

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/01/2014
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NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the investigation of Complaint IN00145652.</p> <p>Complaint IN00145652 substantiated. No deficiencies related to the allegations are cited.</p> <p>This survey resulted in a partially extended survey-Past Non Compliance Immediate Jeopardy.</p> <p>Survey dates: March 24, 25, 26, 27, 28, 31, 2014 and April 1, 2014.</p> <p>Facility number: 000359 Provider number: 155566 AIM number: 100274920</p> <p>Survey team: Tim Long, RN-TC Rick Blain, RN Diane Nilson, RN Carol Miller, RN (3/24, 3/25, 3/26, 3/27, 3/28, 3/31, 2014)</p> <p>Census bed type: SNF: 12 NF: 55 Total: 67</p>	F000000	<p>This plan of correction is to serve as Warsaw Meadows Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Warsaw Meadows or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute agreement or admission of the survey allegations. We are respectfully requesting we be considered for a paper compliance resolution to this survey event.</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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F000157 SS=D	<p>Census Payor type: Medicare: 12 Medicaid: 47 Other: 8 Total: 67</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 7, 2014 by Randy Fry RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p>			
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	<p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review and interview, the facility failed to notify the physician after a resident refused emergency treatment regarding transfer to a hospital. This affected 1 Resident, #80, in a sample of 3 residents reviewed for falls.</p> <p>Findings include:</p> <p>CNA # 11 was interviewed, at 10:20 a.m., on 3/27/14, and indicated Resident #80 liked to be independent and sometimes could transfer herself. She indicated the resident could not walk anymore, could bear weight and stand to transfer to the toilet with one assist, and used a wheelchair.</p> <p>The resident was observed sitting in her wheelchair, at 3:02 p.m., on 3/27/14, propelling herself down the hall using her hands and pedaling her feet</p>	F000157	F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC.)It is the policy of Warsaw Meadows Care Center that notifications of changes in condition, injuries, room changes, and other changes involving residents be made to residents, physicians and caregivers immediately and accurately.I. Resident #80 fell on 11/5/13. Notification of nurse practitioner (NP) and responsible party were made per the policy; however, resident refused to follow order to transfer to the hospital for x-rays and NP was not called back with that information. Resident received x-ray on 11/6/13 and subsequently went to the hospital for treatment of a fracture. Resident's care plan was updated to include history of refusal of treatment with interventions including calling the POA to help the resident with decision making and notifying the physician if the	05/01/2014			

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	<p>independently.</p> <p>The record for Resident #80 was reviewed at 3:05 p.m., on 3/27/14, and indicated the resident was admitted to the facility on 10/18/13 with diagnoses including, but not limited to: Obstructive hydrocephalus, Osteoarthritis, hip fracture, dementia, and Osteoporosis. The Admission Minimum Data Set (MDS), dated 11/1/13, for Resident #80 indicated the resident scored a 14(interviewable) on the Brief Interview for Mental Status, required minimal assistance of one staff member for transfer, locomotion, toileting, and hygiene, and had diagnoses including, but not limited to hip fracture, and dementia.</p> <p>Review of a history and physical, from a hospital visit, dated 10/16/13 indicated the resident had a history of a right hip fracture with surgery in February 2013 after a fall. The resident was discharged to home, fell 2 days later, and refractured below the prosthesis and so was re-admitted to the hospital and had a total hip arthroplasty. The resident's daughter indicated the resident was having more dementia, could not take care of herself, and her walking was worse. An X-ray was completed due to right hip pain, which showed evidence of a prior</p>		<p>resident refuses medication, treatment, or outside services.II. This deficiency could affect any resident that refused a doctor or NP order.III. An in-service was provided by the Director of Nursing on 4/8/14 to train nursing personnel on the continuation of the previous policy in the event that an order is refused by a resident and that all parties must be notified immediately of this refusal. An audit of residents who had orders for x-rays for the past year was completed. No other resident had ever refused that service.IV. Orders are reviewed and discussed every morning in the Interdisciplinary Morning Meeting including those that are "voided" or include information that a resident refused an order. The Director of Nursing will ensure the follow up notifications were completed and disciplinary actions may result from failure to notify physician, NP, or family of refusals. The Director of Nursing will keep on audit form of refusals and their follow up to be included in Quality Assurance (QA) Meetings held quarterly. This audit form will be completed daily for four weeks and the results presented at QA. This practice will continue every month until there is 100% compliance with the notification process.V. Date of compliance: 5/1/14</p>				

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	<p>fracture and hip replacement, but no acute injury.</p> <p>A fall risk assessment, dated 10/18/13 indicated the resident scored a 12 which indicated she was a high risk for falls, was chairbound, and required assist with elimination,</p> <p>The care plan was reviewed at 9:00 a.m., on 3/28/14 and indicated the following: A problem, dated 10/25/13, and updated on 1/25/14, indicated the resident was at risk for falls. Approaches included, but were not limited to: demonstrate use of the call light and ensure the call light was within reach at all times; place personal items such as tissue, phone, over the bed table, within reach; assist with activities of daily living as needed; be sure the resident had on nonskid footwear before transferring, assess injuries and initiate neuro checks if an unwitnessed fall or signs and symptoms of hitting head.</p> <p>The Director of Nursing Services (DNS) was interviewed at 9:58 a.m., on 3/28/14, and indicated the resident had a fall in November, 2013, which resulted in a hip fracture. The DNS provided the nurse fall investigation report, dated 11/5/13, at</p>				

