

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00190259.</p> <p>Complaint IN00190259 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314.</p> <p>Survey dates: February 15, 16, 17, 18 and 19, 2016.</p> <p>Facility number: 000064 Provider number : 155139 AIM number : 100288770</p> <p>Census Bed Type: SNF: 17 SNF/NF: 140 Total: 157</p> <p>Census Payor Type: Medicare: 35 Medicaid: 93 Other: 29 Total: 157</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p>March 11, 2016</p> <p>Ms. Kim Rhoades Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204</p> <p>Dear Ms. Rhoades:</p> <p>Please accept this 2567 Plan of Correction for the Recertification and State Licensure Survey ending February 19, 2016, as our Letter of Credible Allegation and we respectfully request a Desk Review in lieu of a post survey revisit on or after March 16, 2016.</p> <p>Thank you for your time in reviewing our plan of correction and please call with any questions.</p> <p>Sincerely,</p> <p>Cathy S. Greene Executive Director North Woods Village</p> <p>Enclosure</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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F 0223 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality Review completed by 14454 on February 29, 2016.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 5 residents reviewed for abuse. (Resident #81)</p> <p>Finding includes:</p> <p>A record review of the facility investigation of the abuse allegation was completed on 02/17/16 at 11:15 a.m.</p> <p>A written statement from CNA (Certified Nursing Assistant) #1 indicated on 1/19/16 at 8:00 p.m. she was in another resident's room and heard Resident #81's</p>	F 0223	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests Desk Review in lieu of a Post Survey Review on or after March 16, 2016.</p> <p>F 223 Free From Abuse/Involuntary Seclusion It is the practice of this provider to ensure the residents have the right to</p>	03/16/2016	

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	<p>bed alarm going off. CNA #2 entered Resident #81's room twice to shut it off. CNA #1 indicated CNA #2 "...yell[ed] at him and told him to stop moving around cause he's sounding his alarm and it was annoying her. And he yelled back and said 'what? I can't hear you' and she [CNA #2] said 'oh bull s---' and she walked out...." The Director of Nursing Services documented a telephone interview with CNA #1, during which CNA #1 also indicated she heard a smacking sound, but believed CNA #2 had hit an object on her way out of Resident #81's room. CNA #2 then went into the other resident's room with CNA #1 and indicated "...he [Resident #81] was driving her nuts...."</p> <p>CNA #2 was removed from direct care on 1/20/2016, after the facility obtained knowledge of the allegation.</p> <p>During an interview on 02/18/2016 at 8:45 a.m., the DNS (Director of Nursing Services) indicated during her investigation, other staff members indicated CNA #2 cursed and had a bad attitude. The DNS also indicated during her interview with CNA #2, she was unable to definitively state that she did not curse or yell at Resident #81. The facility was unable to substantiate any physical abuse, as there were no</p>		<p>be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> ·Resident #81 interviewed was assessed with nonegative outcome. ·Certified Nursing assistant (C.N.A.) #2 was interviewed and suspended on 1-20-16 and terminated on 1-21-16. C.N.A. #1 was given a one on one counseling on reporting immediately and abuse prevention policy reviewed 1-20-16. ·Staff re-educated on Abuse policy 1-19-16 by DNS/SDC/Designee. ·Staff will be re-educated on alleged abuse, investigations and reporting appropriately on 1-20-16, 3-1-16 and by 3-16-16 by the SDC/designee. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> ·Residents in the facility have the potential to be affected by the alleged deficient practice. 		

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	<p>signs/marks on Resident #81, but they did substantiate verbal abuse and terminated CNA #2 from employment.</p> <p>A current policy, titled "Abuse Prohibition, Reporting, and Investigation," dated July 2015, provided by the Administrator on 02/15/16 at 10:00 a.m., indicated "...It is the policy of American Senior Communities to protect residents from abuse including...verbal abuse...."</p> <p>3.1-27(b)</p>		<p>·Other Residents in the facility were interviewed and no concerns were voiced</p> <p>·Staff will be re-educated on alleged abuse, investigations and reporting appropriately on 1-20-16, 3-1-16 and by 3-16-16 by the SDC/designee.</p> <p>·Certified Nursing assistant (C.N.A.) #2 was interviewed and suspended 1-20-16 and terminated on 1-21-16. C.N.A. #1 was given a one on one counseling on reporting immediately and abuse prevention policy reviewed 1-20-16.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>·Staff will be re-educated by 3-16-16 by the SDC/designee on Abuse policy being followed, proper reporting and investigations of alleged abuse.</p> <p>·Certified Nursing assistant (C.N.A.) #2 was interviewed and suspended on 1-20-16 and terminated on 1-21-16. C.N.A. #1 was given a one on one counseling on reporting immediately and abuse prevention policy reviewed on 1-20-16.</p> <p>·Staff report allegations of abuse, to their immediate supervisor. The Executive Director and/or Director of Nursing</p>		

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			<p>Services are notified and initiate the report to the appropriateregulatory agencies.</p> <ul style="list-style-type: none"> ·Residents who have an alleged abuse will havea complete investigation initiated and residents throughout the facility willbe interviewed to determine if abuse has occurred and if residents feel safe. ·This investigation will include interviews ofstaff, other residents, and family members if necessary. ·Physician and family will be notified ofallegations of abuse as needed. ·Employees that are implicated in an allegation of abuse are removedfrom the schedule, to ensure resident safety, until the investigation iscompleted. ·The interdisciplinary team will review the“24 Hour Report” and “Change of Condition” forms for physician and familynotification Monday – Friday (excluding holidays) at clinical meeting. ·Employees will have a criminal history checkupon hire. ·Employees will receive abuse preventiontraining upon hire and at least annually thereafter. ·The nursing manager on call is notified ofacute resident changes on the weekend. DNS/ED is notified as needed. ·The Executive Director/Designee is responsible for compliance with theAbuse Policy and Procedure and the reporting of allegations of abuse. 	

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F 0225 SS=E Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. The facility must ensure that all alleged		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ·The CQI tool "Staff Treatment of Residents" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months, and quarterly until compliance is achieved for two consecutive quarters. ·The DNS or designee is responsible to monitor for compliance. ·The CQI team reviews the audits monthly and action plans are developed if threshold of 100% is not achieved to ensure continual compliance. Compliance date: 3-16-16		

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	<p>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 review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 5 residents reviewed for abuse. (Resident #81) The facility also failed to thoroughly investigate allegations of misappropriation of property for 3 of 5 residents reviewed for misappropriation of property. (Residents #57, #135 and #17)</p> <p>Findings include:</p> <p>1. On 1/20/16 at approximately 7:30 p.m., the Director of Nursing Services</p>	F 0225	<p>F 225 Investigate/Report allegation/individuals</p> <p>It is the practice of this provider to ensure alleged violations involving mistreatment, neglect, or abuse is reported immediately to administration of the facility and appropriate investigation and corrective action taken.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>·Resident #81 interviewed was assessed with nonnegative outcome.</p>	03/16/2016	

