

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155501	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2014
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF BLUFFTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: June 2, 3, 4, 5, and 6, 2014</p> <p>Facility number: 000465 Provider number: 155501 AIM number: 100273870</p> <p>Survey team: Martha Saull, RN TC Julie Call, RN Sue Brooker, RD Virginia Terveer, RN</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census payor type: Medicare: 5 Medicaid: 42 Other: 8 Total: 55</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 13, 2014 by Randy Fry RN.</p>	F000000	<p>F000000</p> <p>The facility requests that this plan of correction be considered its credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies.</p> <p>The plan of correction is prepared and/or executed solely because of federal and state law.</p>	

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

TITLE

(X6) DATE

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

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F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <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</p>			

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	<p>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> <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</p>			

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	<p>resident property in the facility, and non-compliance with the advance directives requirements.</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 observation, interview and record review, the facility failed to ensure a Notice for Medicare Non-Coverage was signed by 1 of 3 residents reviewed for receipt of the Notice for Medicare Non-Coverage prior to discharge. (Resident #69)</p> <p>Findings include:</p> <p>An interview with the Business Office Manager on 6-5-2014 at 4:55 p.m., indicated Resident #69 was discharged on 4-8-2014 and the Notice of Medicare Non-Coverage form was not signed.</p> <p>A copy of the Notice of Medicare Non-Coverage form was received by the Business Office Manager on 6-5-2014 at 5:05 p.m. and it was unsigned by Resident #69.</p>	F000156	<p>F 156 – D It is the intent of this facility to ensure that a Notice for Medicare Non-Coverage is reviewed and signed by residents prior to discharge.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #69 has had a Notice for Medicare Non-Coverage sent certified to their residence, as resident discharged.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Residents having been discharged within the last sixty days have the potential to have been affected. Those charts have been audited and facility has ensured that each resident discharged received a Notice of Non-Coverage.</p> <p>1.What measures will be put</p>	07/06/2014

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	<p>An interview with PT (Physical Therapist) #27 on 6-6-2014 at 10:50 a.m., indicated Resident #69 was unable to do anything while he was NWB (Non-Weight Bearing) and during therapy, the therapist would have to cue the Resident not to bear weight on the left lower extremity. Further interview with PT #27 indicated a home evaluation for Resident #69 was requested and performed on 4-8-2014 by PT #27.</p> <p>A record review began on 6-6-2014 at 10:30 a.m. and indicated the nurses notes, social service notes and care plan meeting notes did not indicate the Resident #69 was being discharged on 4-8-2014. Resident #69's admission date was 3-8-2014. The April 2014 recapitulation signed by the physician on 4-2-2014 indicated the diagnoses included but were not limited to, chronic infection of knee joint prosthetic, anemia, chronic kidney disease, hypertension, atrial fibrillation, congestive heart failure, diabetes with peripheral circulatory disorder, chronic general pain, depression and anxiety.</p> <p>A review of the admission MDS (Minimum Data Set) assessment done on 3-15-2014, indicated a BIMS (Brief Interview of Mental Status) of 14/15 which indicated Resident #69 was</p>		<p>into place or what systematic changes will be made to ensure that the deficient practice will not recur; Education has been provided to the Business Office Manager on 6-20-2014, by the Regional Business Office Consultant, with regards to the requirements of the regulations and to set up a tracking system to ensure that Notice of Medicare Non-coverage letters are issued to the resident within the requirements of the regulation. Pending discharges will be discussed as a routine agenda item during the daily interdisciplinary team meeting so that appropriate discharge planning and issuance of the notice will be accomplished for each resident.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; CEO will monitor tracking log weekly x 3 weeks; monthly x2 and then quarterly thereafter to ensure compliance and will report findings to the Performance Improvement Committee monthly until substantial (100%) compliance achieved. (See exhibit #1)</p> <p>1.CEO responsible to ensure compliance by 7-6-2014.</p>				

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	<p>cognitively intact. The 30 day MDS assessment completed on 4-5-2014 indicated a BIMS of 15/15.</p> <p>A review of the Discharge Plan/Discharge Plan Review dated 3-11-2014 indicated the anticipated length of stay for Resident #69 was 60 days. The initial anticipated length of stay was "30" days, but was marked out and replaced with "60" days.</p> <p>An interview COTA (Occupational Therapy Assistant) #26, Administrator and the DON (Director of Nursing) on 6-6-2014 at 1:23 p.m., indicated there was a care plan meeting on 4-2-2014 where his discharge was being planned for the following week. The Care Plan meeting notes were reviewed and indicated documentation was present for "discussed discharge planning". Further interview with the Administrator and DON on 6-6-2014 at 1:24 p.m., indicated it was Resident #69's choice to be discharged. The Administrator and DON were unable to provide documentation which indicated it was Resident #69's choice to be discharged on 4-8-2014.</p> <p>A review of the "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" obtained from the CMS (Center for Medicare and</p>			

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F000241 SS=D	<p>Medicaid) website indicated "a Medicare provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries receiving skilled nursing...not later than two days before the termination of services...this notice must be validly delivered...means that the beneficiary must be able to understand the purpose and contents of the notice in order to sign for receipt of it..."</p> <p>3.1-4(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on interview and record review the facility failed to ensure a Resident's</p>	F000241	241 – D It is the intent of this facility to promote care for	07/06/2014			

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	<p>dignity by not providing personal care as ordered resulting in an infection for 1 of 2 Resident's reviewed who met the criteria for dignity. (Resident #9)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #9 on 6/4/14 at 1:20 p.m., indicated the following: diagnoses included, but were not limited to, cellulitis of abdomen and legs, diabetes, diabetic foot wounds, peripheral neuropathy, CHF (congestive heart failure), HTN (hypertension or high blood pressure) Atrial Fibrillation, COPD (chronic obstructive pulmonary disease), obesity and gout.</p> <p>Resident #9 was interviewed on 06/03/2014 at 2:49 p.m., and indicated he had cellulitis and a yeast infection under his abdomen fold and indicated he had to go to the emergency room a few weeks ago because it became blood red. He indicated some of the CNA staff do not always wash under his abdomen or peri area every shift as they are supposed to do. He indicated he does not need assist to go to the bathroom, but he does need assistance to clean these areas. The Resident indicated he should not have to ask the CNAs to wash his private area, he indicated the CNA staff should ask him if</p>		<p>residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #9 continues to reside in the facility. Care plan/behavior monitoring tool for Resident #9 has been reviewed and updated to reflect non-compliance. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential to be affected therefore DON/SDC have educated nursing staff on the importance of documenting care provided, reporting non-compliance and refusals to the charge nurse so that documentation accurately reflects care provided 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; All C.N.A Care Guides have been reviewed and updated to reflect individual preferences. All Nursing staff has been educated by the DON/Designee on ADL/ Bed baths/Peri-Care. Additionally, reporting/documentation requirements were reviewed with staff. Education will be included in new hire orientation and annually thereafter. CEO will</p>	

