

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/22/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00187972 and IN00187525.</p> <p>Complaint IN00187972 - Substantiated. Federal/State deficiencies related to the allegations are cited at F354.</p> <p>Complaint IN00187525 - Substantiated. Federal/State deficiencies related to the allegations are cited at F354.</p> <p>Survey dates: December 15, 16, 17, 18, 19, 20, 21 and 22, 2015.</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 5 Medicaid: 66 Other: 11 Total: 82</p> <p>These deficiencies reflect State findings</p>	F 0000	<p><b>F000</b> - Preparation, submission and implementation of this plan of correction does not constitute an admission of agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on December 31, 2015.</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>			

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to promptly notify the resident's family related to a significant change in medication of an Antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Resident #68)</p> <p>Finding includes:</p> <p>The record for Resident #68 was reviewed on 12/17/15 at 11:34 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, Anxiety disorder and dementia without behavioral disturbance.</p> <p>A Physician Order, dated 8/28/15, indicated Haldol (an Antipsychotic medication) 2 milligrams (mg) IM (Intramuscular) every 6 hours prn (as needed) for Anxiety.</p> <p>The Medication Administration Record (MAR) for the month of 8/2015, indicated the Haldol 2 mg IM was administered to the resident on 8/28/15 at 9:18 p.m.</p>	F 0157	<p><b>F157 -</b></p> <ol style="list-style-type: none"> <li>1) It was verified that resident #68's family was aware of the order for Haldol.</li> <li>2) All residents have the potential to be affected by the alleged deficient practice. Residents who had a change of condition in the past 14 days were reviewed to ensure notification had occurred to the family / responsible party.</li> <li>3) Nurse's were in-serviced on the policy for Physician/family notification. Notification/Care plan audit tool will be used in clinical start-up to verify that appropriate notifications have been completed.</li> <li>4) An audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend concerns, then quarterly thereafter. Action Plans will be developed for any identified concern.</li> <li>5) January 21, 2016</li> </ol>	01/21/2016

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	<p>Nursing Progress Notes, dated 8/28/15 at 9:18 p.m., indicated "hitting staff, yelling at staff and other residents, unable to be redirected." The next documented entry in Nurse's Notes was on 8/29/15 at 12:11 a.m., and indicated "Haldol Solution. Inject 2 mg/ml (milliliter) Intramuscularly every 6 hours as needed for Anxiety. Resident in bed resting quietly. PRN Administration was effective."</p> <p>Continued review of Nurse's Notes indicated there was no indication the resident's family was notified of the prn administration of Haldol.</p> <p>The current 11/11/15 Notification of Change in Resident Health Status policy provided by the Director of Nursing on 12/22/15 at 11:10 a.m., indicated "The center will consult the resident's Physician, Nurse Practitioner or Physician assistant, and if known notify the resident's legal representative or an interested family member where there is a need to alter treatment significantly (i.e. need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)."</p> <p>Interview with the Director of Nursing on 12/21/15 at 10:52 a.m., indicated the</p>			

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F 0159 SS=B Bldg. 00	<p>Physician's Order for the Haldol was ordered by the on call Physician covering for the resident's primary Doctor. She further indicated she had spoken to the Nurse who administered the medication and she could not recall if the resident's family was notified of prn Haldol order and the administration of the medication.</p> <p>3.1-5(a)(3)</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and</p>						

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	<p>separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on observation and interview, the facility failed to ensure residents were aware of "banking hours" in the facility. This had the potential to affect the 68 residents who had a current balance in their personal funds account.</p> <p>Finding includes:</p> <p>Interview with Resident #47 on 12/15/15 at 10:34 a.m., indicated she did not have access to the money in her personal funds account on the weekend.</p>	F 0159	<p><b>F159 -</b></p> <p>1) Resident #47 was informed that personal funds were available 24/7.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. A letter will be given to residents who are their own person and to the responsible parties notifying them of the banking hours. Posting of the banking hours will be in the front lobby as a reminder. ED to request an ad hoc Resident Council to ensure residents are aware of the banking hours.</p> <p>4) In-servicing to be provided to</p>	01/21/2016

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F 0160 SS=B Bldg. 00	<p>Interview with the Business Office Manager on 12/22/15 at 10:01 a.m., indicated the facility had no set banking hours and the residents had access to their funds 24 hours a day seven days a week. When asked about the weekend, the Business Office Manager indicated the Weekend Manager had access to the lock box and funds in case a resident would need any money. When asked where the facility banking hours were posted, the Business Office Manager indicated the residents were told on admission how they could get their money as well as in Resident Council Meetings. She was not aware if any hours were posted.</p> <p>Observation of the lobby area on 12/22/15 at 10:20 a.m., indicated there were no posted banking hours nor was there any information posted to inform the residents how they could obtain money from their personal funds account.</p> <p>3.1-6(f)(1)</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility</p>		<p>departmentheads and charge nurse's on the process for obtaining funds 24 / 7. An audit tool will be completed by the Business Office Manager/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, then weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>		

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F 0225 SS=D	<p>must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on record review and interview, the facility failed to ensure upon expiration of 1 of 3 residents reviewed for personal funds, the resident's account was closed out within 30 days of the resident's death. (Resident #58)</p> <p>Finding includes:</p> <p>The Close transaction report for Resident #58 was reviewed on 12/22/15 at 11:10 a.m. The report indicated the resident passed away on 9/11/15. The resident had a personal funds account balance of \$672.89. The resident's personal funds account was not closed out until 10/20/15.</p> <p>Interview with the Business Office Manager at the time, indicated the resident's personal funds account was not closed out within 30 days.</p> <p>3.1-6(h)</p>	F 0160	<p><b>F160 –</b></p> <p><b>1) Resident #58's account is closed.</b></p> <p><b>2) All residents have the potential to be affected by the alleged deficient practice. Review of residents who were discharged over the past 30 days was conducted to verify that accounts were closed within 30 days.</b></p> <p>3) In-Servicing to be completed with BOM/designee to ensure an understanding of this requirement and process for closing out accounts after discharge. An audit tool will be used to ensure that on the <del>expiration</del> discharge of a resident, that the resident account will be closed within 30 days. This audit tool will be completed by the ED /designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>	01/21/2016	
	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT				

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Bldg. 00	<p><b>ALLEGATIONS/INDIVIDUALS</b></p> <p>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 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 record review and interview, the facility failed to ensure an injury of</p>	F 0225	<p><b>F225 -</b></p> <p>1) Resident #4 remains in the living center and is receiving</p>	01/21/2016

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	<p>unknown origin was thoroughly investigated related to a fracture for 1 of 3 residents reviewed for accidents. (Resident #4)</p> <p>Finding includes:</p> <p>The record for Resident #4 was reviewed on 12/18/15 at 9:17 a.m. The resident's diagnoses included but were not limited to, dementia without behavioral disturbance, osteoporosis, major depressive disorder, anxiety disorder, high blood pressure and chronic ischemic heart disease.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, dated 12/8/15, indicated the resident had short and long term memory problems and was moderately impaired for decision making. The resident was an extensive assist for transfers and toilet use with a 2 person physical assist. The resident had 1 fall since the last assessment with no injury,</p> <p>The Nursing Progress Notes, dated 12/3/15 at 7:37 a.m., indicated the Nurse was called to the resident's room by day shift CNA (Certified Nursing Assistant). The CNA indicated she was transferring the resident to the wheelchair for morning care and as the resident started to stand, she yelled out in pain to the</p>		<p>therapy for her injury.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. Review was conducted by the ED of investigations completed in the last 60 days to ensure the investigation was thorough and documentation from interviews with staff were present.</p> <p>3) Directed In-Servicing to be conducted, by the Field Service Clinical Director, with the Department Heads to ensure an understanding of the policy. DNS/designee will then in-service the staff on identifying and reporting allegations of abuse. ED/designee will audit all verification of investigations in daily stand-up meeting. This audit tool will be completed by the ED /designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>				

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	<p>right leg. The resident was assisted back to bed and there was edema noted to the right ankle. The resident was unable to recall what had happened to her ankle. The resident continued to yell out in pain when her right ankle was touched. The resident's Physician was notified and the she was sent to the Emergency Room.</p> <p>The Nursing Progress Notes, dated 12/3/15 at 11:44 a.m., indicated the resident returned from the hospital with no orders. The Nurse called the hospital and was told the resident had a fracture of the right ankle and needed follow up with an orthopedic Physician.</p> <p>The right ankle xray, dated 12/3/15, indicated there was a non displaced fracture of the distal fibula.</p> <p>The incident report form provided by the Administrator was reviewed. The incident, dated 12/3/15, indicated "Called to resident room by AM (morning) CNA, she was transferring this resident to wheelchair for AM care, as resident started to stand, yelled out in pain with right leg, assisted resident back to bed noted edema to right ankle. Resident unable to recall what happened to ankle." The type of injury was a non-displaced fracture of the distal fibula. The type of preventative measures added were, made</p>			

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	<p>NWB (non weight bear) status and wheelchair leg rest were installed. The Follow up, added 12/10/15, indicated CNAS and Nurses that worked on the Alzheimer unit prior to the incident noted nothing unusual: no falls. The writer specifically interviewed the midnight CNA to see if the resident had any complaints of pain or discomfort that night, and there were none. The resident does try to regularly get up out of her wheelchair and bed and was redirected at those times. The resident was seen by ortho and her foot was placed in a cast.</p> <p>Continued review of the incident report indicated there was no further investigation as to how the resident sustained a right ankle fracture. There were no documented interviews from staff related to the investigation. There was no root cause analysis as to how the resident sustained a fracture without any type of injury. There was no written investigation from the resident's Physician related to the fracture and the possible causes.</p> <p>Interview with the Administrator, on 12/18/15 at 2:00 p.m., indicated there was no documentation of a thorough investigation. He further indicated there was no root cause analysis on how the resident sustained a fracture of unknown</p>						

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F 0226 SS=D Bldg. 00	<p>origin. He indicated all of his interviews were verbal and he had nothing in writing. The Administrator indicated there was no Director of Nursing at the time of the incident and therefore his investigation lacked nursing guidance.</p> <p>Interview with the ACU (Alzheimer's Care Unit) Director on 12/21/15 at 9:37 a.m., indicated there were discussions with the Nurse and CNA that had gotten her up the day of the incident. She indicated they had also spoken to the CNA on midnight shift to see if anything had happened. She indicated there was no other investigation regarding the possibility of a resident to resident altercation or any other investigation as to see what the root cause analysis of the fracture was.</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility's</p>	F 0226	F226 - 1) Resident #4remains in the living center and is receiving	01/21/2016			

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	<p>policy was followed for a thorough investigation of an injury of unknown origin related to a fracture for 1 of 3 residents reviewed for accidents. (Resident #4)</p> <p>Finding includes:</p> <p>The record for Resident #4 was reviewed on 12/18/15 at 9:17 a.m. The resident's diagnoses included but were not limited to, dementia without behavioral disturbance, osteoporosis, major depressive disorder, anxiety disorder, high blood pressure, and chronic ischemic heart disease.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, dated 12/8/15, indicated the resident had short and long term memory problems and was moderately impaired for decision making. The resident was an extensive assist for transfers and toilet use with a 2 person physical assist. The resident had 1 fall since the last assessment with no injury,</p> <p>The Nursing Progress Notes, dated 12/3/15 at 7:37 a.m., indicated the Nurse was called to the resident's room by day shift CNA (Certified Nursing Assistant). The CNA indicated she was transferring the resident to the wheelchair for morning care and as the resident started</p>		<p>therapy for her injury.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. Review was conducted by the ED of investigations completed in the last 60 days to ensure the investigation was thorough and documentation from interviews with staff were present.</p> <p>3) Directed In-Servicing to be conducted, by the Field Service Clinical Director, with the Department Heads to ensure an understanding of the policy. DNS/designee will then in-service the staff on identifying and reporting allegations of abuse. ED/designee will audit all verification of investigations in daily stand-up meeting. This audit tool will be completed by the ED/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>		

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	<p>to stand, she yelled out in pain to the right leg. The resident was assisted back to bed and there was edema noted to the right ankle. The resident was unable to recall what had happened to her ankle. The resident continued to yell out in pain when her right ankle was touched. The resident's Physician was notified and the she was sent to the Emergency Room.</p> <p>The Nursing Progress Notes, dated 12/3/15 at 11:44 a.m., indicated the resident returned from the hospital with no orders. The Nurse called the hospital and was told the resident had a fracture of the right ankle and needed follow up with an orthopedic Physician.</p> <p>The right ankle xray, dated 12/3/15, indicated there was a non displaced fracture of the distal fibula.</p> <p>The incident report form provided by the Administrator was reviewed. The incident, dated 12/3/15, indicated "Called to resident room by AM [morning] CNA, she was transferring this resident to wheelchair for AM care, as resident started to stand, yelled out in pain with right leg, assisted resident back to bed noted edema to right ankle. Resident unable to recall what happened to ankle." The type of injury was a non-displaced fracture of the distal fibula. The type of</p>			

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	<p>preventative measures added were, made NWB (non weight bear) status and wheelchair leg rest were installed. The Follow up, added 12/10/15, indicated CNAS and Nurses that worked on the Alzheimer unit prior to the incident noted nothing unusual: no falls, ext. The writer specifically interviewed the midnight CNA to see if the resident had any complaints of pain or discomfort that night, and there were none. The resident does try to regularly get up out of her wheelchair and bed and was redirected at those times. The resident was seen by ortho and her foot was placed in a cast.</p> <p>Continued review of the incident report indicated there was no further investigation as to how the resident sustained a right ankle fracture. There were no documented interviews from staff related to the investigation. There was no root cause analysis as to how the resident sustained a fracture without any type of injury. There was no written investigation from the resident's Physician related to the fracture and the possible causes.</p> <p>Review of the current reporting and investigation of alleged violations of federal and state laws involving mistreatment, neglect, abuse, injuries of unknown source and misappropriation of</p>			

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	<p>resident's property policy, provided by the Administrator on 12/21/15 at 1:30 p.m., indicated "It is the policy of this company to take appropriate steps to prevent steps to prevent the occurrences of abuse, neglect, and injuries of unknown or origin. The ED [Executive Director] or the Director of Nursing [DNS] will direct a thorough investigation of each such alleged violation. An investigation shall be conducted by the ED or DNS or subject matter expert unless there is a conflict of interest they are implicated in the alleged violations. The investigation shall include interviews of employees, visitors, residents, volunteers, and vendors who may have knowledge of the alleged incident. Factual information only should be documented, not assumptions, speculation or conclusions. The documentation of investigation shall be kept in the ED's office in a secure Administrative file."</p> <p>Interview with the Administrator, on 12/18/15 at 2:00 p.m., indicated there was no documentation of a thorough investigation. He further indicated there was no root cause analysis on how the resident sustained a fracture of unknown origin. He indicated all of his interviews were verbal and he had nothing in writing. The Administrator indicated</p>			

