/15 and included, but were not limited to the following: "...suction as needed...do inner cannula care and change cannula as ordered...administer respiratory treatment as ordered...administer tracheostomy care..."</p> <p>A nurse's note on 7/14/15 at 0025 (12:25 a.m.) included but was not limited to, the following: "...Resident is stable, alert and responding...Resident to be admitted ICU (intensive care unit) at this time...."</p>			

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	<p>A daily skilled nurses note dated 7/14/15 at 2:00 p.m., indicated the following: "Res (resident) returned from hospital at 11 a.m....alert...suctioning..."</p> <p>On 7/20/15 at 11:00 a.m. and on 7/21/15 at 11:00 a.m., the "Signature Outings" list was observed posted in view at the nurses station, where Resident #24's nurse worked. Resident #24's name was on this list.</p> <p>On 7/22/15 at 11:20 a.m., the DON was interviewed and indicated it was the Activity department's responsibility to make nursing aware of which residents would be going on activities held outside of the building. She indicated (name of Activity Director) was very good at letting nursing know which residents were going on activities held outside of the facility. The DON indicated she didn't think the resident would need to take suction equipment along with him on the outing held on 7/21/15.</p> <p>On 7/22/15 at 11:25 a.m., the Administrator and the RN consultant were interviewed. The RN consultant indicated when she "understood the concern, I got a suction machine." Before leaving the facility she indicated she was unaware if the campground had electricity or not. She indicated the</p>			

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	<p>resident "did fine yesterday and had no problems." She indicated she has "had experience with residents with tracheotomies and mucus plugs can happen spontaneously." She indicated the facility "sent heavy duty forces, 3 RNs, physical therapy assistant and had a first responder there also." She indicated the resident had a physician's order to attend out of facility activities.</p> <p>On 7/22/15 at 2:44 p.m., the RN consultant was interviewed. She indicated the resident does go to dialysis three times a week and they do have suction equipment available at the dialysis unit. She indicated she was unaware if the local community transportation unit had suction equipment available. The RN consultant also indicated there were 3 RNs who went on the outing with the residents yesterday. She also indicated the resident had an independent cognition status and also was a "full code" (in the event of a cardiac or respiratory arrest, all efforts would be made to resuscitate the resident).</p> <p>On 7/22/15 at 4:00 p.m., the Activity Director was interviewed. She indicated she posted a list of residents who were going on activities out of the facility at the nurses station at least 24 hours in</p>			

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F 0353 SS=E Bldg. 00	<p>advance. She indicated she posted the list to inform the nurses of which residents would be leaving the facility.</p> <p>On 7/22/15 at 4:03 p.m., LPN #5 was interviewed. She indicated she was made aware of which residents were going on an out of facility activity by the Activity Director posting a list at the nurses station.</p> <p>On 7/22/15 at 4:05 p.m., the facilities Medical Director and the Administrator were interviewed. The Medical Director indicated he felt "reasonable efforts" should be made to maintain the resident's airway patency. The Administrator indicated the resident "had been suctioned twice a day and other than that he had been suctioned only 2 other times in July."</p> <p>3.1-47(a)(5)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial</p>			

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	<p>well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review the facility failed to ensure sufficient staffing to meet the needs of the residents per 9 of 26 confidential resident interviews, 1 of 3 confidential family interviews, and 9 of 9 confidential staff interviews potentially affecting 49 of 49 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During resident interviews conducted on 7/15/15 and 7/16/15, 9 residents interviewed indicated there were not enough staff in the facility to meet their needs. Their confidential comments included the following:</p>	F 0353	<p>F 353- E It is the intent of the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Unable to specifically address those identified due to confidentiality; however, as of July 24, 2015 the facility is providing sufficient staffing to meeting the daily needs of the residents. Staffing patterns/ scheduling have been evaluated by nurse management in collaboration with SCC (Signature Clinical Consultant) and open positions are being covered by appropriate</p>	08/21/2015

