

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2016
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NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00197466.</p> <p>Complaint IN00197466 - Substantiated. Federal/State deficiencies related to the allegations are cited at F242.</p> <p>Survey dates: April 24, 25, 26, 27, 28 and 29, 2016</p> <p>Facility number: 012329 Provider number: 155784 AIM number: 201002500</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 18 Medicaid: 50 Other: 22 Total: 90</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Creekside Village requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	

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

TITLE

(X6) DATE

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

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F 0242 SS=D Bldg. 00	<p>Quality Review completed by 14454 on May 9, 2016.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to give showers on scheduled shower days for 2 of 3 resident's reviewed for choices. (Resident C and Resident D)</p> <p>Findings include:</p> <p>1. During an interview on 4/25/16 at 9:45 A.M., Resident C indicated her shower days were Tuesday, Thursday and Saturday. Resident C indicated she had recently moved to her room and had not had a shower since the move. She further indicated she receives a sponge bath daily but that she doesn't feel she is washed thoroughly. She indicated the staff say they will be in to shower her in the</p>	F 0242	<p>F242 SELF DETERMINATION-RIGHT TO MAKE CHOICES It is the policy of the facility to provide residents the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents C and D were interviewed regarding shower preference. Resident's plan of care was updated, as well as the Nursing Assistant Assignment Worksheet. Residents C and D are now being offered showers per their preference based on resident interviews. Residents are</p>	05/24/2016

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	<p>morning but do not come to do it. Resident C would like to receive her showers.</p> <p>On 4/27/16 at 4:12 P.M., a review of the "Nursing Assistant Assignment Worksheet" provided by the 100/200 Hall Unit Manager indicated Resident C was to receive a shower on Tuesday, Thursday and Saturday nights.</p> <p>On 4/27/16 at 4:30 P.M., a review of the Point of Care ADL (Activities of Daily Living) Category Report indicated for the month of April 2016, Resident C had received a shower on 4/5/16, and 4/27/16, and no refusals of showers documented.</p> <p>On 4/28/16 at 9:30 A.M., a review of the Quarterly MDS (Minimum Data Set) assessment, dated 2/19/16, indicated Resident C had a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment.</p> <p>2. On 4/28/16 at 9:49 A.M., an interview was conducted with Resident D. Resident D indicated he receives a daily bed bath but that he would like to receive a shower at least weekly. Resident D further indicated staff do not ask him if he would like a shower.</p> <p>On 4/28/16 at 10:00 A.M., a review of</p>		<p>receiving showers unless refused by resident, which will be documented accordingly. Residents C and D are alert and oriented. Facility will honor their right to refuse showers. Facility licensed nurses and certified nursing assistants will be educated by DNS/designee on completing showers per resident preference and on proper documentation of showers. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents who reside at the facility have the potential to be affected by the alleged deficient practice. Residents residing in the facility have been interviewed regarding shower preference by 05/18/2016. Resident's plan of care will be updated as well as the Nursing Assistant Assignment Worksheet to reflect changes. Residents are receiving showers unless refused by resident, which will be documented accordingly. Facility will honor their right to refuse showers. Facility licensed nurses and certified nursing assistants will be educated by DNS/designee on completing showers per resident preference and on proper documentation of showers. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p>				

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	<p>the "Nursing Assistant Assignment Sheet," provided by the 100/200 hall Unit Manager, indicated Resident D was to have showers on Tuesday, Thursday and Saturday during the day shift.</p> <p>On 4/28/16 at 10:10 A.M., a review of the Point of Care ADL Category Report, provided by the 100/200 hall Unit Manager on 4/27/16 at 4:12 P.M., indicated for the month of April, Resident D had no refusals of showers documented.</p> <p>On 4/28/16 at 10:13 A.M., a review of the Quarterly MDS assessment, dated 3/5/16, indicated Resident D had a BIMS score of 15 indicating no cognitive impairment.</p> <p>On 4/28/16 at 10:52 A.M., an interview was conducted with CNA (Certified Nursing Assistant) # 17. CNA #17 indicated that she believed both Resident C and D were evening shift showers and they both could tell you if they would like a shower or not. CNA # 17 indicated the facility staff document showers in 2 ways the first being the shower sheet which is a check list of the various activities of the showering event and the kiosk (part of the electronic charting system). When documenting on the kiosk the staff document if the resident receives a bed</p>		<p>Residents residing in the facility have been interviewed regarding shower preference by 05/18/2016. Resident's plan of care will be updated as well as the Nursing Assistant Assignment Worksheet to reflect changes. Residents are receiving showers unless refused by resident, which will be documented accordingly. Facility will honor their right to refuse showers. Facility licensed nurses and certified nursing assistants will be educated by DNS/designee on completing showers per resident preference and on proper documentation of showers. Residents preferences will be reviewed on admission, quarterly and as needed and updates will be made to Nursing Assistant Assignment Worksheet. Director of Nursing is responsible for compliance related to clinical staff following shower preference and clinical documentation. Non-compliance with shower preference/resident choices/procedures may result in further education, and/or disciplinary action up to termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ADNS and/or designee will complete audits of showers for two weeks, then three times a week for two weeks, then weekly for four weeks, then monthly for six</p>		

