

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2012
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NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00103521 and Complaint IN00104011.</p> <p>Complaint IN00103521 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F311.</p> <p>Complaint IN00104011 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 12, 13, 14, 15, and 16, 2012</p> <p>Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800</p> <p>Survey Team: Gloria J. Reisert MSW,TC Avona Connell RN Donna Groan RN Dorothy Navetta RN (2/13, 2/14, 2/15, and 2/16/2012)</p> <p>Census Bed Type: SNF: 02 SNF/NF: 95 Total: 97</p>	F0000	<p>Submission of the Plan of Correction does not constitute an admission by this facility of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted, as required by law. We respectfully request this Plan of Correction serve as our allegation of compliance. And also request a desk review of our Plan of Correction. Date of Compliance 16 MAR 2012</p>	

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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	<p>Census Payor Type: Medicare: 17 Medicaid: 80 Other: 0 Total: 97</p> <p>Sample: 20 Supplemental Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/23/12 by Suzanne Williams, RN</p>			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician or the alternate physician was notified timely of a change in condition for 1 of 4 residents reviewed with a change in</p>	F0157	It is the practice of this facility to ensure the physician or the alternate physician is notified timely of a change in condition of a resident.No other residents were affected by this practice	03/16/2012

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	<p>condition in a supplemental sample of 4. (Resident #100)</p> <p>Findings include:</p> <p>The clinical record for Resident #100 was reviewed on 2/15/12 at 8:05 a.m. The resident's diagnoses included, but were not limited to cardiovascular disease, toxic metabolic encephala and bipolar disorder. The Progress Notes included, but were not limited to:</p> <p>11/24/11 1:30 p.m. "Res.(resident) asleep in w/c (wheelchair), ref. (refused) to go to bed. Not easily awakened. Unable to take 12 p meds. Will monitor."</p> <p>2p "CNAs (Certified Nursing Assistants) assisted res. to bed. Resting abed @ this time. Will monitor."</p> <p>4p "Res. Cont. to be lethargic. Unable to arouse for meds @ this time. V/S (vital signs) WNL (within normal limits). Responds to painful stimuli. Will monitor."</p> <p>5:30 pm "Res. unable to eat dinner. No speaking, wont (sic) open eyes. Staff assisted back to bed. Incontinent of B&B (bowel and bladder). Peri care done per staff. Room sweep done per this writer & another nurse for safety measure. No</p>		<p>through a review of residents records.Nursing Staff were in-serviced on our policy of notification of physician with a change in condition. Orders will be reviewed daily by Unit Manager/designee to ensure of MD notification.Unit Managers/Designee will audit 10% of unit records for physician notification in a timely manner this will be done weekly for 30 days and then monthly X 3 months and the reviewed at QA.Unit Managers/Designee will audit 10% of unit records for physician notification in a timely manner this will be done weekly for 30 days and then monthly X 3 months and the reviewed at QA.</p>		

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	<p>meds noted. V.S : O2 (oxygen) 96 %, P76, B/P 120/90, T96.1, RR10. MD phoned and message left. Awaiting call back."</p> <p>7:15 p "Res not speaking. Wont (sic) open eyes. Slumped over in wheelchair. Only response is gotten after sternum rub. Bp 76/42, HR 58, BS (blood sugar) 121, R 10. Call to Dr. (named) to send to ER. Family notified."</p> <p>In interview with the DON on 2/15/12 at 11 a.m., she indicated when staff were unable to get the attending physician, who is the Medical Director, they should have contacted the alternate MD.</p> <p>On 2/16/12 at 9:35 a.m., the Policy and Procedure provided by the DON on 2/15/12 at 5 p.m., included, but was not limited to: "Notification of Resident Change in condition Procedure: 1. Notify the Physician and family or legal representative at the earliest possible time, during waking hours, if there is a non-critical change in condition (unless requested to do otherwise). 2. Notify the Physician and family or legal representative immediately, if there is a significant change in condition, regardless of the time. a. If the nurse responsible for the care of the resident is remaining with the resident and unable to place the</p>						

