

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2012
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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00102315.</p> <p>Survey dates: January 3, 4, 5, 6, 7, 8, 9, 10, 11, &amp; 12, 2012.</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Survey team: Kathleen (Kitty) Vargas, RN-TC (January 3, 4, 5, 6, 9, 10, 11, &amp; 12, 2012) Lara Richards RN (January 3, 4, 5, 6, 9, 10, 11, &amp; 12, 2012) Heather Tuttle, RN (January 3, 4, 5, 6, 7, 9, 10, 11, &amp; 12, 2012) Janet Adams, RN (January 3, 4, 5, 6, 8, 9, 10, 11, &amp; 12, 2012)</p> <p>Census bed type: SNF/NF 135 Residential 45 Total 180</p>	F0000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	

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

TITLE

(X6) DATE

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

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	<p>Census payor type: Medicare 37 Medicaid 62 Other 81 Total 180</p> <p>Stage 2 sample: 41 Residential sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 20, 2012 by Bev Faulkner, RN</p>				

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F0156 SS=A	<p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p>	F0156			

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	<p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance</p>			

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	<p>directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure 2 of 3 residents reviewed for notification of the discontinuation of skilled services received notification prior to the end of services. (Residents #24 and #12)</p> <p>Findings include:</p> <p>1. On 1/10/12, the Admission's Coordinator provided a list of residents whose Medicare skilled services were discontinued. Resident #24 was listed as having his Medicare skilled services discontinued on 12/19/11.</p> <p>Interview with the Admissions Coordinator on 1/10/12 at 11:17 a.m., indicated the "Generic Notice of Non-Coverage Expedited Determination" form was not provided to the resident or the resident's responsible party.</p>		<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F156 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for residents listed are as follows: Resident 12 and Resident 24 have been discharged. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents who are discharged off therapy have the potential to be affected by the alleged deficient practice. Residents who were recently discharged were reviewed to determine if a notification letter was provided. <b>What measures will be put into</b></p>	02/10/2012

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	<p>Interview with the Admissions Coordinator on 1/10/12 at 11:17 a.m., indicated Resident #24 should have received a "Generic Notice of Non-Coverage Expedited Determination" form.</p> <p>2. On 1/10/12, the Admission's Coordinator provided a list of residents whose Medicare skilled services were discontinued. The last day of Medicare skilled services for Resident #12 was listed as 12/1/11.</p> <p>Interview with the Admissions Coordinator on 1/10/12 at 11:17 a.m., indicated the "Generic Notice of Non-Coverage Expedited Determination" form was not provided to the resident or the resident's responsible party.</p> <p>The policy titled, "Advanced Beneficiary Notices" that was undated, was provided by the Admission's Coordinator on 1/10/12. She indicated the policy was current. The policy indicated that a "Generic Notice of Non-Coverage Expedited Determination" form was to be provided when there was termination of Medicare Part A services. It also indicated the notice was to be provided no later than 2 days before</p>		<p><b>place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Admission staff have been re-educated by Director of Nursing/designee on the following: · All resident who are to be discharged from skilled services are to receive notification prior to the end of that service. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Admissions/designee will perform audits weekly on the residents who are due to be discharged from skilled services to ensure a notification letter was sent prior to the date. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>				

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	<p>covered services ended.</p> <p>Interview with the Admissions Coordinator on 1/10/12 at 11:17 a.m., indicated Resident #12 should have received a "Generic Notice of Non-Coverage Expedited Determination" form.</p> <p>3.1-4(a)</p>			
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F0166 SS=D	<p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure grievances were resolved in a timely manner related to missing clothes and a missing blanket for 1 of 3 residents reviewed of the 4 who met the criteria for personal property. (Resident #B)</p> <p>Findings include:</p> <p>Interview with Resident #B on 1/4/12 at 1:32 p.m., indicated that she had recently given a list of missing items to facility staff. The resident indicated that she was missing two queen size sheets and a blanket. She also indicated that she had four dresses missing since November 2011. She indicated that she had reported this to staff and the items were still missing.</p> <p>The record for Resident #B was reviewed on 1/9/12 at 2:53 p.m. There was no documentation in the Social Service Progress Notes related to the resident's missing items.</p> <p>Grievances filed by the resident were provided by the Social Service Director and were reviewed on 1/9/12 at 8:37 a.m.</p>	F0166	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F166 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for the resident listed are as follows: Resident B was offered \$125 for her missing items. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents who have filed a grievance have the potential to be affected by the same alleged deficient practice. Current grievances were reviewed to determine timeliness of follow-up. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The Concern Form was updated to include what was done for resolution and the resident's response as to their satisfaction. Facility staff have been</p>	02/10/2012	

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	<p>A Resident Council follow-up form, dated 8/24/11, indicated Resident #B was missing a dress for about 3 months. The dress was labeled, and the resident met with laundry one time to discuss the issue. The documented response was "flower, light pink house dress the resident was spoken to and was informed the house dress would be looked for." The form was signed 8/30/11 and there was no further documentation to indicate if the house dress had been found and what kind of investigation was completed.</p> <p>A Resident Council follow-up form, dated 10/26/11, indicated Resident #B was missing her favorite dress, the dress was labeled but never found, and had been missing for at least 6 months. The documented response from the Housekeeping Supervisor indicated, "Note dress missing for almost 1 year. No other resident uses these types of dresses (or size). If found we will definitely return to resident. Apologizes for loss of item." There was no further documentation to indicate if the dress had been found and what kind of investigation was completed.</p> <p>On 12/14/11, the Social Service</p>		<p>re-educated by Social Service/designee on the following: · When a resident/family member has a concern the Concern form is to be completed and a copy given to Social Service · Measures that were taken to resolve the grievance are to be documented on the form · Time period for follow-up is within 5 days <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Social Service/designee will perform audits weekly on the 5 residents who have made a concern to ensure the concern has had follow-up in a timely manner. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>				

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	<p>department received a concern form from the resident related to the resident indicating that she had several missing items. The concern form indicated the Administrator, Unit Supervisor, and Housekeeping were notified. The documented action, dated 12/15/11, indicated to continue to search for missing items and those that staff and I could identify have been brought to administration. The action section was signed by the Housekeeping Director. The Follow up section and resolution section of the form were blank.</p> <p>A Resident Council follow-up form, dated 12/28/11, indicated the resident was missing a green dress and a blanket for 1 month. The blanket was labeled. The documented response by the Housekeeping Supervisor indicated, "Have looked and searched for both items-waiting to speak further with administration." The form was signed on 1/2/12 by the Housekeeping Supervisor.</p> <p>Interview with the resident on 1/10/12 at 8:47 a.m., indicated that she was offered \$50 to replace her missing items a few days ago. The resident feels that is not sufficient and she indicated her missing blanket alone was worth \$30.</p>			
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	<p>Interview with the Social Service Director on 1/11/12 at 12:51 p.m., indicated the resident has had repeated concerns related to missing items. The Social Service Director indicated for the most recent complaints, staff went room to room looking for her items. The resident was offered money for reimbursement and did not take it. She indicated the resident felt her missing items were worth more money. The resident was also educated about marking her items. The Social Service Director indicated a resolution should have been documented for the most recent incident as well as the incidents back in August and October 2011.</p> <p>The Filing Grievances/Complaints policy was provided by the Director of Nursing on 1/10/12 at 9:45 a.m., and identified as current. The policy indicated the following:</p> <p>- "Grievances and/or complaints may be submitted orally or in writing. Written complaints or grievances must be signed by the resident or the person filing the grievance or complaint in behalf of the resident."</p> <p>- "The administrator may delegate investigation of the grievance to the</p>			
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	<p>relevant individual or department head."</p> <p>-"Upon receipt of a written grievance and/or complaint, designated individual will investigate the allegations and submit a written report of such findings to the administrator within 5 working days of receiving the grievance and/or complaint."</p> <p>-"The administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken."</p> <p>-"The resident, or person filing the grievance and/or complaint in behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee, within 5 working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the resident, and a copy will be filed in the business office."</p> <p>3.1-7(a)(2)</p>			
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F0223 SS=A	<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 record review and interview, the facility failed to ensure each resident was free from abuse related to a substantiated allegation of abuse for 1 of 3 allegations of abuse reviewed in the Stage Two Sample of 41. (Resident #176)</p> <p>Findings include:</p> <p>The Facility's State Reportables for allegations of abuse were reviewed on 1/11/12 at 9:22 a.m. There was an allegation of an alleged verbal abuse on 12/2/11 at 4:00 p.m. between Resident #176 and CNA #7.</p> <p>Review of the Facility Incident Report Form, dated 12/3/11, indicated Resident #176 had the diagnoses of arteriosclerosis, hyperlipidemia, epilepsy, psychotic disorder with delusion, constipation, depressive disorder, esophageal reflux. The resident reported the allegation to the Director of Nursing (DoN) on 12/3/11. The resident indicated CNA #7 yelled at her on 12/2/11 at around 4:00 p.m.</p>	F0223	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F223 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 176 – Resident has had no negative effects from the allegation. Employee no longer works at the facility. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Recent abuse investigations were reviewed to ensure a thorough investigation was completed. Inservice records were reviewed to determine the date of the last abuse inservice. <b>What measures will be put into place or what systemic changes will be made</b></p>	02/10/2012

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	<p>The resident stated she was talked to inappropriately.</p> <p>Review of the investigation and interviews with Resident #176 and with the DoN on 12/3/11, indicated the resident had left bingo at around 4:00 p.m., because she thought she was going to have diarrhea so she went back to her room. She indicated that she saw her aide and told her she had to go to the bathroom, so CNA #7 had helped her at that time. The resident told the CNA there was diarrhea in her underwear. So the resident asked the CNA to get her a pull up. The CNA yelled at her and said "Where are you getting those from?" The resident told her that (name) gets them for me. The resident then indicated she went back to bingo and got sick again, came back to her room and could not find her aide, so she placed herself on the toilet by herself and when her aide came in she yelled at her, "What are you doing?" The resident indicated she tried to explain to her, I did not feel good but she was angry. Later when I got dressed in my gown I asked my aide if I had it on right and she grabbed it and pulled it and said, yelling at me, "No it's no right." The resident indicated I could tell she was angry and she needs anger</p>		<p><b>to ensure that the deficient practice does not recur;</b> Facility staff have been re-educated by Director of Nursing/designee on the following: · Examples of the different types of abuse/neglect · What to do if they see or hear any type of abuse/neglect · Who to report the allegation to · What happens to the employee who is accused of the allegation <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Director of Nursing/designee will perform audits weekly on all the allegations of abuse/neglect to ensure that the facility policy was followed, which includes staff interviews, resident interviews, roommate interview, and any interventions to prevent reoccurrence were implemented. A summary of the audits will be presented to the Quality Assurance committee monthly by the Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>				

