

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155801	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 31, September 1, 2, 3, and 8, 2015</p> <p>Facility number: 000450 Provider number: 155801 AIM number: 100273890</p> <p>Census bed type: SNF/NF: 50 Total: 50</p> <p>Census payor type: Medicare: 8 Medicaid: 34 Other: 8 Total: 50</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on September 15, 2015.</p>	F 0000		
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the</p>			

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

TITLE

(X6) DATE

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

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	<p>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 notify the physician regarding changes in the resident's condition for 1 of 2 residents who were reviewed for death. (Resident #62)</p>	F 0157	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation	10/06/2015

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	<p>Findings include:</p> <p>The clinical record for Resident #62 was reviewed on 9/1/15 at 1:55 p.m. Resident #62 was admitted on 6/15/15 and had diagnoses including, but not limited to, acute and chronic respiratory failure, edema, urinary retention, pulmonary hypertension, and myocardial infarction. The admission MDS (Minimum Data Set) assessment, dated 6/22/15, indicated Resident #62 had a BIMS (Brief Interview for Mental Status) score of 3 (three) which indicated severe cognitive impairment.</p> <p>A "Daily Skilled Nurses Note," dated 6/18/15, indicated Resident #62's O2 (oxygen) sat (saturation) level was 85 % (percent) on 2 (two) liters per minute (LPM) of O2 on the night shift; 89% on 2 LPM of O2 on the day shift, and 81% on 2 LPM of O2 on the evening shift. The note documented the resident had rales/rhonchi in the lungs on each shift and had apnea during respiration. The note further indicated the resident had shortness of breath upon exertion, at rest, and while lying flat.</p> <p>A "Daily Skilled Nurses Note," dated 6/19/15, indicated Resident #62's O2 saturation level was 85% on 2 LPM of O2 on the night shift, 88% on 2 LPM on</p>		<p>of compliance effective October 6, 2015 to the state findings of the Recertification and State Licensure Survey conducted on August 31, September 1, 2, 3, and 8, 2015.</p> <p>F – 157</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #62 was provided with comfort measures each day during the dates mentioned June 18th through the 24th related to her diagnosis of acute respiratory failure. The resident was a "do not resuscitate" resident who was actively dying during this time period. The physician was aware of the resident's terminal condition and the family's choice for comfort measures only and that a decline in condition was anticipated. The resident was being assessed and monitored each shift as this information was documented on a nursing assessment checklist style form of documentation or in a narrative nurses notes.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that it is the facility policy to assure that residents are reviewed each business day that have had new physician orders or that if the resident has had an unexpected change in condition through the facility Interdisciplinary</i></p>	

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	<p>the day shift, and 86% on 2 LPM of O2 on the evening shift. The note indicated the resident had rales/rhonchi in the lungs on each shift and had only 50 ml (milliliter) of urinary output at 6:00 a.m. The note further indicated the resident had shortness of breath upon exertion, at rest, and while lying flat.</p> <p>A "Daily Skilled Nurses Note," dated 6/20/15, indicated Resident #62 had an O2 saturation of 90% on 2 LPM of O2 on the night shift, 84% on 2 LPM of O2 on the day shift, and 91% on 2 LPM of O2 on the evening shift. The note indicated the resident had diminished clear lung sounds on the night and day shifts and rales/rhonchi in the lungs on the night and day shifts. The note further indicated the resident had shortness of breath upon exertion, at rest, and while lying flat.</p> <p>A "Daily Skilled Nurses Note," dated 6/21/15, Resident #62 did not have an O2 sat level documented on the day shift. The note indicated the resident had diminished clear lung sounds on the night and day shifts and rales/rhonchi in the lungs on the night and day shifts. The note further indicated the resident had shortness of breath upon exertion, at rest, and while lying flat.</p> <p>A "Daily Skilled Nurses Note," dated</p>		<p>Plan of Care Review. Upon this review the team will modify the plan of care as warranted and ensure all notifications are documented in the clinical record.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed its policy on Resident Change of Condition. A mandatory in-service has been provided for all licensed nurses on the facility policy related to resident change of condition. The nurses have been re-instructed on their responsibility for thoroughly assessing and documenting all changes/declines in a resident's condition including the documented notification of the resident's physician.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implemented of a Quality Assurance Tool. This tool will monitor the documentation to ensure that any change/decline in a resident's condition is thoroughly assessed and the findings documented in the clinical record.</i></p> <p>The tool will also monitor to ensure that there is documentation to support that the physician has been notified of the resident's change/decline in condition. This tool will be completed by the Director of Nursing and/or her designee weekly</p>				