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F 0241 SS=D Bldg. 00	<p>there was no Director of Nursing at the time of the incident and therefore his investigation lacked nursing guidance.</p> <p>Interview with the ACU (Alzheimer's Care Unit) Director, on 12/21/15 at 9:37 a.m., indicated there were discussions with the Nurse and CNA that had gotten her up the day of the incident. She indicated they had also spoken to the CNA on midnight shift to see if anything had happened. She indicated there was no other investigation regarding the possibility of a resident to resident altercation or any other investigation as to see what the root cause analysis of the fracture was.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure residents were treated with dignity related to staff standing while assisting a resident to eat a meal for 1 of 1 meals observed and an uncovered urinary catheter bag for 1 of 3 residents reviewed for dignity.</p>	F 0241	<p><b>F241 -</b> 1) Resident #51 had completed dining at the time of notification. DNS immediately spoke with the CNA who had been standing while assisting resident with meal. Resident #75 had his catheter bag covered immediately upon notification. 2) All residents have</p>	01/21/2016
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	<p>(Resident #51 and #75)</p> <p>Findings include:</p> <p>1. During a continuous observation of the breakfast meal, on 12/15/15 from 7:31 a.m. to 7:53 a.m., in the Alzheimer's Care Unit Boutique Dining Room, the following was observed:</p> <p>At 7:31 a.m., Resident #51 was served her breakfast tray. There were three small bowls of food on the tray.</p> <p>At 7:39 a.m., Resident #51 was observed seated in her wheelchair at the table while CNA (Certified Nursing Assistant) #1 was observed assisting the resident with eating while standing to the left side of the resident.</p> <p>At 7:40 a.m., CNA #1 served another resident their breakfast tray and then returned to assisting Resident #51 with eating while standing to the left side of the resident.</p> <p>At 7:43 a.m., CNA #1 left the Boutique Dining Room to assist with passing trays in the Workshop Dining Room across the hall.</p> <p>At 7:45 a.m., CNA #1 returned to assisting Resident #51 with eating while</p>		<p>the potential to be affected by the alleged deficient practice. All residents with catheter bags were checked to ensure all were contained in dignity bags. No other residents were identified. In-service was immediately done with staff on dignity while dining. 3) DNS conducted in-service of staff on resident dignity. Audits will be conducted by observation of staff providing dignity during interactions with residents. This audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>	

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	<p>standing to the left side of the resident where she remained until 7:53 a.m. CNA #1 then asked Resident #51 if she was "all done?" Resident #51 nodded her head yes and CNA #1 removed her tray from the table.</p> <p>Interview with the Director of Nursing (DON) on 12/15/15 at 11:35 a.m. indicated the CNA should have been seated while assisting the resident with her meal.</p> <p>2. The record for Resident #75 was reviewed on 12/21/15 at 9:04 a.m. The resident's diagnoses included, but were not limited to, obstructive and reflux uropathy, urinary retention and chronic kidney disease. The resident had a urinary catheter and a suprapubic urinary catheter.</p> <p>On 12/16/15 at 2:27 p.m., the resident was observed lying in bed. There were two urinary catheter bags observed hanging from the side of the bed. The larger bag was turned around so that no urine was visible. Yellow urine was visible in the smaller urinary catheter bag.</p> <p>On 12/17/15 at 1:40 p.m., the resident was observed lying in bed watching television. There were two urinary</p>			

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F 0242 SS=D Bldg. 00	<p>catheter bags observed hanging from the side of the bed. The larger bag was turned around so that no urine was visible. Yellow urine was visible from the hallway in the smaller urinary catheter bag.</p> <p>On 12/18/15 at 9:05 a.m., the resident was observed lying in bed. The privacy curtain was pulled shut. There were two urinary catheter bags observed hanging from the side of the bed visible just below the level of the privacy curtain. The larger bag was turned around so that no urine was visible. Yellow urine was visible from the hallway in the smaller urinary catheter bag.</p> <p>Interview with the DON on 12/18/15 at 2:30 p.m. indicated the urinary catheter bag should have been covered with a dignity bag.</p> <p>3.1-3(t)</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</p>			

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	<p>that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents individual preferences were followed, related to not giving the residents a choice of the amount of bathing they would prefer, for 3 of 3 residents reviewed for choices. (Residents #7, #35 and #41)</p> <p>Findings include:</p> <p>1. During an interview on 12/15/15 at 11:17 a.m., Resident #7 indicated his preference was twice a week, on Tuesdays and Saturdays, but was only received one shower a week at times.</p> <p>Resident #7's record was reviewed on 12/17/15 at 3:21 p.m. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure) and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>Review of the resident's care plan, dated 3/4/10, indicated the resident was known to refused care at times and an intervention would have been if the resident refused care, to re-attempt at a later time or with an alternate caregiver.</p> <p>Another care plan, dated 10/1/14, reviewed for Resident #7, indicated the</p>	F 0242	<p><b>F242 -</b></p> <p>1) Social Service Director reviewed showerpreference sheets with residents #7, #35, and #41 andtheir stated preferences were added to the shower lists</p> <p>2) All residents have the potential to beaffected by the alleged deficient practice. SSD completed aninterview with each resident / responsible party to determine what theirpreferences were and then added these to the shower lists</p> <p>3) Nursing staff was in-serviced on showerpreference sheets and notifying SSD if resident states a desired change totheir preferences.Audit tool to becompleted by the SSD/designee, to verify showers were given per theirpreferences, 5 times per week for 4weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for12 weeks. 4) Audit toolwill be reviewed monthly for 6 months in facility QAPI meeting to track andtrend for concerns. Finding no patterns,it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016</p>	01/21/2016			

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	<p>resident voiced his shower preferences and the intervention would have been to offer bed baths/showers as scheduled and to notify my family if bed baths were declined as scheduled.</p> <p>Review of the "Preference Worksheet," dated 4/21/15, indicated a preference of a bed bath, twice a week around 3 p.m.</p> <p>Review of the resident's "Shower Sheets" and "Resident Bathing Type weekly report," indicated the resident received the following:                      week of 11/1/15: 1 full bed bath                      week of 11/8/15: no full bed baths                      week of 11/15/15: the resident refused twice for bathing, the bathing sheets did not indicated the resident was re-approached at a later time to be bathed, nor indicated the family was notified,                      week of 11/22/15: no full bed baths                      week of 11/29/15: no full bed baths, only 1 shower                      week of 12/6/15: no full bed baths and 1 time refusing a bath, the bathing sheets did not indicate the resident was re-approached at a later time to be bathed.</p> <p>During an interview on 12/21/15 at 11:34 a.m., CNA (Certified Nursing Assistant) #3 indicated the resident should receive 2</p>			

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	<p>full bed baths, 2 times a week. If the resident refuses, it is to be written on the shower sheets.</p> <p>During an interview on 12/21/15 at 11:34 a.m., the DON (Director of Nursing) indicated the full bed baths should have been completed 2 times a week and if the resident refused, it should have been documented on the shower sheets and the nurse notified of refusal. The nurse should have tried to re-approach the resident at a later time and with a different person.</p> <p>2. During an interview on 12/15/15 at 10:54 a.m., Resident #35 indicated he preferred a shower 2 times a week and only received a 1 time a week.</p> <p>Resident #35's record was reviewed on 12/17/15 at 3:33 p.m. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure), diabetes mellitus and depression.</p> <p>Review of the resident's care plan, dated 1/21/14, for shower preferences, indicated to offer shower as scheduled.</p> <p>Review of the "Preference Worksheet," dated 1/21/15, indicated a preference of a shower 2 times a week.</p>			

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	<p>Review of the resident's "Shower Sheets" and "Resident Bathing Type weekly report," indicated the resident received the following:</p> <p>week of 12/6/15: 1 shower week of 12/13/15: 1 shower</p> <p>Interview with CNA #3 on 12/20/15 at 10:06 a.m., indicated the resident usually received 2 showers a week. If a resident refused a shower, it would have been written as "refused" on the shower sheet.</p> <p>Interview with the DON on 12/21/15 at 11:23 a.m., indicated the resident should have received 2 showers a week, per his preference and if the resident refused care, it should have been documented on the shower sheet as such.</p> <p>3. During an interview on 12/15/15 at 9:03 a.m., Resident #41 indicated he preferred 3 showers a week, but only received 2 showers a week.</p> <p>Resident #41's record was reviewed on 12/20/15 at 9:07 a.m. The resident's diagnoses included, but were not limited to, aphasia (unable to speak), hypertension (high blood pressure), depression and epilepsy (seizures).</p> <p>Review of the resident's care plan, dated 4/16/15, for shower preferences,</p>			

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	<p>indicated to offer shower as scheduled.</p> <p>Review of the "Preference Worksheet," dated 5/4/15, indicated the resident preferred 4 showers a week in the morning.</p> <p>Review of the resident's "Shower Sheets" and "Resident Bathing Type weekly report," indicated the resident received the following:                      week of 11/1/15: 1 shower                      week of 11/8/15: 2 showers                      week of 11/15/15: 2 showers                      week of 11/22/15: 2 showers                      week of 11/29/15: 1 shower                      week of 12/6/15: 1 shower</p> <p>Interview with CNA #3 on 12/20/15 at 10:07 a.m., indicated the resident was to have received 3 showers a week and if he refused, it should be documented on the shower sheet as a refusal.</p> <p>Interview with the DON on 12/21/15 at 11:27 a.m., indicated the resident should have received the 4 showers a week as per his preference. If the resident refused a shower, it should have been documented on the shower sheet and the nurse should have been notified.</p> <p>3.1-3(u)(1)</p>			

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F 0247 SS=D Bldg. 00	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure documentation was completed prior to a room or roommate change for 2 of 3 residents reviewed for admission/transfer/discharge of the 19 residents who met the criteria for admission/transfer/discharge. (Residents #35 and #75)</p> <p>Findings include:</p> <p>1. Interview with Resident #35 on 12/15/15 at 10:59 a.m., indicated that he had a roommate change in the last nine months. The resident indicated he was not given notice of the roommate change.</p> <p>The record for Resident #35 was reviewed on 12/21/15 at 9:52 a.m. The resident received a roommate on 10/20/15. Documentation in the Nursing progress notes on 10/20/15 indicated the resident was introduced to his roommate. There was no documentation to indicate</p>	F 0247	<p><b>F247</b> - 1) Residents #35 and#75 have voiced no concerns with current rooms. 2) All residents have the potential to be affected by the alleged deficient practice. Residents who were receiving a roommate had notification documented in the medical record. 3) In-services with staff completed by DNS/designee on documenting resident of a room change /room mate. Social Service Director/designee will complete an audit tool to ensure that residents receive proper notification about changes in roommates and that it is documented in the medical record that resident was notified. These changes are discussed and decided in facility daily stand-up meeting and that proper notification is documented. An audit will be performed by the Social Service Director/designee. Audit tool to be completed by the SSD/designee, 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit tool will be</p>	01/21/2016

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	<p>the resident was notified before hand.</p> <p>Interview with the Social Service Director on 12/22/15 at 9:18 a.m., indicated documentation was not completed prior to the resident receiving a new roommate.</p> <p>2. Interview with Resident #75 on 12/16/15 at 2:19 p.m., indicated that he had changed rooms and had received a new roommate within the last 9 months.</p> <p>The record for Resident #75 was reviewed on 12/21/15 at 10:03 a.m. Documentation in the Nursing progress notes on 8/5/15 at 5:15 a.m., indicated the resident was tolerating his room change without difficulty. There was no documentation related to the resident being notified of a room change.</p> <p>The resident received a roommate on 10/1/15. There was no documentation related to the resident receiving a roommate.</p> <p>Interview with the Social Service Director on 12/21/15 at 1:45 p.m., indicated the resident was placed in isolation and that was why the resident was moved to a private room. She indicated there was no documentation to inform the resident he was being moved</p>				<p>reviewed monthly for 6 months in facility QAPI meeting to track and trendfor concerns. Finding no patterns, itwill then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016</p>		

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F 0250 SS=D Bldg. 00	<p>back to his previous room.</p> <p>Interview with the Social Service Director on 12/22/15 at 9:18 a.m., indicated there was no additional documentation to indicate if the resident had been notified of the room and/or roommate changes.</p> <p>3.1-3(v)(2)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to provide follow up for a dental visit related to ill fitting dentures for 1 of 1 residents reviewed for dental status. (Resident #5)</p> <p>Finding includes:</p> <p>On 12/15/15 at 9:33 a.m. Resident #5 was observed seated in her wheelchair in her room. Her top dentures were not in place and were observed sitting next to her on top of her bed.</p>	F 0250	<b>F250</b> 1) Resident #5 will see Dentist on 01/20/16 for denture fitting. 2) All residents have the potential to be affected by the alleged deficient practice. SSD completed areview of residents with dentures to ensure no one else had ill fittingdentures. 3) An audit toolwill be completed with regards to dental services and follow up by the SocialService Director/designee 5 times per week for 4 weeks, then 3x per week times4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit toolwill be reviewed monthly for 6 months in	01/21/2016

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	<p>On 12/16/15 at 11:00 a.m. Resident #5 was observed seated in her wheelchair in her room. Her top dentures were not in place.</p> <p>During an interview with Resident #5, on 12/16/15 at 11:08 a.m., she indicated she had both top and bottom dentures and they didn't fit. She indicated she had tried to get the dentist to help but they told her she had to "get used to them (dentures)."</p> <p>Resident #5's record was reviewed on 12/17/15 at 1:50 p.m. The resident's diagnoses included, but were not limited to, hypertension, polyarthritis, and hyperlipidemia.</p> <p>The 10/22/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and did not have a loosely fitting full or partial denture.</p> <p>A Social Service Progress Note, dated 9/1/15, indicated the Social Service Director had called the dentist to inquire about the resident's new dentures which were currently being made. The note indicated the dentures were to be delivered to the resident on 9/11/15.</p> <p>Dental visit notes, dated 9/11/15,</p>		<p>facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016</p>	

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F 0279 SS=D Bldg. 00	<p>indicated the resident had received her upper complete and lower partial dentures. The notes indicated the resident was instructed to notify staff if any soreness developed.</p> <p>Interview with the Social Service Director on 12/21/15 at 2:08 p.m., indicated the resident's son had requested the resident be seen by the dentist a few weeks ago just to check to make sure everything was alright with her dentures and she had notified the dental service. She further indicated the dentist had been to the facility the first Friday of this month and had not seen the resident that day. She indicated she was not in the facility the day the dentist was there and was unsure why the resident had not been seen but she would follow up with the dental service.</p> <p>3.1-34(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are</p>			

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	<p>identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop resident care plans related to pressure ulcers for 1 of 5 residents reviewed for pressure ulcers. (Residents #57)</p> <p>Finding includes:</p> <p>The record for Resident #57 was reviewed on 12/17/15 at 10:44 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, hypertension, and diabetes mellitus.</p> <p>The resident was admitted to the facility on 10/31/15, and was discharged to the hospital on 12/16/15.</p> <p>The 11/7/15 Admission Minimum Data Set (MDS) assessment indicated the resident was at risk for pressure ulcers and had 1 unstageable pressure ulcer present on admission due to a non removable dressing or device.</p>	F 0279	<p><b>F279 -</b></p> <p>1) Resident #57 was discharged from the facility prior to the survey 2) All residents have the potential to be affected by the alleged deficient practice. Residents having pressure ulcers are at risk for pressure had their care plans reviewed and changes were made as necessary. 3) Nurse's were in-serviced on initiating care plans when receiving new orders and updating them as indicated. Care plan audit tool will be used in clinical start-up to verify that care plans have been completed / modified for residents with or at risk for pressure ulcers. Audit tool will be completed with regards to dental services and follow up by the Social Service Director/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be</p>	01/21/2016

