

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2013
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NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 24, 25, 26, 27, 28 and July 1, 2013</p> <p>Facility number: 011150 Provider number: 155760 AIM number: 200831020</p> <p>Survey team: Lora Swanson, RN-TC Shauna Carlson, RN (6/25, 6/26, 6/27, 6/28, 7/1, 2013) Shelly Miller-Vice, RN (6/25, 6/26, 6/27, 6/28, 7/1, 2013) Chris Greeney, Medical Surveyor</p> <p>Census bed type: SNF: 32 SNF/NF: 19 Total: 51</p> <p>Census payor type: Medicare: 13 Medicaid: 18 Other: 20 Total: 51</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>This is the requested Plan of Correction for the Recertification and State Licensure Survey. Survey dates: June 24, 25, 26, 27, 28, and July 1, 2013 for facility number 011150. This constitutes the written allegation of compliance for the deficiencies cited. However, submission of this PPlan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. The Maples at Waterford Crossing Health Campus desires this Plan of Correction to be considered as the facility's allegation of compliance. Compliance effective August 1, 2013. The Maples at Waterford Crossing Health Campus respectfully requests this Plan of Correction be submitted as desk review for compliance for the deficiencies cited.</p>	
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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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	Quality Review completed on July 10, 2013, by Brenda Meredith, R.N.			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the responsible party after a fall for 1 of 4 records reviewed for accidents. (Resident #92)</p>	F000157	It is the intent of the Maples at Waterford Crossing to notify the physician and responsible party of any resident fall.1. Nurses were educated to notify resident #92's both primary and secondary	08/01/2013			

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	<p>Findings include:</p> <p>On 6/25/13 at 11:02 a.m., interview with Resident #92's family member indicated the resident had fallen on 3/3/13, requiring X-rays, and she was not notified. Resident #92's family member indicated she came into the facility the next morning and found out something had happened by seeing a skin tear on his left elbow.</p> <p>On 6/28/13 at 10:17 a.m., review of Resident #92's chart indicated his diagnoses included but were not limited to "...CVA [cerebrovascular accident - stroke], muscle spasms,...."</p> <p>Review of a nurse's note at this time indicated "3/3/13 7pm Writer summoned to room [room number] where resident was in [sic] floor. Assessed, Vitals WNL [within normal limits],...Resident was leaning over to pick a cookie off the floor. He has L [left] knee abrasion, R [right] knee abrasion, L eye abrasion, L elbow skin tear. [Doctor's Name] notified, [Director of Health Services name], family [son's name] notified...."</p> <p>On 6/28/13 at 11:20 a.m., review of the "Fall Circumstance, Assessment and Intervention" form, completed on 3/3/13, indicated "Fall Circumstance</p>		<p>contact for falls. 2. Upon review of the falls occurring within the campus for the last 30 days, no other residents was noted to be affected by this deficiency.3. The deficiency was evaluated related to system, education and compliance. The DHS (Director of Health Services), or their designee will review fall notifications during morning clinical meetings. Any falls identified as not being communicated per family request and campus policy will be immediately corrected.4. Results from these audits will be reported to the QI (Quality Improvement) Committee. Audits will be conducted on a regular basis each week times 6 months. These audits will continue as stated until 100% compliance for each fall is achieved for 6 consecutive months, or until the QI committee determines otherwise due to the outcome of the audits.</p>				

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	<p>Investigation...date of fall: 3/3/13, time of fall: 7pm...witnessed: N [No]...injury:...abrasion [checked]...skin tear [checked]...MD notified: [Doctors name], Family notified: [Sons name]...." Review at this time of the "Falls" care plan for Resident #92 indicated "At risk for fall/injury AEB [as evidenced by]...potential for fall...r/t [related to]...left side weakness...Interventions:...report falls to physician/responsible party...."</p> <p>On 6/28/13 at 11:45 a.m., review of Resident #92's current face sheet indicated his significant other was listed as the primary contact and his son was listed as the secondary contact. Further review at this time indicated there was a post-it note stuck to the face sheet which indicated "Notify both with all info." Interview at this time with the 100/200 Unit Manager [Employee #10] indicated staff is to call both contacts in the instance of a fall.</p> <p>On 6/28/13 at 2:30 p.m., review of the current "Falls Management Program Guidelines" received from the DHS [Director of Health Services] at this time indicated "...the staff member attending to the resident at the time of the incident should notify the</p>			

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	attending physician...and the responsible party...." 3.1-5(a)(2)			

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F000201 SS=D	<p>483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate. Based on interview and record review, the facility failed to justify why the facility could not meet the needs of 1 resident in a sample of 30 closed records reviewed for community discharge. (Resident #9)</p> <p>Findings include:</p>	F000201	It is the intent of The Maples at Waterford Crossing to meet the needs of any resident placed in the campus for nursing services. 1. Resident #9 has discharged from the campus2. Upon the states review of 30 closed charts, no other resident was noted to be affected by this deficiency. ADDENDUM (8/7/13) On August	08/01/2013			

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	<p>On 6/26/13 at 11:30 a.m., a record review was conducted of Resident #9's closed clinical medical record which indicated a discharge Physicians Order dated 3/29/2013 "...Discharge to another facility c [with] personal belongings...." It also indicated that documentation performed by the nurse did not include, "...patient care plan...."</p> <p>On 6/26/13 at 2:00 p.m., a record review was conducted on Resident #9's clinical medical record which indicated in the "...Social Service Progress Notes on 3/22/13...ED [Executive Director], DHS [Director of Health Services], DRS [Director of Resident Services] and CRS [Clinical Resident Services] went to speak to resident regarding his behavior on 3-21-13. Res. [resident] stated multiple times that he does not want to be here at the [name of facility] and that he is going to call his brother to take him home. ED informed res that DRS [name of DRS] can assist him c [with] discharge plans. Res. stated he did not want the (name of facility) to help him. ED informed res that he would be issued a 30 day discharge due to his behaviors and that he could discharge to another facility or to a psychiatric hospital that could</p>		<p>8th (8/8/13), the Executive Director, Director of Health Services, Assistant Director of Health Services, and the Medical Records Coordinator reviewed 10 closed charts and 10 open charts and determined that no other resident(s) was effected by this allegation of non-compliance.3. The deficiency was evaluated related to system, education and compliance. Residents with behaviors are reviewed each clinical meeting by the IDT (Interdisciplinary Team). These residents are actively discussed and documented during Resident First/Service Plan meetings. Family and resident are invited to participate in these meetings. This discussion may include but not be limited to: Clinical Aggregate and Related Challenges in a social setting, Psych Services, Medical Director review, Responsible Party involvement and support, evaluate Room Assignment and possible changes, as well as Community options available. A resident noted with complex and escalating behaviors will be evaluated utilizing the Discharge Action Evaluation Tool. ADDENDUM 8/7/2013: Staff were re-educated to these systems, as well as the Policies related to them, on Tuesday, July 23, (7/23/13) and/or Wednesday, July 31, 2013 (7/31/13) and ongoing 1:1 education and</p>		

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	<p>help him with his mood. Resident stated he was having a bad day on 3-21-13 because of his blood sugar. Res did state he does have time when his mood changes significantly. Res stated he understands that if he wants to leave prior to 30 days he can. ED did state if he has no behaviors during that 30 days the team and res could address about him staying longer. Res stated he did not want to stay longer. SW [Social Worker] asked if res had preferences in placement and res stated he would let SW know on Monday. SW did let res know she would begin looking for placement today.[signature of SW]." "3/22/13 [separate entry, untimed] SW called [another Long Term Care(LTC) facility] and made referral. They will call back c [with] time to come and assess him. [signature of SW]." "3/22/13 [separate entry untimed] SW called [another (in addition to the above) long term care facility] and faxed referral and they plan on coming out today to assess resident. [signature of SW]." "3/22/13 [separate entry, untimed] SW spoke to res today regarding placement options. Res did not name any specific places but said he will not go to [name of specific LTC]. SW notified [name of LTC facility]. Res</p>		<p>training as needed to assure compliance.4. The Discharge Action Evaluation tool will be utilized if it is determined that the campus cannot meet the residents needs. The Resident, Resident's Family, Ombudsman, Adult Protective Services and the resident's physician will be notified of the utilizationof the Discharge Action Evaluation tool.v The MDS (Minimum Data Set) Coordinator along with the DHS (or designee) will review the Resident First/Service Plan meeting notes as completed by the RSD (Resident Services Director/Social Worker), or their designee, on a Discharge Action Evaluation determination. 5.. Results from these audits will be reported to the QI (Quality Improvement) Committee. Audits will be conducted on a regular basis each week times 6 months. These audits will continue as stated until 100% compliance for each Discharge Action Evaluation determination is acheived for 6 consecutive months, or until the QI committee determines otherwise due to the outcome of the audits.</p>				

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	<p>stated he really liked the lady from [name of LTC facility] and is going to talk to her and wants to move there. SW notified [name of staff person] at [name of LTC facility] and she will be out to see him on Tuesday again. [signature of SW]."</p> <p>"3/27/13 [untimed entry] Res will discharge to [name of LTC facility] per residents request on 3-29-13 to continue c [with] Medicare and possible LTC. [signature of SW]."</p> <p>On 6/26/13 at 3:00 p.m., an interview was conducted with the MDS)Minimum Data Assessment) Nurse indicating that the resident had been discharged to another long term care facility and it was unclear to why the discharge had occurred. It was indicated, "...he came and went from the hospital after he was admitted here from [name of acute hospital]...he came from another acute hospital to which he was admitted from living in his own apartment with his son, I believe...."</p> <p>On 6/26/13 at 3:30 p.m., an interview was conducted with the Director of Social Services indicating that Resident #9 had been discharged to another long term nursing facility on March 29, 2013, due to sexually inappropriate behaviors, mal-adaptive</p>				

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	<p>manipulating behaviors, non-compliance in self-functional capabilities and unmotivated participation in therapy sessions. The SSD indicated, "...he wanted to go home, but that wasn't an option...he was focused on returning to live with his family...we did try to guide him and [name of Executive Director] informed resident that he would be issued a 30-day discharge notice due to his behaviors and that he could discharge to another facility or to a Psychiatric hospital that could help him with his behaviors...."</p> <p>On 6/26/13 at 3:35 p.m., an interview with the Executive Director (ED) indicated, "...the majority of the time he was here he was non compliant with his behavior in the dining room, he'd strip off his clothes; in therapy, he'd refuse to go; he'd go to the wound doctor and return and refuse to comply with the wound instructions; he would claim his resident rights to intimidate the options for care such as, it's my right to not do what the doctors say...one of my physical therapy assistance (name) stayed over all night to help with evaluating the efforts of having a mobile wheelchair...we moved him to different rooms to help with his behaviors...finally staff did an IDT</p>			

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	<p>(inter disciplinary team meeting) to address his behaviors, and he was confronted...I told him consider this your 30-day notice...no, we didn't do the paper work for a 30-day notification... well, we did offer him to reevaluate this if his behaviors changed in those 30 days... We didn't offer him psychiatric services...I have no idea if he had psych services while he was out...."</p> <p>On 6/26/13 at 3:40 p.m., Director of Social Services indicated, "...If your behaviors continued, we would give him a 30-day notice of discharge...I wasn't involved in his care [management]...I had a social work masters degree student in at that time, and they dealt with him; I felt it was good experience to deal with a resident like that...No...he [the resident] was not seen by psychiatric services at [name of acute hospital resident was admitted from]...No... he wasn't seen by psychiatric services at [name of acute hospital resident was discharged and re-admitted to/from while in the facility]...No...he wasn't seen by psychiatric or referred for psychiatric services while a resident here...."</p> <p>On 6/26/13 at 3:10 p.m., CNA #32 was interviewed indicating, "...no, I</p>			

