

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/22/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 15, 16, 17, 18, 19, and 22, 2012</p> <p>Facility number: 000116 Provider number: 155209 AIM number: 100266330</p> <p>Survey team: Diana Sidell RN, TC Cheryl Fielden RN Jill Ross RN Gloria Reisert MSW</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 26 Medicaid: 79 Other: 5 Total: 110</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/29/12 Cathy Emswiller RN</p>	F0000		
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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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F0157 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 record review, interview, and observation, the facility failed to notify the dentist when a resident's dentures did not properly fit. This affected 1 of 3</p>	F0157	The filing of this plan of correction does not constitute an admission that the alleged deficient practice did in fact exist. This plan of correction is filed as evidence of the desire to comply with the	11/09/2012	

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	<p>residents in a sample of 16. (Resident #39)</p> <p>Findings include:</p> <p>During a dining observation on 10/15/12 at 12:25 p.m., Resident #39 was eating lunch without her top dentures. She indicated her dentures did not fit properly so she could not wear them at this time. She stated, "I eat most things but have some trouble eating other things. It takes me a while so sometimes I just give up and don't eat the rest of the meal."</p> <p>Record review for Resident #39 was done on 10/16/12 at 4:20 p.m. She was admitted on 10/30/11. Diagnoses included but were not limited to: depression, pulmonary HTN (high blood pressure), dementia with behaviors, asthma, coronary artery disease, diabetes Type 2, urinary incontinence, arthritis, anxiety, high blood pressure, excessive esophagitis, and Parkinson's.</p> <p>An annual Minimum Data Set Assessment (MDS) dated 9/7/12 indicated no dental issues for this resident.</p> <p>A progress note dated 9/10/12 by Dr. [name of dentist], D.D.S. states, "resident is unhappy with fit of dentures at this time. Made adj [adjustment] to midline</p>		<p>regulation and to comply with quality care. This facility further respectfully requests a desk review for paper compliance based on the evidence enclosed.</p> <p>F- 157 Notification of Changes</p> <p>The facility's intent is for residents, physicians, and interested family members to be notified of changes that warrant change to the treatment plan, transfers or accidents.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Resident #39 was evaluated on 10/23/12 with a remake of dentures ordered.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of all residents in the facility for dental issues. All residents would have the potential to be affected. See Exhibit A.</p> <p>C. MEASURES TAKEN:</p>				

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	<p>palatal [top denture] resident indicates "this time they feel better."</p> <p>During interview with Resident #39 on 10/16/12 at 3:00 p.m. she indicated her dentures were still not right and needed to be readjusted. She indicated she had told staff about the problem with the dentures since they were adjusted.</p> <p>Interview with LPN #3 on 10/17/12 at 2:45 p.m., indicated she didn't even know this resident had dentures. She said, " the dentist comes in once a month and I will be sure he sees her again." On 10/18/12 at 9:00 a.m., LPN #3 indicated they were calling the dentist so he could come back in and recheck her dentures. She indicated she called twice yesterday and was going to call again today.</p> <p>During an interview with LPN #3 on 10/18/12 at 2:45 p.m., she indicated the dentist was to come in Tuesday, 10/23/12 and would definitely see her.</p> <p>3.1-5(a)(3)</p>		<p>1. Social Service will refer any residents needing dental evaluation to a dentist of their choice. See Exhibit A.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor for compliance by reviewing a sample of 10% of nursing summary assessments weekly x 4, monthly x2 then quarterly thereafter. See Exhibit B.</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F0225			11/09/2012		

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	<p>Based on record review and interview, the facility failed to ensure an allegation of misappropriation of resident's money was reported to ISDH. This affected 1 of 3 residents who met the criteria for abuse. (Resident #187)</p> <p>Finding includes:</p> <p>During an interview on 10/15/12 at 4:34 p.m., Resident #187 indicated he had \$35.00 missing one night, about a week ago. He indicated he had the money in a billfold in a jacket pocket and it went missing during the night shift. He indicated he reported it right away, as soon as he noticed it was gone and they offered to put the money under lock and key.</p> <p>Resident #187's record was reviewed on 10/18/12 at 1:28 p.m. The record indicated Resident #187 was admitted with diagnoses that included, but were not limited to, osteoarthritis of the right knee, coronary artery disease, high blood pressure, hypercholesterolemia, gastro esophageal reflux disease, decreased bowel motility, and anxiety.</p> <p>A social service progress note/resident interview, dated 10/11/12, indicated Resident #187 was independent in cognitive skills for daily decision making.</p>		<p>F- 225 Investigation and Report of Allegations of Abuse</p> <p>The facility's intent is to comply with the federal regulation that requires the facility not employ any individual found guilty of abusing, neglecting or mistreating residents. The facility further complies with ensuring all allegations of abuse are reported in accordance with facility policy and regulation. The facility ensures that all allegations are thoroughly investigated and takes every effort possible to ensure the resident(s) are protected during such allegation.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Resident #187 voiced an allegation of missing money on 10/15/12 at which time the facility immediately initiated an investigation per our abuse policy. The investigation determined the alleged missing money could not be substantiated. The incident was reported to Indiana State Department of Health on 10/19/12. The ISDH surveyor was provided a copy of the report.</p>				