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	<p>it needs to be done. He indicated sometimes he has to wait until his next shower day to have the area cleaned well.</p> <p>A Review of Resident's #9 Nurse's Progress Notes indicated the following:</p> <p>-On 5/21/14 at 4:15 p.m., "...Called MD about Resident's having possible cellulitis. N.O. (New Order) Clindamycin (an antibiotic) 300 mg q (every) 6 hr (hours) for 10 days. PT/INR (blood test for bleeding time) q 3 days while on ATB (antibiotic). Pharmacy faxed. Resident/Family aware..."</p> <p>-On 5/21/14 at 5:45 p.m., "...Resident's spouse picked up the Resident to go to ER per MD per Spouse...."</p> <p>-On 5/21/14 at 8:30 p.m., "...Resident return from ER (Emergency Room). N.O. for Econazole 1% cream (an antifungal medication) apply topically BID(2 times a day) for 4 weeks. Continue ATB, T (temperature) - 98.6 degrees F. (Fahrenheit, a measurement of temperature), Pharmacy faxed. Resident/Family aware. Resident needs bathed/bed bath once per shift to help with Candidiasis...."</p> <p>-On 5/22/14 6 a.m., "...Continues on ATB, T- 98.4 degrees F.. Abdomen red</p>		<p>educate all Department Managers and all staff on the Grievance policy and procedure and will ensure that Grievance/concern forms are easily accessible to all residents/ visitors and staff. Grievance forms will be turned in to the CEO for review, logging and given to appropriate Department Manager for resolution. Completed grievance form will be returned to the CEO within 24 hours and follow up completed. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; DON/Designee will monitor shower schedule weekly x 3 week, monthly x 2 months and quarterly thereafter, and report findings to Performance Improvement Committee until substantial compliance has been achieved. (See exhibit #2) Additionally, Social Service Director will interview 5 residents weekly x 3, then monthly x2 and then quarterly thereafter to ensure that residents are receiving showers/ baths as scheduled and, as they desire. (See exhibits #3 and #4) SSD will report any concerns to the DON/ CEO for immediate resolution. Concerns and Grievances will be a standard agenda item for the monthly Performance Improvement Committee. (See exhibit #5) 5. CEO/DON responsible to ensure compliance by July 6, 2014.</p>	

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	<p>with edema (fluid retention). Denies pain/discomfort...."</p> <p>-On 5/22/14 at 1:45 p.m., "...T - 100.5 degrees F. Continue on ATB for cellulitis of abdomen. No reaction noted. Abdomen red and has edema...."</p> <p>-On 5/23/14 at 2:30 p.m., "...Continue on ATB for cellulitis to abdominal area. Continue with increased edema and light redness....No adverse effect from ATB T-98.6 degrees F....."</p> <p>A review of the CNA Flow Sheet Record on 6/4/14 at 2:00 p.m., indicated Resident #9's shower days were on Wednesdays and Saturdays. Also indicated peri care every shift and as needed. The June 2014 CNA flow sheet indicated Peri care was not documented on 6/1/14 1st shift, 6/3/14 3rd and 2nd shifts.</p> <p>An interview with DON on 6/5/14 at 10:30 a.m., indicated the CNA's are to assist Resident #9 with bed bath or peri care every shift. She indicated Resident #9 often refuses. She reviewed the June 2014 CNA Care Flow Sheets and indicated she could not determine if care was missed or refused because nothing was documented on the flow sheet for peri care on 6/1/14, 1st shift and 6/3/14,</p>			

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	<p>3rd and 2nd shifts. She indicated the CNA should have documented if peri care was refused and it should have been reported to the nurse. The DON indicated the Resident should not have to ask to have peri care done and the CNA should ask resident if he needed peri care done for him.</p> <p>Review of Resident #9's March, April and May 2014, CNA Flow Sheet Records provided by the DON on 6/5/14 at 11:16 a.m., indicated Peri care was not documented for 22 shifts in March 2014, 1 shift in April 2014, and 2 shifts in May 2014.</p> <p>On 6/5/14 at 1:10 p.m., an interview with Resident #9 after skin treatment was completed by LPN #30, he indicated as long as the area under his abdomen and private area was washed, dried and the powder was applied every shift, his skin will stay good. He indicated it does not always get done every shift.</p> <p>Review of the Nursing Care Plans on 6/4/14 at 2:30 p.m. indicated, "...Problem of Non Pressure Skin deficit.... Approaches indicated the following: Weekly skin assessment; Follow MD orders for skin care and treatment; Monitor for signs and symptoms of infections; Assess pain/comfort level...."</p>			

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F000244 SS=E	<p>The facility's Resident Rights-Federal, dated 5/1/2004, provided by the Corporate Nurse on 6/6/14 at 1:50 p.m., indicated, "...Routine personal hygiene services and items as required to meet the needs of residents including, but not limited to, hair, hygiene supplies...bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection...."</p> <p>3.1-3(t)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to ensure it acted upon concerns and grievances from the Resident Council concerning sufficient nursing staffing and activities which included outings. This deficient practice had the potential to affect all of the 55</p>	F000244	<p>F 244 – E It is the intent of this facility to ensure that it acts upon grievances and recommendation of residents and families.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Unable to address the "affected</p>	07/06/2014
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	<p>residents who resided in the facility.</p> <p>Findings include:</p> <p>1. A confidential interview with an anonymous resident on 6-5-2014 at 10:51 a.m., indicated the facility sometimes would not listen and act on resident concerns. The confidential resident interview included the following concerns not addressed for the Resident Council group to understand:</p> <ul style="list-style-type: none"> <li>- The facility had not resolved the call light issue. The interviewee indicated there was not enough staff to answer the call lights and the call lights were left unanswered too long.</li> <li>- The confidential interviewee indicated there was uncertainty of what was being done to correct the staffing situation.</li> <li>_ The confidential interviewee indicated the CNAs (Certified Nursing Assistants) were working way too much, "12 hours and sometimes 16 hours" and indicated "how do they have time for their families." The interviewee indicated the CNAs "get too tired" and "when they call in, they are being fired". Further interview with the confidential interviewee indicated the facility was losing good help, thus making the interviewee feel "awful" and "worried." The interviewee indicated "the facility just doesn't have enough help."</li> </ul>		<p>resident" due to the anonymity of resident/family involved.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Concern has the potential to affect all residents. CEO met with resident council on 06/24/2014 to review grievance policy and procedure, and will ensure them of facility commitment to act on/respond to their concerns/questions. Follow-up resident council meeting scheduled for 07/01/2014. Letters sent to families inviting family members to newly developed family council meeting on 07/03/2014. CEO will remind residents and family members of open door policy and her willingness to meet with them regularly, if they choose to address concerns they may have.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; CEO will educate all Department Managers and all staff on the Grievance policy and procedure and will ensure that Grievance/concern forms are easily accessible to all residents/visitors and staff. Grievance forms will be turned in to the CEO for review, logging and given to appropriate Department Manager for resolution. (See Exhibit #6) Completed grievance form</p>		