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	<p>was made aware of an abuse allegation regarding Resident #81. CNA (Certified Nursing Assistant) #1 indicated she heard CNA #2 yelling at Resident #81 on 1/19/2016 at approximately 8:00 p.m. CNA #1 also indicated she heard a smacking sound, but believed CNA #2 had hit an object on her way out of Resident #81's room.</p> <p>A record review of the facility investigation of the abuse allegation, completed on 02/17/16 at 11:15 a.m., indicated the facility had interviewed and obtained written statements from CNA #1 and CNA #2 regarding the allegation. A piece of notebook paper located in the investigation file listed 7 staff members and 6 residents whom had been interviewed during the investigation. No dates, times, or interview details were available regarding the resident and staff interviews. No other investigation information was available.</p> <p>2. On 02/09/2016, Resident #57 reported missing money (\$25) to the facility. The report indicated Resident #57 last saw his money on 02/05/2016. The police department was notified and the facility searched for Resident #57's money, but it could not be located.</p> <p>A record review of the facility</p>		<ul style="list-style-type: none"> ·CertifiedNursing assistant (C.N.A.) #2 was interviewed and suspended on 1-20-16 andterminated on 1-21-16. C.N.A. #1 wasgiven a one on one counseling on reporting immediately and abuse preventionpolicy reviewed 1-20-16 by DNS/designee. ·Resident#17, #57 and #135 rooms and laundry were searched for their money and rings onalleged dates but no items were found. ·Staffwas interviewed and no one had knowledge of the missing item on alleged dates. ·Reportedto appropriate regulatory agencies and local police department on allegeddates. ·No otherresidents had reported missing items on or around alleged dates. ·AResident and Staff Investigation Interview form was created to include name,date, time, interview statement and signature, to document investigationinterviews. ·Staff re-educatedon Abuse policy 1-19-16 by DNS/SDC/Designee. ·Staffwill be re-educated on alleged abuse, investigations and reportingappropriately on 1-20-16, 3-1-16 and by 3-16-16 by the SDC/designee. <p>How will you identify otherresidents having the potential to be affected by the same deficient</p>				

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	<p>investigation of the misappropriation allegation was completed on 02/17/16 at 11:30 a.m. The investigation file contained only a copy of the report made to the Indiana State Department of Health. No information regarding resident or staff interviews was available.</p> <p>3. On 1/11/16, Resident #135 reported missing money to the facility. In the report, Resident #135 indicated she woke up and noted 30 dollars missing from her wallet. The money was last seen the previous night before she went to sleep. The police were notified and the facility searched for Resident #135's money, however it could not be located.</p> <p>A record review of the facility investigation of the misappropriation allegation was completed on 02/17/16 at 12:45 p.m. The investigation file contained only a copy of the report made to the Indiana State Department of Health. No information regarding resident or staff interviews was available.</p> <p>4. On 1/14/16, Resident #17's daughter reported two missing rings to the facility. The police department was notified and the facility searched for the missing jewelry, but they were unable to locate the rings.</p>		<p>practiceand what corrective action will be taken</p> <ul style="list-style-type: none"> ·Residentsin the facility have the potential to be affected by the alleged deficientpractice. ·OtherResidents in the facility did not report missing items and no concerns werevoiced, on or around alleged dates. ·Staffwas interviewed and no one had knowledge of the missing item on alleged dates ·Staffwill be re-educated on alleged abuse, investigations and reportingappropriately on 1-19-16, 3-1-16 and by 3-16-16 by the SDC/designee. ·CertifiedNursing assistant (C.N.A.) #2 was interviewed and suspended 1-20-16 andterminated on 1-21-16. C.N.A. #1 wasgiven a one on one counseling on reporting immediately and abuse preventionpolicy reviewed 1-20-16 by DNS/designee. <p>What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur</p> <ul style="list-style-type: none"> ·AResident and Staff Investigation Interview form was created to include name,date, time, interview statement and signature, to document investigationinterviews. ·Staff re-educatedon Abuse policy 1-19-16 by DNS/SDC/Designee. ·Staffwill be re-educated on 				

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	<p>A record review of the facility investigation of the misappropriation allegation was completed on 02/17/16 at 1:00 p.m. The investigation file contained a copy of the report made to the Indiana State Department of Health. The file also contained notes regarding brief interviews conducted with employees. The job titles and last names of the employees, as well as the date and time of the interviews were not available. No information regarding resident interviews was available.</p> <p>During an interview on 02/18/2015 at 8:45 a.m., the Director of Nursing Services indicated there was no further information to provide for the investigative files. She indicated she usually asked everyone the same questions and typically only documented their responses if they were substantial.</p> <p>A current policy, titled "Abuse Prohibition, Reporting, and Investigation," dated July 2015, provided by the Administrator on 02/15/16 at 10:00 a.m., indicated "...10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...11. The investigation will include: facts and observations by involved</p>		<p>alleged abuse, investigations and reporting appropriately on 1-20-16, 3-1-16 and by 3-16-16 by the SDC/designee.</p> <ul style="list-style-type: none"> ·Staff to report allegations of abuse, to their immediate supervisor. The Executive Director and/or Director of Nursing Services are notified and initiate the report to the appropriate regulatory agencies. ·Residents who have an alleged abuse will have a complete investigation initiated and residents throughout the facility will be interviewed to determine if abuse has occurred and if residents feel safe. ·This investigation will include interviews of staff, other residents, and family members if necessary. ·Physician and family will be notified of allegations of abuse or misappropriation of personal items as needed. ·Employees that are implicated in an allegation of abuse are removed from the schedule, to ensure resident safety, until the investigation is completed. ·The interdisciplinary team will review the "24 Hour Report" and "Change of Condition" forms for physician and family notification Monday – Friday (excluding holidays) at clinical meeting. ·Employees will have a criminal history check upon hire. ·Employees will receive abuse prevention training upon hire, after each report of alleged abuse or 		

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F 0226 SS=D Bldg. 00	<p>employees...witnessing employees...witnessing non-employees...others who might have pertinent information...by the supervisor or individual whom the initial report was made...."</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow their policy</p>	F 0226	<p>misappropriation of personal items and at least annually thereafter.</p> <p>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</p> <ul style="list-style-type: none"> ·The CQI tool "Staff Treatment of Residents" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months, and quarterly until compliance is achieved for two consecutive quarters. ·The DNS or designee is responsible to monitor for compliance. ·The CQI team reviews the audits monthly and action plans are developed if a threshold of 100% is not achieved to ensure continual compliance. <p>Compliance date: 3-16-16</p> <p>F226 Develop/Implement Abuse/Neglect, ETC Policies It is the practice of this provider to</p>	03/16/2016	

