

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155283	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/20/2015
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NAME OF PROVIDER OR SUPPLIER WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 13, 14, 15, 16, 17 and 20.</p> <p>Facility number: 000181 Provider number: 155283 AIM number: 100266860</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicare: 6 Medicaid: 23 Other: 5 Total: 34</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's</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>dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to, an uncovered indwelling urinary catheter bag for 1 of 1 residents reviewed for dignity. (Resident #9)</p> <p>Finding includes:</p> <p>On 4/13/15 at 10:53 a.m., Resident #9 was resting in bed. His urinary catheter bag filled with urine was observed hanging on the side of the bed visible from the doorway.</p> <p>On 4/14/2015 at 9:47 a.m., Resident #9 was resting in bed. His urinary catheter bag was observed hanging uncovered from the side of his bed resting directly on the floor, visible from the doorway.</p> <p>Resident #9's record was reviewed on 4/14/2015 at 2:09 p.m. Diagnoses included, but were not limited to, dementia, acute renal failure, history of UTI (urinary tract infections), and neurogenic bladder [with] urinary retention.</p> <p>Review of Resident #9's care plan for urinary incontinence indicated, resident requires the use of a Foley (urinary) catheter. Interventions included, but</p>	F 241	<p>What Correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?</p> <p>Resident #9's urinary catheter bag was covered to achieveand maintain dignity and privacy. A new urinary catheter "dignity bag" wasapplied to Resident #9's wheelchair and bed, thus providing staff the abilityto keep the urinary catheter bag covered for dignity while visible.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken.</p> <p>This facility has one other resident with an indwelling Foleycatheter. This resident was assessed and observed by the Director of Nursing toensure that the urinary catheter bag was covered in a catheter "dignity bag."The catheter, when visible, was noted to be covered, thus maintaining respectto this resident's dignity.</p> <p>What measures will be put into place or what systemic changes will bemade to ensure that the deficient practice does not recur</p> <p>Each resident with urinary catheter bags will be observed atrandom by the Director of Nursing or designee to ensure that the urinarycatheter bags in use remain covered when visible. The audits/observations willbe conducted at a minimum of at</p>	05/20/2015

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	<p>were not limited to, provide catheter care every shift and as needed, position catheter tubing and drainage bag below the level of the bladder to minimize the risk of urinary reflux, position catheter tubing and drainage bag in such a way to avoid contact with the floor, monitor outputs as indicated, and keep catheter drainage bag covered as to maintain resident dignity and privacy.</p> <p>Interview with the DON on 4/15/2015 at 1:58 a.m., indicated all urinary catheter bags and tubing should have been kept off the floor and should have been covered in a dignity bag whenever visible.</p> <p>3.1-3(t)</p>		<p>least daily on scheduled days of work on alternating shifts to ensure 100% compliance. An In-service was provided to the nursing staff that included content regarding promoting and maintaining resident dignity and urinary drainage bag maintenance.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing will be responsible to monitor for completion of the audits/observations and will monitor the results of the audits/observations. The Director of Nursing will ensure that 100% compliance is achieved and that the deficient practice does not recur, if further problems or non compliance is noted then additional education/instruction for staff will be conducted. The Director of Nursing shall report the results of the audits/observations to the Quality Assurance Team monthly. The Quality Assurance team will deem when necessary or appropriate to increase or decrease the rate of the audits/observations and offer further suggestions to ensure 100% compliance is achieved and maintained.</p> <p>What date the Systematic changes will be completed.</p> <p>May 20th, 2015</p>		

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F 282 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 ensure physician's orders and the plan of care were followed related to fall interventions not in place and a urinary catheter bag and tubing touching the floor for 1 of 3 residents reviewed for accidents of the 6 who met the criteria for accidents and 1 of 1 residents reviewed for urinary catheters. (Resident #9)</p> <p>Finding includes:</p> <p>On 4/14/2015 at 9:47 a.m., Resident #9 was resting in bed. His urinary catheter bag was observed hanging uncovered from the side of his bed resting directly on the floor, visible from the doorway.</p> <p>On 4/15/2015 at 8:46 a.m., Resident #9 was observed sitting in his wheelchair in the dining room eating breakfast. His urinary catheter was in a dignity bag and the catheter tubing was resting directly on the floor. No clip alarm was in place to the resident. LPN #1 was made aware of the catheter tubing resting on floor at the</p>	F 282	<p>What Correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?</p> <p>Resident #9's urinary catheter bag was positioned so thatthe tubing and or the bag were not resting on the floor. Resident #9 was assessedfor symptoms of possible urinary tract infection and his physician notified ofthe potential for an infection. At this time, resident #9 remains free ofsymptoms of a urinary tract infection. On 4/16/15 a clip alarm was reattached to resident #9's wheelchair, andfunction and placement checked routinely. There have been no reports ofresident #9 falling since reattachment of the clip alarm.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken.</p> <p>This facility has one other resident with an indwelling Foleycatheter. This resident was assessed and observed by the Director of Nursing toensure that the urinary catheter bag was positioned so that the bag and or thetubing were not touching or resting on the floor. The resident</p>	05/20/2015