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	<p>No social service notes or nursing notes indicated any problem that Resident #187 had any money missing, or any follow up that this was investigated or reported.</p> <p>A "Compliment and Concern Form" dated 10/15/12, indicated Resident #187 reported the missing money and included an investigation the facility completed. The investigation failed to indicate the allegation had been reported to ISDH.</p> <p>10/19/12 at 11:09 a.m., the Administrator indicated the incident had not been reported to ISDH because they could not substantiate the allegation.</p> <p>A policy and procedure for "Abuse-Reporting", with an issued date of 7/1/11, was provided by the administrator on 10/19/12 at 9:15 a.m. The policy indicated, but was not limited to, "Guideline: It is the intent of the facility to encourage and support all residents, staff, and family members to feel free to report any suspected acts of abuse, neglect, involuntary seclusion, or misappropriation of resident property. The facility will take all measures possible to assure that residents, staff and families are free from reprisal, when reports or incidents are reported to the facility...3...The Administrator (or</p>		<p>B. OTHERS IDENTIFIED:</p> <p>1. All residents would have the potential to be affected. None have been determined to be negatively affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. An inservice was conducted with staff reeducating on the abuse reporting procedures and the Indiana State Department of Health Report of Unusual Occurrence guidelines on 11/1/12.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor daily "Missing Property Report" or the facility "Report of Concern" form to determine if the concern meets the reporting requirements. See Exhibit C.</p> <p>2. The Adm. /Designee will report all allegations of abuse to the Indiana State Department of Health per the reporting requirements.</p>		

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	<p>designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of Health reporting guidelines...5. Once the incident is fully investigated, the Administrator or designee will notify the person making the report of the conclusions and any corrective actions implemented based on investigative findings as appropriate. Report the results of the investigation to the Indiana Department of Health as soon as reasonably possible not to exceed 5 working days per the state guidelines...."</p> <p>3.1-28(c)</p>		<p>3. The Adm. /Designee will review all report of concerns and ISDH reportable occurrences at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>	

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 record review and interview, the facility failed to implement their abuse policy and procedure related to reporting for 1 of 3 residents who met the criteria for abuse. (Resident #187)</p> <p>Finding include:</p> <p>During an interview on 10/15/12 at 4:34 p.m., Resident #187 indicated he had \$35.00 missing one night, about a week ago. He indicated he had the money in a billfold in a jacket pocket and it went missing during the night shift. He indicated he reported it right away, as soon as he noticed it was gone and they offered to put the money under lock and key.</p> <p>Resident #187's record was reviewed on 10/18/12 at 1:28 p.m. The record indicated Resident #187 was admitted with diagnoses that included, but were not limited to, osteoarthritis of the right knee, coronary artery disease, high blood pressure, hypercholesterolemia, gastro</p>	F0226	<p>F- 226 Development of Allegations of Abuse Policy and Procedures</p> <p>The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that prohibit resident mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Resident #187 voiced an allegation of missing money on 10/15/12 at which time the facility immediately initiated an investigation per our abuse policy. The investigation determined the alleged missing money could not be substantiated. The incident was reported to Indiana State Department of Health on 10/19/12. The ISDH surveyor was provided a copy of the report.</p>	11/09/2012	

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	<p>esophageal reflux disease, decreased bowel motility, and anxiety.</p> <p>A social service progress note/resident interview, dated 10/11/12, indicated Resident #187 was independent in cognitive skills for daily decision making.</p> <p>A "Compliment and Concern Form" dated 10/15/12, indicated Resident #187 reported the missing money and included an investigation the facility completed. The investigation failed to indicate the allegation had been reported to ISDH.</p> <p>10/19/12 at 11:09 a.m., the Administrator indicated the incident had not been reported to ISDH because they could not substantiate the allegation.</p> <p>A policy and procedure for "Abuse-Reporting", with an issued date of 7/1/11, was provided by the administrator on 10/19/12 at 9:15 a.m. The policy indicated, but was not limited to, "Guideline: It is the intent of the facility to encourage and support all residents, staff, and family members to feel free to report any suspected acts of abuse, neglect, involuntary seclusion, or misappropriation of resident property. The facility will take all measures possible to assure that residents, staff and families are free from reprisal, when</p>		<p>B. OTHERS IDENTIFIED:</p> <p>1. All residents would have the potential to be affected. None have been determined to be negatively affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. An inservice was conducted with staff reeducating on the abuse reporting procedures and the Indiana State Department of Health Report of Unusual Occurrence guidelines on 11/1/12.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor daily "Missing Property Report" or the facility "Report of Concern" form to determine if the concern meets the reporting requirements. See Exhibit C.</p> <p>2. The Adm. /Designee will report all allegations of abuse to the</p>	

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	<p>reports or incidents are reported to the facility...3...The Administrator (or designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of Health reporting guidelines...5. Once the incident is fully investigated, the Administrator or designee will notify the person making the report of the conclusions and any corrective actions implemented based on investigative findings as appropriate. Report the results of the investigation to the Indiana Department of Health as soon as reasonably possible not to exceed 5 working days per the state guidelines...."</p> <p>3.1-28(a)</p>		<p>Indiana State Department of Health per the reporting requirements.</p> <p>3. The Adm. /Designee will review all report of concerns and ISDH reportable occurrences at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>		

