

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155368	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/20/2014
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NAME OF PROVIDER OR SUPPLIER  TODD DICKEY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 712 W 2ND ST LEAVENWORTH, IN 47137
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey date(s): October 14, 15, 16, 17 and 20, 2014</p> <p>Facility number: 000490 Provider number: 155368 AIM number: 100291320</p> <p>Survey team: Jenny Sartell, RN/TC Gloria Reisert, MSW (October 14, 16, 17 and 20, 2014) Gwen Pumphrey, RN Trudy Lytle, RN Joshua Emily, RN</p> <p>Census bed type: SNF/NF: 51 Total: 51</p> <p>Census payor type: Medicare: 7 Medicaid: 36 Other: 8 Total:51</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		
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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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F000157 SS=D	<p>Quality review completed on October 24, 2014 by Randy Fry RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the 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</p>			

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	<p>interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician and family of a significant weight change in 1 of 1 resident reviewed for significant changes. (Resident #37)</p> <p>Findings include:</p> <p>On 10/16/14 at 10:05 a.m., the clinical record for Resident #37 was reviewed. Diagnoses included, but were not limited to congestive heart failure and dementia.</p> <p>The physicians' order, dated 9/25/14 indicated the discontinuation of Lasix (diuretic) and Spironolactone (diuretic).</p> <p>Review of the document titled Weights Detail Report included the following weights:</p> <p>09/21/14 - 118 pounds 10/01/14 - 122.5 pounds 10/12/14 - 137 pounds 10/13/14 - 142 pounds</p> <p>Review of the Nurses' Notes, dated 10/01/14 through 10/17/14, lacked documentation of physician or family notification of significant weight changes.</p> <p>During an interview on 10/17/14 at 9:40</p>	F000157	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <ol style="list-style-type: none"> <li>1. Resident #37 weight was assessed and MD and family were notified with new orders. Resident #37 is a weekly weight.</li> <li>2. 100% audit has been completed by IDT members reviewing weights and MD/ family notifications of changes.</li> <li>3. Nurses have been re-educated on weight changes policy and procedure and change of condition policy and procedure. DON/designee will audit 5 charts weekly for 90 days for any significant weight changes. Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination.</li> <li>4. The QAPII committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QAPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</li> </ol>	11/17/2014

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	<p>a.m., Resident #37 indicated she had been taking a water pill for 3 years because she retained fluid. She also indicated she did not know whether she was taking a water pill now or not because her feet felt like they were swollen.</p> <p>During at interview with the Director of Nursing (DON) on 10/17/14 at 9:54 a.m., she indicated it would depend on the situation before notifying the physician of a significant weight gain. She also indicated they would re-weigh Resident #37 because she had not had any changes lately.</p> <p>On 10/17/14 at 12:25 p.m., Resident #37 was observed being weighed. The weight was 146.5 pounds.</p> <p>On 10/20/14 at 9:38 a.m., the DON provided a copy of the document titled Notification of Resident Change in Condition. It included, but was not limited to, the following: "Policy: Extencicare Health Services, Inc. (EHSI) clinicians will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial</p>			

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F000225 SS=E	<p>status...Procedure...2. Notify the Physician and family or legal representative at the earliest possible time, during waking hours, if there is a non-critical change in condition...3. Document in the Nurses Notes the times notification was made and the names of the person(s) to whom you spoke...".</p> <p>On 10/20/14 at 10:11 a.m., the DON indicated if there is a 3% weight gain, the physician should be notified.</p> <p>3.1-5(a)(2)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other</p>			

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	<p>officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review the facility failed to ensure allegations of mistreatment were investigated thoroughly and reported appropriately to the Indiana State Department of Health (ISDH). This deficient practice affected 4 of 34 Stage 2 Sampled Residents reviewed. (Resident #30, #58, #44, and #7)</p> <p>Findings include:</p> <p>1. On 10/16/14 at 11:00 a.m., Resident #30 indicated a staff had been rude to her. Resident #30 indicated the staff began to treat her differently after her roommate changed rooms. Resident #30 indicated, "[CNA #1] was really nice to me before my roommate changed rooms.</p>	F000225	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. 1. CNA #1 was suspended pending investigation of concerns expressed by Residents #30, #58, #44, and #7. During investigation of concerns, residents and staff were interviewed, information obtained. An initial report was sent to the ISDH with a 5 day follow-up. CNA #1 was terminated. 2. 100% resident interview was done to determine if residents felt abused, treated rudely or roughly, or mistreated. 3. Staff has been</p>	11/17/2014

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	<p>She would give me a bath and help with my lunches. I told the [Administrator] but I don't think she said anything. Now [named staff] slams my coffee down, you can tell when she puts my lunch tray down, she doesn't give me any showers anymore. Its like she avoids me."</p> <p>On 10/16/14 at 11:30 a.m., the staffing schedule was reviewed. CNA #1 was scheduled to work during the week.</p> <p>On 10/16/14 at 11:45 a.m., the reportable incidents to ISDH were reviewed. No allegations of staff to resident abuse had been reported to ISDH.</p> <p>On 10/16/14 at 12:15 p.m., the Administrator and Nursing Consultant was notified of allegations of staff being rough and rude to residents. The Administrator indicated she knew of one incident that involved Resident #30. She indicated it was a misunderstanding. She indicated she would initiate an investigation regarding the allegations.</p> <p>On 10/17/14 at 9:15 a.m., the Administrator and Director of Nursing (DON) were interviewed. They indicated they interviewed all the residents in the facility and of the three negative interviews they found two to be unsubstantiated and the third involving</p>		<p>re-educated on the abuse policy and procedure as well as reporting abuse. A staff meeting was held to specifically go over the immediacy of reporting and investigating concerns of mistreatment or abuse. Identifying concerns, trends, chain of command and time lines were also presented in this meeting. SSD/ Designee will conduct 5 resident interviews weekly for 90 days at random to determine if residents feel mistreated or abused. Any resident expressed concerns will be reported immediately to the Administrator for further investigation. Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination. 4. The QAPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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	<p>Resident #30 had resolved. The Administrator provided a copy of a staff inservice on customer service dated 10/16/14 and a copy of two documents titled, "Resident Concern Report". The administrator indicated no other documentation was available related to the investigation.</p> <p>The Resident Concern Report dated 9/8/14 indicated Resident #30 reported the staff treat her different. The investigation included interviews with a nurse and CNA providing care to Resident #30. The documentation indicated a follow up with the resident on 9/9/14 and 9/11/14 which indicated "things were better."</p> <p>The Resident Concern Report dated 9/5/14 indicated Resident #58 complained of CNA #1 being rough with her. The report indicated CNA #1 was interviewed and was unaware resident felt this way. The report also indicated other staff and residents were interviewed but did not list names. A follow up with Resident #58 dated 9/10/14 indicated "problem was better". A follow up with Resident #58 on 9/23/14 and 9/30/14 indicated no issues.</p> <p>In an interview on 10/20/14 at 9:13 a.m., the Social Services Director (SSD)</p>						

