

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155224	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/09/2012
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NAME OF PROVIDER OR SUPPLIER  COLUMBIA HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710
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F000000	<p>This was a survey for a Recertification and State licensure survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00119034.</p> <p>Survey dates: October 31, November 1, 2, 5, 7, 8, 9, 2012.</p> <p>Facility number: 000129 Provider number: 155224 AIM number: 100266780</p> <p>Survey Team: Barbara Fowler, RN-TC Vickie Ellis, RN Diane Hancock, RN Amy Wininger, RN 10/31/12, 11/1/12-11/2/12, 11/7/12-11/9/12</p> <p>Census bed type: SNF/NF: 158 Total: 158</p> <p>Census payor type: Medicare: 24 Medicaid: 117 Other: 17 Total: 158</p> <p>These deficiencies reflect state</p>	F000000	<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. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on or after November 30, 2012.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	findings cited in accordance with 410 IAC 16.2.  Quality review completed on November 16, 2012 by Bev Faulkner, RN			

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F000156 SS=A	<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> <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:</p>			

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	<p>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> <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,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide, in writing, a list of services that would no longer be covered under the resident's Medicare, for 1 resident of a sample of 3 residents who met the criteria for review. (Resident #178)</p> <p>Findings include:</p> <p>The BOM [Business Office Manager] indicated Resident #178, when admitted to the facility, had 69 days of Medicare coverage left for the year. The BOM indicated the resident had previously used 31 days of her 100 days of Medicare coverage prior to being admitted on 3/29/12. Resident #178 was admitted to the facility on 3/29/12.</p> <p>During interview of the BOM on 11/8/12 at 9:30 a.m., the BOM obtained Resident #178's record and her record was reviewed. She indicated she did not have documentation of notices of the end of the Medicare coverage for Resident #178. The BOM indicated she had not given Resident#178 notification in writing or verbally of</p>	F000156	<p><b>F156 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Information was provided to resident #178 with no change in situation and no eligibility for appeal.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by the alleged deficient practice. Business office has implemented use of new form provided by home office available for notification to residents that exhaust their Medicare benefits or have a change requiring notification. A facility audit will be completed by the Business Office Manager. This audit will ensure all residents have been given proper notification for the past 90 days related to notice of Medicare non coverage. Any errors or omissions noted during this audit will be clarified and/r corrected immediately. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Business office has implemented use of new form</p>	12/03/2012			

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	<p>possible charges associated with her facility stay after she no longer qualified for Medicare. The BOM indicated when Resident #178 no longer qualified for Medicare, she did not notify the resident or her family regarding possible charges that she may incur during her stay at the facility. The BOM indicated the resident would not have had any charges incurred.</p> <p>Resident #178 continues to reside in the facility.</p> <p>3.1-4(f)(1)(A) 3.1-4(f)(1)(B)</p>		<p>provided by home office available for notification to residents that exhaust their Medicare benefits or have a change requiring notification. The Home Office Consultant/designee will review completion of the Medicare Notifications to ensure residents are notified of services which will no longer be covered under Medicare. <b>The Home Office Consultant will be responsible for in servicing the Business Office Manager and other responsible staff members regarding informing residents and family members of Medicare Services which will no longer be covered How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b> Business office consultant will audit all notifications monthly X 6months to ensure notification is being provided according to plan. A threshold of 100% will be achieved or ED will be notified and action plan will be developed. <b>Compliance date: December 3, 2012</b></p>		

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	What corrective action(s) will	12/03/2012

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	<p>review, the facility failed to ensure allegations of mistreatment and/or abuse were thoroughly investigated and reported to the state agency, for 1 of 3 sampled residents reviewed for abuse allegations, in the sample of 3 who met the criteria. (Resident #182)</p> <p>Finding includes:</p> <p>On 10/31/12 at 3:17 p.m., Resident #182 indicated a CNA had been rude and rough with her in the past, during incontinent care. She indicated she was rough, had cursed, and made derogatory comments toward her. She indicated she had reported the CNA's behavior and the CNA was not allowed to work with her anymore, but was still employed.</p> <p>A list of allegations of mistreatment, abuse, misappropriation since June, 2012, was provided by the Administrator on 11/7/12 at 2:10 p.m. This resident was not listed as having any allegations investigated.</p> <p>The grievance log was provided by the Social Services Director on 11/7/12 at 9:55 a.m. This resident had various care issues logged from 8/12 through 10/12.</p> <p>Interview with Social Worker #2 on</p>		<p><b>be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #182 concerns have been addressed and investigation complete in regards to any concerns.</li> <li>·Customer care representative will continue to interview and monitor resident concerns and report findings per policy.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·Nurse Managers will round daily to ensure any concerns are reported appropriately.</li> <li>·Audit has been completed by nurse managers and department heads to ensure any potential abuse allegation have been thoroughly investigated and reported appropriately.</li> <li>·Customer care rounds with resident interviews have been completed on every resident by department heads and nurse managers.</li> <li>·Facility customer care meeting held on November 29, 2012 to review responses with department heads and nurse managers of every resident in the facility.</li> </ul> <p><b>What measures will be put into place or what systemic</b></p>				

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	<p>11/8/12 10:02 a.m., indicated the resident had reported missing money on a couple occasions and it had been replaced. She had complained about not having enough Fruit Loops and she had gotten her some. She complained about not getting enough soda and they provided her with some. She indicated the resident would occasionally report staff or residents saying things she didn't like and they would discuss it, but nothing abusive. She indicated there were a few CNAs the resident did not like and did not want in her room. She indicated most of that occurred before she was employed in July, 2012. She indicated she thought it was just the resident didn't like the CNAs, not that they had done anything to her.</p> <p>The Social Service Director was interviewed on 11/8/12 at 10:17 a.m. She indicated Resident #182 had requested many CNAs not work with her. She named CNA #1 and indicated she was a CNA the resident did not want to take care of her. She pulled up a specific "grievance" that had been written up, dated 6/21/12. She indicated they had done interviews in preparation for survey over the past few months and this resident had answered yes to questions about staff being rough and</p>		<p><b>changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Staff has been educated by SDC/DNS on abuse policy and resident rights with an emphasis on communication and rude behavior, completed by December 3, 2012.</li> <li>*ED/DNS/Designee/UM/Department heads will conduct rounds daily and communicate with staff and residents to ensure all allegations or concerns are reported and handled according to policy. All allegations or statements regarding resident abuse or mistreatment will be reported immediately to the ED/DNS. The management staff will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH and other agencies as outlined in the facility policy.<b>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?</b></li> <li>·Staff has been educated by DNS and SDC/designee on abuse policy and resident rights by December 3, 2012.</li> <li>·The ED/ DNS/designee will complete CQI tool weekly X 4 weeks, then monthly thereafter. Abuse investigation and staff interview will both be utilized. If threshold of 100% is not achieved action plan will be</li> </ul>				