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	<p>6/22/15, Resident #62 had an O2 sat level of 84% on 2 LPM of O2 on the night shift, 80% on 2 LPM of O2 on the day shift, and 84% on 2 LPM of O2 on the evening shift. The note indicated the resident's lungs were diminished on each shift and the resident had rales/rhonchi on the night shift. The note further indicated Resident #62 was short of breath upon exertion, at rest, and when lying flat on each shift. The note further indicated Resident #62 had a urinary output of 100 ml at 6:00 a.m.</p> <p>A nurse's note, dated 6/24/15 at 12:03 a.m., indicated the resident was found to be unresponsive. The nurse's note indicated Resident #62 had expired at 12:08 a.m. The nurse's note further indicated the coroner, family, and funeral home were notified.</p> <p>A nurse's note, dated 6/24/15 at 12:35 a.m., indicated the physician was paged. The note indicated the physician returned the call at 1:15 a.m. and was notified Resident #62 had expired and an order was received.</p> <p>The clinical record lacked any documentation of any further assessment or the physician had been notified of the resident's decline.</p>		for fourweeks, then monthly for three months and then quarterly for threequarters. The outcomes will be reviewedat the facility's Quality Assurance meetings to determine if any additionalaction is warranted.	

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F 0241 SS=E Bldg. 00	<p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>2. During an observation on 9/1/15 at 12:20 p.m., Resident #31's lunch tray was delivered to the resident's room and the lid was removed from the plate. Resident #31's head of bed was elevated. Resident #31 was observed to be sleeping with no teeth in her mouth.</p> <p>On 9/1/15 at 12:27 p.m., Resident #31 remained asleep with the food tray across the resident on the overbed table.</p> <p>On 9/1/5 at 12:29 p.m., RN #1 was observed to walk down the hall and look</p>	F 0241	<p>F - 241</p> <p>1). The corrective action taken for those residents foundto be affected by the deficient practice is thatthose residents identified as resident # 53, # 51 and resident # 34 are beingserved their meal trays at the same time.</p> <p>2). The corrective action taken for those residents foundto be affected by the deficient practice is that theresident identified as resident #31 is now receiving staff assistance with eachmeal in a manner and in an environment that maintains or enhances theresident's dignity and respect in full recognition of their individuality. The resident is assisted with each meal in atimely</p>	10/06/2015

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	<p>into the resident's room. No attempt was made to awaken Resident #31.</p> <p>On 9/1/15 at 12:30 p.m., Resident #31's roommate (Resident #14) was observed to have finished eating her lunch. Resident #31 remained asleep with the food across the bed on the overbed table.</p> <p>On 9/1/15 at 12:44 p.m., the DON (Director of Nursing) was observed to ambulate down the hall and looked into the room. Resident #31 remained asleep with no attempt observed to awaken the resident.</p> <p>On 9/1/15 at 12:50 p.m., Resident #31's roommate turned on her call light and the General Manager was observed to enter the room and attempted to wake Resident #31. The General Manager exited the room and Resident #31 remained asleep with the uneaten tray of food on the overbed table.</p> <p>On 9/1/15 at 12:52 p.m., CNA #3 was observed to enter Resident #31's room. CNA #3 woke Resident #31 and began feeding the resident the food. CNA #3</p>		<p>manner to ensure the quality and palatability of the food items.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit of each resident has been conducted to identify the level of assistance that each resident needs during meal service. All residents are now receiving care in the manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. Each table of residents eating in the dining room is being served their meals at the same time before the staff serves the next table.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed its policy on Eating Environment. A mandatory in-service has been provided for all staff on the facility policy related to Eating Environment with specific instructions on the staff responsibility in promoting care for all residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the</i></p>	

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F 0257 SS=E Bldg. 00	<p>indicated to Resident #31 that the food would "probably be cold" but made no attempt to reheat the food for Resident #31.</p> <p>During an interview with the General Manager on 9/3/15 at 1:25 p.m., the General Manager indicated the resident should have been fed sooner and the food should have been reheated.</p> <p>3.1-3(t)</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F 0257	<p>development and implementation of a Quality Assurance tool. This tool will monitor to ensure that residents receives the necessary care and services in a manner and in an environment that maintains or enhances the resident's dignity and respect in full recognition of their individuality. This tool will be completed by the Food Service Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</p> <p>F - 257</p> <p>The corrective action taken for those residents found to be affected by the</p>	10/06/2015

