

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2016
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NAME OF PROVIDER OR SUPPLIER LINDBERG CROSSING SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: February 9, 10, 11, 12, 15, 16, 2016</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 8 Medicaid: 31 Other: 6 Total: 45</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on February 19, 2016.</p>	F 0000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a physician was notified about the possible need to alter care or treatment regarding insulin refusal for 1 of 5 residents reviewed regarding drug regimen. (Resident #6)</p>	F 0157	<p>F157</p> <p>1. Resident#6 did not experience any negative outcomes. Resident #6 physician was notified immediately of refusals. LPN #1 was re-educated on the "Notification of Change" policy. Licensed nursing staff were re-educated on the</p>	03/17/2016

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	<p>Findings include:</p> <p>Resident #6's clinical record was reviewed on 2/15/16 at 8:28 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, coronary artery disease, insomnia, and depression.</p> <p>The resident had current physician orders for Humalog insulin 100 units/ml inject 14 units subcutaneous with meals. Humalog insulin sliding scale coverage was to be given before meals and at bedtime for blood sugars as follows: "201 to 250 give 6 units, 251 to 300 give 8 units, 301 to 400 give 10 units, and 401 to 500 give 12 units. Call the physician for blood sugars below 70 or above 500."</p> <p>Review of the Medication Administration Record [MAR] for December, 2015, indicated the resident refused her 14 units of Humalog insulin before each meal on 12/5, 12/6, 12/7, 12/8, 12/9, 12/12, 12/13, 12/16, 12/17, 12/25, 12/29, 12/30 and 12/31/15. The resident refused her routine Humalog insulin 13 days in December. The clinical record lacked an indication of the physician being notified of the refusals of the routine Humalog insulin.</p> <p>Review of the January, 2016, MAR</p>		<p>"Notification of Change" policy including but not limited to notification of physician of refused insulin coverage.</p> <p>2. All residents receiving insulin could be affected. Licensed nursing staff were Re-educated on the "Notification of Change" policy including but not limited to notification of physician of refused insulin coverage. Review of residents receiving insulin records were reviewed to assure physician notification of refusals.</p> <p>3. The facility's policy on Notification of Change was reviewed and no changes are indicated at this time. Licensed nursing staff were re-educated on the policy with a special focus on refusals of insulin. A QA form has been initiated.</p> <p>4. The DON or her designee will monitor resident Blood Glucose Monitoring forms daily on scheduled work days x 1 month then 3 x weekly thereafter to assure any refused insulin coverage was reported to physician. Should concerns be noted, immediate corrective action will be taken. The findings of the monitoring and any corrective actions will be reviewed in the facility's QA meetings on an ongoing basis for a minimum of six months and revision made to the plan, if warranted.</p> <p>5.3-17-16</p>		

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	<p>indicated Resident #6 refused her routine Humalog insulin 14 units before each meal on January 1, 2, 3, 4, 5, 6, 7, 8, 12, 15, 16, 17, 18, 19, 20, 22, 30, and 31, 2016. The resident refused her routine Humalog insulin 18 days without an indication of the physician being notified in the clinical record.</p> <p>Review of the February, 2016, MAR indicated the resident refused her routine Humalog insulin 14 units before each meal on 2/7, 2/8, 2/9, 2/10, 2/11, 2/12, and 2/13/16. The back of the MAR indicated the physician was notified on 2/10/16 of the refusal of Humalog insulin.</p> <p>Review of the 1/22/16, Physician Progress Note indicated Hgb A1C [test to monitor blood sugar] was 7.5 and indicated average control of blood sugar.</p> <p>During a 2/15/16 at 1:41 p.m., interview with LPN #1, she indicated she had left a message on 2/10/16 for the physician related the resident refusing her Humalog insulin. She indicated she had not contacted him about it previously. She indicated the physician should have been notified when a resident refused 3 doses of medication.</p> <p>During an interview with the Director of</p>			

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	<p>Nursing on 2/16/16 at 8:28 a.m., she indicated the resident liked her blood sugars to be in the 200 range. She indicated the resident would ask how much insulin was in the syringe and would only allow the nurses to administer her Humalog insulin coverage if her blood sugars were not real high.</p> <p>During an interview with the Social Services Designee on 2/16/16 at 10:05 a.m., she indicated she had received behavior reports related to Resident #6 refusing her insulin and it was discussed at the morning meetings. She indicated she would always ask nursing if the physician had been notified.</p> <p>The 10/14, "Notification of Change" policy was provided by the Director of Nursing on 2/15/16 at 1:37 p.m. The purpose of the policy was to keep the resident, legal representative (or interested family member), and physician (when applicable) aware of changes which directly affected the care and welfare of the resident. The policy indicated the following: "Facility personnel shall immediately inform resident, consult with resident's physician; and, if known, notify the resident's legal representative or an interested family member when there is:...a need to alter treatment significantly</p>			