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	<p>10:00 a.m., on 3/28/14.</p> <p>A nursing note at 9:00 p.m., on 11/5/13, indicated the resident was found on the floor this evening near her bed, alerted staff when she fell, and indicated she tripped over a table. The note indicated the Nurse Practitioner and family were notified.</p> <p>Another nursing note, at 9:30 p.m., on 11/5/13, indicated, "pt (patient) (the next word was a zero with a checkmark through it) then "what" was crossed out with one line when to go to ER (Emergency room) for X-ray. "</p> <p>There was no additional documentation until 11/6/13, at 5:00 a.m., where only vital signs were recorded.</p> <p>The next nursing note at 9:45 a.m., on 11/6/13, indicated the resident complained of left hip pain related to the "witnessed" fall on 11/5/13. The note indicated there was a large purple bruise on the left hip, the resident had been given a pain medication at 8:30 a.m., and "res (resident) admits to (arrow up) s (without) assist et (and) not utilizing call light for help."</p> <p>The nursing note indicated the Nurse Practitioner was notified of the fall and the resident's condition, and left orders for bilateral hip x-rays to be completed. The note indicated x-ray was notified and stated they would dispatch someone to</p>			

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	<p>the facility.</p> <p>The next nursing note, at 10:00 a.m., on 11/6/13 indicated the resident continued to complain of left hip pain.</p> <p>The next nursing note, dated 11/6/13, no time, indicated vital signs taken, pain medication given at 5:00 p.m.</p> <p>The next nursing note, dated 11/7/13 at 1:50 a.m., indicated x-ray results were received , the Nurse Practitioner notified, and orders received to send the resident to the hospital for evaluation.</p> <p>A nursing note, dated 11/7/13 at 2:00 a.m., indicated the family was notified the resident was being sent to the hospital due to a left hip fracture.</p> <p>Review of an X-ray report, dated 11/6/13, no time, and from the facility contracted X-ray service, indicated, "Examination reveals what appears to be slightly impacted subchapter fracture of the neck of the left femur with slight varus deformity and no significant displacement. "</p> <p>A physician's order, dated 11/5/13 at 9:00 p.m., indicated to send the resident to the emergency room for evaluation and treatment for hip pain. This entire order was crossed out and indicated "void" and resident refused.</p> <p>There was no additional documentation</p>				

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	<p>in the record to indicate why the physician order was crossed out, on 11/5/13, or to indicate the physician had been notified of the resident's refusal to go to the Emergency room for treatment.</p> <p>The Director of Nursing Services (DNS) was interviewed at 11:30 a.m., on 3/31/14 and indicated she was not sure why the physician order, dated 11/5/13 at 9:00 p.m., regarding sending the resident to the Emergency room, was crossed out . The DNS provided additional information regarding the fall on 11/5/13. This information was documented on a nursing note, but the DNS indicated it was an IDT (Interdisciplinary note) and kept in a separate book. She indicated after the resident was discharged this IDT note was given to the medical record person to place in the resident's record. She indicated this was not part of Quality Assurance, but was documented by the former DNS.</p> <p>The DNS also provided at this time a neuro checklist for 11/5, 6, 7, 2013, which indicated neuro checks were documented per facility policy after the unwitnessed fall.</p> <p>In Addition, the DNS provided a pain management flow sheet, dated for November 2013, which indicated the resident had received pain medication for</p>				

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	<p>left hip pain on 11/6/13 at 0830, 12:15 p.m., and 5:00 p.m., and on 11/7/13 at 2:00 a.m.</p> <p>Review of the IDT notes(provided by the DNS), at 11:35 a.m., on 3/31/14, indicated the following: 11/6/13 at 9:00 a.m., the resident had a fall on 11/5/13, complained of hip pain, refused to go to the emergency room. The note indicated the family and physician was notified and would discuss a mobile X-ray, and "she is up smoking transferring self. " 11/6/13 at 10:00 a.m., the resident agreed to a mobile X-ray, the family and physician were notified, complained of discomfort off and on. 11/6/13 at 6:00 p.m., Mobile X-ray here to X-ray, waiting on results. 11/7/13 9:00 a.m., resident went to hospital due to left hip fracture.</p> <p>Thus, the resident fell on 11/5/13, complained of hip pain, the Nurse Practitioner was notified and ordered Emergency room treatment, but the resident refused. Neither the Nurse Practitioner or the Physician were notified of the resident's refusal to go to the Emergency Room for treatment until the following day, when a nursing note, dated 11/6/13 at 9:45 a.m., indicated the resident had a large purple bruise on the</p>						

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	<p>left hip, was complaining of pain in the hip, and the Nurse Practitioner was notified and ordered bilateral hip X-rays , which were completed at the facility on 11/6/13 at 6:00 p.m. The results were received at 1:50 a.m., on 11/7/13, and the resident sent to the hospital at 2:00 a.m., on 11/7/13.</p> <p>The policy for "Right to notification of changes", dated February, 2009, and provided by the DNS at 10:40 a.m., on 3/31/14, indicated "The facility will immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is: an accident involving the resident that results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status"e.g. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; a need to alter treatment significantly ( e.g. a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment)."</p> <p>3.1-5(a)(1)</p>						

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F000241 SS=D	<p>3.1-5(a)(2) 3.1-5(a)(3)</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 promote dignity for 1 of 2 residents reviewed for dignity, Resident #66. This regarded use of an isolation sign posted on the resident's door.</p> <p>Findings include:</p> <p>During initial tour of the facility, beginning at 9:50 a.m., on 3/24/14, a sign was observed posted on the door of Resident #66 which indicated, "Stop, this room in isolation all visitors should see</p>	F000241	<p>F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>I. Resident #66 had a sign posted on the door of their room reading "Stop, this room in isolation all visitors should see nurse before entering."</p> <p>II. This deficiency could affect any resident with medical need for isolation.</p> <p>III. All signage for the facility was reviewed by the Interdisciplinary Team on 4/8/14 and any item which would have violated HIPAA standards or impinge on resident rights would have been destroyed and replaced. There were</p>	04/08/2014			