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	<p>2. A confidential interview on 6-5-2014 at 3:35 p.m., indicated the residents were not getting out of the facility enough. The resident indicated there were 2 trips scheduled to go to the local discount store monthly, but now the activity was being scheduled one time monthly. The resident indicated with the bus used, only 1/2 of the residents wanting to go to the discount store can go each month. The interviewee indicated there were no outings to restaurants anymore.</p> <p>An interview with the Activity Director on 6-5-2014 at 4:25 p.m., indicated when the Resident Council had complaints, a form was filled out and placed in the department heads mailboxes. The DON (Director of Nursing) signs off on the nursing complaints and the Administrator signs off on the other complaints. Further interview with the Activity Director indicated the facility used the WOW (Wells on Wheels) bus to take residents on outings. The Activity Director indicated the WOW bus could only accommodate so many wheelchairs and electric carts and it was difficult to transfer residents in the WOW bus. The Activity Director indicated she could only schedule 1 outing a month at this time and she was unsure how many outings were done per month prior to her</p>		<p>will be returned to the CEO within 24 hours and follow up completed. Education will also address facility Call light policy with regards to all staff being responsible for answering and expected response time. Call light audits will be performed daily x 7 days, weekly x 3, monthly x 2 and quarterly thereafter until substantial compliance achieved according to Resident Council. (See Exhibit #7) Additionally, Social Service Director will interview 5 residents weekly x 3, then monthly x2 and then quarterly thereafter to ensure that residents are receiving showers/baths as scheduled and, as they desire. SSD will report any concerns to the DON/ CEO for immediate resolution. Concerns and Grievances will be a standard agenda item for the monthly Performance Improvement Committee. Social Service Director will educate staff about appropriate interactions with the residents and professional behavior and will educate staff on how to handle/document resident concerns and interact with the resident council. Regional Quality of Life Director will educate facility Quality of Life Director concerning quality of life expectations, activities and outings.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Concern/ Grievance log will be reviewed monthly in Performance</p>		

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	<p>coming in March 2014.</p> <p>A review of the activity calendars on 6-5-2014 at 5:20 p.m. and provided by the Activity Director on 6-5-2014 at 5:05 p.m., indicated the following:</p> <ul style="list-style-type: none"> <li>- 1 discount store trip was scheduled for June 2014, May 2014, and April 2014</li> <li>- 2 discount store trips were scheduled in March 2014.</li> <li>- No discount store trips were scheduled for February 2014.</li> <li>- 1 restaurant outing was scheduled on February 21st, 2014.</li> </ul> <p>A review of the Resident Council minutes and concerns on 6-5-2014 at 5:30 p.m., indicated the following:</p> <ul style="list-style-type: none"> <li>- 12-16-2013 Resident Council Concerns indicated "some residents would like to see more activities that aren't crafts...." and the facility response indicated "holiday crafts were a special part of the November and December calendars...now we are returning to more cooking classes."</li> <li>The Resident Council Concerns to nursing indicated the following "...call lights are not being answered on time...when the call light is answered, the CNA will say 'I'll be right back' and never return." The nursing response indicated "per resident's mostly 1st shift-call lights worse...weekends worse-nurse's are to</li> </ul>		<p>Improvement Committee for any trends and will continue as a standard agenda item. Call light response audit tool will be reviewed monthly x 3 and then quarterly thereafter until substantial compliance has been achieved according to the Resident Council. CEO will monitor activity calendar monthly x 3 and then quarterly thereafter. . CEO will review findings with the Resident Council president monthly x3 and then quarterly thereafter, until Resident Council feels that substantial compliance has been achieved. (see Exhibits #6, 7, 16)</p> <p>1.CEO responsible to ensure compliance by July 6, 2014.</p>	

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F000248 SS=D	<p>answer call lights." - 2-10-2014 Resident Council Concerns indicated "a few residents report that it is taking a while to receive help...." and the response indicated "hiring new staff...educating old staff about answering call lights, nurses also to answer call lights as well as other staff members." - 5-12-2014 Resident Council Minutes indicated "more activities to be held when fully staffed...." and Resident Council Concerns indicated "residents would like to have more activities" and the response indicated "new staff being interviewed and hired, more activities will be provided for residents."</p> <p>A policy "Resident Council Meetings" dated 4-28-2009 and provided by the Administrator on 6-6-2014 at 2:25 p.m., indicated "...address the residents' recommendations and/or concerns...."</p> <p>3.1-3(I)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing</p>						

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	<p>program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure the residents were encouraged to and/or provided an opportunity to attain activity goals and/or failed to assess the activity preferences for 2 of 3 Residents reviewed for activities. Resident # 13, Resident #58</p> <p>Findings include:</p> <p>1. On 6/4/14 at 1:26 P.M., a bead craft type activity was observed in the activity room. Resident #13 was not observed in this activity.</p> <p>On 6/5/14 at 10 A.M., the clinical record of Resident #13 was reviewed. Diagnoses included, but were not limited to, the following: dementia. The MDS (minimum data set assessment) dated 2/20/14 indicated the resident had a severe cognitive impairment and required extensive assistance to walk in corridor.</p> <p>On 6/5/14 at 1:54 P.M., the Activity Director (AD) provided copies of the resident's activity participation logs from February 2014 to current. The AD</p>	F000248	<p>F 248 – D It is the intent of this facility to ensure the residents are encouraged to and/or provided an opportunity to attain activity goals and access resident preferences.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #13 and Resident #58 were assessed by the Activity Director and had their individual preferences updated and care planned.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All other residents have the potential to be affected and will have their activity preference sheets reviewed and updated. Care plans and care guides will be updated to reflect resident preferences as well.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Regional Quality of life Director has reviewed job descriptions with Activity Director and Assistant and they have been educated as to their specific job responsibilities, including</p>	07/06/2014