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	<p>The 11/17/15 MDS assessment Care Area Assessment (CAA) for pressure ulcer was triggered. The CAA indicated the resident had a blister on his right heel and multiple wound areas to his left buttocks, coccyx, and left hip. The care plan decision was marked "yes."</p> <p>A Physician's Order, dated 11/8/15, indicated treatment orders to a left hip pressure ulcer and a coccyx pressure area daily.</p> <p>Review of the November 2015 Treatment Administration Record (TAR) indicated the daily treatments to the left hip and coccyx were started on 11/8/15 on the night shift.</p> <p>A Progress Note, dated 11/18/15 at 1:58 a.m., indicated "...Treat [treatment] to coccyx [sic] changed and L [left] hip. Coccyx is 75-80% cover in slough. Surround [surrounding] tissue is pink. Has mod [moderate] amount of serousanguinous [sic] drainage...L [left] hip is 100% eschar. Surround tissue is pink. No drainage noted...."</p> <p>Review of the resident's care plans indicated there was a lack of a care plan for risk for pressure ulcers or pressure ulcers.</p>		<p>reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016</p>	

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F 0282 SS=E Bldg. 00	<p>There was no indication in the record that any pressure ulcer care plan had been implemented prior to 12/21/15.</p> <p>During an interview on 12/18/15 at 1:27 p.m., the Director of Nursing indicated the resident should have had a care plan for pressure ulcers.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders were followed for fall interventions and lab test (Resident #21 and #71), the plan of care was followed for fall interventions (Resident #21) and wound assessments (Resident #48, Resident #28). This deficient practice affected 1 of 2 reviewed for accidents, 2 of 3 reviewed for pressure ulcers and 1 of 5 reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>1. The record for Resident #48 was</p>	F 0282	<p><b>F282 -</b></p> <p>1) Resident #48's wound evaluation flowsheet has been updated. Resident #21's dycem is inplace in her W/C. Weekly wound assessments are now back in place for Resident#28. Resident #71's urine had been collected and UTI treated accordingly.</p> <p>2) All residents have the potential to be affected by the alleged deficient practices. All residents with wounds were checked for completed wound evaluation sheets and wound assessments. Any discrepancies were corrected at that time. GuardianAngels took</p>	01/21/2016

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	<p>reviewed on 12/18/15 at 1:15 p.m. An entry in the Nursing progress notes, dated 8/11/15 at 10:45 a.m., indicated the resident had an 0.5 centimeter (cm) x 0.5 cm round open area to her right gluteal fold. The resident's Physician was notified and orders were received for derma gel to the right gluteal fold, cleanse area every 3 days and as needed for soiling.</p> <p>A Wound evaluation flow sheet, completed on 8/11/15, indicated the resident had a Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) pressure area that measured 0.5 cm x 0.5 cm x less than 0.1 cm deep. There was no documentation to indicate where the wound was located. There were no further wound measurements after 8/11/15.</p> <p>The plan of care, dated 2/8/15, indicated the resident had an actual pressure ulcer or was at risk due to assistance required in bed mobility. The interventions included, but were not limited to, conduct weekly skin inspection.</p> <p>Interview with the Director of Nursing (DON), on 12/22/15 at 9:15 a.m.,</p>		<p>the CNA assignment sheets and reviewed their resident rooms to make certain that interventions were in place. Residents with current orders for UAs were checked for timeliness and addressed as needed.</p> <p>3) Nurse's were in-serviced on following doctors' orders and care plans, and implementation of care plan interventions.</p> <p>DNS/designee will use an audit tool to monitor that physician orders are followed and that care plan interventions are in place. An audit tool will also be used to randomly check that specific fall intervention orders are being followed 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>		

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	<p>indicated there were no weekly measurements for the area on the resident's right gluteal fold.</p> <p>2. On 12/15/15 at 7:59 a.m., Resident #21 was observed self propelling her wheelchair down the hallway toward the Main Dining Room.</p> <p>Resident #21's record was reviewed on 12/18/15 at 9:46 a.m. The resident's diagnoses included, but were not limited to, disorder of the kidney and ureter, diabetes mellitus and hypertension.</p> <p>A Physician's Order, dated 11/22/15, indicated an order for "...dysom [sic] (dycem - a non skid material) to w/c (wheelchair) check placement q (every) shift...."</p> <p>Review of the November 2015 Treatment Administration Record (TAR), indicated the dysom (sic) was in signed off as in place on 11/28/15 day shift, evening shift and night shift.</p> <p>A Progress Note, dated 11/29/15, indicated the resident had slid out of her wheelchair onto the floor. The note further indicated the resident's dycem was not in her wheelchair at the time of the fall, the Physician was notified, and a dycem was placed in her wheelchair.</p>			

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	<p>A Fall Investigation, dated 11/28/15, indicated the resident had slid out of her wheelchair on 11/28/15 at 5:15 p.m. The contributing factor to the fall was "...dycem was not present to wheelchair and resident did not use call light..."</p> <p>Interview with the DON on 12/18/15 at 1:27 p.m. indicated the dycem should have been in place to the resident's wheelchair as ordered. She further indicated staff had placed a dycem back in the resident's wheelchair after the fall.</p> <p>3. During Resident #28's wound care treatment, on 12/2/15 at 1:12 p.m., with LPN #3, the wounds were observed: *the left heel: measured 1 X 1 x 0.4 cm (centimeters), oblong in shape, pale white in the center of the wound, no pink noted, and the wound edges were white and dry. *the right heel: measured 4 X 3.5 X 0.2 cm, white/yellow tissue in the center of the wound and at the edges.</p> <p>Resident #28's record was reviewed on 12/17/15 at 11:21 a.m. The resident was admitted to the facility on 8/28/15. The resident diagnoses included, but were not limited to fracture of femur, chronic renal (kidney) disease, hypertension (high blood pressure), irregular heart rhythm and blood clots of the lower legs.</p>			

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	<p>Review of the Quarterly MDS (Minimum Data Set) assessment, dated 12/4/15, indicated the resident was at risk for pressure ulcers.</p> <p>Review of the resident's pressure ulcer care plan, dated 9/21/15, indicated weekly wound assessments.</p> <p>Review of the weekly wound assessments, indicated the resident's wounds were only assessed on 9/20/15, the initial assessment and not again until 12/11/5.</p> <p>Review of the Nurse Notes from 9/20/15 through 11/12/15, lacked assessments of the wounds.</p> <p>Interview with the DON (Director of Nursing) on 12/21/15 at 4:24 p.m., indicated the resident's record lacked weekly wound assessments.</p> <p>4. Resident #71's record was reviewed on 12/21/15 at 12:54 p.m. The resident was re-admitted into the facility on 10/20/15. The resident's diagnoses included, but were not limited to, diabetes mellitus, anemia and depression.</p> <p>Review of the resident's care plan for alteration in elimination of bowel and</p>			

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	<p>bladder dated 1/30/15, indicated an intervention was lab/tests as ordered.</p> <p>The Physician's Order, dated 10/20/15, indicated may change Foley catheter, 16 French (size of indwelling catheter), 10 cc (cubic centimeter) (size of the balloon to anchor the indwelling catheter) as needed for leakage, occlusion, dislodgement or malfunction.</p> <p>The Physician's order, dated 10/30/15, indicated to obtain a urinalysis with culture and sensitivity if needed.</p> <p>Review of the Nurse notes indicated the following:                      *10/30/15 at 11:57 a.m., new orders for labs, urinalysis and X-ray.                      *10/30/15 at 14:43 (2:43 p.m.), unable to obtain urine at this time.                      *10/30/15 at 21:25 (9:25 p.m.), unable to obtain urine this shift, urine is dark yellow, Foley catheter is in place and patent.                      *10/31/15 at 04:25 (4:25 a.m.), CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel) (blood work labs), KUB (kidneys, ureters and bladder xray) and urinalysis need to to get in am.                      *11/2/15 at 22:23 (10:23 p.m.), UA (urinalysis) order continues and need to be obtained at this time, urine is dark and</p>			

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F 0309 SS=G Bldg. 00	<p>Foley catheter is in place. *11/3/15 at 06:45 (6:45 a.m.), Urine sample obtained this a.m.</p> <p>The resident's UA results, dated 11/3/15, indicated positive nitrates (a urinary tract infection).</p> <p>The culture and sensitivity results, dated 11/5/15, indicated gram negative rods (bacteria).</p> <p>Interview with the DON (Director of Nursing) on 12/22/15 at 11:08 a.m., indicated there was no reason to why the urine was not collected in a timely manner and further indicated there was not a policy on Physician's Orders.</p> <p>3.1-3(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to ensure the</p>	F 0309	F309 - 1) Resident #68has interventions	01/21/2016	

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	<p>necessary treatment and services were attained to maintain a resident's psychosocial well being related to the administration of an as needed Antipsychotic medication without indications for use or interventions tried first which resulted in a decrease in appetite, a decrease in physical functioning and a fall for 1 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure pain medication was administered on time for a resident who was displaying signs and symptoms of severe pain related to moaning and crying for 1 of 1 residents reviewed for pain and the facility failed to ensure a resident who received dialysis was assessed and monitored for 1 of 1 residents reviewed for dialysis. (Residents #57, #68, &amp;, #112)</p> <p>Findings include:</p> <p>1. On 12/17/15 at 11:16 a.m., Resident #68 was observed in bed. At that time her eyes were closed. The resident was not displaying any behaviors at that time.</p> <p>The record for Resident #68 was reviewed on 12/17/15 at 11:34 a.m. The resident's diagnoses included, but not limited to, Alzheimer's disease, Anxiety disorder and dementia without behavioral disturbance.</p>		<p>in place to be tried before administering PRN medications for anxiety. Resident #112's pain is being monitored and addressed accordingly. Resident #57 was discharged from the facility prior to the survey</p> <p>2) All residents have the potential to be affected by the alleged deficient practices. There are currently no other residents receiving dialysis. Residents currently receiving antipsychotic PRNs have been reviewed for non-pharmacological interventions.</p> <p>3) In-service for nurses on interventions to be tried before passing PRN medications, proper documentation that is required for dialysis patients, and timely assessment of pain and giving appropriate medications to relieve the resident's pain. An audit tool will be completed by the social service director/designee to check that proper interventions are in place before nursing passes PRN medications. An audit tool will be completed by the DNS/designee to verify that nurses are documenting dialysis residents. An audit tool will be completed documenting appropriate timing of responding to resident complaints of pain, and the appropriate administration of pain medication. Audits will be conducted for all 5 times per week for 4 weeks, then 3x per</p>	

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	<p>The Significant Change Minimum Data Set (MDS) assessment, dated 9/18/15, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0, indicating she was not alert and oriented and was severely impaired for decision making. The resident displayed physical behavioral symptoms 4 to 6 days during the assessment reference period and some type of verbal behavioral symptoms occurred daily. The behaviors did not interrupt with resident care, however, the resident's behaviors had worsened since the last assessment. The resident needed supervision with one person physical assist with transfers, dressing, eating, toilet use and personal hygiene.</p> <p>The Physician Orders, dated 11/25/15 and on the current 12/2015 recap (recapitulation of medication orders), indicated Seroquel (an Antipsychotic medication) 12.5 milligrams (mg) three times a day. Another Physician Order, dated 9/10/15 and on the current 12/2015 recap, of Lorazepam (an Antianxiety medication) 0.25 mg three times a day. An Physician Order, dated 8/5/15 and on the 12/2015 recap, of Buspar (an Antianxiety medication) 10 mg three times a day.</p>				<p>week times4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>		

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	<p>Nursing Progress Notes, dated 8/27/15 at 7:41 a.m., indicated the Nurse was called to the resident's room by staff. The resident was on the floor outside of her bathroom laying on her back. The resident was slow to response, had difficulty talking with slurred speech. The resident resident's skin was cool and clammy and her clothes were wet to touch. Her skin color was pale. The resident refused to stay on the floor, so she was assisted back to bed with staff assist. The resident's Physician was notified and orders were obtained to send her to the hospital.</p> <p>Nursing Progress Notes, dated 8/28/15 at 7:03 p.m., indicated the resident had just returned from the hospital. The resident's family was at the bedside. The resident was alert and combative and was unable to redirect.</p> <p>Nursing Progress Notes, dated 8/28/15 at 9:18 p.m., indicated "Hitting staff, yelling at staff and other residents, unable to be redirected." The next documented entry in Nurse's Notes was on 8/29/15 at 12:11 a.m., indicated "Haldol Solution. [an Antipsychotic medication] Inject 2 mg/ml [milliliter] Intramuscularly every 6 hours as needed for Anxiety. Resident in bed resting quietly. PRN Administration was effective."</p>			

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	<p>A Physician Order, dated 8/28/15, indicated Haldol 2 milligrams (mg) IM (Intramuscular) every 6 hours prn (as needed) for Anxiety.</p> <p>A Physician Order, dated 8/29/15 and on the current 12/2015 Physician recap, indicated Lorazepam (an Antianxiety medication) 0.25 mg every 8 hours prn Anxiety.</p> <p>Nursing Progress Notes, dated 8/30/15 at 2:28 p.m., indicated the resident was sleeping most of this shift. Her meals were brought to her in the room with staff assisting with eating. The resident's appetite was poor and fluids were encouraged. Resident refused at times. The family was there to visit at lunch and they were unable to get the resident to eat. Snacks were offered and resident refused.</p> <p>The next documented entry in Nurse's Notes was on 8/30/15 at 7:09 p.m., which indicated the resident was noted to be weak and remained in bed most of the shift. The resident was encouraged to drink fluids and ate minimal for dinner, stating she wasn't hungry. Resident was offered snacks throughout shift.</p> <p>An entry in Nurse's Notes on 8/31/15 at</p>			

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	<p>2:52 a.m., indicated the resident was noted to have increased weakness.</p> <p>Nursing Progress Notes, dated 8/31/15 at 10:49 a.m., indicated "Ativan tablet. Give 0.25 mg by mouth every 8 hours as needed for Anxiety. Toileted, redirected, and given breakfast, continues to show anxiety."</p> <p>Nurse's Notes, dated 8/31/15 at 11:00 a.m., indicated resident continues with being agitated, yelling at Doctor and staff. The prn Ativan was given. Resident shows signs and symptoms of weakness with unsteady gait, stand by assist needed thus far.</p> <p>Nurse's Notes, dated 8/31/15 at 9:06 p.m., resident continues to be unsteady with gait stand by assist needed. The resident had poor safety awareness.</p> <p>The resident's food consumption log was reviewed. The resident's food consumption were not coded on 8/28, 8/29, and 8/30/15. The resident was coded as consuming 50% of breakfast, 25% of lunch and nothing for dinner on 8/31/15.</p> <p>Nurse's Notes, dated 9/1/15 at 12:14 p.m., indicated the resident had slid off the bed to the floor. The CNA was in the</p>			