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	<p>bath, a partial bed bath, a shower or a refusal of a bed bath or a shower. If a resident refuses after 3 attempts the staff are to document it in the kiosk and notify the nurse.</p> <p>On 4/28/16 at 2:00 P.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated the facility did not have a policy to document the showers on the kiosk but that the staff document what took place at the time whether it be a partial bath, a shower or a bed bath. When referencing the shower sheets the Director of Nurses indicated they were an internal facility document and not always used to document the showers. She further indicated the staff should be asking the resident if they would like a shower or not and documenting it appropriately.</p> <p>This Federal Tag relates to Complaint IN00197466.</p> <p>3.1-3 (u)(3)</p>		<p>months. Trends will be reviewed by CQI committee monthly for three months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, and threshold of 95% is not achieved, an action plan will be developed as needed. Audits will be turned into and monitored by the DNS for completion. Identified non-compliance will result in one-to-one education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to CQI committee to determine further educational needs.</p>	

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F 0258 SS=D Bldg. 00	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</p> <p>The facility must provide for the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to provide comfortable sound levels for 2 of 90 residents. (Resident #8 and #99)</p> <p>Finding includes:</p> <p>On 4-24-2016 at 4: 25 P.M., during an initial tour of the facility, a TV in one room could be heard 5 rooms away, in either direction. The sound level was very loud.</p> <p>On 4-25-2016 at 10:59 A.M., during an interview, Resident #8 indicated, "the TV in the next room is on day and night and is so loud, I can't even talk in my room with my door closed very well and I can not sleep at night. I have asked her to turn it down but she just turned it up louder. I know she can hear me because I have a cough right now and when I get to coughing, she turns it [TV] louder." The</p>	F 0258	<p>F258 MAINTENANCE OF COMFORTABLE SOUND LEVELS</p> <p>It is the policy of the facility to ensure that the environment provides comfortable sound levels. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #99 no longer resides at the facility. Resident # 8 remains at the facility and staff to ensure that she remains in an environment with comfortable sound levels. In regards to room identified during survey, facility has met with guardian and resident regarding acceptable sound levels, and have offered many options including; TV volume at 21 or less, speakers, headphones, and moving tv closer to resident. Guardian and resident have agreed to purchase a speaker system per their preference. How other residents having the</p>	05/24/2016

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	<p>interview was conducted in Resident #8's room with the door closed. The conversation was at an above normal sound level and several times questions and answers needed to be repeated to be heard.</p> <p>On 4-28-2016 at 10:36 A.M., during an interview, Resident #99 indicated, "...the TV in that room is on day and night and I can't sleep or even think...yes, I thought about changing rooms but I am leaving soon and they don't know it but I am not paying my bill, not with this noise...I have asked for her [Resident name] to turn it down but she won't...I know she can hear OK because when she has visitors, they talk in a normal voice...."</p> <p>On 4-28-2016 at 9:56 P.M., the noise level, from the TV in Room (specific number) could be heard at the nurses station and in all the halls on the 300 unit. All residents on 300 Hall were in bed or in their rooms getting ready for bed.</p> <p>On 4-29-2016 at 10:05 P.M., during an interview that was 9 rooms away from Room (specific number), LPN (Licensed Practical Nurse) #8, indicated, "Yes, the TV is loud. She [Resident] refuses to close her door or turn her TV down. I will try to talk to her."</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All residents who reside at the facility have the potential to be affected by the alleged deficient practice. The facility/staff are to ensure that comfortable sound levels are maintained throughout building.</p> <p>Facility staff will be educated by Administrator/designee on maintaining comfortable sound levels, and that it is the responsibility of all staff to ensure that comfortable sound levels are maintained.</p> <p>All residents were interviewed by SSD/designee, using QIS question regarding noise, any concerns were addressed immediately by ED/Designee.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Staff will be educated by Administrator/designee on maintaining comfortable sound levels, and that it is the responsibility of all staff to ensure that comfortable sound levels are maintained.</p> <p>Customer Care Coordinator/designee will complete environmental audits of noise levels.</p>	

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F 0318 SS=D Bldg. 00	<p>On 4-29-2016 at 9:22 A.M., during an interview, the Social Service for Hall 300, indicated, "...we have talked about putting a speaker in her room, close to her, but we have one in another room right now and it isn't working well...she [Resident] refuses the headphones we have offered...I do know [Resident #8 name] has complained about the noise...we just don't have a real solution...."</p> <p>The facility was unable to provide a policy for noise control.</p> <p>3.1-19(f)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p>		<p>Any concerns will be addressed by ED/Designee.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Customer Care Coordinator/designee will complete environmental audits of noise levels Monday thru Friday for two weeks, then three times a week for two weeks, then weekly times four weeks, then monthly for three months. Audits will be incorporated on all shifts. Trends will be reviewed by CQI committee monthly for six months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, or if threshold of 95% is not achieved, an action plan will be developed as needed. Audits will be turned into and monitored by the Executive Director for completion. Identified non-compliance will result in one-to-one education up to and including termination.</p>	

