STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaints IN00145187 and IN00145022. Survey dates: March 3, 4, 5, 6, 7 and 10, 2014. Facility number: 010739 Provider number: 155764 AIM number: 200856890 Survey team: Lara Richards, RN-TC Heather Tuttle, RN Cynthia Stramel, RN Yolanda Love, RN Caitlyn Doyle, RN (3/10/14) Julie Ferguson, RN (3/10/14) Census bed type: SNF: 34 SNF/NF: 9 Residential: 66 Total: 109 Census payor type: Medicare: 33 Medicaid: 7	F000000	The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. This facility asks that this Plan of Correction and it's supporting documentation be considered for desk review for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Other: 69 Total: 109 Residential sample: 8 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on March 16, 2014, by Janelyn Kulik, RN.			

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F000157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review, and interview, the facility failed to promptly notify the resident's Physician related to obtaining pulmonary clearance for 1 of 2	F000157	F157It is the intent of this facility to promptly notify the resident's Physician relating to pulmonary clearance.*What corrective action(s) will be accomplished for those residents found to have*	04/04/2014

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	residents reviewed for Urinary Catheter use of the 2 residents who met the criteria for Urinary Catheter use. (Resident #151) Findings include: Staff Interview with LPN #2 on 3/03/14 at 11:23 a.m., indicated Resident #151 had an indwelling foley catheter due to an enlarged prostate. The record for Resident #151 was reviewed on 3/5/14 at 4:39 a.m. The resident was admitted to the facility on 2/21/14 from the hospital. The resident's diagnoses included, but were not limited to, right hip fracture, GERD (gastroesophageal reflux disease), constipation, urinary retention, and asthma. Review of the History and Physical from the hospital indicated the resident was admitted to the hospital with right hip pain on 1/24/14. Review of Physician Progress Notes by the Urologist dated 2/20/14 (while the resident was in the hospital) indicated, "The scheduled Cysto and XPS green light laser photo sensitive vaporization of the prostate had to be canceled for today. To obtain		*been affected by the alleged deficient practice:* ***Resident #151 has received pulmonary clearance and surgery was completed on 3/18/2014 without incident.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents that have Physician orders relating to pending surgeries have the potential of being affected by the alleged deficiency. An audit of current residents with pending surgeries was completed to identify any pending test results and confirm that physicians were notified in a timely manner.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit tool has been developed to review current residents and new admissions for pending tests or surgeries. Audits will be completed on 5 residents per week. Tool will follow test results and Physician notification to assure results are processed timely. Licensed nurses were in-serviced on the need to review the discharge summary and orders from hospital/Physician appointments for new***	

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	pulmonary clearance. Patient has a bed at the nursing home and is to come back on 3/3/14 for the procedure." Review of the discharge instructions from the hospital dated 2/21/14, indicated the patient's foley catheter was to remain in place until the patient had a cystoscopy and green light laser photo selective vaporization of the prostate scheduled on 3/3/14. Review of Physician Progress Notes by the Nurse Practitioner dated 3/3/14, indicated during a hospital stay for hip surgery it was proposed to him to have prostate surgery. The resident needed clearance from a Pulmonologist in which the patient stated was done. Will need to get that report and fax it to the Urologist as patient still needs prostate surgery, and he would like it done as soon as possible before he runs out of Medicare days. Review of the history and physical dated 3/4/14, indicated the resident had a recent hip fracture. The resident had Benign Prostate Hypertrophy (BPH) and urinary retention and was supposed to have surgery, but could not get clearance		***orders/tests and results.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor untill 100% compliance is obtained.*** *Date systemic changes will be completed :* **4/4/2014**	

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	from the Pulmonologist. Review of Nursing Progress Notes dated 2/21-3/3/14, indicated there was no documentation or information regarding if the Pulmonologist was notified after the resident was admitted to the facility to obtain clearance for the surgery. Further review of Nursing Progress Notes for the same time frame indicated there was no documentation or information if the Urologist was also notified to confirm the appointment for the prostate procedure. Interview with the Director of Nursing (DoN) on 3/5/14 at 6:30 a.m., indicated the resident had not seen the Urologist since he had been there. She further indicated she would guess the nurses did not see the information on the discharge instruction sheet regarding the Cystoscopy and the prostate procedure. Further interview with the DoN, indicated Nursing Staff should have attempted to see if a Pulmonologist saw the resident in the hospital and followed through with the discharge instructions from the hospital. 3.1-5(a)(3)			

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F000166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on record review and interview, the facility failed to ensure grievances related to missing hair products were promptly resolved for 1 of 3 residents reviewed for personal property of the 3 residents who met the criteria for personal property. (Resident #29) Findings include: On 3/4/14 at 9:35 a.m., Resident #29 was interviewed. At the time, the resident indicated she was transferred to the hospital on 1/29/2014 and when she returned to the facility, her hair products were missing. The record for Resident #29 was reviewed on 3/7/14 at 8:42 a.m. The resident was admitted to the facility on 1/26/14. Her diagnoses included, but were not limited to, end stage renal disease, diabetes, and anemia. Review of the Amission Minimum Data Set (MDS) Assessment dated 2/6/14, indicated the resident's Brief Interview for Mental Status (BIMS)	F000166	F166It is the intent of this facility to ensure grievances related to missing items are promptly resolved. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***A grievance form was initiated for resident #29 and investigation of missing items was completed.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents that use personal items in their room have the potiential to be affected by this alleged deficent practice. In a follow up interview with resident #29, the resident related that the missing items were found in her room and that everything was fine. An audit was conducted of staff to determine if any concerns or grievances in the last 90 days were not addressed.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***CRCA #5 and Nursing Staff were inserviced on the "Reporting of Resident***	04/04/2014

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	score was 10, which indicated her cognition was intact. Interview with CNA #5 on 3/7/14 at 12:20 p.m., indicated upon the resident's return from the hospital on 1/30/2014, the resident informed her of the missing hair products. At the time, the CNA searched the resident's room for the missing items and did not find them. Interview with Social Services Co-director #2 on 3/7/14 at 12:30 p.m., indicated she did not receive a grievance report related to the resident and/or any missing hair products. Continued interview with CNA #5 on 3/7/14 at 1:55 p.m., indicated she did not notify the Charge Nurse on her unit nor the Director of Nursing (DoN) of the resident's missing items per the facility's policy. Review of page 19 of the Resident Move-in Guide indicated the following: "You have the right to retain and use personal possessions." -"The facility will provide reasonable preventive measures to protect your personal property from theft, loss, or		***Grievance" policy. The Life Enrichment Director/designee will review at the resident council meetings any concerns of staff adherence to this policy.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the monthly Resident Council minutes for compliance. Any concerns of non-compliance will be addressed immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	damage." -"You should promptly report any loss, damage, theft of any personal property to your caregiver, the nurse in charge of your unit, the DoN or to the Administrator." -"The facility will promptly investigate your claim and will provide you with a written report of its investigation and action taken to further prevent recurrence of loss, damage, or theft of your property." -"Our facility personnel should treat your possessions with respect for what they are and what they represent to you. You should report violations." 3.1-7(a)(2)			

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F000247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview, the facility failed to ensure each resident was informed when they were receiving a new roommate for 2 of 3 residents reviewed for Admission, Transfer, and Discharge, of the 3 residents who met the criteria for Admission, Transfer, and Discharge. (Residents #3 & #29) Findings include: Interview with Co-Social Service Director (SSD) #1 on 3/6/14 at 3:25 p.m., indicated Resident #3 received a new roommate on 2/13/14 which was a direct admit from the hospital. Further interview with SSD #1, indicated Resident #29 received a new roommate on 1/27/14 which was a direct admit from the hospital. Interview with Co-SSD #1 and Co-SSD #2 on 3/6/14 at 3:25 p.m., indicated they tell the residents when they are admitted to a semi private room that they could get a roommate at any time. They both indicated when residents were direct admits into the facility from the hospital, they	F000247	F247It is the intent of this facility to ensure that residents are informed when they are receiving a new roommate.*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #3 currently does not have a room mate and resident #29 continues to have the same room mate. Social services has met with both residents with no concerns noted relating to room mates.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents in semi-private rooms who are scheduled to receive a room mate have the potential to be affected by the alleged deficient practice. Admissions, Social Services or designee will continue to alert Nursing Staff and Management of planned Health Care move-ins. Scheduled move-ins to semi-private Health Care rooms with existing room mates will be notified by Social Services/designee and notification will be documented in Social Service notes. In the***	04/04/2014