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	<p>management. The DoN asked her how this made her feel, resident stated "verbally abused." The resident was then asked why she did not report this right away and she indicated she felt more comfortable with the nurses on the day shift.</p> <p>The Final Investigation Report and Five Day Follow Report, dated 12/8/11, indicated Resident #176 had an allegation of Verbal Abuse reported to the DoN on 12/3/11. The facility had contacted CNA #7 and suspended her pending the investigation. The Social Service Director in house was notified and other residents were interviewed. Resident #176 was interviewed and the care plan was reviewed and updated. Continued to Re-interview Resident #176 and the resident continues to maintain the nursing assistant talked to her inappropriately and yelled at. The CNA was terminated.</p> <p>Interview with the DoN on 1/11/12 at 1:19 p.m., indicated she terminated the CNA due to the resident did not change her story regarding the incident. Further interview with the DoN indicated the CNA came in to the facility signed the termination paper but would not give a statement.</p>			
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F0242 SS=D	<p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation and interview, the facility failed to ensure "likes and dislikes" were followed on the residents' tray card for 1 of 3 residents reviewed of the 4 who met the criteria related to food quality. (Resident #B)</p> <p>Findings include:</p> <p>Observation on 1/5/12 at 12:43 p.m., indicated Resident #B was in the Main Dining Room eating her lunch. The resident was served a chicken breast. Small bites of chicken were taken. Interview with the resident at 1:00 p.m., indicated that she was not able to eat the chicken due to she was given white meat, she indicated that she liked the leg or thigh. She indicated that she couldn't eat the white meat due to it being dry and she was missing some of her bottom teeth.</p> <p>On 1/6/12 at 8:42 a.m., the resident was observed in her room eating breakfast. The resident was served</p>	F0242	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F242 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident B – Dietary card was reviewed and preferences updated with resident. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Dietary cards were reviewed for the resident's preference choices. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Dietary staff have been re-educated by</p>		02/10/2012		

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	<p>white toast. Review of the resident's tray card at the time, indicated no white meat or white toast. The resident indicated she preferred wheat toast.</p> <p>On 1/10/12 at 8:47 a.m., the resident was observed in her room eating breakfast. The resident was again served white toast.</p> <p>Interview with the Dietary Food Manager on 1/11/12 at 10:30 a.m., indicated the resident's likes and dislikes were listed on the bottom of the tray card. She also indicated the tray card should be followed to honor the resident's preferences. She indicated the resident should not have received white toast and a chicken breast last week and that she would look into it.</p> <p>3.1-3(u)(3)</p>		<p>Dietary Manager/designee on the following: · When serving each resident's meal tray, thoroughly read the dietary card to identify allergies, food preferences, recommended/ordered interventions, etc. · These preferences should be honored whenever available <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Dietary Manager/designee will perform audits weekly on tray pass for 5 residents to ensure the dietary cards are being followed. Each week a different meal will be audited. Any discrepancies will be corrected immediately and the dietary staff will be alerted to the discrepancy so reoccurrence can be prevented. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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F0253 SS=C	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure the residents' environment was clean, orderly, and comfortable related to marred or gouged walls, doors and closets, tiles broken or discolored, dirty walls, crash carts, activity carts, lift devices, tube feeding equipment on 2 of 2 Nursing Units, 2 of 3 Dining Rooms and 1 of 1 Restorative Rooms. This deficiency had the potential to affect 18 of 135 residents whose rooms were observed. This had the potential to affect the 67 residents on the East Unit and the 68 residents on the West unit.</p> <p>(The East and West Units) (The East and West Dining Rooms) (The Restorative Room)</p> <p>Findings include:</p> <p>1. During the Environmental Tour on 1/9/12 at 1:29 p.m., the following was observed on the East Unit:</p> <p>a. The cove base next to the entrance door and in the bathroom of Room 103 was dirty and marred. Two residents resided in this room.</p>	F0253	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F253 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Room 103 – The base cove was cleaned Room 106 – The base cove was cleaned Room 109 – The tan/green substance was cleaned Room 111 – The tube feeding pole was cleaned Room 117 – A new cover was put on the heating unit Room 121 – The closet door was painted Room 129 – A plastic wall protector was put behind the bed to protect the wall Shower Room East Unit – A new shower room door was ordered, and the shower room remodeled. East Unit Crash Cart – The crash cart was cleaned Ultralift 3500 Hoyer Device on East Unit – The Ultralift was cleaned Room 152 – The base cove was cleaned Room 168 – The gouged area was repaired Room 181 – A new faucet was put in and the bathroom door cleaned Room 184 – The closet door was cleaned Activity cart in West Unit dining</p>	02/10/2012	

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	<p>b. The cove base in the bathroom of Room 106 was marred. One resident resided in this room.</p> <p>c. There were pieces if a tan/greenish colored substance on the wall next to and behind the head of the second bed in Room 109. Two residents resided in this room.</p> <p>d. There was dried tube feeding formula on the tube feeding pump, pump cord, and the base of the tube feeding pole in Room 111. One resident resided in this room</p> <p>e. The heating unit in the wall under the window was pulling off the wall in Room 117. One resident resided in this room.</p> <p>f. The closet door in Room 121 was marred. Two residents resided in this room.</p> <p>g. There was a gouged section of plaster in wall behind the first bed in Room 129. The area was oval in shape and approximately 8 inches by 2 inches. One resident resided in this room.</p> <p>h. A piece of the white door frame was missing on the inside of the Shower Room door. The area was</p>		<p>room was cleaned Two over-bed tables in Shower Room were removed and the shower room remodeled Restorative Room white cabinets – The marred areas were cleaned <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Environment was inspected to identify other rooms/locations with the same alleged deficient areas. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Maintenance and Housekeeping staff have been re-educated by Assistant Administrator/designee on the following: · Cleaning schedule for housekeeping · Maintenance schedules to identify areas in need of repair · Performing spot checks during walking rounds to identify areas in need of repair or cleaning <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Housekeeping Manager/designee will perform audits weekly on 5 resident's rooms on each unit to ensure the</p>		

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	<p>approximately 3 inches by 3 inches. The light cover above on the shower stall was cracked. The tile was cracked at the entrance. A total of 67 residents resided on the East Unit.</p> <p>i. There was an accumulation of dust and dirt on the wheels of the red crash cart in the East Unit Dining Room.</p> <p>j. There was dust and spillage on the base of the Ultralift 3500 Hoyer device on the unit. A total of 67 residents resided on the East Unit.</p> <p>When interviewed at this time, the Maintenance Supervisor and the Housekeeping Supervisors indicated the above areas were in need of cleaning or repair.</p> <p>2. During the environmental tour on 1/9/12 at 2:02 p.m., the following was observed on the West Unit:</p> <p>a. The cove base along the walls in the bathroom of Room 152 was marred and discolored. Two residents resided in this room.</p> <p>b. There was a gouged area on inside of the bathroom door in Room 168. The area was at the bottom of</p>		<p>rooms are properly cleaned. Any areas found to be in need of cleaning/repair will be corrected immediately. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	

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	<p>the cover plate and measured approximately 6 inches. Two residents resided in this room.</p> <p>c. There was lime build up on the faucet in the bathroom of Room 181. There were marred and scraped lines across the bottom of the inside of the bathroom door. Two residents resided in this room.</p> <p>d. There were marred black scratches across the bottom of the closet door in Room 184. One resident resided in this room.</p> <p>e. There was dust on the bars of the three tiered metal activity cart in the dining room.</p> <p>f. The legs and base of two overbed tables in the Shower Room were rusty. A total of 68 residents resided on the West Unit.</p> <p>When interviewed at this time, the Maintenance Supervisor and the Housekeeping Supervisors indicated the above areas were in need of cleaning or repair.</p> <p>3. During the Environmental tour on 1/9/12 at 2:35 p.m., the following was observed in the Restorative Room:</p>			
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	<p>a. There were black marred streaks across the sections of white cabinets under the counter top and the windows.</p> <p>When interviewed at this time, the Maintenance Supervisor and the Housekeeping Supervisors indicated the above areas were in need of cleaning or repair.</p> <p>3.1-19(f)</p>			
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F0280 SS=D	<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>2. The record for Resident #123 was reviewed on 1/5/12 at 221 p.m. The resident had diagnoses that included, but was not limited to, hypothyroidism, depression, and diabetes.</p> <p>Review of the Skin Integrity form, dated 11/18/11, indicated the resident had a pressure ulcer to the left superior buttock that was 1.5 cm (centimeters) x 1.9 cm x 0 in size. The pressure ulcer had intact skin with nonblanchable redness. The resident also had a pressure ulcer on the left inferior buttock 0.9 x 0.9 cm in size that had intact skin with nonblanchable redness. The resident also had a pressure ulcer on the left buttock that was 1.3 x 1.1 cm x &lt;0.1</p>	F0280	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F280 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for residents listed are as follows: Resident 121 – Care plan has been updated to reflect current status and interventions including to perform a skin inspection in the room when the resident refuses her shower. Resident 123 – Care plan has been updated to reflect current skin status and interventions. <b>How the facility</b></p>	02/10/2012

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	<p>cm. The pressure ulcer on the left buttock had a partial thickness loss of dermis.</p> <p>Review of the Resident Progress Notes, dated 12/23/11 at 3:36 p.m., indicated "Readmission skin assessment and observation completed no wounds noted."</p> <p>The resident's current care plans were reviewed. There was a care plan, dated 11/23/11, that indicated, "Alteration in skin integrity, related to current pressure ulcer. Wound healing may be hindered by dx (diagnoses) a-fib (atrial fibrillation, irregular heart rhythm), dm (diabetes mellitus), hypothyroidism, anemia, and htn (hypertension).</p> <p>The care plan goal indicated, "Resident will have ulcer healed without complications by review date."</p> <p>The care plan Approaches indicated: -administer/offer analgesic per MD (physician) order -assess and record condition -assess pressure ulcer for location, stage, size -avoid friction and shearing forces during transfers or position changes -give vitamins and minerals -keep clean and dry as possible</p>		<p><b>will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Care plans have been reviewed to ensure skin interventions and pressure ulcer status are current. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: · Care plans are to be updated with changes in the clinical condition and when pressure ulcers resolve. · If a wound heals, the care plan should be updated within the week · If a resident is refusing their showers, a skin assessment is still required that day to identify any new alterations in skin integrity. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform audits weekly on 5 residents who have skin issues to identify their care plans are up to date. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three</p>		

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	<p>-incontinence care -treatment as per order</p> <p>Interview with the Wound Nurse on 1/10/12 at 10:45 a.m., indicated the current care plan was not updated when the resident's pressure ulcers were healed. She also indicated the care plan did not reflect the resident's current status.</p> <p>3.1-35(d)(2)(B)</p> <p>Based on observation, record review, and interview, the facility failed to ensure care plan interventions were revised to reflect the resident's current status related to the skin assessment checks and pressure ulcer for 1 of 3 residents reviewed of the 4 who met the criteria for pressure ulcers and 1 of 3 residents reviewed of the 8 who met the criteria for skin conditions. (Residents #121 and #123)</p> <p>Findings include:</p> <p>1. On 1/4/12 at 8:54 a.m., a fading greenish/yellow colored bruise was observed to Resident #121's left upper arm. The bruise was approximately the size of a quarter.</p>		<p>months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>				

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	<p>On 1/5/12 at 11:00 a.m., the resident was observed in bed. A small light yellow fading bruise was observed on the resident's left upper arm. The bruise was approximately the size of a nickel.</p> <p>The record for Resident #121 was reviewed on 1/8/12 at 4:35 p.m. The resident's diagnoses included, but were not limited to, senile dementia with depression, insomnia, hypothyroidism, and osteoporosis.</p> <p>A care plan initiated on 5/5/11 indicated the resident was at risk for alteration in skin integrity related to decreased mobility and incontinence. The care plan was last updated with a goal date of 2/6/12. Care plan intervention indicated staff were to conduct a systemic skin inspection with showers. A care plan initiated on 5/4/11 indicated the resident refused showers and preferred to wash up in her own room. The care plan was last updated with a goal date of 1/27/12.</p> <p>Review of the 12/11 and 1/12 Bath and Skin Report sheets indicated the resident refused her shower and skin inspection on 12/2/11, 12/6/11, 12/9/11, 12/13/11, 12/16/11, 12/20/11, 12/23/11, 12/27/11,</p>						

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	<p>12/30/11, 1/3/12, and 1/6/12.</p> <p>When interviewed on 1/10/12 at 9:59 a.m., the Director of Nursing indicated the resident had refused the shower/skin assessments as the resident would wash in bed. The Director of Nursing indicated the care plan interventions should have been updated for skin checks as the resident was refusing showers and to have nurses complete the skin assessment at another time.</p>			