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	<p>indicated the yellow highlighted activities on the monthly activity calendars indicated the resident attended the specific activity. Documentation review indicated the following: In February 2014, the resident attended 1 activity the week of 2/9, 2/16 and 2/23. Documentation was lacking the resident attended and/or refused any activities the week of 2/2. In March 2014, documentation was lacking for the weeks of 3/9, 3/16 and 3/23 of the resident attending and/or refusing any activities. In April 2014, documentation indicated the resident attended two activities the entire month. Documentation was lacking of the resident refusing any activities during the month. The current daily activity participation log for June was blank for the resident.</p> <p>On 6/5/14 at 1:58 P.M., the AD was interviewed. She indicated she began as the Activity Director the end of March 2014. She indicated she got an assistant this month to help her, as prior to this she had been the only activity staff member. At the time, the AD was interviewed regarding the resident likes and dislikes for activities. At the time, the AD was unable to find documentation of this type of assessment for the resident in the clinical record. The AD pointed to the current activity calendar and indicated the</p>		<p>assessments, and required documentation. Activity assessments will be done on admission, quarterly and with significant change, with care plans being updated accordingly.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Audit tool, including assessments, care plan, participation logs, preferences will be done monthly x 3 and then quarterly thereafter and reviewed as a part of the Performance Improvement Committee monthly x3 and quarterly thereafter until substantial compliance is achieved. (See Exhibit #8)</p> <p>1.CEO responsible to ensure compliance by 7-6-2014.</p>				

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	<p>resident had been asked but refused to attend the tailgate party on 5/12/14. Documentation was lacking as to the resident having refused to attend the activity on 5/12/14.</p> <p>On 6/6/14 at 1:35 P.M., the Administrator provided a copy of the "Pleasant and Meaningful Activities" list for Resident #13. This assessment was dated 4/13/2012 and included but was not limited to, the following: "enjoys now: arts and crafts..." She indicated this form had been "thinned off" of the current clinical record.</p> <p>On 6/6/14 at 11:58 P.M., the DON and Adm were interviewed. They indicated they were aware there were issues with documentation in regards to activities.</p> <p>A Care plan summary meeting for Resident #13 dated 1/9/14 included but was not limited to, the following: "...activities: Bingo, listening to singers, watching the birds..." A care plan for Activities was reviewed on 6/5/14 at 2 P.M. The most recent date on the care plan was 7/15/13 and the most recent target date was 5/20/14. Problem included, but was not limited to, the following: enjoys small and large group activities of her choice and interest such as monthly birthday parties and bingo.</p>			

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	<p>The goal was to attend 1-3 group activities per week. Approaches included, but were not limited to, the following: provide positive reinforcement; assist to and from activities as needed and remind her of activities daily.</p> <p>2. Review of the clinical record for Resident #58 on 6/4/14 at 2:37 p.m., indicated the following: diagnoses included, but were not limited to, generalized anxiety, depressive disorder, debility, difficulty in walking, muscle weakness, and paralysis agitans.</p> <p>Resident #58 was not observed to participate in any of the scheduled activities in the facility on 6/2/14, 6/3/14, 6/4/13, 6/5/13, and 6/6/14.</p> <p>A Minimum Data Set (MDS) assessment for Resident #58, dated 1/15/14, indicated a score of 6 out of 15 on the Brief Interview for Mental Status, indicating a severe cognitive impairment. The MDS also indicated a patient interview should be conducted for activity preferences.</p> <p>An Activities Preference Assessment for Resident #58 could not be located in his clinical record.</p> <p>The Activity Director was interviewed on</p>			

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	<p>6/6/14 at 10:30 a.m. During the interview she indicated an activity preference assessment for Resident #58 should have been in his clinical record. She also indicated the activity preference assessment would have been completed by the previous Activity Director.</p> <p>A current facility policy "Patient Assessment", dated 4/26/14 and provided by the Administrator on 6/5/14 at 5:23 p.m., indicated "...A comprehensive, accurate, standardized, reproducible assessment of each patient's functional capacity and needs is conducted...which directs the care of the patient based on his or her individual needs...."</p> <p>3.1-33(a)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under</p>			

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	<p>§483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review the facility failed to develop an activity care plan for 1 resident of 3 residents reviewed for activities.</p> <p>Resident #58</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #58 on 6/4/14 at 2:37 p.m., indicated the following: diagnoses included, but were not limited to, generalized anxiety, depressive disorder, debility, difficulty in walking, muscle weakness, and paralysis agitans.</p> <p>Activity Calendars for Resident #58, provided by the Activity Director on 6/5/14 at 11:40 a.m., indicated the following:</p> <p>- February 2014 - attended an activity on 2/20/14.</p> <p>- March 2014 - attended activities on 3/4/14 and 3/17/14.</p> <p>- April 2014 - attended activities on 4/7/14, 4/11/14, 4/21/14, and 4/30/14.</p>	F000279	<p>F 279 –D It is the intent of this facility to use the results of the assessments to develop, review and revise the resident's comprehensive plan of care.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #58 care plan has been reviewed and updated, following Activity assessment review and updated resident preferences.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential to be affected and all Activity care plans have been updated based upon validating activity preference sheets. Activity Director and Assistant received education with regards to their job description and developing individualized care plans.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Regional Quality of Life Director has reviewed job description with Activity Director and Assistant and they have been educated as to their specific job responsibilities, including</p>	07/06/2014

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	<p>- May 2014 - attended an activity on 5/13/14.</p> <p>- June 2014 - attended an activity on 6/4/14.</p> <p>An In Room Visits, One to One &amp; Independent Activity Data Collection Tool for Resident #58, provided by the Activity Director on 6/5/14 at 11:40 a.m., indicated he received one-to-one visits on 4/4/14 and 4/10/14.</p> <p>A May 2014 Activity Calendar for Resident #58, provided by the Activity Director on 6/5/14 at 11:40 a.m., indicated he attended an Ice Cream Social with 50's music on 5/13/14.</p> <p>Review of the care plans for Resident #58, on 6/4/14 at 2:37 p.m. and on 6/6/14 at 10:12 a.m., did not include a care plan for activities.</p> <p>The Activity Director was interviewed on 6/5/14 at 11:40 a.m. During the interview she indicated the activity care plan for Resident #58 should be in his clinical record. She also indicated care plans for residents had come up missing.</p> <p>The Director of Nursing was interviewed on 6/6/14 at 2:40 p.m. During the interview she indicated each discipline</p>		<p>assessments, and required documentation. Activity assessments will be done on admission, quarterly and with significant change, with care plans being updated accordingly.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Audit tool, including assessments, care plan, participation logs, preferences will be done monthly x 3 and then quarterly thereafter and reviewed as a part of the Performance Improvement Committee monthly x3 and quarterly thereafter until substantial compliance is achieved. (See exhibit #8)</p> <p>1.CEO responsible to ensure compliance by 7-6-2014.</p>	