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	have no way of knowing when they were going to arrive at the facility so they have not been informing the residents they were getting a new roommate. Also, Co-SSD #1 indicated if a resident was admitted over the weekend, again they would have no knowledge of that information to tell the resident they were getting a new roommate. 3.1-3(v)(2)		***case of an after hours/emergency move in, the Nurse Manager will notify existing room mate of pending move in and document in Nurses Notes that notification occurred.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***Social Services will review Health Care move ins for proper documentation daily at the morning Interdisciplinary meeting. Any non-compliance will be reviewed by the IDT for further action. This review will be completed at week day IDT morning meetings for 90 days. . Licensed Nurses and Management team have been in-serviced on the need for notification and proper documention of a room mate move in.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The IDT will review move-ins into semi-private rooms at each week day meeting for proper documentation of room mate notification. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met***	

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			and if the need for additional monitoring is warranted. QAA will monitor until 100% comliance is obtained. *Date systemic changes will be completed:* **4/4/2014**	

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F000258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure comfortable sound levels were maintained on the midnight shift for 1 of 3 units throughout the facility. (Healthcare Unit 2) Findings include: 1. Interview with a member of Resident #64's family on 3/3/14 at 1:54 p.m., indicated staff often converse loudly in the hallway of Healthcare Unit 2. 2. Interview with Resident #3 on 3/4/14 at 8:53 a.m., indicated staff often stand outside of the rooms and talk loudly. She indicated this occurred on the day and night shifts. 3. On 3/5/14 at 4:56 a.m., on Healthcare Unit 2, LPN #5 was observed going in and out of the Medication room. The door slammed each time the LPN went in and out of the Medication room. At 5:48 a.m., LPN #5 and LPN #6 were conversing loudly at the Nurses' station.	F000258	F258 It is the intent of this facility to ensure that comfortable sound levels are maintained on all shifts.*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #64 is not identified on the Sample Resident List provided by the Survey Team. Resident #56 is no longer a resident at this facility. A follow up interview with resident #3 indicated that noise levels are much better and that prior noise levels were a result of staff caring for her room mate, not hallway noises.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents in an area with loud noises occurring have the potential of being affected by this alleged deficiency. Staff have been in-serviced on resident rights in regards to proper noise level/activity. The door closure for HC2 Medication room was adjusted by Plant Operations for smoother closing of door.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*	04/04/2014

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	At 5:54 a.m., Resident #56 asked to be pulled up in bed. LPN #5 stood in the entry way of the resident's room and yelled down the hall for CNA #2. Interview with the Administrator on 3/6/14 at 9:30 a.m., indicated the LPN should not have been yelling down the hall and the noise level on the night shift was being addressed. 3.1-19(f)		***Nursing Managers will interview 10 residents per week x 2 weeks, 5 residents x 2 weeks and 3 residents x 2 weeks for any concerns of noise levels on the night shifts. The Life Enrichment Director/designee will review at the Resident Council meetings for any concerns of staff adherence to noise levels.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools and the Resident Council minutes for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue as scheduled and Council Minutes will be reviewed for 90 days by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure the plan of care and Physician's orders were followed as written related to monitoring of bruising for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 4 who met the criteria for skin conditions (non-pressure related). The facility also failed to ensure nutritional supplements were provided as ordered for 1 of 1 residents reviewed for pressure ulcers of the 1 who met the criteria for pressure ulcers and for 1 of 3 residents reviewed for underweight status and not receiving nutritional supplements of the 5 who met the criteria for underweight and no nutritional supplements. (Residents #3, #15 and #24) Findings include: 1. On 3/4/14 at 9:04 a.m., Resident #3 was observed with a fading green bruise to the top of her left hand and her left forearm.	F000282	F282 It is the intent of this facility to ensure that a plan of care and Physician's orders are followed as written related to monitoring of bruising. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***The bruise for resident #3 has healed. The Ensure Plus has been transcribed onto the MAR for resident #24. Resident #15 has the order for Promod transcribed in the MAR.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents with non pressure related skin conditions have the potential to be affected by the alleged deficient practice. A skin sweep of current Health Care residents was conducted to identify any further residents. An audit of residents with recommendations for supplements was conducted with no concerns noted.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit***	04/04/2014

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	On 3/5/14 at 11:30 a.m., the resident was receiving care from CNA #3. A fading green bruise was observed on the top of the resident's left hand and left forearm. The resident indicated that was where she had recent lab draws. The record for Resident #3 was reviewed on 3/5/14 at 4:47 a.m. The resident's diagnosis included, but was not limited to, deep vein thrombosis (blood clot). Review of the Nursing progress notes and the Change in Condition sheets for the month of March 2014, indicated there was no evidence of documentation related to the bruises to the resident's left hand and forearm. Review of the Wound book on 3/5/14 at 11:20 a.m., indicated there were no non-pressure skin sheets related to bruising for the resident. Review of the resident's plan of care dated 2/2014, indicated the resident had a history of deep vein thrombosis (DVT) and received anticoagulant (blood thinner) medication. This placed the resident at risk for bruising and bleeding. The interventions included, but were not limited to,		***tool has been developed to review residents from the facility weekly skin assessment. This audit will be conducted for accuracy by a Health Care Nurse Manager at 5 residents x 2 weeks, 3 residents x 2 weeks and 1 resident x 2 weeks.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	observe for any bruising and signs of bleeding each shift. Interview with the Healthcare 2 Unit Manager on 3/5/14 at 11:30 a.m., indicated the resident was receiving Coumadin (a blood thinner) and had recent lab draws. The Unit Manager indicated whenever any type of bruise was noted, a non-pressure skin sheet should be completed. The Unit Manager confirmed the presence of the bruises on the left hand and forearm. She indicated the bruises were indeed from a lab draw and she would initiate a change of condition form.			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	2. The record for Resident #24 was reviewed on 3/5/14 at 7:34 a.m. The resident was admitted to the facility on 1/22/14. The resident's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), Coronary Artery Disease, Congestive Heart Failure, and urinary retention. Review of Physician Orders dated 2/24/14, indicated ensure plus (a nutritional supplement) strawberry/chocolate twice a day between meals. Review of the current 1/29/14 plan of care indicated, "I would like to be free from signs and symptoms of fluid imbalance." The approaches were to administer my medications and supplements as ordered. Review of the March 2014 Medication Administration Record (MAR), indicated the ensure plus had not been transcribed onto the MAR. Review of the 2/2014 MAR, indicated	F000282	F282 It is the intent of this facility to ensure that a plan of care and Physician's orders are followed as written related to monitoring of bruising. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***The bruise for resident #3 has healed. The Ensure Plus has been transcribed onto the MAR for resident #24. Resident #15 has the order for Promod transcribed in the MAR.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents with non pressure related skin conditions have the potential to be affected by the alleged deficient practice. A skin sweep of current Health Care residents was conducted to identify any further residents. An audit of residents with recommendations for supplements was conducted with no concerns noted.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit***	04/04/2014

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	the ensure plus strawberry/chocolate had been signed out as being given 2/25-2/28 with the percentage of how much he drank. Interview with LPN #3 on 3/6/14 at 9:00 a.m., indicated the ensure plus was not transcribed onto the MAR for the month of March 2014. She further indicated there was no way to tell if the resident received it or not.		***tool has been developed to review residents from the facility weekly skin assessment. This audit will be conducted for accuracy by a Health Care Nurse Manager at 5 residents x 2 weeks, 3 residents x 2 weeks and 1 resident x 2 weeks.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 3. The record for Resident #15 was reviewed on 3/04/14 at 2:45 p.m. The resident was readmitted to the facility on 10/23/12. The resident's diagnoses included, but were not limited to, osteoarthritis, dementia and diabetes mellitus. The Discharge Minimum Data Set (MDS) Assessment dated 12/1/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 5, which indicated she was cognitively impaired. She required a wheelchair for locomotion, and extensive assistance for transferring. The resident had a care plan dated 1/26/14 for a pressure ulcer to the right heel related to immobility and pressure. The goal was to show signs of healing to existing skin impairment. Approaches included, but were not limited to, monitor for signs and symptoms of infection, provide pressure reducing mattress, monitor meal consumption, and provide treatment per Physician order.	F000282	F282 It is the intent of this facility to ensure that a plan of care and Physician's orders are followed as written related to monitoring of bruising. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***The bruise for resident #3 has healed. The Ensure Plus has been transcribed onto the MAR for resident #24. Resident #15 has the order for Promod transcribed in the MAR.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents with non pressure related skin conditions have the potential to be affected by the alleged deficient practice. A skin sweep of current Health Care residents was conducted to identify any further residents. An audit of residents with recommendations for supplements was conducted with no concerns noted.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit***	04/04/2014