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	<p>telephone calls, another clinician will place the calls. b. Contact the Medical Director if unable to contact attending physician or on-call physician. c. If an emergency, call area emergency number e.g., 911."</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F0177 SS=D	<p>483.10(o) RIGHT TO REFUSE CERTAIN TRANSFERS An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or a resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.</p> <p>A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.</p> <p>Based on record review and interview, the facility failed to allow residents to refuse transfer to another section of the facility and remain in their current rooms when the unit dynamics were changing. This affected 2 of 2 residents reviewed for room changes in a sample of 20 residents. (Residents #72 and 73)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #72 on 2/15/2012 at 3:00 p.m., indicated the resident had diagnoses which included, but were not limited to: seizure disorder, dementia, depression, and anxiety.</p> <p>2. Review of the clinical record for Resident #73 on 2/16/2012 at 2:40 p.m.,</p>	F0177	<p>It is always the intent of this facility to allow a resident the right to refuse a transfer if at all possible. No other residents were affected by this practice through a review of residents. Residents #72 and #73 were given several options before being transferred off the wing. Resident #72 is care planned for lying for attention "will lie on staff when resident does not get her way". Resident is careplanned for being rude to peers and for passing on gossip inaccurately to others. Resident will intentionally say things to others to cause problems and this also is careplanned. Resident has been noted to claim having seizures when there was no indication that resident was having a seizure but wanted attention. Resident that are requested to move will be given a 30 day notice of transfer with the ombudsmans phone number and</p>	03/16/2012			

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	<p>indicated the resident had diagnoses which included, but were not limited to: Alzheimer's disease, depressive disorder and Parkinson's.</p> <p>During the group meeting on 2/14/2012 at 10:15 a.m. with 9 residents deemed alert and oriented by the Activities Director, 2 residents (Residents #72 and 73) indicated they were moved from North hall to Annex hall because North hall was being made more for residents with behavior issues and both residents were not considered appropriate to remain on the unit. Both residents indicated they were upset at having to move and felt they were not able to exercise their rights and not given a choice to remain in their room even though the dynamics of the unit were changing. They also indicated they did not have a problem living among those residents who may wander or had behavior issues.</p> <p>Review of the Intrafacility Transfer Notices for both residents dated 1/20/2012, indicated the move was to occur on 1/26/2012. The reason given for the move was "To be in a more appropriate unit."</p> <p>During the interview with Resident #72 and 73, Resident #72 indicated she does</p>		<p>their rights to refuse. Social Service will follow up with residents during this 30 day period to discuss any concerns and that Social Service/designee will document these conversations and any concerns. The resident will not be moved without a signed waiver of time and/or consent or a hearing with the state ombudsman. All room changes will be reviewed at monthly QA meetings. Resident that are requested to move will be given a 30 day notice of transfer with the ombudsmans phone number and their rights to refuse. Social Service will follow up with residents during this 30 day period to discuss any concerns and that Social Service/designee will document these conversations and any concerns. The resident will not be moved without a signed waiver of time and/or consent or a hearing with the state ombudsman. All room changes will be reviewed at monthly QA meetings.</p>		

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	<p>not handle changes very well and it upset her so much and made her nervous. Both residents said it was the manner in which they were spoken to about moving that gave them impression they had no choice to refuse if they wanted to.</p> <p>A nursing note dated 1/26/2012 at 6 p.m. for Resident #72 indicated: "Rd [resident] and belongings moved to room 116. Roommate called this writer to room stated, 'she's having a seizure'. Very alert for seizure looking around hallway, noted minor twitching..."</p> <p>During an interview with Social Worker #1 on 2/16/2012 at 10:40 a.m., she indicated no one was ever moved against their will and that she explained the reasoning for the move but would have to look at her notes to see where it was documented.</p> <p>During a second interview with Social Worker #1 on 2/16/2012 at 12:15 p.m., the Social Worker indicated she knew she spoke to the residents about moving and gave them a copy of their Resident Rights but was unable to locate documentation in which she spoke to the two residents about being able to remain in their room if they wished.</p> <p>On 2/15/2012 at 4:20 p.m., the Director of</p>						