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>3. The record for Resident #107 was reviewed on 1/5/12 at 12:50 p.m. The resident had diagnoses that included, but were not limited to, hypothyroidism, hypertension, and congestive heart failure.</p> <p>There was a Resident Progress Note, dated 12/12/11, written by the Physician. The progress note indicated the resident's congestive heart failure was stable and labs were to be drawn in the morning.</p> <p>There was a Physician's order, dated 12/12/11, that indicated a BMP (Basic Metabolic Panel), a laboratory test, was to be obtained on 12/13/11.</p> <p>Review of the laboratory results indicated there were no results for a BMP dated 12/13/11.</p> <p>Interview with the Nurse Consultant on 1/9/12 at 2:53 p.m., indicated the nursing staff did not follow the physician's order dated 12/12/11. The lab requisition was not completed for the BMP and the lab was never obtained as ordered by the physician.</p>	F0282	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for residents listed are as follows: Resident B – There has been no negative effects by the missing documentation for bruise monitoring. Resident 62 - Resident was provided non-skid footwear and the care plan and care card updated. The bruising to the left arm was not new and these were from admission. The admission body assessment includes these bruises. Resident 107- The resident did have a follow up lab done in January 2012 and there were no negative effects related to the missing lab in December <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. Resident care</p>	02/10/2012			

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	3.1-35(g)(2)		cards were reviewed to ensure recommended interventions were in place. Lab orders were reviewed to ensure a lab requisition was present and in lab binder. The facility pink communication sheets were audited to ensure those residents with bruises were included to alert the nurses. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: · Residents who have bruises are to be included on the facility pink communication sheets so the nurses know who they are to document on and what for. · For any resident with bruises, each shift the nurse is to observe the bruise and document on their observations. · Once the bruise is resolved, the order in Matrix should be discontinued and the pink communication sheet updated. · The care cards are to reviewed each shift to identify all needed interventions specific to that resident to prevent falls and alteration in skin integrity · When a lab is ordered, a lab requisition must be completed and put in the lab box by the specific date. If the lab is to be drawn on a non-scheduled lab day, the lab must be called to schedule to the test <b>How the corrective action(s) will be</b>		

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	<p>2. On 1/04/2012 at 8:35 a.m., Resident #62 was observed sitting in a Broda chair in her room. The resident was wearing a sweater with 3/4 length sleeves. There was a faded yellow bruise to her right forearm and two red/blue bruises to the left forearm.</p> <p>On 1/5/12 at 1:57 p.m. and at 3:30 p.m., the resident was sitting up in a Broda chair. She was wearing short sleeves. There were two red/blue bruises noted to her left forearm and one yellow bruise to her left right arm.</p> <p>On 1/6/12 at 8:36 a.m. and at 2:34</p>		<p><b>monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform audits weekly on 10 residents to identify if the required charting is complete, lab tests have been drawn, and/or recommended interventions in place. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	
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	<p>p.m., the resident was sitting up in a Broda chair. The resident was wearing short sleeves with two red/blue bruises noted to her left arm and a faded yellow bruise to her right arm.</p> <p>On 1/7/11 at 6:23 a.m., the resident was sitting up in a Broda chair. There were two red/blue bruises noted to the left forearm and a faded yellow bruise to the right forearm.</p> <p>The record for Resident #62 was reviewed on 1/5/12 at 3:00 p.m. The resident's diagnoses included, but were not limited to, CHF, depressive disorder, pain, chronic airway obstruction, dementia, difficulty in walking, falls, urinary incontinence, osteoarthritis, hypertonicity of bladder, and anxiety state.</p> <p>Review of the current plan of care, dated 1/19/11 and updated 12/11, indicated the resident was at risk for abnormal bleeding and bruising related to the use of Coumadin. The nursing approaches were to observe for signs of active bleeding, (ecchymotic areas or hematomas, protect resident from injury/trauma)</p> <p>Review of the Nursing Progress Notes, dated 1/4/12-1/8/12, indicated</p>				

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	<p>there was no assessment or documentation of any red/purple bruising to the left forearm.</p> <p>Interview with LPN #2 on 1/9/12 at 11:06 a.m., indicated she was unaware of any bruising to the left forearm. She indicated that no staff member had reported any bruising to the left forearm to her from the previous shifts. The LPN further indicated the bruises had not been documented or assessed in the resident's chart. She indicated it was the facility's policy to document, assess, and measure when bruises were first observed and they should be documented on until they were resolved.</p> <p>Review Nursing Progress Notes, dated 12/3/11 at 12:29 a.m., indicated staff reported to writer that the resident slid with assist to floor. The writer assessed the resident and resident stated, I'm still sleepy. The writer asked the resident was she in pain and the resident stated, "No." The writer asked the resident if she was dizzy or weak and the resident stated, "I'm just still asleep."</p> <p>Review of the 12/3/11 Fall Event Report indicated the resident fell in the resident's bathroom, the fall was</p>						

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	<p>witnessed by the CNA. The resident slid to the floor with assist. The resident was wearing regular socks to both of her feet with no shoes.</p> <p>Review of the Care Plan, dated 1/19/11 and updated 12/11, indicated the resident was at risk for falling related to decreased mobility, balance, and pivot. The Nursing approach, dated 2/16/10, was to provide proper footwear.</p> <p>Interview with LPN #1 on 1/9/12 at 11:09 a.m., indicated the resident should have had on tennis shoes or some other type of shoe other than plain socks when assisted to the bathroom.</p> <p>Interview with the Restorative Nurse on 1/9/12, at 2:52 p.m., indicated the resident should have had proper footwear on while being assisted to the bathroom.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physicians' Orders were followed as written as well as the Plan of Care for 1 of 3 residents reviewed of the 6 who met the criteria for accidents related to not having on the proper footwear; not obtaining laboratory tests as ordered for 1 of 10</p>			

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	<p>residents who were reviewed for unnecessary medications, and not monitoring bruising for 2 of 3 residents reviewed of the 8 who met the criteria for skin conditions non-pressure related. (Residents #B, #62, and #107)</p> <p>Findings include:</p> <p>1. Observation on 1/4/12 at 1:53 p.m., indicated Resident #B had an area of reddish/purple bruising to the right upper inner arm. The resident also had an area of fading purple/bluish bruising to her left breast.</p> <p>On 1/5/12 at 10:44 a.m., the resident was observed with a small area of red/purple bruising to her right upper inner arm. Interview with the resident at 1:00 p.m., indicated the bruising was caused due to the lift and that she receives Coumadin (a blood thinner).</p> <p>On 1/6/12 at 1:25 p.m. and on 1/11/12 at 9:50 a.m., the resident was observed in her room. The area of reddish/purple bruising remained to the resident's right upper inner arm.</p> <p>The record for Resident #B was reviewed on 1/9/12 at 2:53 p.m. The</p>			
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	<p>resident's diagnoses included, but were not limited to, anemia, heart failure, and arterial disease.</p> <p>An entry in the Nursing Progress Notes, dated 12/17/11 at 1:41 p.m., indicated steri-strips were intact to the left breast due to biopsy. The area was bruised and tender to touch. Documentation at 11:38 p.m., indicated the left breast was bruised and tender to touch.</p> <p>Documentation in the Nursing Progress Notes on 12/18/11 at 2:43 a.m., indicated bruising to the left breast remained and some tenderness was noted to the area. At 1:30 p.m., documentation indicated the bruising had increased to the entire left breast. The physician was notified and orders were received. Documentation at 3:15 p.m., indicated the left breast continued to be bruised in entirety.</p> <p>A Physician's Order, dated 12/18/11, indicated to monitor bruising to entire left breast every shift.</p> <p>Nursing entries, dated 12/19/11 at 12:04 a.m., 3:30 p.m., and 8:01 p.m., did not include an assessment and/or documentation of the left breast bruising.</p>			
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	<p>Documentation in the Nursing Progress Notes on 12/20/11 at 12:58 a.m., 1:00 p.m., and 10:00 p.m., indicated no abnormal bruising or bleeding was noted.</p> <p>Nursing entries, dated 12/21/11 at 2:36 a.m. and 11:04 p.m., did not include an assessment and/or documentation of the left breast bruising. No entry had been completed for the day shift on 12/21/11.</p> <p>Documentation in the Nursing Progress Notes on 12/22/11 at 7:25 a.m., indicated the bruising remained to the left breast.</p> <p>There was no assessment of the bruising to the left breast in the Nursing Progress Notes on 12/24/11 at 2:00 p.m. An entry in the Nursing Progress Notes at 9:36 p.m., indicated the resident had bruising to the right upper arm.</p> <p>A Physician's Order, dated 12/25/11, indicated to monitor bruises to the right upper arm daily until resolved.</p> <p>Documentation on 12/25/11 at 2:00 p.m., indicated no bleeding and/or bruising was noted due to Coumadin</p>			
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	<p>change.</p> <p>There was no documentation related to the left breast and right upper arm bruising on the day shift on 1/1/12 and on the evening shift on 1/5 and 1/7/12.</p> <p>A plan of care, dated 7/13/11 and reviewed in December 2011, indicated the resident was at risk for abnormal bleeding and bruising related to use of insulin injections, lab draws and anticoagulant therapy.</p> <p>The interventions were as follows:</p> <ul style="list-style-type: none"> <li>-12/25/11 Monitor bruises to right upper arm daily until resolved.</li> <li>-12/8/11 Handle resident gently during care</li> <li>-12/8/11 Refer to physician as warranted</li> <li>-Administer Coumadin as ordered</li> <li>-Observe for signs of bleeding and/or bruising</li> </ul> <p>Interview with RN #1 on 1/11/12 at 10:05 a.m., indicated when a bruise was found, documentation was completed in the chart, an investigation was completed and documentation was completed once a shift until the bruising was resolved.</p>						

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	<p>Interview with the West Unit Manager on 1/11/12 at 11:25 a.m., indicated documentation should have been completed at least once a shift on the bruises until they were resolved. She indicated the physician's order was not followed as written. She also indicated some of the documentation was not accurate related to the bruising.</p>			
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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311			
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F0309 SS=D	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>3. On 1/4/12 at 8:54 a.m., a fading greenish/yellow colored bruise was observed to Resident #121's left upper arm. The bruise was approximately the size of a quarter. On 1/5/12 at 11:00 a.m., the resident was observed in bed. A small light yellow fading bruise was observed on the resident' left upper arm. The bruise was approximately the size of a nickel.</p> <p>The record for Resident #121 was reviewed on 1/8/12 at 4:35 p.m. The resident's diagnoses included, but were not limited to, senile dementia with depression, insomnia, hypothyroidism, and osteoporosis.</p> <p>A care plan initiated on 5/5/11 indicated the resident was at risk for alteration in skin integrity related to decreased mobility and incontinence.</p> <p>Review of the Nursing Progress Notes and the Observation Notes indicated there was no documentation of any assessments of the bruise from 1/4/12 through 1/8/12.</p>	F0309	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F309 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for the residents listed are as follows: Resident B – Resident had no negative effects from the missing entries in nursing documentation. Resident 62 – Bruises noted by surveyor were not new bruises. These were from admission and already documented on admission on the admit body assessment. Resident 121 – The resident's skin was checked by Director of Nursing and other nursing staff. There was no bruise noted to the left upper arm of the resident as stated by the surveyor. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the</p>		02/10/2012		

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	<p>When interviewed on 1/10/12 at 9:59 a.m., the Director of Nursing indicated Nurses were to document an assessment of all bruises in the Nursing Progress Notes every shift until the bruise was resolved.</p> <p>3.1-37(a)</p>		<p>potential to be affected by the same alleged deficient practice. The facility pink communication sheets were audited to ensure that resident that currently have bruises are listed. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: · Resident who have newly acquired bruises are to be reported to nursing immediately whether noted in the shower or during ADL care. · All newly acquired bruises are to be noted on the facility pink communication form to alert the nurse of who needs documentation and for what. · Bruises are to be documented each shift until resolved. This nurse should observe the area and document on what they observed. · During a shower if any alteration in skin integrity is observed this should be documented on the shower sheet and the nurse alerted. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform audits weekly on 10 residents to identify if the required charting is completed. A summary of the audits will be presented to the Quality</p>		

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	<p>2. On 1/04/2012 at 8:35 a.m., Resident #62 was observed sitting in a Broda chair in her room. The resident was wearing a sweater with 3/4 sleeves. There was a faded yellow bruise to her right forearm and two red/blue bruises to the left forearm.</p> <p>On 1/5/12 at 1:57 p.m. and on 3:30 p.m., the resident was sitting up in a Broda chair. She was wearing short sleeves. There were two red/blue bruises noted to her left forearm and one yellow bruise to her left right arm.</p> <p>On 1/6/12 at 8:36 a.m. and at 2:34 p.m., the resident was sitting up in a Broda chair. The resident was wearing short sleeves with two red/blue bruises noted to her left arm and a faded yellow bruise to her right arm.</p> <p>On 1/7/11 at 6:23 a.m., the resident was sitting up in a Broda chair. There were two red/blue bruises noted to</p>		Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.		

