

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 25, 26, March 2, 3, and 4, 2015</p> <p>Facility number: 000069 Provider number: 155148 AIM number: 100288980</p> <p>Survey Team: Denise Schwandner, RN- TC Barbara Fowler, RN Diana Perry, RN Anna Villain, RN</p> <p>Census bed type: SNF/NF: 94 Total: 94</p> <p>Census payor type: Medicare: 11 Medicaid: 73 Other: 10 Total: 94</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after April 3rd 2015</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 156 SS=E Bldg. 00	<p>Quality review completed on March 11, 2015 by Jodi Meyer, RN</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p>			
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	<p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p>			

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	<p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to provide appropriate written liability notices to 3 of 3 residents sampled, in that, notices were not provided. (Residents #95, #89, and #110).</p> <p>Findings include:</p> <p>On 03/03/15, at 3:08 p.m., during an interview with SS (Social Services) and the BOM (Business Office Manager), they indicated that liability notices had not been sent since September, 2014.</p> <p>During an interview on 3/3/15, at 3:15 p.m., the current BOM and Interim BOM (a consultant for the company) indicated between September, 2014 and presently, the job of the BOM was being done by the company consultant. The two employees indicated the company consultant did not do the notices as that</p>	F 156	<p>F156 Notice of Resident Right Rules, services and charges It is the practice of this provider to ensure that the facility proves notice to all residents accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice *Resident #95, #89, and #110 were not negatively affected by deficiency *Resident #89 no longer resides in the facility *Resident #95 and #110 received notice of medicare non coverage sent by social services</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken *Any resident residing in facility have the potential to be affected *Any residents who was due to have a liability notice sent in the past 30days were audited by social service to ensure a notice was sent to them</p> <p>3: What measures will be put</p>	04/03/2015

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	<p>was not in the job description of the BOM.</p> <p>During an interview on 3/3/15, at 3:20 p.m., the Rehabilitation Services Manager indicated the following: When Physical Therapy or Occupational Therapy services were discontinued or the resident had reached their goal, an email was sent to the DON (Director of Nursing), the MDS (Minimum Data Set) Coordinator, the SS (the Social Services Designee), and the business office to inform them the service had ended.</p> <p>On 3/3/15, at 3:29 p.m., an interview with the DON indicated the new BOM started two weeks ago. The DON indicated the new BOM had asked about liability notices. The DON indicated she had heard about the problem recently. She indicated that the liability notices was now the responsibility of the SS. The BOM indicated the SS was doing the job now and the SS was educated last Friday and began that date. The DON indicated liability notices had not been sent out since September, 2014. Upon query, the DON indicated she did not believe any charges had been incurred beyond the resident's stay.</p> <p>On 3/3/15, at 3:32 p.m., an interview of the Interim Consultant BOM indicated</p>		<p>into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>*Department head staff will be inserviced by Social Service consultant and/or designee on timely notification of medicare non-coverage notification before 4/3/15 *Social Service will receive communication from Rehab Service Manager at the time the resident meets his/her goal, Social Service will then send a liability notice to the resident/POA. Business Office Manager will inform Social Services of impending exhaust days and notice will be sent to the resident/family. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>*To ensure compliance, Social Service is responsible for the completion of the Notice of Medicare Non-Coverage Letters CQI tool weekly for 4 weeks, monthly for 2 months and then quarterly for 1 month *The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Date of completion: April 3, 2015</p>		

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F 203 SS=D Bldg. 00	<p>she did not believe any of the residents in question had been charged, as one resident was discharged home, one was on hospice, and the third resident had expired. She indicated when a residents 100 of days Medicare had expired, they were then private pay residents or would begin receiving Medicaid if they continued to remain as residents.</p> <p>On 3/4/15, 11:08 a.m., a policy for "Issuing a Notice of Medicare Non-Coverage/Determination on Continued Stay" was received from the Administrator. The policy indicated: "When issuing the Notice of Medicare Non-Coverage, the resident or authorized representative must fill in the date he/she signs the document. This was critical to demonstrating the 2 (two) day notice of the requirement. The form must be issued no later than two days (48 hours) before the proposed end of services."</p> <p>3.1-4(i)(3)</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner</p>			

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	<p>they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility</p>			

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	<p>residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for transfers were transferred without notification of the resident's family and without providing a written reason for the transfer. (Resident #16)</p> <p>Findings include:</p> <p>The clinical record of Resident #16 was reviewed on 3/2/15 at 2:05 p.m. Resident #16 had clinical diagnoses including, but not limited to, dementia, hypertension, chronic obstructive pulmonary disease, and thiamine deficiency.</p> <p>Resident #16 had a quarterly MDS (Minimum Data Set) assessment, dated 11/18/14. The MDS assessment indicated Resident #16 had a BIMS (Brief Interview for Mental Status) assessment score of 8, which indicated moderate cognitive impairment.</p> <p>A transfer form, completed by the Social Worker and dated 12/22/14 at 11:13 a.m., indicated Resident #16 had an emergency</p>	F 203	<p>F203 Notice of discharge and transfer</p> <p>It is the practice of this provider to give residents notice of transfer and discharge in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>*Resident #16 had already transferred and no longer resides in facility</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>*Any residents residing in facility have the potential to be affected by alleged deficiency practice</p> <p>*Social Service will review all residents who were discharged to</p>	04/03/2015