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	<p>regarding reporting and investigation of abuse for 4 of 5 residents reviewed for abuse and misappropriation of property. (Residents #81, #57, #135 and #17)</p> <p>Findings include:</p> <p>1. On 1/20/16 at approximately 7:30 p.m., the Director of Nursing Services (DNS) was made aware of an abuse allegation regarding Resident #81. CNA (Certified Nursing Assistant) #1 indicated she heard CNA #2 yelling at Resident #81 on 1/19/2016 at approximately 8:00 p.m. CNA #1 also indicated she heard a smacking sound, but believed CNA #2 had hit an object on her way out of Resident #81's room.</p> <p>During an interview on 02/18/2016 at 1:08 p.m., the Director of Nursing Services indicated she received a call from LPN (Licensed Practical Nurse) #3 regarding an incident that had occurred on 01/19/16 at 8:00 p.m. The DNS spoke with CNA #1 regarding the incident. CNA #1 indicated she attempted to tell LPN #4 and the Memory Care Unit Manager at the time of the incident, but she felt they were busy. The Memory Care Unit Manager indicated CNA #1 approached her on 01/20/16, but simply indicated she did not believe CNA #2 liked Resident #81 and didn't know if she</p>		<p>follow all written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> · Resident #81 interviewed was assessed with nonegative outcome. · Certified Nursing assistant (C.N.A.) #2 was interviewed and suspended on 1-20-16 and terminated on 1-21-16. C.N.A. #1 was given a one on one counseling on reporting immediately and abuse prevention policy reviewed 1-20-16 by DNS/designee. · Resident #17, #57 and #135 rooms and laundry were searched for their money and rings on alleged dates but no items were found. · Staff was interviewed and no one had knowledge of the missing item on alleged dates. · Reported to appropriate regulatory agencies and local police department on alleged dates. · No other residents had reported missing items on or around alleged dates. · A Resident and Staff Investigation Interview form was created to include name, date, time, interview statement and 		

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	<p>was a good fit for the unit. CNA #1 spoke with LPN #3 the evening of 01/20/16, and the details were shared at that time. The DNS indicated CNA #1 did not follow the policy regarding reporting abuse because she did not report it accurately and immediately.</p> <p>A record review of the facility investigation of the abuse allegation, completed on 02/17/16 at 11:15 a.m., indicated the facility had interviewed and obtained written statements from CNA #1 and CNA #2 regarding the allegation. A piece of notebook paper located in the investigation file listed 7 staff members and 6 residents whom had been interviewed during the investigation. No dates, times, or interview details were available regarding the resident and staff interviews. No other investigation information was available.</p> <p>2. On 02/09/2016, Resident #57 reported missing money (\$25) to the facility. The report indicated Resident #57 last saw his money on 02/05/2016. The police department was notified and the facility searched for Resident #57's money, but it could not be located.</p> <p>A record review of the facility investigation of the misappropriation allegation was completed on 02/17/16 at</p>		<p>signature, to document investigation interviews.</p> <ul style="list-style-type: none"> ·Staff re-educated on Abuse policy 1-19-16 by DNS/SDC/Designee. ·Staff will be re-educated on alleged abuse, investigations and reporting appropriately on 1-20-16, 3-1-16 and by 3-16-16 by the SDC/designee. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> ·Residents in the facility have the potential to be affected by the alleged deficient practice. ·Other Residents in the facility did not report missing items and no concerns were voiced, on or around alleged dates. ·Staff was interviewed and no one had knowledge of the missing item on alleged dates ·Staff will be re-educated on alleged abuse, investigations and reporting appropriately on 1-19-16, 3-1-16 and by 3-16-16 by the SDC/designee. ·Certified Nursing assistant (C.N.A.) #2 was interviewed and suspended 1-20-16 and terminated on 1-21-16. C.N.A. #1 was given a one on one counseling on reporting immediately and abuse prevention policy reviewed 1-20-16 by DNS/designee. 		

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	<p>11:30 a.m. The investigation file contained only a copy of the report made to the Indiana State Department of Health. No information regarding resident or staff interviews was available.</p> <p>3. On 1/11/16, Resident #135 reported missing money to the facility. In the report, Resident #135 indicated she woke up and noted 30 dollars missing from her wallet. The money was last seen the previous night before she went to sleep. The police were notified and the facility searched for Resident #135's money, however it could not be located.</p> <p>A record review of the facility investigation of the misappropriation allegation was completed on 02/17/16 at 12:45 p.m. The investigation file contained only a copy of the report made to the Indiana State Department of Health. No information regarding resident or staff interviews was available.</p> <p>4. On 1/14/16, Resident #17's daughter reported two missing rings to the facility. The police department was notified and the facility searched for the missing jewelry, but they were unable to locate the rings.</p> <p>A record review of the facility investigation of the misappropriation</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · A Resident and Staff Investigation Interview form was created to include name, date, time, interview statement and signature, to document investigation interviews. · Staff re-educated on Abuse policy 1-19-16 by DNS/SDC/Designee. · Staff will be re-educated on alleged abuse, investigations and reporting appropriately on 1-20-16, 3-1-16 and by 3-16-16 by the SDC/designee. · Staff to report allegations of abuse, to their immediate supervisor. The Executive Director and/or Director of Nursing Services is notified and initiate the report to the appropriate regulatory agencies. · Residents who have an alleged abuse will have a complete investigation initiated and residents throughout the facility will be interviewed to determine if abuse has occurred and if residents feel safe. · This investigation will include interviews of staff, other residents, and family members if necessary. · Physician and family will be notified of allegations of abuse or misappropriation of personal items as needed. 		

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	<p>allegation was completed on 02/17/16 at 1:00 p.m. The investigation file contained a copy of the report made to the Indiana State Department of Health. The file also contained notes regarding brief interviews conducted with employees. The job titles and last names of the employees, as well as the date and time of the interviews were not available. No information regarding resident interviews was available.</p> <p>During an interview on 02/18/2015 at 8:45 a.m., the Director of Nursing Services indicated there was no further information to provide for the investigative files. She indicated she usually asked everyone the same questions and typically only documented their responses if they were substantial.</p> <p>A current policy, titled "Abuse Prohibition, Reporting, and Investigation," dated July 2015, provided by the Administrator on 02/15/16 at 10:00 a.m., indicated "Policy/Procedure:...5. All abuse allegations/abuse must be reported to the Executive Director immediately...Resident Abuse - staff member, volunteer, or visitor:...10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and</p>		<ul style="list-style-type: none"> ·Employees that are implicated in an allegation of abuse are removed from the schedule, to ensure resident safety, until the investigation is completed. ·The interdisciplinary team will review the "24 Hour Report" and "Change of Condition" forms for physician and family notification Monday – Friday (excluding holidays) at clinical meeting. ·Employees will have a criminal history check upon hire. ·Employees will receive abuse prevention training upon hire, after each report of alleged abuse or misappropriation of personal items and at least annually thereafter. <p>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</p> <ul style="list-style-type: none"> ·The CQI tool "Staff Treatment of Residents" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months, and quarterly until compliance is achieved for two consecutive quarters. ·The DNS or designee is responsible to monitor for compliance. ·The CQI team reviews the audits monthly and action plans are developed if a threshold of 100% is not achieved to ensure continual compliance. 				

