

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2016
NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922		
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 19, 20, 21, 22 & 25, 2016</p> <p>Facility number: 000559 Provider number: 155719 AIM number: 100267170</p> <p>Census bed type: SNF: 4 SNF/NF:51 Total: 55</p> <p>Census payor type: Medicare: 5 Medicaid: 29 Other: 21 Total: 55</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on January 31, 2016.</p>	F 0000	<p>George Ade Memorial HealthCare Center 3623 East State Road 16 Brook, IN 47922-8800 219/275-2531</p> <p>February 12, 2016 Miriam Buffington, Enforcement Manager Division of Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-13 Indianapolis, IN 46204-3006</p> <p>Re: Survey Event ID 31CO11, POC for George Ade Memorial Health Care Center, Brook IN.</p> <p>Dear Miriam: This letter is our allegation of substantial compliance as of February 24, 2016. With this we are requesting a desk review of the cited tags to clear the survey. We would further request that any and all proposed and/ or imposed penalties be removed at this time.</p> <p>If you have any questions or need further information, please contact me at 219-275-2531 ext. 23 or by email at admin@georgeade.org.</p> <p>Thank You, Scott James</p> <p>The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is Prepared and executed solely because it is required by the</p>		

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

TITLE

(X6) DATE

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

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			<p>provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licenser of the long term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of the participation or that the corrective action was necessary.</p> <p>February 23, 2016 Janelyn Kulik, RN Surveyor Supervisor Long Term Care Division Indiana State Department of Health Facility #: 000559 Provider #: 155719 Survey Event ID: 31CO11 Survey Date: January 25, 2016 The following information is in response to the request from your office regarding the POC for George</p>		

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F 0221 SS=D Bldg. 00	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to a soft vest not being assessed and monitored for 1 of 1 residents reviewed for physical restraints. (Resident #1)</p> <p>Finding includes:</p> <p>On 1/19/16 at 2:20 PM, Resident #1 was observed sitting in his wheelchair at a table in the main dining area during activities. A soft vest was in place to his upper torso which fastened in the back of the chair.</p> <p>On 1/20/16 at 11:35 AM, Resident #1</p>	F 0221	<p>Ade Memorial Health Care Center, Brook, IN. Please include this information with the previous response provided.</p> <p>If there are any questions on further information, please contact W.R. Scott James, HFA at admin@georgeade.org.</p> <p>Thank you. W.R. Scott James, HFA</p> <p>A desk top review is requested for this tag. It is the practice of this facility to preserve the residents right to be free from any physical restraint that would be imposed for purposes of discipline or convenience, they would be used only for residents medical symptoms when needed. The Resident #1 was assessed for physical restraint. A care plan for a resident safety device along with a physician order was added for the resident to use while up in his chair to provide safe positioning. Resident #1 had resident safety device monitoring program added to the EMAR (Electronic medical record) treatment sheet to be assessed on a continual basis while up in a wheelchair. All residents with potential for resident safety</p>	02/01/2016

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	<p>was observed in his wheelchair in the hallway outside the assisted dining room. A soft vest was in place to his upper torso at this time and two staff members were assisting to reposition him in his wheelchair. The vest fastened with Velcro around the back of the chair.</p> <p>On 1/21/16 at 12:08 PM Resident #1 was observed sitting in his wheelchair in the assisted dining room with staff helping with lunch. A soft vest remained in place to his upper torso.</p> <p>On 1/21/16 at 2:55 PM , Resident #1 was observed sitting in his wheelchair in the hallway with a soft vest in place to his upper torso.</p> <p>On 1/21/16 at 3:44 PM, Resident #1 remained in his wheelchair in the hallway with a soft vest in place to his upper torso.</p> <p>Resident #1's record was reviewed on 1/21/16 at 1:27 PM. Diagnoses included, but were not limited to, cerebral palsy (CP), muscle weakness, intellectual disabilities, right arm and hand contractures, anxiety disorder, and major depressive disorder.</p> <p>A Significant Change Minimum Data Set (MDS) assessment dated 11/19/15</p>		<p>device were audited. The DON or her designee will be responsible for auditing and will continue weekly x4 then monthlyx1 then quarterly. All residents new to resident safety device or restraint are audited weekly x4, then monthlyx1 then quarterly. See attachment # 1 and 2. This is done as of 2/01/2016</p> <p>Addendum: F221 See attachment #1: in-service sheet that was presented to nursingstaff as to update resident's profile including restraints.</p>		

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	<p>indicated no restraints were used for Resident #1.</p> <p>An Annual Restraint/ Adaptive Equipment Use form dated 11/18/15 indicated no restraints were in use and adaptive equipment currently in use included bilateral rails to assist with positioning.</p> <p>Review of current Physician's Orders lacked an order for a soft vest.</p> <p>Review of Therapy Notes from November 2015 until present lacked any assessment of the soft vest for Resident #1.</p> <p>Review of the Progress notes from November 2015 until current indicated a lack of monitoring including a release schedule of the soft vest for Resident #1.</p> <p>A Care Plan for ADL (Activities of Daily Living) Functional/ rehabilitation potential updated on 11/23/15 indicated the resident required staff assistance with transfers/ ADLs due to CP. Interventions included, "Currently in a high back positional wheelchair due to exacerbation/ worsening of CP symptoms. He uses a positioning strap to upper chest to maintain alignment and comfort."</p>			

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	<p>Interview on 1/21/16 at 1:38 PM with the Director of Nursing (DON), indicated the soft vest used for Resident #1 was not currently considered a restraint by the facility and was being used for positioning. She further indicated Resident #1 was unable to release the vest by himself.</p> <p>Interview on 1/21/16 at 1:54 PM with the MDS coordinator indicated, she never thought to consider the resident's soft vest as a restraint. The facility had ordered a specialty chair from the CP society which came with the vest, due to a decline in condition. She further indicated it was being using strictly to improve positioning in his chair, so she "didn't think to do restraint assessment or any other documentation" and was unaware of any specific Physician's Order regarding the vest. She also indicated Resident #1 was not able to release the vest on his own.</p> <p>Interview on 1/22/16 at 8:31 AM with Certified Occupational Therapy Assistant (COTA) #1, indicated the therapy department had not evaluated Resident #1's vest as a positioning device. The vest came with a custom chair that was ordered, but the custom chair wasn't working due to a rapid decline. Her</p>			