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	<p>contact person and telephone number listed, but did not indicate the reason for the transfer or that the emergency contact person had been notified. The transfer form did not contain documentation of the date of the resident's last physical, any disabilities or impairments of the resident. It also lacked information regarding whether the resident was incontinent, any advanced directives, a bed hold policy, the date of the resident's last Mantoux skin test (a test for tuberculosis), any laboratory tests or chest x-ray, and any suggestions for active care.</p> <p>A progress note, dated 12/22/14 at 4:54 p.m., indicated Resident #16 was transferred to another long term care facility. The note indicated the resident's clothing, medications, and current orders were sent with the resident.</p> <p>During an interview on 3/3/15 at 1:34 p.m., the SW (Social Worker) indicated the resident was transferred for smoking reasons. The SW indicated the POA (Power of Attorney) had not been notified of the resident's transfer. The SW indicated Resident #16 had moderate cognitive impairment. The SW indicated the receiving facility had notified the transferring facility that a bed was available for the resident on the day of</p>		<p>another facility within the past 30 days to ensure all necessary notifications and paperwork was completed. If not, notification of family and/or paperwork will be sent to the applicable facility.</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>*Department head staff will be inserviced by Director of Nursing/designee on timely notification of transfer/discharge and family notification before 4/3/2015</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>*To ensure compliance, Social Service is responsible for the completion of the Discharge CQI tool weekly for 4 weeks, monthly for 2 months, and quarterly for 1 quarter.</p> <p>*The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% s not achieved an action plan will be developed to</p>	

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F 279 SS=D Bldg. 00	<p>the transfer and Resident #16 needed to be transferred at that time. The SW indicated the receiving facility had been notified that the POA had not been notified regarding the transfer. The SW indicated he found out a few days earlier the POA had not been notified.</p> <p>The discharge/transfer policy, dated 5/2003 and obtained from the Adm (Administrator) on 3/4/15 at 11:09 a.m., indicated nursing documentation was to include the date and time the family was notified and the reason for the transfer.</p> <p>3.1-12(a)(6)(A)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under</p>		<p>ensure compliance.</p> <p>Date of completion: April 3, 2015</p>		

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	<p>§483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to develop a comprehensive plan of care for 2 of 34 residents reviewed during Stage 2, in that, the care plan lacked a plan of care for aggressive behaviors and antidepressant medication monitoring. (Resident #80, Resident #108)</p> <p>Findings include:</p> <p>1. On 3/2/15 at 3:48 p.m., Resident #80's clinical record was reviewed. Resident #80 was admitted on 12/22/14. Resident #80's diagnoses included, but were not limited to, anxiety, episodic mood disorder, psychotic disorder, and dementia with behavioral disturbances.</p> <p>Resident #80's, 60 day MDS (Minimum Data Set) assessment, dated 2/18/15 indicated Resident #80's cognitive status was severely impaired. The MDS further indicated Resident #80 had physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed towards others that had occurred daily.</p> <p>The care plans lacked a plan of care for</p>	F 279	<p>F279 Develop a comprehensive care plan</p> <p>It is the practice of this provider to ensure all residents have a comprehensive care plan in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>*Resident #80 and #108 was not negatively affected by alleged deficiency practice</p> <p>*Resident #80 and #108 care plans were updated immediately to address physical aggression and to monitor side effects for use of antidepressant medication.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>*Any residents residing in the facility have the potential to be</p>	04/03/2015
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	<p>Resident #80's physical aggression towards other residents.</p> <p>On 3/2/15, at 3:55 p.m., the MCF (Memory Care Facility) indicated Resident #80 had a history of going into other resident rooms and lying in their beds. The MCF further indicated Resident #80 had become combative when anyone tried to redirect her. The MCF indicated the behaviors had included other residents.</p> <p>On 3/3/15, at 10:39 a.m., Resident #80 was observed sleeping in bed.</p> <p>On 3/4/15, at 2:00 p.m., the DON indicated there had not been a care plan for Resident #80's physical aggression towards other residents.</p> <p>2. On 3/2/15, at 9:22 a.m., Resident #108 was observed sleeping in bed.</p> <p>On 3/2/15, at 9:30 a.m., Resident #108's clinical record was reviewed. Resident #108 was admitted on 4/15/14. Resident #108's diagnoses included, but were not limited to, depressive disorder.</p> <p>The most recent signed physicians recapitulation orders, signed on the February orders, undated, included, but were not limited to, Elavil (an</p>		<p>affected by alleged deficiency practice.</p> <p>*All residents residing in the facility receiving anti-depressants were reviewed and careplans updated for monitoring for side effects by Social Service.</p> <p>*All resident residing in facility were audited for appropriate care plans for current behaviors by Social Services</p> <p>*All staff trained by Social Services on behavior management program and behavior tracking on 3/17/15</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>*Any residents residing in the facility receiving anti-depressants were reviewed and careplans updated for monitoring for side effects</p> <p>*All staff trained by Social Service on behavior management program and behavior tracking on 3/17/15</p> <p>*SSD/designee will review the facility activity report daily to ensure care plans are developed for residents exhibiting aggressive behavior and for residents who</p>	