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F 0241 SS=D Bldg. 00	<p>the results documented...11. The investigation will include: facts and observations by involved employees...witnessing employees...witnessing non-employees...others who might have pertinent information...by the supervisor or individual whom the initial report was made...."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation and record review, the facility failed to maintain personal dignity related to urinary and fecal incontinence for one of one resident reviewed for dignity. (Resident #100)</p> <p>Finding includes:</p> <p>On 02/16/2016 at 10:00 a.m., resident # 100 smelled as though she had a bowel movement while in her wheelchair. The staff took the sleeping resident to activities without changing her.</p>	F 0241	<p>Compliance date: 3-16-16</p> <p>F241 Dignity and Respect of Individuality</p> <p>It is the practice of this provider to ensure residents are provided care 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>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p>	03/16/2016
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	<p>On 02/17/2016 at 1:17 p.m., the resident was sitting in her wheelchair in the Memory Care dining room with several other residents. A very strong odor of urine and bowel was evident. The residents slacks were saturated with fluid from her lower legs to her thighs. A dinner plate size area of yellow, strong smelling fluid was puddled beneath the residents wheelchair on the floor. The resident was the final person removed from the dining room after lunch.</p> <p>02/17/2016 1:33 p.m., during an observation of peri care, CNA (Certified Nursing Assistant) #5 did not pull the curtain to provide privacy for the resident. The resident's roommate was present in the next bed. More than 15 minutes passed before CNA #5 covered the resident's torso with a towel and then she pulled the privacy curtain.</p> <p>A current policy titled "PERINEAL CARE," dated 02/2010, provided by the Director of Nursing Services on 2/17/16 at 3:16 p.m., indicated: "...Procedure Steps:...2. Provide for privacy...6. Drape resident as needed...."</p> <p>3.1-3(t)</p>		<ul style="list-style-type: none"> • Certified Nursing Assistant (C.N.A.) #5 was re-educated on removing residents from activities/meals if soiled and taking resident to room to be changed and cleaned. C.N.A. was also educated on properly covering resident during care and pulling privacy curtain on 1-17-16 by DNS/Designee. • Staff will be re-educated on removing residents from public area who are soiled and providing privacy/dignity during personal care appropriately on 3-1-16 and by 3-16-16 by the SDC/designee <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> • Residents that require staff assistance with personal care have the potential to be affected by the alleged deficient practice. • Staff will be re-educated on removing residents from public area who are soiled and providing privacy/dignity during personal care appropriately on 3-1-16 and by 3-16-16 by the SDC/designee <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> • Staff will be re-educated on removing residents from public area who are soiled and providing 		

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F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.		<p>privacy/dignity during personal care appropriately on 3-1-16 and by 3-16-16 by the SDC/designee</p> <ul style="list-style-type: none"> The unit managers and charge nurses will be responsible for overseeing the individual residents needing personal care will be removed from public area and given appropriate personal care with proper privacy and dignity daily. <p>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</p> <ul style="list-style-type: none"> The CQI tool "Dignity and Privacy" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter until compliance is achieved for two consecutive quarters The Director of Nursing Services and/or Designee is responsible to monitor for compliance The CQI team reviews the audits monthly and action plans are developed as needed if threshold of 100% is not met to ensure continual compliance <p>Compliant date: 3-16-16</p>	

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	<p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to correctly identify and accurately assess the hospice status for 2 of 3 residents reviewed for hospice. (Residents #33 and #44).</p> <p>Findings include:</p> <p>1. The record for Resident #33 was reviewed on 2/17/16 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, ischemic heart disease,</p>	F 0278	<p>F278 Resident Assessment It is the practice of this facility to ensure that annual and quarterly assessments accurately reflect current status for residents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> Resident #33 MDS has been reviewed and modified as needed immediately on 2-17-16 by MDS coordinator. 	03/16/2016

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	<p>anemia, and depressive disorder.</p> <p>A Physician's order, dated 10/9/15, indicated a request for hospice evaluation and treatment. Admission to hospice was noted on 10/12/15 with a statement indicating the resident had a prognosis of 6 months or less.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 10/21/15, indicated Resident #33 was on hospice and did not have a prognosis of six months or less.</p> <p>An Annual MDS assessment, dated 1/19/16, indicated Resident #33 was on hospice and did not have a prognosis of six months or less.</p> <p>2. The record of Resident #44 was reviewed on 2/18/16 at 1:24 p.m. Diagnoses included, but were not limited to, senile dementia with malnutrition.</p> <p>A physician's order, dated 7/3/15, indicated admission to hospice with a diagnosis of senile dementia with malnutrition.</p> <p>A Significant Change MDS assessment, dated 9/15/15, indicated Resident #44 was on hospice and did not have a prognosis of six months or less.</p>		<ul style="list-style-type: none"> Resident #44 MDS has been reviewed and modified as needed immediately on 2-17-16 by MDS Coordinator. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who are on Hospice services have the potential to be affected by the alleged deficient practice. MDS coordinator and MDS assistant were educated on coding MDS appropriately for correctly and accurately coding Hospice status on 2-17-16 and 3-1-16 and by 3-16-16 by DNS/SDC/Designee. All other Hospice residents were reviewed for proper Hospice status coding on MDS and modified as needed on 2-17-16. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> Hospice Residents will receive an accurate assessment for Hospice status and will be coded appropriately by MDS coordinator/MDS assistant upon admission to Hospice and with significant change. The IDT reviews the MDS assessment at least quarterly for 				

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F 0314 SS=G Bldg. 00	<p>A Significant Change MDS assessment, dated 11/24/15, indicated Resident #44 was on hospice and did not have a prognosis of six months or less.</p> <p>During an interview on 2/19/16 at 1:36 p.m., the MDS coordinator indicated hospice was noted on the MDS, but Resident #33 and Resident#44 did not have a prognosis of less than six months indicated on the MDS.</p> <p>3.1-31(d)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without</p>		<p>accuracy.</p> <ul style="list-style-type: none"> The IDT reviews the physicianorders at the clinical meeting Monday – Friday (excluding holidays) to ensureproper coding is documented on MDS. The MDS coordinator is responsible to monitor compliance. <p>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</p> <ul style="list-style-type: none"> A “RAI Process” CQI tool will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for threemonths and quarterly thereafteruntil compliance is achievedfor two consecutive quarters The MDS coordinator is responsible to monitor compliance with MDS coding upon admission, quarterly and withsignificant change. The governing CQI committee willreview the data. If the threshold for compliance of 100% is not met, an actionplan will be developed. <p>Compliance date: 3-16-16</p>		

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	<p>pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to place wound interventions in a timely manner to prevent a resident from getting a new Deep Tissue Injury (DTI) for 1 of 2 residents reviewed for pressure ulcers. (Resident #E) The facility also failed to use proper infection control technique while changing a resident's wound dressing for 1 of 1 residents observed for wound dressing change. (Resident #49)</p> <p>Finding includes:</p> <p>1. The record review for Resident #49 was completed on 2/17/16 at 1:05 p.m. Diagnoses included, but were not limited to, Parkinson's, dementia, ileus, history of stroke, atrial fibrillation and anemia.</p> <p>The progress notes indicated:</p> <p>*9/08/15 at 5:22 p.m.: The resident returned to the facility via ambulance from the hospital with two Emergency Medical Technician's and his wife at 4:47 p.m. Orientation and initial examination</p>	F 0314	<p>F314 Pressure Sores</p> <p>It is the practice of this provider that based on the comprehensive assessment of a resident, the facility ensures that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #49 no longer resides in the facility. Resident #E no longer resides in the facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Residents that are receiving 	03/16/2016