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	<p>indicated when a resident has a concern a report is initiated and the appropriate department is notified. She indicated the DON or administrator completes investigations related to nursing concerns.</p> <p>With Resident #30, the SSD stated, "CNA #1 doesn't speak to her but she doesn't have a problem with it." With Resident #58's concern she indicated, "CNA #1 was rough but I think [DON] handled that and I talked to [Resident #58] after and everything was fine."</p> <p>When asked what the expectation of staff was when providing care to the residents, the SSD stated, "They should treat the residents how they would want to be treated. We have been ok with how [CNA #1] has been treating [the residents]." The SSD also indicated she was unaware of any other allegations involving residents and staff.</p> <p>2. On 10/20/14 at 9:04 a.m., Resident #58 was interviewed. The resident indicated, "[CNA #1] is rough with snatching,grabbing, and tweaking my catheter. When [CNA #1] answers my [call] light she acts like I'm bothering her. I have reported it to [SSD] but I don't know how [SSD] handled it. [CNA #1] is still rough. She took care of me</p>			

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	<p>yesterday."</p> <p>3. On 10/16/14 at 10:20 a.m., Resident #44 was observed with an indwelling Foley catheter. When asked how the staff provided care for the catheter, he indicated, "I've had some pain with it. This older women jerks on it she says its dirty and it hurts. I don't know her name. It's [catheter] sore and she pulls and wipes here and there."</p> <p>4. On 10/14/14 at 1:37 p.m., Resident #7 stated, "Some of them [staff] are snobby. They [staff] treat you like they are better than you. I can't tell you who they are."</p> <p>On 10/16/14 at 10:00 a.m., when asked for an example of mistreatment Resident #7 indicated, "They won't do nothing for me. They just sit my plate down and go; They won't help me put pepper in my plate or nothing. I don't know her name though. I'm going to tell [named staff]. She's always got a smart remark."</p> <p>A confidential employee interview on 10/17/14 indicated residents have complained about CNA #1. The interviewee indicated the nurse or DON is notified immediately.</p> <p>A second confidential employee interview on 10/17/14 indicated residents</p>				

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	<p>have complained about CNA #1 and it was reported to the SSD.</p> <p>A third confidential employee interview indicated knowledge of staff being rough, rude, or mean to residents and it was reported to the SSD.</p> <p>On 10/20/14 at 11:23 a.m., the DON was interviewed. She indicated when a resident has a concern we interview other staff and residents. She indicated we inservice the staff and discuss dignity and respect with the residents. She indicated CNA #1 was inserviced regarding the allegations and to her knowledge the issues were not abuse but more about how the residents felt they were treated. She indicated CNA #1 had not been suspended during any of the investigations and that CNA #1 was currently employed at the facility. She confirmed the allegations were not reported to ISDH because the residents indicated they did not feel abused.</p> <p>When informed of Residents #30, 58, 44, and 7 with concerns of staff continuing to be rough and rude, and staff indicating they have reported incidents of staff being rough and rude to residents, the DON indicated CNA #1 would be suspended.</p>			

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F000226 SS=E	<p>A copy of the policy titled, "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" was provided by the Administrator on 10/20/14 at 1:30 p.m. The policy indicated, ..."EHSI has designed and implemented processes, which strive to ensure the prevention and reporting of resident abuse, neglect, mistreatment, and/or misappropriation of property....1. Review and investigate using the electronic Accident/Incident report 2. Enter details of the investigation into eAI report. 3. Complete investigation summaries and final outcome questions. 4. Complete and submit the eAI 5. Report the results to the officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. In the case of an employee being investigated for abusing, neglecting, or mistreating a resident the Administrator...must relieve the individual of their duties without pay until the investigation is complete..."</p> <p>3.1-28 (c) 3.1-28 (d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p>			

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	<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 interview and record review the facility failed to follow their policy and procedure related to reporting mistreatment and abuse allegations of residents to the ISDH. This deficient practice had the potential to affect 4 of 32 Sampled Residents currently residing in the facility. (Resident #30, #58, #44, and #7)</p> <p>Findings include:</p> <p>1. On 10/16/14 at 11:00 a.m., Resident #30 indicated a staff had been rude to her. Resident #30 indicated the staff began to treat her differently after her roommate changed rooms. Resident #30 indicated, "[CNA #1] was really nice to me before my roommate changed rooms. She would give me bath, help with my lunches. I told the [Administrator] but I don't think she said anything. Now [named staff] slams my coffee down, you can tell when she puts my lunch tray down, she doesn't give me any showers anymore. its like she avoids me."</p> <p>On 10/16/14 at 11:30 a.m., the staffing schedule was reviewed. CNA #1 was scheduled to work during the week.</p>	F000226	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <p>1. On 10/20/14 a reportable event was sent to ISDH due to resident concerns regarding CNA#1. Investigation was completed and follow up reportable was sent to ISDH on 10/22/14 and CNA#1 was terminated. Residents #30, #58, #44, and #7 were interviewed during and after investigation.</p> <p>2. 100% resident interview was done to determine if residents felt abused, treated rudely or roughly, or mistreated.</p> <p>3. Staff has been re-educated on abuse policy and procedure as well as reporting abuse. An staff meeting was held to specifically go over reporting and investigating concerns of mistreatment or abuse. Identifying concerns, trends, chain of command and time lines were also presented in this meeting. SSD/ Designee will conduct 5 resident interviews weekly for 90 days at random to determine if residents feel mistreated or abused. Any</p>	11/17/2014