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	<p>time of the observation and indicated it should not have been touching the floor for infection control reasons.</p> <p>On 4/15/2015 at 10:02 a.m., Resident #9 was observed in the therapy room. No clip alarm was in place.</p> <p>On 4/16/2015 at 8:46 a.m., staff was observed pushing Resident #9 from the dining room into the therapy room. No clip alarm was in place.</p> <p>On 4/16/15 at 9:03 a.m. during a medication administration observation in Resident #9's room, the ADON was observed to bring a personal clip alarm into the resident's room and explain the alarm to the resident before attaching it to the resident in his wheelchair.</p> <p>Resident #9's record was reviewed on 4/14/2015 at 2:09 p.m. Diagnoses included, but were not limited to, constipation, cerebrovascular disease, hypothyroidism, diabetic retinopathy of both eyes, dementia, acute renal failure, obesity, atrial fibrillation (irregular heartbeat), and neurogenic bladder [with] urinary retention.</p> <p>Review of the April 2015 Physician's Order Summary (POS) indicated the following treatment orders:</p>		<p>was observed to have catheter bag and tubing positioned in a dignity bag and not touching or resting on the floor.</p> <p>To identify other potential residents with personal alarm use, the facility will audit 100% of resident charts for physician orders for personal alarm use. For the residents identified as using a personal alarm of any type, an observation will be conducted by the Director of Nursing or designee to ensure the ordered alarm is in place for each resident.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Each resident with urinary catheter bags will be observed at random by the Director of Nursing or designee to ensure that the urinary catheter bags in use remain positioned so they are not touching or resting on the floor. The audits/observations will be conducted at a minimum of at least daily on scheduled days of work on alternating shifts to ensure 100% compliance. An In-service was provided to the nursing staff that included content regarding maintaining proper positioning of the urinary drainage bag and tubing as to not resting on or touching the floor.</p> <p>Random audits/observations will be conducted by the Director of Nursing and or designee at least 3 times weekly on random shifts to ensure that each resident with an ordered</p>		

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	<p>- clip alarm to wheelchair, check function and placement every shift (started 5/22/14)</p> <p>- pressure alarm to bed, check function and placement every shift to alert staff (started 3/17/15)</p> <p>Review of the CNA resident care assignment sheet provided by the Director of Nursing (DON) on 4/16/2015 at 9:50 a.m., indicated Resident #9 was supposed to have personal and bed alarms in place. It was dated as last updated on 3/13/15 and deemed as current by the DON.</p> <p>Review of Resident #9's care plan for falls dated 3/10/15 indicated, "The resident has multiple risk factors for falls, such as: hx. (history of) falls, weakness, pain, ..., impaired vision, seizure disorder, ..., dementia, depression, incontinence, unsteady balance, decreased mobility, ..., hx. of CVA (stroke), requires up to total assist of 1-2 to meet ADL needs, ..., limited ROM (range of motion) to LLE (left lower extremity)," Interventions included, but were not limited to, clip alarm to wheel chair and pressure alarm to bed.</p> <p>Review of Resident #9's care plan for urinary incontinence indicated, resident requires the use of a Foley (urinary)</p>		<p>personal alarm of any types in place for each resident. The audits/observations will be conducted atleast3 times weeklyuntil 100% compliance is consistently achieved.</p> <p>How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.,what quality assurance program will be put into place.</p> <p>The Director of Nursing will be responsible to monitor forcompletion of the audits/observations and will monitor the results of the audits/observations.The Director of Nursing will ensure that 100% compliance is achieved and thatthe deficient practice does not recur, if further problems or non compliance isnoted then additional education/instruction for staff will be conducted. TheDirector of Nursing shall report the results of the audits/observations to theQuality Assurance Team monthly. The Quality Assurance team will deem whennecessary or appropriate to increase or decrease the rate of the audits/observationsand offer further suggestions to ensure 100% compliance is achieved andmaintained.</p> <p>What date theSystematic changes will be completed.</p> <p>May 20th, 2015</p>		