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	The resident had a care plan dated 2/14/14 for pressure ulcers to the left lower ankle and left heel. Approaches were to monitor for signs and symptoms of infection and provide treatment as ordered by the Physician. A Dietary note dated 12/8/13, indicated the Dietician recommended Promod (a high protein supplement) 30 milliliters (mls) twice a day to promote wound healing. Another Dietary note dated 1/8/14 indicated, "...resident continues on Promod for wound healing." The December 2013 Medication Administration Record (MAR), indicated Promod 30 mls two times daily was initiated on 12/23/13, and given twice daily through December 31, 2013. The January 2014 MAR did not have Promod listed with the other medications. The February 2014 MAR indicated Promod was initiated on February 7,2014. Another Dietary recommendation was made on February 6, 2014 for Promod. A Physician Order dated 2/7/14 was for Promod 30 mls twice daily for wound healing.		***tool has been developed to review residents from the facility weekly skin assessment. This audit will be conducted for accuracy by a Health Care Nurse Manager at 5 residents x 2 weeks, 3 residents x 2 weeks and 1 resident x 2 weeks.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	Interview with the Director of Nursing (DoN) on 3/5/14 at 8:45 a.m., indicated the Promod was not transcribed from the December 2013 to the January 2014 Physician Order Statement. The DoN indicated the resident was sent to the hospital on January 3, 2014 and returned to facility on January 10, 2014. The resident did not receive Promod from January 1, 2014 through February 7, 2014. 3.1-35(g)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure bruises were assessed and monitored for 2 of 3 residents reviewed for skin conditions (non-pressure related) of the 4 who met the criteria for skin conditions (non-pressure related). (Residents #3 and #24) Findings include: 1. On 3/4/14 at 9:04 a.m., Resident #3 was observed with a fading green bruise to the top of her left hand and her left forearm. On 3/5/14 at 11:30 a.m., the resident was receiving care from CNA #3. A fading green bruise was observed on the top of the resident's left hand and left forearm. The resident indicated that was where she had recent lab draws. The record for Resident #3 was reviewed on 3/5/14 at 4:47 a.m. The	F000309	F309 It is the intent of this facility to ensure bruises are assessed and monitored. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***The bruise for resident #3 has healed. The bruise for resident #24 is healing and nursing continues to monitor.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents with non pressure related skin conditions have the potential to be affected by the alleged deficient practice. A skin sweep of current Health Care residents was conducted to identify any further residents and assure that appropriate documentation was completed.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit tool has been developed to review residents from the facility weekly skin assessment. This audit will be***	04/04/2014

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	resident's diagnosis included, but was not limited to, deep vein thrombosis (blood clot). A Physician's order dated 2/24/14, indicated the resident was to receive Coumadin (a blood thinner) 2 milligrams (mg) on Monday and Wednesday and Coumadin 3 mg on Tuesday, Thursday, Friday, Saturday and Sunday. A Physician's order dated 3/3/14, indicated the resident's Coumadin was to be held on 3/3 and 3/4/14 due to elevated Prothrombin (PT) times (a blood clotting test). Review of the Daily Coumadin Assessment sheets for the month of March 2014, indicated there was no documentation of bruising. Review of the Nursing progress notes and the Change in Condition sheets for the month of March 2014, indicated there was no evidence of documentation related to the bruises to the resident's left hand and forearm. Review of the Wound book on 3/5/14 at 11:20 a.m., indicated there were no non-pressure skin sheets related to bruising for the resident.		***conducted for accuracy by a Health Care Nurse Manager at 5 residents x 2 weeks, 3 residents x 2 weeks and 1 resident x 2 weeks.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* ***4/4/2014***	

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	Review of the resident's plan of care dated 2/2014, indicated the resident had a history of deep vein thrombosis (DVT) and received anticoagulant (blood thinner) medication. This placed the resident at risk for bruising and bleeding. The interventions included, but were not limited to, observe for any bruising and signs of bleeding each shift. Interview with the Healthcare 2 Unit Manager on 3/5/14 at 11:30 a.m., indicated the resident was receiving Coumadin (a blood thinner) and had recent lab draws. The Unit Manager indicated whenever any type of bruise was noted, a non-pressure skin sheet should be completed. The Unit Manager confirmed the presence of the bruises on the left hand and forearm. She indicated the bruises were indeed from a lab draw and she would initiate a change of condition form.			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 2. On 3/03/14 at 10:37 a.m., Resident #24 was observed in bed. At that time, there was a purple/bluish bruise noted to his right inner forearm by his elbow. There was also a purple bruise noted on the back of his right hand. On 3/4/14 at 2:44 p.m., the resident was in bed. At that time, there was a purple/bluish bruise noted to his right inner forearm by his elbow. There was also a purple bruise noted on the back of his right hand. On 3/5/14 at 9:45 a.m., and 11:12 a.m., the resident was observed in bed. At that time, there was a red/yellow bruise noted to his right inner arm and a purple bruise noted to the back of his right hand. On 3/6/14 at 1:22 p.m., the resident was standing in his room wearing long sleeves. At that time, LPN #3 assessed the resident's skin. There was a yellow/red bruise observed on	F000309	F309 It is the intent of this facility to ensure bruises are assessed and monitored. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***The bruise for resident #3 has healed. The bruise for resident #24 is healing and nursing continues to monitor.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents with non pressure related skin conditions have the potential to be affected by the alleged deficient practice. A skin sweep of current Health Care residents was conducted to identify any further residents and assure that appropriate documentation was completed.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit tool has been developed to review residents from the facility weekly skin assessment. This audit will be***	04/04/2014

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	the resident's right inner arm near the anticubital space, and there was also a red/blue bruise noted on the back of his right hand. The LPN indicated she was not aware of the bruises and the information had not been passed down to her during the shift end report. She further indicated the procedure for finding bruises was to measure and assess the bruise then document the findings on a bruise sheet. The record for Resident #24 was reviewed on 3/5/14 at 7:34 a.m. The resident was admitted to the facility on 1/22/14. The resident's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), Coronary Artery Disease, Congestive Heart Failure, and urinary retention. Review of the Nursing Re-Admission Assessment dated 2/18/14, indicated there were no identified skin issues such as bruising for the resident. Review of the 1/29/14 Admission Minimum Data Set (MDS) Assessment, indicated the resident's Brief Interview Mental Status (BIMS) was 11 indicating he was alert and oriented with some mild cognitive impairment. The resident had no		***conducted for accuracy by a Health Care Nurse Manager at 5 residents x 2 weeks, 3 residents x 2 weeks and 1 resident x 2 weeks.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410	

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	behaviors. The resident had an indwelling foley catheter. The resident had no pressure ulcers or skin conditions. Review of the current plan of care dated 1/29/14, indicated the problem of alteration in skin integrity. The approaches were weekly skin checks and document any new areas in the care tracker and report it to the nurse. Review of the Skilled Nursing Assessment and Data Collection sheets dated 3/1 7-3 shift indicated no skin impairment, 3/2 3-11 shift indicated no skin impairment, 3/3 3-11 shift indicated no skin impairment, 3/4 7-3 shift indicated no skin impairment, and 3/5/14 7-3 and 3-11 shifts indicated no skin impairment. Review of the Weekly Shower sheets, indicated the resident's skin was assessed on 2/27/14 and there was no bruising noted on the sheet. Review of the Treatment Administration Record (TAR) for the month of March 2014, indicated there was no documentation of any bruises on the resident's right inner arm or the back of his right hand.			

