

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2015
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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F000000	<p>This visit is for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: December 30, 31, 2014, January 5, 6, 7, 8, 2015.</p> <p>Provider number: 012966 Provider number: 155803 AIM number: 201110390</p> <p>Survey team: Diana Perry RN TC Anna Villain RN Denise Schwandner RN Diane Hancock RN Barb Fowler RN (January 5, 6, 7, 8 2015) Sylvia Scales RN (December 30, 31 2014)</p> <p>Census bed type: SNF 40 SNF/NF 56 Residential 44 Total 140</p> <p>Census Payor Type: Medicare 29 Medicaid 43 Other 24</p>	F000000	<p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></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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F000279 SS=D	<p>Total 96</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on January 15, 2015 by Jodi Meyer, RN</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to develop a care plan for depressive</p>	F000279	The facility requests paper compliance for this citation.	02/07/2015

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	<p>disorder and/or the use of an anti-depressant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #17)</p> <p>Findings include:</p> <p>On 1/5/15 at 9:29 a.m., Resident #17's clinical record was reviewed. Resident #17's diagnoses included, but were not limited to, depressive disorder.</p> <p>The most recent physician's recapitulation orders, signed 12/18/14, indicated an order for Zoloft (an anti-depressant medication), 50 mg (milligrams), orally, every day, for depressive disorder.</p> <p>The Annual MDS (Minimum Data Set) assessment, dated 11/26/14, indicated Resident #17 had a diagnosis of depressive disorder and received an anti-depressant medication 7 out of 7 days.</p> <p>The plan of care lacked a care plan for diagnosis of depressive disorder or the use of an anti-depressant medication.</p> <p>On 1/5/15 at 2:17 p.m., MR (Medical Records) provided the printed version of Resident #17's plan of care and the December 2014 Medication</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>Resident #17's plan of care was reviewed and updated to include diagnosis of depressive disorder and current physicians order for anti-depressant medication.</p> <p>2) How the facility identified other residents:</p> <p>All residents with a diagnosis of depressive disorder currently prescribed anti-depressant medication have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>A comprehensive care plan audit was completed for all residents with a</p>	

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F000312	<p>Administration Record. The Medication Record Administration indicated Resident #17 received Zoloft daily. The plan of care lacked a care plan for the diagnosis of depressive disorder or the use of an anti-depressant medication.</p> <p>On 1/6/15 at 9:01 a.m., Resident #17 was observed in bed eating breakfast.</p> <p>On 1/7/15 at 2:12 p.m., SW (Social Worker) #1 was interviewed. SW #1 indicated most people who were on any type of psychoactive medication had care plans for monitoring for side effects of the medication and signs and symptoms of the disease process.</p> <p>On 1/8/15 at 1:25 p.m., the RD (Regional Director) indicated Resident #17's care plan had been accidentally resolved, but was revised on 1/7/15.</p> <p>On 1/8/15 at 2:19 p.m., the RD indicated the facility used Chapter 4 of the RAI (Resident Assessment Instrument) to determine care plan initiation. The RD further indicated if there was an identified issue on the MDS, a care plan was initiated.</p> <p>3.1-35(a) 483.25(a)(3)</p>		<p>diagnosis of depressive disorder that currently receive anti-depressant medication.</p> <p>Licensed nursing staff will be inserviced on developing care plans for all residents receiving anti-depressant therapy.</p> <p>An audit will be completed in Clinical Meeting on business days when new anti-depressant orders are read to check for appropriate care plans in place.</p> <p>The Director of Nursing/designee is responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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SS=D	<p>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide personal care to 1 of 3 residents reviewed for ADLs (activities of daily living), in that, a resident was not provided showers or oral care. (Resident #7)</p> <p>Findings include:</p> <p>1. During an observation on 1/6/15 at 9:30 a.m., Resident #7 was observed to be lying in bed with her hospital gown untied and hanging down below her shoulders. Resident #7 teeth were yellow and stained.</p> <p>During an interview on 1/6/15 at 9:38 a.m., Resident #7 indicated she had been drinking coffee more often and needed her teeth to be brushed daily. Resident #7 indicated she is unable to lift her right arm to her mouth to brush her own teeth and the staff would give her the toothbrush with toothpaste on it and leave. Resident #7 indicated the staff would not brush her teeth. Resident #7</p>	F000312	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #7 was assisted with oral care and offered to shower as scheduled.</p> <p>2) How the facility identified other residents:</p> <p>All residents requiring assistance with oral hygiene and completion of showers have the potential to be affected.</p>	02/07/2015