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	<p>the left forearm and a faded yellow bruise to the right forearm.</p> <p>The record for Resident #62 was reviewed on 1/5/12 at 3:00 p.m. The resident's diagnoses included, but were not limited to, CHF, depressive disorder, pain, chronic airway obstruction, dementia, difficulty in walking, falls, urinary incontinence, osteoarthritis, hypertonicity of bladder, anemia, and anxiety state.</p> <p>The resident was admitted to the hospital on 12/9/11 and she returned on 12/15/11. Review of the Nursing Assessment, dated 12/15/11, indicated there were bruises noted upon readmission to the left inner arm measuring 7 centimeters (cm) x 3 cm and 3 cm x 2 cm, the left forearm 7 cm x 4 cm, and the left antecubital 3 cm x 2 cm.</p> <p>Review of Nursing Progress Notes, dated 1/1/12, indicated the resident had fallen from her bed. The initial observation was a bruise to her right cheek, a dark red bruise to the right inner forearm measuring 2.5 cm by 3.75 cm, and a red bruise to the right upper arm measuring 3 cm by 3 cm. There were no bruises assessed to the left forearm.</p>				

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	<p>Review of the Significant Change Minimum Data Set (MDS) assessment of 12/30/11 indicated the resident was severely impaired for cognition and needed extensive assist for bed mobility, transfers, for locomotion on and off the unit, and for dressing, eating, toilet use and personal hygiene. The resident had range of motion limitations to one side for upper and lower extremities, and used a wheelchair most of the time for her primary mode of transportation.</p> <p>Review of the current plan of care, dated 1/19/11 and updated 12/11, indicated the resident was at risk for abnormal bleeding and bruising related to the use of Coumadin. The nursing approaches were to observe signs of active bleeding, (ecchymotic areas or hematomas, protect resident from injury/trauma)</p> <p>Review of Nursing Progress Notes, dated 1/4/12-1/8/12, indicated there was no assessment or documentation of any red/purple bruising to the left forearm.</p> <p>Interview with LPN #2 on 1/9/12 at 11:06 a.m., indicated she was unaware of any bruising to the left forearm. She indicated that no staff member had reported any bruising to</p>				

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	<p>the left forearm to her from the previous shifts. The LPN further indicated the bruises had not been documented or assessed in the resident's chart. She indicated it was the facility's policy to document, assess, and measure when bruises were first observed and they should be documented on until they were resolved.</p> <p>Further review of Nursing Progress Notes, dated 1/9/12, indicated left anterior wrist black/blue measures 2 cm by 1.5 cm, left forearm distal measured 5.1 cm by 3.4 cm red in color, and the left forearm proximal 1.2 cm by 1 cm red in color.</p> <p>Interview with the East Wing Unit Manager on 1/9/12 at 3:00 p.m., indicated all bruises were to be monitored until resolved and new areas were to be assessed and measured when first observed.</p> <p>Based on observation, record review and interview, the facility failed to ensure an ongoing assessment of bruises was completed for 3 of 3 residents reviewed of the 8 who met the criteria for skin conditions non-pressure related. (Residents #B, #62, and #121)</p>			
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	<p>Findings include:</p> <p>1. Observation on 1/4/12 at 1:53 p.m., indicated Resident #B had an area of reddish/purple bruising to the right upper inner arm. The resident also had an area of fading purple/bluish bruising to her left breast.</p> <p>On 1/5/12 at 10:44 a.m., the resident was observed with a small area of red/purple bruising to her right upper inner arm. Interview with the resident at 1:00 p.m., indicated the bruising was caused due to the lift and that she receives Coumadin (a blood thinner).</p> <p>On 1/6/12 at 1:25 p.m. and on 1/11/12 at 9:50 a.m., the resident was observed in her room. The area of reddish/purple bruising remained to the resident's right upper inner arm.</p> <p>The record for Resident #B was reviewed on 1/9/12 at 2:53 p.m. The resident's diagnoses included, but were not limited to, anemia, heart failure, and arterial disease.</p> <p>An entry in the Nursing Progress Notes, dated 12/17/11 at 1:41 p.m., indicated steri-strips were intact to the left breast due to biopsy. The area</p>						

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	<p>was bruised and tender to touch. Documentation at 11:38 p.m., indicated the left breast was bruised and tender to touch.</p> <p>Documentation in the Nursing Progress Notes on 12/18/11 at 2:43 a.m., indicated bruising to the left breast remained and some tenderness was noted to the area. At 1:30 p.m., documentation indicated the bruising had increased to the entire left breast. The physician was notified an orders were received. Documentation at 3:15 p.m., indicated the left breast continued to be bruised in entirety.</p> <p>A Physician's Order, dated 12/18/11, indicated to monitor bruising to entire left breast every shift.</p> <p>Nursing entries on 12/19/11 at 12:04 a.m., 3:30 p.m., and 8:01 p.m., did not include an assessment of the left breast bruising.</p> <p>Documentation in the Nursing Progress Notes on 12/20/11 at 12:58 a.m., 1:00 p.m., and 10:00 p.m., indicated no abnormal bruising or bleeding was noted.</p> <p>The nursing entries, dated 12/21/11 at 2:36 a.m. and 11:04 p.m., did not</p>			
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	<p>include an assessment of the bruising on the left breast. No entry had been completed for the day shift on 12/21/11.</p> <p>Documentation in the Nursing Progress Notes on 12/22/11 at 7:25 a.m., indicated the bruising remained to the left breast.</p> <p>There was no assessment of the bruising to the left breast in the Nursing Progress Notes on 12/24/11 at 2:00 p.m. An entry in the Nursing Progress Notes at 9:36 p.m., indicated the resident had bruising to the right upper arm.</p> <p>A Physician's Order, dated 12/25/11, indicated to monitor bruises to the right upper arm daily until resolved.</p> <p>Documentation on 12/25/11 at 2:00 p.m., indicated no bleeding and/or bruising was noted due to Coumadin change.</p> <p>There was no documentation related to the left breast and right upper arm bruising on the day shift on 1/1/12 and on the evening shift on 1/5 and 1/7/12.</p> <p>A plan of care, dated 7/13/11 and reviewed in December 2011,</p>			

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	<p>indicated the resident was at risk for abnormal bleeding and bruising related to use of insulin injections, lab draws and anticoagulant therapy.</p> <p>The interventions were as follows:</p> <ul style="list-style-type: none"> <li>-12/25/11 Monitor bruises to right upper arm daily until resolved.</li> <li>-12/8/11 Handle resident gently during care</li> <li>-12/8/11 Refer to physician as warranted</li> <li>-Administer Coumadin as ordered</li> <li>-Observe for signs of bleeding and/or bruising</li> </ul> <p>Interview with RN #1 on 1/11/12 at 10:05 a.m., indicated when a bruise was found, documentation was completed in the chart, an investigation was completed and documentation was completed once a shift until the bruising was resolved.</p> <p>Interview with the West Unit Manager on 1/11/12 at 11:25 a.m., indicated documentation should have been completed at least once a shift on the bruises until they were resolved. She also indicated some of the documentation was not accurate related to the bruising.</p>			

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F0312 SS=D	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>3. Resident #175 was observed on 1/4/12 at 12:57 p.m. The resident's face was unshaven.</p> <p>The resident was observed on 1/5/12 at 11:10 a.m. in the Main Dining Room. He was observed with facial hair; he was unshaven.</p> <p>The resident was again observed on 1/5/12 at 12:36 p.m., his face was unshaven.</p> <p>On 1/5/12 at 3:05 p.m., the resident was observed clean shaven.</p> <p>The record for Resident #175 was reviewed on 1/5/12 at 2:35 p.m.</p> <p>The Annual MDS (Minimum Data Set) assessment, dated 11/13/11, indicated the resident required the limited assistance of one person for personal hygiene. The MDS also indicated the resident had no refusals of care.</p> <p>On 1/6/12 at 1:51 p.m., CNA #1 was interviewed. She indicated she was the resident's aide. She also indicated that the resident was to be shaved by</p>	F0312	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F312 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 121- Nail care was provided to the resident. Resident 35 – Eyes were cleaned. Resident 175 was shaved. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Rounds were made to ensure all residents were shaved, nail properly cleaned and eyes free of debris. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of</p>	02/10/2012	

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	<p>the shower aide. She indicated all the information about the resident's care and what type of assistance he needed was on the care card posted on the inside of the resident's bathroom door.</p> <p>Review of the care card that was on the inside of the resident's bathroom door indicated the resident required extensive assistance with grooming.</p> <p>The shower aide, CNA #2, was interviewed on 1/6/12 at 1:55 p.m. She indicated she shaved the resident yesterday, but showered the resident today. She indicated that the resident receives his showers twice weekly on Tuesdays and Fridays. She also indicated that she was to shave the residents on their shower days and as needed. She indicated that she gave Resident #175 a shower on Tuesday, 1/3/12, but indicated there were no razors available on the unit on that day, so she did not shave the resident. She stated the central supply staff does not come in until later in the day and she showered the resident early in the morning on Tuesday. She also indicated that there were no razors on the unit on Wednesday so again the resident was not shaved. She indicated that he was shaved on Thursday after razors were</p>		<p>Nursing/designee on the following: · ADL care includes oral care, nail care and shaves to maintain residents dignity · If a resident refuses any such care, nursing should be alerted and a notation made in the clinical record under the progress note section · Shower includes shaves and nail care · When getting a resident up in the morning their face is to be washed and their eyes gentled wiped <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform audits weekly on 10 residents to ensure nail care and shave are provided as needed. Any resident found to be in need of ADL care will be corrected immediately. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>				

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	<p>obtained.</p> <p>The Director of Nursing was interviewed on 1/9/12 at 1:30 p.m. She indicated the resident required assistance with shaving. She also indicated the resident should have been shaved on his shower day.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff provide the necessary services for grooming and personal hygiene related to shaving facial hair, nail care and facial cleaning for 3 of 3 residents reviewed of the 5 who met the criteria for Activities of Daily Living. (Residents #35, #121 and #175)</p> <p>Findings include:</p> <p>1. On 1/4/12 at 8:53 a.m., Resident #121 was observed with a brown substance under her fingernails.</p> <p>On 1/5/12 at 11:00 a.m. and 12:25 p.m., the resident was observed in</p>						