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	Review of the current and undated Other Skin Assessment Guidelines policy provided by the Director of Nursing on 3/6/14 at 4:00 p.m., indicated "The purpose was to describe and monitor the healing process of skin impairments other than pressure or stasis ulcers. Initiate the form when an area of impairment. (e.g.; skin tear, rash, excoriation, abrasion, burn, cut, open lesion, bruise and/or surgical wound) is identified. Document description of wound using documentation key: Length, Width, Depth, Exudate, Color, Odor, Wound margins, Surrounding tissue, and Tunneling and/or undermining if applicable. Update the form weekly or with significant change in wound noting the current treatment, medical interventions provided and comments as needed." Interview with the Staff Development Nurse on 3/6/14 at 3:30 p.m., indicated Nursing Staff should have assessed and documented the bruises on the non pressure bruise sheet. 3.1-37(a)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review and interview, the facility failed to provide Activities of Daily Living (ADL) assistance to a dependant resident related to providing showers as scheduled for 1 of 2 residents reviewed for ADL's of the 2 residents who met the criteria for ADL's. (Resident #43) Findings include: Interview with Resident #43's family member on 3/4/14 at 8:45 a.m., indicated she did not think the facility was washing her mother's hair because it would look greasy and smell. She indicated she had spoken with staff about this issue previously. The record for the resident was reviewed on 03/05/2014 at 9:53 a.m. The resident was readmitted to the facility on 4/15/13. The resident's diagnoses included, but were not limited to, history of falls, Right humerus fracture and dementia.	F000312	F312 It is the intent of this facility to provide Activities of Daily Living to dependant residents related to providing showers as scheduled. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #43's shower schedule was changed to Wednesday and Saturday evenings to match the resident preference.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Dependant residents who require assistance with bathing have the potential of being affected by this deficient practice. An audit of current dependant Health Care residents was completed to assure that facility shower lists are coordinated with resident profiles.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***Life Enrichment Team will note resident bathing preferences during admission***	04/04/2014

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	The Quarterly Minimum Data Assessment dated 2/11/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 4, which indicated she was cognitively impaired. Her functional status included use of walker for ambulation and one person physical assistance was needed for bathing. A care plan dated 1/16/14, indicated the resident needed assistance with Activities of Daily Living (ADL's). Approaches included, but were not limited to, provide assistance to the extent needed, and the resident preferred showers on Wednesday and Saturday evenings. The Health Center 2 Shower Schedule, indicated the resident was to receive a shower on Monday and Thursday evenings. Interview on 3/5/14 at 2:30 p.m. with CNA #1, indicated when residents were showered, a shower sheet was to be completed and the Nurse would do a skin assessment. The CNA's were also to document in the computer kiosk if a shower was completed. She indicated the shower schedule was how the CNA's knew which residents were to be showered each day.		***assessment. Preferences will be added to the resident profile. Shower lists will be updated during the Clinical Care Meeting held Monday through Friday and compared to the resident's preference list for compliance. Nursing staff has been in-serviced on locating the shower preferences on the resident profile.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	Review of the CNA shower sheets on 3/6/14 at 8:15 a.m., indicated the resident was showered on the following days: 12/11/13- resident refused shower 1/11/14 1/15/14 1/18/14- resident refused shower 1/25/14 2/8/14 2/12/14 2/19/14 Review of the CNA kiosk, indicated the last time the resident was showered was on 2/20/14. Interview with the Director of Nursing (DoN) and Assistant Director of Nursing (ADoN) on 3/6/14 at 2:25 p.m., indicated the resident's daughter had taken her out to have her hair washed, cut and curled on 3/4/14. The DoN indicated Nurses were responsible for overseeing the CNA's and ensuring the resident's showers were completed. There was no way to document if hair was washed on the shower sheets or in the kiosk. The DoN was unable to provide additional documentation that the resident had been showered since 2/20/2014.			

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	3.1-38(a)(2)(A)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to ensure dietary recommendations for treatment of a pressure ulcer were followed for 1 of 1 residents reviewed for pressure ulcers of the 1 resident who met the criteria for pressure ulcers. (Resident #15) Findings include: The record for Resident #15 was reviewed on 3/04/14 at 2:45 p.m. The resident was readmitted to the facility on 10/23/12. The resident's diagnoses included, but were not limited to, osteoarthritis, dementia and diabetes mellitus. The Discharge Minimum Data Set (MDS) Assessment dated 12/1/13, indicated the resident had a BIMS (Brief Interview for Mental Status)	F000314	F314 It is the intent of this facility to ensure that dietary recommendations for treatment of pressure ulcers are followed. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***The MAR was reviewed for Resident #15 and Promod remains on the resident's orders.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents who have pressure ulcers with orders for dietary supplements have the potential to be affected by the alleged deficient practice. Licensed Nursing Staff have been in serviced on procedures to assure Physician orders are carried over to new Physician Order Sheets/ MARs each month.*** *What measures will be put into place or what systemic*	04/04/2014

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	score of 5, which indicated she was cognitively impaired. She required a wheelchair for locomotion, and extensive assistance for transferring. A care plan dated 1/26/14, indicated the resident had a pressure ulcer to her right heel related to immobility and pressure. The goal was to show signs of healing to existing skin impairment. Approaches included, but were not limited to, monitor for signs and symptoms of infection; provide pressure reducing mattress, monitor meal consumption, and provide treatment per Physician order. A care plan dated 2/14/14, indicated the resident had pressure ulcers to the left lower ankle and left heel. Approaches were to monitor for signs and symptoms of infection and provide treatment as ordered by the Physician. Right heel weekly wound measurements were as follows: 1/25/14 - 4 centimeters (cm) x 7 cm, eschar (discolored skin that occludes wound bed) present. 1/29/14 - 5 cm x 7 cm 2/5/14 - 5 cm x 6 cm , eschar present. 2/19/14 - 4.9 cm x 6.7 cm		*changes will be made to ensure that the deficient practice does not recur:* ***Licensed Nursing Staff was in-serviced on procedures to assure orders are carried over to new MAR's. Nursing management will review dietary recommendations and assure that Physician orders are in place and that noted resident is added to the Clinically At Risk list to assure review at the weekly meeting. Nursing management will audit the supplement list to the MAR/Care Plan 5 times weekly x 2 weeks, 3 times weekly x 2 weeks and 1 time weekly x 2 weeks for compliance.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA***	

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	2/26/14 - 4 cm x 6 cm, eschar present. On 2/14/14, two new Stage 2 pressure ulcers were noted. The left ankle measured 1 cm x 0.9 cm and the left heel measured 1.5 cm x 1.2 cm. A Dietary note dated 12/8/13, indicated the Dietician recommended Promod (high protein supplement) 30 milliliters (ml's) twice a day to promote wound healing. Another Dietary note dated 1/8/14 indicated, "...resident continues on Promod for wound healing." The December 2013 Medication Administration Record (MAR), indicated Promod 30 ml's two times daily was initiated on 12/23/13, and given twice daily through December 31, 2013. The January 2014 MAR did not have Promod listed with the other medications. The February 2014 MAR, indicated Promod was initiated on February 7, 2014. Another Dietary recommendation was made on February 6, 2014 for Promod. A Physician's order dated 2/7/14 was for Promod 30 ml's twice daily for wound healing.		***will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	Interview with the Director of Nursing (DoN) on 3/5/14 at 8:45 a.m., indicated the Promod was not transcribed from the December 2013 to the January 2014 Physician Order Statement. The DoN indicated the resident was sent to the hospital on January 3, 2014 and returned to facility on January 10, 2014. The resident did not receive Promod from January 1, 2014 through February 7, 2014. 3.1-40(a)(2)			

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with an indwelling foley catheter was clinically assessed for the appropriateness of the catheter to restore normal bladder function. The facility also failed to ensure the foley catheter tubing and bag were not on the floor for 1 of 2 residents reviewed for Urinary Catheter use of the 2 residents who met the criteria for Urinary Catheter use. (Resident #24) Findings include: On 3/3/14 at 10:20 a.m., Resident #24 was observed in bed. At that time, his foley catheter bag and tubing was observed on the floor. Interview with LPN #2 on 3/03/14 at 11:24 a.m., indicated the diagnosis	F000315	F315 It is the intent of this facility to ensure that residents with indwelling Foley catheters are clinically assessed for appropriateness of the catheter to restore normal bladder function. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #24 has had his catheter discontinued.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents with catheters have the potential to be affected by the alleged deficient. An audit of current residents with catheters was conducted to assure appropriate diagnosis and assessments were in place.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does*	04/04/2014