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	<p>maintain comfortable temperatures for 2 of 3 halls where residents reside. The hallway thermostats were set at 70 degrees Fahrenheit. (East Hall, West Hall)</p> <p>Findings include:</p> <p>On 8/31/15 at 11:19, during an anonymous interview, Resident #68 indicated it was sometimes cold in the building.</p> <p>On 9/1/15 at 8:33 a.m., the thermostat on the West Hall was observed to be set at 70 degrees Fahrenheit.</p> <p>On 9/1/15 at 8:34 a.m., the thermostat on the East Hall was observed to be set at 70 degrees Fahrenheit.</p> <p>On 9/2/15 at 7:59 a.m., the thermostat on the East Hall was observed to be set at 70 degrees Fahrenheit.</p> <p>On 9/3/15 at 8:57 a.m., Resident #32 and Resident #33 were observed sitting in the common area covered with a blanket.</p> <p>On 9/3/15 at 11:08 a.m., the Maintenance Employee (ME) #1 was interviewed. ME #1 indicated thermostats are set on 72-73 degrees Fahrenheit. ME #1 was queried regarding the observed 70 degree</p>		<p>deficient practice is that abaseline Quality Assurance tool has been completed as a baseline which supportsthat hallways temperature are being maintained between 71 – 81 degrees Fahrenheit. Some residents such as the residentsidentified as resident # 32 and resident # 33 who were mentioned “to be coveredwith a blanket in the common area of the facility” are naturally cold naturedespite how warm the facility temperature may be and prefer to have the comfortof a blanket. This is their personalpreference which is honored by the facility and care planned for resident # 32and # 33.</p> <p><i>The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that all residents have the potential to be affectedby the alleged deficient practice. Thefacility is maintaining all hallway thermostats in a temperature range of 71 –81 degrees Fahrenheit.</i></p> <p>The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for allstaff on the facility policy related to temperature control in thefacility. The staff has been instructedon the requirement to maintain a temperature range of 71 – 81 degreesFahrenheit. In addition the recording ofhallway temperatures has</p>				

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F 0272 SS=D Bldg. 00	<p>readings and indicated someone could have messed with the thermostat.</p> <p>On 9/8/15 at 8:49 a.m., the Administrator provided the Maintenance/Housekeeping Policy, undated. The policy included, but was not limited to, temperature in the facility should be controlled/maintained in accordance with the regulation.</p> <p>On 9/8/15 at 11:56 a.m., the General Manager and ME #1 indicated the number on the screen of the thermostat was the actual temperature reading of the hallway.</p> <p>3.1-19(h)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;</p>		<p>been added to the Director of Environmental Services daily Monday – Friday environmental rounds checklist to ensure proper temperatures are maintained.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool. This tool will include the monitoring of hallway temperatures as well as interviews of alert and oriented residents on the subject of the facility maintaining comfortable and safe temperature levels.</i></p> <p>This tool will be completed by the Executive Director and/or other designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</p>	

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	<p>Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continenence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to complete an accurate comprehensive assessment for 1 of 3 residents reviewed for dental issues in a total sample of 27 residents who met the criteria. The comprehensive assessment's dental status was incorrectly marked. (Resident #5)</p> <p>Findings include:</p> <p>On 8/31/15 at 2:40 p.m., Resident #5 was observed without teeth.</p>	F 0272	<p>F - 272</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #5 has had their MDS corrected to reflect that the resident is edentulous. This correction was completed during the survey process.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit of all current MDSs has been completed to ensure the accuracy of the assessments. No other discrepancies were identified during this audit.</i></p>	10/06/2015

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	<p>On 9/1/15 at 11:14 a.m., Resident #5's clinical record was reviewed.</p> <p>A dental exam, dated 6/3/15 indicated Resident #5 had been edentulous (without teeth) for more than twenty years.</p> <p>The Annual MDS (Minimum Data Set) Assessment, dated 4/21/15, indicated Resident #5 was not edentulous.</p> <p>The care plan, dated 1/29/15, indicated Resident #5 had no teeth.</p> <p>On 9/2/15 at 10:13 a.m., the MDS (Minimum Data Set) Director indicated Resident #5 had no natural teeth even though the MDS Assessment had not indicated such.</p> <p>On 9/8/15 at 8:49 a.m., the Administrator provided the Electronic Transmission of the MDS Policy, dated 8/21/15. The policy included, but was not limited to, the MDS Coordinator is responsible for ensuring that appropriate edits are made....</p> <p>3.1-31(a)</p>		<p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a one on one in-service has been conducted for the MDS coordinator to reiterate her responsibility for the accuracy of the content of the information entered onto the MDS assessment.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool. This tool will monitor the accuracy of the information on the MDS to ensure that it gives an accurate picture of the resident and their condition. This tool will be completed by the Executive Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</i></p>	

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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 23 residents reviewed for unnecessary medications had not had a gradual dose reduction for an antidepressant and 1 of 23 residents reviewed did not have adequate indications for an antipsychotic medication. (Resident #11 , Resident #43)</p>	F 0329	<p>F – 329</p> <p>1).The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 11 had been reviewed by the consultant pharmacist however the pharmacist had transcribed an erroneous date by mistake. The pharmacist has since reviewed the resident for gradual dose reduction and has submitted a gradual dose reduction request to the resident's</p>	10/06/2015