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	<p>catheter. Interventions included, but were not limited to, provide catheter care every shift and as needed, position catheter tubing and drainage bag below the level of the bladder to minimize the risk of urinary reflux, position catheter tubing and drainage bag in such a way to avoid contact with the floor, monitor outputs as indicated, and keep catheter drainage bag covered as to maintain resident dignity and privacy.</p> <p>Interview with the Director of Nursing (DON) on 4/15/2015 at 1:58 a.m., indicated all urinary catheter bags and tubing should have been kept off the floor and should have been covered in a dignity bag whenever visible.</p> <p>Interview with the DON on 4/16/2015 at 8:51 a.m. regarding Resident #9's falls care plan, indicated the care plan dated 3/10/15 was current and measures listed on the care plan should have been in place, including the clip alarm to his wheelchair. She further indicated she would get Resident #9 a clip alarm until his self-releasing belt arrived.</p> <p>Interview on 4/20/2015 at 10:22 a.m. with CNA#1 indicated the resident care assignment sheets were what the CNA's used to know which interventions and treatments were to be in place for a</p>				

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F 315 SS=D Bldg. 00	<p>resident. Further indicated Resident #9 now has a self releasing belt and pressure alarm to his bed and had a clip alarm just last week, but not prior.</p> <p>3.1-35(g)(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 ensure a resident with a urinary catheter received the necessary treatment and services to prevent urinary tract infections, related to the placement of the urinary catheter tubing and drainage bag for 1 of 1 residents reviewed for urinary catheters.</p>	F 315	<p>What Correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?</p> <p>Resident #9's urinary catheter bag was positioned so thatthe tubing and or the bag were not resting on the floor. Resident #9 was assessedfor symptoms of possible</p>	05/20/2015

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	<p>(Resident #9).</p> <p>Finding includes:</p> <p>On 4/14/2015 at 9:47 a.m., Resident #9 was resting in bed. His urinary catheter bag was observed hanging uncovered from the side of his bed resting directly on the floor, visible from the doorway.</p> <p>On 4/15/2015 at 8:46 a.m., Resident #9 was observed sitting in his wheelchair in the dining room eating breakfast. His urinary catheter was in a dignity bag and the catheter tubing was resting directly on the floor. LPN #1 was made aware of the catheter tubing resting on floor at the time of the observation and indicated it should not have been touching the floor for infection control reasons.</p> <p>Resident #9's record was reviewed on 4/14/2015 at 2:09 p.m. Diagnoses included, but were not limited to, dementia, acute renal failure, history of UTI (urinary tract infections), and neurogenic bladder [with] urinary retention.</p> <p>Review of the readmission Minimum Data Set (MDS) assessment dated 1/29/15 indicated a history of UTIs in the last 30 days.</p>		<p>urinary tract infection and his physician notified of the potential for an infection. At this time, resident #9 remains free of symptoms of a urinary tract infection.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</p> <p>This facility has one other resident with an indwelling Foley catheter. This resident was assessed and observed by the Director of Nursing to ensure that the urinary catheter bag was positioned so that the bag and the tubing were not touching or resting on the floor. The resident was observed to consistently have the catheter bag and tubing positioned in a dignity bag and not touching or resting on the floor.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Each resident with urinary catheter bags will be observed at random by the Director of Nursing or designee to ensure that the urinary catheter bags in use remain positioned so they are not touching or resting on the floor. The audits/observations will be conducted at a minimum of at least daily on scheduled days of work on alternating shifts to ensure 100% compliance. An In-service was provided to the nursing staff that included content regarding maintaining proper</p>		