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	for the resident's foley catheter was urinary retention. On 3/5/14 at 5:15 a.m., 6:09 a.m., 9:45 a.m., and 11:12 a.m., the resident was in bed, with the linens over his body. His foley catheter bag and tubing was observed on the floor. The record for Resident #24 was reviewed on 3/5/14 at 7:34 a.m. The resident was admitted to the facility on 1/22/14. The resident's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), Coronary Artery Disease, Congestive Heart Failure, and urinary retention. Review of the 1/29/14 Admission Minimum Data Set (MDS) Assessment, indicated the resident's Brief Interview Mental Status (BIMS) was 11 indicating he was alert and oriented with some mild cognitive impairment. The resident had no behaviors. The resident had an indwelling foley catheter. Review of the current plan of care dated 1/29/14, indicated "I have a foley catheter due to urinary retention." The approaches were to provide catheter care every shift, keep the drainage bag below level of		*not recur:* ***Licensed nursing staff were in-serviced on proper assessment and documentation relating to Foley catheters including appropriate diagnosis and care. New admissions with Foley catheters will be assessed for appropriate diagnosis. Related documentation will be reviewed at the Clinical Care Meeting for accuracy. Facility management and Ambassadors have been in-serviced on importance of observing catheter bags for proper placement while in use and the need to report any non-compliance findings to Director of Health Services/designee immediately.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Audits will be done of 5 residents per week. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the***	

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	the bladder, change the catheter and drainage bag per policy, and keep the catheter bag free from kinks. Review of the History and Physical dated 1/23/13 by the resident's Physician, indicated the current diagnosis was urinary retention; discontinue the foley per the Urologist, if unable to void follow up with the Urologist. Review of Physician Progress Notes dated 2/6/14, indicated the resident could wait to get the foley catheter out. To be seen by Urologist on 2/12/14. Urinary retention; continue foley catheter and follow up with Urology. Review of the Urologist's prescription dated 2/12/14, indicated "today remove foley if bladder scan under 300 cubic centimeters (cc) or 2 checks ok to keep foley out. If he failed voided trials replace foley and change once monthly." Review of Physician Orders dated 2/12/14, indicated today remove foley. If under 300 cc or 2 checks ok to keep foley out. If he fails voided trials replace foley and change once monthly.		***QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	Interview with LPN #3 on 3/6/14 at 10:36 a.m., indicated she was the nurse working when the resident came back from the Urologist's office. She indicated the facility does not have a bladder scan so she called the doctor back and told him the facility did not have a bladder scan. She indicated he gave new orders, however, she did not document in nursing notes that she called the doctor. Review of the Elimination Circumstance Investigation sheet dated 2/12/14, indicated catheter removal and the resident's vital signs were taken. On the back of the sheet there was assessment information regarding the resident. The only documented assessment of the resident was as follows: 2/12/14 3-11 shift "(patient needs to void by 11:30 p.m.)" 2/13/14 (no time) "Unable to void 16 french foley placed with 200 cc coming out without difficulty." Further review of the Elimination Circumstance Investigation sheet indicated there was no other documentation of any assessment of the condition of the resident. There was no assessment of the resident's abdomen or interviews with the			

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	resident regarding the need to urinate. Review of the 24 hour report sheet provided by the Staff Development Nurse on 3/6/14 at 10:50 a.m., indicated "3-11 shift patient to void 300 cc by 11:30 p.m., if no void please put foley back in. voided 50 cc at 10:30 p.m." There was no documentation or assessment of the resident's need to urinate. Further review of Nursing Progress Notes indicated there was no documentation or information regarding if Nursing Staff ever notified the Urologist the foley catheter had been placed back in the resident. Interview with the Staff Development Nurse on 3/6/14 at 10:38 a.m., indicated she called the 3-11 nurse that worked on 2/12/14 and had asked her why she had documented the information regarding if the resident does not void by 11:30 p.m., then put foley back in. The 3-11 Nurse indicated she attempted to call the Urologist's office and received no return call back from him so she called the Medical Director's Nurse			

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	Practitioner who gave the new order to place the foley back in. The 3-11 Nurse indicated she had documented the information on the 24 hour report sheet. The Staff Development Nurse indicated at that time, there was no documentation of an assessment of the resident during the time the foley catheter was out and there was no documentation of a post residual void after the foley catheter was removed. Interview with the Director of Nursing on 3/6/14 at 1:25 p.m., indicated she had spoken to the Nurse Practitioner (NP) who indicated she remembered being told about the resident's inability to void and the facility was unable to get a hold of the Urologist on 2/12/14. The DoN further indicated the NP gave the order to anchor the foley if unable to void. She further indicated Nursing Staff should have assessed the resident after the foley was removed. 3.1-41(a)(1)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a resident who was identified as a fall risk was provided the appropriate footwear to prevent falls for 1 of 3 residents reviewed for accidents of the 4 residents who met the criteria for accidents. (Resident #140) Findings include: On 3/4/14 at 9:40 a.m., Resident #140 was observed wearing a pair of slippers. The slippers were knitted and did not have a non-skid surface. At this time, the resident was observed to attempt to stand from her wheelchair. A pair of shoes was observed underneath the resident's bed. On 3/6/14 at 1:53 p.m., the resident was observed in the Healthcare Unit 2 dining room. The resident was seated in her wheelchair. She was wearing white socks and no shoes. The socks did not have a non-skid	F000323	F323 It is the intent of this facility to ensure that residents identified as a fall risk are provided appropriate footwear. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #140 has been discharged to home.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents who are identified as a fall risk have the potential to be affected by this deficient practice. An audit was completed for all falls in the past 30 days for accuracy of documentation and assurance that fall prevention interventions are in place.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***Nursing staff was in-serviced on how to accurately fill out fall documentation and placement of interventions. An audit of residents***	04/04/2014

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	surface. At 1:59 p.m., the resident attempted to stand unassisted with just socks on. At 2:50 p.m., the resident was observed with no shoes on. A pair of shoes were observed in the resident's room at the foot of her bed. The record for Resident #140 was reviewed on 3/5/14 at 9:53 a.m. The resident's diagnoses included, but were not limited to, chronic back pain and brain damage due to decreased oxygen supply. Review of the Fall Circumstance sheet dated 2/4/14, indicated the resident had an unwitnessed fall in her room due to transferring herself. Review of the Fall Circumstance sheet dated 2/15/14 at 1:00 p.m., indicated the resident was found on the floor in her room. The fall was unwitnessed and the resident was transferring herself at the time. Further documentation indicated the resident was found kneeling by the side of her bed with 1 sock on, both shoes off, and her alarm sounding. The Admission Minimum Data Set (MDS) Assessment dated 2/4/14, indicated the resident was extensive assist for transfers.		***with recent falls will be conducted to assure documentation and interventions are in place for 5 residents x 2 weeks, 3 residents x 2 weeks and 1 resident x 2 weeks to assure compliance.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted.*** *Date systemic changes will be completed:* **4/4/2014**	

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	The plan of care dated 2/2014, indicated the resident was at risk for falls due to a cerebrovascular accident (stroke). The interventions included, but were not limited to: -Lock the brakes -keep my call light and frequently used items within easy reach to prevent me from overstretching. -place a PSA (chair alarm) on my chair to remind me to ask for assist with transfers and to alert you if I don't. Interview with the Healthcare 2 Unit Manager on 3/7/14 at 10:30 a.m., indicated the resident had a pair of shoes but they hurt her feet. The Unit Manager indicated the family had been informed to bring in a new pair of shoes but they have not done so. The Unit Manager indicated the resident should have been wearing non-skid socks instead of the knitted slippers and/or regular socks. 3.1-45(a)(2)			