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	<p>Based on observation, interview and record review, the facility failed to provide restorative services as ordered for 1 of 3 residents reviewed for restorative services. (Resident #3)</p> <p>Findings include:</p> <p>On 4-25-2016 at 9:52 A.M., during an observation and interview with Resident #3, a white hard form fitted ankle and foot splint was observed sitting in the corner of Resident #3's room. Resident #3 indicated, "I used to wear it to help me walk, I have foot drop and need it to keep my foot flat but my legs are swollen and I can't wear it anymore. I used to get therapy but I haven't had it in a while. Sometimes they come in my room and do exercises with me but they haven't lately."</p> <p>On 4-25-2016 at 2:52 P.M., during a staff interview, the DON (Director of Nursing) indicated, "[Resident #3 name] possibly has a contracture to her right arm and right leg and foot. She [Resident #3] does not wear splints but does receive ROM [range of motion] with restorative services."</p> <p>On 4-27-2016 at 11:15 A.M., a record review for Resident #3 was conducted. Diagnosis included, but were not limited</p>	F 0318	<p>F318 INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>The facility is to ensure that residents receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion per policy.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #3 remains at facility. Resident #3 did not have a physicians order for an ankle and foot splint. Resident #3 has been non-ambulatory since admission and throughout therapy treatments. Resident #3 has not had a decline in functional status. Resident #3 is currently on therapy case load and being evaluated for need of splint.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Residents who reside at the facility and have restorative services as their plan of care have the potential to be affected by the alleged deficient practice. The facility is to ensure that residents receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range</p>	05/24/2016

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	<p>to, Cerebral Vascular Accident (Stroke) with left hemiparalysis, Atrial Fibrillation, hyperlipidemia and congestive heart failure. A physician order dated 2-25-2016, indicated, "Restorative referral/recommendations, type of program AROM [Active Range of Motion], transfers." A physician order dated 3-17-2016, indicated, "Discharge from skilled occupational therapy following final treatment on 3-17-2016, please see referral for RNP [Restorative Nursing Program]. A review of the Restorative program book for Hall 200, indicated, Resident #3 had the following restorative programs: AROM bilateral LE (lower extremities) X (times) 20 X 3 in sitting or supine and transfers: using a vertical grab bar requiring min/cga (minimal/contact guided assist) with correct foot placement. The restorative nursing program for March 2016 for Resident #3 indicated Resident #3 received services 10 of 31 days and the April 2016 documentation indicated Resident #3 had received services 4 of 27 days.</p> <p>On 4-28-2016 at 10:50 A.M., during an interview, CNA/RNA (Certified Nursing Assistant/Restorative Nursing Assistant) #17 indicated, "...Yes, she [Resident #3] is on the restorative program...she is to get her 2 programs 6 times a week for 15</p>		<p>of motion.</p> <p>Restorative nursing programs have been evaluated for residents to ensure that appropriate programs are in place and plan of care updated. Restorative Aide cannot be pulled to the floor to work an assignment without prior authorization from the Executive Director. Restorative Aide schedules adjusted to cover 7 days a week. Restorative Aides will report to Rehabilitation Services Manager.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Facility licensed nurses and certified nursing assistants will be educated by DNS/designee on Restorative programs. Restorative Aide cannot be pulled to the floor to work an assignment without prior authorization from the Executive Director.</p> <p>Restorative nursing programs have been evaluated for residents to ensure that appropriate programs are in place and plan of care updated. Restorative Aide schedules adjusted to cover 7 days a week. Restorative Aides will report to Rehabilitation Services Manager. Rehab manager/designee will conduct rounds daily to ensure rehab services are provided per care plan.</p> <p>How the corrective action(s)</p>	

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	<p>minutes each...all our residents on restorative are on a minimum of 2 programs, 6 times a week...I am the only restorative aid during the week and there is a restorative aid that works every weekend but we are pulled to the floor to work the unit because of call offs so we can't get our restorative minutes in with our residents...we have about 40 residents right now on restorative...I am not sure who I report to, it was the MDS [Minimum Data Set] nurse but we haven't had a full time nurse for a few months...I get the restorative referrals and programs from the therapy director...we used to meet weekly but we haven't for a while...."</p> <p>On 4-28-2016 at 10:58 A.M., during an interview, the Therapy Director indicated, "...when a resident is 1 to 2 weeks from finishing therapy, we recommend the restorative aids start working with them on the programs to transition them off of therapy...I recommend the programs and put the paperwork in the MDS nurses mailbox...we have not had anyone in that position for a while...we used to meet weekly but it has been a few months since we have had meeting...."</p> <p>On 4-29-2016 at 10:17 A.M., a policy was received from the DON (Director of</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Rehabilitation Services Manager/designee will complete audits of Restorative documentation, then three times a week for two weeks, then weekly thereafter. Trends will be reviewed by CQI committee monthly for six months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, or if 95% threshold is not achieved, an action plan will be developed as needed. Audits will be turned into and monitored by the DNS for completion. Identified non-compliance will result in one-to-one education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to CQI committee to determine further educational needs. Rehabilitation Services Manager will meet with Restorative Aide three times a week for two weeks, then weekly times four weeks and the quarterly thereafter to monitor appropriateness and compliance of programs. All residents are evaluated for appropriateness of therapy services on admission, re-admission, quarterly and with significant change.</p>	

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F 0323 SS=D Bldg. 00	<p>Nursing), titled "Restorative Nursing Program" and original date: 3/2010, 3/2011, indicated, "Purpose...The resident can also be placed on a program to maintain the ability to function at his or her optimal level within the given environment. These programs facilitate the use of skills that are present but not utilized unless compensations or adaptations are provided and designed to foster maximum independence in functional activities...."</p> <p>3.1-42(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 hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to implement care planned interventions to reduce the risk of an accident for 1 of 3 residents reviewed for falls. (Resident #14)</p> <p>Findings include:</p> <p>On 4-25-16 at 2:02 P.M., an interview was conducted with the DON (Director</p>	F 0323	<p>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Creekside Village is requesting Face to Face IDR as facility disagrees with the scope and severity assigned to this deficiency. The facility is to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistive devices to prevent accidents per policy.</p>	05/24/2016