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F 329 SS=D Bldg. 00	<p>antidepressant medication), 25 mg (milligrams), take one tablet, by mouth, daily at bedtime, for depression. On 2/13/15, the medication had been decreased to 10 mg.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 12/18/14, indicated Resident #108 had received an antidepressant medication 7 out of 7 days during the assessment.</p> <p>The plan of care lacked a care plan related to the monitoring for side effects for the use of an antidepressant medication.</p> <p>3.1-35(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a</p>		<p>receive anti-depressant medications to observe for side effects</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>*A Behavior Management CQI tool will be utilized by Social Service and/or designee weekly x4 weeks, monthly X2 months, and quarterly X1 for at least 6 months</p> <p>*Audit tools will be submitted to the CQI committee and if 95% compliance is not achieved, action plans will be developed.</p> <p>Date of completion: April 3, 2015</p>	

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	<p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 5 of 34 stage 2 sampled residents reviewed were free of unnecessary medications, in that, the facility failed to monitor behaviors and/or side effects in residents receiving psychoactive medications and failed to change sites for a transdermal medication patch. (Resident #108, Resident #45, Resident #121, Resident #80, Resident #24, Resident #106)</p> <p>Findings include:</p> <p>1. During an observation on 3/3/15 at 8:30 a.m., Resident #24 was observed to be sitting in the dining room being fed breakfast. No behaviors were observed during the meal.</p> <p>During an observation on 3/3/15 at 2:46 p.m., Resident #24 was observed to be sleeping in a recliner in her room.</p>	F 329	<p>F 329 Drug regimen is free from unnecessary drugs</p> <p>It is the practice of this provider to ensure that all alleged violations involving drug regimen/free from unnecessary drugs are in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>*Resident #80, #108, #45, #121, #24, and #106 was not negatively affected by alleged deficiency practice</p> <p>*Resident #80, #108, #45, #121, #24, and #106 were reviewed and addressed alleged deficiency practice</p> <p>*Resident #24 and #106 who receive</p>	04/03/2015			

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	<p>The clinical record of Resident #24 was reviewed on 3/2/15 at 10:40 a.m.</p> <p>Resident #24 had clinical diagnoses including, but not limited to, Alzheimer's disease, hypertension, congestive heart failure, depressive disorder, mood disorder, anxiety, chronic obstructive pulmonary disease, anemia, gastroesophageal reflux, cardiac dysrhythmia, atherosclerotic cardiovascular disease, and cardiomegaly.</p> <p>A significant change MDS (Minimum Data Set) assessment, dated 1/15/15, indicated Resident #24 did not have behaviors. The MDS further indicated the resident received antidepressant and antipsychotic medications.</p> <p>Resident #24 had a physician's orders, signed on 2/9/15 and dated 8/10/14, for Lexapro (an antidepressant medication) 20 mg (milligram) every morning for depression and a physician's order, signed on 2/9/15 and dated 9/25/14, for Risperidal 0.5 mg bid (twice a day) for paranoia and tearful episodes.</p> <p>A care plan, dated 7/25/11, indicated Resident #24 was at risk for adverse side effects related to the use of psychotropic medications: antidepressant and antipsychotic. The care plan indicated</p>		<p>antidepressants and antipsychotic medications are being monitored for common significant side effects. If side effects occur, nursing will document side effects and notify the physician.</p> <p>*Resident #108 is being monitored for effectiveness of the antidepressant medication thru the use of behavior tracking sheets completed by nursing staff.</p> <p>*Resident #106 transdermal medication is monitored to ensure patch sites are alternated and location documented by nursing staff</p> <p>*Resident #80 is being monitored by nursing staff for aggressive behavior thru the development of care plan and completion of behavior tracking sheets</p> <p>*Resident #45 and #121 is being monitored for the effectiveness of antidepressant medication by completing PHQ9 assessment by Social Services</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>*Any residents residing in the facility have the potential to be affected by alleged deficiency</p>	