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F 0282 SS=D Bldg. 00	<p>(i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)...."</p> <p>3.15(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure a physician's order regarding reduced potassium rich foods for a resident, who received dialysis services, was followed for 1 of 1 resident reviewed for dialysis related care and treatment (Resident #39).</p> <p>Findings Include:</p> <p>Resident #39's clinical record was reviewed on 2/12/2016 at 8:59 a.m. Resident #39's current diagnosis included, but were not limited to, end stage renal disease, diabetes mellitus and depression. Resident #39 had a current physician's diet order for "Regular, NAS [no added salt], LCS [low concentrated</p>	F 0282	<p>F282</p> <p>1.Resident #39 did not experience any negativeoutcomes. The Food Service Supervisor and RN #2 were re-educated concerningphysician ordered diets, and resident alternative food selections according todiet. Resident's physician notified and new order was received.</p> <p>2.All residents with physician ordered therapeuticdiets records were reviewed to assure therapeutic diet order and tray card arecorrect and appropriate.</p> <p>3.Dietary and nursing staff were re-educated onfollowing physician ordered therapeutic diet orders to assure alternativesubstitutes are appropriate. The Food Service Supervisor will monitor meals</p>	03/17/2016

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	<p>sweets], with thick liquids...no OJ [orange juice], no banana, no tomato products." This order was included on the signed,1/28/16, recapitulation of physician's orders. The order for this diet originated 8/5/15. Resident #39 had a current, 8/5/15, physician's order for "Dialysis every Tuesday, Thursday, and Saturday @ [dialysis center name]."</p> <p>Resident #39 had a 9/28/15, Dialysis Registered Dietitian note which indicated the following: "Below are the results of specific nutritional lab results for [Resident #39] returned from the lab which was drawn on 9/22 [2015]. ...Potassium 6.6 (Goal is 3.5-6.0 mg/dL; when potassium levels are outside the normal range, there is an increased risk of cardiac arrhythmia). As this patient's potassium is above goal, please assist by limiting patient's intake of foods higher in potassium, including potatoes, tomatoes, banana, milk, beans, cantaloupe, honeydew and orange juice."</p> <p>During a lunch observation on 2/12/16 at 11:56 a.m., Resident #39 indicated she did not know what she was getting for lunch. Resident #39 was served a meal of sausage pizza, which had tomato sauce, butter beans and a cheese cake square. The tray instruction card which accompanied Resident #39's meal did not</p>		<p>andtray cards to assure correct therapeutic diets are followed, and alternative substitutes are appropriate. A QAmonitoring tool has been implemented.</p> <p>4.The Food Service Supervisor or designee willcomplete a QA monitoring tool to ensure residents with therapeutic diets traycards are correct and requested substitutes for diet are appropriate.Monitoring will be completed as follows: 5 residents will be reviewed on scheduledwork days 3 times weekly for two weeks, 1 time weekly for two weeks, oncemonthly for two months then quarterly thereafter. Should concerns be noted,immediate corrective action will occur. Results of this monitoring and anycorrective action will be discussed during the facility's QA meetings on anongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p> <p>5.3-17-16</p>				

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	<p>have Resident #39's current diet order. The tray card indicated "limited OJ, banana, tomato products." At this time, RN #2 looked at the meal tray and indicated the pizza did contain a tomato product. RN #2 additionally indicated Resident #39 could have the pizza because the diet card only indicated to "limit" tomato products.</p> <p>During a 2/15/16, 11:19 a.m., interview, the Registered Dietitian indicated there was a difference between a "no orange juice, banana or tomato product diet" or a "diet limiting these food items." She indicated she had explained this conflict with the new Food Services Supervisor.</p> <p>During a 2/15/16, 1:30 p.m., interview, the Food Services Supervisor indicated Resident #39 had not liked the chicken nuggets on her 2/12/16 lunch menu so the Food Services Supervisor had offered her pizza. Resident #39 had accepted the offer of pizza but had not requested pizza herself.</p> <p>Review of a current, 10/2014, facility policy titled "Physician Orders", which was provided by the Director of Nursing on 2/15/16 at 1:37 p.m., indicated the following: "Physician's orders are administered upon the clear, complete and signed order of an individual</p>			

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F 0323 SS=D Bldg. 00	<p>lawfully authorized to prescribe."</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 maintain an environment free of potential accident hazards regarding extension cord use for 2 of 30 resident rooms reviewed for safety. (Room 508 and Room 210). This deficient practice had the potential to affect 2 residents who could reside in the 2 licensed rooms with 1 bed in each room.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Room 508, on 2/10/16 at 11:14 a.m., was observed. A white extension cord, not a power strip, was used to power the resident's fan, nebulizer machine, and the lamp. 2. Room 210 on 2/11/16 at 10:37 a.m., during environmental tour, a white extension cord, not a power strip, was 	F 0323	<p>F323</p> <ol style="list-style-type: none"> 1.The residents in room210 and room 508 were notaffected. The extension cords were removed from these rooms immediately. Staff were re-educated concerning use ofextension cords in resident rooms, as well as the policy "Power Strip Use". 2.All resident rooms were monitored to assure nofurther use of extension cords. There were no other extension cords in use. 3.The facility's policy Power Strip Use wasreviewed and no changes are indicated at this time. Staff were re-educatedconcerning the use of extension cords and the "Power Strip Use" policy. A QAmonitoring tool has been implemented. 4.The administrator and or his designee willreview 5 resident rooms on scheduled work days as follows: daily for 2 weeks,weekly for two weeks, monthly for 2 months then 	03/17/2016	