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	<p>of Nursing). The DON indicated Resident #14 had fallen on 4-18-16 with no injury sustained.</p> <p>On 4-28-16 at 9:17 A.M., the record for Resident #14 was reviewed. Resident #14 was admitted to the facility on 3-3-16, with diagnoses including but not limited to congestive heart failure, chronic kidney disease, muscle weakness, lack of coordination, and difficulty walking.</p> <p>A "Fall Event," dated 4-18-16, indicated "Event Date: 4-18-16 [at] 08:03 P.M...Description: Observed Resident get out of bed and sit on floor...Was fall witnessed? Yes...Describe what the resident was doing prior to the fall: Walking past room and observed Resident get out of bed, slipped and sat on floor...Describe location of the fall: beside of bed...Describe injuries, if any, and the immediate treatment provided: No obvious injuries noted...."</p> <p>An IDT (Interdisciplinary Team) note, dated 4-19-16 at 10:51 A.M., indicated "...IDT met to review resident fall. Nurse was walking past residents room and observed resident get out of bed, slip and sit down on floor...Area well lit, call light in reach, room free of clutter, floor dry. Resident encouraged to call staff for</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?Resident #14 remains at facility. Per resident's care plan documented on paper, non-skid strips were refused by resident and discontinued on 12/31/2015. When paper care plans were converted to electronic care plans in Matrix the intervention was added to the care plan in error. Resident #14 plan of care reviewed for accuracy, and facility ensured all appropriate interventions are in place as resident allows. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who reside at the facility have the potential to be affected by the alleged deficient practice. The facility is to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistive devices to prevent accidents. All residents who are at risk for falls were reviewed by DNS/designee to ensure fall interventions are in place per plan of care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Facility licensed nurses and certified</p>	

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	<p>assist with transfers. Resident has hx [history] of non-compliance with calling for staff assist...."</p> <p>A Fall Care Plan, dated 6-24-15, indicated "...Resident is at risk for fall due to: unsteady, DM [diabetes mellitus], cardiovascular dx [diagnosis], med use, sob [shortness of breath], non-compliant with staff assist...Approach:...Start date: 12-31-15 Non-skid strips in front of closet...Start date: 12-31-15 Non-skid strips to left side of bed...."</p> <p>On 4-28-16 at 10:08 A.M., Resident #14's room was observed. No non-skid strips were observed on the side of her bed or in front of the closet.</p> <p>On 4-28-16 at 10:51 A.M., an interview with LPN (Licensed Practical Nurse) #13 was conducted. LPN #13 indicated "...I was here when she fell on the 18th...I was walking by to answer another call light in another room and out of the corner of my eye I saw her [Resident #14] getting up out of bed. She immediately fell on her butt as soon as she stood up...She needs to ask for help but she usually doesn't...."</p> <p>On 4-29-16 at 8:55 A.M., review of the current "Fall Management Program," last updated 2/2015, received from the DON at this time, indicated "...A care plan will</p>		<p>nursing assistants will be educated by DNS/designee on Plan of Care interventions related to falls. DNS/Designee will conduct rounds on each shift daily to ensure fall interventions are in place per plan of care. Residents who have a fall are to be evaluated by charge nurse to ensure fall interventions are in place. The Interdisciplinary team on the next business day to ensure that an appropriate intervention was put in place relating to the root cause. IDT will place the intervention on a CQI follow up form to ensure that the intervention was put in place. An IDT progress note will be placed in the residents' medical record. The residents care plan will be updated with all interventions that are added, or when an intervention is discontinued. Nursing Assistant Assignment Worksheet will be updated will all fall interventions. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/designee will complete audits of fall interventions for two weeks, then three times a week for two weeks, then weekly times four weeks, then monthly for six months. Trends will be reviewed in CQI monthly for six months and then quarterly thereafter to determine further education</p>	

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F 0328 SS=D Bldg. 00	<p>be developed at time of admission specific to each resident's fall risk factors...."</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure their procedure for the administration and assessment of nebulizer treatments was followed for 1 of 1 resident's reviewed for nebulizer treatments. (Resident #32)</p> <p>Finding includes:</p> <p>On 4/27/16 at 12:42 P.M., Resident #32 was alone in her room, sitting in her</p>	F 0328	<p>and/or monitoring needs. For any identified trends, or if 95% threshold is not achieved an action plan will be developed as needed. Audits will be turned into and monitored by the DNS for completion. Identified non-compliance will result in one-to-one education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented at CQI to determine further educational needs.</p> <p>F328 TREATMENT/CARE FOR SPECIAL NEEDS The facility is to ensure that the procedure for the administration and assessment of nebulizer treatments is followed per policy. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #32 remains at facility.</p>	05/24/2016