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	<p>nurse before entering room." The sign was observed on the door on 3/25, 3/26, and 3/27/14.</p> <p>The Director of Nursing Services (DNS) was interviewed at 8:47 a.m., on 3/27/14, and indicated she was not aware this sign was posted, and indicated the sign should not have identified the room as an isolation room, but only should have indicated to see the nurse before entering.</p> <p>The resident record was reviewed, at 12:30 p.m., on 3/28/14, and indicated diagnoses including, but not limited to: senile dementia with delusional features.</p> <p>The care plan, dated 3/15/14, indicated the resident was on airborne isolation.</p> <p>The DNS was interviewed, at 10:40 a.m., on 3/31/14, and indicated she did not know if the facility had a policy for isolation signs, but indicated the sign that was up identifying the room as "in isolation" was not appropriate, and she did not know where it had come from, and indicated the normal signs that were posted were laminated and only indicated to see nurse before entering room</p> <p>Review of the isolation policy, undated, and provided by the DNS, at 11:12 a.m., on 3/31/14, and reviewed at 11:41 a.m.,</p>		<p>no signs other than the one observed by the surveyors that had that terminology used. That sign was removed and destroyed the day of surveyor notification.</p> <p>IV. All signage created, contracted, or bought will be personally reviewed by the Administrator to ensure there is no violation of any State, Federal, or company policy. Administrator will complete weekly walk throughs for the next three months to review signage. All findings will be included in the quarterly Quality Assurance Meeting and any offending signage will be replaced on the spot.</p> <p>V. Date of compliance: 4/8/14</p>		

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F000246 SS=E	<p>on 3/31/14, indicated, "Should a resident be placed on Respiratory Precautions implement the following:" Place facility-specific signs/stickers on the door, and on the chart.</p> <p>3.1-3(t)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, and interview, the facility failed to ensure 2 residents in a sample of 35 residents reviewed for call light functioning, could easily access their emergency call light in the shared adjoining bathroom. This affected 2 Residents, #16 and #80.</p> <p>Findings include:</p> <p>During interview, with Resident #16, at 2:39 p.m., on 3/24/14, the emergency call light in the adjoining bathroom the resident shared with Resident #80, was observed to have a short chain which the</p>	F000246	F246 483.15(e)(1) REASONABLE ACCOMODATION OF NEEDS/PREFERENCESI. Resident #16 and resident #80 had a call light cord in their shared bathroom snapped in half. That cord was replaced on the spot and all other bathroom cords and call light cords were reviewed that day with no other issues noted facility wide.II. All residents could be affected by this deficiency.III. Call lights and cords for standard lighting are reviewed weekly by the Maintenance Director. All staff personnel were retrained on use of the Work Order Book in	05/01/2014

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F000279 SS=D	<p>resident used to call for assistance. The resident indicated when she used the bathroom, she would normally pull on the chain before she sat down on the toilet because she couldn't reach the chain if she were seated.</p> <p>During interview with Resident #80, at 2:55 p.m., on 3/24/14, the resident indicated she had to reach up to pull the chain on the emergency call light, but indicated it would be easier if there were a longer chain for her to pull.</p> <p>During the Environmental tour, conducted between 2:00 p.m., and 3:15 p.m., on 3/31/14, and accompanied by the Environmental Director, he indicated the emergency call light chain was only 3-4 inches in length and must have broken off, but he could add an extension to the chain to make it easier to reach.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p>		<p>regards to documenting any broken or missing items for the Maintenance Director to address on 4/8/14. Staff were also instructed to watch for call light and standard light cords specifically and to have them fixed or replaced immediately.IV. The Maintenance Director will complete a written audit of call light and standard light cords weekly for the next four weeks to be included in the quarterly Quality Assurance Meeting. Deficiencies will be fixed or replaced upon discovery. This audit will continue in its written form each month until 100% compliance is reached.V. Date of compliance: 5/1/14</p>		

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	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews the facility failed to ensure 1 of 5 Residents (#59) reviewed for medications had a care plan for medications used for insomnia.</p> <p>Findings include:</p> <p>Review of Resident #59's clinical records on 3/26/14 at 2:30 P.M. indicated the resident was admitted to the facility on 10/25/13 with diagnoses including, but not limited to, Alzheimer's disease and dementia with behavior disturbances.</p> <p>On admission Resident #59 had medications including, but not limited to,</p>	F000279	<p>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>I. Resident #59 did not have a specific care plan for insomnia though he did have "watch for symptoms of insomnia" as an intervention on a care plan for Risk of Falls.</p> <p>II. All residents who have a diagnosis of insomnia are at risk of this deficiency.</p> <p>III. All residents charts were reviewed by the Director of Nursing that had a diagnosis of insomnia as printed from our electronic recordkeeping system Point Click Care. Residents identified for having this diagnosis had their care plans reviewed by</p>	05/01/2014

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	<p>Trazadone 50 milligrams (mg) as needed (PRN) for insomnia. On 10/28/14 a physician's order was received to start the resident on Ambien 5 mg at bedtime for insomnia. On 2/26/14, a physician's order was received to start Melatonin 3 mg at bedtime for insomnia.</p> <p>Review of Resident #59's care plans indicated there was no care plan for insomnia.</p> <p>On 3/31/14 at 1:00 P.M., an interview with Employee #4, the Social Service Designee, indicated she did not start a care plan concerning insomnia for Resident #59 because she did not know about his insomnia diagnosis. Employee #4 indicated she did start a care plan for insomnia on 3/27/14 after she found out about his insomnia diagnosis.</p> <p>3.1-35(a)</p>		<p>nurse management. No other residents were missing a specific plan for this diagnosis.</p> <p>IV. Care plans will be reviewed quarterly or when needed by the Interdisciplinary Team as part of our care plan conferences. The MDS Coordinator is responsible for nursing care planning. She will audit each chart in writing weekly for four weeks for residents who take medications related to sleep and ensure proper care planning is accomplished. Results will be reviewed in the quarterly Quality Assurance meeting. Weekly reviews will continue until 100% compliance is reached.</p> <p>V. Date of compliance: 5/1/14</p>		