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	<p>Review of Resident #9's care plan for urinary incontinence indicated, resident requires the use of a Foley (urinary) catheter. Interventions included, but were not limited to, provide catheter care every shift and as needed, position catheter tubing and drainage bag below the level of the bladder to minimize the risk of urinary reflux, position catheter tubing and drainage bag in such a way to avoid contact with the floor, monitor outputs as indicated, and keep catheter drainage bag covered as to maintain resident dignity and privacy.</p> <p>A policy titled "Urinary Drainage Bag Maintenance" was provided by the DON on 4/15/15 at 2:10 p.m. and deemed as current. The policy indicated, ".... Urinary drainage bag should not be allowed to touch the floor"</p> <p>Interview with the DON on 4/15/2015 at 1:58 a.m., indicated all urinary catheter bags and tubing should have been kept off the floor and should have been covered in a dignity bag whenever visible.</p> <p>3.1-41(a)(2)</p>		<p>positioning of the urinary drainage bag and tubing as to notresting on or touching the floor.</p> <p>How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.,what quality assurance program will be put into place.</p> <p>The Director of Nursing will be responsible to monitor forcompletion of the audits/observations and will monitor the results of the audits/observations.The Director of Nursing will ensure that 100% compliance is achieved and thatthe deficient practice does not recur, if further problems or non compliance isnoted then additional education/instruction for staff will be conducted. TheDirector of Nursing shall report the results of the audits/observations to theQuality Assurance Team monthly. The Quality Assurance team will deem whennecessary or appropriate to increase or decrease the rate of the audits/observationsand offer further suggestions to ensure 100% compliance is achieved andmaintained.</p> <p>What date theSystematic changes will be completed.</p> <p>May, 20th 2015</p>		

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F 323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions were in place for 1 of 3 residents reviewed for accidents of the 6 who met the criteria for accidents. (Resident #9)</p> <p>Finding includes:</p> <p>On 4/15/2015 at 8:46 a.m., Resident #9 was observed sitting in his wheelchair in the dining room eating breakfast. No clip alarm was in place to the resident.</p> <p>On 4/15/2015 at 10:02 a.m., Resident #9 was observed sitting in his wheelchair in the therapy room. No clip alarm was in place.</p> <p>On 4/16/2015 at 8:46 a.m., staff was observed pushing Resident #9 in his wheelchair from the dining room to the therapy room. No clip alarm was in place.</p> <p>On 4/16/15 at 9:03 a.m. during a medication administration observation in Resident #9's room, the ADON was observed to bring a personal clip alarm</p>	F 323	<p>What Correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?</p> <p>On 4/16/15 a clip alarm was reattached to resident #9'swheelchair, and function and placement checked routinely. There have been noreports of resident #9 falling since reattachment of the clip alarm.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken.</p> <p>To identify other potential residents with personal alarmuse, the facility will audit 100% of resident charts for physician orders forpersonal alarm use. For the residents identified as using a personal alarm of any type, an observation will be conducted by the Director of Nursing or designeeto ensure the ordered alarm is in place for each resident.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur</p> <p>Random audits/observations will be conducted by the Directorof Nursing</p>	05/20/2015			

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	<p>into the resident's room and explain the alarm to the resident before attaching it to the resident in his wheelchair.</p> <p>Resident #9's record was reviewed on 4/14/2015 at 2:09 p.m. Diagnoses included, but were not limited to, constipation, cerebrovascular disease, hypothyroidism, diabetic retinopathy of both eyes, dementia, acute renal failure, obesity, atrial fibrillation (irregular heartbeat), and neurogenic bladder [with] urinary retention.</p> <p>Review of the April 2015 Physician's Order Summary (POS) indicated the following treatment orders: - clip alarm to wheelchair, check function and placement every shift (started 5/22/14) - pressure alarm to bed, check function and placement every shift to alert staff (started 3/17/15)</p> <p>Review of the CNA resident care assignment sheet provided by the Director of Nursing (DON) on 4/16/2015 at 9:50 a.m., indicated Resident #9 was supposed to have personal and bed alarms in place. It was dated as last updated on 3/13/15 and deemed as current by the DON.</p> <p>Review of the Progress Notes indicated</p>		<p>and or designee at least 3 times weekly to ensure that each resident with an ordered personal alarm of any type is in place for each resident. The Director of Nursing will be responsible to ensure that the deficient practice does not recur. The audits/observations will be conducted at least 3 times weekly until 100% compliance is consistently achieved.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing will be responsible to monitor for completion of the audits/observations and will monitor the results of the audits/observations. The Director of Nursing will ensure that 100% compliance is achieved and that the deficient practice does not recur, if further problems or non compliance is noted then additional education/instruction for staff will be conducted. The Director of Nursing shall report the results of the audits/observations to the Quality Assurance Team monthly. The Quality Assurance team will deem when necessary or appropriate to increase or decrease the rate of the audits/observations and offer further suggestions to ensure 100% compliance is achieved and maintained.</p> <p>What date the Systematic changes</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/20/2015
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NAME OF PROVIDER OR SUPPLIER WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
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	<p>the following entries regarding falls:</p> <p>- 2/25/15 8 am - Resident had fallen OOB (out of bed) @ (at) 3 am - Found sitting on floor stated he thought he could fly et (and) was trying to fly. He is not usually delusional. Possibly dreaming. He was alert et appropriate [after] fall. Has had recent hospitalization & tx (treatment) for infection. Bed alarm functioning. Call light was in reach. Is currently receiving therapy. Will monitor as infection subsides and therapy progresses - enc (encourage) to place alarm higher to sound when upper body is off bed.</p> <p>- 3/10/15 p.m. - Resident "rolled" out of bed. Up until recently resident required turning et repositioning in bed. 2nd fall. SR (side rails) [up] to assist in proper positioning. Bed to lowest position at all times. Resident [with] skin tear to L hand. Resident to recv (receive) low bed.</p> <p>- 4/4/15 10 a - Resident fell out of w/c (wheelchair) 7:20 pm on 4/2/15. Reportedly fell asleep in chair et leaned forward et fell. Abrasion to forehead - at the time of fall - prior to - CNA was approaching resident to take to room for HS (bedtime). She reportedly noticed him leaning and could not get to him in time to break fall. Falling out of chair sleeping is isolated incident but has had 3 falls in</p>		<p>will be completed. May 20th, 2015</p>	