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	<p>rude and being afraid, in regards to this CNA.</p> <p>The Concern/Grievance Form, dated 6/21/12, indicated the resident had reported to a Qualified Medication Aide at 6:00 a.m., on 6/21/12, that CNA #1 refused to help roll her over on her side and told her she needed to roll herself. Statements included in the grievance documentation indicated she had reported the CNA refused to care for her.</p> <p>Documentation by the former Assistant Director of Nursing, dated 6/22/12 at 12:00 noon, indicated a re-interview of the resident had been completed. During that interview, the ADoN indicated the CNA had refused to change her and her room-mate on a separate occasion, had a bad attitude, and she indicated she was afraid of the CNA and what she might do to her.</p> <p>The Director of Nursing was interviewed on 11/8/12 at 11:50 a.m. She indicated they were looking into the allegation regarding the CNA.</p> <p>The Social Services Director and Administrator were interviewed at 2:55 p.m. on 11/8/12. They indicated they had done interviews with several residents, using the survey questions</p>		<p>developed.</p> <ul style="list-style-type: none"> <li>·All audit tools will be brought before the CQI committee monthly</li> <li>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</li> </ul> <p><b>Compliance date:December 3, 2012</b></p>		

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	<p>about staff being rough and rude and residents had not reported anything. They did indicate Resident #182 had answered yes to the questions about staff being rude and rough during an interview, but they did not have any evidence the allegations were thoroughly investigated. The CNA the resident had reported was still employed but did not work with this resident. The re-assignment was done in response to the resident's complaints about her. There was no indication an investigation, including interviewing other residents and staff about this CNAs behaviors, had been done.</p> <p>The Administrator indicated, at the time of the interview, each resident had staff assigned to do rounds, have daily conversations, and frequent contact with residents to inquire about care and nothing else had been reported. She further indicated she understood there should have been more done at the time of this allegation.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the policy and procedure for abuse prohibition, reporting, and investigation was followed, for 1 of 3 residents reviewed for allegations of mistreatment/abuse, in that allegations were not thoroughly investigated and reported to the state agency. (Resident #182)</p> <p>Finding includes:</p> <p>On 10/31/12 at 3:17 p.m., Resident #182 indicated a CNA had been rude and rough with her in the past, during incontinent care. She indicated she was rough, had cursed, and made derogatory comments toward her. She indicated she had reported the CNA's behavior and the CNA was not allowed to work with her anymore, but was still employed.</p> <p>A list of allegations of mistreatment, abuse, misappropriation since June, 2012, was provided by the Administrator on 11/7/12 at 2:10 p.m.</p>	F000226	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #182 concerns have been addressed and investigation complete in regards to any concerns.</li> <li>·Customer care representative will continue to interview and monitor resident concerns and report findings per policy.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·Nurse Managers will round daily to ensure any concerns are reported appropriately.</li> <li>·Audit has been completed by nurse managers and department heads to ensure any potential abuse allegation have been thoroughly investigated and reported appropriately.</li> <li>·Customer care rounds with resident interviews have been completed on every resident by department heads and nurse</li> </ul>	12/03/2012			

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	<p>This resident was not listed as having any allegations investigated.</p> <p>The grievance log was provided by the Social Services Director on 11/7/12 at 9:55 a.m. This resident had various care issues logged from 8/12 through 10/12.</p> <p>Interview with Social Worker #2 on 11/8/12 10:02 a.m., indicated the resident had reported missing money on a couple occasions and it had been replaced. She had complained about not having enough Fruit Loops and she had gotten her some. She complained about not getting enough soda and they provided her with some. She indicated the resident would occasionally report staff or residents saying things she didn't like and they would discuss it, but nothing abusive. She indicated there were a few CNAs the resident did not like and did not want in her room. She indicated most of that occurred before she was employed in July, 2012. She indicated she thought it was just the resident didn't like the CNAs, not that they had done anything to her.</p> <p>The Social Service Director was interviewed on 11/8/12 at 10:17 a.m. She indicated Resident #182 had requested many CNAs not work with</p>		<p>managers.</p> <ul style="list-style-type: none"> <li>·Facility customer care meeting held on November 29, 2012 to review responses with department heads and nurse managers of every resident in the facility.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Staff has been educated by SDC/DNS on abuse policy and resident rights with an emphasis on communication and rude behavior, completed by December 3, 2012.</li> <li>*ED/DNS/Designee/UM/Department heads will conduct rounds daily and communicate with staff and residents to ensure all allegations or concerns are reported and handled according to policy. All allegations or statements regarding resident abuse or mistreatment will be reported immediately to the ED/DNS. The management staff will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH and other agencies as outlined in the facility policy.<b>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?</b></li> <li>·Staff has been educated by DNS and SDC/designee on abuse policy and resident rights</li> </ul>				

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	<p>her. She named CNA #1 and indicated she was a CNA the resident did not want to take care of her. She pulled up a specific "grievance" that had been written up, dated 6/21/12. She indicated they had done interviews in preparation for survey over the past few months and this resident had answered yes to questions about staff being rough and rude and being afraid, in regards to this CNA.</p> <p>The Concern/Grievance Form, dated 6/21/12, indicated the resident had reported to a Qualified Medication Aide at 6:00 a.m., on 6/21/12, that CNA #1 refused to help roll her over on her side and told her she needed to roll herself. Statements included in the grievance documentation indicated she had reported the CNA refused to care for her.</p> <p>Documentation by the former Assistant Director of Nursing, dated 6/22/12 at 12:00 noon, indicated a re-interview of the resident had been completed. During that interview, the ADoN indicated the CNA had refused to change her and her room-mate on a separate occasion, had a bad attitude, and she indicated she was afraid of the CNA and what she might do to her.</p>		<p>by December 3, 2012.</p> <ul style="list-style-type: none"> <li>·The ED/ DNS/designee will complete CQI tool weekly X 4 weeks, then monthly thereafter. Abuse investigation and staff interview will both be utilized. If threshold of 100% is not achieved action plan will be developed.</li> <li>·All audit tools will be brought before the CQI committee monthly</li> <li>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</li> </ul> <p><b>Compliance date:December 3, 2012</b></p>				