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	<p>completed. The resident was alert and oriented X 3 with some forgetfulness. The resident had a Foley catheter in place for retention. He was on a low sodium diet and took his medications crushed in applesauce due to them not being absorbed properly.</p> <p>*9/10/15 at 4:53 p.m.: The resident was admitted to the facility with a reddened buttocks and noted to be deep tissue injury (DTI, Purple or maroon localized area of discoloration intct skin or blood filled blister due to damage of underlying soft tissue from pressure and shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as complared to adjacent tissues.) today to his buttock and his coccyx. There was small amount of bleeding from the center which was open. He had a DTI to his coccyx. The resident had history of Parkinson's and recent hip fracture with surgical repair and surgical incision in the last stage of healing. He was on a facility pressure reducing mattress and would be changed to alternating air. He was sluggish to respond. The resident was on 2 gm Na+ (2 gram sodium) with vitamin daily. He was currently being treated for ileus. Resident had Foley catheter for wound healing. New treatment orders were noted.</p>		<p>wound treatments/dressing changes have thepotential to be affected by the alleged deficient practice</p> <ul style="list-style-type: none"> The wound nurse has been re-educatedon clean dressing changes and signs of pain during treatment on 2-18-16 and3-1-16 and by 3-16-16 by SDC/Designee. Certified Nursing Assistant(C.N.A.) #7 was educated on properly placing affected areas on a clean fieldand wound care procedures immediately on 2-18-16 and 3-1-16 and by 3-16-16 bySDC/Designee. NursingStaffwill be re-educated on proper wound care and signs of pain during wound care on3-1-16 and by 3-16-16 by the SDC/designee Director of Nursing (DNS)/Designee willmonitor wound care weekly on wound rounds and monthly on wound sweep ofresidents. <p>What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur?</p> <ul style="list-style-type: none"> Nursing Staff will be re-educated onproper wound care and signs of pain during wound care on 3-1-16 and by 3-16-16by the SDC/designee Director of Nursing (DNS)/Designee will monitor wound care weekly on wound rounds and monthly on wound sweep ofresidents. 		

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	<p>The resident events documentation indicated: New Skin Event *9/8/15- indicated the wound area was present on admission. Bilateral buttocks wound measurements indicated "reddened"and indicated treatment was "Veraseptine"(a skin protection ointment). Nurse Practitioner was notified and treatment was ordered. This was documented as completed by the Admissions Nurse.</p> <p>The Wound Nurse documented the rest of the pressure skin events: *9/10/16 at 5:08 p.m., indicated, "...found on 9/10/16 suspected deep tissue injury to left buttock measuring 6.0 centimeters [cm] x 3.5 cm x 0.1 cm, was unstagable, purple in color and there was a scant amount of bleeding observed. The treatment order was current orders..." *9/10/15 at 5:09 p.m., indicated, "... found on 9/10/15, suspected deep tissue injury to the coccyx area. The area was unstagable and measured 2.0 cm x 2.5 cm x 0.1 cm..." *9/15/15 indicated, "... found on 9/10/16, a suspected deep tissue injury to coccyx area and was an unstagable area. The area measured 2.0 cm x 2.3 cm x 0.1 cm..." *9/16/15 indicated, "... right buttock, found on 9/16/15 as deep tissue injury</p>		<p>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?</p> <ul style="list-style-type: none"> The CQI tool "Pressure Wounds-Treatment" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter until compliance is achieved for two consecutive quarters The CQI team will review the data. If the threshold for compliance of 100% is not met then an action plan will be developed. <p>Compliance date: 3-16-16</p>	
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	<p>and the area measured 6.5 cm x 1.5 cm x 0.1 cm..."</p> <p>*9/22/15 indicated, "... the coccyx wound measured 0.7cm x 0.3 cm x 0.1 cm and was red with pink surrounding edges...</p> <p>*9/22/15 the left buttock was a DTI and measured 4.5 cm x 3.0 cm x 0.1 cm and the wound was described as yellow in color with a scant amount of serosanguinous serous fluid with blood drainage..."</p> <p>*9/29/15 indicated,"... coccyx area that was a suspected DTI was now closed x 1. The left buttock was a suspected DTI and measured 3.0 cm x 1.7 cm x 0.1 cm and was yellow in color and a small amount of serosanguinous drainage. The origin of the wound was 9/16/15. The right buttock wound that was a suspected DTI, was now closed x 1..."</p> <p>*10/6/15 indicated, "... The left buttock area was a Stage III with yellow slough and measured 2.2 cm x 1.0 cm x 0.1cm, was yellow in color and had scant amount of serosanguinous drainage and surrounding tissue was pink in color...."</p> <p>The Care Plan for skin dated, 9/11/15, indicated: Turn and Reposition every 2 hours, Treatment as ordered, Pressure reducing cushion or Low Air Loss mattress, Pressure reduction cushion in wheelchair, Incontinent care as needed, Moisture</p>			

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	<p>Barrier at bedside as needed, Encourage resident eat at least 75% (percent) of meal, Assess and document skin condition weekly and as needed. Notify MD of abnormal findings</p> <p>The Care Plan for skin indicated, on 9/28/15, a roho cushion was added to the interventions.</p> <p>During an interview on 2/18/16 at 10:04 a.m., the Wound Nurse indicated the resident assessment upon admission was incorrect and that LPN #7 had assessed incompletely and incorrectly. She indicated that it was more deep tissue injury. She indicated the Veraseptine, standard pressure reducing cushion for wheelchair and bed were in place. She indicated the Low Air Loss Mattress (LAL) had been in place on 9/10/15. She indicated the turning and repositioning was done for everyone and was documented in the progress notes. The wound nurse indicated the resident was a heavy gentlemen and that he was "dead weight" and did not move a lot when he first got here. She confirmed that the resident had new DTI wound on left buttock on 9/16/15.</p> <p>The progress notes were reviewed from 9/10/16 through 9/16/16 and the documentation indicated the resident was</p>			

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	<p>turned every two hours on the following dates: 9/10/15 at 1:16 p.m. 9/16/16 at 3:16 p.m.</p> <p>2. The record review for Resident #E was completed on 2/18/16 at 3:30 p.m., Diagnoses included, but were not limited to, Peripheral Vascular Disease, dementia and diabetes.</p> <p>On 2/18/16 at 2:45 p.m., the Wound Nurse and CNA (Certified Nursing Assistant) #7 were present for a wound dressing change. The Wound Nurse indicated at that time that the resident had received the Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed.. Slough may be present but does not obscure the depth of tissue loss.) from her TED hose (thromboembolism - deterrent hose) and her Circaid compression hose (lymphedema hose) as the resident had severe edema concerns over the last year. She also indicated the resident had a long history of lower extremity circulation concerns and had even had surgery to improve circulation in her lower legs.</p> <p>CNA #7 took off the resident's right Circaid compression hose and took off the resident's TED hose. CNA #7 then</p>				