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F0242 SS=C	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>A. Based on record review, interview, and observation the facility failed to provide residents a choice of foods for their meals. This affected 1 out of 92 residents who eat in the facility. There are 17 residents on the 300 hall who receive menus and choose what they want for each meal. (Resident # 39)</p> <p>B. Based on record review, interview and observation the facility failed to give a resident a choice as to when she would shower and whether she took a shower or a tub bath. This affected 1 out of 4 in a sample of 16. (Resident #71)</p> <p>Findings include:</p> <p>A. During dining observation on 10/15/12 at 12:25 p.m., the trays being passed had tickets on them. The only information on them was the resident's name and any diet restrictions or dislikes they had. There was no real menus.</p>	F0242	<p>F- 242 Self Determination</p> <p>The facility's intent is to comply with the resident's choice to make choices about aspects of their life that are significant to the resident.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Resident #39 likes and dislikes was reassessed 11/6/12. (See Exhibit E). This resident's choices are fulfilled within the realm of being able to provide what she wants. However, this resident is on a self-limiting diet which has been care planned prior to this survey (See exhibit F.) The facility will continue to serve her foods that she request. She will be given a copy of the facility menu.</p> <p>2. The facility serves meals in</p>	11/09/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an interview on 10/17/12 at 2:00 p.m., Resident #39 stated, "foods are more cold than hot".</p> <p>During interview with the Dietary Manager on 10/17/12 at 3:05 p.m., she indicated residents can have meat or eggs but not both unless they request it.</p> <p>During interview on 10/22/12 at 9:05 a.m., with Cook #2 she indicated residents do not get a choice for meals. "They are served what is on the menu unless they have an intolerance. People on the skilled unit fill out menus and we fill their trays accordingly."</p> <p>A copy of the menu for the week received on 10/17/12 at 10:11 a.m., from the Dietary Manager, stated, "Breakfast assorted juices, hot cereal or dry cereal, egg of choice, breakfast meat, breakfast bread..." The menu received on 10/19/12 at 9:20 a.m., for the rehab unit, from the Dietary Manager, stated, "Breakfast ...(list of drinks) Choice of cereal:...(list of different cereals) Sausage Patties, Biscuits and gravy, margarine/jelly. These are the menus for the rehab unit (the 300 hall).</p> <p>Interview with Resident #39 on 10/17/12 at 9:05 a.m., indicated they could not have eggs and meat for breakfast. It was</p>		<p>accordance with our Registered Dietician approved menus which is required by federal regulation. Some of those menus have an egg versus a meat for breakfast. However the daily recommended protein requirements are met through all 3 meals. As stated to the surveyor by DM and Adm., if the resident requests an alternative, an alternative is offered per their choice, if available. If their specific request is not available several other options are given. This has been standard practice of this facility and will continue to be.</p> <p>3. Transitional Care Unit residents are provided a menu that is the same as the Long Term Care residents. There is no difference. The layout is the only difference. This too was explained to the surveyor by the administrator.</p> <p>4. Resident #71 had a preference for customary routines assessment completed on 9/11/12. (Exhibit G). At that time she indicated she preferred a sponge bath. At no time did she indicate that she preferred a tub bath. The resident will be reassessed to ensure her daily customary routines are care planned. (See Exhibit H)</p> <p>B. OTHERS IDENTIFIED:</p>		

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	<p>one or the other.</p> <p>Interview with the Dietary Manager on 10/17/12 at 3:05 p.m., she stated, "The resident can have meat or eggs but we don't give them both. If they request it we can give both to them. "The rehab unit is the only area that gets a specific menu."</p> <p>Interview with the Administrator on 10/19/12 at 12:23 p.m., she indicated they have moved the meat protein to another meal. "The residents can ask for both if they want it. The rehab unit gets the specific menus."</p> <p>B. During interview with Resident #71 on 10/17/12 at 2:50 p.m., she indicated she got a shower 2 times a week. They told her when she was going to get it and that it would be a shower. She indicated that she did not get to choose whether she took a shower or a tub bath. They just told her it would be a shower. She indicated she had asked for a shower before and the staff told her she could not have one.</p> <p>During interview on 10/18/12 at 10:45 a.m., with LPN # 4 she indicated showers are scheduled. They are done twice a week. They are divided between shifts. She stated, " We will do showers whenever the resident wants it they just</p>		<p>1. All residents would have the potential to be affected. None have been determined to be negatively affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. An inservice was conducted with staff reeducating on the abuse reporting procedures and the Indiana State Department of Health Report of Unusual Occurrence guidelines on 11/1/12.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor daily "Missing Property Report" or the facility "Report of Concern" form to determine if the concern meets the reporting requirements. See Exhibit C.</p> <p>2. The Adm. /Designee will report all allegations of abuse to the Indiana State Department of Health per the reporting requirements.</p>				

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	<p>need to let us know."</p> <p>During interview on 10/19/12 at 8:50 a.m., with LPN #5 she indicated there is a whirlpool tub in the shower room on the 200 hall but it is full of stuff and she isn't sure it even works.</p> <p>During interview on 10/19/12 at 10:05 a.m., with the Maintenance Supervisor, he indicated he didn't know that there was anything wrong with the whirlpool tub. As far as he knew it worked.</p> <p>Interview with Resident #71 again on 10/18/12 at 1:15 p.m., she indicated she would start asking the staff sometime for a bath instead of a shower. She is not real sure she could even take one. She is transferred by hoyer lift.</p> <p>They (Business Office Manager and Administrator) indicated on 10/22/12 at 10:20 a.m., they do not have a policy and procedure regarding when to take a shower or shower vs tub bath.</p> <p>3.1-3(u)(3)</p>		<p>3. The Adm. /Designee will review all report of concerns and ISDH reportable occurrences at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>		