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	<p>The Director of Nursing was interviewed on 11/8/12 at 11:50 a.m. She indicated they were looking into the allegation regarding the CNA.</p> <p>The Social Services Director and Administrator were interviewed at 2:55 p.m., on 11/8/12. They indicated they had done interviews with several residents, using the survey questions about staff being rough and rude and residents had not reported anything. They did indicate Resident #182 had answered yes to the questions about staff being rude and rough during an interview, but they did not have any evidence the allegations were thoroughly investigated. The CNA the resident had reported was still employed but did not work with this resident. The re-assignment was done in response to the resident's complaints about her. There was no indication an investigation, including interviewing other residents and staff about this CNAs behaviors, had been done.</p> <p>The Administrator indicated, at the time of the interview, each resident had staff assigned to do rounds, have daily conversations, and frequent contact with residents to inquire about care and nothing else had been reported. She further indicated she</p>						

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	<p>understood there should have been more done at the time of this allegation. The issue had not been reported to the state agency as an allegation of abuse either.</p> <p>The policy and procedure for Abuse Prohibition, Reporting, and Investigation, dated February 2010 and revised September 2012, included, but was not limited to, the following: "All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination." "The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed..." "The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be</p>				

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	<p>forwarded to the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations."</p> <p>"A comprehensive record of the abuse investigation is to be kept by the facility Executive Director and/or Director of Nursing Services."</p> <p>"It is the responsibility of every employee of American Senior Communities to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances to his/her immediate supervisor."</p> <p>"Supervisory personnel are responsible to monitor, through observation and counseling as needed, staff/resident interactions, and the provision of care and services to the resident. Staff members showing any trend toward impatience or frustration in routine dealings with residents should be evaluated for possible temporary reassignment of care or unpaid leave of absence..."</p> <p>3.1-28(a)</p>			

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F000241 SS=A	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident's dignity was maintained by posting signs about the resident's care for specific conditions in 2 of 40 residents observed. (#96, #182).</p> <p>Findings include:</p> <p>1. During an observation made on 11/01/12 at 2:03 p.m., a sign was observed above Resident #96's bed. The sign indicated instructions for transfer assistance.</p> <p>On 11/05/12 at 10:00 a.m., an observation was made of CNA [Certified Nurse Assistant] #4 and PTA [Physical Therapy Assistance] # 1 transferring Resident #96 from the bed to the wheelchair. During the observation a sign was noted above the resident's bed. The sign posted instructions including but not limited to not getting out of bed without backbrace, log roll patient when turning, and weight bearing as</p>	F000241	<p>F241 <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Signs were immediately removed in resident #96 and #182 rooms.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice. Specifically any resident receiving therapy services.</li> <li>·Audit has been completed to ensure no additional signs are posted with compromising information in resident rooms.</li> <li>·Customer care rounds are completed on every resident by department heads and nurse managers and department heads and nurse managers have been trained on HIPPA and privacy policies. All managers have been trained by DNS and ED by November 29, 2012 on alternate methods of posting information such as closed bedside binders.</li> </ul> <p><b>What measures will be put into</b></p>	12/03/2012

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	<p>tolerated. There was also a picture of the back brace and instructions for applying the back brace.</p> <p>At the time of the observation PTA # 4 indicated the sign was posted to remind the CNA's of transfer precautions and how to apply the back brace.</p> <p>On 11/07/12 at 11:02 a.m., an observation was made of a sign above Resident #96's bed. The sign indicated care instructions regarding care for the resident's care were, but not limited to not, getting out of bed without a brace and weight bearing as tolerated.</p> <p>A document titled Resident Handbook provided by the Admissions Director on 11/8/12 2:30 p.m., indicated the intention of the facility is to give care to resident's in a dignified manner and in an environment that enhances each resident's dignity.</p> <p>2. On 11/7/12 at 3:00 p.m., Resident #182 was observed laying in bed. Posted on the wall above the bed was a piece of paper with the following information: "Goals:</p>		<p><b>place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>·Customer care rounds are completed on every resident by department heads and nurse managers and department heads and nurse managers have been trained on HIPPA and privacy policies. All managers have been trained by DNS and ED on alternate methods of posting information such as closed bedside binders.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b> Customer care representatives have been instructed to remove any signs immediately and report violation to ED/DNS for follow up. Customer care rounds are made 5X weekly. DNS/SSD/Designee will be responsible for completion of the CQI audit tool entitled dignity/privacy daily for 3 weeks/ weekly for 6 months. If threshold of 90% is not met an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow-up.<b>Compliance date: December 3, 2012</b></p>		

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	<p>Practice toilet transfer at least 3 times a week Complete all hygiene/grooming tasks while sitting in wheelchair or edge of bed without assistance Increase strength in arms Sit up in wheelchair daily for at least 1 hour."  3.1-3(t)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided according to the care plan for 2 of 3 residents reviewed in a sample of 43 who met the criteria for review of care plans. (Resident #31 and Resident #70) In addition, the facility failed to ensure staff followed a recommendation to consult and notify the primary physician regarding an order to discontinue medication for 1 of 43 residents reviewed for physician orders. (#172)</p> <p>Findings include:</p> <p>1. Resident #31 was observed on 11/01/12 at 11:10 a.m., during an activity, with dirty glass lenses, a dark brown substance was noted underneath her fingernails, and hair pressed flat to the sides and standing up on the top of her head. The resident was further observed, at that time, to have bad breath and debris on her tooth.</p>	F000282	<p><b>F282 Services by Qualified persons/per care plan</b> It is the policy of the facility that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Res.#31 has been assessed and all ADLS performed per Plan of care</li> <li>·Res #70 has been assessed and all ADLs performed per plan of correction.</li> <li>·Res #172 medication regimen has been reviewed with primary physician and has been approved.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents that reside within the facility have the potential to be affected by the alleged deficient practice.</li> <li>· All nurses/QMAs/and CNAs that provide and/or oversee care of residents have received training related to basic ADL care</li> </ul>	12/03/2012			