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	<p>less than 3 months. Suggested self release belt in chair et he refused. Educ (educated) to ask to go to bed when tired.</p> <p>- 4/11/15 5:15 am - Post Fall Investigation Worksheet: What was resident attempting to do at the time of the fall - stand up, he was already standing but felt weak. Was not incont (incontinent) at time of fall - foley. Was in bed prior to the fall. Staff was present at the time of the fall, attempting to transfer resident to the w/c. Staff were performing the transfer per policy & were assisting the resident per plan of care. Were previously planned interventions in place at the time of the fall - yes, ineffective due to illness. Possible cause - weakness due to feeling ill (low blood sugar). Clinical status reviewed. Care routine modifications: educ staff assist OOB slowly. Therapy referral made - already recvs. Nurse aide assignment sheets updated.</p> <p>- 4/15/15 Alert charting: Fall follow up - rolled out of bed 1:10 am 4/15/15 no injuries</p> <p>Review of Resident #9's care plan for falls dated 3/10/15 indicated, "The resident has multiple risk factors for falls, such as: hx. (history of) falls, weakness, pain, ..., impaired vision, seizure</p>				

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	<p>disorder,..., dementia, depression, incontinence, unsteady balance, decreased mobility, ..., hx. of CVA (stroke), requires up to total assist of 1-2 to meet ADL needs, ..., limited ROM (range of motion) to LLE (left lower extremity)," Interventions included, but were not limited to, clip alarm to wheel chair and pressure alarm to bed.</p> <p>Interview on 4/20/2015 at 10:22 a.m. with CNA#1 indicated the resident care assignment sheets were what the CNA's used to know which interventions and treatments were to be in place for a resident. Further indicated Resident #9 now has a self releasing belt and pressure alarm to his bed and had a clip alarm just last week, but not prior.</p> <p>Interview with the DON on 4/16/2015 at 8:51 a.m. regarding Resident #9's falls care plan, indicated the care plan dated 3/10/15 was current and measures listed on the care plan should have been in place, including the clip alarm to his wheelchair.</p> <p>3.1-45(a)(2)</p>						

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F 332 SS=D Bldg. 00	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 10 residents observed during 8 medication pass observations. Two errors in medications were observed during 25 opportunities for errors in medication administration. This resulted in a medication error rate of 8.0%. (Residents # 6 and #25)</p> <p>Findings include:</p> <p>1. During an observation of a medication administration pass on 4/15/16 at 3:35 p.m., RN #1 prepared Resident #25's medications, which included risperidone (an antipsychotic medication) 0.25 mg (milligrams) 1/2 tab (tablet) po (by mouth) bid (twice daily). Resident #25 then received this medication whole in applesauce.</p> <p>Review of Resident #25's April Physician Order Summary (POS) indicated an order</p>	F 332	<p>What Correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?</p> <p>Resident #25's physician was contacted and informed thatResident #25 was given the prescribed dose of risperidone at 8am and 4pminstead of 8am and 8pm as indicated on the physician order sheet. The Physicianstated and ordered that the risperidone be given at 8am and 4pm as the Medication Administration Recordindicates. A physician order was writtento reflect the physician order to continue to administer the medication at 8am and4 pm.</p> <p>Resident #6 received the omittedvitamin D 1000 unit tablet as prescribed by LPN #2 during the correct timeframe of this medication pass.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken.</p> <p>Each resident's medication</p>	05/20/2015