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	<p>On 7/15/15 at 2:06 p.m., an anonymous resident interview indicated the facility needed more help. The resident also indicated the good help left the facility all the time.</p> <p>On 7/15/15 at 2:37 p.m., an anonymous resident interview indicated a long wait for the call light to be answered, resulting in incontinence. The resident also indicated staff make him stay up even though he has asked to go to bed.</p> <p>On 7/15/15 at 3:02 p.m., an anonymous resident interview indicated there was a big turn around in facility staff. The resident also indicated a wait of 30 minutes for the call light to be answered.</p> <p>On 7/16/15 at 10:33 a.m., anonymous resident interviews with roommates indicated the facility was short of staff. The residents also indicated a long wait before the call light was answered, resulting in incontinence for one resident.</p> <p>On 7/16/15 at 9:19 a.m., an anonymous resident interview indicated the facility was short of staff. The resident also indicated a wait for over an hour for the call light to be answered.</p> <p>On 7/16/15 at 1:30 p.m., an anonymous resident interview indicated a wait of 30</p>		<p>personnel until positions are permantely filled.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential tobe affected; all resident services are being provided by trained and competentcare givers.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur:</p> <p>Systematic changes will include:</p> <ul style="list-style-type: none"> ·Continuedresident, family and staff interviews using the Abaqis QAPI interview tool toevaluate perception of staffing needs. ·Continuedstakeholder engagement survey, twice yearly to evaluate staff perception ofstaffing needs. ·Redesignof nursing workflow to include redistribution of assignments based on acuity andphysical plant layout, consistent staffing assignments', and more flexiblemedication pass program. ·CEOto meet with Resident Council Monthly to validate their perception of staffingneeds and to explain programmatic changes to enhance care delivery. ·CEO/DON or will meet monthly with Stakeholders during Town Hall meeting to obtainfeedback on staffing needs/ perceptions. 	

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	<p>minutes for the call light to be answered.</p> <p>On 7/16/15 at 1:33 p.m., an anonymous resident interview indicated a wait of 20 minutes for the call light to be answered when staff were really busy.</p> <p>On 7/16/15 at 2:10 p.m., an anonymous resident interview indicated the facility was short of staff.</p> <p>2. During family interviews conducted on 7/15/15 and 7/16/15, one family interviewed on 7/16/15 at 9:19 a.m., indicated there was not enough staff in the facility. The family also indicated they had come to visit their loved one and found the resident wet with urine.</p> <p>3. Confidential interviews with 9 facility staff who worked the day and evening shifts indicated the following:</p> <p>On 7/20/15, a confidential interview with 2 facility staff indicated they worked the Center Halls and the North Hall by themselves. They also indicated the facility needed more staff. They further indicated the residents did not get the attention they needed.</p> <p>On 7/20/15, a confidential interview with 1 facility staff indicated she always worked the South Hall alone. She also</p>		<p>·CEO/Designee will educate all staff by August 11, 2015 on answering call lights (everyone's responsibility) and expected response time.</p> <p>·CEO or designee will educate Department managers and all staff by August 11, 2015 on the Grievance Policy and procedure and will ensure that grievance/ concern forms are easily accessible to all residents/ visitors/ staff. Completed forms will be turned in to the CEO for review, logging and given to the appropriate departmental manager for follow up. Follow up is to be forwarded to the CEO within 24 hours of completion.</p> <p>1. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur: CEO/ SSD/ Designee will conduct 5 interviews per week x 4 week and then 5 interviews monthly x 3. Abaqis QAPI process will continue every 3 months indefinitely and brought to the facility QAPI committee for review of any negative interviews. DON/ Designee will perform 10 random call light audits weekly x 4 and then monthly x 3 and quarterly thereafter. Call light audits will be reviewed in monthly QAPI meeting with any additional recommendations made by the committee. Monitoring of systematic changes will be reviewed by the CEO in the facility monthly QAPI committee</p>				