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F0329 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>Based on record review and interview, the facility failed to ensure one resident's drug regimen was free of psychiatric medications used for excessive duration without a gradual dose reduction (Resident #37). This deficient practice affected 1 of 10 residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>1. Review of the clinical record for</p>	F0329	<p>F- 329 Unnecessary Drugs</p> <p>The facility's intent is to comply with regulation that requires that each resident will be free from any unnecessary drugs.</p> <p>A. ACTIONS TAKEN:</p>	11/09/2012

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	<p>Resident #37 on 10/17/12 at 3:00 p.m., indicated the resident had diagnoses which included, but were not limited to: history of general anxiety disorder, major depression, and dementia w/ agitated features.</p> <p>The October monthly physician orders included a note which indicated "4/2010 - failed attempt for reduction of Zyprexa". The orders also included: - 5/11/11 Zyprexa 15 mg [milligrams] - take 1 QD [daily] at 5 p.m. for delusional behaviors - 5/29/11 Zyprexa 7.5 mg - take 1 q [every] am [morning] for delusional behaviors</p> <p>A 8/23/12 Care Plan was developed for "Resident at risk for behavioral disturbances R/T [related to] DX [diagnosis of] Mood D/O [disorder] and dementia with agitation and delusions". Goal: "Will Have no episodes of behaviors r/t dx" and "res will have no reactions to anti-psychotic meds daily" Approaches included: " 8. Observe for adverse reaction to antipsychotic meds; 9. GDR per guidelines, 12 .Monitor for effectiveness of meds and interventions."</p> <p>During an interview with the Social Worker on 10/18/2012 at 11:50 am, she indicated there have been no GDRs</p>		<p>1. Resident # 37 was reviewed by social service and they contacted the primary care physician, Dr. Ellis, on 9/12/12 requesting a GDR of Zoloft. Dr. Ellis responded back, 9/24/2012, indicating he thought the gradual dose reduction would be contraindicated based on reports of her being with increased symptoms of depression. He further questioned if Dr. Butler, facility psychiatrist, "should see her?" Dr. Butler had reviewed the resident's psychotropic medications on 8/23/12, at which time she stated the GDR would be contraindicated. Based on the professional opinion of 2 physicians, the facility didn't perform a gradual dose reduction on resident #37. The resident will continue to be reviewed for future GDR's in accordance with facility policy and Federal Requirements.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. A 100% audit will be completed of all residents. All residents would have the potential to be affected. None have been determined to be negatively affected.</p>		

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	<p>[gradual dose reductions] for any of the resident's medications since being implemented in 2011. She indicated she had faxed the primary physician on 9/12/12 asking for him to reduce the resident's Zoloft but he deferred to the psychiatrist to make the decision as he had been informed resident was having crying and depression.</p> <p>Review of the psychiatric documentation, the resident was last seen in August 2012. Documentation was lacking of the resident having been seen by the psychiatrist in September per the physician order.</p> <p>During the interview with the Social Worker, she also indicated, "I don't know why the resident was not seen in September by the psychiatric group as they are supposed to honor their contract and make last visits here in October. If the resident has not been seen by end of October, then I will make sure she is on the list to be seen next month by the new psychiatric group."</p> <p>3.1-48(a)(2) 3.1-48(b)(2)</p>		<p>C. MEASURES TAKEN:</p> <p>1. Social Service will review residents with psychotropic medications quarterly with the IDT to determine if a Gradual Dose Reduction should be initiated.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor resident's medication regime to ensure appropriate Gradual Dose Reductions are attempted weekly x 4, monthly x2, quarterly thereafter. (Exhibit K)</p> <p>2. The Adm. /Designee will review findings at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>		

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F0364 SS=F	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on record review, interview and observation the facility failed to ensure proper food temperatures in that the hot food temperatures were below the designated safe range on the test tray. This had the potential to affect 109 of 109 residents receiving food from dietary. There is one resident who gets nothing to eat by mouth.</p> <p>Findings include:</p> <p>A test tray was received on 10/19/12 at 12:23 p.m. The temperature of the roast beef was 80 degrees, the mashed potatoes and gravy were 94, the green beans were 90 and the fruit cup was 70.</p> <p>Interview with the Dietary Manager on 10/22/12 at 10:15 a.m., she indicated she knew the temperatures would be a problem. They have ordered some new plate holders that are suppose to keep the plates hot for 1 hour.</p> <p>The policy received on 10/22/12 at 12:40 p.m., from the Administrator, did not</p>	F0364	<p>F- 364 Nutritive Value, Palatable, Temp The facility's intent to ensure that each resident receives food prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive, and at the proper temperature. A. ACTIONS TAKEN: 1. The test tray was immediately discarded. B. OTHERS IDENTIFIED: 1. 109 residents would have had the potential to be affected. None have been determined to be negatively affected. C. MEASURES TAKEN: 1. Dietary staff will be re-inserviced 11/9/12 on ensuring proper temperature controls are achieved. 2. Nursing staff were reinserviced on 11/1/12 to ensure trays are served timely. D. HOW MONITORED: 1. The dietary manager/designee will monitor food temperatures daily during scheduled work week. (Exhibit L) 2. The Adm. /Designee will review findings at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director. E. This plan of correction constitutes our credible</p>	11/16/2012	