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	<p>bed. The resident's fingernails on both hands were dirty. The resident was not receiving any care from staff at the above times.</p> <p>On 1/6/12 at 8:03 a.m., the resident was observed in bed. The resident was awake. The fingernails on both of the resident's hands were dirty.</p> <p>The record for Resident #121 was reviewed on 1/8/12 at 4:35 p.m. The resident's diagnoses included, but were not limited to, senile dementia with depression, insomnia, hypothyroidism, and osteoporosis.</p> <p>The 10/28/11 Minimum Data Set (MDS) quarterly assessment indicated the resident understood others and had impairment in range of motion of the upper and lower extremities of both sides. The assessment also indicated the resident required extensive assistance of staff set up for personal hygiene and required extensive assistance of one person for bed mobility.</p> <p>The yellow Care Card on the inside of the resident's bathroom door was observed on 1/10/12 at 7:50 a.m. The Care Card indicated staff were to assist the resident with set up for grooming.</p>			
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	<p>When interviewed on 1/9/12 at 9:33 a.m., CNA #4 indicated she was caring for Resident #121. The CNA indicated the resident was able to wash her own face but she needed assistance from staff to brush her teeth or complete oral care, and also needed assistance from staff for nail care.</p> <p>When interviewed on 1/10/12 at 7:50 a.m., CNA #6 indicated each resident has a Care Card on the door and staff are to refer to the Care Card for information related to ADL care, transfers, and other information.</p> <p>2. On 1/5/12 at 8:28 a.m., Resident #35 was observed with both of her eyes matted shut.</p> <p>On 1/5/12 at 11:24 a.m., the resident was observed sitting in a wheelchair in her room. The resident's eyes were closed and there was a dried tan colored crusting over the outer aspect of her left eyelid/eyelash area. The resident attempted to open her eyes when her name was called and she could not fully open her left eye in the corner where the crusting was located. The resident was not receiving care from staff at this time.</p>			
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	<p>There was a yellow Care Card on the inside of the resident's bathroom door. The Care Card indicated the resident required extensive assistance of a staff for grooming and total assistance of staff for bathing.</p> <p>On 1/9/12 at 10:15 a.m. and 11:09 a.m., the resident was observed sitting up in a wheelchair in her room. The resident was dressed at this time. There was dry crusting to the top of her left eyelid/eyelash area. The resident was not receiving care from staff at the above times.</p> <p>The record for Resident #35 was reviewed on 1/5/12 at 2:08 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, upper respiratory disease, osteoporosis, cough, conjunctivitis, and glaucoma.</p> <p>Review of the 10/1/11 Minimum Data Set (MDS) annual assessment indicated the resident required extensive assistance of one person for personal hygiene. The MDS assessment also indicated the resident cognitive skills for decision making were severely impaired as she rarely or never was able to make decisions.</p>						

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	When interviewed on 1/6/12 at 10:50 a.m., CNA #12 indicated she was taking care of Resident #35 today and on a regular basis. The CNA indicated the resident is gotten up and dressed on the midnight shift and is usually up by the time she starts her day shift. The CNA indicated the night shift was to complete the resident's AM care which was to include washing her face and hands and getting her dressed. CNA #12 indicated the resident required total care from staff for bathing, feeding, and washing her face and hands.			
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F0323 SS=D	<p>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 each resident was free from accidents related to a fall in the resident's bathroom without wearing the proper footwear for 1 of 3 residents reviewed of the 6 residents who met the criteria for accidents. (Resident #62)</p> <p>Findings include:</p> <p>On 1/5/12 at 1:57 p.m., Resident #62 was observed sitting up in a Broda chair wearing street clothes with slippers on both of her feet.</p> <p>The record for Resident #62 was reviewed on 1/5/12 at 3:00 p.m. The resident's diagnoses included, but were not limited to, CHF, depressive disorder, pain, chronic airway obstruction, dementia, difficulty in walking, falls, urinary incontinence, osteoarthritis, hypertonicity of bladder, anemia, and anxiety state.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment, dated 12/30/11, indicated the resident was severely</p>	F0323	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>F323</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective actions for residents listed are as follows:</p> <p>Resident 62 - Resident was provided non-skid footwear and the care plan and care card updated.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practices. Resident care cards were reviewed to ensure</p>	02/10/2012	

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	<p>impaired for cognition and needed extensive assist for bed mobility, transfers, for locomotion on and off the unit, and for dressing, eating, toilet use and personal hygiene. The resident had range of motion limitations to one side for upper and lower extremities, and used a wheelchair most of the time for her primary mode of transportation. The resident has had a fall since prior assessment with no major injury.</p> <p>Review of the fall risk assessment, dated 1/1/11, indicated the resident was at risk for falls with the score of 14. Review of the fall risk assessment, dated 10/24/11, indicated a score of 14 which indicated a high risk for falls. Review of the 12/5/11 quarterly fall assessment indicated the resident was high risk for falls with a score of 19.</p> <p>Review of the Care Plan, dated 1/19/11 and updated 12/11, indicated the resident was at risk for falling related to decreased mobility, balance, and pivot. The Nursing approach dated 2/16/10, was to provide proper footwear.</p> <p>Review Nursing Progress Notes, dated 12/3/11 at 12:29 a.m., indicated</p>		<p>recommended interventions were in place.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Nursing staff have been re-educated by Director of Nursing/designee on the following:</p> <ul style="list-style-type: none"> <li>· The care cards are to reviewed each shift to identify all needed interventions specific to that resident to prevent falls and alteration in skin integrity</li> <li>· When toileting a resident, ensure that they have proper footwear in place such as shoes or non-skid socks</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Nursing/designee will perform audits weekly on 10 residents to identify if the required recommended interventions are in place.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality</p>		

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	<p>staff reported to writer that the resident slid with assist to floor. The writer assessed the resident and resident stated, "I'm still sleepy." The writer asked the resident was she in pain and the resident stated, "No." The writer asked the resident if she was dizzy or weak and the resident stated, "I'm just still asleep."</p> <p>Review of the 12/3/11 Fall Event Report indicated the resident fell in the resident's bathroom, the fall was witnessed by the CNA. The resident slid to the floor with assist. The resident was wearing regular socks to both of her feet with no shoes.</p> <p>Review of the 12/5/11 Restorative Nursing Note ICP Team indicated the event of 12/3/11 was reviewed. The resident was observed in bathroom leaning against the wall and slid onto the floor. The charge nurse's investigation by the way of the resident interview indicated the resident stated, "I was sleepy." The CNA interview notes were reviewed and indicated the resident alerted the aide that she wanted to go the bathroom and was assisted by the CNA to the bathroom. The resident was left in the bathroom and the CNA heard the resident yell for help and upon re-entry to bathroom resident</p>		Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.		

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	<p>was then observed on the floor next to recliner.</p> <p>Interview with LPN #1 on 1/9/12 at 11:09 a.m., indicated the resident should have had on tennis shoes or some other type of shoe other than plain socks when assisted to the bathroom.</p> <p>Interview with the Restorative Nurse on 1/9/12, at 2:52 p.m., indicated the resident should have had proper footwear on while being assisted to the bathroom.</p> <p>3.1-45(a)(2)</p>			

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F0332 SS=D	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>2. On 1/10/12 at 9:18 a.m., LPN #1 was observed during medication pass preparing Resident #51's medications. The LPN had placed the high blood pressure medication of lisinopril 10 milligram (mg) into a medication cup. She then approached the resident and took her blood pressure first before giving the medication. The blood pressure was 102/45 with a digital wrist blood pressure cuff. The LPN then administered the resident her lisinopril medication.</p> <p>The record for Resident #51 was reviewed on 1/10/12 at 10:24 a.m. Review of Physician Orders, dated 12/27/11, indicated lisinopril 10 mg one tab daily, hold if systolic blood pressure was less than 110/60.</p> <p>Interview with LPN on 1/10/12 at 1:33 p.m., indicated Resident #51's blood pressure was 102/45 and the order for the lisinopril was to hold the medication if the resident's blood pressure was less than 110/60. She indicated that she had administered the lisinopril medication with the resident's blood pressure being under 110/60.</p>	F0332	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F332 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 100 – The nurse was alerted to the error in dosage prior to administering so the resident suffered no negative outcome. Resident 51 – The resident did not have any negative outcome from receiving the blood pressure medication. Resident 32 – The resident did not have any negative outcome from the liquid potassium not being diluted. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Syringes were provided to any medication that didn't have one so proper dosing can be maintained. Parameters were reviewed to ensure error did</p>	02/10/2012	

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	<p>3. On 1/10/12 at 9:33 a.m., LPN #1 was observed preparing Resident #32's medication. The LPN had poured 15 milliliters (ml) of Potassium Chloride 20 meq (milliequivalent) into a medication cup. The LPN did not add any water to the medication. The label on the bottle indicated the medication was to be diluted with four ounces of water before administration. The LPN then walked into the resident's room with all of the resident's medication and prepared to administer the medication. The LPN indicated the resident received all of his medication by the way of a Percutaneous Endoscopic Gastrostomy (PEG) tube. The LPN then poured the undiluted Potassium Chloride into the PEG tube and flushed the PEG tube before and after with 5 cubic centimeters (cc) of water. The LPN then finished the entire medication pass and flushed the PEG tube with and additional 200 cc of water.</p> <p>The record for Resident #32 was reviewed on 1/10/12 at 10:37 a.m. Review of the current Physician Order Sheet dated January 2012, indicated Potassium Chloride 20 meq, give 15 ml through the PEG tube. Special Instructions were to dilute the</p>		<p>not re-occur. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: · Prior to administering any medication, the order is to be checked three times to ensure accuracy. · The order should be compared to the label on the box and the medication itself. · The order should be read completely to identify any parameters or special instructions · A dosing syringe should be used for liquid medications that have special dosing requirements such as a decimal point (Example: 5.3 ml) <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform med pass audits weekly on 3 nurses to ensure proper medication administration procedures are being followed. Nurses from different shifts will be observed. If any discrepancies are noted, the nurse will be re-educated at that time to prevent re-occurrence. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality</p>		

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	<p>Potassium with 4 ounces of water before administering.</p> <p>Interview with LPN #1 at the time indicated she did not dilute the potassium chloride before administrating it through the peg tube.</p> <p>Review of the current Enteral Medication Administration Policy dated 1/5/05, and provided by the Director of Nursing (DoN) indicated "Dilute liquid medication with 10 ml of water using up 30 ml of water for highly concentrated solutions. Dilute medications that are gastric irritants in water as for oral medication."</p> <p>3.1-48(c)(1)</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 13 residents observed during medication pass. 3 errors were observed during 50 opportunities for error in medication administration. This resulted in a medication error rate of 6%. (Residents #32, #51 and #100)</p> <p>Findings include:</p>		<p>Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	
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	<p>1. On 1/6/12 at 9:42 a.m., RN #2 was observed preparing medications for Resident #100. The resident was to receive 6.8 milliliters (mls) of Ferrous Sulfate (an iron supplement). The RN proceeded to pour the medication into a medication cup. The RN indicated that she measures between 5 mls and 7.5 mls on the medication cup. The RN proceeded to enter the resident's room. The RN was asked at this time to measure the amount of Ferrous Sulfate in the medicine cup. The RN obtained a syringe from the medication room and measured the Ferrous Sulfate. The RN indicated the medication measured 5.8 mls and the resident was going to need another milliliter of the medication.</p> <p>The record for Resident #100 was reviewed on 1/6/12 at 10:30 a.m. The resident's diagnoses included, but was not limited to, anemia. Review of the current Physician's Orders at this time, indicated the resident was to receive Ferrous Sulfate 220 milligrams (mg)/5 mls give 6.8 mls (300 mg) by mouth daily at 9:00 a.m.</p> <p>Interview with the Director of Nursing on 1/10/12 at 1:59 p.m., indicated the nurse should have drawn the Ferrous Sulfate up with a syringe.</p>			
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F0333 SS=D	<p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident was free from a significant medication error related to administering a high blood pressure medication to a resident who had low blood pressure reading for 1 of 13 residents observed during medication pass. (Resident #51)</p> <p>Findings include:</p> <p>On 1/10/12 at 9:18 a.m., LPN #1 was observed during medication pass preparing Resident #51's medications. The LPN had placed the high blood pressure medication of lisinopril 10 milligram (mg) into a medication cup. She then approached the resident and took her blood pressure first before giving the medication. The blood pressure was 102/45 with a digital wrist blood pressure cuff. The LPN then administered the resident her lisinopril medication.</p> <p>The record for Resident #51 was reviewed on 1/10/12 at 10:24 a.m. Review of Physician Orders dated 12/27/11, indicated lisinopril 10 mg one tab daily, hold if systolic blood</p>	F0333	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F333 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 51 – The resident did not have any negative outcome from receiving the blood pressure medication. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Syringes were provided to any medication that didn't have one so proper dosing can be maintained. Parameters were reviewed to ensure error did not re-occur. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the</p>	02/10/2012	