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	<p>Resident #24 was to be observed for side effects of antipsychotic medications and non-antipsychotic medications. The care plan indicated side effects were to be documented as observed and the physician was to be notified.</p> <p>During an interview on 3/2/15 at 11:08 a.m., the DON (Director of Nursing) indicated behaviors are tracked on a behavior tracking form which was located in the front of the MAR (Medication Administration Record). The DON further indicated if a resident had increased, worsening, or new behaviors, the behaviors would be entered on the chart as an event occurrence.</p> <p>During an interview on 3/2/15 at 11:33 a.m., the MCF (Memory Care Facilitator) indicated she was unable to locate any documentation regarding the monitoring of the antidepressant medication or the antipsychotic medication for adverse side effects. The MCF further indicated she was unable to locate any behavior tracking for the antidepressant and could only locate the months of 10/2014, which was only partially completed, 1/2015, and 2/2015, for tracking of the behaviors of delusions and paranoia.</p> <p>The clinical record lacked any</p>		<p>practice</p> <p>*All residents residing in the facility receiving anti-depressants were reviewed and careplans updated for monitoring for side effects by Social Services</p> <p>*All resident residing in facility were audited for appropriate care plans for current behaviors by Social Services</p> <p>*All staff trained by Social Services on behavior management program and behavior tracking on 3/17/15</p> <p>*All residents residing in facility with Exelon patch were reviewed for site and rotation orders by DNS/designee</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>*All residents residing in the facility have the potential to be affected by alleged deficiency practice</p> <p>*All residents residing in the facility receiving anti-depressants were reviewed and careplans updated for monitoring for side effects by Social Services</p> <p>*Any resident residing in facility displaying aggressive behavior will</p>	

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	<p>documentation for monitoring of adverse reactions for antidepressant medications and antipsychotic medications.</p> <p>2. The clinical record for Resident #106 was reviewed on 3/2/15 at 9:40 a.m. Resident #106 had diagnoses including, but not limited to, dementia, Parkinson's disease, urinary tract infection, depression, and hypertension. A quarterly MDS (Minimum Data Set) assessment, dated 11/19/14, indicated Resident #106 had a BIMS (Brief Interview for Mental Status) score of 2, which indicated severe cognitive impairment. The MDS further indicated Resident #106 had verbal and physical behaviors aimed at others and had received an antidepressant and an antipsychotic medication.</p> <p>Resident #106 had a physician's order, signed on 1/16/15, and dated 5/16/14, for Remeron (an antidepressant medication) 30 mg (milligram) every night at bedtime.</p> <p>A care plan, dated 5/27/14, indicated Resident #106 was at risk for adverse side effects related to the use of psychotropic medications - antidepressant. The care plan indicated side effects were to be documented as observed and the physician was to be</p>		<p>have behavior tracking sheets completed and a care plan developed by Social Services</p> <p>*All staff trained by Social Services on behavior management program and behavior tracking on 3/17/15</p> <p>*All residents residing in facility with Exelon patch will be reviewed by DNS/designee for site and rotation orders</p> <p>*Any resident receiving antidepressants will be monitored by nursing staff to ensure the effectiveness of the medication by completing and reviewing the behavior tracking sheets</p> <p>*Any resident receiving an antidepressant will have a PHQ9 assessment completed by Social Services at least quarterly to monitor the effectiveness of the medication</p> <p>*DNS/designee will review residents who receive psychoactive medications to ensure behaviors and/or side effects are documented and monitored by reviewing the facility report</p> <p>*DNS/designee will review residents who receive transdermal medication patch to ensure site changed by reviewing the site rotation flowsheet</p> <p>4: How the corrective action will be</p>	

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	<p>notified. The care plan further indicated the resident was to be observed for effectiveness of the medication.</p> <p>The clinical record lacked documentation the antidepressant was being monitored for effectiveness and the resident was not monitored for adverse side effects.</p> <p>Resident #106 had a physician's order for Exelon Patch (a medication used in the treatment of dementia) 9.5 mg/24 hours every morning for dementia, dated 11/28/14. The physician's order indicated the patch sites were to be alternated.</p> <p>The clinical record lacked documentation of the sites being rotated as ordered for the months of November, 2014 through February, 2014.</p> <p>During an interview on 3/2/15 at 10:05 a.m., LPN #2 indicated if a resident had an order to rotate the sites for a patch, the site would be documented on the MAR (Medication Administration Record).</p> <p>A skills validation procedure titled, "Applying a Transdermal Patch," and dated 1/2010, indicated the resident and the physician's order were to be verified before applying the patch.</p> <p>3. On 3/2/15 at 9:22 a.m., Resident #108 was observed sleeping in bed.</p>		<p>monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>*A Psychoactive Management CQI tool will be utilized by Social Service and/or designee weekly x4 weeks, monthly X2 months, and quarterly X1 for at least 6 months</p> <p>*A Transdermal Skills Validation will be completed on all qualified medical personnel by 4/3/15</p> <p>*Audit tools will be submitted to the CQI committee and if 95% compliance is not achieved, action plans will be developed. Date of completion: April 3, 2015</p>	

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	<p>On 3/2/15 at 9:30 a.m., Resident #108's clinical record was reviewed. Resident #108 was admitted on 4/15/14. Resident #108's diagnoses included, but were not limited to, depressive disorder.</p> <p>The most recent signed physicians recapitulation orders, signed on the February orders, undated, included, but were not limited to, Elavil (an antidepressant medication), 25 mg (milligrams), take one tablet, by mouth, daily at bedtime, for depression. On 2/13/15, the medication had been decreased to 10 mg.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 12/18/14, indicated Resident #108 had received an antidepressant medication 7 out of 7 days during the assessment. The mood score indicated Resident #108 had moderate depression.</p> <p>The care plans included, but were not limited to: "Resident at risk for s/s (signs and symptoms) of depression (sad facial expression, withdrawal, decreased appetite, tearfulness, insomnia, verbalization of depression, ect.) Resident has a dx (diagnosis) of depression, initiated on 4/18/14. Interventions included, but were not</p>			