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	<p>evaluation on 11/11/15 was for his current chair to which she added different padding for positioning. She further indicated the vest must have been carried over from Resident #1's prior chair.</p> <p>Follow up interview with the MDS coordinator on 1/22/16 at 9:54 AM, indicated Resident #1's specialty chair with the vest attached arrived and was put into use on 7/8/16. She further indicated he was not currently using the specialty chair which came with the vest, but the vest continued to be used in his current chair.</p> <p>A policy titled "Resident Safety Devices" was provided by the DON on 1/25/16 at 1:45 PM and deemed as current. The policy indicated, "Purpose: ... to assure resident safety when restrictive devices are required. Definition: Physical Restraint - any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body, which the individual cannot remove easily because it restricts freedom of movement or normal body access to one's body. Guidelines ... 3. A thorough assessment must be conducted with the input of all appropriate staff and disciplines and the plan of care specify the needs and plans. Restrictive devices only used after the trial of other</p>			

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F 0242 SS=D Bldg. 00	<p>non-restrictive interventions have been considered ... 8. Residents in restrictive devices such as Geri-chair with tray and others require frequent monitoring ... Procedures: ... 2. Discuss with the physician and the resident, or resident representative with the team's recommendations. 3. Initiate the written informed consent. Obtain written permission for the specific device. 4. Device may be applied by staff must be released every 2 hours. 5. Review the medical record to ensure physician's order ... 13. Remove safety device or reposition the resident at least every two hours. Monitor frequently in accordance with behavior and mental status"</p> <p>3.1-3(w) 3.1-26(a) 3.1-26(b) 3.1-26(f) 3.1-26(h) 3.1-26(q) 3.1-26(s)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care</p>			

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	<p>consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure a resident's individual preferences were followed, related to not giving the resident a choice of the amount of bathing he would prefer for 1 of 3 residents reviewed for choices. (Resident #71)</p> <p>Finding includes:</p> <p>A family interview on 1/19/16 at 11:45 a.m., indicated Resident #71 received 1 to 2 showers a week, but at home he took a bath every other day. She indicated since the resident's accident of falling before he was admitted to the facility, he would not be able to take a bath anymore so she preferred for him to have a shower every other day.</p> <p>Record review for Resident #71 was completed on 1/20/16 at 1:39 p.m. The residents diagnoses included, but were not limited to, hypertension, cerebral vascular accident, dementia, anxiety, depression, and dysphasia.</p> <p>A Significant Change Minimum Data Set (MDS) assessment completed on</p>	F 0242	<p>A desktop review is requested for this tag. It is the practice of this facility to allow the residents the right to choose activities, schedules, services consistent with their interests as well as allow choices that are significant to them while in a health care facility. The bath preferences and bathing schedule have been adjusted so as to better meet the needs of resident#71. These preferences were reviewed for any affected resident and adjusted accordingly. A revised Social History form (see attached) is now used, which designates the bathing preference prior to and at or after the time of admission. Documentation of ADL's have been reviewed and revised to account for ADL offered/refused and alternate offerings. This is monitored through ongoing review of the ADL documentation system and changes addressed as needed so as to better meet the resident's needs. The MDS coordinator or her designee are responsible for the monitoring which is ongoing. See attachment #3 This is done as of 2/1/2016.</p> <p>Addendum: F242 In-service provided for nursing staff</p>	02/01/2016	

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	<p>11/19/15 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 4, which indicated the resident was severely cognitively impaired. The resident required a total 1 person assist for bathing.</p> <p>A Care Plan dated 11/12/15, indicated: ADLs (Activities of Daily Living): resident required staff assist with all ADLs due to left upper extremity weakness/ confusion/ inability to stand/ post brain bleed. The interventions included for staff to shower resident and give bed baths as needed.</p> <p>A Social History Form completed by Social Service #1 on 9/14/15 with the resident's wife indicated: -method of bathing: tub or shower -how often: every other day</p> <p>A Resident Profile Sheet indicated: -ADL functional/rehabilitation potential; staff to shower/bed baths as needed -did not indicate frequency</p> <p>An ADL report for the dates 1/1/16 through 1/21/16 indicated the resident received a tub bath on Mondays and Thursdays. The report indicated he received the tub bath twice a week and not every other day. The report indicated the resident did not receive a shower</p>		<p>regarding addition of ADLchanges i.e. bathing to the point of care. See attachment #2</p>				

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	<p>during the time period.</p> <p>An interview with the Director of Nursing (DON) on 1/21/16 at 1:45 p.m., indicated the resident was on a schedule to have a shower on Tuesdays and Fridays. She further indicated if the showers were not marked on the ADL report then she had no further documentation to show if the resident received a shower every other day.</p> <p>Interview with Social Service #1 on 1/21/16 at 2:00 p.m., indicated a Social History Form for Resident #71 was completed on admission with the resident's wife. She indicated the resident's wife had indicated the resident received a tub bath or shower every other day when he was at home. She further indicated she informed the wife the residents were offered a shower two times a week and she was ok with that.</p> <p>A follow up interview with Resident #71's wife on 1/21/16 at 3:00 p.m., indicated when the resident was at home he took a bath every other day and sometime showers, but since his accident she believed he would not be able to get into a tub anymore. She indicated she believed he received a shower once to twice a week and just figured that was the facility policy. She further indicated she</p>			

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F 0272 SS=D Bldg. 00	<p>had told the facility when the resident was at home he either took a bath or a shower every other day but they did not ask her what she would prefer him to have here. She further indicated she would prefer the staff attempted to give him a shower every other day because he was use to taking a bath or shower every other day at home.</p> <p>Interview with CNA #1 on 1/22/16 at 12:12 p.m., indicated the resident received two showers a week. She further indicated the resident's care needs are able to be found on the computer that tells them things like how much assistance the resident needs with ADLs and what type of bathing they receive.</p> <p>3.1-35(g)(2)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;</p>			