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F000280 SS=D	<p>was responsible for writing and revising their own care plans for residents.</p> <p>A current facility policy "Comprehensive Plan of Care", dated 8/31/12 and provided by the Administrator on 6/6/14 at 2:27 p.m., indicated "...A comprehensive plan of care is developed for each patient within 7 days after completing the comprehensive assessment...."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared</p>			

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	<p>by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review the facility failed to update the nutrition care plan for 1 resident with a severe weight loss (Resident #58) and 1 resident with a significant weight loss of the 3 residents reviewed for nutrition care plans. Resident #58, Resident #13</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #58 on 6/4/14 at 2:37 p.m., indicated the following: diagnoses included, but were not limited to, generalized anxiety, depressive disorder, and edema.</p> <p>Resident #58 was admitted to the facility on 1/15/14.</p> <p>Physician orders for Resident #58, dated 1/15/14, indicated he received a Regular Diet.</p> <p>Facility weights for Resident #58 indicated the following: 258 pounds on</p>	F000280	<p>F 280 – D It is the intent of this facility to use the results of the assessments to develop, review and revise the resident's comprehensive plan of care. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #58 care plan has been reviewed and updated, following Registered Dietician's assessment. Resident #13 care plan has been reviewed and updated. Both residents were evaluated by the Registered Dietician on 06/23/2014. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential to be affected and all Dietary care plans have been reviewed and updated by contracted Registered Dietician completed on 06/23/2014. Certified Dietary Manager re-educated on required documentation and the development of individualized care plans. Signature Care</p>	07/06/2014

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	<p>1/15/14, 258.2 pounds on 1/21/14, 259 pounds on 1/28/14, 258 pounds on 2/22/14, and 259 pounds on 3/7/14. Facility weights for Resident #58 indicated the following: 237.5 pounds on 4/15/14 and re-weigh on 4/16/14 ( a loss of 21.5 pounds or 8.3% since 3/7/14), and 234.5 pounds on 4/21/14 ( a loss of 24.5 pounds or 9.45% since 3/7/14).</p> <p>A Dietary Progress Note for Resident #58, dated 5/30/14, indicated a current weight of 225.8 pounds on 5/26/14, or a 3.8% loss in 30 days. The note also indicated he remained on a Regular diet.</p> <p>A facility care plan for Resident #58, with a start date of 1/24/14 and a revision date of 4/21/14, indicated the problem area of obesity, intake below 75% of meals ,and edema to bilateral lower extremities. A goal to the nutrition care plan was for the resident to have no significant weight changes. Approaches to the problem included, but were not limited to, diet per order, weigh resident per MD order or policy, nutritional supplements/snacks per MD order, honor food preferences within reason, and encourage intake of meals. The care plan was not updated to reflect the severe weight loss in the past 90 days and the supplements ordered on 6/3/14.</p>		<p>Consultant will educate the Interdisciplinary Team on 06/25/14 regarding the development of individualized care plans. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Dietary assessments will be done upon admission, quarterly and with significant change, with care plans being implemented and updated accordingly. Going forward, care plans will be implemented upon admission, quarterly and with significant change. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Audit tool, including assessments, care plan will be done monthly x 3 and then quarterly thereafter and reviewed as a part of the Performance Improvement Committee monthly x3 and quarterly thereafter until substantial compliance is achieved. (See exhibit #9 and 10)5. CEO responsible to ensure compliance by 7-6-2014.</p>				

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	<p>The Director of Nursing was interviewed on 6/6/14 at 2:40 p.m. During the interview she indicated each discipline was responsible for writing and revising their own care plans for residents.</p> <p>A current facility policy "Comprehensive Plan of Care", dated 8/31/12 and provided by the Administrator on 6/6/14 at 2:27 p.m., indicated "...The care plan is re-evaluated and modified: As necessary to reflect changes in care, service and treatment; With significant change of condition...."</p> <p>2. On 6/5/14 at 2:00 P.M., the clinical record of Resident#13 was reviewed. Diagnoses included, but were not limited to, the following: vascular dementia with depression, depressive disorder, esophageal reflux, malaise and fatigue, hypothyroidism and cerebrovascular accident. The MDS dated 2/20/14 indicated the resident had severe cognitive impairment and was independent in eating.</p> <p>At the time, the weight log in the clinical record indicated the following weights: 1/10/14: 140 lbs (pounds) 2/22/14: 141 lbs 3/17/14: 137.6 lbs 4/7//1/4: 138 lbs 5/5/14: 131 lbs 5/8/14: 131 lbs</p>						

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	<p>A physician order dated 1/20/14 indicated the following: "Healthshake, 1 dly (daily) with lunch for supplement."</p> <p>On 6/5/14 at 4:07 P.M., the FSM (food service manager) was interviewed. She indicated the following: The resident was on a regular diet. She indicated on 1/20/14 the resident was started on health shakes, one daily at lunch. The FSM indicated the resident had a significant weight loss from 4/7/14 to 5/8/14. The FSM indicate the weight loss to be 5.072% in one month.</p> <p>At this time the FSM documented a weight of 131 lbs dated 6/2/14, and for 5/26/14, she documented a weight of 131 lb. The FSM indicated the resident was reweighed on 5/7/14 and the weight was 131 lb. She indicated the resident was currently on weekly weights. She indicated at this time, she thought the RD (registered dietician) had written the weekly weights in the resident's clinical record, but the RD had not done this. The FSM indicated at the time, the last intervention put in place to address weight loss was the health shake, in January 2014. The FSM indicated there had been no new interventions put into place to address the significant weight loss which had been identified on 5/5/14.</p>			

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	<p>The FSM indicated the plan to prevent weight loss was to add another health shake daily for the resident to take. The FSM indicated she thought the Dietician was going to do this the next Monday. Documentation was lacking of weekly weights having been done from the 5/8/14 - 5/26/14.</p> <p>The FSM indicated that for the last month the residents weight had been at 131 lbs. The FSM indicated the former Dietician left the facility in April 2014 and the current dietician started at the facility on 5/22/14. The FSM indicated she and the Director of Nursing "took care of the weights during this time."</p> <p>At the time, the FSM provided a copy of the Dieticians note, dated 5/22/14. The note included, but was not limited to, the following: "Resident with sig (significant) wt (weight) loss at 30 days. Wkly (weekly) wt 5/8 131#, recently some depression, meds (medications) adjusted...Stable, started on health shakes at lunch...f/u (follow up) with further sig (significant) changes. RD (registered dietician f/t prn (as needed)..Recommendations: Wkly (weekly) weights r/t (related to) sig (significant) loss at 30 days; Resident prefers vanilla and strawberry health shakes..."</p>			