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	<p>doorway and witnessed the fall, but could not get to the resident in time. Resident was confused, weak, pale with clammy skin. The resident indicated she was not feeling good and stated, "I am going to die. I am sick." The resident's Physician was notified.</p> <p>Nursing Progress Notes, dated 9/1/15 at 5:28 p.m., indicated "Increased anxiety." The next documented entry in Nurse's Notes was on 9/1/15 at 7:00 p.m., which indicated "PRN Administration was effective."</p> <p>Nursing Progress Notes, dated 9/3/15 at 4:27 p.m., indicated "increased anxiety." The next documented entry in Nurse's Notes was on 9/3/15 at 6:49 p.m., which indicated "PRN Administration was effective."</p> <p>Nursing Progress Notes, dated 9/6/15 at 3:53 p.m., indicated "give 0.25 mg Ativan tablet by mouth every 8 hours as needed for anxiety. Resident was administered med for increased anxiety." The next documented entry in Nurse's Notes was on 9/6/15 at 4:47 p.m., indicated "PRN Administered was effective."</p> <p>The Medication Administration Record (MAR) for the month of 8/2015,</p>			

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	<p>indicated the Haldol 2 mg IM was administered to the resident on 8/28/15 at 9:18 p.m. The 9/2015 MAR was reviewed. The resident was administered Ativan 0.25 mg on 9/1/15 at 5:28 p.m., 9/3/15 at 4:27 p.m., and on 9/6/15 at 3:53 p.m.</p> <p>The Behavior Monthly Flow Sheet, dated 8/2015, indicated the resident was being monitored for agitation, hallucinations/paranoia/delusions, and striking out/hitting. There were no documented behaviors on 8/28, 8/29 and 8/30/15.</p> <p>The Behavior Monthly Flow Sheet, dated 9/2015, indicated the resident was being monitored for agitation, hallucinations/paranoia/delusions, and striking out/hitting. There were no documented behaviors on 9/1, 9/3 and 9/6/15.</p> <p>The current plan of care, updated 12/21/15 with an original date of 7/6/12, indicated the resident displays anxiousness, worries and had repetitive verbalizations and negative statements about death. The resident had short term memory loss and dementia. The Nursing approaches were to redirect resident to an activity of her choice such as reading her religious materials, socializing in small</p>			

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	<p>groups, or going outside to the garden and allow the resident to express her feelings and reassure resident through conversation.</p> <p>Interview with the Director of Nursing (DON) on 2/21/15 at 10:52:53 a.m., indicated the order for the Haldol was obtained from the on call Physician covering for the resident's primary Doctor. She indicated there were no interventions tried first before giving the prn (as needed) Haldol or Ativan.</p> <p>2. On 12/21/15 at 8:40 a.m., Resident #112 was overheard from another room crying and moaning a loud. At that time, the Admissions Coordinator indicated to the resident that she would tell someone about her pain the crying and was observed to walk out of the resident's room.</p> <p>On 12/21/15 at 9:03 a.m., the resident was observed in bed crying. Interview with the resident at that time, indicated she had asked for something for pain a while ago and told some staff member, but she had not come back to give her anything. The resident continued to cry and indicated her legs were so swollen and she was in so much pain.</p> <p>Interview with LPN (Licensed Practical</p>			

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	<p>Nurse) #1 on 12/21/15 at 9:10 a.m., indicated she was the nurse taking care of the resident. She further indicated the resident cries all the time and that was nothing new for her. LPN #1 indicated she had not administered the resident any of her pain medications or her routine medications as of yet. When asked if anyone had informed her the resident was crying and in pain, she indicated the Admission Coordinator had informed her another resident was in pain and needed pain medication but did not remember if she had informed her Resident #112 needed pain medication.</p> <p>Interview with the Admission Coordinator on 12/21/15 at 9:12 a.m., indicated the resident had told her she was having pain and she did inform LPN #1 at that time. She further indicated there were two residents who were in pain, and she did inform the nurse.</p> <p>Continued observation on 12/21/15 at 9:17 a.m.(37 minutes later), indicated the resident's medications including the pain medication were administered by LPN #1.</p> <p>Interview with Resident #112 on 12/21/15 at 10:11 a.m. indicated she was comfortable and the pain had subsided. The resident indicated she had no new</p>			

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	<p>complaints of pain at that time.</p> <p>The record for Resident #112 was reviewed on 12/21/15 at 10:12 a.m. The resident was newly admitted to facility on 12/3/15 from the hospital. The resident's diagnoses included, but were not limited to, malignant neoplasm (cancer) of the rectum, subacute osteomyelitis, bipolar disorder, major depressive disorder, and open wound to anus.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 12/10/15, indicated the Brief Interview for Mental Status (BIMS) score was 14, cognitively intact. The resident was interviewed for mood status and indicated she feels down and depressed or hopeless 2-6 days, had trouble falling asleep or staying asleep 7-11 days, feels tired 7-11 days, had poor appetite 7-11 days, feels bad about herself 7-11 days, and had trouble concentrating on things such as reading the paper 7-11 days. The resident needed physical help with extensive assist and 2 person physical assist for bed mobility and toilet use. The resident needed extensive assist with one person physical assist with dressing and personal hygiene. The resident was interviewed for pain. The resident had scheduled pain meds and prn (as needed) pain medication. The resident indicated she had been</p>			
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	<p>hurting in the last 5 days, she frequently experienced pain in the last 5 days, had limited the day to day activities over the last 5 days due to pain, and her pain rating score was an 8 (A score of 0 was no pain and a score of 10 was the worst pain you can imagine).</p> <p>The current care plan, dated 12/7/15, indicated "Needs pain management and monitoring related to cancer wound and surgical procedure." The Nursing approaches were to administer pain medication as ordered, evaluate need to provide medication prior to treatment or therapy, evaluate what makes the patient's pain worse and repositioning.</p> <p>Physician Orders, dated 12/16/15, indicated Dilaudid (a pain medication) 2 milligrams (mg) every 3 hours prn pain. A Physician Order, dated 12/16/15, indicated Dilaudid 2 mg every 4 hours while awake scheduled 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Another Physician Order, dated 12/16/15, indicated Oramorph (a pain medication) 30 mg twice a day, scheduled at 9:00 a.m. and 5:00 p.m.</p> <p>The Medication Administration Record (MAR) for the month of 12/2015, indicated the Dilaudid 2 mg every 3 hours prn pain was last administered on</p>			

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	<p>12/16/15 at 11:30 a.m. The resident's pain intensity was assessed at level of 10.</p> <p>The 12/3/15 Clinical health status assessment indicated the resident's pain rating score was a 10. The location of the pain was the resident's sacral/coccyx area that was characterized as being sharp, burning, constant and radiating. The resident's level of pain had impacted the quality of life functioning for the resident.</p> <p>Nursing Progress notes, dated 12/3/15 through 12/21/15, indicated there was no documentation of the resident's pain being a behavior problem.</p> <p>The current 2/9/15 Pain Assessment and Management policy provided by the Director of Nursing on 12/22/15 at 11:10 a.m., indicated it was the facility's policy to promptly assess resident pain levels and provide relief of symptoms whenever feasible, using a resident centered and interdisciplinary approach.</p> <p>Interview with the DON on 12/21/15 at 2:30 p.m., indicated she was aware of the resident's severe pain and they had just increased her pain medication recently, however, she indicated the nurse should have administered her medication timely and assessed the resident for pain at the</p>			

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	<p>time of her complaints of pain to ensure the dosage of the medication was adequate.</p> <p>3. The record for Resident #57 was reviewed on 12/17/15 at 10:44 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, hypertension and diabetes mellitus.</p> <p>The resident was admitted to the facility on 10/31/15, and was discharged to the hospital on 12/16/15.</p> <p>The 11/7/15 Admission Minimum Data Set (MDS) assessment indicated the resident received dialysis services.</p> <p>A Clinical Health Status Admission Assessment was completed on 10/31/15. The skin conditions section of the assessment indicated the resident had a dialysis catheter to his right chest.</p> <p>The December 2015 Physician's Order Summary (POS) indicated an order for dialysis every Monday, Wednesday, and Friday. The POS indicated an order to assess for signs/symptoms of infection at the right chest dialysis catheter site every shift.</p> <p>Review of the November 2015 Treatment Administration Record (TAR) indicated</p>			

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	<p>vital signs (weight, blood pressure, temperature, pulse, respirations, and oxygen saturation) were to be recorded on Mondays, Wednesdays and Fridays. The TAR lacked documentation the vital signs were obtained on 11/2/15, 11/4/15, 11/6/15, 11/9/15, 11/16/15, 11/18/15, 11/20/15, 11/23/15, 11/25/15, 11/27/15, and 11/30/15. The TAR lacked documentation the dialysis catheter site had been assessed on 11/8/15 day shift, 11/13/15 evening shift, 11/15/15 evening shift, 11/18/15 day shift, 11/19/15 evening shift, 11/20/15 day and evening shift, 11/25/15 day and evening shift, 11/26/15 day and evening shift, 11/27/15 evening shift and 11/29/15 evening shift.</p> <p>Review of the December 2015 TAR indicated vital signs (weight, blood pressure, temperature, pulse, respirations, and oxygen saturation) were to be recorded on Mondays, Wednesdays and Fridays. The TAR lacked documentation the vital signs were obtained on 12/2/15, 12/9/15, 12/11/15, and 12/14/15. The TAR lacked documentation the dialysis catheter site had been assessed on 12/4/15 evening shift, 12/7/15 evening shift, 12/8/15 day shift, 12/9/15 night shift, 12/11/15 day shift, 12/14/15 evening shift, and 12/16/15 night shift.</p> <p>The resident had a care plan for alteration</p>			

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F 0311 SS=D	<p>in kidney function evidenced by hemodialysis. The nursing interventions included "...check access site daily fistula/graft/catheter-signs of infection...observe for post dialysis hang over-vital signs, mental status, excessive weight gain between treatments, nausea, vomiting, weakness, headache, severe leg cramps...."</p> <p>Interview with the DON on 12/18/15 at 1:27 p.m. indicated staff should have documented the vital signs on the TAR and she was not sure why they had not. She further indicated the dialysis access site should have been checked every shift and documented on the TAR.</p> <p>A facility policy, titled Dialysis Guideline, dated 10/5/15, and received from the DON as current on 12/18/15 at 2:30 p.m., indicated "...Post Dialysis Protocol:...blood pressure prn (as needed)/daily or as the physician orders...Documentation on Treatment Sheets/UDA includes:...checks for signs/symptoms of infection daily...."</p> <p>3.1-37(a)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO</p>			

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Bldg. 00	<p><b>IMPROVE/MAINTAIN ADLS</b></p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to provide Activities of Daily Living (ADL) assistance to residents related to providing at least two showers a week for 2 of 3 residents reviewed for choices. (Resident #7 and #35)</p> <p>Findings include:</p> <p>1. During an interview on 12/15/15 at 11:17 a.m., Resident #7 indicated his preference was twice a week, on Tuesdays and Saturdays, but was only received one shower a week at times.</p> <p>Resident #7's record was reviewed on 12/17/15 at 3:21 p.m. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure) and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>Review of the resident's "Shower Sheets" and "Resident Bathing Type weekly report," indicated the resident received the following:</p> <p>week of 11/1/15: 1 full bed bath week of 11/8/15: no full bed baths week of 11/15/15: the resident refused</p>	F 0311	<p>1) Social Service Director reviewed shower preference sheets with residents #7 and #35 and their stated preferences were added to the shower lists 2) All residents have the potential to be affected by the alleged deficient practice. SSD completed an interview with each resident / responsible party to determine what their preferences were and then added these to the shower lists. 3) Nursing staff was in-serviced on shower preference sheets and notifying SSD if resident states a desired change to their preferences. Audit tool to be completed by the SSD/designee, to verify showers were given per their preferences, 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016</p>	01/21/2016

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	<p>twice for bathing week of 11/22/15: no full bed baths week of 11/29/15: no full bed baths, only 1 shower week of 12/6/15: no full bed baths and 1 time refusing a bath</p> <p>During an interview on 12/21/15 at 11:34 a.m., CNA (Certified Nursing Assistant) #3 indicated the resident should receive 2 full bed baths, 2 times a week. If the resident refuses, it is to be written on the shower sheets.</p> <p>During an interview on 12/21/15 at 11:34 a.m., the DON (Director of Nursing) indicated the full bed baths should have been completed 2 times a week and if the resident refused, it should have been documented on the shower sheets and the nurse notified of refusal. The nurse should have tried to re-approach the resident at a later time and with a different person.</p> <p>During an interview on 12/21/15 at 3:10 p.m., the SSD (Social Service Director) indicated the resident should have been offered at least 2 full bed baths a week.</p> <p>During another interview on 12/22/2015 at 9:55 a.m., the SSD indicated the facility only followed the State regulation of offering 2 showers or full bed baths a</p>			

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	<p>week, and the facility does not have a policy regarding the specific number of baths.</p> <p>2. During an interview on 12/15/15 at 10:55 a.m. with Resident #35, he indicated he preferred a shower 2 times a week and only received a 1 time a week. The resident did not indicated which days of the week he preferred a shower.</p> <p>Resident #35's record was reviewed on 12/17/15 at 3:33 p.m. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure), diabetes mellitus and depression.</p> <p>Review of the resident's "Shower Sheets" and "Resident Bathing Type weekly report," indicated the resident received the following: week of 12/6/15: 1 shower week of 12/13/15: 1 shower</p> <p>During an interview on 12/20/15 at 10:06 a.m., CNA #3 indicated the resident usually received 2 showers a week. If a resident refused a shower, it would have been written as "refused" on the shower sheet.</p> <p>During an interview on 12/21/15 at 11:23 a.m., the DON indicated the resident should have received 2 showers a week,</p>			

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F 0314 SS=G Bldg. 00	<p>per his preference and if the resident refused care, it should have been documented on the shower sheet as such.</p> <p>During an interview on 12/21/2015 at 3:10 p.m., the SSD indicated the resident should have been offered at least 2 showers a week.</p> <p>During another interview on 12/22/2015 at 9:55 a.m., the SSD indicated the facility only followed the State regulation of offering 2 showers or full bed baths a week, and the facility does not have a policy regarding the specific number of baths.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>			