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review, and interview, the facility failed to ensure each resident with a low Body Mass Index (BMI) received nutritional supplements to maintain their current weight for 1 of 3 residents reviewed for nutrition of the 15 who met the criteria for nutrition. (Resident #24) Findings include: On 3/5/14 at 9:45 a.m., and 11:12 a.m., Resident #24 was observed in bed with linens over his head. The room was dark and the resident's eyes were closed. The record for Resident #24 was reviewed on 3/5/14 at 7:34 a.m. The resident was admitted to the facility on 1/22/14. The resident's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), Coronary Artery Disease,	F000325	F325 It is the intent of this facility to ensure that residents with a low Body Mass Index receive nutritional supplements to maintain their current weight.*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***The Ensure Plus has been transcribed onto the MAR for resident #24. This resident has not experienced any weight loss.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents with Dietary recommendations of nutrional suppliments have the potential to be affected by the alleged deficient practice. An audit of residents with recommendations for supplements was conducted with no concerns noted. Licensed nursing staff were in-serviced on procedures to***	04/04/2014

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	Congestive Heart Failure, and urinary retention. Review of the 1/29/14 Admission Minimum Data Set (MDS) Assessment, indicated the resident's Brief Interview Mental Status (BIMS) score was 11 indicating he was alert and oriented with some mild cognitive impairment. The resident had no behaviors. The resident was 73 inches tall and weighed 150 pounds and had no weight loss in the last month. Review of the current 1/29/14 plan of care, indicated "I would like to be free from signs and symptoms of fluid imbalance." The approaches were to administer my medications and supplements as ordered. Further record review indicated the resident was admitted to the hospital on 2/15/14 and returned to the facility on 2/18/14. Review of the Registered Dietitian's (RD) Progress Notes dated 2/20/14, indicated the resident returned from a hospital stay related to exacerbation of congestive heart failure. The resident's weight was 152 pounds and his BMI was 20 slightly below the desirable range. Recommend		***assure orders are transcribed to new Physician Order Sheet/MAR.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit tool has been developed to review resident supplement list to MAR/Care Plan.. This audit will be conducted for accuracy by a Health Care Nurse Manager for 5 residents x 2 weeks, 3 residents x 2 weeks and 1 resident x 2 weeks.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	supplements (Ensure Plus twice a day) and change the diet to no added salt. Review of Physician Orders dated 2/24/14, indicated ensure plus (a nutritional supplement) strawberry/chocolate twice a day between meals. Review of the March 2014 Medication Administration Record (MAR), indicated the ensure plus had not been transcribed onto the MAR. Review of the 2/2014 MAR, indicated the ensure plus strawberry/chocolate had been signed out as being given 2/25-2/28 with the percentage of how much he drank. Interview with LPN #3 on 3/6/14 at 9:00 a.m., indicated the ensure plus was not transcribed onto the MAR for the month of March 2014. She further indicated there was no way to tell if the resident received it or not. 3.1-46(a)(1)			

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F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post the Nurse Staffing sign in a prominent place for all residents and visitors to see. This had the potential to affect 43 of 43 residents who resided in the facility.	F000356	F356 It is the intent of this facility to ensure that the Nurse Staffing sign is posted in a prominent place for all residents and visitors to see. *What corrective action(s) will be accomplished for those residents*	04/04/2014

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	Findings include: On 3/3, 3/4, 3/5, 3/6, and 3/7/14, during the day tour of duty from 8:00 a.m. until 4:00 p.m., the Nurse Staffing sign was observed on the wall hanging outside the Director of Nursing's office which was located on Healthcare 1 (the first floor). There was no information by the main entrance of the building which leads to the Transitional Care Unit (TCU). Where the current Nurse Staffing sign was posted, there was no way residents nor a family member from the TCU would be able to see it without having to walk to the other side of the building where the DoN's office was located. Further observation on 3/7/14 at 9:30 a.m., indicated there was a separate entrance door by Healthcare 1, however, the DoN's office was located around the corner and down the hall from the door. Again, family members would not be able to see the sign as they entered the facility. Interview with the DoN on 3/7/14 at 9:45 a.m., indicated the only Nurse Staffing sign the facility had was posted on the wall outside of her office door.		*found to have been affected by the alleged deficient practice:* ***The Nurse Staffing posting has been relocated to the Health Care entrance located on Health Center 1. This entrance will become the main entrance for the Health Care portion of this facility when the current remodel is completed.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents and families in the Health Care portion of facility have the potential of being affected by this alleged deficiency. Posting of this sign has been moved near the Nurses Station temporarily until current remodel is completed, then posting will be near the Health Care Center reception desk located on Health Center 1.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***The Director of Health Services/designee will monitor the posting for easy visibility. Nursing staff was in-serviced on the procedure and location of the Nurse Staffing posting as to be able to assist any residents or families who may inquire the location of this posting.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what*	

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	3.1-13(a)		*quality assurance program will be put into place:* ***The Executive Director/designee will observe the Nurse Staffing posting routinely to assure the sign remains in good visibility to the public. Any variances will be corrected and reviewed at the following Quality Assurance Meeting for any further actions.*** *Date systemic changes will be completed:* **4/4/2014**	

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F000371 SS=E	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 Based on observation and interview, the facility failed to serve and prepare food under sanitary conditions related to greasy equipment, dirty floors, and touching food with gloved hands for 1 of 1 kitchens observed. (The Main Kitchen) Findings include: 1. On 3/3/14 at 9:12 a.m., during the Brief Sanitation Tour with the Dietary Food Manager, indicated the following: a. There was a large amount of food crumbs, wrappers and adhered dirt behind the stove, convection ovens, and grill. 2. On 3/7/14 at 10:40 a.m., during the Full Kitchen Sanitation tour with the Dietary Food Manager, the following was observed: a. Both sides of the fryer and stove had a large amount of grease build	F000371	F371 It is the intent of this facility to serve and prepare food under sanitary conditions related to greasy equipment, dirty floors and touching food with gloved hands. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***No residents served from the main kitchen were affected by the alleged deficient practice. No individual residents were named in this deficiency. For the food handling with gloved hands concern, the dietary staff were immediately re-trained on safe food handling procedures.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents who are served food prepared from the main kitchen have the potential to be affected by this alleged deficient practice. The grill was in use during inspection and was cleaned after use. Floors were cleaned at end of shift and***	04/04/2014

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	up noted. Interview with the Dietary Food Manager at that time, indicated the fryer was cleaned every Saturday and the stove was cleaned every month. He further indicated both were in need of cleaning. b. Dietary Cook #1 was observed with gloves to both of her hands. She was observed preparing a tossed lettuce salad with tomatoes, cheese and cucumbers. The Dietary Cook removed two hard boiled eggs from a bag with her gloved hands. She did not use tongs or any other type of utensil to remove the eggs. Continued observation at 11:00 a.m., indicated Dietary Aide #1 was cutting lemon meringue pie. She was observed wearing gloves to both of her hands. The Aide cut the pie into slices with a knife and as they were sliced she would place them into her other hand and put them on the plates. She did not use a spatula to lift the pie slice and place it on the plate, she used her gloved hands. Interview with the Dietary Food Manager on 3/7/14 at 11:03 a.m., indicated both Dietary Employees should not have used their gloved hands but rather utensils to serve the food.		***food products touched by gloved hands were discarded before serving to any residents.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***A vendor in-serviced dietary staff on floor cleaning with a new approved cleaner and the proper process to use this product. Dietary staff were in-serviced on cleaning schedules, proper cleaning processes and proper food handling procedures. The Dietary Food Supervisor/designee will do sanitation/cleaning inspections of the kitchen 5 times/week to insure cleaning schedules are being complied. The Dietary Food Supervisor/designee will observe food preparation/service 5 times/week to insure proper procedures are complied. The Dietary consultant/designee will do inspections of the kitchen bi-monthly and observe food preparation/service to assure proper procedures are followed. A report of these observations will be reviewed with the DFS and/or the Executive Director/designee for compliance. Concerns of non-compliance will be corrected immediately. These inspections and reporting will be on-going pending direction of the QA committee.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what*	

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	3.1-21(i)(2)		*quality assurance program will be put into place:* ***The Executive Director/Dietary Food Supervisor will report non-compliance concerns to the QA committee for review monthly and recommendations for further action.*** *Date systemic changes will be completed:* **4/4/2014**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/10/2014

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. 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. Based on observation, record review, and interview, the facility failed to ensure a used Fentanyl patch (a narcotic pain medication) was	F000431	F431 It is the intent of this facility to ensure that used Fentanyl patches are disposed of properly. *What corrective action(s) will be accomplished for those*	04/04/2014