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	<p>On 10/16/14 at 12:15 p.m., the Administrator and Nursing Consultant were notified of allegations of staff being rough and rude to residents. The Administrator indicated she knew of one incident that involved Resident #30. She indicated it was a misunderstanding. She indicated she would initiate an investigation regarding the allegations.</p> <p>On 10/17/14 at 9:15 a.m., the Administrator and Director of Nursing (DON) were interviewed. They indicated they interviewed all the residents in the facility and of the three negative interviews they found two to be unsubstantiated and the third involving Resident #30 had resolved. The Administrator provided a copy of a staff inservice on customer service dated 10/16/14 and a copy of two documents titled, "Resident Concern Report". The administrator indicated no other documentation was available related to the investigation.</p> <p>The Resident Concern Report dated 9/8/14 indicated Resident #30 reported the staff treat her different. The investigation included interviews with a nurse and CNA providing care to Resident #30. The documentation indicated a follow up with the resident on</p>		<p>expressed resident concerns will be reported immediately to the Administrator for investigation. Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination.</p> <p>4. The QPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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	<p>9/9/14 and 9/11/14 which indicated "things were better."</p> <p>The Resident Concern Report dated 9/5/14 indicated Resident #58 complained of CNA #1 being rough with her. The report indicated CNA #1 was interviewed and was unaware the resident felt this way. The report also indicated other staff and residents were interviewed but did not list names. A follow up with Resident #58 dated 9/10/14 indicated "problem was better". A follow up with the resident on 9/23/14 and 9/30/14 indicated no issues.</p> <p>In an interview on 10/20/14 at 9:13 a.m., the Social Services Director (SSD) indicated when a resident has a concern a report is initiated and the appropriate department is notified. She indicated the DON or administrator completes investigations related to nursing concerns.</p> <p>With Resident #30, the SSD stated, "CNA #1 doesn't speak to her but she doesn't have a problem with it." With Resident #58's concern she indicated, "CNA #1 was rough but I think [DON] handled that and I talked to [Resident #58] after and everything was fine."</p> <p>When asked what the expectation of staff</p>			

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	<p>was when providing care to the residents, the SSD stated, "They should treat the residents how they would want to be treated. We have been ok with how [CNA #1] has been treating [the residents]." The SSD also indicated she was unaware of any other allegations involving residents and staff.</p> <p>2. On 10/20/14 at 9:04 a.m., Resident #58 was interviewed. The resident indicated, "[CNA #1] is rough with snatching,grabbing, and tweaking my catheter. When [CNA #1] answers my [call] light she acts like I'm bothering her. I have reported it to [SSD] but I don't know how [SSD] handled it. [CNA #1] is still rough. She took care of me yesterday."</p> <p>3. On 10/16/14 at 10:20 a.m., Resident #44 was observed with an indwelling Foley catheter. When asked how the staff provided care for the catheter, he indicated, "I've had some pain with it. This older women jerks on it she says its dirty and it hurts. I don't know her name. It's [catheter] sore and she pulls and wipes here and there."</p> <p>4. On 10/14/14 at 1:37 p.m., Resident #7 stated, "Some of them [staff] are snobby. They[staff] treat you like they are better than you. I can't tell you who they are."</p>			

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	<p>On 10/16/14 at 10:00 a.m., when asked for an example of mistreatment Resident #7 indicated, "They won't do nothing for me. They just sit my plate down and go; They won't help me put pepper in my plate or nothing. I don't know her name though. I'm going to tell [named staff]. She's always got a smart remark."</p> <p>A confidential employee interview on 10/17/2014 indicated residents have complained about CNA #1. The interviewee indicated the nurse or DON is notified immediately.</p> <p>A second confidential employee interview on 10/17/2014 indicated residents have complained about CNA #1 and it was reported to the SSD.</p> <p>A third confidential employee interview on 10/20/14 indicated knowledge of staff being rough, rude, or mean to residents and it was reported to the SSD.</p> <p>On 10/20/14 at 11:23 a.m., the DON was interviewed. She indicated when a resident has a concern we interview other staff and residents. She indicated we inservice the staff and discuss dignity and respect with the residents. She indicated CNA #1 was inserviced regarding the allegations and to her</p>			

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	<p>knowledge the issues were not abuse but more about how the residents felt they were treated. She indicated CNA #1 had not been suspended during any of the investigations and that CNA #1 was currently employed at the facility. She confirmed the allegations were not reported to ISDH because the residents indicated they did not feel abused.</p> <p>When informed of Residents #30, 58, 44, and 7 with concerns of staff continuing to be rough and rude, and staff indicating they have reported incidents of staff being rough and rude to residents, the DON indicated CNA #1 would be suspended.</p> <p>On 10/16/14 at 11:45 a.m., the reportable incidents to ISDH were reviewed. No allegations of staff to resident abuse had been reported to ISDH.</p> <p>A copy of the policy titled, "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" was provided by the Administrator on 10/20/14 at 1:30 p.m. The policy indicated, ..."EHSI has designed and implemented processes, which strive to ensure the prevention and reporting of resident abuse, neglect, mistreatment, and/or misappropriation of</p>						

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F000242 SS=D	<p>property....1. Review and investigate using the electronic Accident/Incident report 2. Enter details of the investigation into eAI report. 3. Complete investigation summaries and final outcome questions. 4. Complete and submit the eAI 5. Report the results to the officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. In the case of an employee being investigated for abusing, neglecting, or mistreating a resident the Administrator...must relieve the individual of their duties without pay until the investigation is complete..."</p> <p>3.1-28 (c) 3.1-28 (d)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review the facility failed to ensure the residents were assessed for personal preference for</p>	F000242	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies	11/17/2014			

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	<p>choices with Activities of Daily Living for 3 of 3 sampled residents (# 30, 18 and 66).</p> <p>Findings include:</p> <p>1. During an interview on 10/14/14 at 1:34 p.m., Resident # 30 indicated she was not given a choice of the number of times a week she can have a shower. She indicated, "I can only have two, they (the facility) say."</p> <p>On 10/16/14 at 11:08 a.m., the record review of the resident's Life Enrichment Short Stay Care Plan dated 07/19/14 and last updated on 09/09/14 indicated the Daily Preferences were not documented as very important or somewhat important for, but not limited to choose between a tub bath, shower, bed bath or sponge bath. The Preference was also not documented.</p> <p>On 10/16/14 at 1:42 p.m., Resident # 30 indicated, "They didn't ask me at the beginning of my stay here how often I wanted to take a shower. They just told me my shower was on Tuesdays and Fridays." I get up at 5:30 to 6:30 a.m., so that I can get dressed, because I know they will be coming to get me for breakfast. Then I have to wait for an hour in the dining room for my food. I</p>		<p>cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <p>1. Residents #30 and #18 have been interviewed for their preferences of showering and time to get up. Resident # 66 has discharged from facility.</p> <p>2. 100% audit has been completed by IDT members to determine all residents' preference of showers/baths per week and time to get up in the morning.</p> <p>3. Staff have been re-educated on resident choices. SSD/ designee will interview 5 residents per week for 90 days to determine if their preferences are being honored. Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination.</p> <p>4. The QPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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	<p>don't want to go to breakfast in my pajamas like some of the other residents do."</p> <p>On 10/17/14 at 9:25 a.m., the Activities Director indicated "An initial assessment is done and we take the new resident on a tour of the facility and their preferences and interests are noted. We will take the preference to clinical ( a meeting). We usually let them get up to their time preference and choose their shower preference. I don't have a list of residents who want to get up later or shower more often." She named Residents # 67 and 68 as the only two residents who want to sleep in and have more showers weekly.</p> <p>On 10/17/14 at 10:02 a.m., the record review of the Minimum Data Set (MDS) Omnibus Budget Reconciliation Act (OBRA) Admission Assessment, dated 07/24/14, indicated on the "Daily and Activity Preferences Primary Respondent" was documented as the Resident with a "No" checked under "Should the Staff Assessment of Daily and Activity Preferences be Conducted."</p> <p>During an interview on 10/17/14 at 10:13 a.m., the MDS Coordinator indicated, " I usually don't do Section F for Preferences. Activities usually does those. There should be answers</p>			