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	<p>Based on observation, record review, and interview, the facility failed to ensure the timely monitoring, assessing and treating of wounds 3 of 6 residents reviewed for pressure ulcers. This included the development of a Stage 3 pressure ulcer for Resident #47 and Resident #28, an unstageable ulcer for Resident #57.</p> <p>Findings include:</p> <p>1. On 12/22/15 at 9:22 a.m., the Unit Manager was observed to complete the pressure ulcer treatment for Resident #47. The dressing to the left lower buttock was removed. Red tinged drainage was observed on the dressing and packing was removed from the area. The resident was observed with a 1 centimeter (cm) x 1 cm opening to the left lower buttock with depth present. After cleansing the area with normal saline, the LPN (Licensed Practical Nurse) proceeded to pack the wound with an iodoform packing strip (a medicated strip for open wounds) with the use of a q-tip. The tip of the q-tip was able to be inserted inside the wound. After packing the wound, the pressure ulcer was covered with a clean dressing. Interview with the LPN at the time, indicated the pressure ulcer was a Stage 3 (defined as a wound with full thickness tissue loss, subcutaneous fat may be visible but bone, tendon, or</p>	F 0314	<p><b>F314 -</b></p> <p>1) Resident #47's wound is being monitored and cared for accordingly. Resident #57 was discharged from the facility prior to the survey. Resident #28's wounds are being monitored and cared for accordingly.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. All residents with wounds were checked for completed wound evaluation sheets and wound assessments. Any discrepancies were corrected at that time.</p> <p>3) Nurses have been in-serviced on assessment of wounds on new admits and readmits, and have also been educated on on-going documentation of wounds. DNS/designee will review weekly skin assessments, and review any skin concerns with new or re-admitted residents. An audit will be completed by the DNS/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>	01/21/2016			

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	<p>muscle are not exposed, slough may be present and may include undermining and tunneling). She indicated the area was found to the resident's left lower buttock on 12/11/15, when they did the house wide sweep and she did not know how long the area had been there.</p> <p>The record for Resident #47 was reviewed on 12/21/15 at 2:07 p.m. The resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, heart failure, cardiomegaly, embolis and thrombosis of arteries of the lower extremities, epilepsy, generalized anxiety disorder, anemia, hypertension, chronic ischemic heart disease, chronic obstructive pulmonary disease, chronic kidney disease stage 3 and bone disorder.</p> <p>The Braden Scale (a tool for assessing risk of skin breakdown), dated 12/2014, indicated the resident was at risk for pressure ulcers with a score of "19."</p> <p>A Weekly skin review, dated 10/27/15, indicated the resident's skin was intact. There were no further Weekly skin reviews completed after that date.</p> <p>The 10/30/15 significant change Minimum Data Set (MDS) assessment, indicated the resident was at risk for</p>			

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	<p>pressure ulcers. No unhealed pressure ulcers were coded at that time.</p> <p>The plan of care, with a review date of October 2015, indicated the resident was at risk for altered skin integrity related to history of pressure area, excoriation under abdominal fold, the need for some assist with bed mobility at times, frequently incontinent, history of edema, and cellulitis to BLE (Bilateral Lower Extremities), history of noncompliance with treatment and incontinent care. Open area to coccyx and right buttocks (resolved). The interventions included, but were not limited to, conduct weekly skin inspection, provide pressure reduction/relieving mattress, provide thorough skin care after incontinent episodes and apply barrier cream.</p> <p>On 12/11/15 at 12:46 p.m., a "general note" was completed indicating the following: Resident skin check. Treatment of silvadene cream to sacral area daily for 6 cm x 6 cm redness, cover with ABD (large dressing) pad continues. Wound to left ischial 1.2 cm x 0.7 cm x 0.3 cm tunneling (passage of tissue destruction under the skin surface, with an opening at the level from the edge of the wound).</p> <p>A Physician's order, dated 12/11/15,</p>			

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	<p>indicated, cleanse left ischial wound with normal saline, pack with iodoform packing strip (gauze to control drainage), cover with dressing daily until healed.</p> <p>A Wound evaluation flow sheet, dated 12/11/15, indicated Stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure ulcer to left ischial 1.2 cm x 0.7 cm x 0.3 cm deep.</p> <p>A Wound evaluation flow sheet dated, 12/18/15, indicated Stage 3 pressure ulcer to left ischial 1.1 cm x 0.5 cm x 0.3 cm deep.</p> <p>During an interview on 12/21/15 at 3:09 p.m., the Director of Nursing indicated the resident was found with the Stage 3 pressure area on 12/11/15.</p> <p>2. The record for Resident #57 was reviewed on 12/17/15 at 10:44 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, hypertension and diabetes mellitus.</p> <p>The resident was admitted to the facility on 10/31/15 and was discharged to the hospital on 12/16/15. A Clinical Health</p>			

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	<p>Status Admission Assessment was completed on 10/31/15. The skin conditions section of the assessment indicated the resident had 4 surgical incisions, a PICC (peripherally inserted central catheter) line and a dialysis catheter. There was no indication in the record that the resident had any pressure ulcers.</p> <p>A Progress Note, dated 11/1/15 at 2:38 a.m., indicated the resident had been admitted at 9:30 p.m. on 10/31/15. The Progress Note indicated the resident had a surgical incision to his mid line chest, a surgical incision to his upper left chest and a surgical incision to his right inner lower leg. There was no indication in the record that the resident had any pressure ulcers.</p> <p>A Progress Note, dated 11/3/15 at 3:28 a.m., indicated "...dressing to buttocks and chest C(clean)/D(dry)/I(intact)..."</p> <p>A Physician's Order, dated 11/8/15, indicated treatment orders to a left hip pressure ulcer and a coccyx pressure area daily.</p> <p>Review of the November 2015 Treatment Administration Record (TAR) indicated the daily treatments to the left hip and coccyx were started on 11/8/15, on the</p>			

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	<p>night shift.</p> <p>There was no indication in the record that any treatment orders had been obtained prior to 11/8/15, or implemented to the coccyx and left hip pressure areas until 11/8/15.</p> <p>The 11/7/15 Admission Minimum Data Set (MDS) assessment indicated the resident was at risk for pressure ulcers and had 1 unstageable pressure ulcer (defined as a full thickness loss in which the base of the ulcer is covered by slough and/or eschar) present on admission due to a non removable dressing or device.</p> <p>A Progress Note, dated 11/18/15 at 1:58 a.m., indicated "...Treat [treatment] to coccyx [sic] changed and L [left] hip. Coccyx is 75-80% cover in slough. Surround (surrounding) tissue is pink. Has mod [moderate] amount of serousanguinous [sic] drainage...L [left] hip is 100% eschar. Surround [surrounding] tissue is pink. No drainage noted...."</p> <p>A Progress Note, dated 12/1/15 at 11:12 p.m., indicated "...Resident needs to see wound care for coccyx wound. Wound continues to grow."</p> <p>A Progress Note, dated 12/4/15 at 7:52 p.m., indicated "...Appointment made for</p>			

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	<p>12/8/15 2pm...wound clinic for areas to coccyx and left hip..."</p> <p>Wound Center Notes, dated 12/8/15, indicated the resident had an unstageable pressure ulcer to the left trochanter measured at 3.5 x 3.5 x0.1 cm and an unstageable pressure ulcer to the coccyx measured at 16 x 9 x 0.1 cm.</p> <p>A Progress Note, dated 12/11/15 at 4:32 p.m., indicated "...Skin check: wound to coccyx 9.2 x [by] 5.2 cm [centimeters] noted with eschar and slough to wound bed, wound edges are irregular with foul odor and purulent drainage. Wound to left ischial is 4 cm x 3 cm with eschar to wound bed and wound edges are irregular with foul odor. Wounds were upon admission and currently had TX [treatment] of santyl cover with dressing daily. Also being seen at wound clinic..."</p> <p>An Initial Wound Evaluation Flow Sheet for the coccyx/buttocks was initiated on 12/11/15. The assessment indicated a stage III pressure ulcer was present on the coccyx / buttocks. The Stage III area measured 9.2 x 5.2 x 0 cm, had a moderate amount of purulent exudate and a foul odor. The wound bed was sough and necrotic, the wound margins were irregular, and the surrounding tissue was pink/red.</p>			

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	<p>An Initial Wound Evaluation Flow Sheet for the left hip was initiated on 12/11/15. The assessment indicated an unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in ulcer bed.) pressure ulcer was present on the left hip. The unstageable area measured 4 x3x 0 cm, had no exudate and a foul odor. The wound bed was necrotic, the wound margins were irregular and the surrounding tissue was red/pink.</p> <p>There was no indication in the record that any measurements or wound staging of the left hip and coccyx pressure ulcers had been completed prior to 12/11/15.</p> <p>There was no indication in the record that any weekly skin assessments had been completed prior to 12/11/15.</p> <p>During an interview on 12/18/15 at 1:27 p.m., the DON indicated the coccyx and left hip pressure areas were first measured and staged following a skin sweep of all residents in the facility on 12/11/15. She indicated there were no measurements of the wounds, staging of the wounds or weekly skin assessments completed prior to 12/11/15. She further indicated there were no treatment orders obtained for the pressure areas until</p>			

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	<p>11/8/15. She indicated the nurses had told her the resident was admitted with the pressure ulcers but she could not find anywhere where that information was documented. She indicated if the wounds were present on admission they should have been documented on the admission assessment and a wound evaluation flow sheet.</p> <p>3. On 12/19/15 at 10:01 a.m., Resident #28 was observed self propelling his wheelchair with his feet. The resident had on socks and shoes on both feet.</p> <p>On 12/20/2015 at 8:04 a.m., Resident #28 was self propelling his wheelchair. The resident had on a nonskid sock on the right foot and a sock with a shoe on the left foot.</p> <p>During Resident #28's wound care treatment on 12/21/15 at 1:12 p.m. with LPN #3, the wounds were observed: *the left heel: measured 1 X 1 x 0.4 cm (centimeters), oblong in shape, pale white in the center of the wound, no pink noted, and the wound edges were white and dry. *the right heel: measured 4 X 3.5 X 0.2 cm, white/yellow tissue in the center of the wound and at the edges.</p> <p>Resident #28's record was reviewed on 12/17/15 at 11:21 a.m. The resident was</p>			

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	<p>admitted to the facility on 8/28/15. The resident diagnoses included, but were not limited to fracture of femur, chronic renal (kidney) disease, hypertension (high blood pressure), irregular heart rhythm and blood clots of the lower legs.</p> <p>Review of the Braden Scale (a pressure ulcer risk assessment), dated 8/25/15, indicated the resident scored a 17, which is at risk for a pressure sore.</p> <p>Review of the resident's pressure ulcer care plan, dated 9/21/15, indicated weekly wound assessments.</p> <p>Review of the "Wound Evaluation flow sheets," dated 9/20/15, indicated the right heel was a Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister) pressure ulcer, measuring 2.5 X 2.5 X&lt;0.2 cm (centimeters) with a red/dark center with scant amount of drainage. The left heel was a Stage 2 pressure ulcer, measuring 3 X 3 X&lt;0.2 cm with a dark center with a scant amount of drainage.</p> <p>The next evaluation of the wounds were on 12/11/15 with both wounds had worsened. The right heel was a Stage 3,</p>			

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	<p>measuring 3.53 cm with purulent (pus) drainage. The left heel was a Stage 3, measuring 1.3 X 1 cm with moderate purulent drainage and slough.</p> <p>The Nurse notes, from 9/20/15 through 11/12/15, lacked documentation of assessments of the wounds.</p> <p>The Nurse notes, from 9/20/15 through 11/12/15, a lacked documentation of treatments completed from 10/28/15 through 11/12/15.</p> <p>The weekly skin assessments, from 10/3/15 through 12/8/15, indicated the wounds were noted on one day, 11/13/15.</p> <p>The weekly skin assessment, dated 11/13/15, indicated the right heel measured at 3.4 cm, the area was yellowed and calloused and was softer in the center. The wound did not have any slough or eschar (dead tissue) noted. The left heel measured at 2.8 cm X 2.3 cm X less 1 cm, the area was yellowed and calloused area and had a soft calloused center. There was scant amount of seriosanguinous (watery blood) drainage to the dressing that was removed.</p> <p>Review of the Physician's Orders, the October and November MARs (Medication Administration Record),</p>			

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	<p>from 9/20/15 through 12/11/15, indicated a lack of a treatment to both pressure ulcers from 10/28/15 through 11/12/15.</p> <p>Review of the Quarterly MDS (Minimum Data Set) assessment, dated 12/4/15, indicated the resident was at risk for pressure ulcers.</p> <p>During an interview on 12/21/15 at 4:24 p.m., the DON indicated the resident's record lacked weekly wound assessments and there was not an order for a treatment for the wounds from 10/28/15 until 11/12/15. The DON also reviewed the Nurse notes from 9/20/15 through 11/12/15 and indicated the notes lacked documentation of a treatment completed.</p> <p>The policy titled, "Skin Integrity Guideline," was provided by the DON (Director of Nursing) on 12/18/15 at 2:30 p.m., and identified as current. The policy indicated, "...General Guideline:...Living Center develops a routine schedule to review patients/residents with wounds or at risk on a weekly basis and will document findings...Wound status is monitored on a weekly basis...Evaluation/Observation is to be completed within the first twenty-four hours of admission/quarterly/significant change of condition...if identified risk present, the</p>			

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F 0315 SS=D Bldg. 00	<p>interventions will be documented in the Immediate Plan of Care or Comprehensive Care Plan...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with a urinary catheter received the necessary treatment and services to prevent urinary tract infections, related to the placement of the urinary catheter tubing for 1 of 2 residents reviewed for urinary catheter use out of the 2 residents that met the criteria for urinary catheter use. (Resident #21)</p> <p>Finding includes:</p>	F 0315	<p><b>F315 -1)</b> Resident #21'scatheter tubing has been secured. 2) All residents have the potential to be affected by the alleged deficient practice. All residents with catheter bags were checked to ensure all were contained indignity bags, and that their tubing was secured. Those that were not covered and/or had unsecured tubing, were covered with dignity bags and/or had their tubing secured. 3) Nursing staff has been in-serviced to ensure that they are making</p>	01/21/2016

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	<p>On 12/15/15 at 7:59 a.m., Resident #21 was observed self propelling her wheelchair down the hallway toward the Main Dining Room. The resident's urinary catheter tubing was dragging on the floor.</p> <p>On 12/16/15 at 8:45 a.m., the resident was observed seated in her wheelchair at a table in the Main Dining Room. The resident's urinary catheter tubing was resting on the floor.</p> <p>On 12/16/15 at 3:31 p.m., the resident was observed seated in her wheelchair in the Main Dining Room playing bingo. The resident's urinary catheter tubing was resting on the floor.</p> <p>On 12/17/15 at 1:34 p.m., the resident was observed self propelling her wheelchair down the hallway towards the Main Dining Room. The resident's urinary catheter tubing was dragging on the floor.</p> <p>Resident #21's record was reviewed on 12/18/15 at 9:46 a.m. The resident's diagnoses included, but were not limited to, disorder of the kidney and ureter, diabetes mellitus, and hypertension.</p> <p>The Quarterly Minimum Data Set (MDS)</p>		<p>certain that cathetertubing is not touching the floor and that it is securely attached to the W/C. An audit toolwill be completed by the DNS/designee to monitor all residents with catheterbags to make certain that their tubing is not touching the floor while they areup in their W/Cs. An audit will be completed by the DNS/designee 5 times perweek for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and thenmonthly for 12 weeks. 4) Audit toolwill be reviewed monthly for 6 months in facility QAPI meeting to track andtrend for concerns. Finding no patterns,it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21,2016</p>	