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	<p>further indicated she was supposed to receive a shower 2 (two) times a week but had not always received them.</p> <p>The clinical record for Resident #7 was reviewed on 1/5/15 at 2:42 p.m. Resident #7 had a diagnoses including, but not limited to, closed dislocation of left shoulder, generalized muscle weakness, iron deficiency anemia, hypertension, hypothyroidism, atrial fibrillation, pyogenic arthritis, sleep apnea, depressive disorder, and esophageal reflux. The quarterly MDS (Minimum Data Set) assessment, dated 11/28/14, indicated Resident #7 was an extensive assist of 2 persons for transfers, bed mobility, and toilet use and an extensive assist of 1 person for dressing, bathing, and personal hygiene.</p> <p>A care plan, dated 12/4/14, indicated Resident #7 required staff participation for assistance with bathing, personal hygiene, and oral care.</p> <p>An "Oral/Denture Care Evaluation Form" dated 11/4/14, indicated Resident #7 required assistance for oral care.</p> <p>The CNA (certified nursing assistant) assignment sheet, obtained from LPN #2 on 1/5/15 at 8:30 a.m., indicated Resident #7 was to receive a shower 2 times per</p>		<p>3) Measures put into place/ System changes:</p> <p>Nursing staff will be inserviced related to providing assistance with oral hygiene and showers as scheduled per resident preference.</p> <p>Observation audits of residents requiring assistance to complete oral hygiene and showers will be completed 2 times a week on each unit on varying shifts.</p> <p>The Director of Nursing/designee will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance</p>	

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F000314 SS=D	<p>week on Wednesday and Sunday evenings and required the assistance of 1 (one) person for ADL care.</p> <p>The "Showers/Bathing" form, obtained from the Medical Records Coordinator on 1/6/15 at 11:44 a.m. and dated from 11/30/2014 through 12/31/2014, indicated Resident #7 had obtained a shower only on 12/18/14 and 12/22/14. The form indicated the resident did not receive a bath or a shower on 11/30/14, 12/4/14, 12/5/14, 12/6/14, 12/10/14, 12/13/14, 12/14/14, 12/16/14, 12/17/14, 12/19/14, 12/20/14, 12/21/14, 12/24/14, 12/26/14, 12/27/14, 12/28/14, and 12/31/14.</p> <p>During and interview on 1/8/15 at 8:50 a.m., CNA #2 indicated a resident usually received 2 showers a week but a resident could have as many showers as they like. CNA #2 indicated personal care included bathing and oral.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(C)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure</p>			

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	<p>sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to ensure a resident received care for a pressure area in 2 of 3 residents reviewed for pressure ulcers, in that, 1 resident obtained a pressure area with no assessment or physician's orders obtained for care of the area and 1 resident's area was assessed incorrectly. (Resident #40,Resident #32)</p> <p>Findings include:</p> <p>1. Resident #40's clinical record was reviewed on 1/5/15 at 12:45 p.m. The closed clinical record indicated Resident #40 had diagnoses including, but not limited to, vascular dementia, sepsis, generalized muscle weakness, dysphagia, urinary retention, Clostridium Difficile, chronic kidney disease, gout, hypertension, and esophageal reflux. An admission MDS (Minimum Data Set) assessment, dated 9/18/14, indicated Resident #40 was at risk for pressure ulcers.</p> <p>A "potential for pressure ulcer" care plan,</p>	F000314	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified: Skin assessment was completed for resident #32; current pressure related area assessed; and physician notified of current status. Resident #40 has discharged from the facility.</p> <p>2) How the facility identified other residents: All residents requiring assessment and treatment of pressure areas have the potential to be affected.</p> <p>3) Measures put into place/ System changes: An audit will be completed of all residents with pressure areas to ensure that assessment of area has been completed; is accurate; and physician has been notified. Licensed nursing staff will be inserviced regarding accurate completion of an initial pressure ulcer assessment and physician notification required when a pressure area has been noted. An audit of completed weekly skin assessments will be conducted 2 times a week to ensure that each area of concern identified has an accurate assessment completed and that the physician has been notified. The Director of</p>	02/07/2015