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	<p>indicate the proper serving temperatures. It only gave perishable item temperatures.</p> <p>3.1-21(a)(2)</p>		<p>allegation of compliance with all regulatory requirements, our date of completion is: 11/16/12.</p>		

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F0371 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</p> <p>Based on record review, interview and observation the facility failed to ensure food was prepared and served under sanitary conditions in that floors were sticky, hairnets were not worn properly, food in refrigerator was outdated, gloves were not worn properly, dishes were stored wet and dirty, as was a meat slicer. Dishes washed in the 3 compartment sink were left in the sanitizer for only 15 seconds. This was observed during 3 of 3 observations of the kitchen. This had the potential to affect 109 residents who receive food from dietary.</p> <p>Findings include:</p> <p>During tour in the kitchen on 10/15/12 at 9:36 a.m., the floor was sticky in the dry storage room, slaw mix was in the refrigerator opened but not sealed and no opened date was on it, Swiss cheese was opened but not sealed and had no date, cheddar cheese spread expired 10/12/12, french dressing expired 10/6/12, syrup expired 10/13/12, a pitcher of lemonade</p>	F0371	<p>F- 371 Food Procure, Store, Prepare, Serve</p> <p>The facility's intent to procure, store, prepare, distribute and serve food under sanitary conditions.</p> <p>A. ACTIONS TAKEN:</p> <ol style="list-style-type: none"> 1. The identified ideas were corrected immediately. <ol style="list-style-type: none"> a. Floors cleaned b. Staff hair nets were properly applied c. Food outdated discarded d. Floor cleaned e. Staff were inserviced on proper glove use f. Dishes and meat slicer were 	11/16/2012			

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	<p>was in the refrigerator with no date or label. There was a container of cottage cheese with saran wrap partially on it but it was not sealed. Cook #1 wore gloves while touring kitchen and left them on when she was working with cooked chicken. She was touching the chicken with her gloves. She wore the same gloves to reach in a drawer for utensils and went back to work with the chicken. She broke up the chicken pieces with her gloved hands. Cook #1 also had 3 -4 inch long hair strands hanging out of her hairnet around her face and in back. Cook #1 finished washing the blender after she did the chicken she washed the blender and parts and put them in sanitizer. Cook #1 stated, " The dishes are to soak in the sanitizer for 15 seconds."</p> <p>On 10/16/12 at 9:25 a.m., the meat slicer was covered and stored. When the dietary manager uncovered it was dirty. It still had ham on it from when the cook sliced it yesterday. It had been covered as though it was clean.</p> <p>During tour of the kitchen on 10/17/12 at 10:08 a.m., with the Dietary Manager, the sanitizer levels in the 2 bucket and the one sink for sanitizer in the kitchen were checked and met standards. She indicated the dishes are to soak in the sanitizer 45 seconds. She stated, "Gloves should be</p>		<p>rewashed and dried properly</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 109 residents would have had the potential to be affected. None have been determined to be negatively affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. Dietary staff will be re-inserviced 11/9/12 on ensuring proper dietary sanitation measures are implemented including following the cleaning schedule. (See exhibit D).</p> <p>D. HOW MONITORED:</p> <p>1. The dietary manager/designee will monitor daily utilizing a sanitation checklist during scheduled work days to ensure the department is in compliance. (Exhibit M)</p> <p>2. The Dietary Manager /Designee will review findings at the</p>		

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	<p>changed when moving from touching food to opening boxes and back to food."</p> <p>A policy titled, "Glove and Hand Washing Procedures" was received from the Dietary Manager on 10/16/12 at 11:12 a.m. This policy states, "...6. Hands are washed before donning gloves and after removing gloves. 8. Gloves are changed any time hand washing would be required...if the gloves become contaminated by touching the face, hair, uniform, or other non-food contact surface, such as door handles and equipment..."</p> <p>A policy titled, "Dishwashing Manual", was received from the Dietary Manager on 10/22/12 at 11:10 a.m. This policy did not indicate the amount of time dishes should be in the sanitizer after they are washed. It does indicate that dishes are to be air dried before putting away.</p> <p>A policy titled, "Date Marking" was received from the Dietary Manager on 10/22/12 at 11:10 a.m. This policy states, "...4. Food items should be discarded when: The food item has been refrigerated for 7 days, The food item is leftover for more than 72 hours, the food item is older than the expiration date..."</p>		<p>monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/16/12.</p>				

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F0412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on record review, interview and observation the facility failed to provide dental services needed for a resident with improper fitting dentures. This affected 1 of 3 residents reviewed for dental care in a sample of 16. (Resident #39)</p> <p>Findings include:</p> <p>Record review for Resident #39 was done on 10/16/12 at 4:20 p.m. She was admitted on 10/30/11. Diagnoses included but were not limited to: depression, pulmonary HTN (high blood pressure), dementia with behaviors, asthma, coronary artery disease, diabetes Type 2, urinary incontinence, arthritis, anxiety, high blood pressure, excessive esophagitis, and Parkinson's. Minimum Data System (MDS) dated 9/7/12 indicated no dental issues for this resident.</p>	F0412	<p>F- 412 Routine/Emergency Dental Services</p> <p>The facility's intent is for residents, to obtain dental services needed for emergent or routine needs</p> <p>A. ACTIONS TAKEN:</p> <p>1. Resident #39 was evaluated on 10/23/12 with a remake of dentures ordered.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of all residents in</p>	11/09/2012