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	<p>don't recall a time when psychiatric service was here with [name of Resident #9]...No, the resident wasn't moved...he was in the same room the whole time I took care of him...."</p> <p>On 6/26/13 at 3:20 p.m., an interview was conducted with RN #28, with the Hall 100/200 Unit Manager in the room. RN #28 indicated that on , "...3/21/13 there was a confrontation with Resident #9...he was unable to be calmed down, he yelled at me in front of other families and residents...he had a blood sugar over 500...almost 600 I believe...he wouldn't listen to anything I tried to say...it was terrible...." RN #28 indicated that the residents behaviors had been demanding of the primary staff, that staffing alterations had been done to help with staff stress and that her personal experience providing care for Resident #9 had been difficult to manage. It was also indicated that Resident #9 had not been moved to different rooms.</p> <p>On 6/26/13 at 3:30 p.m., an interview was conducted with PTA (Physical Therapy Assistant) #27 indicating that Resident #9 was a behavior problem in the therapy department and that several behavior modification contracts had been provided to offer</p>				

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	<p>the Resident control of his therapy and had not been successful. She indicated that the therapy department had not stayed over into off hour shifts to help with his evaluation of the power wheelchair use. It was also indicated that he had made progress, had continued in therapies and was discharged with residual Medicare days of use.</p> <p>On 6/27/13 at 10:30 a.m., a record review was conducted of Resident #9's care plan for behavior management. A "Behavior Care Plan," dated "2/13," included the following: "Actual Behavior Problem: Verbally abusive, Socially inappropriate, Resistive to care Related to Diabetes. Goals: Resident will not hurt themselves or others secondary to their behaviors. Resident will accepts redirections within 2 minutes of staff intervention, 100% of the time. Target Date: 5/13. Approach: Report to physician changes in behaviors.[Discipline: Nursing] Provide non-confrontational environment for care. [Discipline: Nursing] Anticipate care needs and provide them before the resident becomes overly stressed. [Discipline:All]</p>			

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	<p>Share with the resident other options for dealing with feelings. [Discipline: Nursing/ Social Service]</p> <p>Reinforce positive behaviors. [Discipline: All]</p> <p>Educate the resident/ responsible party on the casual factors of the behaviors and the planned intervention. [Discipline: Nursing/ Social Services]</p> <p>Observe behavior episodes, attempt to determine underlying cause. If observed, document in behavior log/kiosk. [Discipline: All]</p> <p>Intervene as needed to protect the rights and safety of resident and others [i.e. approach in calm manner, divert attention, remove from situation and take to another location, prn] [Discipline: All]</p> <p>If appropriate, discuss behavior with resident, explain why behavior is unacceptable/ unsafe [Discipline: Nursing/ Social Services]</p> <p>Re-approach later if he/she becomes agitated.[Discipline: All]</p> <p>Provide opportunities for positive interaction, attention by stopping and talking with resident when passing in the halls. [Discipline: All]</p> <p>Contact Social Service, prn [Discipline: Nursing]</p> <p>On 6/27/13 at 10:40 a.m., a Discharge Care Plan record review</p>						

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	<p>was also conducted indicating a start date of "1-17-2013. Resident wants to discharge home. Resident will discharge home. Target Date: 4-13. Approach: Provide services according to care plan in an effort to enhance optimum well-being. OT/PT/ST, as ordered. Dietician Consult. Pain Management. [Discipline: All] Discuss with resident/ family representative discharge planning process [Discipline: Social Services] Assess future placement setting to determine if residents needs can be met, prn [Discipline: Social Services/ Therapy] Determine Discharge date:[Discipline Social Services/ Therapy/ Nursing] Investigate need for and referrals to: Home Health Care Home PT. [Discipline: Nursing/ Social Services/ Therapy] Provide resident and/or representative education to include: Daily activity plan, Diet, Treatments, Medications.[Discipline: All] Discharge to home as ordered. [Discipline: Nursing/ Social Services].</p> <p>On 6/27/13 at 10:45 a.m. a record review was conducted of the physicians orders dated from 3/14/13 to 3/29/13. On 3/29/13 a discharge order was written. There were no discharge orders or discussion of</p>			

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	<p>discharge prior to this date in the physicians orders. There were no referrals for psychiatric services, no notifications to the physician for maladaptive behavior.</p> <p>On 6/27/13 at 10:55 a.m., a record review was conducted of the "Post-Discharge Plan of Care," dated "3/27/13," and signed by the Director of Social Services and signed by Resident #9 on "3/29/13." The "Discharge Summary and Recapitulation of Stay. Date of admission: 1/17/13. Date of Discharge: 3/29/13. Date of Summary: 3/29/13. Discharge destination: Acute Rehab. Reason for Discharge: Transfer to other care setting: [name of receiving nursing home]: Recapitulation of Stay: Services provided: Wound care, Respiratory care, nursing observation, injections, pain management, teaching, and other: left blank. Therapy provided: Strengthening, ADL training, Neuromuscular re-education, positioning. Summary of therapy progress: Pt had slight increase in level of function c[with]increase ability to sit at edge of bed and increase in lower extremity to transition to SNF [skilled Nursing Facility]. [signature of PTA #27]. Dietary/nutrition: Services provided;</p>			

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	<p>Current diet; and summary of nutritional progress"... were left blank... "signature of DFS [Director of Food Services]. Social Services: Services provided: Behavior management, psychosocial support, discharge planning: summary of social services interventions and progress: Short term support to referral to another LTC [long term care]. [signature of Director of Social Services]. Activities: No concerns. [Signature of Activity Director]."</p> <p>On 6/27/13 at 11:00 a.m., a record review was conducted of the "Resident Transfer Form. Date of stay at facility transferring from: 3/14/13 to 3/29/13... Reason for transfer: Ins. [Insurance]...Behavior: Cooperative and oriented times 3 [person, place and time]...Resident uses: Electric wheelchair... Social Information: [Adjustment to disability, emotional support from family, motivation for self-care, socializing ability, financial plan, family health problems, etc..."...entire block left blank. There was no mention of behavior difficulties in relationship to this residents discharge into another long term care facility."(signature of LPN #33)."</p> <p>3.1-12(a)(4)(a)</p>						

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F000204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>Based on interview and record review, the facility failed to provide preparation and orientation upon discharge to another long term care facility for 1 resident in a sample of 30 reviewed for community discharge. (Resident #9)</p> <p>Findings include:</p> <p>On 6/26/13 at 11:30 a.m., a record review was conducted of Resident #9's closed clinical medical record. It indicated a discharge Physicians Order dated 3/29/2013 indicating, "Discharge to another facility c (with personal belongings."</p> <p>On 6/26/13 at 2:00 p.m., a record review was conducted on Resident #9's clinical medical record which indicated in the "...Social Service Progress Notes on 3/22/13...ED [Executive Director], DHS [Director of Health Services], DRS [Director of Resident Services] and CRS [Clinical Resident Services] went to speak to resident regarding his behavior on 3-21-13. Res. [resident] stated</p>			F000204	<p>It is the intent of The Maples at Waterford Crossing to provide information for and/or meet the needs of any resident needing preparation and orientation upon discharge to another long term care facility 2. Upon the state review of 30 closed charts, no other resident was noted to be affected by this deficiency. ADDENDUM (8/7/13) On August 8th (8/8/13), the Executive Director, Director of Health Services, Assistant Director of Health Services, and the Medical Records Coordinator reviewed 10 closed charts and 10 open charts and determined that no other resident(s) was effected by this allegation of non-compliance.3. The deficiency was evaluated related to system, education and compliance. Resident's and their families are actively involved in the decision as to where the resident discharges to. The RSD (Resident Services Director/Social Worker), or designee works closely with nursing services and therapy services to assure discharge needs of the resident are met. This may include but not be limited to: Home Health needs,</p>		08/01/2013

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	multiple times that he does not want to be here at the [name of facility] and that he is going to call his brother to take him home. ED informed res that DRS [name of DRS] can assist him c [with] discharge plans. Res. stated he did not want the [name of facility] to help him. ED informed res that he would be issued a 30 day discharge due to his behaviors and that he could discharge to another facility or to a psychiatric hospital that could help him with his mood. Resident stated he was having a bad day on 3-21-13 because of his blood sugar. Res did state he does have time when his mood changes significantly. Res stated he understands that if he wants to leave prior to 30 days he can. ED did state if he has no behaviors during that 30 days the team and res could address about him staying longer. Res stated he did not want to stay longer. SW [social worker] asked if res had preferences in placement and res stated he would let SW know on Monday. SW did let res know she would begin looking for placement today.[signature of SW]." "3/22/13 [separate entry, untimed] SW called [another Long Term Care(LTC) facility] and made referral.. They will call back c [with] time to come and assess him. [signature of SW]."		Durable Medical Equipment needs, future physician's appointments, out patient therapy, or long term care placement. These residents are actively discussed and documented during Resident First/Service Plan meetings, as well as IDT (Interdisciplinary Team) weekly meetings. Care plan goals are reviewed as well as progress to those goals. Family and resident are invited to participate in these meetings. ADDENDUM 8/7/2013: Staff were re-educated to these systems, as well as the Policies related to them, on Tuesday, July 23, (7/23/13) and/or Wednesday, July 31, 2013 (7/31/13) and ongoing 1:1 education and training as needed to assure compliance.4. The MDS (Minimum Data Set) Coordinator along with the DHS (or designee) will review the Resident First/Service Plan meeting notes and Discharge Care Plan, as completed by the RSD (Resident Services Director/Social Worker), or their designee, for compliance with above stated. Compliance will be tracked each week and recorded for QI (Quality Improvement) review.5. Results of these audits will be reported to the QI (Quality Improvement) Committee. Audits will be conducted on a regular basis each week times 6 months. These audits will continue as stated until 100%				

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	<p>"3/22/13 [separate entry untimed] SW called [another (in addition to the above) long term care facility] and faxed referral and they plan on coming out today to assess resident. [signature of SW]."</p> <p>"3/22/13 [separate entry, untimed] SW spoke to res today regarding placement options. Res did not name any specific places but said he will not go to [name of specific LTC]. SW notified [name of LTC facility]. Res stated he really liked the lady from [name of LTC facility] and is going to talk to her and wants to move there. SW notified [name of staff person] at [name of LTC facility] and she will be out to see him on Tuesday again. [signature of SW]."</p> <p>"3/27/13 [untimed entry] Res will discharge to [name of LTC facility] per residents request on 3-29-13 to continue c [with] Medicare and possible LTC. [signature of SW]."</p> <p>On 6/26/13 at 3:30 p.m., an interview was conducted with the Director of Social Services indicating that Resident #9 had been discharged to another long term nursing facility on March 29, 2013, due to sexually inappropriate behaviors, mal-adaptive manipulating behaviors, non-compliance in self-functional capabilities and unmotivated</p>		<p>compliance for each Discharge Action Evaluation determination is acheived for 6 consecutive months, or until the QA committee determines otherwise due to the outcome of the audits.</p>				