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	<p>wheelchair facing her television.</p> <p>Resident #32 had a nebulizer mask lying on her bedside table with the nebulizer machine still running.</p> <p>On 4/27/16 at 12:42 P.M., an interview was conducted with LPN #30 (Licensed Practical Nurse). LPN #30 indicated Resident #32 had received a nebulizer treatment at 11:20 A.M., she further indicated she stayed with Resident #32 for about 15 minutes and then left, Resident #32, she indicated, still had alittle medication in the cup when she left. LPN #30 indicated she normally stayed duration of the treatment but indicated she had a lot of resident's receiving nebulizer treatments on the unit.</p> <p>On 4/27/16 at 12:45 P.M., the clinical record for Resident # 32 was reviewed Resident #32 was admitted to the facility on 12/2/15, with diagnoses including, but not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, personal history of other malignant neoplasm of bronchus and lung and Parkinson's disease.</p> <p>A Medication Administration Record (MAR), dated 4/1/16 thru 4/30/16, indicated Resident #32 had been receiving the following nebulizer</p>		<p>Resident #32 continues to receive Albuterol nebulizer treatments QID. Medical record reviewed to ensure that an appropriate Nebulizer Treatment Flow Sheet is in place and being completed per policy.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All residents receiving nebulizer treatments per physicians order have the potential to be affected by the alleged deficient practice . The facility is to ensure that the procedure for the administration and assessment of nebulizer treatments is followed. Facility licensed nurses will be educated by DNS/designee on Nebulizer Treatment: Nursing Policy & Procedure-Skill Validation. Residents who receive nebulizer treatments medial record will be audited for a Nebulizer Treatment Flow Sheet to ensure staff is documenting assessments per policy. All new admissions receiving nebulizer treatments and residents receiving new orders for nebulizer treatments will be audited immediately to ensure that there is a Nebulizer Treatment Flow Sheet in their medical record. All nebulizer treatments have been evaluated for appropriate scheduling in conjunction with residents plan of care to ensure that</p>	

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	<p>treatments 4 times per day since April 7th, 2016. "...Albuterol [bronchodilator] 2.5mg [milligrams] / 3ml [milliliters] 1 [sic] vial IH [inhaled] nebulizer QID [four times per day].</p> <p>A Nurses Progress Note, dated 4/22/16 at 2:55 P.M., indicated "...Total with all cares...O2 [symbol for Oxygen] @ [at] 2 L [liters] per n/c [nasal cannula] biox [oxygen saturation] 92% [percent] No cold sx [symptoms] observed. Lung sounds diminished. Neb [nebulizer] tx [treatment] as ordered...."</p> <p>On 4/28/16 at 9:58 A.M., a "Nebulizer Treatment Flow Sheet" indicated the following: "... Resident...Date/Time: 4/28/16 [at] 0700 [7:00 A.M.]...Before TX [treatment]: [sic] HR [heart rate] 95 RR [respirations] 20 BS [breath sounds] clear During TX: HR 96, RR 20, and BS clear...After TX: HR 99, RR 20, BS clear.... Total Min [minutes] 15...."</p> <p>On 4/28/16 at 10:01 A.M., a interview was conducted with LPN #31. LPN #31 indicated a assessment of the resident's heartrate, respirations and breathsounds was to be conducted before and after a nebulizer treatment but that she was unable to locate any nebulizer flow sheets containing an assessment prior to 4/28/16 for Resident #32.</p>		<p>nurses have adequate time to administer nebulizer medications per policy.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Facility licensed nurses will be educated by DNS/designee on Nebulizer Treatment: Nursing Policy & Procedure-Skill Validation. Residents who receive nebulizer treatments medial record will be audited for a Nebulizer Treatment Flow Sheet to ensure staff is documenting assessments per policy. All new admissions receiving nebulizer treatments and residents receiving new orders for nebulizer treatments will be audited immediately to ensure that there is a Nebulizer Treatment Flow Sheet in their medical record. All nebulizer treatments have been evaluated for appropriate scheduling in conjunction with residents plan of care to ensure that nurses have adequate time to administer nebulizer medications per policy.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>DNS/designee will complete audits</p>				

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F 0364 SS=D Bldg. 00	<p>On 4/28/16 at 10:22 A.M., the corporate medical records representative provided the current procedure titled "... Nebulizer Treatment (Small Volume Nebulizer-SVN- Medicated Aerosol Therapy) Section: Nursing Policy& Procedure- Skill Validation...Review Date: 01/2015...Procedure Steps: 11. Stay with resident during the entire procedure...13. During procedure perform assessment including pulse, respiration, and breath sounds...16. Perform post-assessment including pulse, respiration, and breath sounds...19. Documentation: Pertinent information on Medication Administration Record (MAR) and Nebulizer Treatment Flow Sheet...." The corporate medical records representative indicated the facility began inservicing on nebulizer treatment on 4/27/16.</p> <p>3.1-47(a)(6)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p>		<p>Monday thru Friday of Nebulizer Treatments daily times two weeks, then three times a week for two weeks, then weekly times four weeks, then monthly times six months. Trends will be reviewed by CQI committee monthly for six months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, or if threshold of 95% is not met an action plan will be developed as needed. Audits will be turned into and monitored by the DNS for completion. Identified non-compliance will result in one-to-one education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented at CQI to determine further educational needs.</p>	

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	<p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure food was prepared to conserve the nutritive value related to pureed food preparation for 3 of 3 meals prepared.</p> <p>Finding includes:</p> <p>On 4-24-16 at 5:00 P.M., Cook #4 was observed to puree a turkey club sandwich. Cook #4 added 5 slices of unweighed sliced turkey into the puree bowl, pureed it, added a unmeasured amount of water, pureed it, poured it into a metal pan. Cook #4 indicate at this time "...I try to give the residents a little extra... a slice and a half of turkey per puree meal...."</p> <p>On 4-24-16 at 5:14 P.M., Dietary Aide #6 was observed to puree fruited gelatin. Dietary Aide #4 placed 2 scoops of Jello with peaches into the puree bowl, pureed it, poured it into 3 dessert bowls. She then sprinkled a unmeasured amount of thickener onto each bowl of pureed Jello, stirred it in.</p> <p>On 4-25-16 at 9:14 A.M., the Dietary</p>	F 0364	<p>F364 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>The facility is to ensure that food is prepared to conserve the nutritive value, flavor and appearance: and that food is palatable, attractive, and at the proper temperature per policy.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Cook #4, Dietary Aide #6, and Dietary Aide #4 were provided 1:1 education on following recipes for altered diets.</p> <p>Registered Dietician to review residents with altered diets for any new recommendations.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Residents receiving altered diets have the potential of being affected by alleged deficient practice. The facility is to ensure that food is prepared to conserve the nutritive value, flavor and appearance: and that food is palatable, attractive, and at the proper temperature.</p>	05/24/2016