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	<p>Nursing presented a copy of the facility's current policy on "Room Changes". Review of this policy at this time included, but was not limited to:</p> <p>"Procedure:...6. Ensure the resident/family has received preparation and orientation prior to the room transfer...8. Document at least the following, in the medical record:...Discussion with the resident/family/legal representative and the results of that discussion..."</p> <p>3.1-12(a)(14)</p>			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>A. Based on record review and interview, the facility failed to ensure a psychiatric evaluation was obtained per recommendations on a Level II evaluation for 1 of 4 residents reviewed with a Level II evaluation in a sample of 20. (Resident #55)</p> <p>B. Based on record review and interview, the facility failed to ensure Social Services encouraged residents to exercise their Resident Rights to refuse room changes and remain in their current room when the dynamics of the unit changed to handle residents with behavior issues. (Resident #72 and 73)</p> <p>Findings include:</p> <p>A. The clinical record for Resident #55 was reviewed on 2/13/12 at 3:34 p.m. The resident's diagnoses included, but were not limited to depression. The resident was admitted to the facility on 11/17/11. The Level II PreAdmission Screening Determination dated 11/17/2011 included, but was not limited to: Continue Current MH (Mental</p>	F0250	<p>It is the intent of this facility to review Level II's and ensure a psychiatric evaluation is obtained if required or any other recommendations.No other resident were found to be affected through a chart review.Social Service/designee will keep a log of all Level II's with the current date and the renewal dated noted and the log will indicate that renewal was done and on what date it was sent for renewal will record date when completed and placed in the residents record for review. Social Service/designee will review monthly level II's during monthly QA meeting.Social Service/designee will keep a log of all Level II's with the current date and the renewal dated noted and the log will indicate that renewal was done and on what date it was sent for renewal will record date when completed and placed in the residents record for review. Social Service/designee will review monthly level II's during monthly QA meeting.Residents #72 and #73 were given several options before being transferred off the wing. Resident #72 is care planed for lying for attention "will</p>	03/16/2012	

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	<p>Health) Services and Psychiatric Evaluation.</p> <p>An Initial Psychiatric Evaluation was dated 2/11/12.</p> <p>In interview on 2/13/12 at 4:15 p.m., with Social Worker #1, when queried as to why the evaluation was not done sooner, she indicated they do follow-up on the Level II's. Social Worker #1 was asked for the lists of residents referred to Psychiatry for November 2011 thru February 2012. She indicated they had no logs, but they'll keep one now.</p>		<p>lie on staff when resident does not get her way". Resident is careplanned for being rude to peers and for passing on gossip inaccurately to others. Resident will intentionally say things to others to cause problems and this also is careplanned. Resident has been noted to claim having seizures when there was no indication that resident was having a seizure but wanted attention. Resident that are requested to move will be given a 30 day notice of transfer with the ombudsmans phone number and their rights to refuse. Social Service will follow up with residents during this 30 day period to discuss any concerns and that Social Service/designee will document these conversations and any concerns. The resident will not be moved without a signed waiver of time and/or consent or a hearing with the state ombudsman. All room changes will be reviewed at monthly QA meetings. Resident that are requested to move will be given a 30 day notice of transfer with the ombudsmans phone number and their rights to refuse. Social Service will follow up with residents during this 30 day period to discuss any concerns and that Social Service/designee will document these conversations and any concerns. The resident will not be moved without a signed waiver of time and/or</p>		

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	<p>B. Review of the clinical record for Resident #72 on 2/15/2012 at 3:00 p.m., indicated the resident had diagnoses which included, but were not limited to: seizure disorder, dementia, depression, and anxiety.</p> <p>B. Review of the clinical record for Resident #73 on 2/16/2012 at 2:40 p.m., indicated the resident had diagnoses which included, but were not limited to: Alzheimer's disease, depressive disorder and Parkinson's.</p> <p>During the group meeting on 2/14/2012 at 10:15 a.m. with 9 residents deemed alert and oriented by the Activities Director, 2 residents (Residents #72 and 73) indicated they were moved from North hall to Annex hall because North hall was being made more for residents with behavior issues and both residents were not considered appropriate to remain on the unit. Both residents indicated they were upset at having to move and felt they were not able to exercise their rights and not given a choice to remain in their room even though the dynamics of the unit were changing. They also indicated they did not have a problem living among</p>		consent or a hearing with the state ombudsman. All room changes will be reviewed at monthly QA meetings.		