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	<p>participation in therapy sessions. The DDS indicated,"...he wanted to go home, but that wasn't an option...he was focused on returning to live with his family...we did try to guide him and [name of Executive Director] informed resident that he would be issued a 30-day discharge notice due to his behaviors and that he could discharge to another facility or to a Psychiatric hospital that could help him with his behaviors...."</p> <p>On 6/26/13 at 3:40 p.m., Director of Social Services indicated,"... If your [Resident #9] behaviors continued, we would give him a 30-day notice of discharge... I wasn't involved in his care [management]... I had a social work masters degree student in at that time, and they dealt with him; I felt it was good experience to deal with a resident like that...No...he [the resident] was not seen by psychiatric services at [name of acute hospital resident was admitted from]...No... he wasn't seen by psychiatric services at [name of acute hospital resident was discharged and re-admitted to/from while in the facility]... No... he wasn't seen by psychiatric or referred for psychiatric services while a resident here...."</p> <p>On 6/27/13 at 10:40 a.m., a</p>			

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	<p>Discharge Care Plan record review was conducted indicating a start date of "1-17-2013. Resident wants to discharge home. Resident will discharge home. Target Date: 4-13. Approach: Provide services according to care plan in an effort to enhance optimum well-being. OT/PT/ST [Occupational, Physical & Speech Therapy], as ordered. Dietician Consult. Pain Management. [Discipline: All]</p> <p>Discuss with resident/ family representative discharge planning process [Discipline: Social Services]</p> <p>Assess future placement setting to determine if residents needs can be met, prn [Discipline: Social Services/ Therapy]</p> <p>Determine Discharge date:[Discipline Social Services/ Therapy/ Nursing]</p> <p>Investigate need for and referrals to: Home Health Care Home PT. [Discipline: Nursing/ Social Services/ Therapy]</p> <p>Provide resident and/or representative education to include: Daily activity plan, Diet, Treatments, Medications.[Discipline: All]</p> <p>Discharge to home as ordered. [Discipline: Nursing/ Social Services].</p> <p>On 6/27/13 at 10:55 a.m., a record review was conducted of the "Post-Discharge Plan of Care," dated</p>				

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	<p>3/27/13, and signed by the Director of Social Services and signed by Resident #9 on 3/29/13: "Discharge Summary and Recapitulation of Stay. Date of admission: 1/17/13. Date of Discharge: 3/29/13. Date of Summary: 3/29/13. Discharge destination: Acute Rehab. Reason for Discharge: Transfer to other care setting: [name of receiving nursing home]... Social Services: Services provided: Behavior management, psychosocial support, discharge planning: summary of social services interventions and progress: Short term support to referral to another LTC [long term care. [signature of Director of Social Services]...."</p> <p>On 6/27/13 at 11:00 a.m., a record review was conducted of the "Resident Transfer Form. Date of stay at facility transferring from: 3/14/13 to 3/29/13... Reason for transfer: Ins. [Insurance]... Behavior: Cooperative and oriented times 3 [person, place and time]... Resident uses: Electric wheelchair... Social Information: [Adjustment to disability, emotional support from family, motivation for self-care, socializing ability, financial plan, family health problems, etc...]," entire</p>						

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	<p>block left blank.</p> <p>There was no mention of behavior difficulties in relationship to this residents' discharge into another long term care facility."[signature of LPN #33]...."</p> <p>3.1-12(a)(21)</p>			

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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to provide 1 resident freedom from potentially intimidating verbal abuse by staff leading up to his discharge from the facility. This affected 1 of 30 discharged residents sampled. (Resident #9)</p> <p>Findings include:</p> <p>On 6/26/13 at 11:30 a.m., a record review was conducted of Resident #9's closed clinical medical record. A discharge Physicians Order, dated 3/29/2013, indicated, "Discharge to another facility c (with) personal belongings." It also indicated that documentation performed by the nurse did not include, "...patient care plan...."</p> <p>On 6/26/13 at 2:00 p.m., a record review was conducted on Resident #9's clinical medical record which indicated in the "...Social Service</p>	F000223	<p>It is the intent of The Maples at Waterford Crossing to provide residents freedom from potentially intimidating verbal abuse by staff. 1. The staff person who allegedly potentially verbally intimidated Resident # 9 was immediately placed on Administrative Leave following state survey exit and review of findings during survey. This allegation was reported to the ISDH, and other relevant organizations. The IDT (Interdisciplinary Team) led by the Executive Director of another campus and supervised by the Divisional Vice President conducted a thorough investigation of the allegation. This investigation revealed that after review of statements from those present during the conversation, and review of statements and documentation of this meeting, the resident was given options and no 30 day notice was ever issued. The resident requested to leave on his own, as opposed to accepting help with his behaviors, and</p>	08/01/2013	

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	<p>Progress Notes on 3/22/13...ED [Executive Director], DHS [Director of Health Services], DRS [Director of Resident Services] and CRS [Clinical Resident Services] went to speak to resident regarding his behavior on 3-21-13. Res. [resident] stated multiple times that he does not want to be here at the [name of facility] and that he is going to call his brother to take him home. ED informed res that DRS [name of DRS] can assist him c [with] discharge plans. Res. stated he did not want the [name of facility] to help him. ED informed res that he would be issued a 30 day discharge due to his behaviors and that he could discharge to another facility or to a psychiatric hospital that could help him with his mood. Resident stated he was having a bad day on 3-21-13 because of his blood sugar. Res did state he does have time when his mood changes significantly. Res stated he understands that if he wants to leave prior to 30 days he can. ED did state if he has no behaviors during that 30 days the team and res could address about him staying longer. Res stated he did not want to stay longer. SW [social worker] asked if res had preferences in placement and res stated he would let SW know on Monday. SW did let res know she would begin looking for</p>		<p>non-compliance with care. 2. Upon state review of 30 closed charts, no other resident was noted to be affected by this deficiency. ADDENDUM (8/7/13) On August 8th (8/8/13), the Executive Director, Director of Health Services, Assistant Director of Health Services, and the Medical Records Coordinator reviewed 10 closed charts and 10 open charts and determined that no other resident(s) was effected by this allegation of non-compliance.3. The deficiency was evaluated related to system, education and compliance. Team members were re-educated to assure that during meetings with residents they ensure the resident has a clear understanding of the conversation and the outcome of that conversation. Their should be documentation in the resident chart by each team mmeber present of the conversation and confirmation that the resident understood. Residents with behaviors are reviewed each clinical meeting by the IDT (Interdisciplinary Team). These residents are actively discussed and documented during Resident First/Service Plan meetings. This discussion may include but not be limited to:Clinical Aggregrate and Related Challenges, Psych Services, Medical Director review, Responsible Party involvement and support, evaluate Room Assignment and</p>				

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	<p>placement today.[signature of SW]."</p> <p>On 6/26/13 at 3:35 p.m., an interview was conducted with the Executive Director indicating, "...the majority of the time he was here he was non compliant with his behavior in the dining room, he'd strip off his clothes; in therapy, he'd refuse to go; he'd go to the wound doctor and return and refuse to comply with the wound instructions; he would claim his resident rights to intimidate the options for care such as, it's my right to not do what the doctors say...one of my physical therapy assistance [name] stayed over all night to help with evaluating the efforts of having a mobile wheelchair... we moved him to different rooms to help with his behaviors... finally staff did an IDT [inter disciplinary team meeting] to address his behaviors, and he was confronted...I told him consider this your 30-day notice...no, we didn't do the paper work for a 30-day notification...well, we did offer him to reevaluate this if his behaviors changed in those 30 days...We didn't offer him psychiatric services...I have no idea if he had psych services while he was out...."</p> <p>3.1-27(b)</p>		<p>possible changes, as well as Community options available. These residents and the charting related to these discussions will be evaluated by the DHS (or designee), Social Services, and or Executive Director to assure there is no feeling of intimidation or fear of retaliation, or abusive verbalization of any type through 1:1 interviews and discussion with the resident and/or their family representative. Compliance will be tracked and recorded for QA review. 5. Results from these audits will be reported to the QA (Quality Assurance) Committee. Audits will be conducted on a regular basis weekly times 6 months. These audits will continue as stated until 100% compliance for each identified need is achieved for 6 consecutive months, or until the QA committee determines otherwise due to the outcome of the audits.</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to assure all employees were knowledgeable of the person to report allegations and incidents of abuse and neglect to within the facility. (Employee #34)</p> <p>Findings include:</p> <p>On 7/1/2013 at 10:00 a.m., Employee # 34 was unable to indicate who should be contacted in the event of abuse and or neglect within the facility. Employee #34 indicated, "...Ya know... I really can't say...no, I don't know where I could find that information in the facility...I've just never needed to know that...."</p> <p>On 7/1/2013 at 3:00 p.m., a review of the current Policy and Procedure of Abuse and Neglect indicated "...immediately notify the Executive Director. If the Executive Director is absent, they may appoint a designee...."</p> <p>3.1-28(a)</p>	F000226	<p>It is the intent of the Maples at Waterford Crossing to utilize the processes they have developed and implemented, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Employees are trained in this area within the first 3 days of employment. 1. The facility immediately re-educated (originally trained 2/19/2013 per employee file) employee #34 to assure they were knowledgeable of the person to report allegations and incidents of abuse and neglect to within the facility. This employee will also attend re-education scheduled for July 23, 2013 on Abuse and Neglect Procedural Guidelines. 2. All residents have the potential to be affected, but no residents are known to be effected by this alleged deficiency.3. The administration of the facility reviewed the Abuse and Neglect Procedural Guidelines signature page to assure staff were trained upon hire. These signature pages affirming training were found to be intact in the employee file. Staff were re-educated to the</p>	08/01/2013			

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			<p>Abuse and Neglect Procedural Guidelines, on July 23, 2013 4. The Executive Director (ED), the Director of Health Services (DHS) and the Assistant Director of Health Services (ADHS) along with the remaining campus managers or their designee, will randomly audit the knowledge of team members related to Abuse and Neglect Procedural Guidelines through questioning of team members during rounding, team meetings and staff education opportunities. This audit may include but not be limited to questions related to: "What would you do if witnessing" "resident to resident.....", "staff member to resident.....", " types of abuse.....", "definitions of abuse.....", etc.5. These audits will be documented and reported to the QI (Quality Improvement) Committee on a monthly basis by the ED (Executive Director). The QIC will monitor these reviews for any trends and make reccomendations until 100% compliance is acheived for a period of six (6) consecutive months.</p>	

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to assess or provide psychiatric services relating to maladaptive behaviors causing difficulties in a social setting for 1 of 30 closed records reviewed for community discharge. (Resident #9)</p> <p>Findings include:</p> <p>On 6/26/13 at 2:00 p.m., a record review was conducted on Resident #9's clinical medical record which indicated in the "...Social Service Progress Notes on 3/22/13...ED [Executive Director], DHS [Director of Health Services], DRS [Director of Resident Services] and CRS [Clinical Resident Services] went to speak to resident regarding his behavior on 3-21-13. Res. [resident] stated multiple times that he does not want to be here at the [name of facility] and that he is going to call his brother to take him home. ED informed res that DRS [name of DRS] can assist him c [with] discharge plans. Res. stated he did not want the [name of facility] to help him. ED informed res that he</p>	F000250	<p>It is the intent of the Maples at Waterford Crossing to assess and provide psychiatric services for those residents identified as having maladaptive behaviors causing difficulty in a social setting. 1. Resident #9 has discharged from the campus.2. Upon state review of 30 closed charts, no other resident was noted to be affected by this deficiency. ADDENDUM (8/7/13) On August 8th (8/8/13), the Executive Director, Director of Health Services, Assistant Director of Health Services, and the Medical Records Coordinator reviewed 10 closed charts and 10 open charts and determined that no other resident(s) was effected by this allegation of non-compliance.3. The deficiency was evaluated related to system, education and compliance. Residents with behaviors are reviewed each clinical meeting by the IDT (Interdisciplinary Team). These residents are actively discussed and documented during Resident First/Service Plan meetings. This discussion may include but not be limited to: Clinical Aggregate and Related Challenges in a social setting, Psych Services, Medical</p>	08/01/2013			