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	<p>assessment, completed on 12/9/15, indicated the resident had an indwelling urinary catheter.</p> <p>The December 2015 Physician Orders indicated the resident had a 16 FR (french, size of catheter) indwelling urinary catheter for a disorder of the kidney.</p> <p>Review of urinalysis culture and sensitivity bacteriology final report, dated 12/6/15, indicated the resident's urine was positive for escherichia coli confirmed extended spectrum beta-lactamase (ESBL, a type of resistant bacteria)</p> <p>Review of the 12/2015 Medication Administration Record (MAR) indicated the resident was treated with Meropenem (an antibiotic medication) 500 mg (milligrams) IV (intravenous) every eight hours for the urinary tract infection starting on 12/6/15 for 7 days.</p> <p>The resident had a care plan for alteration in urinary elimination. The nursing interventions included "...check catheter tubing for proper drainage and positioning...."</p> <p>Interview with the DON (Director of Nursing), on 12/18/15 at 2:30 p.m.,</p>			

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F 0323 SS=D Bldg. 00	<p>indicated the resident's urinary catheter tubing should not have been touching the floor.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure fall interventions were in place for 1 of 3 residents reviewed for accidents. (Resident #21)</p> <p>Finding includes:</p> <p>On 12/15/15 at 7:59 a.m., Resident #21 was observed self propelling her wheelchair down the hallway toward the Main Dining Room.</p> <p>Resident #21's record was reviewed on 12/18/15 at 9:46 a.m. The resident's diagnoses included, but were not limited to, disorder of the kidney and ureter, diabetes mellitus and hypertension.</p> <p>The 5 Day Minimum Data Set (MDS) assessment, completed on 12/1/15,</p>	F 0323	<p><b>F323 -</b></p> <p>1) Resident #21's dycem was placed in herW/C. 2) All residents have the potential to beaffected by the alleged deficient practice. Guardian Angels took the CNAassignment sheets and reviewed their resident rooms to make certain thatinterventions were in place. 3) Staff was in-serviced on ensuring that interventionsto prevent accidents are in place as ordered. An audit tool will be used torandomly check that specific fall intervention orders are being followed. These audit tools will be completed bythe DNS/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks,weekly for 4 weeks, and then monthly for 12 weeks. These audits will bestaggered over all shifts. 4) Audit toolwill be reviewed monthly for 6 months in facility</p>	01/21/2016

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	<p>indicated the resident had one fall since the previous assessment/admission/or reentry, had one fall in the last month prior to admission/entry/or reentry, had a fall in the last 2-6 months prior to admission/entry/or reentry, and had a fracture related to a fall in the last 6 months prior to admission/entry/or reentry.</p> <p>A Physician's Order, dated 11/22/15, indicated an order for "...dysom [sic] [dycem, a non skid material] to w/c [wheelchair] check placement q [every]. shift..."</p> <p>Review of the November 2015 Treatment Administration Record (TAR), indicated the dysom (sic) was in signed off as in place on 11/28/15 day shift, evening shift, and night shift.</p> <p>A Progress Note, dated 11/29/15, indicated the resident had slid out of her wheelchair onto the floor. The note further indicated the resident's dycem was not in her wheelchair at the time of the fall, the Physician was notified, and a dycem was placed in her wheelchair.</p> <p>A Fall Investigation, dated 11/28/15, indicated the resident had slid out of her wheelchair on 11/28/15 at 5:15 p.m. The</p>		<p>QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016.</p>		

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F 0325 SS=D Bldg. 00	<p>contributing factor to the fall was "...dycem was not present to wheelchair and resident did not use call light..."</p> <p>Interview with the DON (Director of Nursing), on 12/18/15 at 1:27 p.m., indicated the dycem should have been in place to the resident's wheelchair as ordered. She further indicated staff had placed a dycem back in the resident's wheelchair after the fall.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to ensure a resident with a history of a significant weight loss was evaluated by the Registered Dietitian (RD) for 1 of 3 residents reviewed for nutrition. (Resident #51)</p> <p>Finding includes:</p>	F 0325	<p><b>F325 -</b></p> <p>1) Resident #51 was assessed by the RD and adjustments were made accordingly. 2) All residents have the potential to be affected by the alleged deficient practice. RD did a wholehouse audit to chart on those residents that had missing information. No other residents</p>	01/21/2016

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	<p>The record for Resident #51 was reviewed on 12/17/15 at 2:03 p.m. The resident's diagnoses included, but were not limited to, dementia without behavior disturbance, depressive episodes and anorexia.</p> <p>The 11/20/15 Quarterly Minimum Data Set (MDS) assessment, indicated the resident's Brief Interview for Mental Status (BIMS) score was a 2 indicating severe cognitive impairment. The resident was also identified as needing extensive assist for eating.</p> <p>The 4/17/15 plan of care indicated the problem of overweight/obesity related to obese with Body Mass Index (BMI) greater than 30. The interventions included, but were not limited to, notify Physician, RD, and responsible party of any significant weight changes.</p> <p>A Physician's order, dated 5/26/15, indicated the resident was to receive Ensure (a nutritional supplement) at bedtime.</p> <p>A Physician's order, dated 5/27/15, indicated the resident was to receive 2 cal (a nutritional supplement).</p> <p>A Physician's order, dated 7/31/15,</p>		<p>appeared to be effected.</p> <p>3) IDT is currently meeting weekly regarding NAR (nutritionally at risk) and weights/orders are being addressed accordingly. RD tracking form and the monthly significant weight change report will be used to monitor weight concerns.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>	

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	<p>indicated the resident was to receive a regular diet with mechanical soft texture.</p> <p>A Physician's order, dated 11/20/15, indicated the resident may have finger foods during meals.</p> <p>The resident's monthly weights were as follows:</p> <p>8/3/15 - 177 pounds 9/10/15 - 172 pounds 10/7/15 - 164 pounds 11/4/15 - 163 pounds 12/9/15 - 156 pounds</p> <p>A Significant weight note, dated 10/7/15, indicated the following: The resident noted to be a 90 day significant weight loss 10.07%. Physician notified, no new orders. Family notified. Resident was on a regular mechanical soft diet, receives 2 cal and Ensure, resident's average meal intake 48%/7 day, resident has no chewing/swallowing difficulties noted. Will continue with current diet/interventions, weights remain stable at this time, will continue monthly weights.</p> <p>A Significant weight note, dated 11/5/15, indicated the following: The resident's current weight 163 and last weight 164, resident was noted to be a 90 day</p>			

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	<p>significant weight loss 7.91%, resident was on a regular mechanical soft diet, receives 2 cal, Ensure, resident without chewing/swallowing difficulties. Will continue with current interventions and diet. Will continue with monthly weights.</p> <p>The 11/17/15 Quarterly nutrition assessment, indicated the resident's ideal body weight range was 94-116 pounds and her usual body weight was 195-199. Resident was consuming 80% of a regular mechanical soft diet. Current wt (weight) is 163 pounds which is a significant loss of 7.91% in 90 days. Resident was also getting Ensure at bedtime and 120 cc's of med pass daily due to history of weight loss. Skin is intact.</p> <p>Interview with the ACU (Alzheimer's Care Unit) Director on 12/22/15 at 9:05 a.m., indicated the resident's appetite was usually pretty good. She indicated the resident does better with finger foods. She also indicated the resident drinks the 2 cal and Ensure with no problem.</p> <p>Interview with the Consultant Dietary Manager on 12/22/15 at 11:10 a.m., indicated the resident was last seen by the RD in May. He did indicate the resident had a recent significant weight loss and would have the resident seen by the RD.</p>			

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F 0329 SS=D Bldg. 00	<p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure there was an indication for the use of Antianxiety medications as well as trying non-pharmacological interventions before giving as needed Antianxiety medication</p>	F 0329	<b>F329 -</b> 1) Resident #68has interventions in place to be tried before administering PRN medications foranxiety. Resident has had the proper diagnosis for the medication that is beingadministered clarified. 2) All residentshave the potential to be	01/21/2016

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	<p>for 1 of 5 residents reviewed for unnecessary medications. (Resident #68)</p> <p>Finding includes:</p> <p>On 12/17/15 at 11:16 a.m., Resident #68 was observed in bed. At that time her eyes were closed. The resident was not displaying any behaviors at that time.</p> <p>The record for Resident #68 was reviewed on 12/17/15 at 11:34 a.m. The resident's diagnoses included, but not limited to, Alzheimer's disease, Anxiety disorder and dementia without behavioral disturbance.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, dated 9/18/15, indicated the resident had Brief Interview for Mental Status (BIMS) score of 0, indicating she was not alert and oriented and was severely impaired for decision making. The resident displayed physical behavioral symptoms 4 to 6 days during the assessment reference period and some type of verbal behavioral symptoms occurred daily. The behaviors did not interrupt with resident care, however, the resident's behaviors had worsened since the last assessment.</p> <p>A Physician Order, dated 8/28/15, indicated Haldol (an Antipsychotic</p>		<p>affected by the alleged deficient practice. There are currently no other residents receiving dialysis. Residents currently receiving antipsychotic PRNs have been reviewed for non-pharmacological interventions. Social service director reviewed all residents on psychotropic medications to ensure that all have the proper diagnosis. 3) In-service for nurses on interventions to be tried before passing PRN medications. An audit tool will be completed by the social service director/designee to check that proper interventions were in place before nursing passes PRN medications and that we have the proper diagnosis for a particular medication. This audit will be 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016.</p>		

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	<p>medication) 2 milligrams (mg) IM (Intramuscular) every 6 hours prn (as needed) for Anxiety.</p> <p>A Physician Order, dated 8/29/15 and on the current 12/2015 Physician recap (recapitulation of medication orders) indicated Lorazepam (an Antianxiety medication) 0.25 mg every 8 hours prn Anxiety.</p> <p>The Medication Administration Record (MAR) for the month of 8/2015, indicated the Haldol 2 mg IM was administered to the resident on 8/28/15 at 9:18 p.m. The 9/2015 MAR was reviewed. The resident was administered Ativan 0.25 mg on 9/1/15 at 5:28 p.m., 9/3/15 at 4:27 p.m. and on 9/6/15 at 3:53 p.m.</p> <p>Nursing Progress Notes, dated 8/28/15 at 9:18 p.m., indicated "hitting staff, yelling at staff and other residents, unable to be redirected." The next documented entry in Nurse's Notes was on 8/29/15 at 12:11 a.m., that indicated "Haldol Solution. Inject 2 mg/ml [milliliter] Intramuscularly every 6 hours as needed for Anxiety. Resident in bed resting quietly. PRN Administration was effective."</p> <p>The Behavior Monthly Flow Sheet, dated</p>			

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	<p>8/2015, indicated the resident was being monitored for agitation, hallucinations/paranoia/delusions, and striking out/hitting. There were no documented behaviors on 8/28 and 8/29/15.</p> <p>Nursing Progress Notes dated 9/1/15 at 5:28 p.m., indicated "Increased anxiety." The next documented entry in Nurse's Notes was on 9/1/15 at 7:00 p.m., which indicated "PRN Administration was effective."</p> <p>Nursing Progress Notes, dated 9/3/15 at 4:27 p.m., indicated "increased anxiety." The next documented entry in Nurse's Notes was on 9/3/15 at 6:49 p.m., which indicated "PRN Administration was effective."</p> <p>Nursing Progress Notes dated 9/6/15 at 3:53 p.m., indicated "give .25 mg Ativan tablet by mouth every 8 hours as needed for anxiety. Resident was administered med for increased anxiety." The next documented entry in Nurse's Notes was on 9/6/15 at 4:47 p.m., indicated "PRN Administered was effective."</p> <p>The Behavior Monthly Flow Sheet, dated 9/2015, indicated the resident was being monitored for agitation, hallucinations/paranoia/delusions, and</p>			

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	<p>striking out/hitting. There were no documented behaviors on 9/1/15, 9/3/15, and 9/6/15.</p> <p>Nursing Progress Notes, dated 8/28/15, 9/1/15, 9/3/15, and 9/6/15, indicated there was no documentation of any non pharmacological interventions tried first before administering the prn Antianxiety and Antipsychotic medications.</p> <p>Interview with the Director of Nursing (DoN) 12/21/15 at 10:52 a.m., indicated there were no interventions tried first before giving the prn Haldol and Ativan. She indicated her expectations for Nursing was to try interventions first before administering prn psychotropic medication.</p> <p>Interview with the Social Service Director on 12/22/15 at 10:03 a.m., indicated there was no facility policy for the administration of psychotropic medications. She indicated it was the expectations of Nursing staff to assess the situation first prior to the administration of prn medication. She further indicated the Nurses should try at least no less than three non pharmacological interventions and document those interventions in Nurses Notes and/or the PRN intervention form before the administration of the prn</p>			

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F 0354 SS=F Bldg. 00	<p>psychotropic medication.</p> <p>3.1-48(a)(4)</p> <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>Based on record review and an interview, the facility failed to provide, on a full time basis, a Director of Nursing.</p> <p>Finding includes:</p> <p>Review of the staffing schedule, as worked, indicated there lacked a DON (Director of Nursing) from 11/21/15 through 12/11/15.</p> <p>Interview with DON on 12/22/15 at 11:14 a.m., indicated she started as the DON on 12/11/15.</p>	F 0354	<p><b>F354 -</b></p> <p>1) DNS in placewith a hire date of 12.11.15</p> <p>2) All residents have the potential to be affected by the alleged deficient practice.</p> <p>3)Should facility need to replace the DNS, on a permanent or temporary basis, an interim RN will be designated as the DNS on record.</p> <p>4) DNS position will be reviewed monthly for 6months in facility QAPI meeting</p> <p>5) January 21,2016.</p>	01/21/2016

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F 0425 SS=D Bldg. 00	<p>An interview with the Administrator on 12/22/15 at 10:13 a.m., indicated the facility lacked a DON from 11/21/15 until the new DON started on 12/11/15. He further indicated, the facility lacked an interim DON as well during that time period.</p> <p>This Federal Tag relates to Complaints #IN00187525 and #IN00187972.</p> <p>3.1-17(b)(4)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who</p>			

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	<p>provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure multidose vials of Haldol (an Antipsychotic medication), Lorazepam (an Antianxiety) and multidose bottles Ear Wax removal were discarded after the expiration date of when the multidose medication was opened for 1 of 2 units. (The South Unit)</p> <p>Finding includes:</p> <p>On 12/22/15 at 10:00 a.m., the following was observed on the South Unit:</p> <p>A. There was one multidose vial of Haldol with a date opened of 10/13/15 in medication cart #1.</p> <p>B. There were two multidose bottles of Ear Wax removal one with an open date of 9/26/15 and the other one was opened 10/26/15 in medication cart #2. There was one multidose vial of Lorazepam open with date of 4/15/15 in medication cart #2.</p> <p>The current and revised 11/2011 vials and ampules of injectable medications policy, provided by the Director of Nursing on 12/22/15 at 11:10 a.m., indicated "Medication in multidose vials</p>	F 0425	<p><b>F425 –</b></p> <p>1) No residents were identified as affected.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. All medication carts and refrigerators were checked for expired medications. Those that were found were disposed of.</p> <p>3) Staff was in-service on appropriate medication disposition procedure. DNS/designee will use an audit tool to record that appropriate medication disposition procedure is performed. The audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016.</p>	01/21/2016