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	<p>Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was assessed correctly for physical restraints related to a soft vest for 1 of 23 residents whose records were reviewed. (Resident #1)</p> <p>Finding includes:</p> <p>On 1/19/16 at 2:20 PM, Resident #1 was observed sitting in his wheelchair at a table in the main dining area during activities. A soft vest was in place to his upper torso at this time. The vest fastened with Velcro around the back of the chair.</p>	F 0272	A desk top review is requested for this tag. It is the practice of this facility to conduct initial and periodic comprehension assessments to document each resident's functional capacity. The Resident #1 was assessed for physical restraint. A care plan for resident safety device was added for the resident to use while up in his chair to provide safe positioning. Resident #1 had resident safety device monitoring program added to the EMAR (Electronic medical record) treatment sheet to be assessed on a continual basis while up in a wheelchair. All residents with potential for resident safety	02/01/2016

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	<p>On 1/20/16 at 11:35 AM, Resident #1 was observed in his wheelchair in the hallway outside the assisted dining room. A soft vest was in place to his upper torso at this time and two staff members were assisting to reposition him in his wheelchair. The vest fastened with Velcro around the back of the chair.</p> <p>Resident #1's record was reviewed on 1/21/16 at 1:27 PM. Diagnoses included, but were not limited to, cerebral palsy (CP), muscle weakness, intellectual disabilities, right arm and hand contractures, anxiety disorder, and major depressive disorder.</p> <p>A Significant Change Minimum Data Set (MDS) assessment dated 11/19/15 indicated no restraints were used for Resident #1.</p> <p>An Annual Restraint/ Adaptive Equipment Use form dated 11/18/15 indicated no restraints were in use and adaptive equipment currently in use included bilateral rails to assist with positioning.</p> <p>Interview on 1/21/16 at 1:38 PM with the Director of Nursing (DON), indicated the soft vest used for Resident #1 was not currently considered a restraint by the facility and was being used for</p>		<p>device were audited. Auditing by DON or designee will continue weekly x4 then monthly x1 then quarterly. All residents new to resident safety device or restraint will have care plans audited weekly x4, then monthly x1 then quarterly. See attachment # 1. This is done as of 2/01/2016</p> <p>Addendum: F272 Yes. All nursing care plan areas will be accessed during audits. See attachment #1 regarding in-service point of care changes/update i.e. bathing. Regarding monitoring of care plans. Care plans are monitored daily by MDS coordinator. During care plan meetings (usually held on Thursday's), medical records and MDS coordinator monitor all resident care plans up for review for all areas of care/needs. Medical records maintains audits on approaches which were checked during care plan meetings. See attachment #3 – Audit sheet</p>				

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	<p>positioning, She further indicated Resident #1 was unable to release the vest by himself.</p> <p>Interview on 1/21/16 at 1:54 PM with the MDS coordinator indicated, she never thought to consider the resident's soft vest as a restraint. The facility had ordered a specialty chair from the CP society which came with the vest, due to a decline in condition. She further indicated it was being using strictly to improve positioning in his chair, so she "didn't think to do restraint assessment or any other documentation" and was unaware of any specific Physician's Order regarding the vest. She also indicated Resident #1 was not able to release the vest on his own.</p> <p>Follow up interview with the MDS coordinator on 1/22/16 at 9:54 AM, indicated Resident #1's specialty chair with the vest attached arrived and was put into use on 7/8/16. She further indicated he was not currently using the specialty chair which came with the vest, but the vest continued to be used in his current chair.</p> <p>3.1-31(a)</p>			

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F 0282 SS=D Bldg. 00	<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, record review and interview, the facility failed to follow physician's orders and care plans, related to no prior interventions attempted before administration of antianxiety and analgesic medications for 1 of 5 residents reviewed for unnecessary medications, and assessment and monitoring of skin for bruising for 2 of 3 residents reviewed for non-pressure related skin conditions of the 5 who met the criteria for non-pressure related skin conditions. (Residents #28, #6, and # 47)</p> <p>Findings include:</p> <p>1. The record for Resident #28 was reviewed on 1/22/16 at 2:07 p.m. The resident's diagnoses included, but were not limited to, anxiety disorder, chronic pain syndrome, and hypertension. Review of the 1/2016 Physician Order Summary indicated an order for Xanax (alprazolam, an antianxiety medication) 0.25 mg (milligrams) BID (twice a day) PRN (as needed) for anxiety and acetaminophen (Tylenol, a pain</p>	F 0282	<p>A desk top review is requested for this tag. It is the practice of the facility to follow physician's orders and care plans related to unnecessary medications. It is the practice of the facility to monitor skin assessments weekly. Resident #28 medical record and physician's orders were reviewed. Care plan and Medication administration orders were updated to include a notation of non-pharmacologic interventions. All residents have the potential to be affected, therefore all residents' medication administration record were audited, and those with PRN medications requiring non-pharmacologic interventions updated. Auditing by DON or designee will continue weekly x4 then monthly x1, then at the discretion of the QA committee when the threshold reaches 95%. See attachment #4. This is done as of 2/01/2016 It is the practice of the facility to assess and monitor resident's skin for skin conditions. The residents #6 and #46 with noted skin discoloration</p>	02/01/2016

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	<p>medication) 500 mg at bedtime as needed for pain.</p> <p>Review of the December 2015 MAR (Medication Administration Record) indicated the resident had received the Xanax medication on 12/29/15. The resident had received the acetaminophen medication on 12/4/15, 12/5/15, 12/7/15, 12/8/15, 12/9/15, 12/11/15, 12/12/15, 12/13/15, 12/17/15, 12/18/15, 12/21/15, 12/22/15, 12/23/15, 12/26/15, 12/27/15, 12/29/15, 12/30/15, and 12/31/15.</p> <p>The record lacked indication of any interventions attempted prior to administering the Xanax medication on 12/29/15 or the acetaminophen medication on 12/4/15, 12/5/15, 12/7/15, 12/8/15, 12/9/15, 12/11/15, 12/12/15, 12/13/15, 12/17/15, 12/18/15, 12/21/15, 12/22/15, 12/23/15, 12/26/15, 12/27/15, 12/29/15, 12/30/15, and 12/31/15.</p> <p>Review of the January 2016 MAR indicated the resident hand received the acetaminophen medication on 1/2/16 1/4/16, 1/6/16, 1/8/16, 1/9/16, 1/10/16, 1/11/16, 1/12/16, 1/13/16, 1/14/16, 1/15/16, 1/18/16, and 1/19/16.</p> <p>The record lacked indication of any interventions attempted prior to administering the acetaminophen medication.</p> <p>Resident #28 had a care plan for pain.</p>		<p>were assessed. Resident #6 and #46 care plan was updated and medical record to include skin discoloration notations. All residents have the potential to have skin discolorations. Re-educated staff about weekly skin assessments, as well as assessments as needed of residents skin. Auditing of weekly skin assessments to continue per DON or designee on a continual basis.</p> <p>Addendum: F282 A head to toe assessment was completed for Resident #47. Yes. All residents were reviewed to ensure Physician orders were being followed. See attached in-service sheet – attachment #1 All nursing staff administering medication were in serviced. Completed as of 2/12/16. Regarding implementation of non-pharmacology interventions prior to administration of PRN meds. There is now a checklist on the E-Mar which is being filled out prior to PRN administration as to what interventions were attempted prior to medication administration. Successfully achieving staff compliance with this additional charting.</p>				