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	<p>would be issued a 30 day discharge due to his behaviors and that he could discharge to another facility or to a psychiatric hospital that could help him with his mood. Resident stated he was having a bad day on 3-21-13 because of his blood sugar. Res did state he does have time when his mood changes significantly. Res stated he understands that if he wants to leave prior to 30 days he can. ED did state if he has no behaviors during that 30 days the team and res could address about him staying longer...."</p> <p>On 6/26/13 at 3:30 p.m., an interview was conducted with the Director of Social Services indicating that Resident #9 had been discharged to another long term nursing facility on March 29, 2013, due to sexually inappropriate behaviors, mal-adaptive manipulating behaviors, non-compliance in self-functional capabilities and unmotivated participation in therapy sessions. It was indicated, "...he wanted to go home, but that wasn't an option...he was focused on returning to live with his family...we did try to guide him and [name of Executive Director] informed resident that he would be issued a 30-day discharge notice due to his behaviors and that he could</p>		<p>Director review, Responsible Party involvement and support, evaluate Room Assignment and possible changes, as well as Community options available. A resident noted with complex and escalating behaviors will be evaluated utilizing the Discharge Action Evaluation Tool. ADDENDUM 8/7/2013: Staff were re-educated to these systems, as well as the Policies related to them, on Tuesday, July 23, (7/23/13) and/or Wednesday, July 31, 2013 (7/31/13) and ongoing 1:1 education and training as needed to assure compliance.4. The Discharge Action Evaluation tool will be utilized if it is determined that the facility cannot meet the residents needs. (see attached). The MDS (Minimum Data Set) Coordinator along with the DHS (or designee) will review the Resident First/Service Plan meeting notes on a Discharge Action Evaluation determination. 4. Results from these reviews will be reported to the QA (Quality Assurance) Committee. Reviews will be conducted on a regular basis weekly times 6 months. These reviews will continue as stated until 100% compliance for each Discharge Action Evaluation determination is achieved for 6 consecutive months, or until the QA committee determines otherwise due to the outcome of the reviews.</p>				

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	<p>discharge to another facility or to a Psychiatric hospital that could help him with his behaviors...."</p> <p>On 6/26/13 at 3:35 p.m., an interview with the Executive Director indicated, "... the majority of the time he was here he was non compliant with his behavior in the dining room, he'd strip off his clothes; in therapy, he'd refuse to go; he'd go to the wound doctor and return and refuse to comply with the wound instructions; he would claim his resident rights to intimidate the options for care such as, it's my right to not do what the doctors say...one of my physical therapy assistance [name] stayed over all night to help with evaluating the efforts of having a mobile wheelchair... we moved him to different rooms to help with his behaviors...finally staff did an IDT [inter disciplinary team meeting] to address his behaviors, and he was confronted.. I told him consider this your 30-day notice...no, we didn't do the paper work for a 30-day notification...well, we did offer him to reevaluate this if his behaviors changed in those 30 days...We didn't offer him psychiatric services...I have no idea if he had psych services while he was out...."</p>			

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	<p>On 6/26/13 at 3:40 p.m., Director of Social Services indicated, "...If your behaviors continued, we would give him a 30-day notice of discharge...I wasn't involved in his care [management]...I had a social work masters degree student in at that time, and they dealt with him; I felt it was good experience to deal with a resident like that...No...he [the resident] was not seen by psychiatric services at [name of acute hospital resident was admitted from]...No...he wasn't seen by psychiatric services at [name of acute hospital resident was discharged and re-admitted to/from while in the facility]... No... he wasn't seen by psychiatric or referred for psychiatric services while a resident here.... "</p> <p>On 6/26/13 at 3:10 p.m., CNA #32 was interviewed indicating, "...no, I don't recall a time when psychiatric service was here with [name of Resident #9]...No, the resident wasn't moved...he was in the same room the whole time I took care of him...."</p> <p>On 6/26/13 at 3:20 p.m., an interview was conducted with RN #28, with the Hall 100/200 Unit Manager in the room. RN #28 indicated that on , " ...3/21/13 there was a confrontation with Resident #9... he was unable to</p>						

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	<p>be calmed down, he yelled at me in front of other families and residents...he had a blood sugar over 500...almost 600 I believe...he wouldn't listen to anything I tried to say...it was terrible...." RN #28 indicated that the residents behaviors had been demanding of the primary staff, that staffing alterations had been done to help with staff stress and that her personal experience providing care for Resident #9 had been difficult to manage. It was also indicated that Resident #9 had not been moved to different room.</p> <p>On 6/26/13 at 3:30 p.m., an interview was conducted with PTA (Physical Therapy Assistant) #27 indicating that Resident #9 was a behavior problem in the therapy department and that several behavior modification contracts had been provided to offer the Resident control of his therapy and had not been successful. She indicated that the therapy department had not stayed over into off hour shifts to help with his evaluation of the power wheelchair use. It was also indicated that he had made progress, had continued in therapies and was discharged with residual Medicare days of use.</p> <p>On 6/27/13 at 10:30 a.m., a record</p>			

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	<p>review was conducted of Resident #9's care plan for behavior management. The "Behavior Care Plan," dated "2/13," did not indicate any psychiatric services to be offered.</p> <p>3.1-34(a)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update and revise a care plan for 1 of 1 residents reviewed for urinary incontinence. (Resident #46)</p> <p>Finding includes:</p> <p>On 6/27/13 at 10:58 A.M., record review indicated Resident #46's diagnosis included but were not limited to "...pleural effusion, shortness of breath, hypertension, atrial fibrillation, congestive heart failure and edema..." Further review of the medical record indicated Resident #46 takes Lasix 40 mg</p>	F000280	<p>It is the intent of the Maples at Waterford Crossing to update and revise the Resident Care Plan through the education and use of the "Interdisciplinary Team Care Plan Guideline". 1. Resident #46 Care Plan was immediately updated by the MDS (Minimum Data Set) Coordinator and those updates were educated to the nursing team providing care to Resident #46. Education included that the care plan should be reviewed and revised as needed with each MDS assessment and/or change of condition. 2. Upon state review of 30 closed charts, no other resident was noted to be affected by this deficiency. ADDENDUM</p>	08/01/2013			

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	<p>(milligrams) daily for edema, and no urinalysis was found in the record.</p> <p>Review of the nursing admission assessment, completed on 3/9/13, indicated resident #46 is occasionally incontinent and wears an incontinence product (pull ups). The admission assessment further indicated that no pattern was able to be established regarding the usual voiding pattern and stress incontinence was marked as no. The elimination plan of care indicated "...observe for signs and symptoms of UTI [urinary tract infection]...assess frequency and type of incontinence Q[every] [blank] to establish pattern...check and change incontinence product Q [blank]...toilet upon rising, before/after meals, before bedtime...."</p> <p>Review of the admission MDS (Minimum Data Set) assessment, completed on 3/16/13, assessed Resident #46 as requiring extensive assistance for toileting and that the resident is always continent.</p> <p>Review of the quarterly MDS assessment, completed on 4/6/13, assessed resident as requiring extensive assistance for toileting and the resident is frequently incontinent.</p>		<p>(8/7/13) On August 8th (8/8/13), the Executive Director, Director of Health Services, Assistant Director of Health Services, and the Medical Records Coordinator reviewed 10 closed charts and 10 open charts and determined that no other resident(s) was effected by this allegation of non-compliance.3. The deficiency was evaluated related to system, education and compliance. Resident MDS and RUG scoring as well as Care Plan is reviewed during Clinical Meeting as well as Resident First/Service Plan meeting. This review may include but is not limited to: Meal Consumptions, ADL decline, Behaviors, recent physician orders, lab orders and results, Outliers, etc. These reviews assist with the determination of interventions required for the well being of the resident. Care Plans are updated quarterly or as needed from these discussions/change of condition.ADDENDUM 8/7/2013: Staff were re-educated to these systems, as well as the Policies related to them, on Tuesday, July 23, (7/23/13) and/or Wednesday, July 31, 2013 (7/31/13) and ongoing 1:1 education and training as needed to assure compliance.4. The MDS Coordinator will assure Care Plans are updated on a quarterly basis and/or at each identified condition change. The Unit Managers or their designee,</p>		

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	<p>Review of the elimination record/schedule, completed on 3/10, 3/11, 3/12, 3/13 and 3/14/13, indicated no check marks under the urinary incontinence column.</p> <p>Review of the incontinence care plan, completed on 3/9/13 with no revision date, indicated resident is incontinent of bladder related to stress incontinence. The goal is to be clean and dry and have less than 1 episode of incontinence per day. The interventions include: check and change q blank hours and prn (as needed), provide incontinence care after each episode of incontinence, toilet before and after meals, upon rising in the AM and before bed at night, monitor for s/s (signs and symptoms) of UTI, assist with clothing change as needed, answer call light promptly.</p> <p>On 6/27/13 at 11:15 A.M., an interview with Employee #14 indicated she would write down to check and change the resident as needed instead of an hourly time. Employee #14 was unsure why the intervention list on the admission assessment and the care plan was incomplete.</p>		<p>during Resident First/Service Plan meeting will assure compliance of updated care plans. There will be auditing of fifteen (15) charts, randomly selected each month by the DHS (Director of Health Services and the ADHS (Assistant Director of Health Services) for compliance. The results of these audits will be reported to the QI (Quality Improvement) Committee.</p> <p>5. These audits will be conducted on a regular basis each month times 6 months. These audits will continue as stated until 100% compliance is acheived for 6 consecutive months, or until the QI Committee determines otherwise due to the outcome of the audits.</p>		

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	<p>On 7/1/13 at 11:30 A.M., review of the current policy titled "Interdisciplinary Team Care Plan Guideline" received from the Director of Nursing indicated "...The care plan should be reviewed and revised as needed with each MDS assessment..."</p> <p>3.1-35(d)(2)(B)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to restore as much normal bladder function as possible for 1 of 1 residents reviewed for urinary incontinence. (Resident #46)</p> <p>Findings include:</p> <p>On 6/27/13 at 10:58 A.M., record review indicated Resident #46's diagnosis included but were not limited to "...pleural effusion, shortness of breath, hypertension, atrial fibrillation, congestive heart failure and edema..." Further review of the medical record indicated Resident #46 takes Lasix 40 mg (milligrams) daily for edema, and no urinalysis was found in the record.</p> <p>Review of the nursing admission assessment, completed on 3/9/13,</p>			F000315	<p>It is the intent of the Maples at Waterford Crossing to restore or maintain normal bladder function as possible. 1. Resident #46 Care Plan was immediately updated by the MDS (Minimum Data Set) Coordinator to accurately reflect the current condition of Resident #46. Those updates were educated to the nursing team providing care to Resident #46. Resident #46 was placed on a structured bowel and bladder program to be reviewed during clinical meeting each week.2. Upon state review of 30 closed charts, no other resident was noted to be affected by this deficiency. ADDENDUM (8/7/13) On August 8th (8/8/13), the Executive Director, Director of Health Services, Assistant Director of Health Services, and the Medical Records Coordinator reviewed 10 closed charts and 10 open charts and determined that no other resident(s) was effected by this allegation of</p>		08/01/2013