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	disposed of properly for 1 of 7 residents observed during medication administration. (Resident #96) Findings include: On 3/6/14 at 8:55 a.m., LPN #2 was observed preparing medications for Resident #96. At that time, she removed a Fentanyl patch (a narcotic pain medication) from the narcotic box and was going to place it on the resident's skin. The LPN finished preparing the rest of the resident's medications and walked into the resident's room. She then removed the old Fentanyl patch that was on the resident's body and threw it into the waste basket next to the resident's bed. The LPN finished the medication pass with the resident and left the room. Interview with the LPN at that time, indicated she was not supposed to throw the patch into the garbage can. She was supposed to dispose of the patch in the sharps container that was either located in the resident's room, or on the side of the medication cart. Review of the policy Disposal of Medication and Medication-Related Supplies dated 9/1/13, provided by		*residents found to have been affected by the alleged deficient practice:* ***Resident #96 remains on the Fentanyl patch. LPN #2 was advised of the improper disposal of the Fentanyl patch and corrected the error immediately after the Medication administration.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents, family, visitors and staff have the potential of being affected by this alleged deficient practice. LPN #2 was in-serviced 1 on 1 and then Licensed Nurses were in-serviced on proper disposal procedures of Fentanyl patches.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***The Director of Health Services/designee will monitor Medication passes involving Fentanyl patches 2 x weekly for 4 weeks and 1 x weekly for 2 weeks or as orders exist to assure proper disposal procedures are followed. Licensed Nurses were in-serviced on proper disposal procedures of Fentanyl patches.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality*	

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	the Director of Nursing, indicated Narcotic patches were to be flushed or cut into pieces and placed in the sharps container. 3.1-25(o)		*assurance program will be put into place:* ***Any concerns of non-compliance will be corrected immediately . The DHS/designee will report any non-compliance to the Executive Director. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to	F000441	F441 It is the intent of this facility to ensure that bed pans and wash	04/04/2014

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	ensure bed pans and wash basins were stored properly on 1 of 3 units throughout the facility. (The 300 unit) Findings include: 1. On 3/4 at 8:55 a.m. and on 3/7/14 at 1:25 p.m., in Room 3112, there was one fracture pan (a type of bed pan), one wash basin, and one bed pan sitting on a shelf in the bathroom and not contained in a bag. All three items were stacked on top of each other. 2. On 3/4 at 8:57 a.m. and on 3/7/14 at 1:27 p.m., in Room 3109, there was one wash basin not bagged and sitting on the shower seat in the bathroom. There was one fracture pan (a type of bed pan) not bagged or contained and placed in between the hand rail and shower in the bathroom. Review of the facility policy titled "Guidelines for Use of Bedpans and Urinals" on 3/10/14 at 3:49 p.m., which was provided by the Director of Nursing and identified as current, indicated the following: "Clean the bedpan or urinal. Wipe dry with a clean paper towel. Discard paper towel into designated container. Store the bedpan or urinal in a plastic		basins are stored properly. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Residents on the 300 unit are in private suites. These units were observed for any non-covered basins/urinals and these items were placed in protective bags.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents, family and visitors have the potential of being affected by this alleged deficient practice. Resident rooms on the 300 unit were observed and non-covered basins/urinals were covered with a protective bag.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***Facility staff were in-serviced on the proper storage of basins and urinals in resident rooms. Managers and Ambassadors will observe resident rooms during week day rounds for any concerns of non-compliance. Any observations of non-compliance will be immediately corrected and reported to Interdisciplinary Team for review.*** *How the corrective action(s) will be*	

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	bag and kept (sic) in bedside stand." Interview with the Director of Nursing on 3/10/14 at 3:00 p.m., indicated the bedpans and wash basins should not have been stacked on top of each other and should have been contained in a plastic bag. 3.1-18(b)(1)		*monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor untill 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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F000465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the kitchen was clean related to walls, floors and baseboards in the dish room for 1 of 1 kitchens observed. (The Main Kitchen) Findings include: On 3/3/14 at 9:12 a.m., during the Brief Sanitation Tour with the Dietary Food Manager, the following was observed: a. There was a black substance noted along the wall approximately four inches from the top of the ceiling throughout the dish room. b. There was a moderate amount of adhered dirt and food particles as well used sugar packet wrappers and straw wrappers noted along the baseboard throughout the dish room. Interview with the Dietary Food Manager at that time, indicated all the above was in need of cleaning. 3.1-19(f)	F000465	F465 It is the intent of this facility to ensure that our kitchen is clean related to walls, floors and baseboards in the dish room. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***No individual residents were identified as being affected.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents who are served on dishes and utensils washed in this dish room have the potential of being affected by this alleged deficient practice. The dish room was cleaned at the end of shift and was noted as being clean by surveyor at final kitchen observation.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***A vendor in-serviced dietary staff on floor cleaning with a new approved cleaner and the proper process to use this product. Dietary staff were in-serviced on cleaning schedules, proper cleaning processes and***	04/04/2014

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			proper food handling procedures. The Dietary Food Supervisor/designee will do cleaning inspections of the kitchen 5 times/week to insure cleaning schedules are being complied. The Dietary consultant/designee will do inspections of the dish room bi-monthly to assure proper cleaning procedures are followed. A report of these observations will be reviewed with the DFS and/or the Executive Director/designee for compliance. Concerns of non-compliance will be corrected immediately. These inspections and reporting will be on-going pending direction of the QA committee. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The Executive Director/Dietary Food Supervisor will report non-compliance concerns to the QA committee for review monthly and recommendations for further action.*** *Date systemic changes will be completed:* **4/4/2014**	

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented following a fall for 1 of 4 residents reviewed for accidents. (Resident #B) Findings include: The closed record for Resident #B was reviewed on 3/4/14 at 2:25 p.m. The resident's diagnoses included, but were not limited to, fall, femoral neck fracture and left hip pain. Review of the Fall Circumstance assessment and intervention sheet dated 2/15/14 at 3:30 p.m., indicated the resident was found on the floor in the dining room. The fall was unwitnessed. There was no	F000514	F514 It is the intent of this facility to maintain clinical records that are complete and accurately documented relating to falls. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #B remains unidentified as this was a part of a related complaint survey. Resident B was discharged from the campus.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents who experience a fall have the potential of being affected by this alleged deficient practice. Licensed Nursing staff was in-serviced on proper fall documentation per facility policy. An audit of falls in the***	04/04/2014

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	documentation related to injury. The resident had no complaints of pain. The resident had been attempting to stand without assistance prior to his fall. The Physician and the resident's Responsible party was notified, however, no time was documented. Review of the Nursing progress notes, indicated an entry was dated for 2/15/14 at 6:00 p.m., but no documentation was completed. Review of the facility Incident/Accident investigation form dated 2/15/14 at 3:30 p.m., indicated the resident was continuously standing and was being redirected to sit. While getting report, the chair alarm went off several times and staff went and sat the resident down. At 3:30 p.m., the resident tried to stand and fell. The resident was sent to the emergency room for evaluation and treatment. Review of the Nurse interview section on the investigation form indicated the following: "Upon starting my shift, resident was in dining room sitting in wheelchair in front of television. Resident continuously stood up. Staff redirected resident to sit in chair. Resident would comply. At 3:30 p.m., resident chair alarm went off again.		***last 30 days was completed to review accuracy of documentation and that interventions were in place.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***An audit tool was developed to monitor fall documentation and implementation of interventions. The audit tool will be reviewed daily in the morning Clinical Care Meeting for compliance. This audit will continue for all falls on the Health Care Units.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The Clinical Care Team will review the fall audits for compliance. Any concerns of non-compliance will be corrected immediately. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. QAA will monitor until 100% compliance is obtained.*** *Date systemic changes will be completed:* **4/4/2014**	

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	This writer looked up and did not see resident standing. Resident was on the floor. This writer and another staff member picked resident up off the floor. Resident was assessed, there were no apparent injuries and resident stated he was not in any pain. Neuro checks were started and were in normal limits. At 5:00 p.m., resident had visitors. He started to complain of pain. When reassessed, there was swelling at the left hip area and resident seemed to be in severe pain. MD (doctor) was called times 3 with no return call. Family was also notified. Director of Nursing was made aware." None of this was documented in the Nursing progress notes. Interview with the Assistant Director of Nursing on 3/7/14 at 11:30 a.m., indicated there was no documentation in the Nursing progress notes related to the resident's fall just documentation on the Fall Circumstance sheet. She indicated there was no follow up assessment as well as information to when the resident was sent to the hospital in the Nursing progress notes. She indicated all of the information was written down on the incident investigation form which was not a permanent part of the resident's			

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	record. 3.1-50(a)(1) 3.1-50(a)(2)			

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R000000	These State findings are cited in accordance with 410 IAC 16.2	R000000	The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. This facility asks that this Plan of Correction and it's supporting documentation be considered for desk review for compliance.	