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	<p>The nursing interventions included "...Offer alternative comfort measures prior to administration of analgesics. These can include repositioning, warm blanket, offer food/fluids/toileting, conversation/diversional activities. Note any effective approaches..."</p> <p>The resident also had a care plan for PRN (as needed) antianxiety medication. The nursing interventions included "...Offer alternative interventions prior to administration of med..."</p> <p>Interview with the Director of Nursing (DON) on 1/25/16 at 1:50 p.m. indicated non-pharmacological interventions should have been attempted and charted in the Nurses Notes.</p> <p>2. On 1/19/16 at 2:39 PM, Resident #6 was observed in her room. Large dark purple discolorations were noted to the back of her right hand, her right forearm by her wrist, and her right forearm by her inner elbow.</p> <p>On 1/21/16 at 3:02 PM, Resident #6 was observed sitting in her wheelchair in the main dining area. Large dark purple discolored areas remain to both areas of her right forearm.</p> <p>On 1/21/16 at 4:00 PM, Resident #6 was observed with the DON (Director of Nursing) sitting in her wheelchair in the</p>			

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	<p>hallway. The two large dark purple areas remain to her right forearm. At the time of the observation, the DON indicated she was unaware of any specific skin areas being monitored for the resident, but was aware the resident had a couple recent falls, so she would have to check the documentation.</p> <p>Resident #6's record was reviewed on 1/21/16 at 3:34 PM. Diagnoses included, but were not limited to, laceration of left wrist, altered mental status, dizziness, heart disease, anemia, and dementia.</p> <p>Review of current Physician Orders included the following: - ASA (aspirin - a medication with anti-clotting properties) DR (delayed release) 81 mg (milligrams) 1 po (by mouth) qd (daily) - Plavix (anti-clotting medication) 75 mg 1 po qd</p> <p>Review of the Progress Notes for January 2016 lacked indication of any bruising to the resident's right forearm until a skin assessment note was added following the observation with the DON on 1/21/16.</p> <p>Review of Events indicated there were no events involving bruising to Resident #6's right forearm.</p>			

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	<p>Review of the resident's care plans indicated the following:</p> <ul style="list-style-type: none"> - Receives an anticoagulant medication. Interventions included labs as ordered, meds (medications) as ordered, and to observe for any s/s (signs/ symptoms) of adverse reaction to the meds. These can include unexplained bruising. - Requires assist with ADLs (activities of daily living) d/t (due to) occasional unsteady gait and dementia. Interventions included.: assist with dressing and grooming. <p>Follow up interview with the DON on 1/22/16 at 8:05 AM indicated there was no prior documentation of any bruises to the resident's right forearm and yesterday's joint observation was the first time she had seen them. She further indicated Resident #6 was a one to two staff assist for ADLs, so the CNAs should have seen the areas during daily care and reported them to the nurse. She also indicated the wound nurse had assessed, measured and documented the areas on night shift.</p> <p>Interview with CNA #3 on 1/25/16 at 11:32 AM, indicated Resident #6 was a one to two staff assist for ADLs and dressing. She further indicated part of the CNA daily routine was to inspect skin during daily care and notify the nurse if</p>			

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	<p>any issues were noted.</p> <p>3. On 1/19/16 at 10:34 AM, Resident #47 was observed sitting in her gerichair in the doorway of her room. Diffuse dark discolorations were observed to the back of both hands with several additional dark reddish circles to her right hand.</p> <p>On 1/21/16 at 8:44 AM, Resident #47 was observed sitting in her gerichair in the hallway. Diffuse discolorations with additional dark reddish circles remained to the back of both hands.</p> <p>On 1/21/16 at 4:01 PM, Resident #47 was observed with the DON, who indicated at the time she thought the resident had always had the diffuse discoloration to the back of her hands, but would have the wound nurse evaluate. She was unsure about the dark reddish circles.</p> <p>Resident #47's record was reviewed on 1/20/16 at 1:30 PM. Diagnoses included, but were not limited to, dementia with behaviors, delusional disorder, anemia, history of falls, and peripheral vascular disease.</p> <p>Review of current physician Orders included the following: - ASA (aspirin) 81 mg po qd</p>			

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	<p>Review of Progress Notes indicated no indication of any discoloration to the back of the resident's hands until the wound nurse skin evaluation on 1/22/16 following the joint observation with the DON.</p> <p>Review of the resident's care plans indicated the following:</p> <ul style="list-style-type: none"> - Requires staff assist with ADLs d/t weakness/ unsteady gait at times and episodes of confusion. Interventions included: assist with dressing - Receives an anticoagulant medication. Interventions included: labs as ordered; med as ordered; observe for any s/s adverse reaction to med. These can include unexplained bruising. <p>Interview with CNA #3 on 1/25/16 at 11:32 AM indicated Resident #47 was a one staff assist for ADLs and dressing. She further indicated part of the CNA daily routine was to inspect skin during daily care and notify the nurse if any issues were noted.</p> <p>Follow up interview with the DON on 1/25/16 at 1:26 PM, indicated the wound nurse had assessed Resident #47's skin the previous night as per the Progress Notes documentation and determined the areas to the back of her hands were new and were now being followed.</p>			