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	<p>removed resident's dirty dressing. The resident's stasis wound appeared as a small oval shape, resembling a small peach pit. The inner wound bed had a pink beefy appearance with scant serous drainage on the dirty dressing. At that time the Wound Nurse went to wash her hands. CNA #7 had set the residents leg with open wound near the pillowcase surface/circaid hose that had been on the resident's leg.</p> <p>On 2/18/16 at 2:50 p.m., the Wound Nurse indicated CNA#7 should not have set the resident's leg down without the protective chuck pad underneath. The wound nurse indicated she had forgotten to put down the cotton chuck pad. At that time, CNA #7 raised the resident's leg and the wound nurse placed the cotton chuck pad underneath of the resident's right lower leg. CNA #7 placed the Circaid back onto the resident's lower right leg. The Wound Nurse at that time told CNA #7 she had to reposition the Circaid as it was not on correctly. CNA #7 at that time indicated she could not find the middle velcro strap when she put it on. The Wound Nurse and CNA #7 repositioned the Circaid device and restrapped the velcro enclosures for the resident's lower right extremity.</p>			

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	<p>On 2/18/16 at 2:57 p.m., during the dressing change of the right lower leg wound the resident was attempting to pull up her right leg as well as moaning on occasion. The resident was observed to have furrowed brows. The Wound Nurse indicated the resident had just recently, within the last few days, started displaying a furrowed brow and having pain with the wound dressing changes.</p> <p>At that time, the Wound Nurse was asked what she would do if a resident was displaying pain during a dressing change. She indicated she would stop and let them rest a bit, and then resume the dressing change.</p> <p>On 2/18/16 at 3:00 p.m., the Wound Nurse had started to remove the old dressing for the lower left leg pressure wound. The wound was the size of a quarter and was light pink in color. The Wound Nurse began rinsing the dressings that were stuck to the wound with Normal Saline, and pulled them away from the wound and the resident started moaning and her brows became more furrowed. The Wound Nurse and CNA#7 both asked the resident if she was hurting and she mumbled. CNA #7 indicated maybe she just needed to be talked to during the dressing change and that might help. The old dressing was</p>				

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	<p>completely removed, but at that time the resident was moaning more often. The Wound Nurse indicated at that time she was going to stop and get ahold of the physician and see about pain medication as the pain medication the resident had received earlier wasn't working.</p> <p>During an interview on 2/18/16 at 3:50 p.m., the Assistant Director of Nursing indicated she would have expected the nurse to have stopped right away if the resident was displaying signs of pain.</p> <p>The Skin Management Policy, dated 2/2015, was provided by the Director of Nursing Services, on 2/18/16 at 5:02 p.m., and indicated this was the policy currently used by the facility. The policy indicated "...PROCEDURE: head to toe assessment will be completed by a licensed nurse upon admission/re-admission and weekly...The wound nurse [licensed nurse assigned responsibility for wounds the building or assigned unit] will be notified of alterations in skin integrity...will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day...."</p> <p>This Federal tag relates to Complaint IN00190129.</p>			

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F 0315 SS=D Bldg. 00	<p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to provide incontinence care in a manner to maintain continence and to prevent infection one of one resident reviewed for peri care. (Resident #100)</p> <p>Findings include: On 02/16/2016 at 10:00 a.m. resident #100 was noted to smell as though she had a bowel movement while in her wheelchair. The staff took the sleeping resident to activities without changing</p>	F 0315	<p>F315 No Catheter, PreventUTI, Restore Bladder This provider ensures thatbased on the resident's comprehensive assessment, a resident who enters thefacility without an indwelling catheter is not catheterized unless theresident's clinical condition demonstrates that catheterization was necessary;and a resident who is incontinent of bladder receives appropriate treatment andservices to prevent urinary tract infections and to restore as much normalbladder function as possible.</p> <p>What corrective action(s) will be accomplished for those residents</p>	03/16/2016

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	<p>her.</p> <p>On 02/17/2016 at 1:17 p.m., the resident was sitting in her wheelchair in the Memory Care dining room with several other residents. A very strong odor of urine and bowel was evident. The residents slacks were saturated with fluid from her lower legs to her thighs. A dinner plate size area of yellow, strong smelling fluid was puddled beneath the residents wheelchair on the floor. The resident was the final person removed from the dining room after lunch.</p> <p>On 02/17/2016 at 1:33 p.m., during an observation of peri care provided by CNA (Certified Nursing Assistant) #5, a very strong odor of bowel was noted in the room. The resident was in bed in supine position she had light brown stool above her brief on both flanks and back to mid calves and ankles. Observed wet, tan slacks in plastic bag. CNA removed the residents brief to expose resident's peri/rectal area. The brief was saturated with yellow fluid and large amounts of soft, light brown stool. The stool pooled on peri area, thighs and buttocks. The CNA wiped the resident's peri area in an upward manner using damp washcloths to remove stool. She indicated at that time that she always wiped upward and</p>		<p>found to have been affected by thedeficient practice</p> <ul style="list-style-type: none"> Resident # 100 was reassessedand have no signs or symptoms of UTI on 2-16-16. C.N.A. #5, #6 and unit managerhave been re-educated on proper peri- care procedure on 2-16-16 by DNS/Designee. <p>How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken</p> <ul style="list-style-type: none"> Residents with incontinence havethe potential to be affected by the alleged deficient practice. Licensed nurses and C.N.A. werere-educated on assessment of UTI and proper peri-care on 3-1-16 and by 3-16-16by the SDC/DNS/designee. Noncompliance with facility policyand procedure may result in employee re-education, and/or disciplinary actionup to and including termination. <p>What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur</p> <ul style="list-style-type: none"> Licensed nurses and C.N.A. werere-educated on assessment of UTI and proper peri-care on 3-1-16 and by 		

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	<p>demonstrated hand motions when she spoke. She continued to use damp washcloths as she cleansed the stool from the peri area and between inner labia. At 1:47 p.m., the Memory Care Unit Manager and CNA #6 entered the room to assistance to CNA #5. The Unit Manager and CNA #6 provided additional damp washcloths, bed underpads to CNA. At no time was a basin of warm water or soap observed to be utilized to cleanse the resident. The resident had a dry, clean brief applied by CNA #5 and was covered with blanket by CNA #6. The residents wheelchair had large amounts of foul smelling beige fluid puddled on the wheel chair seat and on the ROHO cushion (pressure reducing cushion).</p> <p>During an interview on 02/18/2016 at 1:02 p.m., the Director of Nursing Services (DNS) indicated she was aware of the poor peri care provided for resident by CNA #5 on 2/17/16, as reported to her by the Memory care Unit Manager. She indicated peri care should be provided according to policy and should be performed using a front to back method. The DNS indicated at no time should peri care be performed using a back to front method.</p> <p>A current policy titled "PERINEAL</p>		<p>3-16-16by the SDC/DNS/designee.</p> <ul style="list-style-type: none"> Resident change of status relatedto signs and symptoms of UTI will be placed on the 24 Hour Report Sheet by thecharge nurse and the physician will be notified, as needed. The Unit Managers and theInterdisciplinary Team will review the 24 Hour Report Sheet and new PhysicianOrders at the Change of Condition Meeting Monday – Friday (excluding holidays). <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place</p> <ul style="list-style-type: none"> A “ Incontinence” CQI tool will be utilized weekly x 4, monthly x 2 andquarterly thereafter, until compliance is achieved for two consecutive quarters to monitor compliance withproper personal care. The governing CQI committee will review thedata. If the threshold for compliance of 100% is not met, an action plan willbe developed. Noncompliance with facility policyand procedure may result in employee re-education, and /or disciplinary actionup to and including termination. <p>Compliance date: 3-16-16</p>				

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	CARE," dated 02/2010, provied by the Director of Nursing Services on,2 17/16 at 3:16 p.m., indicated: "...Procedure Steps:...2. Provide for privacy...6. Drape resident as needed. 7. Fill wash basin with warm water and have resident check temperature...9. Wet and soap folded wash cloth...11. Obtain clean wash cloth. Wet, soap and fold wash cloth. Females: 12. Separate labia and was urethral area first. 13. Wash between and outside labia in downward strokes. 14. Alternate from side to side-wipe from front to back and from center of perineum outward. 15. Use a clean area of the was cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed...20. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction when washing. 21. Gently pat area dry in same direction as when washing. 22. Assist resident turn onto side away. 23. Wet and soap wash cloth. 24. Clean anal area from front to back, using a clean are of wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed. 25. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 26. Gently pat area dry in same direction as when washing...."			