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	<p>those residents who may wander or had behavior issues.</p> <p>Review of the Intrafacility Transfer Notices for both residents dated 1/20/2012, indicated the move was to occur on 1/26/2012. The reason given for the move was "To be in a more appropriate unit."</p> <p>During the interview with Resident #72 and 73, Resident #72 indicated she does not handle changes very well and it upset her so much and made her nervous. Both residents said it was the manner in which they were spoken to about moving that gave them impression they had no choice to refuse if they wanted to and felt it went against their rights.</p> <p>During an interview with Social Worker #1 on 2/16/2012 at 10:40 a.m., she indicated no one was ever moved against their will and that she explained the reasoning for the move but would have to look at her notes to see where it was documented.</p> <p>During a second interview with Social Worker #1 on 2/16/2012 at 12:15 p.m., the Social Worker indicated she knew she spoke to the residents about moving and gave them a copy of their Resident Rights but was unable to locate documentation in</p>						

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	<p>which she spoke to the two residents about being able to remain in their room if they wished.</p> <p>On 2/15/2012 at 4:20 p.m., the Director of Nursing presented a copy of the facility's current policy on "Room Changes". Review of this policy at this time included, but was not limited to: "Procedure:...6. Ensure the resident/family has received preparation and orientation prior to the room transfer...8. Document at least the following, in the medical record:...Discussion with the resident/family/legal representative and the results of that discussion..."</p> <p>On 2/16/2012 at 9:00 a.m., the Staff Development Coordinator presented a copy of Social Worker #1's signed "Job Description dated 5/18/2011. Review of this "Job Description" at this time included, but was not limited to: "...Essential Functions:...6. Informs residents/patients when room change or roommate change is anticipated. Counsels regarding changes and follow-ups as necessary. Documents resident/patient response. 7. Assesses the social, emotional, and spiritual needs of the residents/patients and ensures that the social services intervention is a part of the resident's/patient's Plan of Care. Ensures</p>						

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	<p>that the required Social Services interventions, as identified in each resident/patient Plan of Care are provided either directly through the department or through outside referrals. 8. Ensure that assessments are initiated and completed according to the resident's/patient's Level of Care, as required. 9. Monitors and collaborates with outside agencies to ensure quality interventions and communicates these interventions and outcomes to the team through the appropriate Clinical Meeting and as required...19. Resident Rights: Knows Resident Rights. helps the residents/patients exercise and/or protect their rights..."</p> <p>3.1-34(a)</p>				

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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, record review and interview, the facility failed to ensure equipment was clean, functioning, and in good repair in 4 of 4 shower rooms, ceiling vents in therapy, and floor coverings in 1 of 3 halls. This deficient practice had the potential to affect 97 of 97 residents currently residing in the facility.</p> <p>Findings include:</p> <p>1. On 02/12/12 at 2:25 p.m. the following was observed in the women's shower room on the south hall:</p> <p>A large area of paint approximately 2 feet by 3 feet was chipped off the door. One white tile was missing in the shower above the hand bar. The window sill had chipped paint.</p> <p>The flooring had a raised area approximately 2 1/2 by 6 inches near the fire extinguisher and across from the physical therapy department.</p> <p>2. On 02/15/12 between the hours of 7:30 a.m. and 8:00 a.m., the following was</p>	F0253	<p>It is the intent of this facility to provide housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior.No residents were found to be effected by this practice.The door on south hall womans shower room has been repaired with new paint, and the tile has been replaced.A flooring contractor has been notified and awaiting bid to repair raised area and replace flooring.Caulking around the toilet on annex shower room will be replaced. And floor has been scrubed. Ceiling lights above the shower drain and near toilet was working however, it is a special switch due to moisture and located by cabinet on the wall.Curtains were placed in the mens shower room on south hall imediately.and shower room was cleaned. Housekeeping will monitor shower curtains dailey for cleaning and replacement. All dinning room furniture in annex dinning room will be cleaned daily by Housekeeping and furniture taken out of service when necessary.Wall paper is being removed and annex dinning room is being painted and all repairs to walls will be completed with painting.Hand rail cover was re-aligned on south hall going to</p>	03/16/2012