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	<p>A plan of care dated 5/22/14 included the following: "addressed problem: "Resident with sig wt loss at 30 days...Goal: wt will remain 131# +/- 5 pounds thru next review. Approaches: healthshake at lunch."</p> <p>A Care Plan Conference Summary dated 6/5/14, included but was not limited to, the following: "Wt (weight) 131 lb. Has had a signif (significant) wt (weight) change x 6 months...Care plan conference discussion:...Res (resident) is on weekly weights, receives healthshakes at lunch, receives reg diet."</p> <p>On 6/6/14 at 12:03 P.M., the Administrator (Adm) and Director of Nursing were interviewed. The Adm indicated the Dietician would come to the facility next week. The DON indicated the resident had been a little depressed as her roommate left the facility right before Christmas.</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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>Based on observation, interview and record review, the facility failed to ensure a physician prescribed fluid restriction was followed for 1 of 1 resident's reviewed on a fluid restriction and failed to follow physician orders for 1 resident of 1 resident's reviewed with a skin tear. Resident #27, Resident #19</p> <p>Findings include:</p> <p>1. On 6/3/14 at 11 A.M., the clinical record of Resident #27 was reviewed. Diagnoses included, but were not limited to, the following: End stage renal disease. The MDS (minimum data set) assessment dated 4/26/14, indicated the resident was independent in cognition and no behaviors were observed.</p> <p>A physician order with an origination date of 10/10/13, indicated the following: regular liquids 1600 ml/24 hr fluid</p>	F000282	F 282 –D It is the intent of the facility to provide care and services by qualified persons in accordance with each resident's written plan of care. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #19 – Skin tear healed on 6-20-2014. Resident #27- Remains in facility and fluid restriction order clarified with attending physician. Care plan has been reviewed and updated to reflect non-compliance, CNA care guide updated, resident educated with regards to risks of non-compliance and resident desire to keep water pitcher at bedside; tray card updated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential for being affected by this practice. Current residents' care plans were reviewed and compared to the	07/06/2014

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	<p>restriction.</p> <p>A dietary note dated 5/22/14, indicated the resident went to renal dialysis on Mondays, Wednesdays and Fridays weekly.</p> <p>On 6/3/14 at 10:12 A.M., CNA #23 (certified nursing assistant) was observed to refill the resident's bedside water pitcher with ice and place it back on the resident's bedside table. The water pitcher was observed to have a lid on it and also had an uncovered straw in the pitcher.</p> <p>On 6/3/14 at 10:15 A.M., the resident was interviewed. She indicated she only gets ice in her pitcher.</p> <p>On 6/4/14 at 12:15 P.M., the resident was observed to have a 1/2 pitcher of water at her bedside. No fluid restriction notice was observed in the room.</p> <p>On 6/5/14 at 1:36 P.M., LPN #24 was interviewed. She indicated at the end of the meal, a CNA goes around to where each resident was seated in the dining room and entered in the meal intake record, the amount the resident ate and/or drank.</p> <p>LPN #24 indicated Resident #27 was on a fluid restriction. She verified the orders</p>		<p>CNA care guides for accuracy and implementation by Nursing Administration and IDT (interdisciplinary team) and discrepancies were corrected immediately. Two residents are on Fluid restrictions, their orders were clarified by the physician, reconciled by tray cards and hydration cart, care plans were updated and CNA care guides were updated. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; DON educated all staff regarding the Fluid Restriction policy and procedure, including documentation on the MAR (Medication Administration Record), the dietary menu card, "pink dot system" for identifying fluid restrictions, thickened liquids, and NPO. Dietary Manager/Nursing Administration completed 100% audit of physician's dietary orders to dietary tray cards, MARs (medication administration records), Care plans and CNA care guides. Nursing staff was educated on documentation of events, skin sheets and shower process, treatment process, and order transcription process. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Care plan audit tool will be reviewed in the Performance Improvement meeting monthly x</p>	

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	<p>and indicated the resident was on a 1600 cc intake per 24 hour period. She indicated when she gives the resident her pills, she (LPN #24) will pour a full glass of water which is used for medication pass, but the resident usually uses approximately 1/2 of the water.</p> <p>LPN #24 indicated the resident may take 60 ccs of water with each medication pass. LPN #24 indicated on non dialysis days, the resident will get two medication passes on the day shift and on the dialysis days, she only gets one medication pass on the day shift. LPN #24 indicated there was no area on the MAR (medication administration record) that specified how much fluid the resident was allowed for each medication pass. She indicated the fluid restriction order "just says 1600 ccs." LPN #24 indicated each shift signed the MAR and by doing so indicated "this means that they (staff) were signing that the resident didn't go over her allotted amount of fluid." LPN #24 indicated that mentally she knows how much fluid the resident took in on her shift. LPN #24 indicated the initials on the MAR for the fluid restriction were staff acknowledging "the resident was on a fluid restriction." She reviewed the resident's MAR and/or clinical record at this time. Documentation was lacking of a specific fluid distribution plan for the</p>		3 and then quarterly until compliance is achieved, as determined by the committee. (see Exhibit #9 and 21) 5. CEO is responsible to ensure compliance by July 6, 2014.	

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	<p>fluid restriction.</p> <p>On 6/5/14 at 1:45 P.M. CNA #25 was interviewed. She indicated she does document the meal and fluid intakes at times when residents are done with their meals in the dining room. She indicated the follow fluid amounts: a coffee cup held 120 ccs; the taller stemmed goblets, she doesn't know how much was in those; the short stemmed juice goblets held 120 ccs and she indicated she would document intake of ice cream at 100%, 75%, etc. but not by ccs contained in the ice cream container.</p> <p>On 6/5/14 at 2 P.M., the medication cup LPN #24 indicated she used to give water to the resident was observed. A 30 cc medication cup was used to put water in the cup to fill to the top rim and it was determined the cup, holds 1 ounce of fluid.</p> <p>On 6/5/14 at 4:21 P.M., the FSM (Food Service Manager) was interviewed. She indicated the following: resident was on a 1600 cc/day fluid restriction; nursing gives the resident 270 cc daily and 1330 ccs given daily per dietary; the resident gets 12 oz at breakfast, 16 oz at lunch and 16 oz at dinner. The FSM indicated the resident should not have water at her bedside. The FSM indicated the</p>						