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	<p>dated 10/2/14, indicated the physician would be notified for any open or red area.</p> <p>Resident #40 had a "Weekly Skin Assessment" form, dated 10/7/14, which indicated Resident #40 had an open pressure area on the coccyx.</p> <p>Resident #40 had a "Weekly Skin Assessment" form, dated 10/16/14, which indicated Resident #40 had an open pressure area on the coccyx.</p> <p>The clinical record lacked any documentation for an assessment of the pressure area, notification of the physician, or treatment for the pressure ulcer.</p> <p>During an interview on 1/6/15 at 10:17 a.m., LPN #1 indicated he was the wound nurse for the unit and was not notified Resident #40 had a pressure ulcer. LPN #1 indicated he had done the initial assessment when Resident #40 was admitted to the facility. LPN #1 indicated he did not have any treatment orders for wound care for Resident #40.</p> <p>2. On 12/31/14 at 10:05 a.m., Unit Manager #1 indicated Resident #32 had a pressure ulcer on the right buttock that was unstageable.</p>		<p>Nursing/designee is responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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	<p>Resident #32's clinical record was reviewed on 1/5/15 at 11:24 a.m. The resident had a significant change Minimum Data Set (MDS) assessment, dated 11/5/14. The assessment indicated the resident required extensive assistance of one staff for transfers and bed mobility and was unable to ambulate. The resident had no pressure sores according to the MDS.</p> <p>The resident had a care plan, dated 4/5/13, for having the potential for pressure ulcers related to decreased mobility. The diagnosis associated with the care plan was history of a cerebrovascular accident with right side hemiplegia. Interventions included, but were not limited to the following: "Administer treatments as ordered and observe for effectiveness." "Follow facility policies/procedures for the prevention/treatment of skin breakdown." "Obtain lab/diagnostic work as ordered...notify MD..."</p> <p>The resident also had a care plan, dated 11/10/14, for having an unstageable pressure ulcer on the right buttocks. Interventions included, but were not limited to, the following: -administer treatments as ordered and monitor effectiveness</p>			

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	<p>-assess/record/monitor wound healing weekly</p> <p>-pressure relieving/reducing device on my bed/chair</p> <p>-need monitoring/reminding/assistance to turn/reposition approximately every 2 hours...</p> <p>The record included an Initial Pressure Ulcer Report, dated 11/7/14, 10:18 p.m. The report indicated the resident had a left buttock pressure area, 2.0 centimeters (cm) wide by 2.0 cm long; identified as a stage II area (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough). The report indicated duoderm (a type of dressing) and skin prep (a barrier solution) had been applied to the area and the physician, family, and dietary had been notified.</p> <p>On 11/10/14 at 1:34 p.m., an Initial Pressure Ulcer Report was completed for an area and indicated it was on the right buttock. The area was identified as 3.0 cm wide by 2.5 cm long and unstageable due to slough. The wound was described as 50% slough and 50% red, granulated tissue. The area of slough was to the center of the wound. There was scant serosanguinous exudate; the periwound was intact and no odor was noted.</p> <p>The wound was assessed on 11/18/14,</p>			

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	<p>11/25/14, 12/3/14, 12/10/14, and 12/15/14.</p> <p>On 12/24/14, the wound was assessed as 1.5 cm by 1.0 cm by 0.2 cm deep. It was then identified as a stage III area (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss). Slough was no longer present.</p> <p>Nursing progress notes included, but were not limited to, the following: 11/7/14 22:12 (10:12 p.m.) "...Physician notified concerning area to left buttocks." 11/10/14 14:33 (2:33 p.m.) "Daughter/POA notified of unstageable pressure ulcer on right buttock and new wound care orders..."</p> <p>On 1/5/14 at 1:00 p.m., the treatment records were reviewed. The record indicated a treatment started to the right buttock on 11/11/14; the treatment was for Santyl (debriding agent) ointment, apply to right buttock topically every day shift for unstageable pressure ulcer.</p> <p>On 1/06/15 at 10:55 a.m., LPN #1 (the wound nurse) was observed to provide treatment to Resident #32's right buttock. The area was observed to have irregular shaped areas of redness, with one open</p>			

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F000323 SS=D	<p>area greater than 1 cm wide. The area had minimal depth and no slough was observed.</p> <p>On 1/7/14 at 2:03 p.m., LPN #1 was interviewed regarding Resident #32's wounds. He indicated the floor nurse had documented the initial pressure sore report on 11/7/14 and had indicated the area was on the left side, but it was on the right side. He indicated 11/7/14 was a Friday evening. He came in on Monday and did a full assessment and called the physician and got orders. He indicated when wounds were found on weekends/off hours, nurses were responsible for calling and getting orders.</p> <p>The policy and procedure for Skin Condition and Pressure Ulcer Assessment, dated 6/2012, included the purpose was "to establish guidelines for assessing, monitoring and documenting the presence of skin breakdown and pressure ulcers and assuring interventions are implemented."</p> <p>3.1-40(a)(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</p>			