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	<p>plugged into an outlet approximately 10 inches from the ceiling, on the wall beside the closet. The extension cord ran down the wall and was used to power the resident's TV.</p> <p>The environmental tour was conducted on 2/11/16 from 10:35 a.m. to 11:02 a.m., with the Maintenance Assistant, the Administrator, the Housekeeping Supervisor and the Corporate Consultant Nurse. The areas of concern in both resident rooms were brought to the attention of the Administrative Staff.</p> <p>The 2/9/16, "Bed Inventory" form, completed by the Administrator for the survey, indicated the following Rooms 210 and 508 were each licensed for 1 bed. Resulting in the possibility of 2 residents residing in the rooms with identified concerns.</p> <p>Review of the current facility policy, dated 1/2015, titled "POWER STRIP USE", provided by the Administrator on 2/16/16 at 8:59 a.m., included, but was not limited to, the following:</p> <p>"POLICY:</p> <p>This facility shall adhere to K147 - Electrical Requirements</p> <p>1. Power strips shall not be used for</p>		<p>quarterly thereafter to ensure no extension cords are present or in use in resident rooms. Should a concern benoted, immediate corrective action will occur. Results of this monitoring and any corrective action will be discussed during the facility's QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p> <p>5.3-17-16</p>		

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F 0387 SS=D Bldg. 00	<p>items other than computers, TVs, and other electronic equipment for which they were designed.</p> <p>2. Unacceptable devices include high current draw devices/appliances, such as hair dryers, refrigerators, microwaves, coffee pots, air conditioner, and medical equipment and shall not be plugged into power strips.</p> <p>3. Should power strips be observed inappropriately in use, immediate intervention shall be implemented. Applicable staff, resident(s) and family member(s)/legal representative(s) shall be addressed and re-educated as to appropriate use upon discovery."</p> <p>3.1-19(b) 3.1-19(c)</p> <p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on record review and interview,</p>	F 0387	F387	03/17/2016

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	<p>the facility failed to develop and implement a system to ensure timely physician visits for 2 of 22 residents reviewed for timely physician visits. (Resident #'s 6 and 30)</p> <p>Findings include:</p> <p>1. Resident #6's clinical record was reviewed on 2/15/16 at 8:28 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, coronary artery disease, insomnia, and depression.</p> <p>The resident's medications included, but were not limited to, Plavix 75 mg everyday for coronary artery disease, Toprol XL 25 mg everyday for hypertension, Zoloft 50 mg everyday for depression and anxiety and alprazolam 1 mg four times a day for anxiety. The resident had orders for Levemir insulin 60 units twice a day, Humalog insulin 14 units with meals and Humalog insulin per sliding scale before meals and at bedtime. The resident had an order for blood sugar checks before meals and at bedtime.</p> <p>Review of the resident's clinical record lacked any indication of a physician visit from 9/5/15 until 1/22/16. The resident had physician progress notes, dated 9/4/15 and 1/22/16. There were 139 days</p>		<p>1. Residents #6 and #22 were not affected. The physician for these residents was contacted regarding the lack of frequency and timeliness of visits and was re-educated on the proper visit schedule. The Medical Director of the facility has also been in contact with the physician concerning the proper visit schedule.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. A record review was completed to assure physician visits are timely. If indicated, physicians were notified and re-educated on the proper frequency and timeliness of visits.</p> <p>3. The facility's policy on Physician Visits has been reviewed and no changes are indicated at this time. The licensed nursing staff, the medical records designee and DON were re-educated on the policy for physician visits. A QA monitoring form has been initiated</p> <p>4. The medical records designee and or her designee will monitor physician visits daily for 2 weeks then weekly thereafter to assure proper timeliness and frequency. Should concerns be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a</p>	

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	<p>between physician visits.</p> <p>During an interview with LPN #1 on 2/15/16 at 10:05 a.m., she indicated she did not know who was responsible for notifying the physician of when a visit was due.</p> <p>During an interview with the Director of Nursing on 2/16/16 at 8:28 a.m., she indicated the facility normally scheduled doctors visits but [name of Medical Doctor] had his own schedule to come and see his residents and the facility never knew when he would be in.</p> <p>2. Resident #30's clinical record was reviewed on 2/16/16 at 11:35 a.m. Her diagnoses included, but were not limited to, hypertension, Alzheimer's disease, iron deficiency and anemia.</p> <p>The resident's clinical record had physician progress notes dated 7/18/15 and 1/22/16. The resident's clinical record lacked any indication of a physician visit from 7/19/15 until 1/22/16. There were 184 days between physician visits.</p> <p>During an interview with the Director of Nursing at the time of the chart review on 2/16/16 at 11:35 a.m., she indicated the physician had made a visit in September,</p>		<p>minimum of six months. 5.3-17-16</p>	

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	<p>2015. She indicated [name of Medical Doctor] had only Resident #30 and Resident #6 as patients in the facility and had seen them both in September, 2015. Copies of the physician progress notes or signed orders for the September visit were requested at that time.</p> <p>Copies of the July, 2015, and January, 2016, physician progress notes were provided by the Assistant Director of Nursing on 2/16/16 at 11:45 a.m. No information was provided related to a physician visit for September, 2015.</p> <p>The 1/15, "Physician Visits" policy was provided by the Director of Nursing on 2/16/16 at 10:57 a.m. The policy indicated the following: "This facility shall monitor physician visits to ensure regulatory compliance with the following requirements: - The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Note* A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required...the facility may request the Medical Director to intercede and visit the resident in an effort to meet regulatory requirements...."</p> <p>No additional information was provided at time of exit on 2/16/16 at 11:58 a.m.</p>			