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	<p>observed:</p> <p>The shower room across from the nursing station on the 100 hall had the caulking around the toilet soiled/ discolored. The tile floor had 3 brown nickel size dried brown spots on the floor near the floor drain.</p> <p>3. The shower room across from the storage room and room 112 had stained caulking at the toilet base. The ceiling lights above the shower drain and near the toilet failed to light, when turned on.</p> <p>4. The men's shower room on the south hall lacked curtains for privacy for the shower, and 2 toilets. The lid of the trash container was soiled with dried brown and white substances.</p> <p>In interview with the Housekeeping Supervisor on 02/16/12 at 10:15 a.m., she indicated she was not aware curtains were not up for privacy. She added at one time cubicle curtains were used, but taken down and not enough new ones were ordered. She indicated there was no system in place to monitor the curtains to provide privacy.</p> <p>5. The wood frames of 4 of 7 chairs in the Annex dining room were soiled with heavy dust and the finish of 1 chair was marred.</p>		<p>annex.All ceiling vents have been cleaned and will be cleaned monthly unless it is needed more often by maintanceLight in South Hall Medication room has been fixed.Housekeeping and Maintenance will keep daily logs of rooms checked and maintenance request will be reviewed weekly by HFA/designee for completion.The thirty day maintenance summary will be reviewed by HFA/designee monthly and reviewed during monthly QAHousekeeping and Maintenance will keep daily logs of rooms checked and maintenance request will be reviewed weekly by HFA/designee for completion.The thirty day maintenance summary will be reviewed by HFA/designee monthly and reviewed during monthly QA</p>				

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	<p>6. The wallpaper in the Annex dining room was loose and bubbling out under the window in an area approximately 12 inches by 6 inches. A hole was observed in the wall by the electrical socket and 5 areas of wallpaper were torn the approximate size of a quarter.</p> <p>7. The handrail cover was separated on the ramp from the annex to the south hall in an area measuring approximately 1/4 to 1/2 inch.</p> <p>8. In the therapy room 2 of 4 ceiling vents were soiled with heavy dust. A copy of the cleaning schedule for the ceiling vents was provided and reviewed on 02/16/12 at 12:20 p.m. The vents were last cleaned on 12/3/12.</p> <p>9. On 02/12/12 at 2:25 p.m., the light cover in the south hall med room was hanging down. Licensed Practical Nurse #2, indicated the cover would not stay up.</p> <p>3.1-19(f)</p>			

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F0282 SS=D	<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>A. Based on record review, observation and interview the facility failed to ensure that a order for a nose cup was implemented. This affected 1 of 1 resident reviewed for a nose cup in a supplemental sample of 4. (Resident C)</p> <p>B. Based on record review and interview, the facility failed to administer a medication for low albumin [protein in skin to aid in healing wounds] after the resident's gastrostomy tube [feeding tube] was removed. This affected 1 of 2 residents with a feeding tube in a sample of 20 residents. (Resident #97)</p> <p>Findings include:</p> <p>A. The clinical record of Resident #C was reviewed on 2/15/2012 at 9:00 a.m. Diagnoses included, but were not limited to: cerebral vascular accident (stroke), dementia, anxiety, hypertension, syncope (dizziness), chronic renal insufficiency, history of malnutrition.</p> <p>Review of physician orders written on 2/7/2012 indicated an order for "res</p>	F0282	<p>It is the policy of this facility to ensure that orders are reviewed and implemented as ordered. The facility's intent is also to ensure that medications are being administered as ordered and/or order changed per requirements. No other resident were found to be affected. A new contracted Therapist had written an order and did not flag order to be taken off. An audit was completed to ensure that all Speech Therapy orders have been reviewed and implemented as ordered. An audit has been completed to ensure that all Medication are being given as ordered; Orders will be review daily at morning meetings by Unit Managers/designee for changes in medications. Speech Therapy will provide a list weekly of residents seen and their charts will be reviewed by the Unit Managers/designee weekly or 30 days and then monthly there after to ensure all orders are</p>	03/16/2012

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	<p>(resident) to use nose cups for liquids."</p> <p>Observation of Resident #C during meal times on 2/13/2012 at 5:56 p.m., 2/14/2012 at 11:57 a.m., 2/15/2012 at 12:40 p.m., and coffee hour on 2/15/2012 at 9:30 a.m. it was noted that a nose cup was not used.</p> <p>On 2/15/2012 at 4:45 p.m., in an interview during the daily exit conference, the Director of Nursing (DON) indicated "I couldn't find an order for the nose cup; did he have one?"</p> <p>On 2/16/2012 at 9:35 a.m., in an interview with the Administrator and DON, they indicated that the order was found and had been overlooked. The Administrator indicated the Speech Therapist is new and they had told her that she needs to flag orders and write them on internal information paper.</p> <p>B. Review of the clinical record for Resident #97 on 2/15/2012 at 12:20 p.m., indicated the resident was admitted on 5/17/2011 and had diagnoses which included, but were not limited to, chronic respiratory failure, end stage renal disease, and chronic obstructive pulmonary disease.</p> <p>Review of the February 2012 Medication Administration Record [MAR] indicated</p>		implemented. Therapy orders will be reviewed at monthly QA meetings.				