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	<p>hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a hazardous chemical was inaccessible to 1 of 35 resident reviewed in stage 1, in that, a can of room freshener was observed in a resident's bathroom. (Resident #227)</p> <p>Findings include:</p> <p>During an observation on 12/31/14 at 3:14 p.m., Resident #227 was observed to have a bottle of Lysol room deodorizer.</p> <p>The clinical record of Resident #227 was reviewed on 1/5/15 at 1:15 p.m. The admission MDS (Minimum Data Set) assessment, dated 12/18/14, indicated Resident #227 had severe cognitive impairment.</p> <p>During an interview on 1/8/14 at 8:55 a.m., Housekeeping #1 indicated residents were not allowed to have aerosol cans of deodorizers in their rooms. Housekeeping #1 indicated the housekeeping department has crystal bead air deodorizers that could be placed up high in a resident's room if a</p>	F000323	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified:</p> <p>Lysol spray was removed from room #227.</p> <p>2) How the facility identified other residents:</p> <p>All residents residing in the facility have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>A facility audit will be completed of all resident rooms to ensure</p>	02/07/2015

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F000363	<p>deodorizer is necessary.</p> <p>A policy titled, "Best Practices for Environmental Cleaning for the Control and Preventions of Infections," revised 7/2010 and obtained from the administrator on 1/8/14 at 2:33 p.m., indicated all disinfectants should be stored to eliminate risks of inhalation, skin contact, or personal injury.</p> <p>3.1-45(a)(1)</p> <p>483.35(c)</p>		<p>environment remains free of hazardous chemicals.</p> <p>Facility staff will be inserviced related to ensuring that hazardous chemicals are inaccessible to residents.</p> <p>Facility rounds will be completed three times a week per management team, to ensure environment is free of accessibility of hazardous chemicals.</p> <p>The Administrator/designee will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>		

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SS=E	<p>MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview, and record review, the facility failed to ensure menus for pureed foods were followed, in that a recipe was not used to prepare the pureed chicken and dumplings and pureed spinach. This had the potential to affect 5 residents who received pureed diets. (Residents #68, #92, #34, #67, #236)</p> <p>Finding includes: On 1/6/15 at 10:29 a.m., Cook #1 was observed preparing pureed chicken and dumplings and pureed spinach. He obtained a large scoop and scooped out 4-5 scoopfuls of the chicken and dumplings from the pan. He poured the unmeasured amount into the food processor. He indicated he then would add bread to "get it to the right consistency." He placed 5 pieces of bread into the food processor and then added 4 packets of butter. He processed the food, checked consistency and indicated he was getting the lumps out. He then poured the pureed food into a</p>	F000363	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified:</p> <p>On day of survey the AM Cook discussed his misunderstanding of the surveyor's question regarding how he had prepared Puree food. An immediate "on the spot" training in-service was conducted with all of the Cook Staff to review proper puree preparation. The pureed food in question was discarded prior to service and re-prepared per facility recipes and served per diet extension sheets. Dietary Cook staff signed the "on the spot" in-service on 1/6/2015.</p> <p>2) How the facility identified other residents:</p>	02/07/2015			

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	<p>pan. He indicated he didn't measure anything.</p> <p>On 1/6/15 at 10:40 a.m., Cook #1 spooned 7 and 1/2 four ounce scoops of spinach into the food processor. He then added thickener and processed the spinach and put it in a pan.</p> <p>On 1/6/15 at 11:20 a.m., the Dietary Manager indicated the cook "knew he had messed up..." He was supposed to measure out the portions, and add the same number of bread slices for the puree. He indicated he had provided an inservice and provided a copy of the inservice record at that time.</p> <p>Review of the inservice record, dated 1/6/15 at 11:02 a.m., indicated the puree recipes were reviewed and the staff was instructed on the correct way to portion for the puree diets using the recipes.</p> <p>The Regional Director provided a list of residents receiving pureed diets on 1/8/15 at 2:50 p.m. The following residents were listed: Residents #68, #92, #34, #67, #236.</p> <p>3.1-20(i)(1) 3.1-20(i)(4)</p>		<p>No residents were impacted, as the puree food was prepared per facility recipes and served per facility menu extension.</p> <p>3) Measures put into place/ System changes:</p> <p>Dietary Cook staff was in-serviced immediately on 1/6/15 regarding the proper procedure for puree food preparation and serving portions per recipes and diet extension sheets.</p> <p>All dietary staff will be in-serviced on 01/19/15 by Consultant Dietitian regarding:</p> <ol style="list-style-type: none"> 1. Proper preparation of puree foods per facility recipes and menu extensions. 2. Follow the dietary menu spreadsheets in reference to correct portion sizes. 3. The nutritional value of providing the food in adequate portions and following puree recipes. 4. Quick references will be posted in the kitchen for portion utensil color, number and size. 				