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F 0309 SS=D Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services related to the assessment and monitoring of skin for bruising for 2 of 3 residents reviewed for non-pressure related skin conditions of the 5 who met the criteria for non-pressure related skin conditions. (Residents #6 and #47)</p> <p>Findings include:</p> <p>1. On 1/19/16 at 2:39 PM, Resident #6 was observed in her room. Large dark purple discolorations were noted to the back of her right hand, her right forearm by her wrist, and her right forearm by her inner elbow.</p>	F 0309	<p>A desk top review is requested for this tag. It is the practice of the facility to ensure the residents received the necessary treatment and services related to the assessment and monitoring for all skin conditions. The residents #6 and #46 with noted skin discoloration were assessed. Resident #6 and #46 care plan was updated and medical record to include skin discoloration notations. All residents have the potential to have skin discolorations. Re-educated staff about weekly skin assessments, as well as assessments as needed of resident skin. Auditing of weekly skin assessments to continue per DON or designee on a continual basis. see attachment #5 #10 #11 This is done as of 2/01/2016</p>	02/01/2016

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	<p>On 1/21/16 at 3:02 PM, Resident #6 was observed sitting in her wheelchair in he main dining area. Large dark purple discolored areas remain to both areas of her right forearm.</p> <p>On 1/21/16 at 4:00 PM, Resident #6 was observed with the DON (Director of Nursing) sitting in her wheelchair in the hallway. The two large dark purple areas remain to her right forearm. At the time of the observation, the DON indicated she was unaware of any specific skin areas being monitored for the resident, but was aware the resident had a couple recent falls, so she would have to check the documentation.</p> <p>Resident #6's record was reviewed on 1/21/16 at 3:34 PM. Diagnoses included, but were not limited to, laceration of left wrist, altered mental status, dizziness, heart disease, anemia, and dementia.</p> <p>Review of current Physician Orders included the following: - ASA (aspirin - a medication with anti-clotting properties) DR (delayed release) 81 mg (milligrams) 1 po (by mouth) qd (daily) - Plavix (anti-clotting medication) 75 mg 1 po qd</p>		<p>Addendum: F309 Resident assessed head to toe and notified of skincondition. Diagnosis was updated.</p>	

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	<p>Review of the January 2016 Medication Administration Record (MAR) indicated Resident #6 received her ASA and Plavix as ordered except for two missed doses each.</p> <p>Review of the Progress Notes for January 2016 lacked indication of any bruising to the resident's right forearm until a skin assessment note was added following the observation with the DON on 1/21/16.</p> <p>Review of Events indicated there were no events involving bruising to Resident #6's right forearm.</p> <p>Review of the resident's care plans indicated the following: - Receives an anticoagulant medication. Interventions included labs as ordered, meds (medications) as ordered, and to observe for any s/s (signs/ symptoms) of adverse reaction to the meds. These can include unexplained bruising. - Requires assist with ADLs (activities of daily living) d/t (due to) occasional unsteady gait and dementia. Interventions included.: assist with dressing and grooming.</p> <p>Follow up interview with the DON on 1/22/16 at 8:05 AM indicated there was no prior documentation of any bruises to the resident's right forearm and</p>			

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	<p>yesterday's joint observation was the first time she had seen them. She further indicated Resident #6 was a one to two staff assist for ADLs, so the CNAs should have seen the areas during daily care and reported them to the nurse. She also indicated the wound nurse had assessed, measured and documented the areas on night shift.</p> <p>Interview with CNA #3 on 1/25/16 at 11:32 AM, indicated Resident #6 was a one to two staff assist for ADLs and dressing. She further indicated part of the CNA daily routine was to inspect skin during daily care and notify the nurse if any issues were noted.</p> <p>2. On 1/19/16 at 10:34 AM, Resident #47 was observed sitting in her gerichair in the doorway of her room. Diffuse dark discolorations were observed to the back of both hands with several additional dark reddish circles to her right hand.</p> <p>On 1/21/16 at 8:44 AM, Resident #47 was observed sitting in her gerichair in the hallway. Diffuse discolorations with additional dark reddish circles remained to the back of both hands.</p> <p>On 1/21/16 at 4:01 PM, Resident #47 was observed with the DON, who indicated at the time she thought the</p>			

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	<p>resident had always had the diffuse discoloration to the back of her hands, but would have the wound nurse evaluate. She was unsure about the dark reddish circles.</p> <p>Resident #47's record was reviewed on 1/20/16 at 1:30 PM. Diagnoses included, but were not limited to, dementia with behaviors, delusional disorder, anemia, history of falls, and peripheral vascular disease.</p> <p>Review of current physician Orders included the following: - ASA (aspirin) 81 mg po qd</p> <p>Review of January 2016 MARs indicated Resident #47 received her ASA daily as ordered.</p> <p>Review of Progress Notes indicated no indication of any discoloration to the back of the resident's hands until the wound nurse skin evaluation on 1/22/16 following the joint observation with the DON.</p> <p>Review of the resident's care plans indicated the following: - Requires staff assist with ADLs d/t weakness/ unsteady gait at times and episodes of confusion. Interventions included: assist with dressing - Receives an anticoagulant medication.</p>			

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	<p>Interventions included: labs as ordered; med as ordered; observe for any s/s adverse reaction to med. These can include unexplained bruising.</p> <p>Interview with CNA #3 on 1/25/16 at 11:32 AM indicated Resident #47 was a one staff assist for ADLs and dressing. She further indicated part of the CNA daily routine was to inspect skin during daily care and notify the nurse if any issues were noted.</p> <p>Follow up interview with the DON on 1/25/16 at 1:26 PM, indicated the wound nurse had assessed Resident #47's skin the previous night as per the Progress Notes documentation and determined the areas to the back of her hands were new and were now being followed.</p> <p>A policy titled "Skin Condition, and Pressure Ulcer Policy" was presented by the DON on 1/21/16 at 3:50 PM and deemed as current. The policy indicated, ".... Standards: ... 4. Each resident will be observed for skin breakdown daily during care, on the assigned bath day by the CNA. Changes shall be prompt [sic] reported to the supervising nurse who will perform the detailed assessment. 5. Caregivers are responsible for promptly notifying the charge nurse of skin observations which include: a. redness/</p>			

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F 0329 SS=D Bldg. 00	<p>swelling b. bruises ... h. skin discoloration"</p> <p>3.1-37(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 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to no prior interventions attempted before the administration of</p>	F 0329	A desk top review is requested for this tag. It is the practice of the facility to review each resident drug regimen and to ensure that the resident is free from unnecessary drugs. Resident#28 medical record and physician's	02/01/2016