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	<p>The clinical record of Resident #31 was reviewed on 11/07/12 at 2:21 p.m. The November 2012 Physician's Order Recap indicated the diagnoses of Resident #31 included, but were not limited to: dementia.</p> <p>The MDS (Minimum Data Set Assessment, dated 10/02/12, indicated Resident #31 was an extensive assist of one staff for personal hygiene. The MDS further indicated Resident #31 was severely cognitively impaired.</p> <p>The care plan, dated 10/12/12, indicated Resident #31 required assistance with ADL's (Activities of Daily Living) with interventions that included, but were not limited to, "...assist resident with all ADL's..."</p> <p>A care plan for behavior, dated 10/12/12, indicated Resident #31 "...is resistive to care; does not like to change clothes..." The plan of care lacked any documentation related to Resident #31 being resistive to care related to personal hygiene assistance.</p> <p>The clinical record lacked any documentation that Resident #31 had refused care on 11/01/12.</p>		<p>by December 3, 2012</p> <ul style="list-style-type: none"> <li>· IE:oral care, fingernail hygiene, and, hair combing by DNS/SDC</li> <li>·Accommodation of needs tool will be utilized to ensure care is provided as designated on the care plan.</li> <li>·All nurses that transcribe orders have been educated on proper process for order transcription by SDC/DNS by December 3, 2012.</li> <li>·DNS/Designee to ensure all orders are transcribed correctly.</li> <li>·An audit of the residents ' charts was conducted by the DNS to ensure the primary care physician was notified if any new orders were received by a specialist physician.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>All nurses/QMAs/and CNAs that provide and/or oversee care of residents have received training related to basic ADL care by December 3, 2012</p> <ul style="list-style-type: none"> <li>·Customer Service reps will make rounds 5 X per week and weekend supervisor on weekends to ensure residents have adequate ADL care provided. Any concerns noted will be corrected immediately. DNS/Unit managers/designee will utilize the accommodation of needs tool 5X per week X 4 weeks. Then weekly X 4 weeks and</li> </ul>		

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	<p>The Point of Care Report provided by the DoN on 11/07/12 at 12:19 p.m., lacked any documentation the personal hygiene assistance had been provided to Resident #31 on 11/01/12</p> <p>2. The clinical record of Resident #70 was reviewed on 11/07/12 at 9:18 a.m. The September 2012 Physician's Order indicated the diagnoses included, but were not limited to, diabetes.</p> <p>The Admission MDS (Minimum Data Set Assessment), dated 09/16/12, indicated Resident #70 required extensive assist of one staff for personal hygiene. The MDS further indicated Resident #70 had cognitive impairment.</p> <p>CNA #5 and CNA #6 were observed on 11/07/12 at 10:30 a.m., to provide a.m. care to Resident #70. Dental care was not observed to be provided to Resident #70. At that time, Resident #70 was observed to have food and debris along the bottom of his teeth at the gum line. CNA #5 and CNA #6 were then observed to transfer Resident #70 in a wheelchair and Resident #70 was transported from the room by LPN #5 at 10:53</p>		<p>monthly thereafter for at least 6 months</p> <ul style="list-style-type: none"> <li>·All orders will be reviewed by nurse management for accurate follow up.</li> <li>·All nurses that transcribe orders have been educated on proper process for order transcription by SDC/DNS by December 3, 2012.</li> <li>·DNS/Designee to ensure all orders are transcribed correctly.</li> </ul> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>·All nurses/QMAs/and CNAs that provide and/or oversee care of residents have received training related to basic ADL care IE:oral care, finger nail hygiene, and hair combing by SDC/DNS/designee.</li> <li>·All nurses that transcribe orders have been educated on proper process for order transcription by SDC/DNS.</li> <li>·DNS/Designee to ensure all orders are transcribed correctly.</li> <li>·Customer Service reps will ensure residents have adequate ADL care provided. DNS/Unit managers/designee will utilize the accommodation of needs tool 5X per week X 4 weeks. Then weekly X 4 weeks and monthly thereafter for at least 6 months. Threshold of 90% will be achieved or an additional action plan will be developed.</li> <li>·All audit tools will be</li> </ul>		

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	<p>a.m.</p> <p>During an interview on 11/07/12 at 10:56 a.m., CNA #5 indicated she had completed care on Resident #70.</p> <p>During an interview on 11/07/12 at 10:58 a.m., LPN #5 indicated routine dental care had not been provided to Resident #70 and returned the resident to the room.</p> <p>A care plan, dated 10/04/12, indicated Resident #70 required assistance for ADL's. The interventions included, but were not limited to, "Assist/provide Oral care twice daily and as needed."</p> <p>During an interview with the DoN (Director of Nursing) on 11/07/12 at 12:19 p.m., she indicated assistance with only late loss ADL's (Activities of Daily Living) were documented. She further indicated at that time, the hygiene and dental care assistance should be provided by the at least daily but were not documented by the CNA's (Certified Nursing Assistant).</p> <p>3. Resident #172's record were reviewed on 11/7/12 at 12:30 p.m.</p> <p>An order was located in the resident's</p>		<p>brought before the CQI committee monthly</p> <p>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</p> <p><b>Compliance date: December 3, 2012</b></p>		

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	<p>record, dated 10/30/12 at 10:00 a.m., which indicated the resident's primary physician be notified in order to discontinue the resident's Meclizine by the resident's ENT {ear, nose, and throat] specialist. During review of Resident #154's record, no documentation was found indicating the resident's physician had been notified.</p> <p>Interview with LPN #6 and LPN #2 on 11/7/12 at 12:15 p.m., indicated the the resident's primary physician was never notified and therefore the Meclizine was not discontinued.</p> <p>3.1-35(g)(2)</p>			

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F000312 SS=D	<p>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 observation, interview, and record review, the facility failed to ensure hair care, oral care, and nail care was provided to 1 of 7 residents who met the criteria for cleanliness of grooming. (Resident #31)</p> <p>Findings include:</p> <p>1. Resident #31 was observed on 11/01/12 at 11:10 a.m., during an activity, with dirty glass lenses, a dark brown substance was noted underneath her fingernails, and her hair was pressed flat to the sides and standing up on the top of her head. The resident was further observed, at that time, to have bad breath and debris on her tooth.</p> <p>The clinical record of Resident #31 was reviewed on 11/07/12 at 2:21 p.m. The November 2012 Physician's Order Recap indicated the diagnoses of Resident #31 included, but were not limited to: dementia.</p> <p>The MDS (Minimum Data Set</p>	F000312	<p><b>F312 ADL care provided for dependent residents</b> It is the policy of the facility that the facility must ensure that 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. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Res.#31 has been assessed and all ADLS performed per Plan of care</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents that reside within the facility have the potential to be affected by the alleged deficient practice.</li> <li>· All nurses/QMAs/and CNAs that provide and/or oversee care of residents have received training related to basic ADL care IE:oral</li> <li>·care, fingernail hygiene, and,</li> </ul>	12/03/2012			