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F 0441 SS=D Bldg. 00	<p>3.1-22(d)(1)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by</p>			

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	<p>accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to follow infection control practices to prevent the possible spread of infection regarding staff kneeling on a visibly soiled floor for 2 of 2 observations of foot care and 1 of 2 staff observed during foot care. (Resident #40 and LPN #1)</p> <p>Findings include:</p> <p>1. During an observation on 2/9/16 at 2:24 p.m., LPN #1 placed both knees on the visibly soiled floor in front of Resident #40's right foot without having placed a barrier on the floor. While LPN #1 knelt on the floor, she removed Resident #40's wet protective boot.</p> <p>2. During an observation on 2/9/16 at 3:27 p.m., LPN #1 placed both knees on the floor of the main dining room in front of Resident #40's right foot without having placed a barrier on the floor. While LPN #1 knelt on the floor, she applied a dry protective boot. LPN #1 was wearing the same uniform she was wearing during the 2:24 p.m. observation.</p>	F 0441	<p>F441</p> <p>1. Resident #40 was not affected by this alleged deficient practice. LPN #1 was re-educated on the use of a barrier on the floor if kneeling on the floor for resident care.</p> <p>2. All residents have the potential to be affected. All staff has been re-educated on infection control including but not limited to placing a barrier on the floor if kneeling for resident care.</p> <p>3. The facility policy for infection control, Standard Precautions was reviewed and no changes are indicated at this time. All staff has been re-educated on infection control including but not limited to placing a barrier on the floor if kneeling for resident care. A QA monitoring tool has been initiated.</p> <p>4. The DON and or her designee will monitor resident care 3 times per week x 1 month, weekly x 1 month, then monthly thereafter to ensure proper barrier on floor if kneeling on floor for resident care. Should concerns be noted, immediate corrective action will be taken. Results of the monitoring and any corrective actions will be discussed at the facility's QA meetings on an ongoing basis for a minimum of</p>	03/17/2016			

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F 0463 SS=D Bldg. 00	<p>During an interview on 2/15/16 at 2:55 p.m., LPN #1 indicated she should have placed a barrier on the floor before she knelt on the floor.</p> <p>During an interview on 2/16/16 at 9:11 a.m., RN #7 indicated a barrier must be placed on the floor before kneeling on the floor for resident care.</p> <p>Review of the current facility policy, dated 10/2015, titled "STANDARD PRECAUTIONS", provided by the Director of Nursing on 2/16/16 at 10:57 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Standard Precautions are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is delivered. These practices are designed to both protect health care workers and prevent health care workers from spreading infections among residents...."</p> <p>3.1-18(a)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p>		<p>six months ant theplan adjusted if indicated 5.3-17-16</p>		

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	<p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation, interview and record review, the facility failed to ensure call systems functioned properly for 2 of 30 residents rooms reviewed to have functioning call lights (Room # 214 and Room # 616). This deficient practice had the potential to affect 2 of 30 residents reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Room 214, on 2/10/16 at 10:44 a.m., the call system review and observation was completed. Neither the light over the room door or at the nurses station illuminated nor did the system sound when the call button that was attached to the resident's recliner was pushed. Room 616, on 2/9/16 at 11:26 a.m., the call system observation was completed. Neither the light over the room door or at the nurses station illuminated nor did the system sound when the call button that was attached to the resident's couch was pushed. <p>During an interview on 2/10/16 at 8:10 a.m., the Director of Nursing and the RN Consultant indicated each resident room was checked yesterday [2/9/16] to ensure</p>	F 0463	<p>F463</p> <ol style="list-style-type: none"> Residents in rooms 214 and 216 were not affected. Call light system was fixed immediately. All residents have the potential to be affected. The call light system was serviced immediately and is functioning properly. Staff has been re-educated to promptly notify maintenance and the administrator of nonfunctioning call lights, and a temporary call system will be put into place until system is serviced. (Call bell) The facility's policy Call Light Use was reviewed and no changes are indicated at this time. Staff has been re-educated to promptly notify maintenance and the administrator of nonfunctioning call lights, and a temporary call system will be put into place until system is serviced. (Call bell) A QA monitoring tool has been implemented. The administrator and or his designee will review 5 resident rooms on scheduled work days as follows: daily for 2 weeks, weekly for two weeks, monthly for 2 months then quarterly thereafter to ensure call light are functioning properly. Should a concern be noted, immediate corrective action will occur. Results of this monitoring 	03/17/2016			

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	<p>all facility call lights were functioning. If a new resident was to be admitted into the facility, the call light system would be checked before placing a resident in the room. The Director of Nursing indicated the audit of call lights had been performed every two hours continuously last night.</p> <p>During an interview on 2/16/16 at 10:12 a.m., the Administrator indicated the call system had been serviced and was functioning correctly.</p> <p>The 2/9/16, "Bed Inventory" form, completed by the Administrator indicated the Rooms 214 and 616 were each licensed for 1 bed. Resulting in the possibility of 2 resident residing in the rooms with identified concerns. Review of the current facility policy, dated 10/2014, titled "CALL LIGHT", provided by the Administrator on 2/16/16 at 8:59 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Resident will have a call light to summon facility personnel to ensure the resident's needs will be met...</p> <p>...7. If call light is defective, report to maintenance. 8. Call lights must remain functional..."</p>		<p>and any corrective action will be discussed during the facility's QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated. 5.3-17-16</p>				