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	<p>antianxiety and analgesic medications and an antipsychotic gradual dose reduction not completed as ordered for 2 of 5 residents reviewed for unnecessary medications. (Residents #28 and #7) Findings include:</p> <p>1. The record for Resident #28 was reviewed on 1/22/16 at 2:07 p.m. The resident's diagnoses included, but were not limited to, anxiety disorder, chronic pain syndrome, and hypertension. Review of the 1/2016 Physician Order Summary indicated an order for Xanax (alprazolam, an antianxiety medication) 0.25 mg (milligrams) BID (twice a day) PRN (as needed) for anxiety and acetaminophen (Tylenol, a pain medication) 500 mg at bedtime as needed for pain.</p> <p>Review of the December 2015 MAR (Medication Administration Record) indicated the resident had received the Xanax medication on 12/29/15. The resident had received the acetaminophen medication on 12/4/15, 12/5/15, 12/7/15, 12/8/15, 12/9/15, 12/11/15, 12/12/15, 12/13/15, 12/17/15, 12/18/15, 12/21/15, 12/22/15, 12/23/15, 12/26/15, 12/27/15, 12/29/15, 12/30/15, and 12/31/15.</p> <p>The record lacked indication of any interventions attempted prior to administering the Xanax medication on</p>		<p>orders were reviewed. Care plan and Medication administration record were updated to include a notation of non-pharmacologic interventions. All residents have the potential to be affected, therefore all residents' medication administration record were audited, and those with PRN medications allowing for non-pharmacologic interventions updated. Auditing by DON or designee will continue weekly x4 then monthly x1, then at the discretions of the QA committee when the threshold reaches 95%. It is the practice of the facility to follow physician's orders and educate Power of Attorney and/or responsible party on pharmacy recommendations and allow the responsible party or resident to exercise their rights. Resident #7 medical record reviewed, notified Resident # 7 Medical Power of Attorney of the dose reduction, and the reasons pharmacist had recommended. Notified physician of pharmacy recommendation, and dose reduction was corrected. The Medical Power of Attorney and physician are in agreement with the current dosage for Resident #7 at this time. Attached is the GDR review sheet for Resident #7.</p> <p>Attachment #6 All residents on psycho-actives have the potential to be affected. All residents with pharmacy recommendations related to anti-psychotics reviewed. The facilities policy for</p>				

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	<p>12/29/15 or the acetaminophen medication on 12/4/15, 12/5/15, 12/7/15, 12/8/15, 12/9/15, 12/11/15, 12/12/15, 12/13/15, 12/17/15, 12/18/15, 12/21/15, 12/22/15, 12/23/15, 12/26/15, 12/27/15, 12/29/15, 12/30/15, and 12/31/15.</p> <p>Review of the January 2016 MAR indicated the resident hand received the acetaminophen medication on 1/2/16 1/4/16, 1/6/16, 1/8/16, 1/9/16, 1/10/16, 1/11/16, 1/12/16, 1/13/16, 1/14/16, 1/15/16, 1/18/16, and 1/19/16.</p> <p>The record lacked indication of any interventions attempted prior to administering the acetaminophen medication.</p> <p>Interview with the Director of Nursing (DON) on 1/25/16 at 1:50 p.m. indicated non-pharmacological interventions should have been attempted and charted in the Nurses Notes.</p> <p>2. The record for Resident #7 was reviewed on 1/20/16 at 2:51 p.m. The resident's diagnoses included, but were not limited to, Schizophrenia, dementia, depression, diabetes.</p> <p>Review of the January 2016 Physician's Order Summary (POS), indicated the resident was receiving Geodon (an anti-psychotic medication) 80 mg (milligrams) 1 capsule twice a day.</p>		<p>drug reduction is included for review. Attachment # 7. Monthly auditing by pharmacy, social services, Director of nursing or designee to continue without a stop date. This is done as of 2/01/2016</p> <p>Addendum: F329</p> <p>Pharmacy recommendations are reviewed monthly along with GDRreviews for affected residents. Physician as well as resident and or responsible party are notified of changes. This is ongoing on a monthly basis.</p>				

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	<p>Review of a Pharmacy Recommendation dated 5/4/15, indicated the resident had been receiving 80 mg of Geodon twice a day. The recommendation indicated to consider a gradual dose reduction from 80 mg to 60 mg twice a day. The Physician agreed to the dose reduction with his signature dated 5/4/15.</p> <p>Review of the Nurse Note dated 5/5/15 at 8:33 p.m., indicated the Physician was aware of the family's request not to change the dose of Geodon and a new order was received to maintain current dose of Geodon of 80 mg twice a day.</p> <p>Interview with the DON (Director Of Nursing) on 01/21/2016 at 9:18:a.m., indicated that was not the facility's normal procedure to accept a family's request to not change the dose of a medication. The medication should have been attempted to be reduced and the family should have been educated on gradual dose reduction. The DON further indicated there was not a policy on gradual dose reduction.</p> <p>3.1-48(a)(3) 3.1-48(b)(2)</p>			

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F 0371 SS=D Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to distribute food under sanitary conditions related to foods uncovered during serving of the Main Street Hallway room trays. This affected 1 of 2 hallways observed for room tray distribution. (Main Street Hallway)</p> <p>Finding includes:</p> <p>During an observation of lunch service on 1/19/16 at 12:02 p.m., on the Main Street Hallway, the Director of Nursing (DON) was observed removing a food tray from a cart by the Main Dining Room. The tray contained a covered dish, covered liquids, but the salad and dessert on the tray were uncovered. The DON proceeded to take the tray down the hall to room 24. Interview during the time of the observation with the DON indicated the food should have been covered before she took it down the hallway and she would make sure the resident received a new salad and dessert.</p>	F 0371	<p>A desk top review is requested for this tag. It is the practice of this facility to procure food from approved sources that are considered satisfactory by federal, state and local authorities. Likewise store prepare and distribute food under sanitary conditions. Both trays served by DON and CNA#2 were immediately removed and the uncovered items were replaced with covered items. All residents have the ability to be affected by this. Carts are equipped with tray covering dispensers. All Staff inserviced on proper food distribution under sanitary conditions. The Dietary Manager or her designee will be responsible to see that the dispenser is in place when they food carts leave the dietary department. Weekly auditing X4 then at discretion of the QA team when threshold reaches 100%. see attachment #12 #13 Addendum: F371 Yes. All three meals are rechecked at the time they leave the dietary area.</p>	02/01/2016