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F000329 SS=J	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 record review and interview, the facility failed to ensure laboratory tests were obtained and monitored as ordered by the physician for 1 of 3 residents reviewed for anticoagulation medication, which resulted in a</p>	F000329	Past noncompliance: No POC required.	04/10/2014

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	<p>hospitalization for blood in the urine, elevated PT/INR (prothrombin time/international normalized ratio) levels, and anemia, in a sample of 7 residents reviewed for unnecessary medications (Resident #48).</p> <p>The Immediate Jeopardy began on 11/28/2013 when the facility failed to obtain laboratory tests as ordered and was not identified until 12/19/2013, when the resident was transferred to the emergency room. Resident #48 required hospitalization for stabilization of the PT/INR. The facility Administrator and Director of Nursing were informed of the Immediate Jeopardy on 3/28/2014 at 10:20 A.M. The Immediate Jeopardy was removed and corrected on 12/19/2013 when the facility completed audits of clinical records for all residents on anticoagulation medications, in-serviced all nursing staff on obtaining laboratory work for residents on anticoagulation therapy, implemented a flow sheet for monitoring residents on anticoagulation therapy, and instituted on-going daily audits of all residents on anticoagulation therapy. The correction date was prior to the start of the survey and was therefore Past Noncompliance.</p> <p>Findings include:</p>						

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	<p>The record for Resident #48 was reviewed on 3/26/2014 at 10:30 A.M. Diagnoses included, but were not limited to, psychosis, explosive disorder, cirrhosis, encephalopathy, history of hepatitis C, and history of right iliac occlusive thrombosis with right lower extremity ischemia.</p> <p>Facility physician orders, dated 10/4/2013, indicated warfarin (generic Coumadin, an anticoagulant medication used to prevent blood clots) 3.5 mg daily was prescribed for Resident #48 upon his admission to the facility.</p> <p>A nursing note, dated 11/1/2013 at 6:00 P.M., indicated orders were received to have the resident transported to a behavioral health hospital.</p> <p>A physician order, dated 11/1/2013, indicated " May send to (behavioral health hospital) for eval (evaluation). "</p> <p>A " Patient Transfer Orders " form from (behavioral health hospital), dated 11/27/13, indicated discharge orders included, but were not limited to, Coumadin. The orders further indicated PT/INR (a laboratory test used to determine the clotting tendency of blood to assess the anticoagulation effects of Coumadin) testing was to be done daily</p>						

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	<p>upon the resident 's readmission to the nursing facility.</p> <p>A nursing note, dated 11/27/13 at 9:40 P.M., indicated Resident #48 was re-admitted to the nursing facility at 5:40 P.M. The note further indicated "(Physician's name) authorized meds returned c (with) until can be reviewed per (physician's name)."</p> <p>Facility Physician's Orders, dated 11/27/13, indicated Coumadin 6 mg (milligrams) daily was ordered for Resident #48.</p> <p>There was no documentation in the record indicating the daily PT/INR's had been obtained as ordered following Resident #48 's re-admission to the nursing facility.</p> <p>A nursing note, dated 12/18/13 at 6:30 P.M., indicated " Resident showered this shift, pull up dirty, wet c (with) urine et (and) blood ... "</p> <p>A nursing note, dated 12/18/13 at 9:30 P.M., indicated " received new orders @ 9 P.M. for U/A (urinalysis) c C&amp;S (culture and sensitivity), CBC (complete blood count), PT/INR d/t (due to) hematuria (blood in urine) .... "</p>						

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	<p>A nursing note, dated 12/19/13 at 5:30 A.M., indicated the resident continued to have blood in his urine. The note indicated the Nurse Practitioner was notified and orders were received to have the resident transferred to the emergency room. The note indicated EMS (emergency medical service) arrived and transferred the resident to the hospital emergency room by ambulance.</p> <p>A hospital history and physical report, dated 12/19/13, indicated "(Patient name) is a 48 yo (year old) male with brain damage secondary to HSV (herpes simplex virus) encephalitis transferred from (hospital) for gross hematuria and suprathereapeutic INR &gt; (greater than) 10. He was brought in to (hospital) ED (emergency department) by EMS from nursing home. In the ED he was found to have suprathereapeutic INR of &gt; 11 and was given 1 unit of FFP (fresh frozen plasma), 40 mg Protonix (medication used to reduce stomach acid) IV (intravenous) drip 8 mg/hr (milligrams per hour). Pt (patient) had gross hematuria and positive FOBT (fecal occult blood test used to detect blood in stool). Hgb (hemoglobin) verbally reported to be 8.5, hct (hematocrit) 25.8. No current labs accompanied patient from outside facility."</p>			

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	<p>A hospital laboratory report, dated 12/19/2013, indicated Resident #48's INR was "&gt; 11.0" and was indicated as being high. The reference range for INR was indicated as being as 0.8 - 1.2. A note on the report indicated "...called critical laboratory result(s) to ER (physician name) on 12/19/2013 @ 9:40."</p> <p>A hospital consultation report, dated 12/20/13, indicated "(Resident name) is a patient who is on Coumadin and came with suprathereapeutic INR greater than 10 with gross hematuria. He was transferred from (hospital) emergency department. Apparently a CT (computed tomography) scan done there showed left hydronephrosis (fluid build up in the kidney) and hydroureter (abnormal distention of ureter with urine) with obstruction at the mid level of the ureter of unclear etiology". The Assessment and Plan indicated "(Resident name) has gross hematuria (blood in urine) and left sided hydronephrosis which will need work up as an outpatient. Right now I think the thing to do is correct his INR...."</p> <p>A hospital discharge summary report, dated 12/23/2013, indicated "(Resident name) is a 48 year old male transferred from (hospital) ED to (hospital) for further management of acute urogenital</p>				