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F 0465 SS=F Bldg. 00	<p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure clean and well maintained common areas and resident rooms for 14 of 30 residents reviewed, the common areas in the 500 and 600 hallways and the main dining rooms. This deficient practice had the potential to affect 45 residents who could reside in the 45 licensed beds. (104, 113, 203, 206, 208, 210, 211, 214, 501, 502, 505, 506, 507, 508, 515, 615)</p> <p>Findings include:</p> <p>The following observations of resident rooms were made during the following dates and times:</p> <p>1. Room 104 was observed on 2/10/16 at 9:18 a.m. The entrance wall had an opening measuring approximately 3 inches by 5 inches and was 1 foot up from the floor and 1 inch over from the door. The area had a metal square inset with a receptacle in the center. The area had no cover. The sliding closet door</p>	F 0465	<p>F465</p> <p>1.No residents were affected by the alleged deficient practice. Room 104: the opening in the entrance hall was covered. The sliding closet door was repaired. The bathroom was deep cleaned and the urine odor was eliminated. The standing floor stand was cleaned. The over bed table was replaced and the missing cove base was replaced. Room 113: the gashes in the wall were repaired and repainted. Room 203: The closet door was repaired. The scuff marks and missing paint were repaired and repainted. The missing cove base was replaced. Room 206: The floor tiles in the bathroom were replaced. Room 208: The closet door was repaired; the water spots on the ceiling were repaired and repainted. Room 210: The room was deep cleaned; the gouged and scuffed walls were repaired and repainted. Room 211: The cove base was replaced and the scuff marks were repaired and repainted. Room 214: The sink and the wall behind the toilet were cleaned. The metal</p>	03/17/2016	

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	<p>was off the hinges. The bathroom had a strong smell of urine when entering the bathroom. The toilet had a yellow colored liquid remaining in the bowl. The standing floor fan had visible dust build up on the inside blades. The metal leg of the over-the-bed table had rust color spots covering approximately the lower two thirds of the table leg. The cove base approximately 3 inches next to the closet was missing.</p> <p>2. Room 113 was observed on 2/9/16 at 2:27 p.m. The wall beside the resident bed had deep gashes 6 inches long by 8 to 12 inches in width.</p> <p>3. Room 203 was observed on 2/10/16 at 1:23 p.m. The sliding closet door was off the hinges. The corner cove base in the bathroom was scrapped with paint missing. The lower part of the bathroom wall had dark scuff marks. The bathroom wall had an area of missing paint approximately the size of a quarter next to the call light pull cord.</p> <p>4. Room 206 was observed on 2/10/16 at 9:24 a.m. The tile floor in the bathroom was discolored in front of the sink and toilet.</p> <p>5. Room 208 was observed on 2/9/16 at 11:47 a.m. The sliding closet door was</p>		<p>plate was replaced and the metalbracket behind the bed was removed. The water spots on the ceiling wererepaired and repainted. Room 501 the corner molding was replaced and thechipped wall was repaired and repainted. Room 502: The toilet paper holder wasreplaced. Room 505: The closet door was repaired. Room 506: the closet door wasrepaired and the clothing on the closet floor was laundered. Room 507: Thebrown stain on the floor around the toilet base was cleaned. Room 508: thecloset door was repaired. Room 515: The bed frame, floor and over the bedtables were cleaned. Room 615: The closet door was repaired. The scraped andgouged walls were repaired and repainted. The floor fan was cleaned. Thecaulking around the sink was repaired and the toilet bolts were covered. Thefloors were cleaned. The Common areas of the building: The Hoyer lift wascleaned. The window frames in the main dining room were repaired and repainted.The exit door in the dining room was repaired and repainted. The gauges in theopening between the dining room and hall have been repaired and repainted. Thecart in the dining room was cleaned and removed from the dining room duringmeal times. The pantry door wasimmediately locked, the scuff marks beside the refrigerator was repaired</p>	