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R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure a Physician prescribed medication was administered as ordered for 1 of 7 residents reviewed, related to incorrect sliding scale insulin administration (insulin given per blood glucose test result). (Resident #2) Findings include: The record for Resident #2 was reviewed on 3/10/14 at 10:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. Review of the Physician's Recapitulation Orders, dated 3/2014, indicated an order for sliding scale (insulin given per blood glucose test result) Novolog flexpen (insulin) 4 times per day, according to the following scale: below 70= Call Physician 100-150= 3 units	R000241	R241 It is the intent of this facility to ensure that Physician prescribed medications are administered as ordered relating to sliding scale insulin administration.*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #2 had a planned discharge and is no longer in facility.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents that receive insulin on a sliding scale have the potential of being affected by the alleged deficient practice. An audit was completed of Assisted Living residents with orders for insulin on a sliding scale for compliance.*** *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***Licensed Nurses were in-serviced on providing accurate coverage for blood sugars/sliding scale orders.***	04/04/2014

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	151-200= 4 units 201-250= 6 units 251-300= 7 units 301-350= 8 units 351-400= 9 units above 400= Call Physician The Medication Administration Record (MAR) dated 2/2014, indicated the resident's blood glucose test result on 2/1/14 before dinner was 307 and 7 units of insulin was given. The resident should have received 8 units of insulin. The resident's blood glucose test result on 2/3/14 before breakfast was 209 and 4 units of insulin was given. The resident should have received 6 units of insulin. The resident's blood glucose test result on 2/4/14 before breakfast was 101 and no insulin was given. The resident should have received 3 units of insulin. The resident's blood glucose test result on 2/5/14 before breakfast was 147 and no insulin was given. The resident should have received 3 units of insulin. The resident's blood glucose test result on 2/15/14 before lunch was 342 and 9 units of insulin was given. The resident should have received 8 units of insulin. The resident's blood glucose test result on 2/18/14 before dinner was 178 and 3 units of insulin was given. The		***An audit tool has been developed for shift to shift peer review for accuracy of prior shift insulin coverage. This audit process will be on-going. DHS/designee will review 5 residents per week for compliance with insulin orders.****How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be reported to the DHS/designee for review. Monitoring non-compliance will be reviewed by the QA committee monthly for further action. QAA will monitor until 100% compliance is obtained.****Date systemic changes will be completed:* **4/4/2014**	

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	resident should have received 4 units of insulin. The resident's blood glucose test result on 2/25/14 at bedtime was 390 and 8 units of insulin was given. The resident should have received 9 units of insulin. The resident's blood glucose test result on 2/28/14 before breakfast was 378 and 8 units of insulin was given. The resident should have received 9 units of insulin. Interview with the Residential Unit Manager on 3/10/14 at 10:40 a.m., indicated the insulin was not given as ordered and the insulin should have been given according to the sliding scale.			

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to serve and prepare food under sanitary conditions related to greasy equipment, dirty floors, dirty walls, and touching food with gloved hands for 1 of 1 kitchens observed. (The Main Kitchen) Findings include: 1. On 3/3/14 at 9:12 a.m., during the Brief Sanitation Tour with the Dietary Food Manager, indicated the following: a. There was a large amount of food crumbs, wrappers and adhered dirt behind the stove, convection ovens, and grill. b. There was a black substance noted along the wall approximately four inches from the top of the ceiling throughout the dish room. c. There was a moderate amount of adhered dirt and food particles as well used sugar packet wrappers and straw wrappers noted along the	R000273	R273 It is the intent of this facility to serve and prepare food under sanitary conditions related to greasy equipment, dirty floors and touching food with gloved hands. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***No residents served from the main kitchen were affected by the alleged deficient practice. No individual residents were named in this deficiency. For the food handling with gloved hands concern, the dietary staff were immediately re-trained on safe food handling procedures.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* ***Residents who are served food prepared in the main kitchen have the potential to be affected by this alleged deficient practice. The grill was in use during inspection and was cleaned after use. Floors were cleaned and food products touched by gloved hands were discarded before serving to any residents.***	04/04/2014

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	baseboard throughout the dish room. 2. On 3/7/14 at 10:40 a.m., during the Full Kitchen Sanitation tour with the Dietary Food Manager, the following was observed: a. Both sides of the fryer and stove had a large amount of grease build up noted. Interview with the Dietary Food Manager at that time, indicated the fryer was cleaned every Saturday and the stove was cleaned every month. He further indicated both were in need of cleaning. b. Dietary Cook #1 was observed with gloves to both of her hands. She was observed preparing a tossed lettuce salad with tomatoes, cheese and cucumbers. The Dietary Cook removed two hard boiled eggs from a bag with her gloved hands. She did not use tongs or any other type of utensil to remove the eggs. Continued observation at 11:00 a.m., indicated Dietary Aide #1 was cutting lemon meringue pie. She was observed wearing gloves to both of her hands. The Aide cut the pie into slices with a knife and as they were sliced she would place them into her other hand and put them on the plates. She did not use a spatula to		*What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***A vendor in-serviced dietary staff on floor cleaning with a new approved cleaner and the proper process to use this product. Dietary staff were in-serviced on cleaning schedules, proper cleaning processes and proper food handling procedures. The Dietary Food Supervisor/designee will do sanitation/cleaning inspections of the kitchen 5 times/week to insure cleaning schedules are being complied. The Dietary Food Supervisor/designee will observe food preparation/service 5 times/week to insure proper procedures are complied. The Dietary consultant/designee will do inspections of the kitchen bi-monthly and observe food preparation/service to assure proper procedures are followed. A report of these observations will be reviewed with the DFS and/or the Executive Director/designee for compliance. Concerns of non-compliance will be corrected immediately. These inspections and reporting will be on-going pending direction of the QA committee.*** *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***The Executive Director/Dietary Food***	

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	lift the pie slice and place it on the plate, she used her gloved hands. Interview with the Dietary Food Manager on 3/7/14 at 11:03 a.m., indicated both Dietary Employees should not have used their gloved hands but rather utensils to serve the food.		***Supervisor will report non-compliance concerns to the QA committee for review monthly and recommendations for further action.*** *Date systemic changes will be completed:* **4/4/2014**	

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R000408	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to ensure a chest x-ray was completed within 6 months of admission for 1 of 7 records reviewed. (Resident #70) Findings include: The record for Resident #7 was reviewed on 03/10/14 at 1:30 p.m. The record indicated the resident was admitted to the facility on 10/23/13. The record indicated there was no evidence of documentation related to a chest x-ray being completed at the time of admission or 6 months prior. Interview with the Legacy Unit Manager on 03/10/14 at 3:15 p.m., indicated a chest x-ray was not completed upon the resident's admission or 6 months prior to the admission date.	R000408	R408 It is the intent of this facility to ensure that a chest x-ray is completed within 6 months prior to admission. *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:* ***Resident #70 is not identified on the Resident Identifier list provided at exit by the surveyors.*** *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* *New admissions who have not received a chest x-ray within 6 months of admission have the potential to be affected by this alleged deficiency.* *Admissions/designee and Licensed Nurse for unit will review pre-admission paperwork to assure a current chest x-ray is completed.* *What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:* ***Admissions Staff and Licensed Nursing Staff have been in-serviced on required paperwork related to chest x-rays prior to admission.*** ***Medical Records will audit***	04/04/2014

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			admission paperwork to assure proper documentation is in place. Any findings of non-compliance will be reported to the Executive Director/designee. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:* ***Medical Records/designee will review admission paperwork for inclusion of chest x-rays completed within 6 months.. Any concerns of non-compliance will be reported to the Executive Director/designee and reviewed by the Quality Assurance Committee for further action.*** *Date systemic changes will be completed:* 4/4/2014	