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	<p>bleeding secondary to suprathapeutic INR &gt; 10." The discharge summary further indicated "Pt bled down to hgb of 7.1 for which he received a total of 5 u (units) of FFP and 2 u of PRBCs (packed red blood cells) in addition to oral vitamin K. Mesalamine (medication used to treat ulcerative colitis) was held due to INR and heme positive stool test at (hospital) ER." The discharge summary also indicated "INR gradually came down to therapeutic range and was restarted today at reduced dose of 2.5 mg daily." Hospital discharge diagnoses included, but were not limited to, suprathapeutic INR, gross hematuria, and anemia associated with acute blood loss.</p> <p>The facility Director of Nursing (DON) was interviewed on 3/27/14 at 1:30 P.M. During the interview, the DON indicated the nurse had called her on the evening of 12/18/13 regarding Resident #48 and informed her that the resident had blood in his urine. The DON indicated she asked the nurse what medications the resident was on. When the nurse told her he was on Coumadin, the DON asked the nurse what the most recent PT/INR level was. The nurse reviewed the chart and told her that a PT/INR hadn't been done since his return from the behavioral health hospital on 11/27/13. The DON indicated she told the nurse to call the</p>						

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	<p>physician to inform him and to request orders. Orders were received for lab tests as indicated in the nursing notes. The DON indicated the resident was transferred to the hospital ER on 12/19/13 before the labs could be obtained. During the interview, the DON indicated new orders for laboratory tests were to be transcribed on to a laboratory requisition and the requisition was then sent to the lab. The DON indicated copies of the laboratory requisitions were kept on file in the facility. The DON indicated there was no laboratory requisition on file for PT/INR levels for Resident #48 as ordered on his re-admission to the facility on 11/27/2013. The DON indicated the daily PT/INR's had not been obtained as ordered on 11/27/13 when Resident #48 was readmitted to the facility from the behavioral health hospital.</p> <p>A facility policy entitled " Orders for Anticoagulation " , dated 07/2009, and provide by the facility DON on 3/26/2014 at 1:00 P.M., indicated " Orders for anticoagulants shall be prescribed only with proper clinical and laboratory monitoring. "</p> <p>The Past Noncompliance Immediate Jeopardy began on 11/28/2013. The Immediate Jeopardy was removed and</p>						

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F000371 SS=E	<p>corrected on 12/19/2013 when the facility completed audits of clinical records for all residents on anticoagulation medications, in-serviced all nursing staff on obtaining laboratory work for residents on anticoagulation therapy, implemented a flow sheet for monitoring residents on anticoagulation therapy, and instituted on-going daily audits of all residents on anticoagulation therapy. The correction date was prior to the start of the survey and was therefore Past Noncompliance.</p> <p>3.1 - 48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>			

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observations, interviews, and record review, the facility failed to ensure dietary staff wore hair restraints correctly, failed to ensure the outside of the walk-in freezer was not marred with paint chips, and failed to ensure the inside of the walk-in refrigerator door was not marred with paint chips. The facility further failed to ensure kitchen staff washed their hands upon entering the kitchen and when touching contaminated areas. This deficiency had the potential to affect 60 of 60 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>On 3/24/14 at 9:50 a.m. observations with the Dietary Manager on the inside of the walk-in refrigerator door was observed to be marred with paint chips. Also there was a smaller door incorporated on the outside to the walk-in freezer that was marred with paint chips. The Dietary Manager was interviewed and indicated she had notified the Maintenance Man, in regard to the paint chips on the inside of the walk in refrigerator door and on the small reach in door on the outside of the walk in</p>	F000371	<p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</p> <p>I. Surveyors observed one of the walk in freezers had slashes in the paint of the inner door. Surveyors also observed Dietary Aide #3 throw away a paper towel and then pour drinks without washing her hands. They also observed Cook #1 and Cook #2 not having their hair completely covered by their hairnets.</p> <p>II. All residents could be affected by this deficiency.</p> <p>III. Dietary Staff in-serviced on 4/8/14 on proper handwashing procedures and the use of hairnets. Walk in freezers painted on 4/11/14.</p> <p>IV. The Administrator will audit the kitchen weekly for the next four weeks to ensure proper hairnet use and handwashing is completed. Results will be reviewed in quarterly Quality Assurance meeting. Weekly audits will continue until 100% compliance is recorded for three straight audits.</p> <p>V. Date of compliance: 5/1/14</p>	05/01/2014

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	<p>freezer door, and were scheduled to be repaired.</p> <p>On 3/24/14 at 11:00 a.m. Cook #1 was observed in the kitchen during food preparation with her hair net on but her hair was not completely restrained by the hair net.</p> <p>On 3/28/14 at 10:30 a.m. both Cook #1 and Cook #2 were observed in the kitchen during food preparation with their hair nets on but the hair nets did not completely restrain their hair.</p> <p>On 3/28/14 at 10:45 a.m. an interview with the Dietary Manager indicated dietary staff should have all their hair restrained by a hair net.</p> <p>The undated Personal Hygiene policy received from the Director Of Nursing on 3/28/14 at 11:15 a.m. indicated "...If hair is long and not covered properly with a cap, a hairnet must be worn..."</p> <p>On 3/24/14 at 11:45 a.m. Dietary Aide #3 was observed reentering the kitchen and she did not wash her hands. Dietary Aide #3 lifted the trash can lid with her hand and threw away a paper towel then she poured drinks touching the lip of the Styrofoam cups with fingers. Dietary Aide #3 then covered the cups with</p>						