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	<p>Findings include:</p> <p>1. During an observation on 9/1/15 at 11:10 a.m., Resident #11 was observed to be a wheelchair in her room visiting with a family member. Resident #11 was talking and laughing.</p> <p>The clinical record for Resident #11 was reviewed on 9/2/15 at 8:00 a.m. Resident #11 had diagnoses including, but not limited to, depression, dementia, and anxiety. A quarterly MDS (Minimum Data Set) assessment, dated 5/15/15, indicated Resident #11 had a BIMS (Brief Interview for Mental Status) score of 6 out of 15, which indicated severe cognitive impairment.</p> <p>The recapitulation physician's order, dated 7/1/15 - 7/30/15 and signed on 7/24/15, indicated Resident #11 received Celexa (an antidepressant) 10 (ten) mg (milligram) 1 (one) tablet po (orally) daily, which had initially been started on 2/14/15.</p> <p>A monthly pharmacy review, dated 3/10/15, indicated the Celexa had been started in March, 2015.</p> <p>The behavior tracking record for February, 2015, and March 2015,</p>		<p>physician for consideration.</p> <p>2).The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #43 now has supportive documentation on the behavior tracking record to indicate the need for the use of psychotropic medications.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been conducted on all residents receiving psychotropic medications. Each resident receiving psychotropic medications has documentation to support adequate indications for the use of the medications. Each resident also has documented gradual dose reduction recommendations communicated to their respective physicians along with the physician's response to each recommendation.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed its policy and procedure on gradual dose reduction. A mandatory in-service has been conducted for all licensed nurses and the social service director on the facility policy related to gradual dose reduction. The in-service also includes instruction on the nurses' responsibility in documenting the</p>	

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	<p>indicated Resident #11 had not had any behaviors related to depression.</p> <p>The clinical record lacked documentation of an attempted GDR (gradual dose reduction) for the Celexa.</p> <p>During an interview on 9/2/15 at 1:35 p.m., the DON (Director of Nursing) indicated the pharmacist had reviewed the resident's clinical record every month but had documented the wrong date for the Celexa. The DON indicated the policy of the facility is to attempt GDR yearly and the Celexa should have had a GDR before now.</p> <p>A policy titled, "Drug Regimen Review," dated 3/19/15 and obtained from the Administer on 9/8/15 at 8:49 a.m., indicated medications will be prescribed and monitored consistent with good practice and regulatory requirements.</p> <p>2. On 9/1/2015 at 1:50 p.m., clinical record review indicated that Resident #43 had diagnoses of, but not limited to, dementia with aggressive behaviors, anemia, cancer of colon with colostomy, overactive bladder, MRSA (Methicillin Resistant Staphylococcus Aureus) in a coccyx pressure wound which is unstageable, and a femur fracture</p>		<p>behaviors to justify the medicalnecessary of the psychotropic medication. The purpose of this in-service is toensure their understanding of the policy and their responsibility in thedocumentation related in the use of these medications.</p> <p><i>The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program</i> by the development and implementation of aQuality Assurance tool. This tool willinclude the monitoring of the documentation to ensure that each resident on apsychotropic medication has adequate indications for the use of the medicationand also documentation to support that gradual dose reductions have beenattempted in accordance with the regulations. This tool will be completed by the Social Service and/or her designeeweekly for four weeks, then monthly for three months and then quarterly forthree quarters. The outcomes will bereviewed at the facility's Quality Assurance meetings to determine if anyadditional action is warranted.</p>	

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	<p>5/28/15.</p> <p>On 8/19/15, Resident #43 had a physician's order for Risperdal (an antipsychotic) 0.5 mg (milligrams) at hour of sleep and Buspar (an anti-anxiety medication) 5 milligrams 1 (one) tablet three times a day.</p> <p>The 7/1/15 behavior tracking sheet for July 1, 2015, indicated no behaviors for anxiety, no other dates were filled in. The behavior tracking sheet for August, 2015, indicated the resident had anxious ("help, help") statements for 21 of 31 days.</p> <p>A MDS(Minimum Data Set) assessment, dated 7/11/15 and 3/25/15, indicated Resident # 43 had no behaviors.</p> <p>A MDS assessment, dated 7/25/15, indicated Resident #43 had no potential for psychosis, had unorganized thinking and inattention, and s/s (signs/symptoms) of delirium.</p> <p>A Social Service note, dated 6/2/15, indicated no behaviors. The note indicated on 6/25/15 there were no exit seeking behaviors at this time. An interview with the current Social Worker designee on 9/2/15 at 2 p.m., indicated she had only started working on 8/31/15 and was not familiar with any of the</p>			

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	<p>residents yet.</p> <p>On 7/27/15 at 7:30 p.m., a nurses note indicated Resident #43 was yelling loudly and trying to get out of bed. The note indicated the staff pushed the resident's legs back into bed several times throughout the night. The note indicated Resident #43 had been repositioned several times by staff. At 8 p.m., the resident's physician was notified of the resident's behaviors. A physician order was received to administer Ativan (an antianxiety medication) 0.5 mg x (times) 1 tonight which could be repeated x 1 in 6 hours, obtain a urinalysis with a culture and sensitivity, and obtain a complete metabolic panel, and complete blood count in a.m.</p> <p>On 9/1/15, review of nurses notes indicated from 7/30/15 through 8/20/15, for 23 of 32 days, Resident #43 had episodes of yelling out for hours and calling "help, help." Resident was comforted by repositioning, fluids being given, 1:1 care, including sitting with the resident and holding the hands, saying a prayer, or administering a backrub. If the methods were unsuccessful, Ativan or Tramadol (pain medication) should be administered. The resident had an unstageable pressure area on the coccyx which contained MRSA and was</p>			