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	<p>During the same lunch service on 1/19/16 at 12:13 p.m., on the Main Street Hallway, CNA #2 was observed removing a food tray from a cart by the Main Dining Room. The tray contained a covered dish, covered liquids, but the salad and dessert on the tray were uncovered. CNA #2 proceeded to take the tray down the hall to room 14. Interview during the time of the observation with CNA #2 indicated she was not sure if the food had to be covered going down the hallway but she would find out. A follow up interview with CNA #2 on 1/19/16 at 2:09 p.m., indicated the food should have been covered when transporting down the hallway and the resident did receive a new salad and dessert.</p> <p>Interview with the Dietary Manager on 1/19/16 at 3:46 p.m., indicated the food should have been covered when it was transported down the hallway. She indicated the kitchen had sent out five room trays on the cart that were covered. The two room trays that were observed with uncovered food must have been for residents who decided to stay in their rooms to eat. She further indicated if a resident would decide to eat in their room the staff were suppose to use plastic wrap to cover the food before transporting it</p>		<p>See attached audit sheet – Attachment #4 This is done as of 2/01/2016</p>				

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F 0441 SS=D Bldg. 00	<p>down the hallway.</p> <p>A "Dietary Services Meal Tray Service Policy & Procedure", received as current from the Dietary Manager on 1/19/16 at 3:46 p.m., indicated "...Procedure: 5. If a resident changes their mind or is ill and must eat in room, appropriate materials will be provided on top of enclosed cart for each unit. Nursing staff will cover food item before delivery of tray and shall be removed when the food reaches the resident...."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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</p>			

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	<p>(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. Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained related to lack of glove use by staff during a glucometer test (blood sugar check) for 1 of 1 random observation of glucometer testing. (Resident #3) Finding includes: During an observation of Resident #3's glucometer testing on 1/21/16 at 10:33 a.m., LPN #1 entered Resident #3's room, put a glucometer testing strip in the glucometer, cleaned the resident's left index finger with an alcohol swab,</p>	F 0441	A desk top review is requested for this tag. It is the practice of this facility to maintain an established infection control program that has been designed to provide a safe, sanitary and comfortable environment that helps in the prevention and transmission of diseases and infections. LPN# 1 educated on proper infection control and wearing gloves during glucometer checks. All residents have potential to be affected by this. All staff educated on proper infection control techniques. The DON or her designee will be responsible to see this is done so as to avoid further issues. Staff to be randomly auditing weekly x4 then at the discretion of the QA	02/01/2016

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F 0463 SS=E Bldg. 00	<p>pressed the lancet (needle) to the resident's finger, applied a blood sample drop to the glucometer strip, and cleaned the resident's finger with an alcohol swab. During the glucometer test LPN #1 did not don gloves.</p> <p>Interview with LPN #1 on 1/21/16 at 10:36 a.m. indicated she usually wore gloves when performing glucometer testing but forgot. She further indicated she was supposed to wear gloves.</p> <p>A facility policy titled "Accu-Check II-Blood Glucose Monitoring", undated, and received as current from the Director of Nursing, indicated "...NOTE: Nurse shall wear non-sterile gloves while performing procedure and wash hands before and after glove use..."</p> <p>3.1-18(a)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the resident's safety was maintained related to missing call light systems in the bathrooms and non-functioning call lights in the</p>	F 0463	<p>team whenthreshold reaches 100% of Staff. see attachment #8 #9 #14 This is done as of2/01/2016</p> <p>Addendum: F441 See attached audit sheet – Attachment #9 from priorsubmission. Audits are conducted on all three shifts so as to observeall licensed nurses when doing glucometer checks and that they are properlyprotected when doing so. Licensed nursesto be randomly audited weekly x 4 then at the discretionary of the QA team whenthe threshold reaches 100%.</p> <p>A desk top review is requested for this tag. It is the practice of this facility to maintain a nurse callsystem so to allow staff to receive residents' call through it from theresident's rooms,</p>	02/24/2016			

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	<p>resident's rooms on 2 of 2 Hallways. (Main Street Hallway and Elm Court Hallway)</p> <p>Findings include:</p> <p>1. During the Environmental Tour (1/25/16 from 11:10 -11:50 a.m.) the following was observed during room observation on Main Street Hallway:</p> <p>a. In Room 32B on 1/20/16 at 11:67 a.m., the bathroom lacked a call light system in the bathroom. The current resident that resided in the room, did not use the bathroom. The resident received a room mate later that day and the new room mate did use the bathroom.</p> <p>b. In Room 41P on 1/20/16 at 11:05 a.m., the bathroom lacked a call light system in the bathroom. The resident in that resided in this private room, used the bed side commode.</p> <p>2. During the Environmental Tour (1/25/16 from 11:10 -11:50 a.m.) the following was observed during room observation on Elm Court Hallway:</p> <p>a. In Room 110 A&B on 1/19/16 at 3:15 p.m., both call systems in the bed room were not functioning. Two resident resided in this room.</p>		<p>bathrooms and bathing facilities. The missing and or non-functioning call lights have beenfound and/or replaced and are fully functional at this time. Call lights are checked and maintained in a functional stateso as to provide notification service for resident use at any time. The call lights for room 32B has been replaced in thebathroom. The call lights for rooms 41Pand 121A were located and placed in the proper location within those residents'rooms. The call light for room 110A & B have been replaced andis now functioning properly. The call light system is checked on a regularly (weekly) basisfor functioning and resident rooms are checked weekly for light placement. Staff have been reminded to informmaintenance whenever call lights are not functioning properly or not located withinthe proper location in residents' rooms and baths. The environmental and nursing staff will report any missingand/or nonfunctioning device to the maintenance department for repair orreplacement. The Maintenance Supervisor or designee will be responsible tomaintain the system in working order. see attachment #15 #16 This is done as of 2/24/2016.</p>				