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	<p>indicated resident #46 is occasionally incontinent and wears an incontinence product (pull ups). The admission assessment further indicated that no pattern was able to be established regarding the usual voiding pattern and stress incontinence was marked as no. The elimination plan of care indicated "...observe for signs and symptoms of UTI [urinary tract infection]...assess frequency and type of incontinence Q [every] [blank] to establish pattern...check and change incontinence product Q [blank]...toilet upon rising, before/after meals, before bedtime...."</p> <p>Review of the incontinence care plan, completed on 3/9/13 with no revision date, indicated resident is incontinent of bladder related to stress incontinence. The goal is to be clean and dry and have less than 1 episode of incontinence per day. The interventions include: check and change q (blank) hours and prn (as needed), provide incontinence care after each episode of incontinence, toilet before and after meals, upon rising in the AM and before bed at night, monitor for s/s (signs and symptoms) of UTI, assist with clothing change as needed, answer call light promptly.</p>		<p>non-compliance.3. The deficiency was evaluated related to system, education and compliance. Resident MDS and RUG scoring as well as Care Plan is reviewed during Clinical Meeting as well as Resident First/Service Plan meeting. This review may include but is not limited to: Meal Consumptions, Incontinent/Continent Changes, ADL decline, Behaviors, recent physician orders, lab orders and results, Outliers, etc. These reviews assist with the determination of interventions required for the well being of the resident. Care Plans are updated quarterly or as needed from these discussions/change of condition. The nursing department will work with current incontinent residents to identify those who may benefit from a structured bowel and bladder program. ADDENDUM 8/7/2013: Staff were re-educated to these systems, as well as the Policies related to them, on Tuesday, July 23, (7/23/13) and/or Wednesday, July 31, 2013 (7/31/13) and ongoing 1:1 education and training as needed to assure compliance.4. The MDS Coordinator will assure Care Plans are updated on a quarterly basis and/or at each identified condition change. The Unit Managers or their designee, during Resident First/Service Plan meeting will assure compliance of updated care</p>				

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	<p>Review of the admission MDS (Minimum Data Set) assessment, completed on 3/16/13, assessed Resident #46 as requiring extensive assistance for toileting and that the resident is always continent.</p> <p>Review of the quarterly MDS assessment, completed on 4/6/13, assessed resident as requiring extensive assistance for toileting and the resident is frequently incontinent.</p> <p>Review of the elimination record/schedule, completed on 3/10, 3/11, 3/12, 3/13 and 3/14/13, indicated no check marks under the urinary incontinence column.</p> <p>On 6/27/13 at 9:13 A.M., an interview with Employee #13 indicated Resident #46 is able to get up and go to the bathroom on her own, sometimes she will call us but most of the time she can go on her own. She does wear an incontinence pad, and is incontinent sometimes.</p> <p>On 7/1/13 at 11:00 A.M., an interview with Resident #46 indicated that she is incontinent at times and can't always hold it long enough to get to the bathroom. The resident further indicated she does not recall staff</p>		<p>plans. There will be auditing of fifteen (15) charts, randomly selected each month by the DHS (Director of Health Services and the ADHS (Assistant Director of Health Services) for compliance. The results of these audits will be reported to the QI (Quality Improvement) Committee. Those residents placed on a structured bowel and bladder program will be reviewed each week during clinical meeting. This program will be tracked and trended for results. These results will be reported to the QI Committee5. These above audits will be conducted on a regular basis each month times 6 months. These audits will continue as stated until 100% compliance is acheived for 6 consecutive months, or until the QI Committee determines otherwise due to the outcome of the audits.</p>				

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	<p>coming into her room to assist her on a routine basis before or after meals or when she awakens in the morning. Resident #46 indicated she usually takes herself to the restroom but occasionally needs to call the staff for assistance, and the staff tell me they will come right back to help me but sometimes it takes so long for them to return I wet myself and that is very embarrassing.</p> <p>3.1-41(a)(2)</p>			

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F000323 SS=D	<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, record review and interview, the facility failed to ensure hazardous chemicals were stored behind a locked door. This affected 1 of 1 dirty utility rooms.</p> <p>Findings include:</p> <p>On 6/27/2013 at 10:30 a.m., an observation was made of the Hall 300 dirty utility room indicating an unlocked door, stored dirty linen containers, stored biohazard containers, disinfectant pull-wipe towelettes with warning label to "...keep out of the reach of children...", disinfectant non-aerosol hand spray with warning label to "keep out of the reach of children...", room odor deodorizer with warning labels to , "keep out of the reach of children...", and stored red plastic biohazard bags. The location of this dirty utility room was in direct location of residents rooms and activity area.</p> <p>On 6/27/13 at 11:30 a.m., an interview was conducted with the</p>	F000323	<p>It is the intent of the Maples at Waterford Crossing to ensure hazardous chemicals are stored behind a locked door for the safety of the residents we serve. 1. The facility immediately removed the chemicals located in this area. Staff were re-educated to the proper storage of chemicals, keeping this door locked and review of compliance for safety. 2. All residents have the potential to be affected, but no residents were effected by this alleged deficiency.3. The administration of the facility reviewed the Policy and Procedure for "Storage Areas". Staff were re-educated to same. 4. The ESD (Environmental Services Director) or designee, along with the assist of the managers on duty will check the status of "Storage Areas" daily during rounding. This audit may include but not be limited to: contents of the storage area, locked door of storage area, etc. for compliance.5. These audits will be documented and reported to the QI (Quality Improvement) Committee on a monthly basis by the ESD (Environmental Services</p>	08/01/2013			

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	<p>DHS (Director of Health Services) indicating that the policy of the facility was not to keep hazardous material behind unlocked doors in resident care areas.</p> <p>On 6/27/13 at 3:55 p.m., a record review was conducted of a policy and procedure titled, "...Storage Areas...3. Cleaning supplies, etc., shall be stored in areas separate from food storage rooms and shall be stored as instructed on the labels of such products...."</p> <p>3.1-45(a)(2)</p>		<p>Director). The QIC will monitor these reviews for any trends and make reccomendations until 100% compliance is acheived for a period of six (6) consecutive months.</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>1. Based on interview and record review, the facility failed to appropriately monitor the blood pressure and pulse per physician order before giving a cardiac medicine for 1 of 10 residents who fit the criteria for unnecessary medications. (Resident #2)</p> <p>2. Based on interview and record review, the facility failed to ensure nebulizer inhalation treatments were being given under the supervision of</p>	F000329	It is the intent of the Maples at Waterford Crossing to ensure the blood pressure and pulse of residents who are taking a cardiac medication be monitored per physician's order. It is the intent of the Maples at Waterford Crossing to ensure residents with a physician "self administration of medications order" are identified as able to safely administer the prescribed medication through the completion of the "Self Medication Assessment" tool. The resident will be properly educated as to the administration	08/01/2013	

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	<p>licensed staff for 1 of 1 residents reviewed for respiratory treatments. (Resident's #28)</p> <p>Findings include:</p> <p>1. On 7/1/13 at 2:21 p.m., review of Resident #2's record indicated his diagnoses included but were not limited to "...cerebral vascular disease, paroxysmal afib [atrial fibrillation - irregular heart beat], syncope, htn [hypertension] with postural hypotension. CHF [congestive heart failure]...."</p> <p>Physician orders written 7/6/11 indicated "Metoprolol Trt [tartrate] [cardiac medicine for hypertension] 25 mg [milligram] tab. Give 1 tab orally daily for htn [hypertension] *Hold if BP [blood pressure] < [less than] 90/50 or Pulse <50* SEE B/P SHEET...."</p> <p>Review of Resident #2's cardiac care plan indicated "Resident is at risk for decreased cardiac output r/t [related to]...Atrial Fib...Hypertension...CHF...Interventions: Administer meds per order...assess for irregular heart sounds and vital signs...."</p> <p>On 7/1/13 at 2:45 p.m., review of</p>		<p>of the medication and audited for compliance. 1. The DHS (Director of Health Services) immediately re-educated the nursing team regarding follow through of physician's orders, recording of information related to cardiac medications i.e.: blood pressures and pulse. Staff will be re-educated again at nursing meeting conducted on July 31, 2013. The DHS immediately educated the nursing team regarding compliance of auditing the self administration of any medication routinely for safety of the resident and best practice for self administration of medication. This audit will be completed quarterly and/or at change of condition. This education will be repeated on July 31, 2013 to the Licensed Nurse and QMA (Qualified Medication Aide) team.2. All residents have the potential to be affected. A review of residents Medication Administration Records and Self Administration of Medication orders revealed two residents were effected by this alleged deficiency.3. Nursing Administration reviewed physician's orders for compliance of required documentation prior to administration of ordered medication. The decision was made to document BP, Pulse or other information related to the order on the MAR (Medication Administration Record) directly</p>				

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	<p>Resident #2's "Daily Blood Pressure Log" for May and June of 2013 indicated the following dates were missing a documented daily blood pressure to correspond with the administration of the prescribed Metoprolol: 5/3, 5/4, 5/5, 5/7, 5/8, 5/10, 5/11, 5/12, 5/14, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23, 5/25, 5/26, 5/27, 5/28, 5/30, 5/31, 6/1, 6/3, 6/4, 6/5, 6/7, 6/8, 6/9, 6/10, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, and 6/24/13.</p> <p>On 7/1/13 at 3:10 p.m., interview with the DHS [Director of Health Services] indicated he was unsure why there were holes in the blood pressure monitoring log. Review of the current Medication Administration-General Guidelines policy, last revised on 9/17/12, and received from the DHS at this time, indicated, "...Medications are administered in accordance with written orders of the attending physician...."</p> <p>2. On 6/25/13 at 11:00 a.m., interview with Resident #28 indicated she has been doing her own nebulizer treatments "for a long time" and she was curious why this week it has stopped. Resident #28 indicated the nurse had told her now that "State is in the building," so the nurse has to</p>		<p>under the initials of the nurse administering the medication. Nursing was educated to this direction immediately and again on July 31, 2013. Nursing Administration reviewed charts of those residents having "Self Administration of Medication" orders for compliance with "Self Medication Assessment" tool and education of resident regarding safety and best practice. Nursing was educated to this direction immediately and again on July 31, 2013.4. The DHS (Director of Health Services) or designee, along with the assist of the other nursing managers on duty will audit the MAR during rounding and periodically throughout the shift for compliance three (3) times weekly. This audit may include but not be limited to: blood pressure and pulse documentation for cardiac medications. The DHS (Director of Health Services) or designee, along with the assist of the other nursing managers on duty will audit the resident(s) having "Self Administration of Medication" during rounding, periodically throughout the shift, and/or if change of condition for compliance to safety and best practice at the time of the administration of the medication. Care Plans will be updated as needed and reviewed during Resident First meetings. The resident chart will be</p>				

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	<p>be in the room to give her her treatment instead of letting her do it herself. Resident #28 further indicated she was unsure why they (facility) were allowing her to do it herself if they were not supposed to.</p> <p>On 6/27/13 at 10:00 am, interview with RN #9 indicated Resident #28 had a breathing treatment scheduled at 11:00 a.m. "...but I don't actually give it to her. I just walk in and hand it to her and she does it herself. She does all her own setup too...."</p> <p>On 6/27/13 at 3:14 p.m., review of the Assessment Review and Considerations completed on 3/7/13, indicated, "...Self Medication:...Medications will be administered by authorized staff [checked]...." Further record review at this time of the Monthly Nursing Assessment & Data Collection, completed on 6/5/13, indicated, "...Resident:...Does not self-medicate [checked]...."</p> <p>On 6/28/13 at 10:20 a.m., record review was completed again on Resident #28's chart which indicated a new physician's order dated as completed on 6/24/13 and indicated, "...Ok to self administer nebulizer treatments...." A "Self-Medication"</p>		<p>reviewed quarterly and/or at change of condition for compliance with documentation of education and "Self Administration of Medication" tool, as well as updates to the resident Care Plan. 5. These audits will be documented and reported to the QI (Quality Improvement) Committee on a monthly basis by the DHS (Director of Health Services). The QIC will monitor these reviews for any trends and make reccomendations until 100% compliance is acheived for a period of six (6) consecutive months.</p>				