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	<p>Assessment, dated 10/02/12, indicated Resident #31 was an extensive assist of one staff for personal hygiene. The MDS further indicated Resident #31 was severely cognitively impaired.</p> <p>The care plan, dated 10/12/12, indicated Resident #31 required assistance with ADL's (Activities of Daily Living) with interventions that included, but were not limited to, "...assist resident with all ADL's..."</p> <p>A care plan for behavior, dated 10/12/12, indicated Resident #31 "...is resistive to care; does not like to change clothes..." The plan of care lacked any documentation related to Resident #31 being resistive to care related to personal hygiene assistance.</p> <p>The clinical record lacked any documentation that Resident #31 had refused care on 11/01/12.</p> <p>The Point of Care Report provided by the DoN on 11/07/12 at 12:19 p.m., lacked any documentation the personal hygiene assistance had been provided to Resident #31 on 11/01/12.</p> <p>During an interview with the DoN</p>		<p>hair combing by DNS/SDC</p> <ul style="list-style-type: none"> <li>·Accommodation of needs tool will be utilized to ensure care is provided. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Customer Service reps will ensure residents have adequate ADL care provided. DNS/Unit managers/designee will utilize the accommodation of needs tool 5X per week X 4 weeks . Then weekly X 4 weeks and monthly thereafter</li> <li>·<b>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?</b></li> </ul> <p>All nurses/QMAs/and CNAs that provide and/or oversee care of residents have received training related to basic ADL care IE:oral care, finger nail hygiene, and hair combing by SDC/DNS/designee.</p> <ul style="list-style-type: none"> <li>·The DNS /designee will complete accommodation of needs CQI tool 5X weekly X 4 weeks, weekly X 4, and monthlyf or a minimum of 6 months</li> <li>·All audit tools will be brought before the CQI committee monthly</li> <li>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</li> </ul> <p>Copletion Date:December 3, 2012</p>				

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	<p>(Director of Nursing) on 11/07/12 at 12:19 p.m., she indicated hygiene and dental care assistance should be provided by the at least daily but were not documented by the CNA's (Certified Nursing Assistant).</p> <p>The Resident Handbook provided by the Business Office Manager on 11/08/12 at 2:30 p.m., indicated, "...a nurse assistant provides each resident with daily dental hygiene...our nursing staff is available to assist or provide each resident with daily hygiene and grooming care..."</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-389(a)(3)(E)</p>			

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F000332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% for 3 of 10 residents observed during medication pass. Six (6) medication errors were observed during 64 opportunities for error. This resulted in an error rate of 9.375% as food was not provided with specific medications as ordered by a physician. (Resident # 71, Resident #126, Resident #8).</p> <p>Findings include:</p> <p>1. An observation was made on 11/08/12 at 8:50 a.m., of Licensed Practical Nurse [LPN] #1 giving morning medications to Resident #71. The medications included but were not limited to Calcium 600 milligrams [mg]+ Vitamin D 400 units [a vitamin supplement] 1 tab by mouth. No food was observed to be given to the resident at this time. During this observation, RN #1 asked the resident what she had eaten for breakfast. The resident indicated she had not eaten any of her breakfast.</p>	F000332	<p><b>F332 Free of Medication Error Rates of 5% or More. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #71, Resident #126, and Resident #8 have been assessed and MD was notified of alleged error.</li> <li>·Residents are now receiving medication per physician orders.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents that have a PO med order that states with meals or with food has the potential to be affected.</li> <li>·Every resident's medication regimen have been reviewed and communicated with appropriate physicians</li> <li>·Medication changes have been made according to the residents needs.</li> <li>·New admit charts will be reviewed by the IDT for medication orders.</li> <li>·Crackers will be stocked on medication carts for residents that have medications ordered with food.</li> </ul>	12/03/2012			

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	<p>A clinical record review on 11/08/12 at 10:30 a.m., of Resident #71's record was done. There was a physician's order, dated 12/24/06, for Calcium 600 mg + vitamin D 400 units to be taken by the resident twice a day by mouth with meals.</p> <p>In an interview with Unit Manager LPN #2 on 11/08/12 at 10:40 a.m., she indicated breakfast trays were served at 7:30 a.m. This was one hour and twenty minutes prior to the medication being given.</p> <p>A policy titled medication administration guidelines and dated 7/2011 was provided by the Administrator on 11/09/12 at 11:45 a.m. The policy indicated it was the facility's policy to give medications ordered with meals within the time frame of 15 minutes prior to fifteen minutes after the meal.</p>		<p><b>.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Staff have been educated on proper procedure of medication administration. If the med is to be given with food and/or with meals. Education done by DNS/SDC by December 3, 2012.</li> <li>·MAR will include space to initial if food was offered when ordered.</li> <li>·DNS/designee will review MAR of any resident with an order for meds with food and/or meals. Review will be conducted daily to ensure physician orders are followed.</li> </ul> <p><b>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?</b></p> <p>DNS/designee will complete medication audit tool for any resident with an order for PO meds to be given with food and/or meals. A threshold of 98% will be achieved or an action plan will be developed.</p> <ul style="list-style-type: none"> <li>·5X weekly X 4 weeks, weekly X 4, and quarterly thereafter. For a minimum of 6 months</li> <li>·All audit tools will be brought before the CQI committee monthly</li> <li>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</li> </ul>		

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	<p>2. Resident # 126's record was reviewed on 11/8/12 at 10:15 a.m.</p> <p>Resident #126 had an order dated, 10/26/09, for Aspirin 81 mg chew tablet 1 orally daily with food.</p> <p>LPN #6 administered Aspirin 81 mg chew tablet 1 orally at 9:09 a.m., to Resident #126. The resident was not offered any food and did not have any food on her overbed table.</p> <p>Interview with CNA #3 and QMA #1 indicated the resident received her breakfast at approximately 7:30 a.m.</p> <p>3. Resident # 8's record was reviewed on 11/8/12 at 10:00 a.m.</p> <p>Resident #8 had a order, dated 4/7/11, for Folbee [a dietary supplement] , 1/2.5/25 mg tablet 1 orally daily with breakfast and Calcium 600 with Vitamin D 400 I.U. [international units] [ a medication containing calcium and vitamin D] daily with meals, an order, dated 7/25/11, for Ferrex [an iron supplement] 150 mg cap 1 orally daily with breakfast, and an order, dated 7/17/12, for Daily Vite [a vitamin]</p>		<p><b>Compliance date: December 3, 2012</b></p>		