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F 0371 SS=F Bldg. 00	<p>3.1-41(a)(2)</p> <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 ensure a sanitary kitchen environment related to cleanliness of the oven, vents, cooler and ice machine; the dishwasher rinse temperature; food labeling and dating; and, handwashing. This deficient practice had the potential to affect 66 of 66 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>An initial tour of the kitchen was performed on 2/15/16 at 10:03 a.m. with the Dietary Manager (DM). The following was observed:</p> <p>1.) On 2/15/16 at 10:03 a.m., there were 2 ovens observed. Both of the ovens had</p>	F 0371	<p>F371 Food Procure,store/prepare/serve/sanitary This provider ensures thefacility stores, prepares, distributes, and serves food under sanitaryconditions.</p> <p>What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice</p> <ul style="list-style-type: none"> • There were no residents identified for the alleged deficient practice. • Ovens were cleaned immediatelyafter they cooled down on 2-15-16 by Dietary aide. • Vent was cleaned immediatelyafter meal served on2-15-16, by Dietary aide. • Dietary #10 was instructed on useof booster heat being turned 	03/16/2016

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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901		
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	<p>dark debris on the bottom shelves. At that time, the DM indicated that the ovens were cleaned weekly, but they were in need of cleaning.</p> <p>2.) On 2/15/16 at 10:04 a.m., the main food prep area had a large air vent that had gray fuzzy debris observed inside of the vents. Cook #11 was making 4 batches of macaroni and beef casserole, they were uncovered and were directly underneath of the vent on the table beneath it.</p> <p>3.) On 2/17/16 at 10:05 a.m., The dishwasher was observed to range from 141-146 degrees during the wash cycle. The DM indicated the wash cycle should be at least 165 degrees. At that time Dietary Aid #10 indicated it had been having trouble over the weekend getting up to temperature. The DM asked if she had ensured the heat booster was turned on. Dietary Aide #10 indicated she wasn't sure where it was located. The DM showed her where it was, and at that time turned on the booster.</p> <p>4.) On 2/17/16 at 10:35 a.m., 1 of 3 stand up refrigerators had unlabeled, undated, and uncovered items in dishes. The items were identified by DM as follows: 18 puddings and 7 cottage cheese. The</p>		<p>on 2-17-16, by Dietician.</p> <ul style="list-style-type: none"> Food was immediately removed from stand up refrigerator and discarded that was not labeled and dated on 2-17-16. Milk cooler was cleaned immediately on 2-17-16. Food was immediately removed from walk in freezer and discarded that was not labeled and dated on 2-17-16 by dietary aide . Ice machine was delimed on 2-15-16 by maintenance Dietary manager was instructed on proper handwashing on 2-15-16 by Dietician Dietary Aide #10 was instructed on proper handwashing and serving food on 2-15-16, by dietician. Dietary Aide #9 was instructed on proper use of Dish machine and what to do if not temping at proper temperature on 2-15-16 by Dietary Manager. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who consume food from Kitchen have the potential to be affected by the alleged deficient practice. Dietary Staff has been re-educated on Storage, labeling, dating items in refrigerator and freezer, Handwashing, cleaning ice 		

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	<p>DM indicated the items should be labeled and dated and covered.</p> <p>5.) On 2/17/16 at 10:58 a.m., the milk cooler was observed to have dark particulate debris and dried white debris at the bottom of it. The DM indicated the cooler was to be cleaned weekly.</p> <p>6.) On 2/17/16 at 11:02 a.m., there were 3 unlabeled and undated items in the walk in freezer. The DM indicated the items should be labeled and dated.</p> <p>7.) On 2/15/16 11:06 a.m., the ice machine had a yellow residue on the lip of where the ice machine produces ice. The DM indicated at that time she did not what the substance was and she did not know who cleaned it.</p> <p>8.) On 2/15/16 at 11:56 a.m., the DM was observed answering the phone, then she opened the refrigerator door. She had grabbed a bag of grapes out of the refrigerator and then donned gloves. The DM with gloved hands touched the drawer, grabbed a cluster of grapes out of the bag, rinsed them, grabbed the cluster of grapes out the colander and placed into a bowl for a resident. At no time was she observed washing or sanitizing her hands.</p> <p>9.) On 2/15/16 at 12:03 p.m., Dietary Aid</p>		<p>machine, milk cooler and oven, temperature of dishmachine and foodhandling on 3-1-16 and by 3-16-16 by Dietician/SDC/Designee</p> <ul style="list-style-type: none"> • Noncompliance with facility policyand procedure may result in employee re-education and/or disciplinary action. <p>What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur</p> <ul style="list-style-type: none"> • Daily short sanitation check off will monitorrefrigerators, freezer, oven, ice machine, temperatures of dishmachine, handwashing and food handling. • Dietary Staff has been re-educatendon refrigerators, freezer, oven, ice machine, temperatures of dishmachine, handwashing and food handling, on 3-1-16, and by 3-16-16 by Dietician/SDC/Designee. <p>How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place</p> <ul style="list-style-type: none"> • A "Sanitation Review" CQI audit tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter, until compliance is achieved for two consecutivequarters tomonitor compliance with proper sanitary guidelines. 	