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	<p>off the hinges. The ceiling in the resident's room had 4 water spots the size of quarters located in front of the closet.</p> <p>6. Room 210 was observed on 2/9/16 at 2:37 p.m. The wall above the resident's head board had gouges in the plaster approximately 8 inches by 5 inches. There was plaster debris on the floor under the resident's head board. The area behind the resident's recliner had food and dust build up. The bathroom walls and doorframe were scuffed and missing paint.</p> <p>7. Room 211 was observed on 2/10/16 at 2:29 p.m. The bathroom wall had the paint scuffed. The cove base had a dark purple area approximately 9 inches long. The Maintenance Assistant indicated that it could have been the glue seeping through the cove base.</p> <p>8. Room 214 was observed on 2/10/16 at 10:27 a.m. The sink in the resident's bathroom had debris on it behind the faucet. The metal plate, used to cover the hole in the wall where the water pipes entered the bathroom and attached to the toilet, was not attached to the wall with an area approximately the size of an orange open. The wall directly behind the toilet tank had a toilet paper wrapper stuck to the wall. The Maintenance</p>		<p>andrepainted, and the pantry was cleaned. The kitchen door was immediately locked. The 500 hall floor was cleaned immediately. The new carpet to be laid per scheduled remodel. The new Housekeeping supervisor has been re-educated on the Quality inspection log, deep clean calendar, Resident room cleaning daily policy, Room Cleaning policy, and the Quality Inspection policy.</p> <p>2. All residents have the potential to be affected. All resident rooms and common areas were checked to ensure: urine odors are eliminated, any openings in walls are covered, sliding closet doors are on correctly, standing floor fans are clean, over bed tables are clean and free of rust, cove base is intact, walls are free of gouges and scuff marks and missing paint, floors in bathrooms are not stained or dirty, there are no water spots on the ceilings, caulking on sinks is intact, toilet bolts are covered, there are no brackets hanging without a use, corner molding is intact to closet doors, doors to pantry and kitchen remain locked and rooms are clean.</p> <p>3. Staff has been educated on providing a clean, odor free environment that is in good repair. A QA monitoring tool has been implemented.</p> <p>4. The Administrator or designee will monitor resident</p>				

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	<p>Assistant indicated the wall may get wet when staff or residents reach for the paper towel from the paper towel holder directly above the toilet tank. Then the new rolls of toilet paper may get stuck to the wet surface. The wall directly above the resident's head board had a metal bracket approximately 9 inches in length attached to the wall. The bracket had no apparent use. The ceiling in the center of the resident's room had a water mark approximately 3 feet long by 3 inches wide.</p> <p>9. Room 501 was observed on 2/10/16 at 9:51 a.m. The corner molding on the entrance wall of the resident's room was chipped and missing paint.</p> <p>10. Room 502 was observed on 2/10/16 at 2:49 p.m. The toilet paper holder in the resident's bathroom was missing the bar to attach a roll of toilet paper to the holder. There were 2 rolls of toilet paper sitting on the toilet tank.</p> <p>11. Room 505 was observed on 2/10/16 at 8:45 a.m. The closet door was not attached to the closet. It was in the resident bathroom leaning against the wall next to the toilet.</p> <p>12. Room 506 was observed on 2/9/16 at 11:13 a.m. The resident's closet door</p>		<p>rooms and common areas on a daily basis on scheduled days of work to ensure urine odors are eliminated, any openings in walls are covered, sliding closet doors are on correctly, standing floor fans are clean, over bed tables are clean and free of rust, cove base is intact, walls are free of gashes gouges and scuff marks and missing paint, floors in bathrooms are not stained or dirty, there are no water spots on the ceilings, caulking on sinks is intact, toilet bolts are covered, there are no brackets hanging without a use, corner molding is intact to closet doors, doors to pantry and kitchen remain locked and rooms are clean. Should concerns be noted, immediate corrective action will be taken. Results of the monitoring and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p> <p>5.3-17-16</p>	

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	<p>was off the tracks and leaning into the residents closet. There were clothing visible and lying on floor of resident's closet.</p> <p>13. Room 507 was observed on 2/10/16 at 2:57 p.m. The resident's bathroom had a brown stain on the floor around the toilet base.</p> <p>14. Room 508 was observed on 2/10/16 at 11:13 a.m. The closet door was not attached to the closet.</p> <p>15. Room 515 was observed on 2/10/16 at 9:16 a.m. The resident's bed frame under the bed had heavy dust build up. The floor had bright yellow spots approximately the size of golf balls at the foot of the resident's bed. There were 3 over-the-bed tables with dried liquid on the legs.</p> <p>16. Room 615 was observed on 2/9/16 at 2:50 p.m. The sliding closet door was off the hinges. The wall below the window had been scraped. The wall around the window had missing paint the entire length of the window approximately 2 feet up from the floor. The corner of the closet near the bathroom door had a large gouge with missing paint approximately 10 inches in length. The standing floor fan had visible</p>			

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	<p>dust build up on the inside blades. The bathroom sink was missing caulking where the sink attached to the wall. The toilet bolts, that attach the toilet to the floor, were not covered. The floor between the resident's bed and the wall had crumbs of food with 3 cookie and 4 cracker wrappers.</p> <p>The 2/9/16, "Bed Inventory" form, completed by the Administrator, indicated the following: Rooms 104, 113, 203, 206, 208, 210, 211, 214, 501, 508, 515 and 615 were each licensed for 1 bed. Rooms 502, 505, 506, and 507 were each licensed for 2 beds. Resulting in the possibility of 20 residents residing in the rooms with identified concerns.</p> <p>17. The following common areas were observed during the initial tour on 2/9/16 at 9:45 a.m.:</p> <p>The hoier lift sitting in the 200 hall next to Room 206, had dust build up and debris on the legs, strings of hair and dust around wheels.</p> <p>All four window frames in the main dining room had scuff marks and missing paint.</p> <p>The bottom of the exit door in the main dining room was rusty, and the door</p>			