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	<p>indicated the facility needed more staff.</p> <p>On 7/20/15, a confidential interview with 2 facility staff indicated they worked the Center Halls and the North Hall by themselves. They also indicated the facility needed more help.</p> <p>On 7/20/15, a confidential interview with 1 facility staff indicated she worked the South Hall by herself. She also indicated there was not enough help. She further indicated depending on the day and what was going on, it was difficult to provide all the assistance residents needed.</p> <p>On 7/21/15, a confidential interview with 1 facility staff indicated she was not bothered when she worked short. She also indicated depending on the day, residents did not receive 100% of the care they needed.</p> <p>On 7/21/15, a confidential interview with 1 facility staff indicated she worked the South Hall alone. She also indicated the facility needed more staff. She further indicated it was difficult to get her work done.</p> <p>On 7/21/15, a confidential interview with 1 facility staff indicated the facility needed more help.</p>		<p>meeting monthly x3 and then quarterly thereafter or until such time as committee feels substantial compliance has been achieved. Facility will continue with Abaqis QAPI process three times annually, along with bi-annual stakeholder engagement surveys and resident / family customer satisfaction surveys. These will be part of the regular standing QAPI agenda items.</p> <p>Compliance by August 21, 2015.</p> <p>Resident Interview</p> <p>1. Do you feel there is enough staff available to get the care and assistance you need?</p> <p>2. Do you feel like your call light is answered timely?</p> <p>3. Do you feel that staff is attentive to your needs?</p> <p>4. Overall how satisfied are you with this facility on a scale of 1-10...with 10 being the most satisfied?</p> <p>5. How likely are you to recommend this facility to others?</p> <p>6. Is there any issue you would like us to address?</p> <p>Family Interview</p> <p>1. Do you feel there is enough staff available to give the care and assistance your loved one needs?</p> <p>1. Do you feel like your loved one's call light is answered timely?</p> <p>1. Do you feel that staff is attentive to your loved one's</p>		

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	<p>The Resident Census and Conditions of Residents report, dated 7/16/15 and provided by the Administrator, indicated the following:</p> <p>Forty-five residents required the assistance of 1 or 2 staff for bathing and four residents were dependent on staff.</p> <p>Forty-one residents required the assistance of 1 or 2 staff for dressing and two residents were dependent on staff.</p> <p>Twenty-one residents required the assistance of 1 or 2 staff for transfers and eleven residents were dependent on staff.</p> <p>Twenty-six residents required the assistance of 1 or 2 staff for toileting and fifteen residents were dependent on staff.</p> <p>Five residents required the assistance of 1 or 2 staff for eating and four residents were dependent on staff.</p> <p>The Daily Census Sheet, provided by the Director of Nursing on 7/21/15 at 9:22 a.m., indicated there were 18 residents on the South Hall, 10 residents on the North Hall, and 18 residents on the Center Halls. Information on the Daily Census Sheet identified 8 residents in the facility required the use of a Hoyer lift (requiring 2 staff) for transfers and 3 residents in the</p>		<p>needs?</p> <p>1.Overall how satisfied are you with this facility on a scale of 1-10...with 10 being the most satisfied?</p> <p>1.How likely are you to recommend this facility to others?</p> <p>1.Is there any issue you would like us to address? Staff Interview</p> <p>1.Do you feel there is enough staff available to give the care and assistance our residents' need?</p> <p>1.Do you feel like call lights are answered timely?</p> <p>1.Do you feel as a team we are attentive to resident needs?</p> <p>1.Overall how satisfied are you with this facilities care on a scale of 1-10...with 10 being the most satisfied?</p> <p>1.How likely are you to recommend this facility for employment to others?</p> <p>1.Is there any issue you would like us to address?</p> <p>Month/ Year Needs Met Comments August 2015</p>	

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	<p>facility required the use of a stand-up lift for transfers.</p> <p>The Corporate Nurse Consultant and the Administrator were interviewed on 7/22/15 at 8:37 a.m. During the interview they indicated all residents and staff had recently been interviewed concerning staffing levels and the amount of time needed to answer a call light. They also indicated no concerns were noted.</p> <p>3.1-17(a)</p>		<p>September 2015 October 2015 November 2015 December 2015 January 2016 February 2016 March 2016 April 2016 May 2016 June 2016 July 2016</p> <p>Month / Year Needs Met</p> <p>Comments</p> <p><i>August 2015</i> <i>September 2015</i> <i>October 2015</i> <i>November 2015</i> <i>December 2015</i> <i>January 2016</i> <i>February 2016</i> <i>March 2016</i> <i>April 2016</i> <i>May 2016</i> <i>June 2016</i> <i>July 2016</i></p> <p>Date</p> <p>Stakeholder Room Number Department Lapsed Time Comments</p>	