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	<p>for Risperidone 0.25 mg 1/2 tab po at 8 am and 8 pm daily.</p> <p>Review of a Physician's Order dated 3/31/15 indicated, "Change Risperidone time to 8 am & 8 pm."</p> <p>Review of Resident #25's April 2015 Medication Administration Record (MAR) indicated, Risperidone 0.25 mg 1/2 tab po timed at 8 am and 4 pm.</p> <p>Interview with the Director of Nursing (DON) on 4/16/2015 at 9:25:51 a.m., indicated the Risperidone for Resident #25 had previously been given at 8 am & 4 pm. She confirmed an order was written on 3/31/15 to change the timing to 8 am & 8 pm. The DON further indicated the time for the Risperidone was changed on the April POS but not on the April MAR and that step in the transcription was missed.</p> <p>2. During an observation of a medication administration pass on 4/16/15 at 11:31 a.m., LPN #2 prepared Resident #6's medications, which included orders for vitamin D 1000 u (units) - 2 tabs (tablets) po qd (daily) w/(with) a meal and hydrocodone/APAP (pain medication) 5/325 mg 1 po qid (four times daily). LPN #1 was observed to only place 1 vitamin D tablet and 1</p>		<p>administration record and physician order sheet will be compared to ensure that 100% of the residents are receiving their medications at the time indicated by the physician order. The Director of Nursing or the Assistant Director of Nursing will observe medication passes completed by 100% of the nurses or QMA's. The Director of Nursing or Assistant Director of Nursing will ensure that proper medication pass techniques and facility policies are being followed, and no further medication errors are being made.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>The staff that complete medication passes will have an in-service to include content regarding proper medication pass, administering medications at the right time, and right dose. The Director of Nursing or the Assistant Director of Nursing will conduct random audits/observations of medication passes at different times to ensure that the deficient practice does not recur. The audits/observations will be performed at the rate of at least 3 per week to ensure that 100% compliance is achieved and maintained.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p>				

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	<p>hydrocodone/APAP tablet in separate plastic baggies to crush, and confirmed she had crushed 2 tablets total before giving the medication to Resident #6 in applesauce.</p> <p>Review of Resident #6's April POS indicated an order for Vitamin D 1000 u - 2 tabs po qd with a meal.</p> <p>Interview with LPN #2 on 4/16/2015 at 11:43 a.m., indicated Resident #6's MAR and the medication label both read 2 tabs of vitamin D were to be given and further indicated she only gave 1 tablet. At that time, she went back and gave Resident #6 a second vitamin D tablet..</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>		<p>put into place.</p> <p>The Director of Nursing will be responsible to monitor forcompletion of the audits/observations and will monitor the results of the audits/observations.The Director of Nursing will ensure that 100% compliance is achieved and thatthe deficient practice does not recur, if further problems or non compliance isnoted then additional education/instruction for staff will be conducted. TheDirector of Nursing shall report the results of the audits/observations to theQuality Assurance Team monthly. The Quality Assurance team will deem whennecessary or appropriate to increase or decrease the rate of the audits/observationsand offer further suggestions to ensure 100% compliance is achieved andmaintained.</p>		

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F 428 SS=D Bldg. 00	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure a pharmacy recommendation was acted upon timely for 1 of 5 residents reviewed for unnecessary medications. (Resident #34)</p> <p>Finding includes:</p> <p>Resident # 34's record was reviewed on 4/15/15 at 3:05 p.m. The resident's diagnoses included, but were not limited to, hypertension, coronary artery disease and diabetes mellitus.</p> <p>Review of a pharmacy recommendation created between 12/1/14 and 12/3/14 indicated to add heart rate monitoring parameter to Metoprolol (blood pressure medication)... "like HR (heart rate) <50, call MD" (medical doctor).</p> <p>Review of the MAR's (Medication Administration Record) for December 2014-April 2015 indicated the monitoring for the medication had not</p>	F 428	<p>What Correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?</p> <p>Resident #34's physician was contacted to seek parametersfor the medication Metoprolol, parameters were obtained and orders were written;</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken.</p> <p>100% of the resident charts and each resident pharmacyrecommendation will be reviewed by the Director of Nursing or Designee toensure that the Pharmacist recommendation has been acted upon. In addition,residents that are on medications that require heart rate monitoring parameterhave the parameter order in place.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur</p>	05/20/2015	