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	<p>Manager provided the following recipes "Pureed Turkey Club and Pureed Fruited Gelatin." The Pureed Turkey Club recipe indicated "...Bib Pureed Bread & Biscuit Mix 4 ounce ... Water for Bread Mix 1 1/4 cup...Cooked Sliced Deli Turkey Breast 10 ounce ...Bacon 10- 1 ounce slice... Salad dressing 2 Tablespoon ...Water 1 1/4 cup ... Thicken -up #1, 2 3/4 Teaspoon ...Fresh Medium Tomato 0.625 1 med each ...Water 1/4 cup 1 1/4 Tablespoon Thicken -up#2, 1/4 cup 1 1/3 Tablespoon ...Bib Pureed Bread & Biscuit Mix 4 ounce ...Water for Bread Mix #2 ,1 1/4 cup Fresh Whole Iceberg Lettuce 2 1/4 cup...Bread Layer:</p> <p>1. Prepare Puree Bread Mix [#1] according to package directions. 2. Pour into full steam pan... Meat Layer: 3. Measure the amount of sliced turkey and COOKED bacon needed and place in food processor...4. Add water and process briefly until mixed. 5. Add Resource Thicken Up [[#1] ad process briefly until mixed. Scrape down sides with spatula and reprocess. Spread evenly over bread layer. Vegetable layer: 6. Seed the tomatoes. 7. Measure amount of tomatoes and lettuce needed and place in food processor. Add water until smooth in texture. 8. Add Resource Thicken UP [#2] and process briefly until mixed. Scrape down sides with spatula and reprocess. Spread evenly over meat layer.</p>		<p>Dietary staff has been in-serviced on following recipes for altered diets. Dietary manager to observe the mixing of pureed diet to ensure the recipe is being followed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Dietary staff has been in-serviced on following recipes for altered diets. Registered Dietician to review residents with altered diets for any new recommendations. Dietary manager to observe the mixing of pureed diet to ensure the recipe is being followed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Dietary Manager/designee will complete audits five days a week times two weeks, then three times a week times two weeks, then weekly times four weeks, then monthly times six months. Trends will be reviewed in CQI monthly for six months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, or if 95% threshold is not received, an action plan will be developed as needed. Audits will be completed on random days of the week, including</p>	

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F 0371 SS=F Bldg. 00	<p>Bread Layer: 9. Prepare Puree Bread Mix [#2] according to package directions. 10. Pour over vegetable layer. 11. Chill until set...."</p> <p>The Pureed Fruited Gelatin recipe indicated "...Fruited Gelatin [1/2 cup fruit] 5-1 slice... Food thickener 1 Tablespoon... 1... Remove portions to be pureed...2. Place in food processor and process until fine in consistency. 3. Gradually add a food thickener to gelatin while processing. 4. Scrape down sides of processor with a rubber spatula and process for 30 seconds...."</p> <p>During an interview on 4-27-16 at 10:30 A.M., the Corporate Dietary Manager indicated " ...recipes for pureed meals should be followed...."</p> <p>3.1-21(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food</p>		weekends. Audits will be turned into and monitored by the DNS for completion. Identified non-compliance will result in one-to-one education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented at CQI to determine further educational needs.				

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	<p>under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure meals were being served under sanitary conditions in regards to, proper use of hairnets, food thawing, hand washing, and food and plate storage for 1 of 1 Kitchens.</p> <p>Findings include:</p> <p>On 4-24-16, between 4:00 P.M. and 5:20 P.M., during the initial kitchen tour, accompanied by Cook # 4, the following was observed:</p> <p>Dietary Aide #2 was observed with large amounts of long hair hanging out from underneath the right side of her hairnet, onto her collar.</p> <p>In the reach in cooler: One bowl and one plastic container of egg salad dated 4-20-16, use by 4-22-16.</p> <p>One shelves below the serving line: 40 small dessert plates, 55 saucers, 15 dessert bowls, and two handled cups, all stored uncovered and upright. Dietary Aide #2 indicated at this time "...they are always stored like that...."</p> <p>In the prep sink:</p>	F 0371	<p>F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>Facility to ensure meals are being served under sanitary conditions in regards to, proper use of hairnets, food thawing, hand washing, and food and plate storage per policy.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents were identified as being affected by the alleged deficient practice. Hairnets are worn per protocol, food is being thawed per protocol, staff are washing hands per protocol, and food and plates are cleaned and stored properly. Undated bread undated container of green beans, container of diced ham, 2% milk, bacon crumbles, cranberry juice, prune juice, apple juice, fortified milk, crab salad and slice tomatoes, can of green beans, can of kidney beans, and mashed potatoes were discarded.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p>	05/24/2016	