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and</p>		<p>An audit tool will be completed three times a week on 3 residents and will be done at varying meal times.</p> <p>The Dietary Manager and Consultant Dietician are responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>		

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	<p>include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were not stored longer than recommended, for 3 of 7 medication carts observed. The facility also failed to ensure medications were labeled with open dates, resident names, and that medications were stored to prevent contamination This affected 3 residents who had medications stored on the carts. (300 hall cart, 900 hall cart, 400 hall cart) (Residents # 33, # 97, # 32, # 233, # 234, # 235)</p> <p>Findings include:</p>	F000431	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified:</p> <p>Unlabeled and/or outdated medications were removed from the skilled medication room, 300 hall, 400 hall and 900 hall medication carts. Medications requiring replacement for resident's# 33, 97, 32, 233, 234 and 235 have been obtained, and labeled with opened</p>	02/07/2015

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	<p>1. Observation of a medication cart on 1/7/15 at 1:15 p.m. on the 300 hall, indicated medications with an open date exceeding the recommended time frames listed in the facility policy. Flonase nasal spray for Resident # 33 was opened on 10/27/14.</p> <p>2. Observation of a medication cart on 1/7/15 at 1:30 p.m. on the 900 hall, indicated medications with an open date exceeding the recommended time frames listed in the facility policy. Advair disk for Resident # 97 was opened on 12/2/14.</p> <p>3. Observation of a medication cart on 1/7/15 at 2:15 p.m. on the 400 hall, indicated two bottles of Flonase nasal spray for Resident # 32 had no open dates noted.</p> <p>4. Observation of a medication room on the Rehabilitation Unit on 1/8/14 at 8:42 a.m. indicated sterile urine cups, culture swabs, and medications stored under the sink. The medications included Align (probiotic) for Resident # 233, Milk of Magnesia (laxative) for Resident # 234, and Constulose (laxative) for Resident # 235. A cabinet contained two bottles of Cal-Gest (antacid) had no resident name and one of the bottles had a lid that was improperly placed. It also contained a plastic bag with two bottles of Equate</p>		<p>dates.</p> <p>2) How the facility identified other residents:</p> <p>All residents residing in the facility have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>An audit of all medication carts and medication rooms was completed ensuring medications are stored to prevent contamination; medications are labeled with resident name and opened dates if indicated. Medications noted without proper label and/or exceeding recommended indicated time frame have been removed and replaced as indicated.</p> <p>Licensed nursing staff will be in-serviced regarding medication storage; including storage of medication is not to exceed recommended time frame; medications are to be stored to prevent contamination; ensuring medications are labeled with resident names and opened dates.</p>				

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F000441 SS=D	<p>Nasal Spray, Vicks Vapo Rub (topical decongestant), Equate Anti Itch Cream, and saline nasal gel.</p> <p>An interview on 1/8/15 a.m. with UM #1 indicated that all medications should have a pharmacy label.</p> <p>A policy titled Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles was provided by the RD on 1/8/15 at 1:15 p.m. and indicated "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels."</p> <p>3.1-25(j) 3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to</p>		<p>All medication carts and medication storage rooms will be audited weekly to ensure compliance.</p> <p>The Director of Nursing/designee is responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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	<p>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 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 safe, sanitary, and comfortable environment for 2 of 4 residents observed for care, in that, gloves were not changed</p>	F000441	The facility requests paper compliance for this citation.	02/07/2015

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	<p>and handwashing was not done for residents who received personal care. (Resident #7, Resident #32)</p> <p>Findings include:</p> <p>1. During an observation on 1/6/15 at 9:48 a.m., CNA #1 was observed to be assisting CNA #2 with giving a bed bath to Resident #7. CNA #1 and CNA #2 were observed to apply gloves prior to the bath. CNA #1 assisted with drying of Resident #7 upper torso. After drying the upper torso, CNA #1 removed her gloves and turned off the water in the bathroom that had been left on when CNA #2 changed her gloves and washed her hands. CNA #1 applied clean gloves and proceeded to wash and dry Resident #7's left leg and foot. CNA #1 pulled the privacy curtain around the foot of the bed. CNA #2 washed the resident's perineal area and CNA #1 dried the area. CNA #1 was observed to assist Resident with turning to her left side. CNA #2 washed and dried Resident #7's back and rectal area. CNA #1 assisted Resident #7 to her right side and CNA #1 removed a soiled adult brief from under the resident's buttocks. CNA #1 changed her gloves, with no handwashing done, and placed Resident #7 onto the bedpan. CNA #1 assisted with applying a bra and shirt on Resident #7. CNA #1 changed</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>Resident's # 7 and 32 have had no adverse effects noted from the alleged deficient practice.</p> <p>2) How the facility identified other residents:</p> <p>All residents residing in the facility have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Nursing staff will be inserviced on hand washing protocol and will be required to successfully complete a hand washing skills check off.</p> <p>Observation audits will be completed 2 times a week on varying shifts and halls to ensure staff are washing</p>	