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	<p>pressure was less than 110/60.</p> <p>Review of the 2010 Nursing Spectrum Drug Handbook indicated an adverse reaction to lisinopril was hypotension, low blood pressure.</p> <p>Interview with LPN on 1/10/12 at 1:33 p.m., indicated Resident #51's blood pressure was 102/45 and the order for the lisinopril was to hold the medication if the resident's blood pressure was less than 110/60. She indicated that she had administered the lisinopril medication with the resident's blood pressure being under 110/60.</p> <p>3.1-48(c)(2)</p>		<p>following: · Prior to administering any medication, the order is to be checked three times to ensure accuracy. · The order should be compared to the label on the box and the medication itself. · The order should be read completely to identify any parameters or special instructions. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform med pass audits weekly on 3 nurses to ensure proper medication administration procedures are being followed. Nurses from different shifts will be observed. If any discrepancies are noted, the nurse will be re-educated at that time to prevent re-occurrence. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to lime build up inside of the steam table, dried food on bowls and residue on the inside of the coffee cups. This had the potential to affect 132 residents in the facility who received oral diets out of a total population of 136 residents.</p> <p>Findings include:</p> <p>During the Kitchen Sanitation Tour on 1/11/12 at 10:25 a.m., with the Dietary Food Manager, the following was observed:</p> <p>a. The steam table located next to the wall had an accumulation of lime build up on the inside of three of the compartments. Interview with the Dietary Food Manager at the time, indicated the steam table was to be delimed weekly and that the table was in need of cleaning.</p> <p>b. A tray of twelve coffee cups, identified as clean, were observed on a shelf underneath the coffee</p>	F0371	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F371 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Steam table was de-limed. The tray of coffee cups were re-cleaned. The dish rack of bowls were re-cleaned. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Cleaning schedules were reviewed to ensure all necessary areas of cleaning are present. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Dietary staff have been re-educated by Dietary Manager/designee on the following: · Cleaning Schedules</p>	02/10/2012			

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	<p>machine. A dark residue was observed on the inside of three coffee cups. The Dietary Manager took a napkin and wiped the inside of the cups. A dark substance was observed on the napkin. The Dietary Manager indicated at this time that the residue must be from the coffee and the coffee cups would be run through the dishwasher.</p> <p>c. A dishrack containing sixteen plastic bowls was observed in the clean dish area. The bowls were identified as clean by the Dietary Food Manager. On the outside of four of the bowls, was dried food spillage. Interview with the Dietary Food Manager at the time, indicated the bowls needed to be washed again.</p> <p>3.1-21(i)(3)</p>		<p>· Frequency of de-liming · Spot checking dishes that have been run through the dish machines to ensure proper cleaning <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Dietary Manager/designee will perform audits weekly on the kitchen cleaning schedules to ensure cleanliness. Any area found in need of cleaning will be corrected immediately by the dietary staff. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Dietary Manager/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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F0412 SS=D	<p>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 observation, record review and interview, the facility failed to ensure dental services were provided as ordered for 1 of 3 residents reviewed of the 5 who met the criteria for dental services. (Resident #B)</p> <p>Findings include:</p> <p>Interview with Resident #B on 1/4/12 at 1:44 p.m., indicated that her bottom partial was loose and that she had not seen the dentist in awhile.</p> <p>On 1/5/12 at 12:43 p.m., the resident was observed in the Main Dining Room eating lunch. Interview with the resident at 1:00 p.m., indicated that she could not eat her chicken breast due to it being dry and she was missing some of her bottom teeth. She indicated at this time that she needed to see a dentist.</p> <p>The record for Resident #B was reviewed on 1/9/12 at 2:53 p.m. The</p>	F0412	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F412 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident B was added to the dentist list for the next visit. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Resident were reviewed to identify those that need to be seen on the next dentist visit and consents obtained. <b>What measures will be put into place or what systemic changes will be made to ensure that the</b></p>	02/10/2012			

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	<p>resident was a Medicaid recipient. The resident was last seen by the dentist on 1/12/11. Documentation on the dental form indicated the resident needed an antibiotic one hour before cleaning. There was no other dental forms available for review.</p> <p>Interview with the resident on 1/11/12 at 9:55 a.m., indicated that she had not seen the dentist for a cleaning in a long time.</p> <p>Interview with Social Service Staff Member #1 on 1/11/12 at 3:00 p.m., indicated the resident was on the dental list for a cleaning on 6/29/11 and she was not sure if she was seen. The previous dental company was to be contacted to see if the resident was seen. She did indicate the resident was on the list to be seen by the dentist on 2/3/12.</p> <p>Interview with Social Service Staff Member #1 on 1/12/12 at 9:41 a.m., indicated the resident was not seen in June 2011 due to a clerical error and that she will be seen in February 2012.</p> <p>3.1-24(a)(1)</p>		<p><b>deficient practice does not recur;</b> Nursing and Social Service staff have been re-educated by Director of Nursing/designee on the following: · If a resident needs to be seen by the dentist, social service should be notified. · Consent will be obtained and faxed to the dental company. · If there is any pre-medical instructions that need to be carried out prior to the dentist visit, social service will alert nursing. · If the resident refuses to be seen, a notation will be made in the progress note section. If the resident still needs to be seen, depending on the dental need, the resident will be added to the next dental visit list. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Social service/designee will perform audits monthly on the residents that were on the dental list to ensure that they were seen or if they need to be added to the next dental list. If the resident refused, the progress note section will be audited to ensure notation was made. A summary of the audits will be presented to the Quality Assurance committee monthly by Social Service/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing</p>				

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			and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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F0431 SS=E	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>2. On 1/9/12 at 2:04 p.m., the medication cart on the West unit was observed. The medication cart was not locked. There were no licensed staff near the cart. The cart was in front of Room 155.</p>	F0431	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F431 What</b></p>		02/10/2012		

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	<p>Continued observation on 1/9/12 at 2:10 p.m., indicated the medication cart remained unlocked.</p> <p>Interview with the West Unit Manager on 1/9/12 at 2:35 p.m., indicated the medication cart was to be locked at all times.</p> <p>3.1-25(k)(5) 3.1-25(m)</p>		<p><b>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 87 – A Direction Change sticker was placed on the medication. The resident only received one tablet of the medication. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. The labels for resident taking Spiriva were checked to ensure proper labeling. Medication carts were checked at that time to ensure the rest of the carts were locked. Nurse was inserviced about proper procedure for locking medication cart. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: · Prior to administering any medication, the order is to be checked three times to ensure accuracy. · The order should be compared to the label on the box and the medication itself. · If a label is incorrect, a Direction Change sticker will be applied to</p>		

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	Based on observation, record review and interview, the facility failed to ensure each resident's medications were properly labeled related to a Spirivia inhaler for 1 of 13 residents observed during medication pass and failed to ensure the medication carts were locked when not in use for 1 of 2		<p>alert nursing of a change. Medication carts are to be locked at all times when out of line of vision by the nurse. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform med pass audits weekly on 3 nurses to ensure proper medication administration procedures are being followed and carts are being locked when out of site. Nurses from different shifts will be observed. If any discrepancies are noted between the medication and the label, a Direction Change sticker will be applied immediately. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	

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	<p>units. (Resident #87 and the West unit) This had the potential to effect 68 residents located on the West unit.</p> <p>Findings include:</p> <p>On 1/10/12 at 9:18 a.m., LPN #1 was observed preparing medication for Resident #87. The LPN removed the medication Spirivia (an inhaler) from a clear plastic bag with the medication label that indicated give two capsules daily. The LPN pulled out one capsule and placed it on top of the medication cart. After having intent to administer the medication the LPN was asked to step back outside of the room and review of the medication label and the medication sheet. The medication sheet indicated the resident was to receive one capsule daily. Review of the label indicated the medication was delivered to the facility on 11/8/11. The nurse indicated she was going to call the pharmacy and see about the label on the package, but she did not think the order was new because he had been receiving the medication for a long time and only just receiving one capsule.</p> <p>The record for Resident #87 was reviewed on 1/10/12 at 10:22 a.m. The Physician Order, dated 11/8/11,</p>				

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	<p>indicated Spirivia inhaler one capsule two puffs daily. A new Physician Order, dated 12/29/11, indicated Spirivia inhaler one capsule daily.</p> <p>Interview with LPN #1 on 1/10/12 at 2:33 p.m., indicated the pharmacy had placed the wrong label on the bag that was sent on 11/9/11. She indicated that she called pharmacy and they confirmed the label was wrong it should have been 1 capsule two puffs daily. She further indicated that nursing staff should have changed the label once it was first observed.</p> <p>Interview with the East Wing Unit Manager on 1/10/12 at 2:35 a.m., indicated the Spirivia inhaler was placed in the old medication bag with the old label. The bag should have been discarded when the new order was obtained on 12/29/11.</p>			

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F0441 SS=E	<p>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>Based on observation, record review, and interview, the facility failed to ensure nursing staff followed the facility's policy and procedure for</p>	F0441	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by	02/10/2012

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	<p>disposing of facial masks before leaving a resident's room who was in Respiratory Isolation and for ensuring proper hand washing occurred after administering eye drops and glove removal for 1 of 2 residents observed with eye drops and for 1 of 1 residents in Respiratory Isolation (Residents #51 and #62)</p> <p>Findings include:</p> <p>1. On 1/10/12 at 9:44 a.m., LPN #1 was observed preparing the medication administration for Resident #51. After administering the resident's medication, the LPN applied clean gloves on both of her hands to administer eye drops to both of the resident's eyes. The LPN did not wash her hands first before placing on the clean gloves. The LPN placed two eye drops into each eye and removed her gloves and threw them in the garbage can on the side of the medication cart. The LPN then walked across the hallway to another resident's room who had their call light on. She then entered his room and told the resident she was coming over to him next to give him his medications. She then turned off the call light and left the room. She did not wash her hands with soap and water at any time.</p>		<p>the facility and is submitted only in response to the regulatory requirement. <b>F441 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 51 – There were no negative outcomes to the resident from the nurse not washing her hands before putting on gloves to administer eye drops. There were no negative outcomes to the two other residents from the nurse not washing her hands prior to caring for the them. Resident 62 – There were no negative outcomes for this resident related to the aids not removing her mask and gloves prior to exiting the room, or not washing their hands and disposing the items in the wrong trash container. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. Staff were educated about proper isolation procedures to prevent re-occurrence. Nurse was inserviced about proper handing washing procedure during eye drop administration to prevent re-occurrence. <b>What measures will be put into place or what systemic changes will be made</b></p>				