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F 0428 SS=D Bldg. 00	<p>may be used (until the manufacture's expiration date/for the length of time allowed by state law/according to facility policy/for thirty days) if inspection reveals no problems during that time. Guidelines recommend discarding multidose vials (other than some insulins) at 28 days after opened."</p> <p>Interview with LPN (Licensed Practical Nurse) #2 on 12/22/15 at 10:00 a.m., indicated she had thought the multidose vials were to be discarded after 30 days after the open date.</p> <p>Interview with the Director of Nursing on 12/22/15 at 11:10 a.m., indicated the multidose vials and bottles should have been discarded after 30 days of the date opened.</p> <p>3.1-25(o)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview,</p>	F 0428	F428 -	01/21/2016

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	<p>the facility failed to ensure the Pharmacist's recommendations were acted upon for 1 of 5 residents reviewed for unnecessary medication of the 5 residents. (Resident #68)</p> <p>Finding includes:</p> <p>The record for Resident #68 was reviewed on 12/17/15 at 11:34 a.m. The resident's diagnoses included, but were not limited to Alzheimer's disease, anxiety disorder, and unspecified dementia without behavioral disturbance.</p> <p>A Physician Order, dated 8/29/15 and on the current Physician recap (recapitulation of medication orders) dated 12/2015, indicated Lorazepam 0.25 milligrams (mg) every 8 hours prn (as needed) for anxiety.</p> <p>A Pharmacy review, dated 6/2015, indicated the resident was receiving Ativan prn with no request for administration over 60 days. The Pharmacist had recommended to consider discontinuing the medication order due to non use at that time. The recommendation had not been signed by the Physician as either accepting or rejecting the recommendation.</p> <p>Interview with the Director of Nursing</p>		<p>1) Resident #68's Ativan order has been resolved.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice.</p> <p>3) In-service will be conducted with the nursing staff on pharmacy recommendations and implementing applicable changes from the physician's as they are received.</p> <p>An audit tool will be completed by the DNS/designee to verify that pharmacy recommendations are being followed up on. The audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016.</p>	

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F 0431 SS=D Bldg. 00	<p>(DON), on 12/18/15 at 1:45 p.m., indicated she was unsure if the June 2015 pharmacy recommendations were acted on. She further indicated there was no documentation by the Physician whether it was or not, however, she had just started as the DON on 12/11/15.</p> <p>3.1-25(i)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; 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,</p>			

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	<p>permanently affixed compartments for 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, record review and interview, the facility failed to ensure multidose vials of Lorazepam (an Antianxiety medication), Octrotide (a medication used to treat cancer), and a Novolog (Insulin) pen was dated when opened for 1 of 2 units. (The South Unit)</p> <p>Finding includes:</p> <p>On 12/22/15 at 10:00 a.m., on the South Unit, the following was observed:</p> <p>A. There were three multidose vials of Lorazepam opened with no date and two vials of Octrotide opened with no date in medication cart #2.</p> <p>B. There was one Novolog Insulin pen open with no date in medication cart #3.</p> <p>The current and revised 11/2011 vials and ampules of injectable medications policy, provided by the Director of Nursing on 12/22/15 at 11:10 a.m., indicated "The date opened and the initials of the first person to use the vial</p>	F 0431	<p><b>F431 -</b></p> <p>1)A sweep of the medication carts was completed and any issues with dates and signatures were addressed immediately.</p> <p>2)All residents have the potential to be affected by the alleged deficient practice.</p> <p>3) Nurses were in-service on the proper documentation procedures regarding the opening of medications with respect to dating and initialing. An audit tool will be completed by the DNS/designee that will be done once per week for 12 weeks,</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016.</p>	01/21/2016

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F 0441 SS=E Bldg. 00	<p>are recorded on multidose vials/on the vial label or an accessory label affixed for that purpose."</p> <p>Interview with LPN (Licensed Practical Nurse) #2 on 12/22/15 at 10:00 a.m., indicated the multidose vials and the Insulin pen were open with no date.</p> <p>3.1-25(j)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility</p>			

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	<p>must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure an infection control program was maintained related to completing monthly logs and monitoring for patterns and trends as well as the storage of urinals on 2 of 2 units and the cleaning of a glucometer. The facility also failed to ensure infection control was maintained related to a sign missing from 1 of the 3 isolation rooms. (The First and Second unit)</p> <p>Findings include:</p> <p>1. Review of the monthly Infection Control logs on 12/22/15 at 9:10 a.m., indicated the October 2015 surveillance log had been completed, however, the monthly analysis which broke down infections by unit and percentage had not been completed. A surveillance log had not been completed for the month of</p>	F 0441	<p><b>F441 -</b></p> <p>1) Infectioncontrol logs have been implemented and are being kept current. Urinals wereremoved from bathrooms and bedside tables where appropriate and disposed ofproperly. A review of proper cleaning of glucometers was performed with thenurses. Signage was placed on the room of the resident who is in contactisolation that did not have a posting.</p> <p>2) All residentshave the potential to be affected by the alleged deficient practice. There weretwo other residents on contact isolation, and their signage was checked. DNSimmediately in-serviced the nurses on the proper procedure for cleaning theglucometers. A facility-wide inspection of resident rooms for improper storageof urinals, bed pans, or urine collection devices, was completed, andcorrections were made as appropriate.</p>	01/21/2016

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	<p>November 2015 as well as a monthly analysis.</p> <p>Interview with the Director of Nursing (DON) on 12/22/15 at 9:10 a.m., indicated the monthly logs as well as patterns and trends had been monitored June through September 2015. The DON indicated that she had recently started at the facility and she would be taking over the infection control program. She also indicated that she had already started compiling information for the December 2015 report and log.</p> <p>2. On 12/15/15 at 9:22 a.m., a urinal was hanging from the assist rail in the bathroom of Room (A). The urinal was not covered, nor capped. This bathroom was shared with Room (B). One resident resided in Room (A) and two residents resided in Room (B).</p> <p>3. On 12/16/15 at 10:25 a.m., a urinal was observed on the over bed table in Room (C). The lid on the urinal was not closed and the urinal was not covered.</p> <p>On 12/22/15 at 10:38 a.m., the urinal was observed on the over bed table. Urine was present in the urinal and there was no lid covering the urinal. Two residents resided in this room.</p>		<p>3) Staff wasin-serviced on proper storage of bed pans, urinals, and urine collectiondevices. Additionally, nurses werein-serviced on proper cleaning of the glucometers and making certain thatsignage is in place for residents on isolation. Environmental audit rounds arebeing completed to ensure proper placement of bed pans, urinal, and urine collectiondevices. An audit toolwill be completed by the DNS/designee 5 times per week for 4 weeks, then 3x perweek times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit toolwill be reviewed monthly for 6 months in facility QAPI meeting to track andtrend for concerns. Finding no patterns,it will then be reviewed quarterly thereafter. Action Plans will be developedfor any identified concern.</p> <p>5) January 21,2016</p>	

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	<p>4. On 12/16/15 at 10:26 a.m., a urinal was observed hanging from the assist rail in the bathroom of Room (D). The urinal was not covered at this time. Two residents resided in this room.</p> <p>Interview with the Director of Nursing on 12/22/15 at 12:38 p.m., indicated the urinals should have been covered and stored appropriately.</p> <p>The Cleaning and Disinfecting Non-Critical Resident Care Items policy was reviewed on 12/22/15 at 12:38 p.m., the policy was provided by the Director of Nursing and identified as current. The policy indicated the bedpan or urinal was to be returned to the resident's bedside cabinet when not in use.</p> <p>5. On 12/15/15 at 6:35 a.m. with the Unit Manager, the following was observed after Resident #57's blood glucose test was performed. The Unit Manager placed the glucometer on the Medicare Unit medication cart, removed a bleach germicidal wipe from the container, wiped the glucometer with no visible blood on it, and then placed back into medication cart drawer.</p> <p>After returning from giving the resident insulin, the Unit Manager at 6:42 a.m. removed the same glucometer from the</p>			

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	<p>medication cart's drawer and used it to test Resident # 91's blood glucose. Upon returning from Resident #91's room, the Unit Manager then removed a bleach germicidal wipe from its container and wiped the glucometer and wrapped it and placed it on top on the medication cart at 6:45 a.m.</p> <p>At 6:46 a.m., the Unit Manager unwrapped the glucometer, threw away the wipe and placed the glucometer back into the medication cart's drawer.</p> <p>Interview with the Unit Manager on 12/15/2015 at 6:48 a.m., indicated she should have keep/wrapped the glucometer in Clorox wipe for 5 minutes, then let it dry for 2-3 minutes. Everyone uses the same glucometer.</p> <p>The policy titled, "Blood Glucose Monitoring Decontamination," was provided by the DON on 12/16/15 at 8:40 a.m., and was identified as the current policy used by the facility. The policy indicated, "...A wipe that is an EPS [Environmental Protection Agency] registered as tuberculocidal; effective against HIV [human immunodeficiency virus/AIDS], HBV [human pappillomavirus] and a broad spectrum of bacteria...Procedure...After performing the glucose testing, the nurse, wearing</p>			

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	<p>gloves, will use a disposable wipe to clean all external parts of the monitor. III. A second wipe will be used to disinfect the blood glucose monitor. IV. The disinfectant monitor will be placed on another clean surface...."</p> <p>6. During an observation on 12/15/15 at 8:00 a.m., Room (E) had a cart outside the room with gowns and 2 cans inside the resident's room labeled linens and trash. No observable sign on the residents door to indicate to see Nurse before entering the room.</p> <p>Interview with CNA (Certified Nursing Assistant) #4 at 8:02 a.m., indicated the resident was in contact isolation.</p> <p>At 8:13 a.m., CNA #5 was observed to have added gloves to the cart outside the resident's room.</p> <p>At 9:35 a.m. on 12/15/15, the DON (Director of Nursing) , the Activities Director and the resident's wife was observed to enter the resident's room without putting on the personal protective equipment. The resident's door lacked a sign to indicate the resident was in isolation.</p> <p>At 9:59 a.m., the resident's door lacked a sign to indicate the resident was in</p>			

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	<p>isolation.</p> <p>On 12/15/15 at 10:04 a.m., interview with CNA #5 indicated the resident was on contact isolation.</p> <p>On 12/15/15 at 10:07 a.m., an interview with the DON indicated the resident was in contact isolation.</p> <p>On 12/15/15 at 12:38 a.m., the resident's door still lacked a sign to indicate the resident was in contact isolation.</p> <p>At 12:40 p.m. on 12/15/15, an interview with the DON indicated the resident was in contact isolation and there should have been a sign on the door due to Staph (Staphylococcus aureus) in his urine.</p> <p>Resident #108's record was reviewed at 12:42 p.m. and the resident's urinalysis dated 11/26/15 indicated positive for Staphylococcus aureus (bacteria).</p> <p>The policy titled, " Isolation-Initiating Transmission-Based Precautions," was provided by the DON on 12/16/15 at 8 a.m. and identified as current. The policy indicated, "...5. When Transmission-Based Precautions are implemented, ...This facility process for notification is to post a sign...."</p>			

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F 0463 SS=D Bldg. 00	<p>3.1-18 (a) 3.1-18 (b) 3.1-18 (j)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the call light system was functioning on 2 of 2 units. (The ACU unit and the 200 unit)</p> <p>Findings include:</p> <p>1. On 12/15/15 at 1:46 p.m., the call light in Room 108 did not light up outside of the room when the button was pushed. The ACU (Alzheimer's Care Unit) Director indicated the lights sometime get loose from the wall and don't light up. When pushed again, the call light did not light up. After being pushed into the wall, the call light lit up outside of the room.</p> <p>2. On 12/15/15 at 9:28 a.m., the call light in Room 209 was not functioning. At</p>	F 0463	<p><b>F463 -</b></p> <p>1) Resident inrooms 108 and 209 had their call lights checked and corrected to be in properworking order.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. Maintenance director conducted a sweep of all call lights to make certain that all werefunctioning. No other call lights were identified.</p> <p>3) In-service to staff conducted on checking the function of the call light and the procedure to follow should one be found not in working condition. Call light checkshave been added to the guardian angel rounds that are completed by themanagement staff 5 times weekly. ED/designee will audit rounds 5 times per weekfor 4 weeks, then 3x per week times 4</p>	01/21/2016

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F 0465 SS=B Bldg. 00	<p>9:31 a.m., the call light was functioning. The Social Service Director indicated sometimes the call light had to be unplugged from the wall and plugged back in again.</p> <p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls, doors, and stained privacy curtains on 1 of 2 units. (The 200 unit)</p> <p>Finding includes:</p> <p>During the Environmental Tour on 12/22/15 at 10:15 a.m., with the Housekeeping and Maintenance Supervisors, the following was observed:</p> <p>The 200 unit:</p> <p>a. The privacy curtain in Room 204 was stained in sections. Two residents resided in this room.</p>	F 0465	<p>weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p> <p><b>F465 -</b></p> <p>1) Privacy curtain in room 204 was cleaned. The wall in room 212 was repaired. The metal strip on room 213 was replaced. The floor tile outside room 213 was replaced. The toilet seat in room 225 was replaced.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice.</p> <p>3) Maintenance Director/designee was in-serviced on the importance of timely follow-up of problems that are noticed on the scheduled PMs and/or entered on to their work order system. An audit tool will be completed by the ED/designee to make observations, on a random basis, of marred walls, toilet seats and kick plates. The Housekeeping/Laundry</p>	01/21/2016

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F 0520 SS=G Bldg. 00	<p>b. The wall underneath the sink in Room 212 had sections of bubbling paint as well as a black spot on the tile underneath the sink. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor at the time, indicated there had been a leak in the resident's room.</p> <p>c. The metal strip on the base of the door in Room 213 was scratched and marred. The floor tile was also scratched from where the door rubs against the tile. Two residents reside in this room.</p> <p>d. The toilet seat in the bathroom of Room 225 was scratched and marred. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor at the time, indicated all of the above were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p>		<p>Supervisor will complete an audit tool observing the cleanliness of the privacy curtains. Audit tool will be completed by the Maintenance Supervisor/designee 5 times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) January 21, 2016</p>		

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	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility failed to identify and implement plans of action to correct quality deficiencies related to pressure ulcers for 3 of 5 residents reviewed for pressure ulcers. (Resident #47, #57 and #28)</p> <p>Findings include:</p> <p>The facility failed to ensure residents were being monitored and assessed for pressure ulcers for Residents #47, #57 and #28.</p>	F 0520	<p><b>F520 -</b></p> <p>1) Residents #47, #57 and #28 were addressed on previous tags. 2) All residents have the potential to be affected by the alleged deficient practice. 3) ED and DNS in-service on the proper use of the QAPI monthly template by a sister facility's DNS to ensure that all concerns are being addressed and that the appropriate performance action plans are placed into action. Corporate clinical consultants will be reviewing this facility's monthly QAPI minutes to make certain that all issues are being addressed. 4) All concerns will be reviewed</p>	01/21/2016