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	<p>somewhere in that section, whether the resident or the family is interviewed, with preferences indicated."</p> <p>2. On 10/14/14 at 11:11 a.m., Resident # 18 indicated during an interview, she was not given a choice for the time she gets up in the morning, how many times a week she takes a shower or bath or whether it is a tub or bed bath or a shower.</p> <p>On 10/16/14 at 10:44 a.m., the resident's Life Enrichment Short Stay Care Plan indicated the "Daily Preferences" dated 09/22/14 and updated on 09/26/14 was documented it is important to the resident to choose between a tub bath, shower, bed-bath, or sponge bath and to choose my own bedtime with no preferences documented.</p> <p>On 10/17/14 at 9:43 a.m., the review of the MDS Resident Assessment and Care Screening, dated 09/20/14 indicated no documentation of an assessment upon admission for Preferences for Daily Care or Activities.</p> <p>On 10/17/14 at 10:09 a.m., the review of the MDS OBRA Admission Assessment, dated 09/27/14, indicated on the "Daily and Activity Preferences Primary Respondent" was documented with a</p>			

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	<p>"No" checked under "Should the Staff Assessment of Daily and Activity Preferences be Conducted."</p> <p>During an interview on 10/17/14 at 10:24 a.m., Resident # 18 indicated "We don't have a choice, but it is the same time every morning. No assessment was done when I was admitted, because I guess I just don't have a choice."</p> <p>3. During an interview on 10/14/14 at 1:00 p.m., Resident # 66 indicated she does not have a choice of time to get up in the mornings or if she can have a shower or bath.</p> <p>On 10/16/14 at 10:26 a.m., the Life Enrichment Short Stay Care Plan indicated the Daily Preferences for Resident # 66 was to choose her own bedtime and to choose between a tub bath, shower, bed bath, or sponge bath, with no Daily Preference documented. The care plan was originated on 07/11/14 and last updated on 09/11/14.</p> <p>On 10/17/14 at 9:48 a.m., the review of the MDS Quarterly Assessment, dated 09/11/2014, indicated no Preferences for Daily Care and Activities was charted.</p> <p>On 10/17/14 at 10:08 a.m., the record review of the MDS OBRA Admission</p>			

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F000272 SS=D	<p>Assessment, dated 07/18/14, indicated the "Daily and Activity Preferences Primary Respondent" was documented as the Resident with a "No" checked under "Should the Staff Assessment of Daily and Activity Preferences be Conducted."</p> <p>On 10/17/14 at 10:41 a.m., Resident # 66 indicated she has gotten used to getting up early in the morning, "I have to get up at 7:00 a.m., but I would rather get up around 9:00 a.m. They did an assessment when I was admitted and I told them that I would like to sleep later in the morning."</p> <p>3.1-3(u)(1)(3)</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;</p>			

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	<p>Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; 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, interview and record review, the facility failed to ensure complete and accurate assessments for 1 of 3 residents with an indwelling Foley catheter (Resident #55) and regarding a resident's ability to dress self in 1 of 2 residents reviewed for ability to dress self in a sample of 11 residents. (Resident #40)</p> <p>Findings included:</p> <p>1. On 10/14, 10/15, 10/16, 10/17, and 10/20/14 Resident #55 was observed with an indwelling Foley catheter.</p> <p>In an interview on 10/14/14 at 12:53 p.m., LPN #1 indicated Resident #55 had</p>	F000272	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <p>1. Resident #55 has had his Foley catheter discontinued. Resident #40 is discharged.</p> <p>2. 100% audit has been done by IDT members to ensure all Foley catheters have supporting diagnosis and assessment and also to ensure all ADL declines have supporting assessments.</p> <p>3. Nurse have been re-educated on Foley catheter policy and procedure. Nurses have also been re-educated on decline in ADLS with supporting assessment. DON/ designee will</p>	11/17/2014

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	<p>a Foley catheter due to urinary retention.</p> <p>On 10/16/14 at 11:00 a.m., Resident #55's clinical record was reviewed. He had diagnosis including atrial fibrillation, dementia, chronic kidney disease, stage III pressure ulcer, dehydration, and pneumonia.</p> <p>Hospital discharge instructions dated 8/10/14 indicated, "Continue with Foley cath [catheter] secondary to poor urine output and possible retention."</p> <p>Facility admission orders dated 8/10/14 indicated Foley catheter to bedside for urinary retention.</p> <p>A document titled, "SBAR Communication Form and Progress Note" dated 9/9/14 requested a physician order to discontinue the Foley catheter. A response dated 9/10/14 indicated, "Not at this time". No other documentation present.</p> <p>A nurses note dated 9/9/14 at 9:30 p.m., indicated the physician ordered to "keep the f/c [Foley catheter] r/t [related to] urinary retention.</p> <p>The Minimum Data Set [MDS] Assessment dated 9/11/14 indicated the resident had an indwelling catheter.</p>		<p>audit 5 resident charts weekly for 90 days for Foley catheter use and ADL decline. Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination.</p> <p>4. The QPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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	<p>The clinical record lacked documentation of an assessment for the continued use of a Foley catheter.</p> <p>On 10/20/14 at 11:15 a. m, the Director of Nursing indicated residents with a diagnosis of urinary retention are assessed with a post void residual. Documentation of Resident #55's post void residual was requested and not provided. The DON indicated the physician requested to continue the Foley catheter.</p> <p>On 10/20/14 at 2:18 p.m., a comprehensive assessment of the Foley catheter was requested from the MDS coordinator. She indicated, "I go by the physician's order. I'm just looking to see if the resident has an catheter or not. I'm not looking to see if they have an assessment for the catheter."</p> <p>A copy of the policy titled, "Indwelling Urinary Catheters" was provided by the DON on 10/17/14 at 12:21 p.m. The policy stated..., " A comprehensive assessment includes underlying factors supporting medical justification, determination of which factors can be reversed and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14</p>			