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	<p>b. In Room 121A on 1/20/16 at 10:05 a.m., the bathroom lacked a call light system. Two residents resided in this room.</p> <p>Interview on 1/25/16 during the Environmental Tour from 11:10 -11:50 a.m., the Maintenance Supervisor and the Environmental Services Supervisor, indicated rooms 41 and 121 did not have a call light system in the bathroom.</p> <p>Interview on 1/25/16 at 1:00 p.m. with the Maintenance Supervisor, indicated the call light systems were found and put into bathrooms in Rooms 41 and 121.</p> <p>Interview with the Director of Nursing on 1/25/16 at 1:47 p.m., indicated the facility did not a policy on call lights and every bedroom and bathroom should have had a call light system and it should have been functioning.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922
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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>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 maintain a safe, clean, homelike environment in a state of good repair, related to marred and gouged wall and doors, green discolored pipes, dirty and missing bathroom floor tiles, and yellow/ brown substances on the bathroom pull cords on 2 of 2 Hallways. (Main Street Hallway and Elm Court Hallway)</p> <p>Findings include:</p> <p>During the Environmental Tour on 1/25/16 from 11:10-11:50 a.m. with the Maintenance Supervisor and the Environmental Service Supervisor, the following was observed:</p> <p>1. Main Street Hallway:</p> <p>a. In Room 10 P, the wall was gouged behind the resident's recliner. One resident resided in this room.</p> <p>b. In Room 11 P, the bathroom's faucet was rusted, the pipe under the sink</p>	F 0465	<p>A desk top review is requested for this tag. It is the practice of this facility to provide a safe, functional, sanitary environment for the residents' staff and public. The rooms and areas noted have been repaired for rooms #10P, 11P, 14A, 15B, 22A, 24A & B, 26A, 29B, 27B, 28A, 31A & B, 32B and 41P on Main Street's units. Rooms 110A&B, 112A&B, 114B, 117B, and 121A, 123A have also been repaired per the noted areas. The rooms and areas noted will be maintained and repaired as needed along with any other areas of service so as to maintain a clean comfortable environment for our residents. The repairs, painting and replacement of the bathroom fixtures has been addressed for the rooms listed above. The upkeep and maintenance of the physical plant is ongoing and rooms are checked weekly and repairs made accordingly. Environmental staff will notify maintenance of any repairs/painting in need as part of their daily cleaning routine. The environmental supervisor and</p>	02/24/2016

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	<p>leaked, and the tile behind the sink was stained with a brown substance. In the resident's room, the door was gouged and marred, the entryway wall was marred, and the wall between the mirror and dresser was gouged. One resident resided in this room.</p> <p>c. In Room 14 A, the bathroom's faucet was rusted, the wall was stained and peeling by the bathroom light and the door jamb was marred. Two residents resided in this room.</p> <p>d. In Room 15 B, the bathroom's pull light cord was stained yellow, the floor tile was dirty, the faucet, faucet handles and box by the toilet were green. Two residents resided in this room.</p> <p>e. In Room 22 A, the room had a large brown stain on the floor in front of the dresser, marred entryway wall, marred bathroom door jamb, stained and peeling wall by the bathroom light, and the bathroom's faucet was rusted. One resident resided in this room.</p> <p>f. In Room 24 A&B, the bathroom inner door was marred, stained and peeling wall by the bathroom light, a brown stain on the toilet seat riser, dirty floor tile, green pipes behind the toilet and the corner wall was gouged by the bathroom</p>		<p>staff will be responsible to report needed repair to maintenance for repair. Check list and or repair request slips will be used to inform maintenance of such repairs. Daily assignment sheets will be checked weekly for needed repairs. This will be a continuous process. see attachment #15 #16 Completed and implemented as of 2/24/2016.</p> <p>Addendum: F465 Staff are reminded during orientation and regularly to notify maintenance as to needed repairs. Repair slips are available at the nurses' stations and time clock area for staff to utilize. This is also done through housekeeping assignment sheets to make maintenance aware of repair needs.</p>	

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	<p>door and closet. Two residents resided in this room.</p> <p>g. In Room 26 A, the bathroom door was gouged and the toilet pipes and handle were green. One resident resided in this room.</p> <p>h. In Room 29 B, the bathroom pull light cord had a brown substance on it, the pipes behind the toilet were green and the floor tile was dirty. One resident resided in this room.</p> <p>I. In Room 27 B, the bathroom door was gouged, the pipes in the back of the toilet were green, the wall in the bathroom was gouged and had chipped paint, and the wall around the register in the bedroom was gouged. One resident resided in this room.</p> <p>J. In Room 28 A, the bathroom pull light cord had a brown substance on it, the bathroom door jamb and door was marred, and the closet by the bathroom was marred. Two residents resided in this room.</p> <p>K. In Room 31 A&B, the inside of the bathroom door was gouged, the pipes behind the toilet were green, the inside of the bathroom sink and by the faucet handles had a orange discoloration and</p>			

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	<p>paint missing on the wall by the bathroom light. Two residents resided in this room.</p> <p>L. In Room 32 B, the inside bottom of the bathroom door was gouged, and the pipes behind the toilet were green. Two residents resided in this room.</p> <p>M. In Room 41 P, the bathroom shower tile had a yellow/brown stain, the corner wall by the closet was gouged and the carpet by the head of the bed was separated. One resident resided in this room.</p> <p>2. Elm Court Hallway:</p> <p>a. In Room 110 A&B, the bathroom faucet handles were a green/black discoloration, the call light pull cord had a yellow substance by the buttons, and the outer bathroom door was marred. Two residents resided in this room.</p> <p>b. In Room 112 A&B, the bathroom and room door was marred, the bathroom faucet handles were a green/black discoloration. Two residents resided in this room.</p> <p>c. In Room 114 B, the bathroom floor tiles were dirty, and the bathroom call light cord had a yellow substance by the</p>			

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	<p>button. Two residents resided in this room.</p> <p>d. In Room 117 B, the tile under the toilet was missing and the wall beside the bed and the bathroom was gouged and marred. Two resident resided in this room.</p> <p>e. In Room 121 A, the tile was missing under the toilet, and the corner wall by the closet was gouged. Two residents resided in this room.</p> <p>f. In Room 123 A, the bathroom faucet was green, gouged wall behind the resident's recliner, rust on the floor next to the radiator and gouges on the corner wall by the closet. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor and the Environmental Services Supervisor at the end of the Environmental Tour, indicated all things were in need or repair and/or cleaning.</p> <p>3.1-19 (f)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/29/2016

FORM APPROVED

OMB NO. 0938-0391

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