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	<p>been put into place.</p> <p>Interview with the DON (Director of Nursing) on 4/16/15 at 1:22 p.m., indicated the pharmacy request from December for Resident #24 had been missed and should have been addressed before now. She further indicated she would speak to the doctor today to see if he would like the medication to be monitored with parameters.</p> <p>3.1-25(i)</p>		<p>The Director of Nursing will be responsible for obtaining and reviewing each Pharmacist Recommendation every month. The Director of Nursing will place a copy of the recommendation in a binder for her reference, and then distribute the recommendation to the appropriate physician for review. The Director of Nursing will ensure that each recommendation is completed with the physician response, and or nursing response (if a nursing recommendation) in a timely manner, and that the new orders, if applicable, are being followed through. The monthly Pharmacy Recommendations will be audited at the end of each month by the Nurse Consultant and or the Director of Nursing, to audit for timely completion of each recommendation.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Nurse Consultant and or the Director of Nursing will be responsible to monitor for completion of the audits/observations and will monitor the results of the audits/observations. The Director of Nursing will ensure that 100% compliance is achieved and that the deficient practice does not recur, if further problems or non compliance is noted then</p>	

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F 465 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 functional and safe environment related to gouged walls, chipped floor tile, a stained privacy curtain, and gouged doors throughout the facility. (100 Hall, 200 Hall, 300 Hall)</p> <p>Findings include:</p> <p>During an environmental tour with the Administrator, Housekeeping Supervisor, and Maintenance Supervisor on 4/20/15 at 9:50 a.m. through 10:00 a.m., the following was observed:</p>	F 465	<p>additional education/instruction for staff will be conducted. The Director of Nursing shall report the results of the audits/observations to the Quality Assurance Team monthly. The Quality Assurance team will deem when necessary or appropriate to increase or decrease the rate of the audits/observations and offer further suggestions to ensure 100% compliance is achieved and maintained.</p> <p>What date the Systematic changes will be completed. May, 20th 2015</p> <p>What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Room 101B- Area behind bed was repaired and repainted. Room 108B- The privacy curtain was removed and laundered. The chipped tile area on the floor was repaired. The bathroom door was repaired correcting gouged areas. Room 205A- The bathroom door was repaired correcting gouged areas. Room 206B- The bathroom door was repaired correcting gouged areas. Room 301B- The bedside dresser was replaced.</p> <p>How other residents having the</p>	05/20/2015

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	<p>1. 100 Hall</p> <p>a. Room 101B: The wall behind the head of the bed was gouged. The wall on the side of the bed was marred and gouged. Two residents resided in the room.</p> <p>b. Room 108B: The privacy curtain had multiple large pink stains on it. The floor tile near the room entrance was chipped and missing a small piece. The inside bottom of the bathroom door was gouged. Two residents resided in the room.</p> <p>2. 200 Hall</p> <p>a. Room 205A: The inside bottom of the bathroom door was gouged. One resident resided in the room.</p> <p>b. Room 206B: The inside bottom of the bathroom door was gouged. One resident resided in the room.</p> <p>3. 300 Hall</p> <p>a. Room 301B: The top of the bedside dresser was marred. One resident resided in the room.</p> <p>Interview with the Administrator at the time of the tour indicated all above areas</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</p> <p>The Maintenance Director and the Administrator completed facility rounds identifying other affected areas. Affected areas have been repaired and/or replaced.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>The Maintenance Director was re-educated on the need for routine repairs. Maintenance Director will complete monthly environmental rounds correcting areas and bringing areas of concern forward at the monthly Quality Assurance meetings.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance Director was re-educated on the need for routine repairs. Maintenance Director will complete monthly environmental rounds correcting areas and bringing areas of concern forward at monthly Quality Assurance meetings. This monitoring will be ongoing for continued compliance.</p> <p>What date the systematic changes will be completed.</p> <p>May 20th, 2015</p>		

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	were in need of repair. 3.1-19(f)				