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	<p>2-10 pound deli turkey breasts sitting in a empty sink. Cook #4 indicated at this time "... those are thawing... they were frozen... I took them out of the freezer at noon and put them there to thaw...."</p> <p>On the bread rack: A open, undated, loaf of toast sandwich bread.</p> <p>In the walk in cooler: A undated container of green beans. A undated container of diced ham. A gallon of 2% milk dated open 4-11-16 use by 4-18-16. A open to air, package of bacon crumbles. A pitcher container of cranberry juice with a use by date of 4-23-16. A pitcher of prune juice with a use by date of 4-23-16. Two pitchers of apple juice with a use by date of 4-23-16. A container of fortified milk with no date. A plastic container of crab salad with a use by date of 4-23-16. A container of sliced tomatoes with a use by date of 4-23-16.</p> <p>In the dry storage: A 6 pound can of green beans and a 6 pound can of kidney beans with a dent in the side.</p>		<p>All residents who reside at the facility have the potential to be affected by the alleged deficient practice. Facility to ensure meals are being served under sanitary conditions in regards to, proper use of hairnets, food thawing, hand washing, and food and plate storage per policy.</p> <p>Dietary staff in-serviced by Executive Director/designee on proper storage of dinnerware and cups, proper thawing of food items, sending back dented cans of food items, proper handling and storage of food at the serving line.</p> <p>Staff in-serviced by Executive Director/designee on dating food and beverage items, storage of food and beverage items, hand washing, discarding outdated food and beverage items, appropriate application of hair nets, and cross contamination while stirring residents beverages.</p> <p>Dietary manager inspected dry storage area, reach in cooler, shelves around serving line, bread rack, walk in cooler, and observed all kitchen staff to ensure food was labeled and stored properly, and staff hairnets were properly applied.</p> <p>What measures will be put into</p>	

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	<p>On the shelf above the serving line: A large, uncovered, plastic container of fortified mashed potatoes.</p> <p>Dietary Aide#2 observed to wash her hands for 4 seconds, put on gloves, then placed dinner desserts on trays.</p> <p>During an interview on 4-24-16 at 5:20 P.M., the DM (Dietary Manager) indicated "... meat should be thawed in a container of water in the sink or we pull it from the freezer and put it in the cooler a few days before we need it..."</p> <p>On 4-24-16 from 5:42 P.M. to 6:25 P.M., observation of the dinner meal was conducted in the main dining room. During this time the following were observed:</p> <p>At 5:58 P.M., CNA (Certified Nursing Assistant) #7 was observed exiting the kitchen with her bangs hanging out the front of her hairnet.</p> <p>At 6:05 P.M., LPN (Licensed Practical Nurse) #8 was observed exiting the kitchen with her bangs hanging out of the front of her hairnet</p> <p>CNA #7 was observed to wash her hands for 10 seconds, then serve coffee.</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Dietary staff in-serviced by Executive Director/designee on proper storage of dinnerware and cups, proper thawing of food items, sending back dented cans of food items, proper handling and stargaze of food at the serving line</p> <p>Staff in-serviced by Executive Director/designee on dating food and beverage items, storage of food and beverage items, hand washing, discarding outdated food and beverage items, appropriate application of hair nets, and cross contamination while stirring residents beverages.</p> <p>Dietary manager/designee will observe during each meal service, staff washing hands, hair nets, food storage areas, dish storage area to ensure proper protocols are followed</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Dietary Manager/designee will complete sanitation review five days a week times two weeks, then three</p>	

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	<p>On 4-27-16 from 11:50 A.M. to 12:24 P.M., observation of the lunch meal was conducted in the main dining room. During this time the following were observed:</p> <p>At 12:01 P.M., Employee #9 was observed stirring a residents hot chocolate then with same spoon, stirred a second and then a third residents hot chocolate.</p> <p>At 12:07 P.M., Employee #9 was observed entering the kitchen without a hairnet on.</p> <p>During an interview on 4-27-16 at 10:30 A.M., the Corporate Dietary Manager indicated "... dented cans should be sent back...food should not be used if it is out dated...hand washing should be for one minute...everyone that is in the kitchen should where hairnets, they need to be worn correctly covering all the hair... plates should be stored upside down...."</p> <p>On 4-27-16 at 11:22 A.M., the Corporate Dietary Manager provided the current policies titled "General Food Preparation and Handling" revised 7/15, and " Food Storage" revised 7/15. The polices indicated " ...11. Leftovers must be dated, labeled, covered...5...dented cans and</p>		<p>times a week times two weeks, then weekly times four weeks, then monthly times six months. Audits will be completed on random days of the week, including weekends. This audit will cover proper storage of dinnerware and cups, proper thawing of food items, sending back dented cans of food items, proper handling and stargaze of food at the serving line. Trends will be reviewed in CQI monthly for six months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, an action plan will be developed as needed. Audits will be turned into and monitored by the Executive Director for completion. Identified non-compliance will result in one-to-one education up to and including termination. Clinical Education Coordinator/designee will complete audits Monday thru Friday which will include properly dated food and beverage items, storage of food and beverage items, hand washing, discarding outdated food and beverage items, appropriate application of hair nets, and cross contamination while stirring resident's beverages. Trends will be reviewed in CQI monthly for six months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, or if 95%</p>	

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F 0431 SS=D Bldg. 00	<p>spoiled foods should be disposed of promptly...12...the food must clearly labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded...leftover foods can be held ...for no more than 3 days...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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 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</p>		<p>threshold is not achieved, an action plan will be developed as needed. Audits will be turned into and monitored by theDNS for completion. Identified non-compliance will result in one-to-one education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented at CQI to determine further educational needs.</p>		