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	her gloves and applied lotion to the resident's legs and feet. CNA #1 also assisted with placing socks and trousers on Resident #7. CNA #1 removed her gloves and washed her hands for 7 seconds prior to applying clean gloves. Resident #7 was removed from the bedpan by CNA #2. CNA #1 assisted with turning the resident to the left side and washed the resident's buttocks. After repositioning Resident #7 to her back, CNA #1 assisted with positioning an adult brief on the resident. CNA #1 removed her gloves and washed her hands for 10 seconds. CNA #1 obtained a battery-operated toothbrush and toothpaste and began brushing the resident's teeth. Resident #7 indicated she did not use a battery-operated toothbrush and CNA #1 proceeded to obtain a regular toothbrush with toothpaste. After brushing the resident's teeth, CNA #1 sprayed cologne onto the resident's shirt. CNA #1 obtained a wash basin for Resident #7 to use when rinsing her mouth after having her teeth brushed. CNA #1 emptied the basin, removed her gloves, and washed her hands for 10 seconds. CNA #1 applied gloves, pulled up Resident #7's pants. CNA #1 removed her gloves but did not wash her hands. CNA #1 assisted Resident #7 to the side of the bed and applied a gaitbelt to the resident's waist area. CNA #1		hands per facility policy during care observation. The Director of Nursing/designee is responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.				

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	<p>assisted Resident #7 to a wheelchair and removed the gaitbelt. CNA #1 washed her hand for 10 seconds and left the room.</p> <p>During an interview on 1/6/15 at 2:08 p.m., CNA #3 indicated hands should be washed upon entering a resident's room and after giving resident care. CNA #3 further indicated hands should be washed whenever gloves are changed and hands should be washed for 30 seconds.</p> <p>A policy titled, "Personal Protective Equipment - Using Gloves," revised 8/2011 and obtained from the Regional Director on 1/8/15 at 1:15 p.m., indicated hands should be washed after removing gloves.</p> <p>A policy titled, "Handwashing/Hand Hygiene," revised 8/2011 and obtained from the Regional Director on 1/8/15 at 1:15 p.m., indicated hands should be washed for at least 15 seconds. The policy further indicated hands were to be washed after using soiled or used linens, before and after assisting a resident with toileting, after performing personal hygiene, and after removing gloves.</p> <p>2. LPN #1 (wound nurse) was observed providing treatment to areas on Resident #32's buttocks. He washed his hands,</p>			

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F000465 SS=E	<p>donned gloves, removed the soiled dressings and disposed of them, and then removed his gloves. He then donned clean gloves and proceeded to cleanse the area and place the dressing.</p> <p>The policy and procedure for Dressings, Dry/Clean, dated 2001, revised 2011, was provided by the Regional Director on 1/8/15 at 1:15 p.m. The policy included, but was not limited to, the following: "Put on clean gloves. Loosen tape and remove soiled dressing." "Pull glove over dressing and discard into plastic or biohazard bag." "Wash and dry your hands thoroughly." "Put on clean gloves." "Cleanse the wound..."</p> <p>3.1-18(l) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a sanitary and comfortable environment for residents in 8 of 34 rooms observed in the stage 1 sample, in that, personal care items were not labeled, walls were chipped, covered</p>	F000465	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified:</p>	02/07/2015