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	<p>limited to, allow resident to express feelings and frustrations, offer validation and support, emphasize and promote independence and feelings of control/choice, encourage activities of interest, medications per order, and obtain psych consult/psychotherapy consult."</p> <p>The clinical record lacked any tracking for the effectiveness and/or the lack of effectiveness of the antidepressant medication.</p> <p>On 3/3/15 at 11:19 a.m., the ADON (Assistant Director of Nursing) indicated they did not have any behavior tracking sheets for Resident #108.</p> <p>On 3/3/15 at 2:11 p.m., the ADON indicated signs and symptoms of depression are tracked initially. The ADON indicated that once the medication is effective the facility stopped the behavior tracking.</p> <p>On 3/4/15 at 1:00 p.m., the Nurse Consultant indicated signs and symptoms of depression are assessed quarterly.</p> <p>4. On 3/2/15 at 9:23 a.m., Resident #45 was observed lying in bed.</p> <p>On 3/2/15 at 10:29 a.m., Resident #45's</p>			

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	<p>clinical record was reviewed. Resident #45 was admitted on 10/11/13. Resident #45's diagnoses included, but were not limited to, suicidal ideation, obsessive compulsive disorder, and major depressive disorder.</p> <p>The most recent signed physician's recapitulation orders, signed 2/19/15, included, but were not limited to, fluvoxamine (an antidepressant medication), 50 mg (milligrams), take one tablet, by mouth, daily at bedtime, for OCD (Obsessive Compulsive Disorder) and depressive disorder, ordered 10/11/14.</p> <p>The Significant Change MDS (Minimum Data Set) Assessment, dated 1/21/15, indicated Resident #45 had received an antidepressant medication 7 out of 7 days during the assessment. The MDS mood score further indicated Resident #45 had moderate depression.</p> <p>The care plans included, but were not limited to: "Resident at risk for s/s (signs and symptoms) of depression (sad facial expression, withdrawal, decreased appetite, tearfulness, insomnia, verbalization of depression, ect), initiated on 10/18/13.</p> <p>Interventions included, but were not limited to, allow resident to express</p>			

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	<p>feelings and frustrations; offer validation and support, emphasize and promote independence and feelings of control/choice, encourage activities of interest, encourage family support and involvement, medications per order, and obtain psych consult/psychotherapy consult as needed."</p> <p>On 03/03/15 11:20 a.m., the ADON (Assistant Director of Nursing) provided the behavior tracking sheets for Resident #45. The sheets lacked tracking for signs and symptoms of depression.</p> <p>On 3/3/15 at 2:11 p.m., the ADON indicated signs and symptoms of depression are tracked initially. The ADON further indicated once the medication is effective, the facility stopped tracking the behavior.</p> <p>On 3/4/15 at 1:00 p.m., the Nurse Consultant indicated signs and symptoms of depression are assessed when the required quarterly assessments were completed. The last quarterly MDS Assessment had been completed on 12/26/14.</p> <p>5. On 2/25/15 at 11:57 a.m., Resident #121 was observed in the main dining room.</p>			

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	<p>On 3/3/15 at 11:19 a.m., Resident #121's clinical record was reviewed. Resident #121 was admitted on 1/21/15. Resident #121's diagnoses included, but were not limited to, depression.</p> <p>The most recent signed physician's recapitulation orders, signed 2/10/15, included, but were not limited to, Celexa 40 mg (milligrams), take one tablet, by mouth, daily for depression, ordered on 1/21/15.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 1/28/15, indicated Resident #121 had received an antidepressant medication 7 out of 7 days during the assessment. The mood score indicated Resident #121 had minimal depression.</p> <p>The care plans included, but were not limited to: "Resident at risk for s/s (signs and symptoms) of depression (sad facial expression, withdrawal, decreased appetite, tearfulness, insomnia, verbalization of depression, ect), initiated on 2/27/15.</p> <p>The interventions included, but were not limited to, allow resident to express feelings and frustrations, offer validation and support, emphasize and promote independence and feelings of control/choice, encourage activities of</p>			

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	<p>interest, and medications per order."</p> <p>The behavior flowsheet lacked tracking for signs and symptoms of depression.</p> <p>On 3/3/15 at 2:11 p.m., the ADON (Assistant Director of Nursing) indicated signs and symptoms of depression are tracked initially. The ADON further indicated once the medication is effective, the facility stopped tracking the behavior.</p> <p>On 3/4/15 at 1:00 p.m., the Nurse Consultant indicated signs and symptoms of depression are assessed quarterly.</p> <p>6. On 3/2/15 at 3:48 p.m., Resident #80's clinical record was reviewed. Resident #80 was admitted on 12/22/14. Resident #80's diagnoses included, but were not limited to, anxiety, episodic mood disorder, psychotic disorder, and dementia with behavioral disturbances.</p> <p>Resident #80's 60 day MDS (Minimum Data Set) Assessment, dated 2/18/15 indicated Resident #80's cognitive status was severely impaired. The MDS further indicated Resident #80 had physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed</p>			