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F 0431 SS=E Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for</p>			

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	<p>storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review the facility failed to ensure 2 vials of insulin were not used after the expiration date and failed to remove the expired vials of insulin from the medication cart for 1 of 3 medication carts effecting 1 resident. (Resident #20) The facility further failed to label insulin, eye drops, an eye ointment and an inhaler with opened dates on 3 of 3 medication carts effecting 9 residents. (Resident # 14, #36, #31, #24, #5, #20, #60, #39 and #41)</p> <p>Findings include:</p> <p>1. An observation of the 400 Hall Medication Cart on 7/20/15 at 3:45 p.m. with LPN #3 indicated the following:</p> <p>One opened vial of Novolog Insulin for Resident #14 was not labeled with an opened date, with a prescription (Rx) filled date of 7/8/15.</p> <p>One opened vial of Novolog Insulin for Resident #36 was not labeled with an</p>	F 0431	<p>F 431 – E It is the intent of the facility to label and store drugs and biologicals in accordance with professional principals.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents#20, 14, 36, 31, 24, 5, 60, 39 and 41 had medications pulled and reordered.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Med carts were audited by DON and ADON on July 24, 2015 for deficient practice no other residents found to have been affected.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur: ·DON Educated Nursing staff on July 28, 2015 regarding labeling and storage of drugs and biologicals per policy. ·Medication cart check list will be implemented to increase professional accountability</p>	08/21/2015

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	<p>opened date, with a Rx filled date of 7/4/15.</p> <p>One unopened vial of Lantus Insulin for Resident #31 was stored in the top drawer of the medication cart. The pharmacy affixed labels on the insulin box indicated the insulin was to be refrigerated until opened.</p> <p>One unopened vial of Lantus Insulin for Resident #24 was stored in the top drawer of the medication cart. The pharmacy affixed labels on the insulin box indicated the insulin was to be refrigerated until opened.</p> <p>One opened tube of (Brand) Refresh P.M. Lubricant Eye Ointment for Resident #14 was not labeled with an opened date.</p> <p>One opened bottle of Brimonidine Tartrate 0.15% Ophthalmic Solution (for glaucoma) for Resident #5 was not labeled with an opened date.</p> <p>An observation of the 300/500 Hall Medication Cart on 7/20/15 at 4:05 p.m. with LPN #3 indicated the following:</p> <p>One opened vial of Lantus Insulin for Resident #20 was not labeled with an opened date on the vial or the Rx label for opened date. A pharmacy affixed</p>		<p>forstorage/ labeling. Night time nursingstaff will conduct audit daily to ensure compliance using a Medication CartAudit tool to be reviewed by DON or ADON Monday through Friday as animplemented protocol.</p> <p>1.How the corrective action(s) will bemonitored to ensure the deficient practice will not reoccur: Medication cart audit regarding the storage and labeling of drugs andbiologicals will be reviewed weekly x 4 and then monthly x 3 and quarterlythereafter by DON or ADON until substantial compliance is achieved as decidedby the QAPI committee.</p> <p>Compliance by August 21, 2015.</p> <p>DATE DATE INSULIN OPENED DATE INSULIN EXPIRES DATE MULTI DOSE OPENED MULTI DOSE EXPIRATION DATE EXPIRED MEDS DISPOSED D/C'D MEDS REMOVED MEDS SENT BACK TO PHARMACY</p> <p>1 2 3 4 5 6 7 8 9 10 11 12 13</p>	