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	<p>bricks were used to keep resident's entry doors open, and urine was observed to be left in a bedpan. (Room # 301, Room # 306, Room #312, Room #400, Room #405, Room #901, Room #905, Room #906)</p> <p>Findings include:</p> <p>1. During an observation on 12/31/14 at 10:15 a.m., Room #301 was observed to have an unlabeled bedpan with urine in the bedpan which was stored uncovered in the shower of the bathroom. The bathroom was observed to have chipped paint.</p> <p>During an observation on 1/5/15 at 9:45 a.m., Room #301 was observed to have a small, round, red-colored tablet on the floor under the sink in the bathroom. A covered, unlabeled bedpan was observed to be sitting in a wheelchair in the shower in the bathroom. The bathroom wall was unchanged.</p> <p>During an interview on 1/5/15 at 9:48 a.m., RN #2 indicated the small, round, red-colored tablet did not belong to either</p>		<p>Bed pan replaced, labeled and stored in plastic bag and round red tablet disposed of per protocol for room 301.</p> <p>Work order initiated for room's 301, 405, 901 and 905 related to chipped paint in bathroom.</p> <p>Personal care items were replaced, labeled and stored in separate containers for each resident residing in room's 312, 905 and 906.</p> <p>Brick removed from in front of the entry doors of rooms 306 and 312.</p> <p>Zinc Oxide removed from 312 and disposed of per facility policy.</p> <p>Work order initiated for room 400 related to pull light above bed.</p> <p>Incontinent products were obtained, labeled and stored separately for residents residing in room 405 and 906.</p> <p>Foley bag replaced for room 901.</p> <p>2) How the facility identified other residents:</p> <p>All residents residing in the facility have the potential to be affected.</p>				

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	<p>resident. RN #2 indicated the tablet did not "look like it had been in anyone's mouth."</p> <p>2. During an observation on 12/31/14 at 10:42 a.m., Room #306 was observed to have a brick, covered with a torn thromboembolytic hose, sitting on the floor in front of the entry door to keep the door open. The same was observed on 1/5/15 at 9:39 a.m.</p> <p>3. During an observation on 12/31/14 at 10:40 a.m., Room #312 was observed to have a covered brick sitting on the floor holding the entry door opened. Two (2) bottles of powders, 2 tubes of toothpaste, 2 toothbrushes, and 2 bottles of body wash were observed sitting on a bar behind the commode with no names on them.</p> <p>During an observation on 1/5/15 at 9:51 a.m., Room #312 was observed to have a covered brick holding the entry door opened. 2 bottles of powder, 2 bottles of lotion, 1 bottle of body wash, and 1 tube of dental paste were observed, with no names on them, on the bar behind the</p>		<p>3) Measures put into place/ System changes:</p> <p>A facility audit will be completed to ensure that resident care items are labeled and stored in separate containers for each resident.</p> <p>A facility audit will be completed to ensure that medications are not accessible in resident rooms.</p> <p>A facility audit will be completed to ensure that areas with chipped paint have been identified, work orders have been initiated and repairs in progress.</p> <p>Facility staff will be inserviced on initiating work orders, proper labeling and storage of personal care items.</p> <p>Facility rounds will be completed three times a week per management team to ensure environment is monitored for areas of chipped paint, labeling and storage of personal care items for each resident is completed.</p>	

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	<p>back of the commode. One (1) tube of Zinc Oxide, 2 bottles of deodorant, and 1 bottle of lens cleanser were observed, with no names on them, on the back of the commode.</p> <p>4. During an observation on 12/31/14 at 2:53 p.m., Room #400 B was observed to have no string attached to the pull light located above the bed. The same was observed on 1/5/14 at 9:37 a.m.</p> <p>5. During an observation on 12/31/4 at 9:39 a.m., Room #405 was observed to have chipped paint off in the bathroom and a package of unlabeled adult briefs on the bar behind the commode. The same was observed on 1/5/14 at 9:32 a.m. The room was shared by 2 (two) residents.</p> <p>6. During an observation on 12/31/14 at 9:49 a.m., Room #901 B was observed to have a Foley catheter lying in the floor and the bathroom wall had chipped paint.</p> <p>During an observation on 1/5/14 at 10:32 a.m., Room #901 was observed to have chipped paint in the bathroom.</p>		<p>The Director of Nursing/designee is responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>	

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	<p>7. During an observation on 12/31/14 at 11:06 a.m., Room #905 was observed to have a bar of soap and a wet washcloth in the floor of the bathroom shower. The bathroom wall had chipped paint.</p> <p>During an observation on 1/5/14, Room #905 was observed to have a bar of soap in the bathroom shower and chipped paint in the bathroom. The room was shared by 2 residents.</p> <p>8. During an observation 12/31/14 at 10:22 a.m., Room #906 was observed to have unlabeled incontinence pads and deodorant on the back of the commode. The same was observed on 1/5/14 at 10:39 a.m. The room was shared by 2 residents.</p> <p>9. During an interview on 1/6/14 at 1:36 p.m., Housekeeper #1 indicated if chipped paint or gouged walls is observed, the area is to be turned into the receptionist, who forwards it to the Administrator, who then checks it out and has maintenance repair it. Hskp #1 indicated she did not know who was</p>			