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	<p>A progress note dated 9/10/12 by Dr. [name of dentist], D.D.S. states, "resident is unhappy with fit of dentures at this time. Made adj [adjustment] to midline palatal [top denture] resident indicates "this time they feel better."</p> <p>During interview with Resident #39 on 10/16/12 at 3:00 p.m. she indicated her dentures were still not right and needed to be readjusted. She indicated she had told staff about the problem with the dentures.</p> <p>Interview with LPN #3 on 10/17/12 at 2:45 p.m., indicated she didn't even know this resident had dentures. Said the "dentist comes in once a month and I will be sure he sees her again. On 10/18/12 at 9:00 a.m., LPN #3 indicated they were calling the dentist so he could come back in and recheck her dentures. She indicated she called twice yesterday and was going to call again today.</p> <p>Interview with LPN #3 on 10/18/12 at 2:45 p.m., she indicated the dentist was to come in Tuesday, 10/23/12 and would definitely see her.</p> <p>3.1-24(a)(1)</p>		<p>the facility for dental issues. All residents would have the potential to be affected. See Exhibit A.</p> <p>C. MEASURES TAKEN:</p> <p>1. Social Service will refer any residents needing dental evaluation to a dentist of their choice. See Exhibit A.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor for compliance by reviewing a sample of 10% of nursing summary assessments weekly x 4, monthly x2 then quarterly thereafter. See Exhibit B.</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation</p>		

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			of compliance with all regulatory requirements, our date of completion is: 11/9/12.		

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the pharmacist reviewed and reported the need for gradual dose reductions to the physician and Director of Nursing (Resident #37) and failed to follow up on the pharmacist's recommendation to consider discontinuing a medication. (Resident #100)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #37 on 10/17/12 at 3:00 p.m., indicated the resident had diagnoses which included, but were not limited to: history of general anxiety disorder, major depression, and dementia w/ agitated features.</p> <p>The October monthly physician orders included a note which indicated "4/2010 - failed attempt for reduction of Zyprexa". The orders also included: - 5/11/11 Zyprexa 15 mg [milligrams] -</p>	F0428	<p>F- 428 Drug Regimen Review</p> <p>The facility's intent is for resident's drug regimen to be reviewed monthly by a licensed pharmacist.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Resident #37 was reviewed monthly by the facility's licensed pharmacist. On 7/24/12, the pharmacist noted that a GDR of Zyprexa was contraindicated based on previous attempts caused delusions. 8/29/12, pharmacist documented that a GDR of Zoloft and Zyprexa was contraindicated. (See Exhibit N).</p> <p>2. Resident #37 was evaluated by Dr. Butler on 8/23/12 who indicated that a GDR was contraindicated. (See Exhibit O).</p>	11/09/2012	

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	<p>take 1 QD [daily] at 5 p.m. for delusional behaviors</p> <p>- 5/29/11 Zyprexa 7.5 mg - take 1 q [every] am [morning] for delusional behavior</p> <p>- 4/12/2012 Zoloft 100 mg - 1 tab daily</p> <p>During an interview with the Social Worker on 10/18/2012 at 11:50 am, she indicated there have been no GDRs for any of the resident's medications.</p> <p>The 7/24, 8/29, and 9/26/12 Consultant Pharmacist reviews indicated no recommendations were made for GDR of the medications. Reference was made to a 8/12/12 psych note which indicated it was contraindicated to discontinue it - no attempts had been made since April 2010.</p> <p>2. Review of the clinical record for Resident # 100 on 10/18/12 at 2:00 p.m., indicated the resident had diagnoses which included but were not limited to: depression, mood disorder, Alzheimer dementia with disturbance of mood & behavior, and anxiety.</p> <p>On 6/19/12, the resident returned from the area psychiatric unit with a new order for</p> <p>- Invega Sust Inj 117/0.75 - inject .75 ml once monthly - Dementia with disturbance of mood & behavior (for</p>		<p>3. Resident #100 was reviewed by the facility licensed pharmacist each month. (See Exhibit P)</p> <p>4. Resident #100- the consultant pharmacy review indicated – “NOTES-Invega? D/C order?”- They surveyor alleged the facility made no follow-up to the recommendation. The facility had indeed followed up to the recommendation and investigated to determine that it had been left off the prior printed orders. Pharmacy was called to ensure it would be on the next months printed physician orders. (See Exhibit Q).</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of all residents in the facility has been completed to ensure all pharmacy recommendations have been communicated. All residents would have the potential to be affected. None have been found to be negatively affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. Director of Nursing and Unit managers’ inserviced to ensure</p>		