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	<p>tablet 1 orally with breakfast.</p> <p>On 11/8/12 at 9:22 a.m., LPN #6 administered Folbee, Calcium 600 with Vitamin D, Ferrex, and Daily Vite to Resident #8 with water.</p> <p>Interview with CNA #3 and QMA #1 on 11/8/12 at 9:45 a.m., indicated Resident #8 had her breakfast at approximately 7:30 a.m.</p> <p>3.1-48(c)(1)</p>				

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F000364 SS=B	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure the pureed carrots were prepared in a manner to ensure nutritive value, during 1 of 1 observation of the puree food process, in that the carrots were measured prior to cooking and did not include enough as required by the recipe. This had the potential to affect 16 residents who received pureed diets.</p> <p>Finding includes:  On 11/7/12 at 3:20 p.m., Cook #1 was observed preparing pureed carrots for the evening meal. She indicated, when queried, she was making 25 servings, and referred to the recipe for 25 servings. She was observed to start placing cooked carrots into the food processor. She indicated she had measured the carrots prior to cooking them; they had been frozen. She then measured the carrots she had prepared to puree. They measured 2 quarts. She had</p>	F000364	<p><b>F364 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> ·No residents were affected because correction was made prior to serving. ·Residents receiving pureed food have food prepared following recipe/menu as prescribed. ·<b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> ·All residents on modified consistency diets have the potential to be affected by the alleged deficient practice. ·Registered dietician will in-service dietary staff on correct procedure for measurement conversions and menu compliance. Education done on November 30, 2012. ·Preparation of food will be monitored by dietary manager/designee to ensure recipe and menu is followed for optimal nutritive value. ·<b>What measures will be put into place or what systemic</b></p>	12/03/2012	

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	<p>previously measured the 1/2 cup and 2 tablespoons of margarine and the 1/4 cup and 2 and 2/3 tablespoons of thickener, as the recipe indicated.</p> <p>The recipe for pureed carrots was reviewed at that time. For 25 servings, the following were required: Carrots- 3 quarts 1/2 cup (instructions indicated to remove portions required from the regular prepared vegetable and to drain the liquid)</p> <p>The recipe indicated it would provide 25 servings using a #12 scoop.</p> <p>Cook #1 was observed to add 1 quart and 1/2 cup of carrots to the initial amount to ensure there would be 25 servings.</p> <p>The Administrator indicated, during interview at 10:00 a.m., on 11/9/12, there were only 16 residents who received pureed diets, so there would have been enough carrots to go around, they just would have had extra margarine and thickener in them.</p> <p>3.1-21(a)(1)</p>		<p><b>changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Staff has been educated on measurement conversions and menu compliance. Training and oversight by Registered dietician will be provided to all cooks. Inservice complete by November 30, 2012.</li> <li>·Conversion chart has been posted in kitchen to assist cook when needed</li> <li>·Measurements for ingredients of all menus will be done according to recipe and monitored by dietary manager/designee.</li> </ul> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>· Registered dietician will monitor meal preparation at least once per week X 4 weeks and each quarter on schedule with seasonal menu changes for a minimum of 6 months. If recipe not followed 100% a corrective action plan will be developed.</li> <li>· Any need for additional training will be reported to ED.</li> </ul> <p><b>Compliance date:December 3, 2012</b></p>		

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, record review, and interview, the facility failed to notify a physician of pharmacy recommendations for 1 residents in a sample of 44 residents who were reviewed for pharmacy recommendations. (Resident #154</p> <p>Findings include:</p> <p>1. During initial tour on 10/31/12 at 1:10 p.m., Resident #154's medication orders were reviewed. A pharmacy recommendation, dated 9/26/12 at 10:32 a.m., was located in the resident's record with orders listed under the "physician/provider medication response" to discontinue Resident #154's Ativan 0.5 mg bid [twice a day] and start Ativan 0.5 mg po [orally] every HS [hour of sleep]. No order change was found on the resident's medication administration order.</p>	F000428	<p><b>F428 Drug regimen review</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #154 medications have been reviewed by primary physician and are being given per physician order/plan of care.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·Residents with a pharmacy recommendation have the potential to be affected by the alleged deficient practice</li> <li>·All pharmacy recommendations will be brought to the daily clinical meeting to ensure proper follow through.</li> <li>·The DNS /designee is responsible to ensure compliance</li> <li>·Pharmacy recs audited for last 60 days to ensure all orders transcribed correctly with appropriate follow up. Audit completed by DNS.</li> </ul> <p><b>What measures will be put into</b></p>	12/03/2012			

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	<p>Interview with LPN #9 on 10/31/12 at 1:20 p.m., she indicated she had signed the order but did not think the Ativan was a order. She indicated she thought the pharmacist had wrote it in the "physician/prescriber response" area but she was unsure if the pharmacist or the physician had actually written the order.</p> <p>Interview with LPN # 9 on 11/7/12 at 3:10 p.m., indicated the recommendation was faxed to the wrong physician and Resident #154's primary physician was to visit with the resident today and she would request clarification of the order.</p> <p>Interview with LPN #9 on 11/8/12 at 8:45 a.m., indicated Resident #154's physician had clarified the order and followed the pharmacy's recommendations.</p> <p>Interview with the RPh [Registered Pharmacist] for the facility on 11/7/12 at 11:55 a.m., she indicated the documentation on the "physician/prescriber response" should have been processed as a physician's order and/or the facility should have clarified the order with the physician if they if they were not certain.</p>		<p><b>place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Nurse management have received education by SDC/DNS/designee over the proper procedure to handle pahrmacy recommendations completed by December 3, 2012.</li> <li>All pharmacy recommendations will be addressed daily in the clinical meeting until all are responded to.</li> <li>·IDT will review and compare physician order with actual pharmacy recommendation to ensure that it is transcribed correctly and that proper follow through has occurred.</li> <li>·The DNS/designee is responsible to ensure compliance</li> <li>·Non-compliance with these procedures will result in disciplinary action.</li> </ul> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>·All pharmacy recommendations will be written on pharmacy recomendation CQI form and followed up on daily to ensure timeliness with responses and accurate transcription.</li> <li>DNS/designee responsible for completion with a 90% threshold or additional action plan will be developed.</li> <li>·All audit tools will be brought before the CQI committee</li> </ul>		

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	3.1-25(j)		monthly ·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination. <b>Compliance date:December 3, 2012</b>		

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure insulin vials were dated when opened and discarded when expired</p>	F000431	<b>F431 Drug records, label/store drugs and biologicals</b> <b>What corrective action(s) will be accomplished for those residents found to have been</b>	12/03/2012			