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	<p>days....a. Urinary retention that cannot be treated or corrected medically or surgically for which alternative therapy is into feasible, and which is characterized by: documented post void residual volumes in a range over 200 ml. Inability to manage the retention/incontinence with intermittent catheterization, and persistent overflow incontinence, symptomatic infections, and/or renal dysfunction..."</p> <p>B. Review of the clinical record for Resident #40 on 10/17/14 at 10:00 a.m., indicated diagnoses included, but were not limited to: weakness, dementia, atrial fibrillation and hypertension.</p> <p>A 4/27/14 Quarterly Minimum Data Set (MDS) assessment indicated the resident required only supervision with cues in dressing self. A 7/27/14 MDS assessment indicated the resident now required extensive assist in order to dress self.</p> <p>The 4/22/14 and 7/25/14 Quarterly Nursing assessments indicated the resident was independent for dressing and most ADL (Activities of Daily Living) tasks.</p> <p>The SBAR communication forms (form used to document information to be passed onto the physician when a resident</p>			

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	<p>has a change in condition) and nursing notes between 5/1/14 and 7/27/14, indicated the resident had experienced periodic falls while transferring self in/out of wheel chair and to/from bathroom. No injuries were noted. Documentation was lacking which indicated a reason as to why the resident may have had a decline.</p> <p>A 7/1/14 Therapy screening tool indicated that on 6/30/14, the resident sustained a fall while attempting to self transfer and required some assist with all ADLs - but no change in abilities was noted since last quarter. The note also indicated the resident refused therapy due to being private pay and did not want to have to pay.</p> <p>On 10/17/14 at 1:44 p.m., the MDS coordinator indicated "I'm not sure if it was an error in coding or because night shift was doing the nursing assessments and did not really see her get dressed. She had periods of confusion where she needed more assist and with her falls. I couldn't find any other documentation for the decline. "</p> <p>3.1-31(c)(2) 3.1-31(c)(3) 3.1-31(c)(6) 3.1-31(d)(3)</p>				

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F000309 SS=D	<p>3.1-31(i)</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.</p> <p>Based on observation, interview, and record review, the facility failed to accurately document and assess residents with non pressure related skin conditions. This deficient practice affected 2 of 4 residents reviewed for non pressure related skin conditions. (Resident #55 and Resident #69)</p> <p>1. On 10/16/14 at 2:22 p.m., Resident #55 was observed to have four purple, reddish discolorations on the left cheek. The first discoloration measured 1 inch by 1 inch. The second discoloration measured 1 inch by 1/2 inch. The third discoloration measured two and a half inches by one half inch in diameter. Three deep purple discolorations were observed on the left side of Resident #55's neck, all three were half inch by a half inch in diameter. Observed Resident #55's lower right cheek to contain a deep</p>	F000309	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. 1. Residents # 55 and #69 have had full skin assessments. Impairments have been reported to MD and family, care planned, and is being monitored daily until healed. 2. 100% skin audit was done for all residents. Impairments have been reported to MD and family, care planned, and are being monitored daily until healed. 3. Nursing staff have been re-educated on weekly skin assessment, identification of skin changes, and reporting skin impairments. DON/designee will perform 5 skin assessments weekly for 90 days to ensure completion of assessments.</p>	11/17/2014

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	<p>purple discoloration with a measurement of one inch by one inch. Observed on the middle of the right cheek was dry skin with a deep purple discoloration with a measurement of one half inch by one half inch. Observed on the top of Resident # 55's right ear running backwards was a deep purple discoloration with a measurement of one inch by one half inch. Observed on the center of Resident #55's forehead was a scab that was one quarter inch in size.</p> <p>The record for Resident #55 was reviewed on 10/17/14 at 9:28 a.m. Resident #55's diagnose's included but were not limited to; atrial fibrillation, hypertension, dementia, and depression. Resident #55's medications included but were not limited to aspirin 81 mg given once a day related to atrial fibrillation. Review of the treatment record indicated weekly skin assessments for Resident #55 were completed on Tuesdays. The treatment record indicated LPN #2 completed skin assessments dated 10/14/2014 and 10/7/2014 with no new skin issues. The progress nursing notes for dates of 10/14/2014 and 10/7/14 indicated no skin issues were found by LPN #2 during skin assessments for Resident #55. The skin integrity assessment prevention and treatment plan of care last updated 10/11/14 indicated no</p>		<p>Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination. 4. The QPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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	<p>problems were noted concerning discoloration of head, neck, and ear. No situation, background, assessment, and recommendation (SBAR) form were found in chart concerning Resident #55's discoloration of head, neck and ear.</p> <p>During an interview on 10/17/2014 at 9:44 a.m., Licensed Practical Nurse (LPN) #2 indicated, she was unaware of discolorations on Resident #55's face, neck, and ear. LPN #2 indicated she had done the past two previous skin assessments and did not find any new areas. LPN #2 indicated she had given Resident #55's medications on 10/16/2014 and 10/17/2014, but did not notice any discolorations. LPN #2 indicated she did not have the time to pay attention as she was too busy. LPN #2 indicated she had no knowledge of the discolorations. LPN #2 indicated if a new skin condition was found a situation, background, assessment, and recommendation (SBAR) form would be completed, doctor and family would be notified, nursing note would be done, care plan would be updated, and treatment assessment record updated.</p> <p>During an interview on 10/17/2014 at 9:50 a.m., the Director of Nursing (DON), indicated she was unaware of any discolorations on Resident #55's face,</p>			

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	<p>neck, and ear.</p> <p>During an interview on 10/17/2014 at 9:57 a.m., Certified Nursing Assistant (CNA) #11 and CNA #12, both indicated Resident #55's discolorations to the neck, face, and ear had been present for three weeks. CNA #11 and CNA #12 both indicated they had been told by another shift of discolorations, and did not fill out the required paperwork to notify nurse, the form is called the stop and watch form. CNA #11 and CNA #12 both indicated they verbally talked to a nurse about the discolorations. CNA #11 and CNA #12 indicated for new skin issues seen they would fill out a communication form for the nurse called a the stop and watch form and alert the nurse to new issues.</p> <p>During an interview on 10/17/14 at 2:00 p.m., the Director of Nursing (DON) indicated it was a problem that the residents skin assessments and skin issues were not being properly documented and the physician and family were not notified properly. The DON indicated skin assessments were done weekly by a nurse. Certified Nursing Assistants (CNA) would use the stop and watch form and alert the nurse, if new areas were found on the skin. A nurse would fill out a situation, background,</p>			