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F 431 SS=D Bldg. 00	<p>towards others that had occurred daily.</p> <p>The care plans lacked a plan of care related to Resident #80's physical aggression towards other residents.</p> <p>The behavior flowsheet lacked tracking related to Resident #80's physical aggression towards other residents.</p> <p>On 3/2/15 at 3:55 p.m., the MCF (Memory Care Facility) indicated Resident #80 had a history of going into other resident rooms and lying in their beds. The MCF further indicated Resident #80 had become combative when anyone tried to redirect her. The MCF further indicated this included other residents.</p> <p>On 3/3/15 at 10:39 a.m., Resident #80 was observed sleeping in bed.</p> <p>On 3/4/15 at 2:00 p.m., the DON indicated they had not been tracking Resident #80's physical aggression towards other residents.</p> <p>3.1-48(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the</p>			

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	<p>services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure accounting for controlled drugs was in order for 3 of 10 residents' drugs reviewed on the East Hall. (Resident # 87, Resident #57, Resident #78)</p>	F 431	<p>F431 Drug records, label/store drug biological</p> <p>It is the practice of this provider to ensure all control drugs are stored and controlled in accordance with</p>	04/03/2015	

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	<p>Findings include:</p> <p>The East Unit narcotic count was reviewed with LPN #1 on 3/3/15 at 3:15 p.m., comparing medications in the drawer with the documented count sheets. The following medications had not been signed out during the shift:</p> <p>Resident #87's Hydrocodone/APAP (a narcotic pain medication) 5-325 mg (milligram), ordered bid (2 times a day); the 9:00 a.m. dose was not signed out. The package contained 41 (forty-one) tablets but the count sheet indicated the count sheet indicated there should have been 42 (forty-two) tablets.</p> <p>Resident #57's Oxycodone/Acetaminophen (a narcotic pain medication) 10-325 mg every 4 (four) hours routinely; the 9:00 a.m. dose was not signed out. The package contained 37 (thirty-seven) tablets but the count sheet indicated there should have been 38 (thirty-eight) tablets.</p> <p>Resident #78's Alprazolam (an antianxiety medication) 0.25 mg bid; the 9:00 a.m. dose was not signed out. The package contained 17 (seventeen) but the count sheet indicated there should have been 18 (eighteen) tablets.</p>		<p>State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>*Resident #87,#57, and #78 was not negatively affected by alleged deficiency practice</p> <p>*Resident #87, #57, #78 narcotic counts were corrected immediately.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>*All residents residing in the facility have the potential to be affected by alleged deficiency practice</p> <p>*All residents receiving controlled narcotics were reviewed by DNS/designee for correct count by auditing the narcotic logs</p> <p>*All licensed staff will be inserviced by DNS/designee on medication administration on the signing out of controlled substances by 4/3/15</p> <p>*All control substance logs will be audited daily by DNS/designee for compliance of sign out</p>	

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	<p>During an interview on 3/3/15 at 3:17 p.m., LPN #1 indicated medications should be signed out when they are given to the resident. She further indicated she had not signed out for the medications.</p> <p>A skills validation form obtained from the Adm (Administrator) on 3/4/15 at 11:08 a.m., indicated medications were to be signed out on the proper log if the medication contains a controlled substance.</p> <p>3.1-25(n)</p>		<p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>*All residents residing in the facility have the potential to be affected by alleged deficiency practice</p> <p>*All residents receiving controlled narcotics were reviewed by DNS/designee for correct count by auditing the narcotic logs</p> <p>*All licensed staff will be inserviced by DNS/designee on medication administration on the signing out of controlled substances by 4/3/15</p> <p>*All control substance logs will be audited daily by DNS/designee for compliance of sign out</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>*A Controlled Substance CQI tool will be utilized by Social Service and/or designee daily x30daily, weekly x4 weeks, monthly X2 months, and quarterly X1 for at least 6 months</p> <p>*Audit tools will be</p>	

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F 465 SS=F Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, function, and sanitary environment for 23 of 35 rooms, on 3 of 3 nursing units reviewed, in that, dirt and debris was built up on the floors, resident care equipment was uncovered and unlabeled, the caulking around the commode was soiled, the toilet paper holders were empty, and cove base was loose. (Room #133, 134, 122, 139, 147, 118, 137, 126, 125, 135, 141, 140, 121, 168, 152, 151, 160, 159, 124, 155, 153, 119, and 117)</p> <p>Findings include:</p> <p>1. On 2/25/15 at 10:51 a.m., Room #133 was observed. Dirt and debris was observed to be built up in the corners and along the edges in the bathroom. On 3/2/15 at 3:12 p.m., the same was observed.</p>	F 465	<p>submitted to the CQI committee and if 95% compliance is not achieved, action plans will be developed.</p> <p>Date of completion: April 3, 2015</p> <p>F465 Safe comfortable sanitary environment</p> <p>It is the practice of this provider to ensure that the facility maintain a safe, functional sanitary and comfortable environment in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>*Room 133, 134, 122, 139, 118, 126, 125, 135, 141, 140, 121, 168, 152, 151, 160, 159, 124, 155, 153, 119, and 117 were cleaned of dirt and debris in corners and edges</p> <p>*Room 134, 152 toothbrush is covered and labeled</p> <p>*Room 122 bag of trash removed</p>	04/03/2015