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	<p>following fluid amounts: coffee mug was 6 oz = 180 cc; larger stemmed goblet was 240 cc; smaller juice goblet was 120 cc. She indicated there was a copy of the beverage plan worksheet, which specified how much fluid the resident was to have received from nursing and dietary in a 24 hour period, in the resident's MAR (medication administration record), in her office and on the beverage cart. The FSM indicated documentation was lacking of a total for the resident's daily fluid intake to ensure the resident had maintained her 1600 cc fluid restriction.</p> <p>On 6/5/14 at 4:30 P.M., the resident was interviewed. She indicated she does at times consume ice/melted ice from her bedside pitcher "when she gets really thirsty, but not a lot." She continued with the pitcher at her bedside with the straw in the lid.</p> <p>On 6/5/14 at 4:30 P.M., the FSM reviewed the MAR for the resident with LPN #22. LPN #22 indicated the MAR only indicated a 1600 cc fluid restriction but documentation was lacking of a specific fluid distribution plan. LPN #22 indicated she was unaware how the resident's fluids were distributed to maintain her 1600 cc fluid restriction.</p> <p>On 6/5/14 at 4:40 P.M., the Individual</p>			

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	<p>Resident Meal Intake Record was reviewed for the month of June 2014. This form had documented the following: meal intake for solid foods as well as liquid intake for each meal. The area on the form for snacks was left blank.</p> <p>On 6/6/14 at 8:30 A.M., the Administration provided a current copy of the facility policy and procedure, dated 8/31/13, for "Fluid Restrictions." This policy included, but was not limited to, the following: "Patients requiring a controlled amount of fluid intake (fluid restricted) are provided the correct amount of daily fluid intake by designated staff as indicated in the fluid restriction medical order...Licensed nursing staff...will remove the bedside pitchers and place a fluid restriction notice in the patient room when fluid restrictions are ordered...Licensed nursing staff...will document in the medical record the amount of fluids consumed by the patient at meals and throughout the day..."</p> <p>On 6/6/14 at 12:25 P.M., the DON and Administrator (ADM) were interviewed. They indicated the resident was on a 1600 cc daily. fluid restriction. The DON indicated the Activities department and Dietary Department should specify specific fluid distribution plans. The</p>			

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	<p>DON indicated this was on the worksheet in the resident's MAR, the Beverage Plan Worksheet. The ADM stated she was normally in the dining room for meals and Resident #27 will tell you that she never eats what she isn't supposed to eat and that she won't drink what she isn't supposed to drink. The ADM indicated Resident #27 was very non compliant with her fluid intake.</p> <p>On 6/6/14 at 1 P.M., a plan of care for "Is on fluid restriction" was dated 10/29/13. Goals included, but were not limited to, the following: "...will have no serious fluid shifts thru next review." Approaches included, but were not limited to, the following: "...fluid restriction per orders..."</p> <p>On 6/6/14 at 2:45 P.M. the DON provided a current copy of the "Beverage Plan Worksheet" for resident # 27. This form included, but was not limited to, the following: Fluid restriction ordered: 1600 ml (milliliters). Total for nursing per each shift was 90 ml. Total for 24 hours nursing was 270 ml. Total for Nutrition Services for 24 hours was 1330 ml. The breakdown of the nutrition services was as follows: breakfast fluids=360 ml; lunch= 480 ml; and supper= 480 ml. When added, these fluids total = 1320 ml.</p>			

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	<p>2. Review of the clinical record for Resident #19 on 6/4/14 at 1:39 p.m., indicated the following: diagnoses included, but were not limited to, ischemic heart disease, muscle weakness, and edema.</p> <p>Resident #19 was interviewed on 06/03/2014 at 10:23 a.m. During the interview a very large skin tear was noted on the interior of his left wrist. The area was dark red in color with some weeping noted. There were also areas of dark crusted skin.</p> <p>A Resident Weekly Skin Check Sheet for Resident #19, dated 5/27/14, indicated there were no new skin issues. The check sheet did not identify the skin tear on his left wrist.</p> <p>A physician's order for Resident #19, dated 5/25/14, indicated to apply dry dressing to area on left wrist BID (twice a day) until healed.</p> <p>A physician's order for Resident #19, dated 5/26/14, indicated steri-strips to skin tear on left wrist, wrap with Kerlix, and change wrap daily.</p> <p>A Resident Progress Notes for Resident #19, dated 5/26/14 as a late entry for</p>			

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	<p>5/25/14, indicated an area noted on his left wrist approximately 2 cm (centimeters) in length. The notes also indicated steri-strips were on with a Kerlix wrap when found. The notes further indicated an order for a dry dressing BID until healed in place.</p> <p>A Resident Progress Notes for Resident #19, dated 5/26/14 as a late entry for 5/25/14, indicated he had a skin tear on his left wrist. The notes also indicated steri strip and dressing applied.</p> <p>The Medication Administration Record for Resident #19, dated for the month of May, 2014, indicated to change wrap daily to left wrist on day shift. Initials were only documented on 5/26/14, indicating the treatment was done.</p> <p>A Resident Progress Notes for Resident #19, dated 5/29/14, indicated left wrist was healing well with dressing intact.</p> <p>The Treatment Administration Record for Resident #19 for the month of June, 2014, did not include the order for the wrap daily to left wrist.</p> <p>There was no physician order to discontinue the treatment to the skin tear on his left wrist.</p>						

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	<p>During an observation on 6/3/14 at 11:30 a.m., Resident #19 was observed seated in his wheelchair in the dining room. The skin tear on his left wrist was not observed to be covered.</p> <p>Resident #19 was interviewed on 6/4/14 at 3:50 p.m. During the interview he indicated staff had just put a dressing on his skin tear after lunch on 6/3/14.</p> <p>During an observation on 6/5/14 at 8:35 a.m., Resident #19 was observed in his wheelchair in the dining room. The skin tear on his left wrist was not observed to be covered.</p> <p>During an observation on 6/5/14 at 1:45 p.m., Resident #19 was observed resting in bed. The skin tear on his left wrist was not observed to be covered. During the observation he indicated the skin tear had been seeping on 6/4/14.</p> <p>The Director of Nursing was interviewed on 6/5/14 at 8:58 a.m. During the interview she indicated when a temporary care plan was highlighted in yellow, it meant the temporary problem was resolved.</p> <p>A facility Care Plan Temporary Problems for Resident #19, dated 5/25/14, indicated the problem area of skin tear.</p>			

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F000309 SS=D	<p>Approaches to the problem indicated to keep area clean and watch for signs/symptoms of infection. The temporary care plan was not highlighted in yellow.</p> <p>The Director of Nursing was interviewed on 6/5/14 at 1:45 p.m. During the interview she indicated the physician orders should have been followed.</p> <p>The Director of Nursing was interviewed on 6/6/14 at 10:14 a.m. During the interview she indicated the skin tear for Resident #19 actually measured 5 cm.</p> <p>A Current facility policy "Physician Orders", dated 11/21/12 and provided by the Administrator on 6/5/14 at 5:23 p.m., indicated "...Write a telephone order to discontinue the previous orders..."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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>			