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	<p>label indicated, "Expires in 28 days after opened" with a hand written date of 7/an illegible number/15. The Rx filled date was 2/12/15.</p> <p>During an interview with LPN #3 on 7/20/15 at 4:08 p.m., LPN #3 indicated she could not determine if the hand written illegible date was a 4, an 8 or a 9 on Resident #20's Lantus Insulin. She also indicated she could not determine if the hand written date was an expiration date or an opened date on the Lantus insulin. She indicated the opened date should be written on the "Opened Date" label on the vial of insulin. LPN #5 removed the Lantus insulin from the medication cart.</p> <p>One opened vial of Humalog Insulin for Resident #20 was labeled with an opened date of 6/7/15. A pharmacy affixed label indicated, "expires in 28 days after opened...."</p> <p>During an interview with LPN #3 on 7/20/15 at 4:10 p.m., LPN #3 indicated Resident #20's Humalog Insulin was expired and should not have be in the medication cart and should not be administered to the resident. LPN #3 removed the expired insulin from the medication cart.</p>		<p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p>	

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	<p>One opened vial of Novolin R Insulin for Resident # 60 was not labeled with an opened date. with a Rx filled date of 7/1/15.</p> <p>During an interview with the DON (Director of Nursing) on 7/20/15 at 4:45 p.m., the DON indicated insulin should be labeled with a open date when the vial was opened. She indicated the nurse administering the insulin should make sure the insulin was labeled with an open date and make sure the insulin was not past the expiration date before administering the insulin to a resident. She also indicated unopened insulin was to be stored in the refrigerator. She further indicated all multi-dose medications should be labeled with open dates.</p> <p>On 7/20/15 at 4:50 p.m., review of Resident #20's MAR (Medication Administration Record Sheet) indicated the following:</p> <p>Humalog Insulin was administered 11 times per sliding scale after the expiration date of 7/4/15 and was administered to Resident #20 on the following dates: On 7/6/15 at 2000 (8:00 p.m.), 4 units (insulin dose) given; On 7/7/15 at 8:00 p.m., 9 units given; On 7/8/15 at 8:00 p.m., 3 units given;</p>			

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	<p>On 7/9/15 at 8:00 p.m., 4 units given; On 7/10/15 at 8:00 p.m., 3 units given; On 7/11/15 at 8:00 p.m., 4 units given; On 7/12/14 at 0700 (7:00 a.m.) 3 units given; On 7/14/15 at 8:00 p.m., 4 units given; On 7/15/15 at 8:00 p.m., 3 units given; On 7/18/15 at 8:00 p.m., 3 units given; On 7/19/15 at 8:00 p.m., 6 units given.</p> <p>Lantus Insulin was administered 14 times at 2000 (8:00 p.m.) after the insulin expiration date of 7/4/15 (28 days after 6/7/15) and was administered to Resident #20 on the following dates at 8:00 p.m.: 7/5/15, 7/6/15, 7/7/15, 7/8/15, 7/9/15, 7/11/15, 7/12/15, 7/13/15, 7/14/15, 7/16/15, 7/17/15, 7/18/15, 7/19/15. The MARS indicated Resident #20 refused Lantus Insulin on 7/10/15.</p> <p>During an interview with the DON on 7/21/15 at 2:30 p.m., the DON indicated the Pharmacy does not send a Tech (technician) to go through the medication and treatment carts. She indicated the night shift nurse was to check the medication and treatment carts for discontinued and expired medications. She indicated they do not document when the medication and treatment carts were reviewed.</p> <p>During an interview with the DON and</p>			

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	<p>ADON (Assistant Director of Nursing) on 7-22-2015 at 2:35 p.m., the DON and ADON indicated insulins, eye drops, and inhalers should be labeled with opened dates when opened. The ADON also indicated liquid medications should also be labeled with open dates.</p> <p>2. An observation of the South Hall Medication cart with LPN (Licensed Practical Nurse) #4 on 7-20-2015 at 3:50 p.m., indicated the following: No open date was recorded on an opened Symbicort inhaler with a pharmacy refill date of 6-5-2015 for Resident #39. A tag was observed on the label not to use the opened inhaler after 3 months. No open date was recorded for the Artificial Tears Solution with a refill date of 6-30-2015 for Resident #41.</p> <p>An interview with the DON (Director of Nursing) on 7-20-2015 at 3:15 p.m., indicated when multi-dose eye drops and inhalers were opened, an open date should be recorded on the container/label.</p> <p>A review of the current facility policy provided by the DON on 7/20/15 at 5:04 p.m., titled, Storage of Medication, dated 09/10, indicated, "...Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations to maintain their</p>			