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	<p>the resident had an order for Pro-Stat 101 liquid - give 60 ml [milliliters] via g-tube [gastrostomy tube] 3 times a day R/T [related to] low albumin (5 a.m., 5 p.m., 8 p.m.) dated 11/29/2011.</p> <p>On 2/1/2012, the resident underwent removal of her g-tube. The February MAR indicated the 5 a.m. and the 5 p.m. doses on 2/1/2012 were given with the 8 p.m. and the 2/2/2012 5 a.m. doses held and then the medication was discontinued. Documentation was lacking of a physician order being obtained to discontinue the medication.</p> <p>During an interview with the Director of Nursing on 2/15/2012 at 4:45 p.m., she indicated nursing should have obtained a physician order before stopping the medication.</p> <p>This Federal tag was related to Complaint IN00103521.</p> <p>3.1-35(g)(2)</p>				

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS 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, observation and interview, the facility failed to ensure that a treatment plan for a nosey cup was implemented to maintain the resident's ability with eating and swallowing properly. This affected 1 of 1 resident reviewed for a nosey cup in a supplemental sample of 4. (Resident C)</p> <p>Findings include:</p> <p>The clinical record of Resident #C was reviewed on 2/15/2012 at 9:00 a.m. Diagnoses included, but were not limited to: cerebral vascular accident (stroke), dementia, anxiety, hypertension, syncope (dizziness), chronic renal insufficiency, history of malnutrition.</p> <p>Review of Speech Therapy notes indicated, but were not limited to, under the Initial Assessment section, Swallowing, Swallow Status "...risk of aspiration on liquids..." Under Clinical Impression: "Pt's (patient's) swallowing continues to be severely compromised."</p>	F0311	<p>It is the intent of this facility to ensure that a treatment plan for a nosey cup will be implemented as ordered. Resident #C has recieved nosey cup with all meals.No other residents was found to be affected.A new contracted Therapist had written an order and did not flag order to be taken off. An audit was completed to ensure that all Speech Therapy orders have been reviewed and implemented as ordered.An audit has been completed to ensure that all orders have been completed and implemented. Speech Therapy will provide a list weekly of residents seen and their charts will be reviewed by the Unit Managers/designe weekly or 30 days and then monthly there after to ensure all orders are implemented.Speech Therapy will provide a list weekly of residents seen and their charts will be reviewed by the Unit Managers/designe weekly or 30 days and then monthly there after to ensure all orders are implemented. Therapy orders will be reviewed at monthly QA meetings.</p>	03/16/2012			