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	<p>assessment, and recommendation (SBAR) form, write a nursing note, contact and notify doctor and family, write an order for monitoring the condition on the treatment administration record, and the care plan would be updated.</p> <p>2. On 10/16/2014 at 2:18 p.m., Resident #69 was observed to have three purple discolorations above the left elbow on the outside of the arm, all three were one quarter inch in size. Observed on Resident #69's right arm was one deep purple discoloration, one quarter inch in size located beneath the elbow on outer side of the arm. Observed on Resident #69's right arm above the elbow on the back of the arm was a deep purple discoloration, measuring one half inch by one quarter of an inch.</p> <p>The record for Resident #69 was reviewed on 10/16/2014 at 2:25 p.m. Resident #69's diagnosis included, but were not limited to: binary prostate hypertrophy, osteoarthritis, hypertension, polio, and hypothyroidism. The treatment administration record indicated Resident #69 received skin assessments on 10/13/2014 and 10/6/2014 with no skin issues noted. Nursing progress notes dated 10/13/2014 and 10/6/2014 had nothing noted for skin issues. The " Skin</p>			

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	<p>Integrity Assessment: Prevention and Treatment Care Plan " dated 10/9/2014 indicated no skin issues had been documented on the arms nor were being monitored for Resident #69. No situation, background, assessment, and recommendation (SBAR) form were found in the chart concerning Resident #69's discoloration to arms.</p> <p>During an interview on 10/17/14 at 1:45 p.m., Licensed Practical Nurse (LPN) #2 indicated she was unaware of the bruises on the arms of Resident #69. LPN #2 indicated she did not know what the discolorations were on the arm.</p> <p>During an observation of Resident #69 with the Director of Nursing (DON) present, on 10/17/14 at 2:10 p.m., the DON indicated she was unaware of discolorations on the arms. The DON indicated it was a problem that staff were unaware of the changes in the skin conditions of the residents.</p> <p>A policy and procedure titled, "Weekly Skin Assessment," was provided by the Director of Nursing on 10/17/2014 at 10:54 a.m., and was identified as current. The policy indicated, skin assessments include a head to toe visualization of the resident's skin. Any skin impairment such as but not limited to a bruise would</p>			

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	<p>be documented. Documentation of location, type and size of skin impairment would be documented in the left column box of the "Treatment Administration Record." Significant change would be documented in the nursing progress note. A Physicians order would be obtained for treatment protocol. Communicating intervention to other staff would be done by documenting on "Skin Integrity Assessment Prevention and Treatment Care Plan." Staff would be provided training as needed. Staff would implement the physician's order and notify the responsible party and document notification.</p> <p>A policy and procedure titled, "Skin Integrity Assessment: Prevention and Treatment Care Plan," was provided by the Director of Nursing (DON) on 10/20/2014 at 1:55 p.m., and was identified as current. This policy indicated to sign and date, each new assessment. The policy indicated to add the new assessment risk factor, intervention and goal to the care plan.</p> <p>A policy and procedure titled, "Stop and Watch Early Warning Tool," was provided by the Director of Nursing on 10/20/2014 at 1:55 p.m., and was identified as current. This policy</p>			

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F000329 SS=E	<p>indicated staff members who have direct contact with the resident will complete this form for all changes in resident status on a shift-by-shift basis. The policy indicated the completed form will be done at the end of the shift and provide information to the nurse taking care of the resident, then a copy will be provided to the Director of Nursing.</p> <p>Policy and procedure titled, "Notification of Resident Change in Condition," was provided by the Director of Nursing on 10/20/2014 at 1:55 p.m., and was identified as current. The policy indicated for a change in condition, the family or legal representative would be notified. Documentation would be added in the nurses notes or a situation, background, assessment, and recommendation (SBAR) form would be filled out by the nurse in charge of resident.</p> <p>3.1-37(a)</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</p>			

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	<p>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 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, interview and record review, the facility failed to monitor a resident on anti-coagulant therapy (Resident #30), provide appropriate rationale for declining pharmacy recommendations (Residents #66, #37, and #26), and to attempt non-pharmacological interventions before administering anti-anxiety medication (Resident #8) for 5 of 5 residents reviewed for monitoring medications and unnecessary medications.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #30 was reviewed on 10/17/14 at 1:30 p.m. Diagnoses included, but were not limited to hypertension, atrial fibrillation and chronic angina.</p>	F000329	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <p>1. Resident #30 has monitoring for Coumadin therapy per policy. Resident # 66 has discharged from facility. Resident #37 &amp; #26 have had pharmacy recommendations re-submitted to MD for review or clinical rationale description on pharmacy recommendation. Resident #8's antianxiety medicine has been reviewed.</p> <p>2. Residents on Coumadin therapy have monitoring in place for signs and symptoms of bleeding. Pharmacy recommendations for October have clinical rationale for declines.</p>	11/17/2014

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	<p>The care plan titled Anticoagulant Therapy Plan of Care for Resident #30 was reviewed on 10/17/14 at 1:35 p.m. It included, but was not limited to the following: "Problem...Goal...Due Date...Intervention: Anticoagulant Therapy:...Monitor for sign and symptoms of bleeding when using an anticoagulant...".</p> <p>Review of the Treatment Administration Record and Nurses Notes for September 2014 and October 2014 for Resident #30 lacked documentation of monitoring for signs and symptoms of bleeding.</p> <p>On 10/17/14 at 1:45 p.m., during an interview with LPN #2, she indicated they do not monitor for signs and symptoms of bleeding for residents' on blood thinners (anticoagulants).</p> <p>On 10//17/14 at 2:50 p.m., during an interview with the DON, she indicated the CNA's (Certified Nursing Assistant) monitor for signs and symptoms of bleeding and the assignment sheets list those residents' on blood thinners.</p> <p>On 10/17/14 at 3:30 p.m., the DON provided a current copy of the document titled Nursing Assistant Assignment Sheet. Resident #30 lacked</p>		<p>3. Re-education provided to nurses on monitoring Coumadin therapy, pharmacy recommendations declines with clinical rationale, and use of PRN anti-psychotropic medications first try and document non-pharmacological attempts before giving med. DON/designee will audit 5 residents' charts weekly for 90 days for Coumadin therapy monitoring, pharmacy recommendations, and PRN anti-psychotropic meds used. Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination.</p> <p>4. The QPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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	<p>documentation, under Comments/Special Needs, for monitoring for signs and symptoms of bleeding.</p> <p>2. The clinical record for Resident #66 was reviewed on 10/16/14 at 9:35 a.m. Diagnoses included, but were not limited to depression.</p> <p>Review of the document titled Consultation Report, dated 8/4/14 included, but was not limited to, the following: "...Comment: (Resident #66) is receiving citalopram at a dose of greater than 20 mg (milligrams) daily (40 mg QD (everyday). She also receives Wellbutrin 300 mg QD. Recommendation: Please consider decreasing citalopram to 20 mg orally daily...If therapy is to continue at this dose, it is recommended that: a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual...Physician Response: ...Rationale: no (triangle) (change) - pt (patient) clinically stable..."</p> <p>The clinical record lacked documentation of an assessment of risk versus benefit.</p> <p>Review of the document titled Consultation Report, dated 9/9/14,</p>			