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	<p>recovering from a fracture of the femur from a fall on 5/28/15.</p> <p>On 9/1/15 at 9:37 a.m., Resident #43 was observed to be receiving a bath. The resident was pleasant and cooperative.</p> <p>On 9/1/15 at 11:07 a.m., Resident #43 was observed to be having the dressing to the pressure wound changed. The resident was pleasant.</p> <p>On 9/1/15 at 1:39 p.m., Resident #43 was observed to be in a wheelchair in the lounge. No behaviors or yelling were observed.</p> <p>On 9/2/15 at 9:25 a.m., Resident #43 was observed to be in bed sleeping.</p> <p>On 9/2/15 at 11:35 a.m., Resident #43 was observed sitting in a wheelchair in the resident's room. Resident #43 was observed to be working puzzles. No behaviors were observed.</p> <p>On 9/3/15 at 9:30 a.m., Resident #43 was observed in bed asleep.</p> <p>On 9/3/15 at 11:00 a.m., Resident #43 was observed in bed sleeping.</p> <p>A care plan, updated on 8/19/15, indicated the following:</p>			

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	<p>Impaired cognitive function/ dementia: history of alternated mood state impaired thought process history of verbal aggression increased behavioral and agitation, yelling out and anxious body posture</p> <p>Interventions on 7/3/15 included: give choices during activities of daily living and honor her preferences inform of events and assist, give cues and redirection for participation listen for any suspicious/ confused verbalizations and assure as needed listen for any changes in mood or cognition.</p> <p>On 9/3/15 at 8:59 a.m., an interview with the Medical Records staff indicated Resident #43 was placed on Risperdal as the resident had received it in the past.</p> <p>On 9/3/15 at 9:25 a.m., LPN #1 was queried on why the resident had been placed on Risperdal. LPN #1 indicated she thought it was because Resident #43 had received Risperdal in the past. LPN #1 indicated the resident's behaviors were better. LPN #1 further indicated she did not know why the resident had not been placed on an antianxiety medication. LPN #1 indicated that, even though the resident's spouse had recently expired, she did not feel the resident would</p>			

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	<p>benefit from grief counseling as she thought the resident would not be able to comprehend what the counseling was for. LPN #1 further indicated Resident #43's family indicated the resident was not aware of what had happened when at the funeral home for the spouse in mid-August, 2015.</p> <p>On 9/8/15 at 11:50 p.m., the DON (Director of Nursing) indicated Resident #43 had a history of hitting and pinching. The DON indicated the behaviors were not charted on the resident's clinical record. A note, found in nurses notes, indicated the resident had been combative during care on 8/7/15 at 10:30 p.m. The note indicated the resident was throwing pillows and blankets on floor. On 8/30/15 at 9:30 p.m., a nurses note indicated the resident was restless and anxious and , when asked what kind of help was needed, the resident stated not yours, and hit the facility nurse.</p> <p>On 9/8/15 at 9:00 a.m., a policy was received from General Manager titled, "Antipsychotic Medication Use." The policy indicated antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition. The policy further indicated nursing staff would document, in detail, an individual's target symptoms or indicators utilizing</p>			

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F 0371	<p>the Behavior Intervention Monthly Flow Record.</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.35(i)</p>			

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SS=E Bldg. 00	<p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was prepared and served in a sanitary manner for 2 of 2 observations of the kitchen.</p> <p>Findings include:</p> <p>1. On 8/31/15 at 9:04 a.m., the Interim Kitchen Manager was observed in the kitchen without a covering over his facial hair.</p> <p>On 9/2/15 at 11:18 a.m., the Interim Kitchen Manager was observed in the kitchen without a covering over his facial hair.</p> <p>On 9/8/15 at 8:49 a.m., the Administrator provided the Dress Code Policy, dated 3/19/15. The policy included, but was not limited to, all dietary staff as well as all non-dietary staff will wear appropriate hair coverage upon entering the dietary department.</p>	F 0371	<p>F - 371</p> <p>1). The corrective action taken for those residents found to be affected by the deficient practice is that the Interim Kitchen Manager who was observed in the kitchen without covering his facial hair no longer is employed by the facility. All other dietary staff or anyone entering the kitchen is now wearing the appropriate hair coverage to cover their hair and/or any facial hair.</p> <p>2). The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 41 is now being served her meal tray in a sanitary manner in that the cups and dishes are served by the staff by handling the cups and dishes by the side of the containers instead of by the rim or edges of the containers.</p> <p>3). The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 14 is now being served her meal tray in a sanitary manner in that the cups and dishes are being served by the staff</p>	10/06/2015