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	<p>Review of physician orders written on 2/7/2012, indicated an order for "res (resident) to use nose cups for liquids," according to the Speech Therapist recommendation.</p> <p>During observation of Resident #C at meal times on 2/13/2012 at 5:56 p.m., 2/14/2012 at 11:57 a.m., 2/15/2012 at 12:40 p.m., and coffee hour on 2/15/2012 at 9:30 a.m., it was noted that a nose cup was not used. During these observations, it was noted that Resident #C was fed by a staff member.</p> <p>On 2/15/2012 at 4:45 p.m., in an interview during the daily exit conference, the Director of Nursing (DON) indicated "I couldn't find an order for the nose cup; did he have one?"</p> <p>On 2/16/2012 at 9:35 a.m., in an interview with the Administrator and DON, they indicated the order was found and had been overlooked. The Administrator indicated the Speech Therapist is new, and they had told her she needs to flag orders and write them on internal information paper.</p> <p>This Federal tag was related to Complaint IN00103521.</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review and interview, the facility failed to ensure kitchen equipment was clean and in good repair during 1 of 2 dietary observations. This deficient practice had the potential to affect 97 of 97 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>On 02/12/12 between 1:50 p.m. and 2:15 p.m., the following was observed:</p> <ol style="list-style-type: none"> The dispensing pump on a container of Simply Thick liquid was soiled with a dried caked brown substance. In interview with Dietary aide #1, at this time, she was not sure who was responsible to clean the dispensing pump. The can opener blade was soiled with a dried black and white substance. In interview with the evening cook, at this time, he indicated the can opener was to be cleaned after every meal. 	F0371	<p>It is the intent of this facility to ensure that the kitchen equipment is clean and in good repair.No negative outcomes have been noted secondary to this practice.All kitchen equipment has been cleaned. Kitchen staff have been inserviced on sanitation solutions and prouper storage of equipment and food storage.Ceiling vents have been cleaned and placed on a cleaning schedule.Door of food cart has been repaired. Dietary Aide #1 has had her jDining Services Aide Competencies check list completed.Dietary Manager has implemented a cook check off list to be completed Daily before the Cook and staff can leave. The Dietary Manager/designee will review these check list no less that 5 days a week for 30 days then weekly for 1 monthly then monthly there after and results to be review during monthly QA meetings.</p>	03/16/2012	

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	<p>3. A large can of open applesauce was on the counter with the scoop/dipper in the applesauce. The can lacked a cover.</p> <p>4. A container of pureed bread was on the counter with the dipper/scoop in the mix. The pureed bread lacked a cover.</p> <p>5. A large plastic container with tongs, scoops, and ladles was soiled on the inner surface with food debris.</p> <p>6. The steam table pans were stored on a shelf soiled with a yellow dried substance.</p> <p>7. The bowl and post of the large mixer was soiled with a dried yellow/brown substance.</p> <p>8. A bag of Tostitos was on the sink drain board. The entire top of the bag was open.</p> <p>9. The ceiling vent over the microwave was soiled with heavy dust which hung downward from the grate. This vent remained soiled on 02/14/12 at 10:00 a.m., during observation of the pureed food preparation.</p> <p>10. Dietary aide #1 and #2, indicated they lacked the knowledge on how to check the level of sanitizer in the sanitizer bucket. Dietary aide #1 indicated she had</p>						

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	<p>never checked the level and has worked at the facility for 3 years. Dietary aide#2 indicated she had not been trained and has worked at the facility for 6 weeks.</p> <p>On 2/13/12 at 5:27 p.m., as the dietary staff was delivering the food cart to the North Hall Main Dining Room, a loud crash was heard outside of the closed doors. The door had fallen off of the food cart.</p> <p>On 02/16/12 at 8:51 a.m., the "Dining Services Aide Competencies" checklist, provided by the SDC (Staff Development Coordinator), was reviewed for Dietary aide #1. Under the section "Performance Standard" #14 "Understands and performs sanitizing procedures," a check mark for "Meets Standard" was noted. The employee hire date was listed as 07/21/07 with evaluation date 07/22/07. Dietary aide #2, with start date of 12/16/11, lacked a "Dining Services Aide Competencies" checklist. At this time, the staff SDC indicated the employee must still have the checklist.</p> <p>3.1-21(i)(3)</p>				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the clinical record contained the completed Level II forms with the recommendations, for 2 of 5 residents in a sample of 20 reviewed with a Level II requirement (Residents #84, 41), and failed to ensure the code status was accurate for 1 of 20 residents reviewed with code status in the sample of 20. (Resident #82)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #84 was reviewed on 2/14/12 at 1:35 p.m. The resident's diagnoses included, but were not limited to, depression and mental retardation. A "Preadmission Screening Level II Case Analysis Form" was in the record, dated 11/26/2010. The form indicated a yearly review was</p>	F0514	<p>It is the intent for this facility to ensure that all clinical records contain all required documents including Level II's it is also the intent of the facility to have correct code status and sticker for each resident.No other residents were found to be affected through record review.The Level II for resident #84 was sent in for the annual certification however, the form could not be found the day the surveyor was looking in the Chart. The certify agency was notified and a copy of the certification was sent with-in 10 minutes of the request.Social Service/designee will keep a log of all Level II's with the current date and the renewal dated noted and the log will indicate that renewal was done and on what date it was sent for renewal will record date when completed and placed in the residents record for review. Social</p>	03/16/2012			