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	<p>included, but was not limited to the following: "...Comment: (Resident #66) has heart failure requiring diuretic therapy with, Furosemide, and also receives routine NSAID therapy with Meloxicam. Recommendation: Please re-evaluate continued NSAID use and consider discontinuation or alternative therapy with Tylenol 650 mg po (orally) TID (three times a day).....Prescriber Response: ...I decline the recommendation(s)...continue current mgmt (management). not clinically indicated..."</p> <p>The clinical record lacked documentation of an assessment of risk versus benefit.</p> <p>3. The clinical record for Resident #37 was reviewed on 10/17/14 at 10:15 a.m. Diagnoses included, but were not limited to congestive heart failure and dementia.</p> <p>The document titled Change of Condition Medication Regimen Review Report, dated 9/5/14, included, but was not limited to the following: ..."Comment: (issued on 09/05/2014) (resident name) is noted to be experiencing signs/symptoms that may indicate new onset or worsening mental status changes defined on a change of condition medication regimen review request completed by the facility as "night time delusions new onset".</p>			

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	<p>orders for Zoloft (anti-depressant) 100 mg daily, alprazolam (anxiolytic) 0.5 mg at bedtime and use has been associated with changes in mental status. Please evaluate...Physician's Response: ...I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: "...". There was no rationale for declining the recommendation.</p> <p>The physician progress notes lacked documentation for declining the recommendation.</p> <p>4. The clinical record for Resident #26 was reviewed 10/16/14 at 9:20 a.m. Diagnoses included, but were not limited to dementia, depression and anxiety.</p> <p>Review of the document titled Consultation Report, dated 4/1/2014, included but was not limited to the following: "...Comment: (resident name) receives Armour Thyroid, USP 60 mg QD, considered a high risk medication for use in the elderly due to the increased risk of cardiac arrhythmia's. Additionally, it may not be covered by the residents' Part D or other insurance prescription plan. Recommendation: Please consider discontinuing Armour Thyroid and initiating levothyroxine 100 mcg QD at 6 AM...Physicians Response:...I decline the</p>			

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	<p>recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: ..." There was no reason or rationale documented by the physician.</p> <p>The progress notes lacked documentation by the physician for declining recommendation.</p> <p>During an interview with the DON on 10/17/14 at 11:20 a.m., she indicated the physician should be documenting rationale as to why when declining pharmacy recommendations.</p> <p>5. The clinical record for Resident #8 was reviewed on 10/17/14 at 10:28 a.m. Diagnoses included, but were not limited to anxiety, anemia and diabetes.</p> <p>Resident #8 was admitted on 7/16/14 with a physicians' order for Ativan, 0.5 mg orally 3 times a day as needed for anxiety.</p> <p>Review of September 2014 MAR (Medication Administration Record) indicated Ativan, 0.5 mg was given on 9/10/14, 9/11/14 and 9/12/14.</p> <p>Review of the care plan titled Mood and Behavior Symptom Assessment/Plan of Care included, but was not limited to the</p>			

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F000371 SS=E	<p>following: "Psychosocial Well-Being - Mood State...Interventions...Other: Enc (sic) to vent feelings...Enc. (sic) OOR (out of room) activities...Assure that needs will be met..."</p> <p>During an interview with the DON on 10/17/14 at 10:40 a.m., she indicated that non-pharmacological interventions should be tried before as needed medication is given and documented on the back of the MAR or in the Nurses Notes.</p> <p>The MAR and Nurses Notes lacked documentation of non-pharmacological interventions attempted before administering Ativan.</p> <p>On 10/17/14 at 11:41 a.m., the document titled Behavior Detail Report indicated between 9/9/14 and 9/14/14, Resident #8 exhibited no behaviors.</p> <p>3.1-48(a)(3) 3.1-48(a)(6) 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>						

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	<p>Based on observation, interview, and record review, the facility failed to plate food under sanitary conditions and utilize proper hand washing technique. This deficient practice had the potential to affect 49 of 51 residents eating food prepared in kitchen.</p> <p>Findings include:</p> <p>On 10/16/2014 at 11:20 a.m., Cook #4 was observed to place an ungloved thumb on the inside of bowls while picking up the bowls, the thumb was touching the food-contact area of the bowls, then immediately after bowls were picked up in this manner, food was placed in the bowls where her ungloved thumb had touched the bowls. Thirty five bowls were observed to be affected in this way.</p> <p>On 10/16/2014 at 11:35 a.m., Dietary Aid #5 was observed placing fruit bowls on trays and inserting plated food trays onto the rack to serve to residents, Dietary Aid #5 was observed then entering the Dietary Managers office, picking up the telephone and talking on the phone, then returning back and continuing work plating food without washing hands and with ungloved hands.</p> <p>On 10/16/2014 at 11:40 a.m., Dietary Aid #5 was observed to cough on self, then</p>	F000371	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <ol style="list-style-type: none"> <li>Dietary Manager performed directed education with the Dietary Manager #6, Cook #4 and Dietary Aid #5, in reference to how to handle bowls and utensils during food preparation and hand washing. The ETD did a refresher in-service on proper hand washing. This was followed by a secondary in-service by our registered dietician on both hand washing and handling bowls during food preparation.</li> <li>A 100% audit of handling dishware and hand washing was performed by dietary administration, to insure proper procedures are being followed.</li> <li>Dietary staff have been re-educated on proper handling dishware and hand washing procedures. Dietary Manager and/or designee will perform an audit five days a week for three weeks, initially, to insure proper procedure is followed. Weekly audits will continue for a month. A random audit will be performed for a month after that. The regional dietician will also provide oversight during this audit period. Identified non-compliance will result in 1:1 education with repeat non</li> </ol>	11/17/2014