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	<p>The LPN then observed another resident standing in the hallway by her wheelchair. She then assisted that resident in the hallway back to her room and came back to the medication cart. The LPN still had not washed her hands since removing the gloves. The LPN pulled the medication cart to another resident's door and walked into the resident's room and finally washed her hands with soap and water.</p> <p>Interview with LPN #1 at that time, indicated she did not wash her hands with soap and water after removing her gloves from the eye medication administration. She further indicated she should have washed her hands with soap and water.</p> <p>2. On 1/6/12 at 8:34 a.m., CNA #8 was observed walking into Resident #62's room to give the resident her breakfast tray. At that time, the CNA was observed to place a mask on her face and put on a pair of clean gloves before entering the resident's room. The resident's door indicated "Stop before entering." The resident was in Respiratory Isolation. The CNA then assisted the resident with her meal tray and walked out of the room wearing the mask and gloves to both</p>		<p><b>to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: · Proper hand washing procedures when administering eye drops · Proper infection control procedures when entering and exiting isolation rooms <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform med pass audits weekly on 3 nurses to ensure proper hand washing during eye drop administration are being followed. Nurses from different shifts will be observed. If the nurse is noted to be non-compliant with proper hand washing, the nurse will be re-educated at that time to prevent re-occurrence by the auditor. During the weekly audits of the 10 residents for nail care and shaves, nursing/designee will monitor staff members going in/out of isolations rooms to ensure proper infection control procedures. Any staff member found to be non-compliant with infection control will be educated at that time by the auditor to prevent re-occurrence. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if</p>				

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	<p>of her hands. The CNA then removed her mask and gloves and held them in her hands and continued to walk down the hallway. She then walked to the Nurse's Station and threw her gloves and mask away in a regular garbage can and spoke to the nurse at the station regarding Resident #62. The CNA did not wash her hands with soap or water or use alcohol gel at any time after leaving the resident's room or before she left the resident's room.</p> <p>Interview with LPN #2 at that time, indicated Resident #62 was in Respiratory Isolation due to MRSA (Methacillin Resistant Staph Aurous) of both nares.</p> <p>Interview with CNA #8 on 1/6/12 at 8:45 a.m., indicated she had placed a mask on her face to enter Resident #62's room due to she had a nasal infection. The CNA then indicated she was aware of the Respiratory Isolation policy and indicated she should have disposed of her mask and gloves before leaving the resident's room and washed her hands with soap and water. She further indicated she should have placed the mask and gloves in the red isolation bin inside the bathroom instead of a regular trash can.</p>		determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.				

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	<p>On 1/7/12 at 6:33 a.m., CNA #9 was observed walking out of Resident #62's room wearing a mask over her face and gloves to both of her hands. She then took off her mask in the hallway and removed her gloves and then threw them all away in a regular trash can. She did not wash her hands with soap or water after removing the mask and gloves to both of her hands.</p> <p>Interview with the CNA at 6:40 a.m., indicated she was aware the resident was in isolation and she indicated she was supposed to throw the mask away in the red trash can inside the resident's bathroom. She further indicated she did not wash her hands with soap or water before leaving the resident's room.</p> <p>Review of the current undated Hand Washing Policy provided by the Director of Nursing (DoN) indicated Hand Washing will be practiced as follows: Immediately after glove removal, before leaving the room of a resident in an isolation room.</p> <p>3.1-18(l)</p>						

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F0465 SS=C	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>2. During Environmental Tour on 1/9/12 at 1:29 p.m., the following was observed on the East Unit:</p> <p>a. There was an accumulation of dried food spillage on the inside of the microwave oven in the Pantry. A total of 67 residents resided on the East Unit.</p> <p>When interviewed at this time, the Housekeeping Supervisor indicated the microwave was in need of cleaning.</p> <p>3. During the Environmental tour on 1/9/12 at 2:02 p.m., the following was observed on the West Unit:</p> <p>a. There was an accumulation of dried food spillage on the inside of the microwave oven in the Pantry. A total of 68 residents resided on the West Unit.</p> <p>When interviewed at this time, the Housekeeping Supervisor indicated the microwave was in need of cleaning.</p> <p>3.1-19(f)</p>	F0465	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F465 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Microwaves of both pantries on the nursing units were cleaned. The ceiling fan in the dish room was cleaned. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. All microwaves in facility were checked to ensure they were free of debris. All ceiling fans were checked to ensure they were free of dirt. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: * When using any microwave to clean out any food</p>	02/10/2012	

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	Based on observation and interview, the facility failed to ensure a sanitary environment was maintained related to an accumulation of dust on the wall fan located in the dish room in the kitchen and food spillage in the microwaves of 2 of 2 pantries		debris to maintain cleanliness. * Housekeeping staff should wipe down the microwave when cleaning the pantries. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing Manager/designee will complete weekly audits for the microwaves in the facility to ensure they are clean and free of debris. If there is a microwave in need of cleaning, housekeeping will be alerted immediately. Dietary Manager/designee will observed ceiling fans during their weekly audit for cleanliness. Dietary staff will alert maintenance if the fan needs to be cleaned. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	<p>throughout the facility. This had the potential to affect the 132 residents in the facility who received oral diets in the population of 135. (The Main Kitchen, the East Pantry and the West Pantry)</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation Tour on 1/11/12 at 10:25 a.m., the fan located above the dishwasher in the dish room was observed to have a thick accumulation of dust. The vent leading to the outside also had a thick accumulation of dust.</p> <p>Interview with the Dietary Food Manager at the time, indicated the fan and vent were in need of cleaning.</p>			
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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 10 residents reviewed for unnecessary medications had a documented diagnosis to support the use of a medication used to treat an overactive bladder. (Resident #46)</p> <p>Findings include:</p> <p>The record for Resident #46 was reviewed on 1/5/12 at 2:34 p.m. The resident's diagnoses included, but was not limited to, urinary tract infection.</p> <p>Review of the January 2012 Physician's Order Summary (POS), indicated the resident was receiving Ditropan XL (a medication used to treat bladder spasms) 10 milligrams by mouth twice a day. The diagnosis listed for the medication was difficulty walking.</p>	F0514	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>F514 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 46 – The thinned medical record was reviewed and the diagnosis of neurogenic bladder was noted in the paper clinical record. This diagnosis was added to the current order for the drug Ditropan XL. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Orders were reviewed for proper</p>		02/10/2012		

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	<p>Review of the 2010 Nursing Spectrum Drug Handbook on 1/10/12 at 9:00 a.m., indicated the indications for the use of Ditropan XL were as follows: frequent urination, urinary urgency or incontinence, and nocturia caused by neurogenic bladder and overactive bladder.</p> <p>Interview with RN #1 on 1/11/12 at 11:11 a.m., indicated the resident did not have a diagnosis to support the use of the Ditropan and the Director of Nursing was going to have to research the issue.</p> <p>Interview with the Director of Nursing on 1/11/12 at 11:44 a.m., indicated the resident had a diagnosis of over active bladder back in 3/2010. She indicated diagnosis must not have gotten carried over when she was readmitted. She indicated the diagnosis should have been documented in the record.</p> <p>3.1-50(a)(1) 3.1-50(A)(2)</p>		<p>diagnoses. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Director of Nursing/designee on the following: · All medications must have correct diagnoses when inputting an order in Matrix. If they do not know the diagnosis, they hospital record should be reviewed or the physician called · MDS may be called if the nurses need help in coding the diagnosis <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Nursing/designee will perform audits weekly on 10 residents, which should include any new admits/readmits to ensure all ordered medication have proper diagnoses. If a medication does not have an appropriate diagnosis, the hospital records will be reviewed and/or physician called to obtain the diagnosis. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will</p>		

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R0000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R0000	be on going.  Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.		

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R0187	<p>(k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.</p> <p>Based on observation, record review and interview, the facility failed to ensure hot water temperatures were not greater than 120 degrees Fahrenheit for 1 of 5 rooms observed for hot water temperatures. (Room 117)</p> <p>Findings include:</p> <p>On 1/11/12 at 10:17 a.m., during the environmental tour, the hot water in Room 117 registered 124 degrees Fahrenheit.</p> <p>Interview with the Maintenance Supervisor at that time indicated the hot water temperature was too high.</p> <p>The hot water heater in the room next to Room 117 was observed on 1/11/12 at 10:20 a.m. The temperature gauge on the hot water heater indicated the temperature was 126 degrees Fahrenheit. The Maintenance Supervisor opened a valve to discharge the hot water. Interview with the Maintenance Supervisor at that time indicated he</p>	R0187	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>R187 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Mixing Valve was cleaned and water temperature rechecked to ensure in proper range. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. Spot check was completed with additional rooms to ensure water temperatures were in range. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Maintenance staff have been</p>	02/10/2012

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	<p>would inspect the mixing valve and repair it if needed. He also indicated that he checks hot water temperatures weekly.</p> <p>Review of the hot water check logs on 1/11/12 at 12:15 p.m., indicated the facility observed and documented the hot water temperatures weekly. The weekly temperatures recorded from June 2011 through January 2012 were not higher than 120 degrees Fahrenheit.</p> <p>The temperature of the hot water in Room 117 was obtained on 1/11/12 at 1:25 p.m. The temperature of the water was 108 degrees Fahrenheit. Interview with the Maintenance Supervisor at that time, indicated he had repaired the mixing valve on the hot water heater.</p>		<p>re-educated by Administration/designee on the following: · Performing spot checks of resident rooms to ensure proper water temperature.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Maintenance department/designee will perform weekly water checks of two room from each unit to ensure proper water temperature ranges. If the water temperature is out of range, maintenance staff will implement necessary steps, depending on the cause of abnormal temperature, to bring water temperature back to proper range. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>	
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R0217	<p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure a Service Plan was updated following a change in status for 1 of 7 residential records reviewed in a Residential Sample of 8. (Resident #242)</p> <p>Findings include:</p> <p>The record for Resident #242 was</p>	R0217	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>R217 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b></p>	02/10/2012	

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	<p>reviewed on 1/11/12 at 12:40 p.m. The resident's Service Plan was last reviewed on 5/9/11.</p> <p>Review of the Nursing Progress Notes indicated the resident became lethargic on 9/21/11 at 10:30 a.m. The resident was admitted to the hospital and returned to the facility on 10/26/11.</p> <p>Documentation in the Nursing Progress Notes on 11/3/11 at 8:30 a.m., indicated the resident had fallen out of bed. The resident was admitted to the hospital with a right femur fracture. She returned to the facility on 11/13/11.</p> <p>The resident was sent to the hospital for right sided weakness on 11/29/11. She returned to the facility on 12/9/11. The resident was admitted to hospice care on 12/13/11.</p> <p>The resident's assessment was updated on 11/13/11; however, the resident's Service Plan was not updated to reflect the resident's current status.</p> <p>Interview with the Care Coordinator on 1/11/12 at 2:00 p.m., indicated the resident's Service Plan had not been updated to reflect her current status.</p>		<p><b>practice; Resident 242 – the Service Plan was updated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. Clinical records of the current residents were audited to ensure current service plans were present. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Clinical Specialist/designee on the following: · Service Plans are to be updated every six (6) months and with any significant change. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Resident Care Coordinator/designee will perform weekly audits on 10 residents to ensure the Service Plan in the clinical record is up to date. If a Service Plan is found to be out dated, the Service Plan will be updated by the Resident Care Coordinator immediately. A summary of the audits will be presented to the Quality Assurance committee monthly by</p>		