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	<p>physical aggression)</p> <p>- a blank was noted on 8/29 Medication Administration Record - indicating it was unclear if the injection had been given. On the July MAR, it was circled on 7/29 as having not been given.</p> <p>Review of the August, and September monthly physician re-writes indicated it was not listed as a medication to be given, but was listed on the MARs.</p> <p>The Consultant Pharmacy review on 8/30/2012 made no reference to the Invega not being administered.</p> <p>The 9/20/12 Consultant Pharmacy review indicated- "NOTES - Invega? DC Order?" - no follow-up to the pharmacist's recommendation was noted.</p> <p>On 10/22/12 at 12:40 p.m., the Administrator presented a copy of the facility's current "Consultant Pharmacy Services Provider Agreement". Review of the agreement at this time included, but was not limited to: "Policy: regular Consultant Pharmacist services are provided to residents for nursing facilities that have a written agreement for such services. Procedures: ... Reviewing the medication regimen of each resident monthly...and documenting the review</p>		<p>timely communication and follow-up of all pharmacy recommendations. (See Exhibit R).</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor for compliance by reviewing a sample of 10% of pharmacy recommendations weekly x 4, monthly x2 then quarterly thereafter. (See Exhibit S).</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>				

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	<p>and finding in the resident's medical record..."</p> <p>During the final exit meeting with the Administrator, Director of Nursing and the Administrator in Training on 10/22/2012 at 2:00 p.m., the Administrator indicated that after the State reviewed the clinical record, the facility also did a check of the record and got an order to discontinue the Invega order.</p> <p>3.1-25(i) 3.1-25(j)</p>			
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F0441 SS=E	<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. Based on record review, interview and observation, the facility failed to ensure</p>	F0441	F- 441 Infection Control	11/09/2012			

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	<p>their infection control policies related to hand hygiene during meal service were followed during 1 of 4 dining room meal observations. This deficient practice had the potential to affect 37 of 110 residents who ate in the main dining room.</p> <p>Finding includes:</p> <p>During the lunch meal observation on 10/15/2012, the following was observed:</p> <p>- 12:38 p.m. - the Social Worker opened the trash can under the counter in the main dining room with the foot pedal, threw away the trash touching the lid while talking to someone, then poured coffee for a resident - no handwashing was observed.</p> <p>- 12:43 p.m. - LPN #3 rubbed a resident on the shoulder as she passed by and then obtained a bowl of mashed potatoes for another resident - no handwashing was observed.</p> <p>During an interview with LPN #3 at 1:00 p.m. on 10/15/12, she indicated that usually the staff used the alcohol gel hanging in the dietary window between trays unless they touched a resident while fixing their tray in which the staff would then need to use soap and water to wash their hands.</p>		<p>The facility's intent is to have an effective program that provides a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Facility handwashing policy was reviewed with no revisions necessary.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 37 residents had the potential to be affected. None have been found to be negatively affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. Staff inserviced on the handwashing procedures on 11/1/12.</p>				

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	<p>On 10/22/12 at 12:40 p.m., the Administrator presented a copy of the facility's current policy on "Handwashing". Review of this policy at this time included, but was not limited to: "Policy: All staff will use proper handwashing techniques to prevent the spread of infection as per Center of Disease Control Guidelines..."</p> <p>During an interview with the Administrator at 2:02 p.m. on 10/22/12, she indicated there were 37 residents who currently ate in the main dining room.</p> <p>3.1-18(b)(1)</p>		<p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor for compliance by auditing meal service to ensure proper handwashing weekly x 4, monthly x2 then quarterly thereafter. (See Exhibit T).</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>		

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F0465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, record review, and interview, the facility failed to provide a sanitary environment in that the carpeting had soiled areas on 3 of 3 halls and had the potential to affect all 110 residents in the facility.</p> <p>Findings include:</p> <p>During initial observations of the facility on 10/15/12 at 9:30 a.m., scattered areas of gray and dark gray stains were observed on the carpeting on the 100 hall. Scattered areas were observed on the 200 hall, in front of rooms 201 and 202, and on the 300 hall between rooms 301 and 305. A large dark gray soiled area was observed outside the door of the supply closet, across from the 100 hall nurse's station.</p> <p>During the environmental tour on 10/19/12 at 10:35 a.m., with the Maintenance Supervisor, black and gray stained areas were observed in the carpeting by rooms 101, 115, 116, 201, and 202. There were 3 large stains</p>	F0465	<p>F- 465 Safe, Functional, Sanitary, and Comfortable Environment The facility's intent is to provide a safe, function, sanitary and comfortable environment for residents, staff and the public. A. ACTIONS TAKEN: 1. The areas identified in the survey have been cleaned. B. OTHERS IDENTIFIED: 1. All residents had the potential to be affected. None have been found to be negatively affected. C. MEASURES TAKEN: 1. The facility floor cleaning protocols were reviewed for any necessary changes. D. HOW MONITORED: 1. The Maint. Director /Designee will monitor for compliance by conducting daily walk through on scheduled work days to ensure floors are clean weekly. (See Exhibit U). 2. The Maint. Director /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 11/9/12.</p>	11/09/2012

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	<p>between 318 and 319 one was half the width of the hall, one was 2 foot by 9 inches, and one was 3 feet long by 2 feet wide. A large gray stained area was observed in the carpet in front of the supply closet, across from nursing desk, and in the hallway carpet by the shower room.</p> <p>On 10/19/12 at 11:25 a.m., the Maintenance Supervisor indicated the carpets are cleaned on a schedule every day, it takes about 2 hours to clean a "zone", and they have a floor man who works every evening to clean the carpets.</p> <p>3.1-19(f)</p>			