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F009999	<p>responsible for labeling resident care items.</p> <p>10. During an interview on 1/6/14 at 2:08 p.m., CNA # 3 indicated the Central Supply person would be responsible for labeling resident care items when they are delivered to the resident's room. CNA #3 indicated all resident care items are to be labeled with the resident's name.</p> <p>11. During an interview on 1/8/15 at 1:25 p.m., the ADON (Assistant Director of Nursing) indicated only nurses were to apply Zinc Oxide ointment to the resident and it should not be left in a resident's room.</p> <p>3.1-19(f)</p> <p>3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a</p>	F009999	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents identified as affected. C.N.A. #1, #4 and #5 have completed annual inservice required for Residents Rights and Dementia</p>	02/07/2015

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	<p>minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of the cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure inservices were provided for 3 of 5 employees reviewed, in that, annual Resident Rights and Dementia training was not completed. (CNA #1, CNA #4, CNA #5)</p> <p>Findings include:</p> <p>On 1/7/15 at 10:00 a.m., the employee files were reviewed. The employee files lacked an annual inservice for Resident Rights and Dementia training for CNA #1, CNA #4, and CNA #5.</p> <p>On 1/7/15 at 1:00 p.m., HR (Human Resources) provided the paper inservices for 2014. The paper inservices lacked an annual inservice for Resident Rights and Dementia training for CNA #1, CNA #4,</p>		<p>training.</p> <p>2) How the facility identified other residents:</p> <p>No residents identified as affected.</p> <p>3) Measures put into place/ System changes:</p> <p>An audit of current employee files will be completed to ensure that annual inservice related to Residents Rights and dementia training is in compliance.</p> <p>Facility staff will be inserviced regarding requirement to complete annual inservices/ training as scheduled per Human Resources.</p> <p>Human Resources will notify staff of upcoming months scheduled inservice. Staff will have until the last day of the month to complete required inservice/training scheduled for that month. Human Resources</p>	

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R000000	<p>and CNA #5.</p> <p>On 1/7/15 at 1: 45 p.m., HR indicated the company had been transitioning between online learning companies during 2014. She indicated the additional paper inservices were all the information that was available. HR further indicated she was sure the employees had been inserviced but was unable to locate any documentation.</p> <p>On 1/8/15 at 2:19 p.m., the RD (Regional Director) provided the "Required In-Serving" policy, updated 01/2014. The policy indicated, "All employees of the healthcare facility will receive in-servicing upon hire and annually as indicated by the state and federal regulations". The policy further indicated, "All staff will be required to complete on hire and annually the following in-service materials which meet both the state and federal regulations". The materials included, but were not limited to, resident rights and dementia.</p> <p>3.1-14(k)(1) 3.1-14(u)</p> <p>This deficiency reflects state findings</p>	R000000	<p>will maintain a tracking log of completed inservices and next due dates.</p> <p>Administrator/ designee will audit 2 employee files a week to ensure that required inservice/ training has been completed.</p> <p>The Director of Nursing/ designee is responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p> <p><i>This Plan of Correction is the</i></p>				

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R000120	<p>cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with</p>		<p><i>center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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	<p>dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review the facility failed to ensure inservices were provided for 3 of 5 employees reviewed, in that, annual Resident Rights training was not completed. (RN #1, AP #1, AP #2)</p> <p>Findings include:</p> <p>On 1/7/15 at 10:00 a.m., the employee files were reviewed. The employee files lacked an annual inservice for Resident Rights training for RN #1, AP (Activities Personal) #1, and AP #2.</p> <p>On 1/7/15 at 1:00 p.m., HR (Human Resources) provided the paper inservices for 2014. The paper inservices lacked an annual inservice for Resident Rights training for RN #1, AP #1, and AP #2.</p> <p>On 1/7/15 at 1: 45 p.m., HR indicated the company had been transitioning between online learning companies during 2014. She indicated the additional paper</p>	R000120	<p>The facility requests paper compliance for this citation.</p> <p>1) Immediate actions taken for those residents identified: No residents identified as affected. C.N.A. #1, #4 and #5 have completed annual inservice required for Residents Rights and Dementia training. 2) How the facility identified other residents: No residents identified as affected. 3) Measures put into place/ System changes: An audit of current employee files will be completed to ensure that annual inservice related to Residents Rights and dementia training is in compliance. Facility staff will be inserviced regarding requirement to complete annual inservices/ training as scheduled per Human Resources. Human Resources will notify staff of upcoming months scheduled inservice. Staff will have until the last day of the month to complete required inservice/training scheduled for that month. Human Resources will maintain a tracking log of completed</p>	02/07/2015			

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