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F 0441 SS=E	<p>integrity and to support safe effective drug administrations....Insulin products should be be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature....Outdated, contaminated, discontinued or deteriorated medications...are immediately removed from stock, disposed of according to procedures for medication disposal....."</p> <p>A review of the current facility policy provided by the DON on 7/20/15 at 5:04 p.m., titled, Medications and Medication Labels, dated 12/12, indicated, "...Medications are labeled in accordance with currently accepted professional principles including appropriate auxiliary and cautionary instructions to promote safe medication use following stat and federal laws....Multi-dose vials shall be labeled to assure product integrity, considering the manufactures specifications. (Example: Modified expiration dates upon opening the multi-dose vial.)...."</p> <p>3.1-25(j)(k)(l)</p>						
	483.65 INFECTION CONTROL, PREVENT						

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Bldg. 00	<p>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 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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, interview and record review the facility failed</p>	F 0441	F 441- E It is the intent of the facility to transport clean resident clothing and linen in a manner to prevent potential	08/21/2015			

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	<p>to transport clean resident clothing in a manner to prevent potential contamination potentially affecting 25 of 49 residents who resided on the South Hall and the North Hall.</p> <p>Findings include:</p> <p>1. During an observation on the 500 Hall on 7/15/15 at 11:03 a.m., Laundry #1 was observed to remove clean resident clothing, which were on hangers, from a covered laundry cart. She was observed to place the clean clothing on hangers over her left arm with the clothing touching her arm and uniform.</p> <p>2. During an observation on the 500 Hall on 7/17/15 at 11:40 a.m., Laundry #1 was observed to remove clean resident clothing, which were on hangers, from a covered laundry cart and grasp the hangers in her right hand. She was observed to bend down from her waist to obtain a clean item from the bottom of the laundry cart. Her right arm had lowered and the clean clothing on hangers in her right hand were observed to drag on the floor.</p> <p>3. During observations on the 500</p>		<p>contamination.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Laundry Stakeholder #1 received individual education with regards to policy and procedure on July 24, 2015 for the handling and transportation of linen and principals of infection control by the CEO.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. CEO educated all stakeholders on July 28, 2015 regarding policy and procedure for linen handling, transportation of linen and infection control principals. Additionally, Laundry/ Housekeeping supervisor has been employed by CEO with starting date August 3, 2015.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur: Systematic changes have been implemented to include: <ul style="list-style-type: none"> · Education conducted for all laundry and housekeeping staff on proper linen handling and infection control principals August 28, 2015 by CEO. · New laundry employees will be educated on hire and annually </p>	

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	<p>Hall on 7/20/15, the following was observed:</p> <p>At 10:07 a.m., Laundry #1 was observed delivering clean clothing to residents' rooms. She was observed to remove clean resident clothing, which were on hangers, from a covered laundry cart and grasp the hangers with her right hand. She was observed to bend down from her waist to obtain clean folded items from the bottom of the laundry cart. Her right arm had lowered and the clean clothing on hangers in her right hand were observed to drag on the floor.</p> <p>At 10:10 a.m., Laundry #1 continue to deliver clean laundry to residents' rooms in the 500 Hall. She was again observed to remove clean resident clothing, which were on hangers, from a covered laundry cart and grasp the hangers with her right hand. She was observed to bend down from her waist to obtain clean folded items from the bottom of the laundry cart. Her right arm had lowered and the clean clothing on hangers in her right hand were observed to drag on the floor.</p> <p>4. During an observation on South</p>		<p>thereafter.</p> <p>·CEO will do weekly QA rounds weekly x 4 weeks, then monthly x 6 months.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur: The QAPI committee will review audits monthly x3 and quarterly thereafter until substantial compliance is achieved and will make any further recommendations necessary. Compliance by August 21, 2015.</p> <p>DATE</p> <p>STAFF/ DEPT.</p> <p>TRANSPORT</p> <p>HANDLING</p> <p>DISTRIBUTING</p> <p>COMMENTS</p>	