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	<p>washed hands for a total of three seconds. Dietary Aid #5 then mixed thickener into a drink with ungloved hands.</p> <p>On 10/16/2014 at 11:41 a.m., Dietary Manager #6 was observed to wash hands for a total of five seconds, and then began plating food to serve to residents.</p> <p>On 10/16/2014 at 11:49 a.m., Dietary Aid #5 was observed to wash hands for a total of five seconds then started putting orange bowls on trays for residents.</p> <p>On 10/17/14 at 11:38 a.m., Cook #4 was observed to place an ungloved thumb on the inside of bowls while picking up the bowls, the thumb was touching the food-contact area of the bowls, then immediately after bowls were picked up in this manner, food was placed in the bowls where her ungloved thumb had touched the bowls. Two bowls were observed to be affected in this manner.</p> <p>During an interview on 10/17/14 at 1:15 p.m., the Dietary Manager indicated the edges of the bowls should only be touched, never the inside of the bowls, on the food-contact surface. The Dietary Manager indicated food would be disposed of and dish unused if the bowl would be touched on the food-contact</p>		<p>compliance resulting in disciplinary action per policy up to and including termination.</p> <p>4. The QPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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F000465 SS=E	<p>area. The Dietary Manager indicated if the phone, doorknob or any other commonly touched area were touched by staff, staff should wash hands. The Dietary Manager indicated hands should be washed for fifteen to twenty seconds. A policy, titled " Nutrition Services Practice Manual, Sanitation Procedure, " was provided by the Administrator on 10/17/2014 at 2:10 p.m., and was identified as current. The policy indicated, while serving food, never touch food-contact area of plates, bowls, glasses, or cups. The policy indicated wash hands after the following activities, including, but not limited to: sneezing, coughing, touching door knobs, touching work surfaces, and after touching anything that may contaminate your hands. The policy indicated to rub hands together vigorously for twenty seconds, generating friction on all surfaces of the hands and fingers, when washing hands. 3.1-21(i)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations and interview, the</p>	F000465	This Plan of Correction constitutes	11/17/2014

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	<p>facility failed to ensure a clean and sanitary environment for 6 of 6 resident's rooms and 11 of 11 residents, 2 of 2 exterior lint vents and 1 of 2 showers observed (East and West Hall Showers; Rooms 203, 204, 206, 302, 304 and 406 for Residents # 6, 26, 60, 65,12, 22, 13, 54, 44, 1 and 49). This deficiency had the potential to affect all 52 residents residing in the facility.</p> <p>Findings include:</p> <p>On 10/16/14 between 9:23 and 9:50 a.m., during a facility tour with the Maintenance Director the following was observed:</p> <ol style="list-style-type: none"> <li>1. The observation of the East Hall Shower indicated the cove baseboard was peeling away from the wall from the entry door to the first shower stall. Cracks were noted on the bottom 6 inches of the tile trim and the connecting 1/2 tile between the two shower stalls.</li> <li>2. A tour of Room 204 indicated the wall at the upper corners of the air unit to be cracked and peeling. The Maintenance Director indicated wood could be placed on the wall around the unit to cover it.</li> <li>3. A tour of Room 203 also indicated the same cracked and peeling plaster on the</li> </ol>		<p>this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <ol style="list-style-type: none"> <li>1. The tile and cove base in the East Hall Shower Room has been repaired. The wall in Room 204 has been repaired. The wall in Room 203 has been repaired. The bathroom wall in Room 206 has been repaired. The wall in Room 406 has been repaired. The door in Room 302 has been repaired. The cove base and the hand rail in Room 304 have been repaired. The exterior dryer vents for laundry have been cleaned out. The cove base in the hallway between East and West wings has been repaired. The wallpaper indicated in the findings in resident room sand the hallways between West and East wings have been repaired.</li> <li>2. A 100% audit was performed in resident rooms to identify any other areas that need repair. A 100% audit was performed in the hallways to identify cove base and wall paper that needs repaired.</li> <li>3. Staff have been educated to identify environmental repair concerns and to inform maintenance of issues when they are discovered. The maintenance personnel have been in-serviced on policy and procedure for proper maintenance of the facility environment. The</li> </ol>	

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	<p>wall at the corners of the air unit.</p> <p>4. Room 206's bathroom wall plaster was observed to be cracked at the bottom 2 feet of the wall corners on the right side of the room.</p> <p>5. A tour of Room 406 indicated the white wall panel, which had been placed over the plaster wall to the right of the bathroom sink, had scattered one inch cuts which were peeling outward on the panel. The room also had an exposed water pipe, which had been capped, sticking out 1/2 inch on the wall above the toilet.</p> <p>6. The observation of Room 302 indicate the back of the room's entrance door was scraped in an eight inch long strip midway up the door, lining up with the handle of the bathroom door. The Maintenance Director indicated the rooms were not built for both doors to be opened at the same time.</p> <p>7. Room 304 had loose cove baseboard along the wall in a four inch section to the inside right of the entry door. The hand rail had a 1 inch gouge in the hand rail to the left side of the bathroom door.</p> <p>8. The cove baseboard trim was pulling away from the wall in multiple areas of</p>		<p>administrator and/or designee will make weekly audits of environment, for three months, to identify issues and initiate repairs. Identified non-compliance will result in 1:1 education with repeat non compliance resulting in disciplinary action per policy up to and including termination.</p> <p>4. The QPI committee will review the results of these audits on a monthly basis for any changes or updates, as indicated. Identified trends will be reviewed in QPI meetings for 6 months and then quarterly for two quarters following to determine further recommendations as needed.</p>	

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	<p>the halls in the facility between the West and East Halls. The wall paper was also observed to be peeling at the corners and seams of the wallpaper in multiple areas of the resident's rooms and in the hallways between the West and East Halls.</p> <p>9. The dryer vents on the exterior wall of the building had an accumulation of lint inside the 2 exterior pipes. The Maintenance Director indicated, "I have been following a suggested manufacturer vent trap maintenance program, but I can see it had accumulated."</p> <p>During the tour the Maintenance Director indicated, "The staff lets me know when there are problems and they fill out work orders for me to do repairs. I have noticed problems and the need for repairs since I started working here 3 months ago and I have not gotten around to it yet." The Maintenance Director could not provide any work orders for the future repairs. He also indicated the facility does not have the money for the repairs he would like to do.</p> <p>3.1-19(f)</p>				