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	<p>frame was gouged and rusty.</p> <p>The opening between the dining room and the hall had 3 gouges approximately the size of golf balls, with missing paint.</p> <p>During the lunch observation, on 2/9/16, sixteen residents were observed eating in the main dining room.</p> <p>A cart in the dining room had uneaten food and a spoon on a plate lying on the top shelf of the cart. Resident #1 was observed removing the soiled spoon from the plate and took the spoon to his table where he had a coffee cup sitting. The cart had dried food and debris on the legs and wheels of the cart. Multiple residents were observed traveling freely throughout the area.</p> <p>The door of the pantry, located across from the back hall nurses station, was not locked. The pantry wall had scuff marks beside the refrigerator, the pantry counter had a clear liquid spill on it approximately the size of a dinner plate next to the sink.</p> <p>The entry door to the kitchen from the hall across from the main dining room was not locked.</p> <p>During an observation on 2/9/16 at 10:55</p>			

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	<p>a.m., the 500 hall floor had no carpet or tile. The dust and debris on the floor was tracked into residents' rooms. The hall was observed to have the same debris and dust build up on 2/9/16 at 12:15 p.m., 2:30 p.m. and on 2/10/16 at 9:00 a.m., 10:43 a.m., and 1:05 p.m. Multiple residents were observed traveling freely throughout the area.</p> <p>18. The environmental tour was conducted on 2/11/16 from 10:35 a.m. to 11:02 a.m., with the Maintenance Assistant, the Administrator, the Housekeeping Supervisor and the Corporate Consultant. The areas of concern in both resident rooms and common areas were brought to the attention of the Administrative Staff.</p> <p>During record review on 2/15/16 at 1:21 p.m., the, undated "QUALITY INSPECTION" log, the undated "DEEP CLEAN CALENDAR", and the undated "PROJECT CALENDAR" was provided by the Administrator. The logs were not completed for the months of January or February, 2016.</p> <p>During an interview on 2/9/16 at 9:55 a.m., LPN #1 indicated staff/residents should not be able to enter the pantry without using the key pad to unlock the door.</p>			

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	<p>During an interview on 2/9/16 at 10:00 a.m., Dietary Staff #8 indicated staff/residents should not be able to enter the kitchen.</p> <p>During an interview on 2/15/16 at 1:27 p.m., the Administrator indicated he had no documentation of deep cleaning, quality inspections or project reports being completed. He indicated he had recently hired a Housekeeping Supervisor, and was in the process of hiring a Maintenance Supervisor. He indicated the 100 and 200 hall renovations had been completed.</p> <p>The "Facility Census" form was completed by the Administrator on 2/9/16 and indicated 45 residents resided in the facility.</p> <p>Review of the current undated facility policy, titled "RESIDENT ROOM CLEANING, DAILY ", provided by the Administrator on 2/15/16 at 2:07 p.m., included, but was not limited to, the following:</p> <p>"POLICY:...The resident's room is that resident's home: it is to be treated and cleaned as such. Using Infection Control procedures is the goal of an effective room cleaning technique...</p>			

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	<p>...PROCEDURE:...</p> <p>...Do a quick straighten up Complete the following 5-Step cleaning method: Empty trash: get the trash out of all the rooms first, proceed to wipe the basket, if necessary, replace the liner Horizontal dusting: with a cloth and disinfectant, wipe all horizontal (flat) surfaces Dust mop the floor: use the dust mop to gather all trash and debris on the floor, sweep to the door and pick up with a dust pain Damp mop the floor: with [name of cleaner], damp mop the floor working from the back corner to the door...."</p> <p>Review of the current undated facility policy, titled "ROOM CLEANING", provided by the Administrator on 2/15/16 at 2:07 p.m., included, but was not limited to, the following:</p> <p>"POLICY: Completing a Room Cleaning ensures that every bed, closet and drawer is disinfected. A Room Cleaning must be completed at least once a month...."</p> <p>...PROCEDURE: Set up a calendar outlining what rooms are to be cleaned on which days</p>			
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	<p>Coordinate with the Charge Nurse on duty at the start of each shift to have the room ready</p> <p>If the room is not ready, the Housekeeping Supervisor must make an adjustment to have the room clean sometime during the day</p> <p>CNAs should strip the beds and empty closets and drawers</p> <p>Complete the 5-Step method</p> <p>Additional work to be completed:</p> <p>Clean and sanitize the mattress, bed frame, springs and rails</p> <p>Clean and sanitize the closet and drawers</p> <p>Coordinate the complete room cleaning with the exterminator's visit"</p> <p>Review of the current undated facility policy, titled "QUALITY INSPECTION", provided by the Administrator on 2/15/16 at 2:07 p.m., included, but was not limited to, the following:</p> <p>"POLICY: The objective of a Quality Inspection provides an opportunity for the Administrator and Housekeeping Supervisor to tour the facility and evaluate the condition of the facility. The Quality Inspection Form provides an overview of the facility's condition as well as a chance to evaluate the Housekeeping Department.</p>			