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	<p>During an interview with the Administrator and the Director of Nursing on 12/22/15 at 11:14 a.m., indicated the Quality Assessment and Assurance committee meets monthly and it was not indicated that pressure ulcers were a problem. He further indicated, until the Unit Manager did a full house skin sweep on 12/11/5, we did not know there was a problem.</p> <p>1. On 12/22/15 at 9:22 a.m., the Unit Manager was observed to complete the pressure ulcer treatment for Resident #47. The dressing to the left lower buttock was removed. Red tinged drainage was observed on the dressing and packing was removed from the area. The resident was observed with a 1 centimeter (cm) x 1 cm opening to the left lower buttock with depth present. After cleansing the area with normal saline, the LPN (licensed Practical Nurse) proceeded to pack the wound with an iodoform packing strip (a medicated strip for open wounds) with the use of a q-tip. The tip of the q-tip was able to be inserted inside the wound. After packing the wound, the pressure ulcer was covered with a clean dressing. Interview with the LPN at the time, indicated the pressure ulcer was a Stage 3 (defined as a wound with full thickness tissue loss, subcutaneous fat may be visible but bone, tendon, or</p>		<p>monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016</p>				

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	<p>muscle are not exposed, slough may be present and may include undermining and tunneling). She indicated the area was found to the resident's left lower buttock on 12/11/15 when they did the house wide sweep and she did not know how long the area had been there.</p> <p>The record for Resident #47 was reviewed on 12/21/15 at 2:07 p.m. The resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, heart failure, cardiomegaly, embolis and thrombosis of arteries of the lower extremities, epilepsy, generalized anxiety disorder, anemia, hypertension, chronic ischemic heart disease, chronic obstructive pulmonary disease, chronic kidney disease stage 3 and bone disorder.</p> <p>The 10/30/15 significant change Minimum Data Set (MDS) assessment, indicated the resident was at risk for pressure ulcers. No unhealed pressure ulcers were coded at that time.</p> <p>There was no recent Braden scale (a pressure ulcer determination risk) in the resident's clinical record. The last Braden scale was dated 12/2014 which indicated the resident was at risk for pressure ulcers with a score of "19."</p>			

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	<p>The plan of care, dated 2/12/10 and reviewed on October 2015, indicated the resident was at risk for altered skin integrity related to history of pressure area, excoriation under abdominal fold, the need for some assist with bed mobility at times, frequently incontinent, history of edema, and cellulitis to BLE, history of noncompliance with treatment and incontinent care. Open area to coccyx and right buttocks (resolved). The interventions included, but were not limited to, conduct weekly skin inspection, provide pressure reduction/relieving mattress, provide thorough skin care after incontinent episodes and apply barrier cream.</p> <p>A Weekly skin review, dated 10/27/15, indicated the resident's skin was intact. There were no further Weekly skin reviews completed after that date.</p> <p>On 12/11/15 at 12:46 p.m., a "general note" was completed indicating the following: Resident skin check. Treatment of silvadene cream to sacral area daily for 6 cm x 6 cm redness, cover with ABD (large dressing) pad continues. Wound to left ischial 1.2 cm x 0.7 cm x 0.3 cm tunneling.</p> <p>A Physician's order dated 12/11/15 indicated, cleanse left ischial wound with</p>			

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	<p>normal saline, pack with iodoform packing strip, cover with dressing daily until healed.</p> <p>A Wound evaluation flow sheet dated 12/11/15, indicated Stage 3 pressure ulcer to left ischial 1.2 cm x 0.7 cm x 0.3 cm deep.</p> <p>A Wound evaluation flow sheet dated 12/18/15, indicated Stage 3 pressure ulcer to left ischial 1.1 cm x 0.5 cm x 0.3 cm deep.</p> <p>Interview with the Director of Nursing (DON) on 12/21/15 at 3:09 p.m., indicated the resident was found with the Stage 3 pressure area on 12/11/15.</p> <p>2. The record for Resident #57 was reviewed on 12/17/15 at 10:44 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, hypertension and diabetes mellitus.</p> <p>The resident was admitted to the facility on 10/31/15 and was discharged to the hospital on 12/16/15.</p> <p>The 11/7/15 Admission Minimum Data Set (MDS) assessment indicated the resident was at risk for pressure ulcers and had 1 unstageable pressure ulcer present on admission due to a non</p>			

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	<p>removable dressing or device.</p> <p>A Clinical Health Status Admission Assessment was completed on 10/31/15. The skin conditions section of the assessment indicated the resident had 4 surgical incisions, a PICC (peripherally inserted central catheter) line, and a dialysis catheter. There was no indication in the record that the resident had any pressure ulcers.</p> <p>A Progress Note, dated 11/1/15 at 2:38 a.m., indicated the resident had been admitted at 9:30 p.m. on 10/31/15. The Progress Note indicated the resident had a surgical incision to his mid line chest, a surgical incision to his upper left chest and a surgical incision to his right inner lower leg. There was no indication in the record that the resident had any pressure ulcers.</p> <p>A Progress Note, dated 11/3/15 at 3:28 a.m., indicated "...dressing to buttocks and chest C(clean)/D(dry)/I(intact)..."</p> <p>A Physician's Order, dated 11/8/15, indicated treatment orders to a left hip pressure ulcer and a coccyx pressure area daily.</p> <p>Review of the November 2015 Treatment Administration Record (TAR) indicated</p>			

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	<p>the daily treatments to the left hip and coccyx were started on 11/8/15 on the night shift.</p> <p>There was no indication in the record that any treatment orders had been obtained prior to 11/8/15 or implemented to the coccyx and left hip pressure areas until 11/8/15.</p> <p>A Progress Note, dated 11/18/15 at 1:58 a.m., indicated "...Treat (treatment) to coccyx [sic] changed and L (left) hip. Coccyx is 75-80% cover in slough. Surround (surrounding) tissue is pink. Has mod (moderate) amount of serousanguinous [sic] drainage...L (left) hip is 100% eschar. Surround (surrounding) tissue is pink. No drainage noted..."</p> <p>A Progress Note, dated 12/1/15 at 11:12 p.m., indicated "...Resident needs to see wound care for coccyx wound. Wound continues to grow."</p> <p>A Progress Note, dated 12/4/15 at 7:52 p.m., indicated "...Appointment made for 12/8/15 2pm...wound clinic for areas to coccyx and left hip..."</p> <p>Wound Center Notes, dated 12/8/15, indicated the resident had an unstageable pressure ulcer to the left trochanter measured at 3.5 x 3.5 x 0.1 cm and an</p>			

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	<p>unstageable pressure ulcer to the coccyx measured at 16 x 9 x 0.1 cm.</p> <p>A Progress Note, dated 12/11/15 at 4:32 p.m., indicated "...Skin check: wound to coccyx 9.2 x (by) 5.2 cm (centimeters) noted with eschar and slough to wound bed, wound edges are irregular with foul odor and purulent drainage. Wound to left ischial is 4 cm x 3 cm with eschar to wound bed and wound edges are irregular with foul odor. Wounds were upon admission and currently had TX (treatment) of santyl cover with dressing daily. Also being seen at wound clinic..."</p> <p>An Initial Wound Evaluation Flow Sheet for the coccyx/buttocks was initiated on 12/11/15. The assessment indicated a stage III pressure ulcer was present on the coccyx/buttocks. The stage III area measured 9.2 x 5.2 x 0 cm, had a moderate amount of purulent exudate and a foul odor. The wound bed was sough and necrotic, the wound margins were irregular, and the surrounding tissue was pink/red.</p> <p>An Initial Wound Evaluation Flow Sheet for the left hip was initiated on 12/11/15. The assessment indicated an unstageable pressure ulcer was present on the left hip. The unstageable (defined as a full thickness loss in which the base of the</p>			

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	<p>ulcer is covered by slough and/or eschar) area measured 4 x3x 0 cm, had no exudate and a foul odor. The wound bed was necrotic, the wound margins were irregular, and the surrounding tissue was red/pink.</p> <p>There was no indication in the record that any measurements or wound staging of the left hip and coccyx pressure ulcers had been completed prior to 12/11/15.</p> <p>There was no indication in the record that any weekly skin assessments had been completed prior to 12/11/15.</p> <p>Interview with the DON, on 12/18/15 at 1:27 p.m., indicated the coccyx and left hip pressure areas were first measured and staged following a skin sweep of all residents in the facility on 12/11/15. She indicated there were no measurements of the wounds, staging of the wounds or weekly skin assessments completed prior to 12/11/15. She further indicated there were no treatment orders obtained for the pressure areas until 11/8/15. She indicated the nurses had told her the resident was admitted with the pressure ulcers but she could not find anywhere where that information was documented. She indicated if the wounds were present on admission they should have been documented on the admission assessment</p>			

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	<p>and a wound evaluation flow sheet.</p> <p>3. During Resident #28's wound care treatment on 12/21/15 at 1:12 p.m. with LPN #3, the wounds were observed: *the left heel: measured 1 X 1 x 0.4 cm (centimeters), oblong in shape, pale white in the center of the wound, no pink noted, and the wound edges were white and dry. *the right heel: measured 4 X 3.5 X 0.2 cm, white/yellow tissue in the center of the wound and at the edges.</p> <p>On 12/19/15 at 10:01 a.m., the resident was observed self propelling his wheelchair with his feet. The resident had on socks and shoes on both feet.</p> <p>Another observation of the resident was on 12/20/2015 at 8:04 a.m., he was self propelling his wheelchair. The resident had on a nonskid sock on the right foot and a sock with a shoe on the left foot.</p> <p>Resident #28's record was reviewed on 12/17/15 at 11:21 a.m. The resident was admitted to the facility on 8/28/15. The resident diagnoses included, but were not limited to fracture of femur, chronic renal (kidney) disease, hypertension (high blood pressure), irregular heart rhythm and blood clots of the lower legs.</p> <p>Review of the Quarterly MDS (Minimum</p>			

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	<p>Data Set) assessment, dated 12/4/15, indicated the resident was at risk for pressure ulcers.</p> <p>Review of the Braden Scale (a pressure ulcer risk assessment), dated 8/25/15, indicated the resident scored a 17, which is at risk for a pressure sore.</p> <p>Review of the resident's pressure ulcer care plan, dated 9/21/15, indicated weekly wound assessments.</p> <p>Review of the "Wound Evaluation flow sheets," dated 9/20/15, indicated the right heel was a stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister) pressure ulcer, measuring 2.5 X 2.5 X&lt;0.2 cm (centimeters) with a red/dark center with scant amount of drainage. The left heel was a stage 2 pressure ulcer, measuring 3 X 3 X&lt;0.2 cm with a dark center with a scant amount of drainage.</p> <p>The next evaluation of the wounds were on 12/11/15, with both wounds had worsened. The right heel was a stage 3, measuring 3.53 cm with purulent (pus) drainage. The left heel was a stage 3, measuring 1.3 X 1 cm with moderate purulent drainage and slough.</p>			

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	<p>Review of the Nurse notes, from 9/20/15 through 11/12/15, lacked assessments of the wounds.</p> <p>Review of the Nurse notes, from 9/20/15 through 11/12/15, indicated a lack of treatments completed from 10/28/15 through 11/12/15.</p> <p>Review of the weekly skin assessments, from 10/3/15 through 12/8/15, indicated the wounds were noted on one day, 11/13/15.</p> <p>The weekly skin assessment, dated 11/13/15, indicated the right heel measured at 3.4 cm, the area was yellowed and calloused and was softer in the center. The wound did not have any slough or eschar(dead tissue) noted. The left heel measured at 2.8 cm X 2.3 cm X less 1 cm, the area was yellowed and calloused area and had a soft calloused center. There was scant amount of seriosanguinous (watery blood) drainage to the dressing that was removed.</p> <p>Review of the Physician's Orders, the October and November MARs (Medication Administration Record) from 9/20/15 through 12/11/15, indicated a lack of a treatment to both pressure ulcers from 10/28/15 through 11/12/15.</p>			

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F 9999  Bldg. 00	<p>Interview with the DON (Director of Nursing) on 12/21/15 at 4:24 p.m., indicated the resident's record lacked weekly wound assessments and there was not an order for a treatment for the wounds from 10/28/15 until 11/12/15. The DON also reviewed the Nurse notes from 9/20/15 through 11/12/15 and indicated the notes lacked documentation of a treatment completed.</p> <p>3.1-52(b)(2)</p> <p>3.1-14 PERSONNEL</p> <p>There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure facility staff</p>	F 9999	<p><b>F9999</b> - 1)All employees are current on their abuse and resident rights in-services. Staffis current with their general and specific orientation requirements. 2) All residentshave the potential to be affected by the alleged deficient practice. 3) BOM/designeewill ensure that these requirements are met. An audit tool will be completed 5times per week for 4 weeks, then 3x per week times 4 weeks, weekly for 4 weeks,and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 monthsin facility QAPI meeting to track and trend for concerns.</p>	01/21/2016

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	<p>completed annual resident rights and abuse inservices for 2 of 10 employee records reviewed. (Cook #1 and Maintenance #1)</p> <p>Finding includes:</p> <p>The employee record for Cook #1 was reviewed on 12/19/15 at 9:00 a.m. Cook #1 was hired on 4/25/2013. There was lack of documentation in the employee's record to indicate a yearly abuse inservice had been completed.</p> <p>The employee record for Maintenance #1 was reviewed on 12/19/15 at 9:00 a.m. Maintenance #1 was hired on 5/20/1968. There was lack of documentation in the employee's record to indicate a yearly abuse and resident's rights inservice had been completed.</p> <p>Interview with the Administrator, on 12/22/15 at 10:14 a.m., indicated he was unable to find the resident rights inservices or the abuse inservices.</p> <p>3.1-14(k)</p> <p>3.1-14 Personnel</p> <p>(q) Each facility shall maintain current</p>		<p>Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) January 21, 2016</p>		

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	<p>and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) Documentation of orientation to the facility and to the specific job skills.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the facility had evidence of a general and specific job orientation for 4 of 10 employee records reviewed. (Dietary Assistant #1, LPN (Licensed Practical Nurse) #4, CNA (Certified Nursing Assistant) #6, and Activities Assistant #1.</p> <p>Finding includes:</p> <p>The employee records for Dietary Assistant #1, LPN #4, CNA #6, and Activities Assistant #1 were reviewed on 12/19/15 at 9:00 a.m. The Dietary Assistant #1 was hired on 8/18/2015, LPN #4 was hired on 8/31/2015, and CNA #6 was hired on 9/7/2015. There was a lack of documentation in the employees' records to indicate a general and specific orientation had been completed.</p> <p>Interview with the Administrator, on 12/22/15 at 10:14 a.m., indicated he was</p>			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	unable to find the general and specific orientation information.  3.1-14(q)(7)				