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	<p>care plan and a "Self-Medication Assessment" were now also in the record for Resident #28, both dated as completed on 6/24/13.</p> <p>On 6/28/13 at 10:44 a.m., review of the Medication Administration policy indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...."</p> <p>3.1-48(a)(3)</p>			

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to post the current daily resident census on the "Today's Staffing" Form for 4 of 6 days the posting was observed. (6/24, 6/26, 6/28, 7/1)</p>	F000356	It is the intent of the Maples at Waterford Crossing to post "Today's Staffing" form complete with staffing levels as required and resident census.1. The facility immediately manually corrected the "Today's	08/01/2013			

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	<p>Findings include:</p> <p>The "Today's Staffing" form was observed and reviewed during the 6 days of the survey from 6/24 through 7/1. The posting included the total number of RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and CNAs (Certified Nurse Aides) and the hours worked. The posting did not include the daily resident census at the start of each shift for the days of 6/24, 6/26, 6/28, and 7/1.</p> <p>During an interview on 7/1/13 at 11:15 a.m., the ADHS (Assistant Director of Health Services) indicated she was the one responsible for these forms and, when the staffing form is printed before the start of the day, the census number is not populated. The ADHS further indicated the census number should be on all the forms each day.</p> <p>3.1-13(a)</p>		<p>Staffing" form posting to include census of the day.2. No residents were effected by this alleged deficiency.3. The administration of the facility reviewed the "Today's Staffing" form and determined the format was not generating census. This census will now be manually added each day at time of posting. As well, the IT (Information Technology) team was notified that the current SmartLynx system we are using for this task is not populating current census.4. The ADHS, or designee, will be posting "Today's Staffing" form daily, verify census, and manually add the census for the day prior to posting. This will be reviewed during rounding by managers on duty on a daily basis for compliance.5. These reviews will be documented and reported to the QI (Quality Improvement) Committee on a monthly basis by the DHS (Director of Health Services). The QIC will monitor these reviews for any trends and make reccomendations until 100% compliance is acheived for a period of three (3) consecutive months.</p>		

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F000371 SS=F	<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 under sanitary conditions Based on observation, interview and record review, the facility failed to distribute and serve food under sanitary conditions. This deficiency had the potential to affect for 33 of 33 residents who receive meals in the dining room.</p> <p>Findings include:</p> <p>1. On 6/24/13 at 12:21 P.M., the Dietary Manager (Employee #8) was observed serving food from the steam table in the main dining room with gloved hands. The Dietary Manager stopped serving food and walked across the dining room to a cabinet and proceeded to open 2 drawers with his gloved hands. He then entered the kitchen area through a door and came back into the dining room and continued to serve food without changing his gloves or washing his hands.</p> <p>On 6/24/13 at 12:41 P.M., CNA #11 was observed feeding Resident #44</p>	F000371	<p>It is the intent of The Maples at Waterford Crossing to distribute and serve food under sanitary conditionas at all times.1. Food being served from the steam table will be served utilizing only utensils designated for proper serving of the item. When gloves are used at the steam table, the Glove Use Limitations policy (attachment #) will be followed: single use gloves shall be used and will be discarded when damaged or soiled, or when interruptions occur during the service. Staff will carry alcohol based gels/foams/rinses to provide an acceptable alternative to hadwashing while feeding or assisting residents during the meal service. Staff will wash hands with soap and water after 4-5 uses of the alcohol based product.2a Desserts presented on the dessert cart will be covered until which time the resident requests an item. Staff transporting residents to and from the dining area will wash their hands prior to assisting with beverage and meal service. Room service tray meal items will be individually covered</p>	08/01/2013			

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	<p>her lunch. CNA #11 started to feed Resident #44, put the spoon down, rubbed her hand under her nose, scratched her face, then picked the spoon back up and continued to feed Resident #44 without washing her hands or using hand sanitizing gel.</p> <p>On 6/27/13 at 12:10 P.M., the Dietary Manager was observed serving food at the steam table in the main dining room. The Dietary Manager started to serve food with his gloved hands, then stopped serving food and organized the menus in front of him. After organizing the menus the Dietary Manager did not change his gloves or wash his hands.</p> <p>On 6/27/13 at 3:30 P.M., record review of the current policy titled "Glove Use" received from the Dietician indicated "...single-use gloves shall be used for only one task...and discarded when damaged or soiled, or when interruptions occur in the operation...."</p> <p>On 6/27/13 at 3:30 P.M., record review of the current policy titled "Guidelines For Handwashing" received from the Dietician indicated "...All health care workers shall wash their hands frequently and appropriately...Health care workers</p>		<p>while transporting from the Room Service cart to the individual resident room. 2b The open air storage rack was immediately moved away from the ice machine. All items on the rack, including the rack itself, was immediately washed and sanitized according to policy. The items were then relocated to different areas of the kitchen and properly stored to prevent contamination. 3. Upon review no resident was noted to be affected by these alleged deficiencies.4. The deficiency was evaluated related to system, education and compliance. Signage was placed on the ice machine regarding non-storage in the area of the blower fan. Staff were re-educated on the proper wrapping, labeling and dating of food and beverage items during transport from the kitchen via the Room Service cart to the resident room.5a The ED (Executive Director), the Meal Manager and the DFS (Director of Food Service) or their designee will audit the use of proper utensils designated for handling of food items during the serving of meals from the steam table in the dining area daily.5b The DFS or their designee will audit the area of the ice machine blower fan to assure no items are stored in this area daily.5c The DHS (Director of Health Services), the Meal Manager and the DFS or their designee will audit the proper use</p>				

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	<p>shall wash hands at times such as:...blowing nose, coughing, sneezing, handling hair, etc...."</p> <p>2A. On 6/24/13 from 11:45 A.M. to 12:50 P.M., an observation was completed of the noon meal in which the following occurred:</p> <p>From 11:45 A.M. to 12:05 A.M., apple pie slices sat uncovered on a serving cart in a corner of the main dining room.</p> <p>At 11:55 A.M., CNA #3 transported Resident #6 into the main dining room in their wheel chair and proceeded to serve him a cup of coffee without washing her hands first.</p> <p>At 12:30 P.M., hall trays were transported by Dietary Staff #5 and the DHS (Director of Health Services) with pie and soup uncovered from the</p>		<p>of handwashing and/or gel products during the meal service to include transportation of residents and/or assisting of residents daily. Results from these audits will be reported to the QA (Quality Assurance) Committee. Audits will be conducted on a daily basis times 2 weeks, then weekly times 6 months. These audits will continue as stated until 100% compliance at each meal is achieved for 6 consecutive months, or until the QA committee determines otherwise due to the outcome of the audits.</p>		

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	<p>tray cart to the rooms of Resident #8, Resident #132, Resident #62, Resident #76, and Resident #134.</p> <p>On 7/1/13 at 1:10 P.M., interview with the Director of Food Service (DFS) indicated it was the expectation that food be covered during transport. The DFS further indicated there were no written procedures on how food was to be protected during transport.</p> <p>On 7/1/13 at 1:35 P.M., review of the facility's "Guidelines for Handwashing", last revised March 2013, indicated the facility policy was "...Health Care Workers shall wash hands at times such as...before/after preparing/serving meals, drinks,...etc...."</p> <p>2B. On 6/28/13 from 10:55 A.M. to 11:26 A.M., and observation was made of an ice machine in the facility kitchen which had a blower fan that was blowing directly onto an open air storage rack containing clean plastic containers and lids.</p> <p>On 6/28/13 at 11:30 A.M., interview with the DFS indicated he was not aware that the stored containers were not protected from the exhaust of the ice machine blower fan.</p>						

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	3.1-2(i)(3)				

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F000372 SS=F	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all trash bins in the kitchen area were covered unless actively being used. This deficiency had the potential to affect 33 of 33 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>On 6/28/13 from 10:55 A.M. to 11:26 A.M., an observation was completed on a garbage container attached to a moveable cart which sat uncovered the entire observation. The trash container was full of discarded food, including partially eaten bread, among other trash. The cart sat in the dishwashing area and was not used or moved the entire observation. Interview with the DFS (Director of Food Services) at 11:35 A.M., indicated the trash bag had not been emptied since before the morning breakfast service.</p> <p>On 7/1/13 at 1:55 P.M., review of the current facility policy "Garbage and Refuse", dated April 2009, indicated "...All garbage and refuse will be stored and disposed of daily in a</p>	F000372	<p>It is the intent of The Maples at Waterford Crossing to ensure all trash bins in the kitchen areas are covered unless actively being used. 1. On 6/28/2013 the DFS (Director of Food Services) removed the trash container in question and replaced same with a floor model, foot operated, covered trash container lined with a sturdy liner that is tied and removed at the conclusion of each meal and as often as needed to maintain sanitary conditions as outlined in the attached policy and procedure. Staff were then educated as to the use of the container and sanitization guidelines. 2. Upon review no residents were noted to be affected by this deficiency. 3. The system was evaluated related to system, education and compliance. Re-education of staff will be conducted by the Director of Food Services (DFS) by July 31, 2013, related to the Garbage and Refuse policy. 4. The system will be monitored by the DFS (or designee) during meals and the Dietitian on a weekly basis. Results from these audits will be reported to the QA (Quality Assurance) Committee. Audits will continue as stated until 100% compliance at each meal is</p>	08/01/2013	

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	sanitary manner according to defined procedures...Garbage receptacles will be lined with sturdy garbage bags and covered at all times, except during active use...." 3.1-21(i)(5)		acheived for 6 consecutive months, or until the QA committee determines otherwise due to the outcome of the audits.	

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F000441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by 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>1. Based on observation, interview and record review, the facility failed to</p>	F000441	It is the intent of The Maples at Waterford Crossing to maintain	08/01/2013			

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	<p>include a trending modality into the functionality of the Infection Control Program. This had the potential of affecting 51 of 51 residents in the facility at the time of the survey.</p> <p>2. Based on observation, record review and interview, the facility failed to ensure staff washed their hands. This affected 5 of 5 staff observed on Hall 300.</p> <p>3. Based on observation, record review and interview, the facility failed to keep clean linen on the 300 hall separate from sources of contamination. This affected 1 of 1 linen storage closets on Hall 300.</p> <p>4. Based on observation, interview, and record review, the facility failed to prevent the potential to spread infection by not posting an isolation sign on the door of an isolation room. This deficiency had the potential to affect 51 of 51 residents residing in the facility. (Resident #24)</p> <p>Findings include:</p> <p>1). On 7/1/2013 at 2:50 p.m., an interview was conducted with the Director of Nursing Services (DNS). It was identified that the DNS was in charge of maintaining the program of</p>		<p>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. It is the intend of the facility to include a trending modality into the functionality of the Infection Control Program. Staff #25, #34, #35, #36, and #37 were re-educated immediately upon notification of failutre to wash hands. Re-education to remaining staff was held on July 17, 2013 to include but not limited to handwashing prior to and following resident care, use of alcohol based gels, handling and delivery of linens, sanitation of Kiosk charting screens, and medication administration. Isolation signage was placed on door of room of Resident #24 and staff were immediately re-educated as to location and usage of Isolation signage as well as Policy and Procedure related to Isolation. The "Infection Assessment and Review Form" and the "Change in Condition Form" usage was re-educated to nursing staff on July 17, 2013. Staff were re-educated to the location of the form, the use of the form, completion of the form in its entirety, and the filing of the form for compliance with the Policies and Procedures related to the use of the form. The "Clean Linen" closet was immediately cleaned upon notification of</p>				