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	<p>On 9/8/15 at 10:00 a.m., the General Manager and Administrator indicated they were aware the Interim Kitchen Manager had not covered his facial hair and had discussed the issue with the employee.</p> <p>2. During an observation on 8/31/15 at 12:01 p.m., CNA # 4 was observed to obtain a coffee cup from a tray of cups and handle to cup by the edge with her hands prior to placing coffee in it and delivering the tray to Resident #41. After placing the tray onto the overbed table in the resident's room, CNA #4 was observed to handle the dessert cup and lemonade cup by the edge with her hands.</p> <p>3. During an observation on 8/31/15 at 12:26 p.m., Housekeeping #2 was observed to deliver the lunch tray to Resident #14. Housekeeper #2 was observed to moved the drinks (lemonade and coffee) and the dessert by the rims of the containers.</p> <p>During an interview with CNA #1 on 9/2/15 at 7:45 a.m., CNA #1 indicated cups and glasses should be handled by the side of the containers and not around the rim or edges.</p>		<p>by handlingthe cups and dishes by the side of the containers instead of by the rim oredges of the containers.</p> <p><i>The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that all dietary staff with facial hair are nowwearing appropriate hair coverage while working in the kitchen and eachresident's meal tray is served by the staff in a sanitary manner in that thecups and dishes are handled by transferring the containers (cups, glassesand dishes) by the sides of thecontainers instead of by the rim or edge of the containers.</i></p> <p>The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for allstaff related to the acceptable standards and practices in the preparation andserving of meals in a sanitary manner. The staff was instructed on the policy related to appropriate haircoverage while in the dietary department and the proper manner of serving mealtrays by transferring cups, glasses and dishes by the sides of the containersand not by the rims or edges of the containers.</p> <p><i>The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by</i></p>		

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F 0441 SS=D Bldg. 00	<p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p>		<p>development and implementation of a Quality Assurance tool. This tool will monitor to ensure appropriate hair coverage is worn in the dietary department by all staff. The tool will also monitor to ensure that meal trays are served in a sanitary manner in that cups, glasses and dishes are transferred by the sides of the containers and not by the rims or edges. This tool will be completed by the Director of Food Service and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</p>		

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	<p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to provide a sanitary environment to prevent the spread of infections. During resident care glove changes and hand hygiene was not performed following contact with body fluids 3 of 4 residents observed for care. (Resident #19, Resident #14, Resident #31)</p> <p>Findings include:</p> <p>1. On 9/2/15 at 9:29 a.m., CNA #6 and CNA #4 were observed to provide a complete bed bath for Resident #19. At the end of the bed bath, CNA #6 was observed to cleanse Resident #19's buttocks. Feces were observed on the</p>	F 0441	<p>F 441</p> <p>1).The corrective action taken for those residents foundto be affected by the deficient practice is that theresident identified as resident # 19 is now receiving personal care by nursingstaff that is providing a sanitary environment to prevent the spread ofinfection in that proper glove usage and proper hand hygiene are performedfollowing contact with body fluids. Thestaff are sanitizing their hands and changing gloves between soiled and cleantasks in accordance with acceptable standards of infection control practices.</p> <p>2).The corrective action taken for those residents foundto be affected by the deficient practice is that that the resident identified as resident #</p>	10/06/2015			

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	<p>washcloth. CNA #6 was observed to discard the soiled washcloth and obtain a clean washcloth to rinse the resident's back and buttocks. There was no hand hygiene or glove change observed between the two tasks. CNA #6 proceeded to obtain a clean pad and placed it underneath the resident. CNA #6 obtained a clean shirt and placed it on the resident. CNA #6 then removed the dirty top sheet and obtained and placed a clean one. CNA #6 and CNA #4 placed the resident's bed comforter back over the resident. CNA #6 obtained a clean pillow case and placed it on the resident's pillow. CNA #6 then adjusted the resident's head and pillow for comfort. CNA #6 then removed her gloves, disposed of the soiled bath water, and performed hand hygiene. The same gloves were used for clean and soiled activities.</p> <p>On 9/8/15 at 8:49 a.m., Administrator provided the Infection Control Policy, undated. The policy included, but was not limited to, employees must wash their hands for at least 20 seconds....after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin.</p>		<p>14 is now receiving personal care by nursing staff that is providing a sanitary environment to prevent the spread of infection in that proper glove usage and proper hand hygiene are performed following contact with body fluids. The staff are sanitizing their hands and changing gloves between soiled and clean tasks in accordance with acceptable standards of infection control practices.</p> <p>3). The corrective action taken for those residents found to be affected by the deficient practice is that that the resident identified as resident # 31 is now receiving personal care by nursing staff that is providing a sanitary environment to prevent the spread of infection in that proper glove usage and proper hand hygiene are performed following contact with body fluids. The staff are sanitizing their hands and changing gloves between soiled and clean tasks in accordance with acceptable standards of infection control practices.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. All residents are now receiving personal care by staff that is providing a sanitary environment to prevent the spread of infection. All nursing staff is providing personal care in</i></p>				