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	<p>2. On 2/25/15 at 10:58 a.m., Room #134 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom. An unlabeled and uncovered toothbrush was observed on the back of the toilet in the bathroom. ON 3/2/15 at 3:10 p.m., the same was observed.</p> <p>3. On 2/25/15 at 11:07 a.m., Room #122 was observed. A bag of trash was observed to be lying on the floor and dirt and debris was built up in the corners and along the edges of the bedroom and bathroom. On 3/3/15 at 3:05 p.m., the same was observed.</p> <p>4. On 2/25/15 at 11:08 a.m., Room #139 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom floor. On 3/3/15 at 2:45 p.m., the same was observed.</p> <p>5. On 2/25/15 at 11:40 a.m., Room #147 was observed. The floor around the commode was observed to be black. On 3/3/15 at 2:42 p.m., the same was observed.</p> <p>6. On 2/25/15 at 2:24 p.m., Room #118 was observed. The caulking at the base of the commode was observed to be black and dirt and debris was observed to</p>		<p>*Room 147, 153 floor of commode cleaned</p> <p>*Room 137 bed A was moved away from the outlet socket</p> <p>*Room 126, 152, 160 toilet paper holder was replaced with toilet paper</p> <p>*Room 125 vinyl was replaced around the bed, tile by sink was replaced, bathroom tile was replaced</p> <p>*Room 141 cove base was replaced</p> <p>*Room 121 and 117 drywall was repaired</p> <p>*Room 152 and 151 fan was repaired</p> <p>*Room 151 base of commode was cleaned</p> <p>*Room 160 bathroom door frame was painted</p> <p>*Room 159 non-slip strips in bathroom were cleaned, grout in the bathroom cleaned</p> <p>*Room 155 overbed light was repaired</p> <p>*Room 153 toilet seat was replaced, cardboard was removed from heating unit</p>	

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	<p>be built up in the corners and along the edges of the bedroom and bathroom. On 3/3/15 at 3:35 p.m., the same was observed.</p> <p>7. On 2/25/15 at 3:30 p.m., Room #137 was observed. Bed A was observed to against the wall. Resident #18 was not able to communicate and was observed with his arm in the air trying to unplug a plug that was in a four outlet socket. Resident #18's fingers were almost in the other three sockets. The DON (Director of Nursing) was notified.</p> <p>8. On 2/25/15 at 2:35 p.m., Room #126 was observed. There was no toilet paper in the bathroom and the toilet paper holder was observed on the floor. Dirt and debris was observed to be built up in the corners and along the edges of the bedroom and bathroom. On 3/3/15 at 2:36 p.m., the same was observed.</p> <p>9. On 2/25/15 at 2:46 p.m., Room #125 was observed. The vinyl like material around the mattress on Bed A was observed to be torn. The caulking around the base of the commode was observed to be black. The tile above the bathroom sink was observed to be cracked. The bedroom tile was observed to be broken in a straight line down the bedroom floor. On 3/3/15 at 2:24 p.m., the same was</p>		<p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>*All residents have the potential to be affected by alleged deficiency practice</p> <p>*All rooms were inspected on or before 4/3/15 to ensure the rooms were clean, functional, and safe. Any additional cleaning completed. All residents rooms were deep cleaned by 4/3/15. All items in bathrooms were checked by DNS/designee to ensure items were appropriately labeled by 4/3/15</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>*All resident rooms including floors placed on painting, deep clean, and floor clean schedule</p> <p>*Housekeeping Supervisor to inservice all staff on environmental expectations by 4/3/15</p> <p>*Housekeeping</p>	

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	<p>observed.</p> <p>10. On 2/25/15 at 2:53 p.m., Room #135 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom. On 3/2/15 at 3:13 p.m., the same was observed.</p> <p>11. On 2/25/15 at 3:03 p.m., Room #141 was observed. The cove base in the bathroom was observed to be loose. Dirt and debris was observed to be built up in the corners and along the edges. ON 3/3/15 at 2:41 p.m., the same was observed.</p> <p>12. On 2/25/15 at 3:11 p.m., Room #140 was observed. The caulking around the base of the commode was observed to be black. On 3/3/15 on 2:59 p.m., the same was observed.</p> <p>13. On 2/25/15 at 4:23 p.m., Room #121 was observed. The drywall to the left of the bathroom door was observed to be missing and dirt and debris was observed to be built up in the corners and along the edges of the bedroom. On 3/3/15 at 2:54 p.m., the same was observed.</p> <p>14. On 2/25/15 at 4:36 p.m., Room #168 was observed. Dirt and debris was observed to be built up in the corners and</p>		<p>Supervisor/designee will inspect each room daily to ensure rooms are appropriately cleaned and safe</p> <p>*Customer Care Reps will review rooms to ensure rooms are safe, functional, sanitary, and comfortable for the residents. Any repairs will be reported to maintenance.</p> <p>*ED/designee will review log to ensure repairs are completed timely</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>*A Environmental CQI tool will be utilized by Social Service and/or designee daily x30daily, weekly x4 weeks, monthly X2 months, and quarterly X1 for at least 6 months</p> <p>*Audit tools will be submitted to the CQI committee and if 95% compliance is not achieved, action plans will be developed.</p> <p>Date of completion: April 3, 2015</p>		