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	<p>Infection Control for this facility. Upon interviewing the DNS it was identified that to his current knowledge, a trending component of the Infection Control Program could not be manifested. It was indicated that surveillance, identifying, preventing were established components and were supported in documentation and record keeping. However, the trending for historical means of preventing re-occurrences of organisms and the location of particular organisms within the facility was not available. There was not a system in place to be used for trending house-wide organisms and their activities.</p> <p>On 7/1/2013 at 2:52 p.m., a record review was completed alongside the DNS of the forms titled," Infection Assessment and Review," indicating a process of assessing the type of organism, symptoms presented by the host, treatment required, vital signs, environmental and equipment inspection and notification of Medical Doctor(MD) and Responsible Party. It also indicated, "Infection Risk Re-Assessment, Infection Update and IDT (interdisciplinary) Review. On the back side of this form was a templated 12- sectioned form for daily "follow-Up."</p>		<p>concern from the survey team. All items not of "linen" were removed and disposed of or stored properly in the appropriate area. Linens were laundered per policy and replaced on the designated shelf in the clean linen room. Linens were covered top to bottom during storage. Both nursing and Laundry staff were re-educated to the proper handling and storage of linens.2. All residents have the potential to be affected by this deficiency. Upon review, no resident was noted to be affected by this deficiency. 3. The deficiency was evaluated related to system, education and compliance. Handwashing will be monitored through daily random audits conducted by the DHS (Director of Health Services), the Unit Managers, and the remaining department managers upon rounding of the campus. Auditing will include but not be limited to the proper use of handwashing and/or gel products during resident care, charting of said care, handling and delivery of linens, and medication administration. Signage for resident may include but not be limited to: oxygen use, isolation, etc. will be monitored through random audits conducted by the DHS (Director of Health Services), the Unit Managers, and the remaining department managers upon rounding of the campus. The "Clean Linen"</p>				

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	<p>A second infection control form titled, "Change in Condition Form" indicated a change in condition and request for a MD to provide orders, Vital Signs, an area for Describing Signs and Symptoms of Condition change, Physicians order/ response to communication, the Nurses signature of receiving and transcribing the MD order, Care Plan initiation, review, interventions; Notification of responsible part and response of the notification , additional comments and a the signature of the one completing this form. On the backside of this form was a templated 9- sectioned form for daily "follow-up." Upon interviewing the DNS while reviewing these two forms it was indicated by the DNS that the facility did not conduct a monthly review of the information received and noted. The DNS did indicate that the facility used a computer based program for the components of trending and tracking to prevent reoccurrences of an organism, yet could not locate this on the computer provided the facility for his personal work usage.</p> <p>2). On 6/27/2013 from 10:00 a.m. until 11:30 a.m., an observation was conducted of Hall 300's dirty utility room located in the 300 nurses work-station.</p>		<p>room of 300 hall will be monitored through random daily audits conducted by the DHS (Director of Health Services), the Unit Managers, and the remaining department managers upon rounding of the campus. The DHS (or designee) with the input of other department managers will identify infectious trends in the facility through the use of a color coded mapping system that will identify various infections, and locations of those infections weekly. This trending modality tool will be educated to staff on July 17, and again on July 31, 2013, and posted in each work area for reference by staff at any time. The trending modality tool will be reviewed during Clinical Morning Meeting weekly and results of this trending modality tool will be reviewed and prevention plans will be developed. This will be discussed at each Quality Assurance (QA) meeting monthly. 5. Results from the use of this trending modality tool will be reported to the QA (Quality Assurance) Committee each month. The results of the trending modality tool, and the prevention plans will be reviewed for compliance and effectiveness. These reviews will continue as stated and will be available for reference within the QA minutes. Results from these audits will be reported to the QA (Quality Assurance) Committee.</p>		

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	<p>During this hour and a half it was observed of staff #25, #34, # 35, #36, and #37 to open the unlocked door to the dirty utility with ungloved hand, place a clear bag of cloth items into a plastic lidded container, and leave the room. It was also observed of staff #25, #35, #36 and #37 upon leaving the dirty utility room, to then complete work related items on a computer-touch-screen charting. It was also observed of staff #25 to then proceed from charting to enter Resident #55's room an proceed to touch the resident and use the wheelchair without having washed their hands.</p> <p>Another observation was completed on 6/28/13 at 10:30 a.m., of Staff #36 providing medication care for Resident's #62 and #57 whom shared a room indicating no washing of hands or use of hand sanitizing gel between contact of the residents' person.</p> <p>On 6/27/13 at 11:31 a.m., an interview was conducted with the DNS indicating that the policy of the facility was for the staff to wash their hands between resident contact and between disposing items in the dirty utility room. It was also noted that touching the computerized screen on</p>		<p>Audits will be conducted on a daily basis times 2 weeks, then weekly times 6 months. These audits will continue as stated until 100% compliance at each meal is acheived for 6 consecutive months, or until the QA committee determines otherwise due to the outcome of the audits.</p>				

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	<p>the wall outside of room #318 had not been addressed by the facility.</p> <p>On 6/27/13 at 3:55 p.m., a record review was conducted of a policy and procedure titled, "Guidelines for Handwashing...Procedure. 1. All health care workers shall wash their hands frequently and appropriately....3.b. Before/after having direct contact with residents."</p> <p>On 6/27/13 at 3:57 p.m., a record review was conducted of a policy and procedure titled, "Guidelines for Handling Linen. Dirty Linen. 1. Follow Standard Precautions when handling dirty linen...."</p> <p>3.) On 6/27/13 at 11:30 a.m., an observation was made simultaneously with an interview with the DNS of the Hall 300 of a room with the sinage," clean linen' located on the outside of the room. Upon observation of the room, the door was unlocked and inside a sink,a pull paper-towel dispenser, working water faucet soap dispenser and wastebasket was noted. Also inside was a approximately 7 foot tall, white, 4 shelved linen cart covered in a mesh protector with velcro connections at the side. It was observed that the mesh was not connected at the</p>				

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	<p>bottom 2 shelves and clean linen was exposed. Also included in this room was an upright, 5 foot tall oscillating, electrical fan that was unplugged and dirty upon observation, a basket of odds and ends including a bladder to a blood pressure arm cuff, several bed/chair alarms, an aresol can of deodorizer/ room spray, 3 plastic storage basket with sample-sized daily cleaning-care items located on a shelf above the sink station area. It was also noted that located on the floor in front of the wash station, was a 2' (foot)x4'x4' cardboard box with flaps opened to reveal clean disposable-type undergarments for incontinency. The box on the floor was blocking the area to stand allowing usage of the sink/ wash station. The interview with the DNS indicated that this was not for clean storage yet for a wash station for the staff to use during resident care.</p> <p>On 6/27/13 at 3:58 p.m., a record review was conducted of a policy and procedure titled, "Guidelines for Handling Linen. Clean Linen. Purpose. To provide clean, fresh linen to each resident. To prevent contamination of clean linen." The policy/ procedure did not support the storage of clean linen on the resident halls to prevent contamination.</p>						

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	<p>On 6/27/13 at 3:59 p.m., a record review was conducted of a policy and procedure titled,"Storage Areas. Policy Statement. Housekeeping and laundry department storage areas shall be maintained in a clean and safe manner. Policy Interpretation and Implementation. 1. All housekeeping and laundry storage areas shall be kept free from accumulation of trash, rubbish, oily rags, paper, etc., at all times..."</p> <p>4.) On 6/27/13 at 4:45 P.M., record review indicated Resident #24's diagnosis included but were not limited to "...hypertension, diabetes type II, schizophrenia, left femoral neck fracture, MRSA (Methicillin-resistant Staphylococcus aureus)...."</p> <p>On 6/28/13 at 2:00 P.M., an interview with Unit Manager Hall 300 (Employee #7) indicated Resident #24's physician contacted her on 6/14/13 regarding the results of the wound culture taken on 6/10/13. The physician placed Resident #24 on an antibiotic until further notice and she was placed in contact isolation at that time.</p>			

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	<p>On 6/24/13 at 10:00 A.M., during the initial tour of the facility a 3 drawer cart was observed in the hallway outside of Resident #24's room. The cart contained yellow gowns and non sterile gloves. No sign to stop and see the nurse before entering the room was posted on the door or outside of the room.</p> <p>On 6/25/13 11:00 A.M. and 6/26/13 at 9:45 A.M., no isolation sign was posted outside of Resident #24's room.</p> <p>On 6/26/13 at 10:05 A.M., 3 EMT's (emergency medical technicians) entered Resident #24' room. 2 EMT's assisted the resident from the bed onto a cart, then repositioned her and her clothing before covering the resident with a sheet. None of the emergency workers were observed with protective gowns or gloves in place.</p> <p>On 6/25/13 at 10:45 A.M., an interview with LPN #12 indicated Resident #24 is in contact isolation only. She had a hip replacement a while back and then had to have the hardware removed. She developed an infection (MRSA) in the incision. Protective equipment is only needed if giving direct patient care.</p>			

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	<p>On 6/26/13 at 10:15 A.M., record review of the current policy titled "Standard Precautions" received from the Director of Nursing indicated "...Contact precautions should be used for individuals known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the environment...Examples of infections requiring Contact Precautions include but are not limited to: ...multi-drug resistant bacteria (MRSA)...clean, non-sterile gloves should be worn when entering the room...A clean, non-sterile gown should be worn when entering the room if: ...It is anticipated that clothing will have substantial contact with an actively infected resident, environmental surfaces, or items in the resident room...Place a sign (preferably orange) at the doorway instructing visitors to report to the nurses station before entering the room...."</p> <p>3.1-18(b)(1) 3.1-18(l) 3.1-19(g)(1)(2) 3.1-18(j)</p>			

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F000507 SS=D	<p>483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.</p> <p>1) Based on record review and interview, the facility failed to provide a lab result for 1 of 10 residents reviewed. (Resident #49)</p> <p>2) Based on record review and interview, the facility failed to provide lab results with the name and address of the testing lab for 1 of 10 residents reviewed. (Resident #49)</p> <p>Findings included:</p> <p>1. On 6/27/13 at 10:45 a.m., a record review was completed for Resident #49 indicating that a complete blood count was to be completed "every 6 months...." The last documented lab result located on the clinical medical record (CMR) was dated, 10/9/2012.</p> <p>On 6/27/13 at 3:00 p.m., LPN #33 was interviewed indicating that a complete blood count (CBC) result for Resident #49, due every 6 months, was not found on the CMR.</p> <p>On 6/27/13 at 3:15 p.m., LPN#33</p>	F000507	<p>It is the intent of The Maples at Waterford Crossing to provide a lab result for residents in a timely manner and documentation of same. 1a Labs for Resident #49 were reviewed for the past 6 (six) months. Physician and family were notified of any ordered lab that was missed. Identified missing lab work was re-ordered by the physician. 1b The PT/INR for resident #49 was completed as ordered, but the documentation for the one day in question was missing from the MAR (Medication Administration Record). Nurses were re- educated as to where results of the PT/INR are to be recorded, as well as the Policy and Procedure related to PT/INR. 2a Upon review of residents residing on 300 hall, 2 (two) of 34 (thirty four) other residents were found to be effected by missing lab work. Physician and family were notified of any ordered lab that was missed. Identified missing lab work was re-ordered by the physician. 2b Upon random review of 4 (four) residents with a PT/INR orders there were no residents effected by this alleged deficiency. 3. The deficiency was evaluated related to system,</p>	08/01/2013	