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	<p>On 9/8/15 at 1:35 p.m., CNA #4 indicated gloves are changed and hand hygiene was performed after each resident contact and after contact with body fluids.</p> <p>2. During an observation on 9/1/15 at 8:47 a.m., CNA #1 and CNA #2 were observed to be providing pericare to Resident #14. Both CNAs were observed to assist with turning Resident #14 onto the left side, CNA #1 was observed to obtain a bottle of periwash from the night stand of Resident #14, spray it onto a dry, clean washcloth, and wash the resident's buttocks. Two (2) clean pads were placed onto the bed of the resident and the wet bed pads were rolled under the resident. Resident #14 was assisted to turn onto the right side and CNA #2 was observed to obtain a clean, dry washcloth and spray periwash onto it and wash the resident's right buttock. The wet bed pads were removed from under the resident and the clean pads were pulled through onto the right side. Both CNAs removed their gloves and discarded them. The CNAs were observed to then provide pericare to Resident #31 who was in the same room as Resident #14. The same gloves were used for clean and soiled activities.</p>		<p>accordance with the facility policies related to glove usage and hand hygiene.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed its policies on Giving a Bed Bath and Infection Control Guidelines. A mandatory in-service has been conducted for all nursing staff on the facility policies related to giving a bed bath and infection control guidelines to ensure their knowledge level with the expected standards of infection control practices. A special focus was placed on proper glove usage between soiled and clean tasks as well as proper hand hygiene.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool. The tool will monitor infection control practices during personal care with a special focus on the proper use of gloves between soiled and clean tasks and proper hand hygiene upon removal of soiled gloves as well as proper hand hygiene between residents. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality</i></p>	

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	<p>3. During an observation on 9/1/15 at 9:02 a.m., CNA #1 was observed to elevate Resident #31's bed and assist with turning the resident to the right side. CNA #1 was observed to obtain a clean, dry washcloth, sprayed periwash onto the dry washcloth and wash Resident #31's perineal area. CNA #2 was observed to assist the resident to turn onto the left side and placed 2 (two) clean bed pads under Resident #31's buttock area. CNA #2 was observed to spray the periwash onto Resident #31's right hip and buttock and dried the areas with a clean, dry washcloth. CNA #1 was observed to remove her gloves and leave the room and obtained a clean top sheet. CNA #2 was observed to remove her gloves and cover the resident with a blanket. Both CNAs were observed to the clean top sheet and blanket over the resident. Both CNAs left the room. The same gloves were used for clean and soiled activities.</p> <p>No hand hygiene was performed by either CNA until after leaving the room</p> <p>During an interview with CNA #1 on 9/3/15 at 7:57 a.m., CNA #1 indicated hand hygiene should be done upon entering and leaving a resident's room, between residents, and when going from dirty to clean areas.</p>		Assurance meetings to determine if any additional action is warranted.	

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F 0465 SS=E Bldg. 00	<p>3.1-18(b)(2) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment. Resident rooms were dirty and had peeling paint. (Room #13, 14, 16, 17, 24, 21)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 8/31/15 at 4:01 p.m., Room #13 was observed to have dirt/debris along the edges and in the corners of the cove base. The same was observed on 9/3/15 at 8:50 a.m. 2. During an observation on 8/31/15 at 2:56 p.m., Room #14 was observed to have dirt/debris along the edges and in the corners of the cove base. The same was observed on 9/3/15 at 8:55 a.m. 3. During an observation on 8/31/15 at 4:56 p.m., Room #16 was observed to 	F 0465	<p>F - 465</p> <ol style="list-style-type: none"> 1). The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 13 has been thoroughly cleaned and is free of dirt/debris along the edges and in the corners of the cove base. 2). The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 14 has been thoroughly cleaned and is free of dirt/debris along the edges and in the corners of the cove base. 3). The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 16 has had the wood board attached to the wall repainted and is now free of chipped paint. The room has been thoroughly cleaned and is free of dirt/debris along the edges and in the corners of the cove base. The free standing closet has been repaired and is free of chipped wood. 	10/06/2015