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	<p>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 stored in a secure locked area for 1 of 4 nurses stations.</p> <p>Finding includes:</p> <p>On 4/28/16 at 9:40 P.M., 20 boxes of unopened medications were observed sitting on the counter of the 100 Hall nurses station. The Nurses Station was unattended at the time as the unit nurse was observed around the corner in the hallway passing medications.</p> <p>On 4/28/16 at 9:44 P.M., an interview was conducted with RN (Registered Nurse) #32. RN #32 indicated the medication should not be stored at the nurses station but he was behind passing medications because of admissions and</p>	F 0431	<p>F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS</p> <p>Facility is to ensure medications are stored in a secure locked area per policy.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents were affected by the alleged deficient practice. Facility licensed nurses will be educated by DNS/designee on Proper Storage of Medications.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All residents who reside at the</p>	05/24/2016

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	<p>had just not put them away.</p> <p>On 4/28/16 at 10:30 P.M., during an interview, the DON (Director of Nurses) indicated medications should be not be left unattended at the nurses station they should be stored in a locked secure area.</p> <p>On /29/16 at 11:00 A.M., a copy of the "[Pharmacy Name] Storage and Expiration Dating of Drugs, Bilogicals Syringes and Needles" policy was provided by the DON. The policy indicated "... Procedure: 2. 2.3 The Facility should ensure that all drugs and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room, inaccessible by residents and visitors...."</p> <p>3.1-25(m)</p>		<p>facility have the potential to be affected by the alleged deficient practice. Facility is to ensure medications are stored in a secure locked area per policy.</p> <p>Facility licensed nurses will be educated by DNS/designee on Proper Storage of Medications. Medication carts were inspected by DNS/Designee to ensure all medications were properly stored per protocol.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Facility licensed nurses will be educated by DNS/designee on Proper Storage of Medications. Facility to provide additional tote for nurses to place medication deliveries in upon pharmacy delivery to place securely in medication room when unable to place in medication cart immediately. DNS/Designee will observe medication carts per shift to ensure medications are properly stored.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>ADNS and/or designee will complete audits of medication storgae</p>		

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F 0441 SS=D Bldg. 00	<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</p>		<p>Monday thru Friday for two weeks, then three times a week for two weeks, then weekly for four weeks, then monthly for three months. Trends will be reviewed by CQI committee monthly for six months and then quarterly thereafter to determine further education and/or monitoring needs. For any identified trends, or threshold of 95% compliance is not met, an action plan will be developed as needed. Audits will be turned into and monitored by the DNS for completion. Identified non-compliance will result in one-to-one education up to and including termination. Any identified trends will be forwarded to the Administrator for review and presented to CQI committee to determine further educational needs.</p>	

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	<p>resident; and</p> <p>(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, record review, and interviews, the facility failed to ensure staff followed infection control procedures for linen for 2 of 4 units, the 100 and 200 units.</p> <p>Findings include:</p> <p>On 4-27-16 at 3:51 P.M., Laundry Aide #14 was observed walking down the 200 hall entering and exiting resident rooms with clean residents clothes held, uncovered, against her body.</p>	F 0441	<p>F441 Infection Control, Prevent Spread, Linens It is the policy of the facility to 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>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>No residents were identified as being affected by the alleged</p>	05/24/2016

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	<p>During an interview on 4-27-16 at 3:59 P.M., Laundry Aide #14 indicated "... I just had a few things...I should have at least threw a cover over them...."</p> <p>On 4-28-16 at 9:03 A.M., Dietary Aide #15 was observed walking down the 100 hall into the assisted dinning room, holding 6 clean dinning room table cloths against her body .</p> <p>During an interview on 4-28-16 at 10:36 A.M., the Dietary Manager indicated "... Tablecloths should be transported to the dinning room on a cart...."</p> <p>During an interview on 4-28-16 at 1:44 P.M., the Housekeeping Supervisor indicated "... clothes that are hung up should have a bag over them...bras and underwear are placed in a bag and tied ...if I have a lot of clothes they go on a covered cart ...other residents laundry should not be taken into other residents rooms"</p> <p>On 4-28-16 at 2:00 P.M., the Corporate Housekeeping Manager provided the current policy, revised 2/2012, titled "Laundry/Linen." The policy indicated, "...2... A. Clean linen should be carried away from body to prevent contamination...5... Cover clean linen...."</p>		<p>deficient practice.</p> <ul style="list-style-type: none"> Facility staff have been inserviced on proper transportation and handling of clean linen. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <ul style="list-style-type: none"> All residents who reside in this facility have the potential to be affected by the alleged deficient practice. Facility staff have been inserviced on proper transportation and handling of clean linen. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Carts for transporting clean laundry and linens have been put into place for dietary and laundry to ensure proper transport. Infection control rounds will be completed by Housekeeping Supervisor or designee. The Executive Director is responsible for compliance related to clean linen handling and transport. Non-compliance with to clean linen handling and transport procedures may result in further education, and/or disciplinary action 	

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	3.1-19(g)(1)		<p>up to termination.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Infection control rounds will be completed by Housekeeping Supervisor or designee daily time 3 weeks, 3 times weekly for one month and monthly thereafter. · Audit tools will be submitted to the CQI committee and if 95% threshold is not achieved, action plans will be developed as needed. 		