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F 0514 SS=D Bldg. 00	<p>PROCEDURE:...</p> <p>...2. On a monthly basis the Administrator and Housekeeping Supervisor will complete a walk-through of the facility documenting all comments and concerns (Quality Inspection Form attached). Should a 'Fair' or 'Unacceptable' be noted, through comments with an improvement plan and completed follow-up date must be documented.</p> <p>3. All comments made by the Administrator or Housekeeping Supervisor must be addressed by the follow-up date.</p> <p>4. Quality Inspection Forms are to be signed by both the Administrator and Housekeeping Supervisor".</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>			
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	<p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure meal replacements were documented for 2 of 4 residents reviewed for nutritional risk. (Resident #7 and #3)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #7 was reviewed on 2/15/16 at 9:59 a.m. Diagnoses for Resident #7 included, but were not limited to, diabetes, anemia and hypertension.</p> <p>Review of the meal consumption record indicated "B" equaled "Bites". The meal consumption record also indicated "*If a resident consumes less than 50%, an alternate shall be offered. The amount of the alternate will be recorded."</p> <p>Review of the February, 2016 "MEAL CONSUMPTION RECORD" indicated Resident #7 consumed the following:</p> <p>February 1, 2016, lunch, "B" of the meal was documented, no alternate was documented as having been offered.</p>	F 0514	<p>F514</p> <p>1. Resident #7 and resident #23 were not affected by the incomplete record. C.N.A.'s #10, 11, 12, 13 were re-educated concerning proper documentation for meal consumption not limited to documentation of offering alternative if resident eats less than 50% of meal.</p> <p>2. Residents at nutritional risk could be affected. A record review of all resident meal consumption records was completed to assure residents received an alternative if meal consumption was less than 50%. Nursing staff were re-educated on the policy for documenting on the Meal Consumption Record.</p> <p>3. The facility's policy "Meal Consumption Record" was reviewed and no changes are indicated at this time. The staff were re-educated on documentation of the meals and documenting and reporting alternatives if consumption of a meal is less than 50% to ensure a means to monitor residents daily intake. A QA monitoring tool has been implemented.</p> <p>4. The DON and or her designee will review 10 resident meal</p>	03/17/2016			

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	February 5, 2016, lunch, "B" of the meal was documented, no alternate was documented as having been offered.		consumption records on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, then monthly thereafter to ensure documentation of resident meal intakes and alternatives offered. Should a concern be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated. 5.3-17-16		
	February 6, 2016, lunch, "B" of the meal was documented, no alternate was documented as having been offered.				
	February 7, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.				
	February 9, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.				
	February 10, 2016, lunch, 25% of the meal was documented, no alternate was documented as having been offered.				
	February 11, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.				
	February 12, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.				
	February 13, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.				
	February 14, 2016, lunch, 50% of the				

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	<p>meal was documented, no alternate was documented as having been offered.</p> <p>February 15, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 3, 2016, supper, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 4, 2016, supper, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 7, 2016, supper, 25% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 8, 2016, supper, 25% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 9, 2016, supper, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 11, 2016, supper, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 12, 2016, supper, 50% of the meal was documented, no alternate was documented as having been offered.</p>			

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	<p>February 13, 2016, supper, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 14, 2016, supper, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>Resident #7 should have been offered an alternate for 20 meals in February, 2016.</p> <p>During an interview on 2/15/16 at 2:23 p.m., CNA #10 indicated she offered Resident #7 alternates if she did not eat 50% of her meals. She indicated she forget to document the alternatives. CNA #10 indicated she fed Resident #7 two ice creams routinely when the resident did not eat much of her meal.</p> <p>2. The clinical record for #23 was reviewed on 2/15/16 at 1:08 p.m. Diagnoses for Resident #23 included, but were not limited to, diabetes, congestive heart failure, and hypertension.</p> <p>Review of the meal consumption record indicated "B" equaled "Bites". The meal consumption record also indicated "*If a resident consumes less than 50%, an alternate shall be offered. The amount of the alternate will be recorded."</p>			

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	<p>Review of the February, 2016 "MEAL CONSUMPTION RECORD" indicated Resident #23 consumed the following:</p> <p>February 3, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 5, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 6, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 9, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 12, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>February 14, 2016, lunch, 50% of the meal was documented, no alternate was documented as having been offered.</p> <p>Resident #23 should have been offered an alternate for 6 meals in February, 2016.</p> <p>During an interview on 2/15/16 at 1:16 p.m., the Director of Nursing indicated there was no other place to document an</p>			

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	<p>alternative offered to a resident except the Meal Consumption Record.</p> <p>During an interview on 2/15/16 at 2:09 p.m., CNA #12 and CNA #13 both indicated, if a resident ate less than 50% of his/her meal, an alternative needed to be offered and documented on the Meal Consumption Record. They also indicated the amount of the alternative the resident ate or drank needed to be documented on the Meal Consumption Record also.</p> <p>During an interview on 2/15/16 at 2:23 p.m., CNA #10 indicated she offered Resident #7 alternates if she did not eat 50% of her meals. She indicated she often forget to document the alternatives on the Meal Consumption Record for Resident #7. CNA #11 indicated she had sometimes forgotten to document alternatives on the Meal Consumption Record for Resident #23. CNA #10 and CNA #11 both indicated an alternative and the percent of an alternative consumed by the resident was to be documented on the Meal Consumption Record.</p> <p>Review of the current facility policy, dated 10/2014, titled "MEAL CONSUMPTION RECORD", provided by the Administrator on 2/15/16 at 2:07</p>			

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	<p>p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To provide a means to monitor the resident's daily intake....</p> <p>...2. Report the following to nurse as appropriate: consumption of less than 50% of meal...."</p> <p>3.1-50(a)(1)</p>				