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	<p>have a wood board attached to the wall with chipped paint and dirt/debris along the edges and in the corners of the base board. A free-standing closet was observed to have the wood chipped off. The same was observed on 9/3/15 at 9:10 a.m.</p> <p>4. During an observation on 8/31/15 at 2:27 p.m., Room #17 was observed to have dirt/debris along the edges and in the corners of the cove base. The floor was sticky at the head of the bed 1 (one) and paper scraps were observed under the bed. A set of wheelchair leg rests were observed to be lying at the head of bed 1. The same was observed on 9/3/15 at 9:15 a.m. except the floor was not sticky.</p> <p>5. During an observation on 8/31/15 at 10:43 a.m., Room #24 was observed to have dirt/debris along the cove base and in the corners of the room. A wooden board along the wall was observed to have chipped paint. The entry room door would not close completely. The same was observed on 9/3/15 at 11:22 a.m.</p> <p>6. On 9/1/15 at 8:42 a.m., Room #21 was observed to have peeling paint on a board attached to the wall, behind bed 1. The same was observed on 9/3/15 at 10:15</p>		<p>4). The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 17 has been thoroughly cleaned and is free of dirt/debris along the edges and in the corners of the cove base. The floor has been mopped and is free of any sticky surface. The floor is free of paper scraps. The wheelchair leg rests are now properly stored in the resident's closet when not in use.</p> <p>5). The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 24 has been thoroughly clean and is free of dirt/debris along the edges and in the corners of the cove base. The wooden board attached to the wall has been re-painted and is free of chipped paint. The entry door has been repaired and now closes completely.</p> <p>6). The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 21 has had the wooden board attached to the wall behind bed # 1 has been re-painted and is now free of peeling paint. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all resident rooms have the potential to be affected by the deficient practice. A housewide</i></p>	

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	<p>a.m.</p> <p>A policy titled, "Maintenance/Housekeeping Policy," undated, indicated the housekeeping cleaning schedule would be followed which included daily cleaning of the resident rooms. The policy indicated each room should be deep-cleaned at least monthly. The policy further indicated floors throughout building were to be cleaned in accordance with the cleaning schedule.</p> <p>3.1-19(f)</p>		<p>audit of all residents' room has been conducted. All resident rooms have been thoroughly cleaned. The rooms are free of dirt/debris along the edges and in the corners of the cove base. All wooden boards attached to the walls are free of chipped and/or peeling paint. The floors have been cleaned and are free of paper scraps and the surfaces are clean and not sticky. All entry doors close completely and all free-standing closets are free of chipped wood.</p> <p>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur is that the facility has reviewed its maintenance and housekeeping policy. A mandatory in-service has been conducted for the maintenance and housekeeping staff to review the facility policy related to the cleanliness of resident rooms to ensure each resident has a safe and sanitary environment. The staff was instructed on their responsibility to ensure the cleanliness and safety of each resident's room.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool. The tool will monitor the cleanliness and safety of resident rooms. A special</i></p>	

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCES SIBLE</p> <p>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> <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 record review and interview,</p>	F 0514	<p>focus has been placed on ensuring the rooms are free of dirt/debris along the edges and in the corners of the covebase and that all wooden boards attached to the walls are free of chipped or peeling paint. The tool will also monitor for the cleanliness of the floors and to ensure that free-standing closets are free of chipped wood. The resident entry doors are also being monitored to ensure that they close completely. This tool will be completed by the Executive Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</p>	10/06/2015

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	<p>the facility failed to document that a care plan for daily active range of motion was being completed for 1 of 3 residents reviewed in a total sample of 30 who met the criteria for ROM (range of motion). (Resident #15)</p> <p>Findings include:</p> <p>On 9/1/15 at 1:22 p.m., a care plan for active range of motion (AROM), dated 7/8/15, was reviewed for Resident # 15. The care plan indicated the resident was to receive AROM daily to bilateral upper and lower extremities. A intervention on the care plan indicated to document minutes and number of repetitions on the flow sheet daily.</p> <p>On 9/2/15 at 2:45 p.m., the restorative documentation folder was reviewed for Resident #15. The following dates lacked documentation that AROM had been performed: August 11, 15, 21, 22, 28, 30, and 31, 2015.</p> <p>On 9/2/15 at 10:46 a.m., CNA #5 (certified nursing assistant), was interviewed. CNA #5 indicated Resident #15 received daily AROM which was documented daily.</p> <p>A policy titled, "Using the Care Plan," dated 4/15/15, and obtained from the</p>		<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 15 now has documentation to support that they are receiving active range of motion daily.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit of all residents receiving restorative nursing programs has been completed. All resident receiving restorative nursing programs have documentation to support that they are receiving their restorative nursing programs in accordance with their current plan of care.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff that provide restorative nursing programs for the residents. The staff has been instructed on their responsibility to document the resident's restorative programs in the clinical record in accordance with their individual plan of care.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of</i></p>	

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	Administrator on 9/8/15 at 3:53 p.m., indicated documentation must be consistent to the resident's care plan. 3.1-50(a)(2)		a QualityAssurance tool. This tool will monitorthedocumentation of restorative programs to ensure that the documentationsupports the residents' plan of care. This tool will be completed by the MDS Coordinator and/or her designee weekly for four weeks, then monthly for three months and then quarterly forthree quarters. The outcomes will bereviewed at the facility's Quality Assurance meetings to determine if anyadditional action is warranted.		