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	<p>required. Documentation was lacking in the record of the Level II being completed in 2011. The Pre-Admission Screening/Annual Review Certification For Nursing Facility Services Certification dated 8/25/11, was faxed to the facility on 2/14/12 at 1:43 p.m.</p> <p>2. The clinical record for Resident #41 was reviewed on 2/14/12 at 12:40 p.m. The resident's diagnoses included, but were not limited to, mental retardation. The Pre-Admission Screening/Annual Review Certification for Nursing Facility Services Level II was dated 05/10/2010 which included, but was not limited to: "Requires resident review in one year."</p> <p>In interview with the Social Worker #1 on 2/14/12 at 12:55 p.m., she indicated the form was faxed to the facility today for the recommendations from May of 2011. The form was faced to the facility on 2/14/12 at 1:45 p.m.</p> <p>In interview with the Medical Records person on 2/14/12 at 1 p.m., she indicated she has difficulty obtaining the forms from the Agency.</p> <p>3. The clinical record for Resident #82 was reviewed on 2/14/12 at 10:40 a.m.. The CPR (Cardiopulmonary Resuscitation) form included, but was not</p>		<p>Service/designee will review monthly level II's during monthly QA meeting. An audit of all charts was completed to verify that all code status were correct and matched chart sticker. When admission charts are reviewed through DCR the code status will be verified and check to assure the correct sticker is on the chart. If there is a code status change the record will also be reviewed during DCR. Code status changes will be review monthly at QA meeting.</p>				

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	<p>limited to: "It is my desire that I be given: NO CPR." The form was signed and dated on 1/29/12 by the POA (Power of Attorney). The inside of the chart binder indicated the resident was a "FULL CODE."</p> <p>On 2/14/12 at 1 p.m., in interview with the DON, she indicated "the order had just been clarified."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				

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F9999	<p>State Finding</p> <p>3.1-18 INFECTION CONTROL</p> <p>Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventative therapy for infection, shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to exclude a resident with a documented history of positive tuberculin skin test from receiving a first and second step PPD [tuberculin skin test]. This affected 1 of 1 resident with a positive history of tuberculin skin test in a sample of 20 residents. (Resident #26)</p> <p>Finding includes:</p>	F9999	<p>It is the intent of this facility ensure that residents do not receive a PPD if they have a positive history of a PPD. No other residents were found to be affected. Staff in-serviced on when and when not to give residents a PPD. When admission charts are reviewed through DCR the PPD status will be verified and check to assure that PPD's are not given to a resident with a history of converting. If there is a history of positive PPD The DCR team will assure that documentation is complete and X-ray ordered. Residents with a history of PPD converting will be reviewed month the first month or second month in the building at QA to assure policies are being followed. When admission charts are reviewed through DCR the PPD status will be verified and check to assure that PPD's are not given to a resident with a history of converting. If there is a history of positive PPD The DCR team will assure that documentation is complete and X-ray ordered. Residents with a history of PPD converting will be reviewed month the first month or second month in the building at QA to assure policies are being followed.</p>	03/16/2012	

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	<p>Review of the clinical record for Resident #26 on 2/15/2012 at 9:10 a.m., indicated the resident was admitted on 10/28/2011 and had diagnoses which included, but were not limited to, positive PPD reactor, paranoid schizophrenia, chronic obstructive pulmonary disease and coronary artery disease.</p> <p>The "Tuberculosis Screening Record" for Resident #26 indicated she was given the first step PPD on 10/28/2011 by LPN #4 and was read on 10/31/2011 as "0 mm" [zero millimeters - negative] by the Director of Nursing. The second step PPD was given on 11/11/11 by LPN #3 and read on 11/14/2011 as "0 mm" by the DoN.</p> <p>On 2/15/2012 at 4:00 p.m., the Medical Records Clerk presented a copy of the Tuberculin Education Program Course LPN #3, #4 and the DoN completed to indicate they had successfully demonstrated the ability to administer, read and record the Mantoux tuberculin skin test on 11/7/2011.</p> <p>During the daily exit meeting with the Administrator and the DoN on 2/15/2012 at 4:45 p.m., the DoN indicated this resident never should have been given the PPD skin tests since she had a positive skin test in the past.</p>						

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	3.1-18(i)			