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	<p>Hall on 7/21/15 at 10:38 a.m., Laundry #1 was observed to remove clean resident clothing, which were on hangers, from a covered laundry cart. She was observed to grasp the hangers in her right hand and carry the clean clothing to the resident's room. Her right arm had lowered and the clean clothing was observed to drag on the floor.</p> <p>The Director of Nursing was interviewed on 7/22/15 at 8:49 a.m. During the interview she indicated clean resident clothing should not touch any part of a staff's body. She also indicated clean resident clothing should never touch or drag on the floor.</p> <p>5. During an observation on the 500 Hall on 7/15/15 at 11:17 a.m., Laundry #1 was observed to remove clean resident clothing, which was hanging on hangers, from the covered laundry cart. Laundry #1 then draped the clean hanging clothes over her left forearm and held the clean laundry against her uniform while she picked up the clean folded resident laundry with her right hand and entered a resident's room with the hanging laundry against her uniform.</p>			

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	<p>6. During an observation on the 500 Hall on 7/15/15 at 11:25 a.m., Laundry #1 was observed to remove clean hanging resident laundry from the covered laundry cart. She then bent over to get the folded laundry from the cart and the clean hanging laundry touched the floor. Laundry #1 carried the resident's clean laundry by the hanger and the bottom edges of the clean laundry touched the floor while she carried the laundry into a resident's room.</p> <p>A current facility policy "Handling Clean Linen", dated January 2005 and provided by the Director of Nursing on 7/22/15 at 9:24 a.m., indicated "...Residents clothing and clean linen are handled properly on the units and in the Laundry to prevent contamination...Do not allow linens to drag on floor...."</p> <p>3.1-19(g)(1)(2)(3)</p>			

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F 9999 Bldg. 00	<p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>(w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and</p>	F 9999	<p>F 9999 It is the intention of the facility to ensure that staff assigned to the Memory Care Unit, have completed the required dementia training within the required time frame. The unit has been newly created, renovated and accepted its first patient on June 5, 2015 with a total of 3 residents residing in the unit at the time of the annual survey. With sudden turnover of the Unit Director the Director of Nursing provided the immediate oversight until new unit director was on boarded.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Stakeholders #6, 7, 9 and DON will have required education by August 21, 2015. Stakeholder #8 is on maternity LOA, but will have the required training on Corporate SHClearn. A Director of the</p>	08/21/2015

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	<p>experience requirements. The director shall have a minimum of twelve (12) special care unit and six (6) hours annually thereafter to:</p> <p>(1) meet the needs or preferences, or both, of cognitively impaired residents; and</p> <p>(2) gain understanding of the current standards of care for residents with dementia.</p> <p>(x) The director of the Alzheimer's and dementia special care unit shall do the following:</p> <p>(2) Ensure that:</p> <p>(A) personnel assigned to the unit receive required in-service training.</p> <p>3.1-14 PERSONNEL</p> <p>(u) In addition to the required in-service hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>These state rules were not met as</p>		<p>Memory Unit has been hired and she will complete her 12 hours of dementia training by August 21, 2015.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents residing on the MemoryCare Unit have the potential of being effected.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur: The following systematic changes have been implemented:</p> <ul style="list-style-type: none"> ·New employees will receive 6 hours of dementia training within 30 days of hire and 3 hours annually thereafter. ·Current stakeholder files will be audited for completed dementia training and anyone found in non-compliance will receive appropriate training by CEO, SDC or DON by August 21, 2015. ·CEO, HR or SDC will audit new employee files monthly to ensure dementia training is in compliance. ·Employee files will be audited quarterly to ensure continued compliance with dementia training requirements by CEO, HR or SDC. <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur: New employee dementia training</p>	