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	<p>plastic wrap, lifted the trash can lid with her hand and threw away a paper towel.</p> <p>Interview with Dietary Aide #3 on 3/27/14 at 9:00 a.m. indicated after she had entered the kitchen she should have first washed her hands.</p> <p>On 3/28/14 at 11:15 a.m. the undated Personal Hygiene policy was received from the Director Of Nursing and indicated, "Hands must always be washed after ...handling any unsanitary items."</p> <p>On 3/31/14 at 10:00 a.m. the Dietary Manager was interviewed and indicated dietary staff should have washed her hands after touching the trash can lid.</p> <p>3.1-21(i)(3)</p>			

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F000412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interviews, and record review, the facility failed to provide timely services or follow-up, after a resident was assessed to have need for new dentures. This affected 1 of 3 residents reviewed for dental status, Resident #29.</p> <p>Findings include:</p> <p>Resident #29 was interviewed, at 11:30 a.m., on 3/24/14, and was noted to have numerous missing teeth. The resident indicated he only had 6 teeth, had gone to the dentist over a month ago and was getting new dentures, but had not heard anything about the dentures since he had seen the dentist. He indicated the missing teeth did not affect his eating, and he had no mouth sores, but had a dry mouth.</p> <p>The Minimum Data Set (MDS) quarterly,</p>	F000412	<p>F412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>I. Resident #29 was seen by a dentist that did not follow through with the Medicaid procedure for payment and resident was not given appointment to have dentures remade. Resident has had no adverse effects of missing teeth (weight loss, pain, etc.). Resident #29 has stated often and is documented as saying he does not want dentures since the appointment referenced by the surveyors.</p> <p>II. All residents who have dental needs in the community have the potential of being affected by this alleged deficiency.</p> <p>III. Resident #29 is now in the process of receiving new dentures through the community dental office.</p> <p>IV. A complete audit of all</p>	04/16/2014

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	<p>dated 3/3/14, was reviewed, at 11:00 a.m. on 3/26/14, and indicated the resident was interviewable and scored a 13 on the brief interview for mental status (BIMs).</p> <p>The MDS RN nurse was interviewed, at 11:03 a.m., on 3/26/14, regarding the most recent MDS full assessment, and indicated it had been completed in May 2013, but did not have anything checked or marked for dental status to indicate any dental concerns. She indicated the MDS assessment did not ask regarding missing teeth, so if there were any dental concerns regarding missing teeth, it would be addressed in the care plan.</p> <p>The resident record was reviewed, at 11:05 a.m., on 3/26/14 and indicated the resident was originally admitted to the facility on 7/11/12, and re-admitted on 3/8/13, with diagnoses including, but not limited to: anxiety state, Chronic Obstructive Pulmonary Disease, hypertension, and depression. Review of a Nutritional risk assessment, dated 8/3/12, indicated the resident had few remaining teeth, a c/p(complete/partial plate) which did not fit, and the resident was on a regular diet with no chewing or swallowing problems. Review of a dietician assessment and follow-up form from a psychiatric center,</p>		<p>residents will be completed by Social Services on 4/16/14. All residents who are alert and oriented will be asked if they have dental pain or discomfort and positive reactions will be followed up on with dental appointments and appropriate documentation. Residents who are not alert and oriented will have coordination through nursing to determine if there is any dental pain or discomfort and will be subsequently followed up on with dental services with proper documentation completed. Social Services will document each appointment with community dental services and set dates of follow up weekly until final outcome is complete.</p> <p>V. Date of completion: 4/16/14</p>	

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	<p>dated 7/11/12, indicated the resident had few remaining teeth, dentures which did not fit, and a c/p (complete/partial) but the resident did not wear it due to a poor fit.</p> <p>Review of the most recent full MDS assessment, provided by the MDS coordinator, and dated 5/7/13, indicated no broken or loosely fitting full or partial denture(chipped, cracked, uncleanable, or loose), and no other dental issues.</p> <p>Review of the most recent quarterly assessments, dated 9/3/13, 12/4/13, and 3/3/14, indicated nothing was marked on the on the oral/dental status assessments including any concerns with broken or loosely fitting full or partial dentures(chipped, cracked, uncleanable, or loose).</p> <p>Review of the only dental exam found in the record, dated 11/19/13, indicated the resident was seen by the contracted facility dental service, at the facility, and an exam completed, which indicated, "we are writing referral for pain around #28 (tooth). He does have an upper. He does have a lower partial but chooses not to wear it. Told him to take dentures to referral. "</p> <p>The Social Service Director was interviewed, at 11:15 a.m., on 3/26/14,</p>				

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	<p>and indicated the contracted dental service who saw residents at the facility only did assessments and cleaned teeth, then made referrals if other services were required. She indicated any referrals were then made to the outside dental office the facility used. She indicated there was only one dentist in the area who accepted Medicaid Insurance so Resident #29 was referred to this dentist.</p> <p>The Social Service Director indicated once the facility dentist assessed the resident, and made a referral for the resident, she would take care of setting up the appointment for the resident to be seen by the outside dental service. She indicated she reviewed her social service documentation, but could find no documentation she had made this referral. She then indicated she reviewed her personal calendar for 2013, and indicated she had documented on the calendar the resident had an appointment with the outside dental office on 12/17/13. She indicated since she could find no documentation regarding the dental appointment, she would contact the dentist's office to see if the resident had been seen on 12/17/13.</p> <p>The resident was interviewed, at 1:10 p.m., on 3/26/14, and indicated he only had 6 bottom teeth, and would get pain in</p>						