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			Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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R0306	<p>(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:</p> <ol style="list-style-type: none"> <li>(1) The name of the resident.</li> <li>(2) The name and strength of the drug.</li> <li>(3) The prescription number.</li> <li>(4) The reason for disposal.</li> <li>(5) The amount disposed of.</li> <li>(6) The method of disposition.</li> <li>(7) The date of the disposal.</li> <li>(8) The signature of the person conducting the disposal of the drug.</li> <li>(9) The signature of a witness, if any, to the disposal of the drug.</li> </ol> <p>Based on record review and interview, the facility failed to ensure the disposition of the resident's medications was documented appropriately for 1 of 2 closed records reviewed in a Residential Sample of 8. (Resident #245)</p> <p>Findings include:</p> <p>The closed record for Resident #245 was reviewed on 1/11/12 at 10:05 a.m. The resident had been discharged from the facility on 9/12/11.</p> <p>Review of the Physician's Order Sheet, dated 9/2011, indicated the resident was receiving the following medications:</p>	R0306	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>R306 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 245 has been discharged from facility. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices.</p>	02/10/2012			

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	<p>Xanax 0.25 mg (milligrams) (an antianxiety medication) Levothyroid 50 mc (micrograms) (a thyroid medication) losartan potassium 100 mg (a medication for hypertension) magnesium oxide 400 mg (a mineral supplement) metformin 500 mg (a medication for diabetes) metoprolol 25 mg (a medication for hypertension) phospha 250 (a mineral supplement) tab-a-vit (a vitamin supplement) Tramadol 50 mg (a pain medication)</p> <p>Review of the Medication Disposition Record Form indicated only the medication, Xanax, was documented on the record as disposed of on 9/2/11. There was no documentation of the disposition of Levothyroid, losartan potassium, magnesium oxide, metformin, metoprolol, phospha, tab-a-vit, and Tramadol.</p> <p>Interview with the Resident Care Coordinator on 1/11/12 at 11:05 a.m., indicated the drug disposition record was incomplete. She indicated all of the resident's medications were not included on the form and appropriately documented for disposal.</p>		<p>Any resident(s) that recently discharged were audited to ensure disposition sheets were completed. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Clinical Specialist/designee on the following: · Medication disposition sheets are to be completed for any medication that is discontinued, changed, or when the resident is discharged to show evidence of what happened to the unused medication · The disposition sheet is to be maintained as part of the clinical record. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Resident Care Coordinator/designee will perform weekly audits on 10 residents which should include any resident that discharged or had a medication change to ensure a disposition sheet was completed when necessary. If a disposition sheet was not found, the medication cart will be checked to see if the medication has not been pulled from the cart and a form will be completed at that time. A summary of the audits will be presented to the Quality Assurance committee monthly by</p>				

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			Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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R0349	<p>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>3. The record for Resident #243 was reviewed on 1/11/12 at 9:00 a.m. The resident was admitted to the facility on 5/22/11. The resident's diagnoses included, but were not limited to, anemia and osteoarthritis.</p> <p>There was a physician's order dated 1/6/12, that indicated a treatment change. The order indicated to discontinue the telfa pad dressing and change the dressing to a non-stick pad, and wrap twice daily.</p> <p>Review of the nursing progress notes dated 1/1/12 through 1/6/12 indicated there was no documentation related to a wound or a dressing.</p> <p>Interview with the Resident Care Director on 1/11/12 at 2:10 p.m., indicated the resident had a skin biopsy performed on her right knee. She indicated she could not recall when the biopsy occurred. She indicated a dressing had been applied to the biopsy site and on 1/6/12 the</p>	R0349	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>R349 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for resident listed are as follows: Resident 240 – The Medication Administration Record was corrected. Resident 241 – The order for the Urinalysis was discontinued by the physician. Resident 243 – The surgical wound continues to be documented on for status. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. Current residents were reviewed to determine if there were any</p>		02/10/2012		

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	<p>physician changed the treatment.</p> <p>Continued interview with the Resident Care Director on 1/11/12 at 2:10 p.m., indicated the resident's record was incomplete. She indicated there was no documentation related to the biopsy site.</p>		<p>others in need for current documentation. Medication Administration Records were reviewed to ensure accuracy. Current orders were reviewed to determine if there were any other urine samples in need of collecting. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Clinical Specialist/designee on the following: · When there is a change in medication, the previous order on the Medication Administration Record should be identified as "Discontinued" with the date of the discontinuation to avoid signing out the old order. · The new order should be transcribed to the Medication Administration Record with the date it was ordered. · Prior to signing out your initials, the order should be read to ensure you are signing for the correct order that you just administered. · When an order is received for a urine sample, all efforts should be made to obtain the specimen. If sample is not able to be obtained this should be documented in the progress notes along with the reason. · The 24 hour communication report should be reviewed by the nurse each time they report for duty to determine all residents that require clinical observation and documentation of</p>	
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	Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to the signing out of medications on the Medication Administration Record incorrectly, the		the specific concern. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Resident Care Coordinator/designee will perform weekly audits on 10 resident's clinical records to ensure all ordered diagnostics were obtained and any necessary clinical observations were documented in the progress notes section. This audit will also include review of their Medication Administration Records for proper signage of current orders. If there are any non-compliance, the Resident Care Coordinator will address the issue with the appropriate nursing staff to prevent re-occurrence. A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.		

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	<p>lack of documentation of attempts to obtain a urine sample, and the lack of documentation of a surgical wound for 3 residents in the Residential Sample of 8. (Residents #240, #241 and #243.</p> <p>Findings include:</p> <p>1. The record for Resident #240 was reviewed on 1/11/12 at 8:10 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, mental disorder, and depression.</p> <p>A physician's order was obtained on 4/30/11 for the resident to receive Gabapentin 600 milligrams twice a day at 8:00 a.m. and 6:00 p.m. Another physician's order was written on 1/3/12 to decrease the Gabapentin to 300 milligrams twice a day.</p> <p>Review of the 1/2012 Medication Administration Record indicated both the 600 milligram and the 300 milligram doses were signed out on 1/4/2012.</p> <p>When interviewed on 1/11/12 at 9:30 a.m., the Resident Care Coordinator indicated both doses of the medication should not have been signed out as given.</p>			
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	<p>2. The record for Resident #241 was reviewed on 1/11/12 at 8:45 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, high blood pressure, and coronary stent. A physician's order was written on 12/30/11 for the resident to receive Macrobid (an antibiotic) 100 milligrams twice a day for 3 days and then repeat a urinalysis.</p> <p>Review of the laboratory test results and the Nursing Progress Notes indicated there was no documentation of the urinalysis being collected.</p> <p>When interviewed on 1/11/12 at 1:00 p.m., the Resident Care Coordinator indicated the facility protocol is to collect the urinalysis 72 hours after the completion of the antibiotic. The Resident Care Coordinator indicated the staff had been making attempts to obtain the specimen but the resident had been incontinent. The Resident Care Coordinator indicated the attempts should have been documented in the resident's clinical record.</p>			
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R0356	<p>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</p> <p>(2) The resident ' s hospital preference.</p> <p>(3) The name and phone number of any legally authorized representative.</p> <p>(4) The name and phone number of the resident ' s physician of record.</p> <p>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>3. The record for Resident #243 was reviewed on 1/11/12 at 9:00 a.m. The resident was admitted to the facility on 5/22/11. The resident's diagnoses included, but were not limited to, anemia and osteoarthritis.</p> <p>Review of the resident's Emergency File indicated the resident's hospital preference was not listed.</p> <p>Interview with the Resident Care Coordinator on 1/11/12 at 9:55 a.m., indicated the resident's hospital preference should have been listed on the resident's Emergency File.</p>	R0356	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>R356 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for residents listed are as follows: The hospital preference has been updated in the clinical record for Residents 239, 240, and 243. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</b></p>	02/10/2012			

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			<p><b>taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. Clinical records were reviewed to ensure all current resident have the hospital preference listed. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Clinical Specialist/designee on the following: · Upon admission, the resident should be interviewed to determine what hospital preference they have and this hospital should be listed on the face sheet. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Resident Care Coordinator/designee will perform weekly audits on 10 residents, which should include any resident that admitted that week, to ensure the hospital preference is identified on the face sheet. If there is no entry in that field, the resident will be interviewed as soon as possible for that information and the face sheet updated at that time. A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality</p>	
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	<p>Based on record review and interview, the facility failed to ensure Emergency Files were complete related to hospital preferences for 3 of 7 records reviewed for Emergency Files in the Residential Sample of 8. (Residents #239, #240 and #243)</p> <p>Finding include:</p> <p>1. The record for Resident #239 was reviewed on 1/10/12 at 1:10 p.m. The resident was admitted to the facility on 8/20/11. The resident's diagnoses included, but were not limited to, seizure disorder, cerebral aneurysm, anxiety, and hypotension.</p> <p>Review of the resident's record indicated the resident's hospital preference was not listed on the face sheet for her Emergency File.</p> <p>When interviewed on 1/10/12 at 1:35 p.m., the Resident Care Coordinator indicated the resident's hospital preference should have been listed on the face sheet.</p> <p>2. The record for Resident #240 was reviewed on 1/11/12 at 8:10 a.m. The</p>		Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.				

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	<p>resident's diagnoses included, but were not limited to, diabetes mellitus, mental disorder, and depression. The resident was admitted to the facility on 4/30/11.</p> <p>Review of the resident's record indicated the resident's hospital preference was not listed on the face sheet for her Emergency File.</p> <p>When interviewed on 1/10/12 at 1:35 p.m., the Resident Care Coordinator indicated the resident's hospital preference should have been listed on the face sheet.</p>			

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R0410	<p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure Tuberculin testing was completed upon or 3 months prior to admission for 2 of 7 residents reviewed for Tuberculin testing in the Residential Sample of 8. (Residents #239 and #240)</p> <p>Findings include:</p> <p>1. The record for Resident #239 was reviewed on 1/10/12 at 1:10 p.m. The resident was admitted to the facility on 8/20/11. The resident's diagnoses included, but were not limited to, seizure disorder, cerebral aneurysm, anxiety, and hypotension.</p>	R0410	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>R410 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective actions for residents listed are as follows: The clinical records were reviewed for Residents 239 and 240 and an up-to-date TB test was noted. <b>How the facility will identify other residents having the potential to be affected by</b></p>		02/10/2012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/12/2012
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	<p>Review of the resident's record indicated a Tuberculin skin test were administered on 4/6/11 and 4/22/11, more then 3 months prior to her admission to the facility on 8/20/11.</p> <p>When interviewed on 1/11/12 at 1:30 p.m., the Resident Care Coordinator indicated the pre admission Tuberculin test was not completed within 3 months of admission to the facility as required.</p> <p>2. The record for Resident #240 was reviewed on 1/11/12 at 8:10 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, mental disorder, and depression. The resident was admitted to the facility 4/30/11.</p> <p>Review of the resident's record indicated a Tuberculin skin test was administered on 9/23/10, more then 3 months prior to his admission to the facility on 4/30/11.</p> <p>When interviewed on 1/11/12 at 1:30 p.m., the Resident Care Coordinator indicated the pre admission Tuberculin test was not completed within 3 months of admission to the facility as required.</p>		<p><b>the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practices. The clinical records for the current residents were reviewed to ensure all have a current TB test or CXR for those who tested positive in the past. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff have been re-educated by Clinical Specialist/designee on the following: · Prior to admitting a new resident to the facility the chest x-ray must be within 6 months and the TB test must be within 3 months. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Resident Care Coordinator/designee will perform weekly audits on 10 residents, which should include any resident who admitted that week, to ensure that a current TB test, or CXR for those who cannot have the TB test, is present. If one cannot be found, a TB test, or CXR for those that cannot have the TB test, will be completed immediately. A summary of the audits will be presented to the Quality Assurance committee monthly by Resident Care</p>		

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			Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.		