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F0514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure signed monthly physician orders and pharmacy reviews were readily acceptable on the clinical records for 8 of 36 residents reviewed for accessible records. (Residents #6, 14, 71, 106, 118, 125, 163, and 37)</p> <p>Findings include:</p> <p>1. A review of Resident #6's record on 10/19/12 at 10:30 a.m., revealed that unsigned copies of the physician recapitulation orders were in the clinical record. The signed physician recapitulation orders were not in the clinical record.</p> <p>2. A review of Resident #14's clinical</p>	F0514	<p>F- 514 Clinical Records</p> <p>The facility's intent is to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; and systemically organized.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Resident 6, 14, 71, 106, 118, 125, 163, 37 signed physician orders were placed on the medical record.</p>	11/09/2012			

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	<p>record on 10/19/12 8:40 a.m., revealed that unsigned copies of the physician recapitulation orders for October, 2012 were in the clinical record. The signed physician recapitulation orders were not in the clinical record.</p> <p>3. A review of Resident #71's clinical record on 10/19/12 at 8:40 a.m., revealed that July, August, September, and October unsigned original recapitulation orders were in the clinical record.</p> <p>4. A review of Resident #106's clinical record on 10/19/12 at 8:40 a.m., revealed that unsigned copies of the physician recapitulation orders for August, September, and October, 2012 were in the clinical record. The signed physician recapitulation orders were not in the clinical record.</p> <p>5. A review of Resident #118 's clinical record on 10/19/12 at 8:40 a.m., revealed that unsigned copies of the physician recapitulation orders for September and October, 2012 were in the clinical record. The signed physician recapitulation orders were not in the clinical record.</p> <p>An interview with the Administrator on 10/19/12 at 10:30 a.m., indicated that the signed physician recapitulation orders are located in the medical records office.</p>		<p>B. OTHERS IDENTIFIED:</p> <p>1. An 100% audit has been completed. None have been found to be negatively affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. Medical records was reinserviced on 11/1/12.</p> <p>D. HOW MONITORED:</p> <p>1. The Adm. /Designee will monitor for compliance by auditing a sample of 10% weekly x 4, monthly x2 then quarterly thereafter. (See Exhibit V).</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p>		

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	<p>6. Review of the clinical record for Resident #125 on 10/18/12 at 9:00 a.m., indicated the resident was admitted to the facility on 2/27/12 and had diagnoses which included, but were not limited to: dementia, R/O bipolar disorder, insulin dependent diabetes mellitus, hyperlipidemia, osteoarthritis, coronary artery disease, immobility, and advanced spondylasis.</p> <p>Review of the June, July, August, September, and October 2012 monthly MD orders indicated only pink copies were on the chart. The clinical record was lacking the originals with the physician's signatures.</p> <p>The monthly Consultant Pharmacy reviews were also lacking on the clinical record.</p> <p>7. Review of the clinical record for Resident #163 on 10/19/2012 at 2:00 p.m., indicated that the resident was</p>		<p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/9/12.</p>		

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	<p>admitted on 6/8/12 with a re-admission from the hospital and had diagnoses which included, but were not limited to: diabetes mellitus Type 2, hypertension, gastroesophageal reflux disease, peripheral vascular disease, bi-polar disorder, neuropathy, pain , cerebral vascular accident with latent effects of L side hemiparesis, depression, anxiety, mood disorder, psychosis mood.</p> <p>Review of the October 2012 monthly physician orders indicated only pink copies were on the chart. The clinical record was lacking the originals with the physician's signatures. The last signed by MD was on 9/14/2012 when the resident returned from the hospital on 9/13/2012.</p> <p>The monthly Consultant Pharmacy reviews were also lacking on the clinical record.</p> <p>8. Review of the clinical record for Resident #37 on 10/17/2012 at 3:00 p.m. indicated the resident had diagnoses which included, but were not limited to: history of general anxiety disorder, hypothyroidism, arteriosclerotic cardiovascular disease, gastroesophageal reflux disease, osteoarthritis, degenerative joint disease, glaucoma, major depression, dementia w/ agitated features, small bowel obstruction surgery, angina,</p>			

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	<p>anemia, and hypertension.</p> <p>Review of the August, September and October 2012 monthly physician orders indicated only the pink copies were on the chart. The clinical record was lacking the originals with the physician's signatures.</p> <p>The monthly Consultant Pharmacy reviews were also lacking on the clinical record.</p> <p>During an interview with the Minimum Data Set Coordinator on 10/18/2012 at 3:00 p.m., she indicated "The Consultant Pharmacist reviews are now kept in each of the med rooms on the units. They are not accessible unless you have the key."</p> <p>During an interview with the Medical Records clerk on 10/18/2012 at 3:35 p.m., she indicated the monthly orders were signed by the physician, but has not had the chance to put all of them on the clinical records yet.</p> <p>On 10/22/12 at 12:40 p.m., the Administrator presented a copy of the facility's current "Consultant Pharmacy Services Provider Agreement". Review of the agreement at this time included, but was not limited to: "Policy: regular Consultant Pharmacist services are</p>			

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	<p>provided to residents for nursing facilities that have a written agreement for such services. Procedures: ... Reviewing the medication regimen of each resident monthly...and documenting the review and finding in the resident's medical record..."</p> <p>3.1-50(a)(3)</p>			