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	<p>his mouth because at night when he was sleeping, he would "grind" his teeth, and the bottom teeth would bite into his upper gum and cause pain. He indicated he had a upper dental plate, which he didn't wear because it was loose, and did not fit. He indicated he had a lower partial plate but could not wear it because it wasn't comfortable to wear.</p> <p>Review of nursing notes from the thinned file, provided by the Social Service Director, at 1:17 p.m., on 3/26/14, indicated a nurse's note, dated 12/17/13, which indicated the resident went out to the dentist. Another note, dated 12/17/13, indicated the resident returned from the dentist and "awaiting rec (record) from DDS(Doctor of dental surgery)."</p> <p>The Social Service Director was interviewed, at 1:17 p.m., on 3/26/14, and indicated she had called the dentist office before lunch today, and talked to the Patient Representative at the office, who indicated Resident #29 was seen on 12/17/13, and the dentist realigned the current upper denture appliance for the resident but indicated the bone structure was not good, so the dentist had realigned it to help for the time being. She indicated the dentist also recommended the resident have new dentures.</p>						

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	<p>She indicated after the outside dentist had seen the resident, the dentist's office was responsible to get prior authorization from Medicaid for further treatment. She indicated once Medicaid authorization was received, which could take 2-3 months, the facility would be contacted. The SSD indicated when she contacted the dentist's office today, the Patient Representative told her "they dropped the ball" and had never sent for prior authorization from Medicaid so the resident could be fitted for dentures. The SSD indicated she talked to the resident frequently and he had never complained about any dental issues to her since the dental visit in December 2013, or she would have contacted the office. She indicated normally once she sets up the appointment with the dentist, she would wait for the dentist office to contact the facility regarding the prior authorization being received from medicaid, so indicated since the resident had not complained of any dental issues, she had not contacted the office back. She indicated if the dentist sent any progress notes or information back after the visit, the nurses would get this information. She indicated she had reviewed the resident record and could not find any documentation regarding the visit.</p>			

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	<p>CNA #10 was interviewed, at 8:55 a.m., on 3/27/14, and indicated the resident was able to do most of his own Activity of daily living care, did not complain of mouth pain, and did his own mouth care. She indicated she had never seen him wear dentures, and had been taking care of him for at least one year.</p> <p>Review of a treatment note, from the dentist's office, dated 12/17/13, and provided by Social Service Director (SSD) , at 3:00 p.m., on 3/26/14, indicated the resident presented with a loose upper denture, 7 years old, and the resident wore a lower partial but was having discomfort with the lower teeth. The note also indicated, "rec (recommend) reline upper denture and due to decay have a lower immediate denture made. "</p> <p>Review of the facility contracted dental service exam visits, provided by the SSD at 11:07 a.m., on 3/27/14, indicated the following: 10/1/12 Dentist did not see due to resident ill 12/5/12 initial oral exam which indicated the resident had some broken teeth but did not want referral for them and was not interested in a new c\p (complete/partial) set due to finances.</p>						

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	<p>8/23/13 refused to be seen 9/25/13 not seen today due to "other"</p> <p>Review of the only care plan for dental issues was dated 3/3/14, and indicated a problem "Resident missing several of his natural teeth" with a goal, "Will not suffer any weight loss d/t (due to) missing teeth. " The approaches indicated the following: Serve diet per physician's order Monitor for pain while eating Oral care twice a day Monitor weight and intake Encourage resident to voice any pain while eating.</p> <p>The Assistant DNS was interviewed, at 12:33 p.m., on 3/31/14 and indicated there was no dental policy.</p> <p>3.1-24(a)(1) 3.1-24(a)(3)</p>						

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F000431 SS=D	<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, 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 and interview, the facility failed to ensure medications stored in refrigerators in one of two medication storage rooms were</p>	F000431	<p>F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>I. The Medication refrigerator in the Memory Care Hall</p>	05/01/2014

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	<p>maintained at the proper temperature, potentially affecting 3 of 67 residents (#3, 31, 17) in the facility on medications.</p> <p>Findings include:</p> <p>A review of medication storage on 4/1/14 at 9:45 A.M. on the Memory units medication storage room indicated the refrigerator temperature was 26 degrees. A list on the refrigerator titled Refrigerator and Freezer Temp Log/Med Audit, March, 2014 for the Memory Med room refrigerator indicated temperatures for the refrigerator: 3/1/14: 26 degrees; 3/2/14: 26 degrees; 3/3/14: 30 degrees; 3/4/14: 32 degrees; 3/5/14: 30 degrees; 3/6/14, 31 degrees; 3/7/14 32 degrees; 3/8/14, 30 degrees; 3/9/14, 30 degrees; 3/10/14: 31 degrees; 3/11/14: 29 degrees; 3/12/14: 28 degrees; 3/13/14: 25 degrees; 3/14/14: 25 degrees; 3/15/14: 24 degrees; 3/16/14: 25 degrees; 3/17/14: 23 degrees; 3/18/14: 24 degrees; 3/19/14: 24 degrees; 3/20/14: 22 degrees; 3/21/14: 25 degrees; 3/22/14: 24 degrees; 3/23/14: 30 degrees; 3/24/14: 28 degrees; 3/25/14: 20 degrees; 3/26/14: 24 degrees; 3/27/14: 28 degrees; 3/28/14: 22 degrees; 3/29/14: 26 degrees; 3/30/14: 24 degrees; 3/31/14: 20 degrees.</p> <p>Review of the medications in the refrigerator on 4/1/14 at 9:45 A.M. indicated Resident #3 had an unopened</p>		<p>Medicine Room was found to be set too low for the recommended temperature of insulin products.</p> <p>II. All residents who require insulin products have the potential to be affected by this deficiency.</p> <p>III. Temperature was adjusted to meet the recommended standard.</p> <p>IV. All refrigerators are monitored daily for temperatures and their logs have been marked to indicate recommended temperatures for medications kept there. Logs will be audited weekly for four weeks and the results will be reviewed in quarterly Quality Assurance Meeting. Weekly audits will continue until 100% compliance is resulted four consecutive weeks.</p> <p>V. Date of completion: 5/1/14</p>	