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	<p>evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure 5 of 10 staff assigned to work in the Memory Care unit, had completed the required dementia training within the required time frame. (Director of the Memory Unit which was the Director of Nursing, DON, Certified Nursing Assistant, CNA #6, CNA #7, Licensed Practical Nurse, LPN #8 and CNA #9).</p> <p>Findings include:</p> <p>During a review of the personnel records on 7-21-2015 at 1:30 p.m., dementia training documentation was not present in the records for the following staff: DON with a start date of 9-18-2013. CNA #6 with a start date of 6-8-2015. CNA #7 with a start date of 6-8-2015. LPN #8 with a start date of 2-9-2015. CNA #9 with a start date of 6-8-2015.</p> <p>A review of the daily staffing sheets for July 2015 and provided by the Administrator on 7-20-2015 at 12:03 p.m., indicated the following staff without the required dementia training worked in the Memory Unit as follows: 7-9-2015 CNA #6 7-10-2015 CNA #9 7-11-2015 LPN #8 and CNA #6</p>		<p>will be reviewed and submitted monthly by the CEO to the QAPI committee monthly x 3 for compliance and for further recommendations if indicated. Compliance by August 21, 2015. STAKEHOLDER DATE HIRED DATE COMPLETED NUMBER OF HOURS CERTIFICATE ON FILE</p> <p>DATE OF HIRE STAKEHOLDER DEMENTIA COMPLETION DATE</p>	

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	<p>7-12-2015 LPN #8 7-13-2015 CNA #9 7-14-2015 CNA #7 7-16-2015 CNA #6 7-17-2015 CNA #9 7-18-2015 CNA #7 7-20-2015 CNA #7 7-21-2015 CNA #7 7-22-2015 CNA #9</p> <p>An interview with the DON on 7-22-2015 at 10:42 a.m., indicated she was unable to find the documentation of the 6 hours of dementia training for CNA #6, CNA #7, LPN #8 and CNA #9.</p> <p>The dementia training documentation provided by the DON for her dementia training on 7-22-2015 at 10:42 a.m., included the following: 0.15 hrs CMS (Center for Medicare and Medicaid Services) Hand in Hand module 1, lesson 1, What is Dementia? completed on 3-29-2015. 0.20 hrs CMS Hand in Hand module 1, lesson 2, Types of Dementia completed on 3-29-2015. Two additional certificates were provided for the same 2 lessons as above and were dated 12-27-2014. The DON also provided 3 undated paper tests for dementia training, Post Test Module 1, Understanding Memory Loss, Post Test Module 2, What is Abuse? and</p>		Stakeholder Quarter Compliant Need	

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	<p>Post test Module 4, Being with a Person with Dementia Actions and Reactions.</p> <p>An interview with the Administrator on 7-22-2015 at 11:05 a.m., indicated the previous Staff Development Coordinator did not document the dementia training for CNA #6, CNA #7, LPN #8 and CNA #9.</p> <p>An interview with the DON on 7-22-2015 at 1:40 p.m., indicated the Director of the Dementia unit needed 12 hours of Dementia training and the staff CNAs and nurses needed 6 hours of dementia training within 30 days to care for residents in the Memory Care unit.</p> <p>An interview with the Administrator on 7-22-2015 at 2:00 p.m., indicated the staff nurses and CNAs working in the Memory Care unit needed 6 hours of dementia training within 30 days of hire to work in the unit and the Unit Director needed 12 hours. The Administrator indicated the DON was the Director of the Memory Care unit.</p> <p>Further interview with the Administrator, indicated the Daily Staffing from 7-9-2015 through 7-22-2015 was reviewed for the staffing of the Memory Care unit and the following staff had worked during that time in the unit</p>			

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	without documentation of the required 6 hours of dementia training (CNA #6, CNA #7, LPN #8 and CNA #9). In addition, the Director of the Memory Care unit (DON) did not have documentation of the 12 hours of required dementia training. The Administrator indicated the facility followed state guidelines for the dementia training for staff and the Director assigned to the Memory Care unit. The Administrator further indicated the facility did not have a policy regarding dementia training for the Memory Care unit.			