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	<p>in 2 of 9 medication carts checked for proper labeling and storage of medications.</p> <p>Findings include:</p> <p>An observation was made on 11/07/12 at 3:20 p.m., of the 2400 unit medication cart. The following insulin vials were found to be opened, but not dated when opened:</p> <p>Resident #46's Novolin insulin Resident #40's Lantus insulin Resident #123's Novolog insulin</p> <p>During the same observation of the 2400 unit cart, an observation was made of Resident #46's Lantus insulin vial which was dated as opened on 9/15/12. This would indicate the Lantus had been opened for longer than 30 days.</p> <p>An observation was made on 11/07/12 at 3:30 p.m., of the 2500 unit cart. During this observation, Resident #153's Novolog insulin vial was observed to be opened, but not dated when opened. During this observation the 2nd floor Unit Manager, LPN [Licensed Practical Nurse] #5 indicated the facility policy was to date the insulin vial when opened and all insulin vials that had</p>		<p><b>affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident # 46,#40, #123, #153 insulin have been re-ordered and dated when opened.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·Any resident that receives insulin has the potential to be affected by this alleged deficient practice.</li> <li>·All carts will be checked by the shift supervisor daily for open vials and ensure that they are dated and not expired.</li> <li>·The DNS /designee is responsible to ensure compliance</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·All nurses have been educated by SDC/DNS over insulin labeling and storage by December 3, 2012. All medication carts will be checked daily by shift supervisor to ensure insulin is dated when opened and that the insulin is not expired..</li> <li>·The DNS/designee is responsible to ensure compliance</li> <li>·Non-compliance with these procedures will result in disciplinary action.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>		

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	<p>been opened for more than 30 days should be discarded.</p> <p>A document provided by the DoN [Director of Nursing] on 11/09/12 at 2:30 p.m., titled "Guide for Insulin Storage" and dated 7/2011, indicated it was facility policy for opened Novolin to be discarded 30 days after opening. Novolog and Lantus were to be discarded 28 days after opening.</p> <p>3.1-25(m)</p>		<p><b>i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Medication storage review CQI tool will be utilized</li> <li>·The DNS/designee will complete medication storage review CQI tool 5x weekly x 4 weeks, weekly x 4 weeks, and quarterly thereafter for a minimum of 6 months.</li> <li>·All audit tools will be brought before the CQI committee monthly a threshold below 90% will result in action plan being developed.</li> <li>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</li> </ul> <p><b>Compliance date December 3, 2012</b></p>		

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility 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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview,</p>	F000441	<b>F329 441 Infection control, prevent spread, linens. What</b>	12/03/2012			

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	<p>and record review the facility failed to ensure proper hand hygiene was performed after glove changes for 1 of 3 residents observed for care. (Resident #70).</p> <p>B. Based on record review and interview, the facility failed to ensure an employee had a chest x-ray or a tuberculosis test prior to working at the facility in 1 employee reviewed in a sample of 5 employees for tuberculosis screening. (LPN #7)</p> <p>Findings include:</p> <p>A.1. CNA #5 and CNA #6 were observed on 11/07/12 at 10:30 a.m., to provide a.m. care to Resident #70. CNA #5 was observed to perform pericare to the front side of the body, remove gloves and re-apply a new set of gloves without performing hand hygiene or handwashing. CNA #5 was then observed to clean the catheter tubing, remove gloves and apply a new set of gloves without performing hand hygiene or handwashing. CNA #5 was then observed to perform pericare to the back side of the body.</p> <p>In an interview with CNA #7 on 11/09/12 at 9:30 a.m., she indicated</p>		<p><b>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #70 was assessed and showed no negative reaction related to the alleged deficient practice. Resident is receiving care using proper handwashing technique.</li> <li>·No residents were affected by LPN #7 Chest x-ray. LPN # 7 CXR/TB information is up to date.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents that reside at facility have the potential to be affected by the alleged deficient practice.</li> <li>·All staff on all shifts will be checked off on proper hand washing and glove procedure utilizing the hand washing tool by SDC/designee by December 3, 2012 using skills validation check off for C.N.A.s.</li> <li>·SDC/designee has conducted an audit of all employee files to ensure all PPD information is complete and timely.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Staff have been educated on proper procedure of hand</li> </ul>		

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	<p>handwashing or hand hygiene should be performed after each glove change.</p> <p>The policy and procedure for non-sterile gloving technique provided by the DoN 11/08/12 at 9:48 a.m., indicated, "...Procedure: 4. perform procedure/task...5. Remove the first glove...8. Wash hands..."</p>		<p>hygiene/glove usage by SDC/DNS/designee by December 3, 2012.</p> <ul style="list-style-type: none"> <li>·ED/designee provided education to SDC regarding no employee entering orientation without proper PPD/CXR documentation.</li> <li>·SDC/designee will perform daily rounds on all shifts to ensure staff are performing proper hand hygiene/glove usage.</li> <li>·All employee files have been audited by SDC to ensure all chest x-rays are completed in timely manner.</li> </ul> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>·Staff have been educated on proper procedure of hand hygiene/glove usage by SDC/DNS/designee.</li> <li>·SDC/DNS /designee will complete infection control CQI 5X weekly X 4 weeks, weekly X 4, and quarterly thereafter. For a minimum of 6 months A threshold of 90 % will be achieved or an action plan will be developed.</li> <li>·All audit tools will be brought before the CQI committee monthly</li> <li>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</li> </ul>		

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	<p>B.1. Record review for LPN #1 was completed on 11/8/12 at 9:15 a.m.</p> <p>LPN #7 completed a "Tuberculosis Screening Questionnaire for Resident/Employees/Volunteers" on 8/27/12, which indicated LPN#7 had a history of a significant reaction to a tuberculin skin test. The record indicated LPN #7 had a chest x-ray completed in December, 2010.</p> <p>LPN #7 was hired by the facility and began working on 9/5/12.</p> <p>On September 13, 2012, LPN #7 had a chest x-ray related to her having a significant reaction to a tuberculin skin test in the past.</p> <p>Interview with the HFA [Health Facility Administrator] and LPN #8 on 11/8/12 at 2:00 p.m., indicated LPN#7 began working on 9/5/12 without having any tuberculin documentation on her record. The HFA indicated LPN #7</p>		<p>Personnel file audit tool will be utilized by the Business Office Manager for any new hires monthly for at least 6 months to ensure chest x-ray and PPDs are current. The audit will be reviewed by the CQI committee. If 100% threshold is not met an action plan will be developed. <b>Compliance date: December 3, 2012</b></p>		