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	<p>along the edges of the bathroom. On 3/3/15 at 2:56 p.m., the same was observed.</p> <p>15. On 2/26/15 at 8:18 a.m., Room #152 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom. The toilet paper holder was observed to be empty. An unlabeled light green toothbrush holder was observed to be sitting on the back of the sink. The fan in the bathroom was observed to be loose from the ceiling. On 3/2/15 at 3:03 p.m., the same was observed.</p> <p>16. On 2/26/15 at 8:47 a.m., Room #151 was observed. The fan in the bathroom was observed to be loose. The caulking around the base of the commode was observed to be yellow-brown in color. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom and bedroom. ON 3/2/15 at 3:01 p.m., the same was observed.</p> <p>17. On 2/26/15 at 9:00 a.m., Room #160 was observed. Dirt and debris was observed to be built up under the register and in the corners and along the edges of the bedroom and bathroom. The bathroom doorframe was observed with chipped paint. The toilet paper holder</p>			

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	<p>was observed to be empty. On 3/2/15 at 1:26 p.m., the same was observed.</p> <p>18. On 2/26/15 at 9:05 a.m., Room #159 was observed. Dirt and debris was observed to be built up in the corners of the bathroom and bedroom. The non-slip strips in the bathroom were observed to be soiled. The grout in the bathroom was observed to be soiled. On 3/2/15 at 2:56 p.m., the same was observed.</p> <p>19. On 2/26/15 at 9:18 a.m., Room #124 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bedroom. ON 3/3/15 at 3:05 p.m., the same was observed.</p> <p>20. On 2/26/15 at 10:08 a.m., Room #155 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bedroom. The overbed light cover was observed to not fit properly. On 3/3/15 at 2:48 p.m., the same was observed.</p> <p>21. On 2/26/15 at 10:13 a.m., Room #153 was observed. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom. The caulking around the base of the commode was observed to be black. The toilet seat was observed to be too small for the commode. A piece of cardboard was</p>			

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	<p>observed to be placed between the heating/cooling unit and the front panel of the unit. On 3/3/15 at 2:47 p.m., the same was observed.</p> <p>22. On 2/26/15 at 10:44 a.m., Room #119 was observed. The caulking around the base of the commode was observed to be brown and dirt and debris was built up in the corners and along the edges. On 3/3/14 at 2:54 p.m., the same was observed.</p> <p>23. On 2/26/15 at 11:41 a.m., Room #117 was observed. The drywall was chipped in the bedroom and the floors had dirt and debris built up in the corners and along the edges of the bathroom and bedroom. On 3/3/15 at 3:20 p.m., the same was observed.</p> <p>24. On 3/4/15 at 8:48 a.m., the Resident Council Minutes were reviewed. The minutes indicated the following resident complaints: On 1/28/15, residents complained of rooms not being cleaned good. On 11/26/14, residents complained of rooms not being cleaned, there was no sweeping, mopping, or dusting. On 10/29/14, residents complained of dirty floors and running out of paper towels and toilet tissue. On 8/28/14, residents complained that housekeeping staff had</p>			

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	<p>not been sweeping the floors before mopping them. Residents further complained that at times staff was only spot mopping the floors and the rooms had not been cleaned well. On 7/21/14 residents complained that floors had not been mopped. On 6/25/14, residents complained that housekeeping had not been sweeping prior to mopping. On 5/20/14, residents complained that rooms were not being cleaned properly. On 4/24/14, residents requested floors be swept thoroughly and then mopped.</p> <p>On 3/4/15 at 9:03 a.m., the Housekeeping Supervisor indicated that on a daily basis, housekeeping staff were to wipe everything in the room down daily, including but not limited to, the overbed tables, countertops, dressers, window blinds, window ledges, toilets, and sinks. The Housekeeping Supervisor further indicated the housekeeping staff should sweep and mop the floors daily.</p> <p>On 3/4/15 at 9:13 a.m., the Housekeeping Supervisor provided the "Cleaning Guidelines" policy, no date. The policy included, but was not limited to, clean and disinfect restroom, replenish soap, paper towels and toilet tissue, clean and disinfect horizontal surfaces, and sweep and mop floor.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710		
(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	
	On 3/4/15 at 9:24 a.m., the Maintenance Supervisor indicated there was a maintenance log at each nursing station. The Maintenance Supervisor further indicated the maintenance logs were reviewed every morning and afternoon. 3.1-19(f)				