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F000465 SS=E	<p>vial of Novolog (an insulin)100 units (u)/milliliters (ml), 10 ml per vial. Resident # 3 also had an unopened vial of Levemir (an insulin) 100 u/ml, 10 ml vial. Resident #31 had 4 unopened vials of Levemir 100 u/ml, 10 ml vial. Resident #17 had 1 vial of Novolog 100 u/ml, 10 ml vial.</p> <p>Review of the instructions for storage of unopened Levemir indicated the medication is to be kept between 36-46 degrees in the refrigerator. Review of the instructions for storage of unopened Novolog indicated the medication is to be stored between 36-46 degrees.</p> <p>An interview with the Director of Nursing (DN) on 4/1/14 at 10:05 A.M. indicated refrigerator temperatures should be between 36 and 46 degrees.</p> <p>3.1-25(m)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p>			

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	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>1. Based on observation and interview, the facility failed to ensure a safe and comfortable environment was maintained on 3 of 3 units.</p> <p>2. Based on observations and interviews, the facility failed to ensure the ceiling in the Main Dining Room was free of cracks and water stains, and failed to ensure the Main Dining Room had no chips in the baseboard along the floor at the entrance to Main Dining Room. This deficiency had the potential to affect all 67 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Resident #27 was observed coming out of her room, at 9:25 a.m., on 3/25/14, walking independently down the hall. She was observed a short time later outside in the smoking area with several other residents and a staff member.</p> <p>During observation of Resident #27's room, at 9:50 a.m., on 3/25/14, a square piece of baseboard, 7 inches by 7 inches, located to the right of the closet door on entrance to the room, was partially detached from the wall and sticking out away from the wall.</p> <p>The Director of Nursing Services (DNS)</p>	F000465	<p>F465 483.70 (h)</p> <p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>I. Surveyor found the following areas of concern during tour: Resident #27 had a 7 inch baseboard in front of their closet which was separated from the wall, Room 66 had a baseboard separated from the wall in their bathroom, Room 48 had chipped paint on its' bathroom doorframe, Room 49 had chipped paint on the wall next to the bathroom, Room 22 had chipped paint on its' bathroom doorframe and the bedside nightstand was chipped, Room 35 had chipped paint and dry wall damage right of the dresser and paint chipped on the doorframe to the bathroom, baseboard along the wall in the Main Dining Room had separated and there was a crack in the ceiling.</p> <p>II. All residents have the potential of being affected by this deficiency.</p> <p>III. All areas indicated have been painted or repaired as needed. New furniture was procured to replace what was indicated and the old items were discarded.</p> <p>IV. Maintenance Director will complete a weekly audit of door frames, furniture, baseboards, and resident room walls for the next four weeks. Results will be reviewed in</p>	05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/01/2014
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580		
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	<p>was notified of the concern, at 10:00 a.m., on 3/25/14. She confirmed the baseboard needed to be repaired right away because the resident was self ambulatory and the potential for injury since the baseboard was sticking out away from the wall.</p> <p>During the Environmental tour, conducted between 2:00 p.m., and 3:15 p.m., on 3/31/14, and accompanied by the Environmental Director, the following areas of concern were noted in resident occupied rooms:</p> <p>Primrose Hall:</p> <p>In Room 66, the baseboard on the left side of the bathroom, located on the left side of the sink was loose and detached from the wall. The Maintenance Director indicated the area measured 18 inches in length.</p> <p>In Room 64, the frame and legs on the bedside table were noted to have areas of chipped and/or scratched paint throughout the frame and legs. The Maintenance Director indicated it was an old table.</p> <p>In Room 48, there were areas of missing and/or chipped pain on the inner side of the narrow wall to the left of the bathroom doorframe on entrance to the</p>		<p>quarterly Quality Assurance meeting. Preventative maintenance procedures have been put in place that include weekly painting or "touch ups" of any area needing attention. Outside contractors have been employed to assist in this project.</p> <p>V. Date of Completion: 5/1/14</p>		

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	<p>bathroom, which extended half way up the wall from the floor. There were areas of missing and /or chipped paint on the outer side of the narrow wall which extended 26 inches from the floor.</p> <p>In Room 49, there were areas of chipped pain on the narrow wall to the right of the bathroom door. The Maintenance Director indicated the area extended up approximately 12 inches from the floor.</p> <p>Harmony Hall:</p> <p>In Room 19, on both sides of the door frame on entrance to the room, there were areas of scraped and/or chipped paint. The Maintenance Director indicated the area extended up from the floor approximately 18 inches and was due to the wheelchairs hitting the doorframe. He indicated he had painted the area approximately 2 months ago.</p> <p>Memory Hall:</p> <p>In Room 22, there were areas of rust and chipped paint on both sides of the door frame on entrance to the bathroom. The area on the right side extended up 10 inches from the floor. There were scattered areas of rust on the left side which the Maintenance Director indicated extended up from the floor</p>				

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	<p>approximately 6 inches.</p> <p>There was also an area of rust on both sides, where the doorframe met the floor. The Maintenance Director indicated the area measured about 2 inches and was due to moisture coming up from the floor.</p> <p>The base area of the bedside nightstand in Room 22 had scattered areas of chipped and/or missing paint. The Maintenance Director indicated the finish was coming off of the nightstand, and it was a facility nightstand.</p> <p>In Room 35 there was a 3 by 1 inch area of drywall and paint missing on the wall to the right of the dresser where the Television was setting. There were scattered areas of chipped/cracked paint extending 30 inches up the same wall area from the baseboard. The door frame on both sides of the entrance to the bathroom had rusted areas extending up approximately 4- 6 inches from the floor.</p> <p>The Maintenance Director indicated he had been working on the hallways, and painted all the hallways, re-textured the walls in the hallways, put up new handrails, and several other improvements. He indicated he was planning on doing maintenance in the resident rooms, but had not scheduled any work on the rooms at this time.</p>				