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	<p>had worked at another facility and she had a chest x-ray done there. She indicated the facility had not obtained a copy of the chest x-ray prior to employment at the facility. The HFA indicated the facility policy was a chest x-ray is "good" for 2 years but no policy was produced verifying the length of time a chest x-ray is "good." LPN #8 indicated LPN #7's last chest x-ray was done in December, 2010, and she would obtain a the copy of the x-ray for the employee's file. A chest x-ray report obtained on 11/8/12 at 4:00 p.m., and dated December, 2010, indicated no significant abnormality of the chest.</p> <p>The "Hiring Process/Guidelines" obtained from the HFA on 11/9/12 at 11:40 a.m., indicated for a new hire "once the PPD {purified protein derivative or tuberculin} and post-offer physical have been completed the SDC [Staff Development Coordinator] must ensure the employee has no restrictions on their post-offer physical, along with a negative PPD."</p> <p>3.1-18(b)(1) 3.1-18(1)</p>						

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F000465 SS=B	<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.</p> <p>Based on observation and interview, the facility failed to ensure resident areas were maintained in a sanitary and orderly manner, for 6 of 34 resident rooms observed during Stage 1 reviews, and for 7 of 8 shower rooms observed during the general environment tour, in that floors were soiled, walls were marred, and non-skid strips were worn and torn. (Rooms #2304, 2406, 2204, 2301, 2209, and 2105)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Room #2304 was observed on 10/31/12 at 12:05 p.m. The bathroom walls were marred with black marks.</li> <li>2. Room #2406 was observed on 11/1/12 at 1:58 p.m. The cove molding, the edges and corners of the floors were soiled with dirt and debris. The pull cord in the bathroom was soiled brown in color.</li> <li>3. Room #2204 was observed on 11/1/12 at 10:10 a.m. The corners and edges of the room were soiled</li> </ol>	F000465	<p><b>F465 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Rooms #2304, 2406, 2204, 2301, 2209, and 2105 have been deep cleaned with attention to cove base and corners. Floors have been striped and waxed.</li> <li>·Rooms #2304, 2204 and 2301 have been painted and repaired when walls were marred or had marks.</li> <li>·Room 2301 whole in wall repaired</li> <li>·Room 2406 pull cord replaced</li> <li>·Shower rooms on 2100, 2200, 1100, 1200 and 1500 have had broken tiles replaced.</li> <li>·All cords on emergency call lights in shower rooms have been replaced</li> <li>·Non- skid shower strips have been replaced in all shower rooms.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·Nurse Managers/ department heads will round daily to ensure</li> </ul>	12/03/2012
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	<p>with dirt and debris. The lower portion of the room walls had long black marks on them.</p> <p>4. Room #2301 was observed on 11/1/12 at 9:56 a.m. The walls were marred with black marks. There was a dried brown substance on the wall below the window. The corners and edges of the floors were soiled with dirt and debris. There was an 8 inch by 5 inch hole in the bathroom wall just above the cove molding.</p> <p>5. Room #2209 was observed on 11/1/12 at 10:17 a.m. There was a very strong urine odor in the bathroom. The floor was wet with standing liquid in a large puddle. The corners and edges of the room were soiled with dirt and debris.</p> <p>6. Room #2105 was observed on 11/1/12 at 9:31 a.m. There was soil in the corners and edges of the room.</p> <p>7. On 11/9/12 9:55 a.m., the observations were reviewed with the Administrator and Director of Nursing. The Administrator indicated they had some issues with housekeeping and had hired a new housekeeping manager who started 3 weeks ago and hadn't had a chance to get it all done.</p>		<p>any concerns are reported appropriately and maintenance request are filled out so timely repairs will be made.</p> <ul style="list-style-type: none"> <li>·Customer care rounds will be made and environmental issues will be directed to the maintainace director through the request process.</li> <li>·Audit has been completed to ensure problem areas of a similar nature have been addressed</li> <li>·ED/designee will review maintenance log and housekeeping request to ensure all necessary repairs and correction have been completed.</li> <li>·Entire building on rotating deep clean schedule that will turn approximately every 30 days</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Housekeeping supervisor to evaluate and perform detailed audit of each room every 2 weeks x 3months and monthly x 6 months.</li> <li>·Entire building on rotating deep clean schedule that will turn approximately every 30 days</li> <li>·All housekeeping staff re-educated by supervisor on deep clean techniques with attention to detail.</li> <li>·Maintenance will monitor shower rooms weekly X 12 weeks and monthly X 6 months and promptly make required repairs</li> <li>·n-service of all staff will be</li> </ul>				

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	<p>8. On 11/08/12 at 3:45 p.m., the following was observed:</p> <p>A. The safety strips outside of the resident common shower on the 1100 unit, 1200 unit, and 1500 unit were in disrepair and missing in places. The common showers on the 1100 unit, 1200 unit, and 1500 unit had missing/broken tiles and the floor was separated from the wall of the shower.</p> <p>B. The safety strips outside of the resident common shower on the 2100 unit, 2200 unit, and the 2500 unit were in disrepair and missing in places. The common showers on the 2100 and 2200 had broken tiles. The common showers on the 2400 unit and 2500 unit had no cord on the the emergency call light.</p> <p>During an interview on 11/09/12 at 8:45 a.m., CNA #3 indicated the showers on the 1100 unit, the 1200 unit, and the 1500 unit were used to provide showers to the residents on the first floor.</p> <p>During an interview on 11/09/12 at 8:50 a.m., CNA #2 indicated the showers on the 2100 unit, 2200 unit,</p>		<p>conducted by SDC/Designee to include review facility policy related to notification to the maintenance department, housekeeping department for housekeeping concerns, repairs, maintenance needs and the importance of maintaining a safe functional , sanitary comfortable environment by December 3, 2012.</p> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>·Housekeeping supervisor to evaluate and perform detailed audit of each room every 2 weeks x 3months and monthly x 6 months. A threshold of 90% will be achieved or an action plan will be developed.</li> <li>·Customer care rounds will be made and reported in monthly meeting specifically addressing environmental concerns</li> <li>·Maintenance director will monitor each shower room weekly X 12 weeks to check for repair needs and monthly thereafter x 6 months</li> </ul> <p><b>Compliance date:Decmber 3, 2012</b></p>				

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	<p>and the 2500 unit were used to provide showers to the residents on the second floor.</p> <p>During an interview with the RHFA (Regional Health Facilities Administrator) on 11/09/12 at 10:00 a.m., he indicated the shower rooms were scheduled to be renovated.</p> <p>3.1-19(f)</p>			