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	<p>indicated that the CBC for April 2013 had been missed and was not available.</p> <p>2. On 6/27/13 at 10:45 a.m., a record review was ordered for Resident #49 indicating that a Prothrombin Time (PT) and an International Normalized Ratio (INR) indicating an initialized order of origination dated, "12/18/2012. PT/INR on Tuesdays. Notify MD (medical doctor) if <2 or >3 (less than 2 or greater than 3). Notify MD of PT/INR results before giving Coumadin (anti-coagulation chemical).</p> <p>On 6/27/13 at 10:50 a.m., an interview was conducted with LPN #33 indicating that the PT/INR results were not placed directly to the clinical medical record (CMR) or residents medical chart, yet the PT/INR results were placed on a Corporate template form titled, "Resident Coag Testing Record" located on the resident's medication administration record (MAR) that was located on the nurses medication cart. It was also indicated that, "... all labs are monitored by putting the lab in the Lab Tracking Log..." and "... we don't put our PT/INR blood labs in that book..."</p> <p>On 6/27/13 at 10:51 a.m., an</p>		<p>education and compliance. Unit Managers will track all lab orders using the Lab Tracking Log. The DHS (or designee) will review the Lab Tracking Log each week to evaluate compliance with P&P regarding receipt and follow through of physicians orders related to orders for lab work and to assure results are obtained, communicated, and filed in a timely manner. Nurses will be re-educated regarding the use of, cleaning of, and recording of results using the Coag Machine on July 17 and again July 31, 2013. 4. Results from these audits will be reported to the QA (Quality Assurance) Committee. Audits will be conducted on a regular basis each week, times 6 months. These audits will continue as stated until 100% compliance for each lab order is achieved for 6 consecutive months, or until the QA committee determines otherwise due to the outcome of the audits.</p>				

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	<p>interview was conducted with LPN #36 and a record review was made of Resident #49's MAR found on the medication cart indicating that the PT/INR had been tested on the following dates and charted on the Resident Coag Testing Record: "6/11/13. LPN#36. Test Strip Lot 476. Results: 2.1. Current Medication 1 mg. Physician notified: MD#37. Physicians order: (blank). Family notification:(blank). 6/18/13. LPN #38. Test Strip Lot 476. Results: 2.5. Current Medication 1 mg. Physicians orders: nursing order (n.o.). Family Notification: Resident 6/18/13. 6/25/13. LPN #36. Test strip Lot 476. Results: 2.2. Current Medication: 1 mg. Physician notified: nursing order (n.o.): Family Notification: Resident 6/25/13." Upon interview of LPN #36, it was indicated that no other Resident Coag Testing Record could be located for Resident #49, and it was not protocol to keep past records for PT/INR results.</p> <p>On 6/27/13 at 10 54 a.m., an interview was conducted with LPN#33 indicating that the facility performed there own PT/INR's with a "CoAg machine" and that the facility had one and wasn't sure if the facility quit</p>			

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	<p>using it and used the contracted services of a local laboratory or if the CoAg machine was currently being used.</p> <p>On 6/27/13 at 11:00 a.m., an interview was conducted with the DNS about the use or not use of the facility provided CoAg machine indicating that the DNS was unaware if the contracted services of a local laboratory was currently being used to provide PT/INR's for the anti-coagulation blood lab results.</p> <p>On 6/27/13 at 11:02 a.m., a record review, alongside of LPN #33 was conducted of a template form titled, "Cleaning of Coag Machine Log" was provided for Resident #49 indicating that a Coag Machine of the facility had been cleaned prior to using the machine for a PT/INR reading. On this record the following was indicated: "Date. 4/9/13. Resident #49. Machine cleaned prior to use: yes. Machine cleaned after use: yes. Nurses signature: LPN #33. Date: 4/16/13. Resident #49. Machine cleaned prior to use: checkmarked. Machine cleaned after use: check-marked. Nurses signature: LPN#33. Date: 4/23/13. Resident #49.</p>			

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	<p>Machine cleaned prior to use: check-marked. Machine cleaned after use: check-marked. Nurses signature: LPN #38. Date: 6/18/13. Resident #49. Machine cleaned prior to use: slash-mark. Machine cleaned after use: slash mark. Nurses signature: LPN#38." It was indicated the the lapse of readings from 4/23/13 to 6/18/13 had been supported by a, "...lab draw by the (name of contracted local laboratory) because (MD#37 name) had asked us to not do the PT/INR's until our machine (Coag machine) was fixed..." When questioned about the "fixing of the coag machine" the LPN#33 indicated she was not sure what had happened during that timeframe.</p> <p>On 6/27/13 at 11:15 a.m., an interview was conducted with the DNS indicating that he was unsure of a coag machine in the facility yet he would, "..look into that and I'll get back with you...."</p> <p>On 6/27/13 at 11:17 a.m., a record review was conducted of the Physicians order sheets for Resident #49 indicating that the PT/INR was ordered for both April and May 2013 as indicated above. A record review</p>						

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	<p>was also conducted of the April and May MAR's for documentation of the PT/INR readings indicating that May 21, 2013, April 9, 2013 and April 30, 2013 were missing. It was noted that Coumadin orders had been addressed and dosing had been adjusted, yet the reading for the blood levels were missing from the MAR.</p> <p>On 6/27/13 at 11:20 a.m., an interview was conducted with LPN#33 indicating, "...when the doctor asked us to have the PT/INR's drawn by the (local laboratory) it was to do a side check with 'our' coag machine to be sure the readings we were getting were really accurate... when the nurses do the coag blood checks on our machine's the readings are then put on the Resident Roster that the nurses use for between shift reporting...."</p> <p>On 6/27/13 at 11:24 a.m., a record review was conducted alongside of LPN#33 of the "Resident Roster shift reports." The dates were located on the front page only of a 4-paged, front and back sectioned off page. The date had been had scribbled over the printed date and a handwritten date had been placed. This made it difficult to accurately place the dates the resident roster shift report was</p>						

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	<p>supporting. On the form, Resident #49 was located and the PT/INR's were handwritten in. The dates of the PT/INR reading was not supported. LPN#33 indicated,"... we've been doing this since I began over 2 years ago... we do our own PT/INR's and place the reading on the resident roster shift reports... the dates are accurate because that's when we 'print' the form...."</p> <p>On 6/28/13 at 10:00 a.m., an interview and record review was conducted with the DNS about the PT/INR recording of blood values completed by the facility using their Coag machine. It was indicated that the facility did have a "...few times when the doctor wanted us to run a blood test simultaneously with our cog machine and the lab... we weren't sure the reading were accurate... we place our lab values on the MAR of the resident, they are not located in the lab section of the charts... I am not sure why [Resident #49's name] was not written in there..." It was indicated that the PT/INR's mentioned above as missing from the MAR's could not be located as having been done either by the facility or by the local laboratory.</p> <p>On 7/1/2013 at 5:00 p.m., a record</p>						

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	<p>review was made of the policy and procedure titled, "Lab Tracking Guidelines. Purpose. To facilitate a method of tracking laboratory tests ordered and monitor test has been completed in a timely manner to identify and treat infections and/or make medication adjustments. Procedure:1. When an order is received for a laboratory test it shall be added to the "Lab Tracking Log". 2. The nursing staff or person designated by the Executive Director or Director of Health Services shall monitor the "Tracking Log" to ensure tests have been completed per the physicians order. 3. When results are received it shall be so noted on the "Tracking Log" with the physician notified of the results in accordance with the "Notification Guidelines". 4. The responsible party shall be notified of lab results and physician responses. 5. Comments may be noted on the tracking log. Follow-up requirements should also be noted on the 24 Hour Nursing Report."</p> <p>On 7/1/2013 at 5:01 p.m., a record review was conducted of a form titled, "Coffee Break. Topic: Anticoagulation Therapy. Audience: Nursing Staff....3. Use the Lab Tracking Log and the Coumadin Log to ensure all steps in the lab monitoring process</p>			

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	<p>have been completed. Order, lab draw completed, results obtained, results communicated to the physician, physician response carried through....6. Follow (Cooperate name) protocols and practices for communication and follow-up: Morning Stand Up Meeting- review physician orders for labs, med changes and follow up. Change in Condition form- note any significant lab variances, medication side effects, physician response, responsible party notification and care plan update....Lab monitoring and Coumadin Log to ensure all steps are completed."</p> <p>On 7/1/2013 at 5:02 p.m., a record review was conducted of the form titled," Procedural Guidelines. CoagCheckXS System. Overview. Introduction. Residents on warfarin, a commonly used anticoagulant, must be carefully monitored to ensure their anticoagulation therapy is maintained in the therapeutic range.... Quality Control Requirements. The CoagCheck XS System has quality control functions integrated into the meter and tests strips, which does not require the nurse to run quality control tests...Documenting test results. Memory. The CoagCheck XS meter stores the last 100 test results along</p>						

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	<p>with the time and date....Login the results: Record the date, time, initials of the nurse, resident name, resident ID number and result on the resident log....Documentation: Retain the requisitions, test authorizations, and test results for a minimum of seven years Medical Record Documentation:...Linking the resident test with the appropriate CoaguChekXS mete and test strip lot number creates an audit trail...."</p> <p>3.1-49(f)(4)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure accurate documentation of an antibiotic for 1 of 10 residents reviewed for unnecessary medications. (Resident #18)</p> <p>Findings include:</p> <p>On 6/26/13 at 3:20 P.M., review of the MAR (Medication Administration Record) for Resident #18 indicated a physicians order for Aroid (an antibiotic)100 mg (milligrams) twice daily at 8 A.M. and 8 P.M. for 7 days with the order start date of 6/8/13. Further review of the MAR for Resident #18 indicated there was no initials to signify a dose given for the A.M. dose for the days of 6/9, 6/11, 6/12, and 6/14/2013.</p>	F000514	It is the intent of the Maples at Waterford Crossing to ensure accurate documentation of administration of medication as ordered by the attending physician through the education and implementation of the "Medication Administration" policy. 1. The DHS (Director of Health Services) immediately re-educated the nursing team regarding follow through of physician's orders and the recording of information related to medications as administered. The physician and family weer notified of the alleged missing documentation to support the administration of this antibiotic for resident #18. Staff will be re-educated again at nursing meeting conducted on July 31, 20132. All residents have the potential to be affected. A review of residents Medication	08/01/2013			

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	<p>On 6/26/13 at 3:25 P.M., interview with the 300 hall Unit Manager indicated the medication had been prescribed for a urinary tract infection, that "...the medication had not been signed out...", and she could not confirm the medication had been given.</p> <p>On 7/1/13 at 3:10 PM, review of the "Medication Administration" policy, received from the DHS (Director of Health Services), indicated "...the individual who administers the medication dose records the the administration on the resident's MAR directly after the dose is given. At the end of of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications...."</p> <p>3.1-50(a)(2)</p>		<p>Administration Records revealed resident #18 was effected by this alleged deficiency.3. Nursing Administration reviewed physician's orders for compliance of required documentation and follow through documentation to support the administration of ordered medication(s). Nursing was re-educated to the "Medication Administration" policy immediately and again on July 17, and July 31, 2013.4. The Nursing Unit Managers will audit the MAR during rounding each week and periodically throughout the shift(s) for compliance. This audit may include but not be limited to: missing supportive documentation of administered medication, blood pressure and pulse documentation for cardiac medications. This audit will also test the nurses working knowledge of the contents of the "Medication Administration" policy through random interview questions of the nursing staff. 5. These audits will be documented and reported to the QI (Quality Improvement) Committee on a monthly basis by the DHS (Director of Health Services). The QIC will monitor these reviews for any trends and make reccomendations until 100% compliance is acheived for a period of six (6) consecutive months.</p>		