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F 0425 SS=D Bldg. 00	<p>#10 who was serving food onto trays for the residents, was observed wiping her fingers on a cloth rag that was observed to be gray in color. Dietary #10 also wiped her fingers on the side of her apron and her pants. Dietary Aid #10 then took her hands without washing or sanitizing them, and grabbed plates for residents and placed food on them.</p> <p>10.) On 2/15/16 at 12:15 p.m., Dietary Aid #9 indicated the dishwasher was still staying at 157 degrees. At that time, the temperature gague on the outside of the machine was observed to read 157 degrees for the wash cycle.</p> <p>3.1-21(i)(2)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>		<ul style="list-style-type: none"> The governing CQI committee willreview the data. If the threshold for compliance of 100% is not met, an actionplan will be developed. Noncompliance with facility policyand procedure may result in employee re-education and/or disciplinary action. <p>Compliance date: 3-16-16</p>		

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	<p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and interview, the facility failed to ensure expired medications were removed from medication storage areas. This affected 1 of 3 medication rooms reviewed for expired medications.</p> <p>Findings include:</p> <p>During a review of medication storage areas on 2/18/16 at 2:00 p.m., the Magnolia and Willow hall medication refrigerator was observed to contain one vial of opened Acetylcysteine 10% solution (a mucolytic) ordered for Resident #175. The resident continued on the medication. The marking on the vial indicated the vial was opened on 2/10/16. The label on the packaging indicated the vial was to be refrigerated and expired 96 hours after opening.</p> <p>During an interview on 2/18/16 at 2:15 p.m., the Magnolia and Willow unit manager indicated nurses were responsible for discarding expired medications.</p> <p>The policy titled "Medication Administration," dated 11/2013, provided</p>	F 0425	<p>F425 PharmaceuticalSVC-Accurate Procedures, RPH It is the practice of thisprovider to provide routine and emergency drugs and biologicals to itsresidents, or obtain them under an agreement and provide pharmaceuticalservices (including procedures that assure the accurate acquiring, receiving,dispensing, and administering of all drugs and biologicals) to meet the needsof each resident.</p> <p>What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice</p> <ul style="list-style-type: none"> Resident #175 Acetylcysteine 10% solution was discarded immediately 2-18-16by unit manager, it had not been used and new bottle had already been opened and used. Unit Manager was instructed tocheck for expired medications daily and discard when found on 2-18-16 byDNS/Designee. <p>How will you identify</p>	03/16/2016			

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	<p>by the Assistant Director of Nursing (ADON) on 2/18/16 at 4:00 p.m., indicated "... 2.1. Medications must be checked by the facility regularly for expiration dated and deterioration. 2.2 Expired medications will be removed from use and destroyed as per facility's policies and procedures...."</p> <p>3.1-25(o)</p>		<p>other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who receive medications have the potential to be affected by the alleged deficient practice. Licensed Nurses have been re-educated on expired medications on 3-1-16 and by 3-16-16 by SDC/DNS/Designee. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> Medication carts and medication refrigerators are checked daily by licensed nurses for expired medications The Pharmacy consultant will check medication carts and medication refrigerator for expired medication on facility visits, but no less than monthly. Expired Medications will be discarded and replaced immediately. Licensed Nurses have been re-educated on expired medications 3-1-16 and by 3-16-16 by SDC/DNS/Designee <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program</p>	

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</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 ensure 4 of 40 resident room walls and furniture were in good repair and clean. (Rooms #220, 233, 225, and 227). The facility failed to ensure the handrails were uncovered and walls behind the handrails marred and scratched for 1 of 2 elevators in facility utilized by the residents and public.</p> <p>Findings include:</p>	F 0465	<p>will be put into place</p> <ul style="list-style-type: none"> A "Medication Storage" CQI tool will be utilized weekly x 4, monthly x2 and quarterly thereafter, until compliance is achieved for two consecutive quarters to monitor compliance with proper removal of expired medication. The governing CQI committee will review the data. If the threshold for compliance of 100% is not met, an action plan will be developed. <p>Compliance date: 3-16-16</p> <p>F465 Other Environment It is the practice of this provider to provide a safe and comfortable environment for residents, staff and the public.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> No residents were identified to be affected by the alleged deficient practice. The handrail was replaced 	03/16/2016	

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	<p>1. During the initial tour on 2/15/16 at 9:30 a.m., the following was observed:</p> <p>a.) the handrails in the elevator had bare corners with metal showing</p> <p>b.) walls behind the handrails were marred and scratched, corners of walls on the first floor crosswalk were gouged.</p> <p>2. During resident room observations on 2/15/16 and 2/16/16, the following was observed:</p> <p>a.) Room 113, the privacy curtain had brown stain behind the bedside commode.</p> <p>b.) Room 114, wall beneath heating unit was patched and cracked</p> <p>c.) Room 121, marring on the wall by dresser</p> <p>d.) Room 220, ceiling had apparent leak, plaster off the ceiling, brown substance on the ceiling, plaster coming down on side of window.</p> <p>e.) Room 227, wall behind bed had scratches and wallboard off</p> <p>f.) Room 214, back of toilet lid didn't fit and moved easily</p>		<p>2-22-16 by Maintenance.</p> <ul style="list-style-type: none"> The walls behind the handrail on first floor crosswalk were sanded and repainted 2-16-16 by Maintenance. Room 113 privacy curtain was replaced immediately on 2-15-16 by Housekeeping Supervisor. Rooms 114, 121, 220, 227, 240, 255, walls and ceilings were repaired and painted by 3-16-16 by Maintenance. Room 214 toilet was replaced 2-16-16 by Maintenance. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents residing in the facility have the potential to be affected by the alleged deficient practice. A staff in service will be completed on 3-1-16 and by 3-16-16 on reporting of findings of marred walls, walls/ceilings and handrails in need of painting and any other maintenance/environmental concerns to maintenance department per maintenance communication slips at each nurses station, by the SDC/designee. Maintenance will also monitor monthly preventive maintenance and per maintenance slips daily. Facility will hire a painting 	

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	<p>g.) Room 255, gouges in wall by television, ceiling tiles didn't fit correctly near door</p> <p>h.) Room 240, walls marred</p> <p>During the environmental tour on 2/18/16 at 8:30 a.m. with the Administrator and Maintenance Supervisor, they indicated they were unaware the resident rooms needed repair. The Administrator indicated a painter was scheduled to enter the building in March. The Administrator indicated the facility had a system in place for all staff to document environmental concerns, but it was not written. Maintenance request forms were available at each nurses station.</p> <p>During an interview on 2/19/16 at 12:54 p.m. the Maintainance Director indicated on 10/23/15 he received a maintenance request for room 220 due to " water leaking out of the ceiling and down the wall He indicated he fixed the ceiling first and had not returned to fix the wall." A 2nd request, dated 1/14/16, indicated "wall looked beat up and spots on ceiling."</p> <p>3.1-19(f)</p>		<p>crewto come into building and paint all residents rooms.</p> <ul style="list-style-type: none"> Home office painter came intofacility and did touch up painting of doors and door frames throughout facilitythe first week of March. <p>What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur</p> <ul style="list-style-type: none"> Residents residing in the facility have the potential to be affected bythe alleged deficient practice. A staff inservice will becomepleted on 3-1-16 and by 3-16-16 on reporting of findings of marred walls,walls/ceilings and handrails in need of painting and any othermaintenance/environmental concerns to maintenance department per maintenancemunication slips at each nurses station, by the SDC/designee. Maintenance will also monitormonthly per preventive maintenance and per maintenance slips daily. Facility will hire a painting crewto come into building and paint all residents rooms. Home office painter came intofacility and did touch up painting of doors and door frames throughout facilitythe first week of March <p>How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program</p>				

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			<p>will be put into place</p> <ul style="list-style-type: none"> The CQI Tool "Facility Environmental Review" tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter, until compliance is achieved for two consecutive quarters to monitor compliance with Maintenance/Environmental items in need of repair/painted. The governing CQI committee will review the data. If the threshold for compliance of 100% is not met, an action plan will be developed. <p>Compliance date: 3-16-16</p>		