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	<p>Based on observation, interview and record review the facility failed to adequately assess a large skin tear for a resident and/or ensure the personal care was performed every shift to prevent an infection for 2 of 5 residents reviewed who met the criteria for skin related problems. Resident #19 and Resident #9</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #19 on 6/4/14 at 1:39 p.m., indicated the following: diagnoses included, but were not limited to, ischemic heart disease, muscle weakness, and edema.</p> <p>Resident #19 was interviewed on 06/03/2014 at 10:23 a.m. During the interview a very large skin tear was noted on the interior of his left wrist. The area was dark red in color with some weeping noted. There were also areas of dry crusted skin</p> <p>A Resident Weekly Skin Check Sheet for Resident #19, dated 5/27/14, indicated there were no new skin issues. The check sheet did not identify the skin tear on his left wrist.</p> <p>A Resident Progress Notes for Resident</p>	F000309	<p>F 309 – D It is the intent of the facility to provide the necessary care and services to attain and maintain the highest practicable well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #19 Skin tear immediately assessed by DON, skin tear healed on 06/20/2014 without further complications. Resident #9 immediately offered and accepted shower with peri-care provided by staff. DON assessed abdomen to assure no signs/symptoms of infection and that peri-care was completed and adequate. .</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential for being affected by this practice. Current residents' care plans were reviewed and compared to the CNA care guides for accuracy and implementation by Nursing Administration and IDT (interdisciplinary team) and discrepancies were corrected immediately. Nursing staff was educated on documentation of events, skin sheets and shower process, treatment process, and order transcription process. New orders will be reviewed in the</p>	07/06/2014

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	<p>#19, dated 5/26/14 as a late entry for 5/25/14, indicated an area noted on his left wrist approximately 2 cm (centimeter) in length. The notes also indicated steri-strips were on with a Kerlix wrap when found. The notes further indicated an order for a dry dressing BID (twice a day) until healed in place.</p> <p>A Resident Progress Notes for Resident #19, dated 5/26/14 as a late entry for 5/25/14, indicated he had a skin tear on his left wrist. The notes also indicated steri-strip and dressing applied.</p> <p>The Progress Notes did not indicated what happened to cause the skin tear to the wrist of Resident #19. An assessment of the incident/injury could not be located in the clinical record.</p> <p>A physician's order for Resident #19, dated 5/25/14, indicated to apply dry dressing to area on left wrist BID until healed.</p> <p>A Resident Progress Notes for Resident #19, dated 5/29/14, indicated left wrist was healing well with dressing intact.</p> <p>During an observation on 6/3/14 at 11:30 a.m., Resident #19 was observed seated in his wheelchair in the dining room.</p>		<p>daily clinical meeting by the DON and issues followed through until resolution using the "white board" process.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Nursing staff was educated on documentation of events, skin sheets and shower process, treatment process, and order transcription process. New orders will be reviewed in the daily clinical meeting by the DON and issues followed through until resolution using the "white board" process. Care plan and care guides will be updated as needed to reflect new orders, condition change.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Care plan audit tool will be reviewed in the Performance Improvement meeting monthly x 3 and then quarterly until compliance is achieved, as determined by the committee. See Exhibits #11 and 12)</p> <p>1.CEO is responsible to ensure compliance by July 6, 2014.</p>				

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	<p>The skin tear on his left wrist was not observed to be covered.</p> <p>Resident #19 was interviewed on 6/4/14 at 3:50 p.m. During the interview he indicated staff had just put a dressing on his skin tear after lunch on 6/3/14.</p> <p>During an observation on 6/5/14 at 8:35 a.m., Resident #19 was observed in his wheelchair in the dining room. The skin tear on his left wrist was not observed to be covered.</p> <p>During an observation on 6/5/14 at 1:45 p.m., Resident #19 was observed resting in bed. The skin tear on his left wrist was not observed to be covered. During the observation he indicated the skin tear had been seeping on 6/4/14.</p> <p>The Director of Nursing was interviewed on 6/5/14 at 8:58 a.m. During the interview she indicated when a temporary care plan was highlighted in yellow, it meant to temporary problem was resolved.</p> <p>A facility Care Plan Temporary Problems for Resident #19, dated 5/25/14, indicated the problem area of skin tear. Approaches to the problem indicated to keep area clean and watch for signs/symptoms of infection. The</p>			

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	<p>temporary care plan was not highlighted in yellow.</p> <p>The Director of Nursing was interviewed on 6/5/14 at 1:45 p.m. During the interview she indicated the nurse on duty did not complete a Resident Event Report Worksheet, which described event details, event nature, and event adverse effect for the skin tear on Resident #19's wrist. She also indicated the skin tear should have been assessed.</p> <p>The Director of Nursing was interviewed on 6/6/14 at 10:14 a.m. During the interview she indicated the skin tear for Resident #19 actually measured 5 cm.</p> <p>A current facility policy "Patient Assessment", dated 4/26/14 and provided by the Administrator on 6/5/14 at 5:23 p.m., indicated "...Patient data is collected on data collection and/or assessment forms...to individualize and direct patient care...Patient data collected so an analysis/evaluation of the patient's physical and mental condition or abilities may be determine by the appropriate discipline...Data may include, but is not limited to: skin...."</p> <p>2. Review of the clinical record for Resident #9 on 6/4/14 at 1:20 p.m.,</p>			

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	<p>indicated the following: diagnoses included, but were not limited to, cellulitis of abdomen and legs, diabetes, diabetic foot wounds, peripheral neuropathy, CHF (congestive heart failure), HTN (hypertension or high blood pressure) Atrial Fibrillation, COPD (chronic obstructive pulmonary disease), obesity and gout.</p> <p>Resident #9 was interviewed on 06/03/2014 at 2:49 p.m., and indicated he had cellulitis and a yeast infection under his abdomen fold and indicated he had to go to the emergency room a few weeks ago because it became blood red. He indicated the nursing staff do not always wash under his abdomen or peri area every shift as they are supposed to do. He indicated he does not need assist to go to the bathroom, but he does need assist to clean these areas.</p> <p>A Review of Resident's #9 Nurse's Progress Notes indicated the following:</p> <p>-On 5/21/14 at 10:30 a.m., "...Residents abdomen warm, red, tender to touch. MD notified by Night Nurse...Blood Sugar log also sent to MD office for review per order..."</p> <p>-On 5/21/14 at 3 p.m., "...Res came back from wound clinic. No new orders.</p>			

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	<p>Continue same treatment, next appointment 5/28/14 at 1:30 p.m.. Changed dressing to L great toe due to bandage soaked through with blood. Res tolerated well...."</p> <p>-On 5/21/14 at 4:15 p.m., "...Called MD about Resident's having possible cellulitis. N.O. (New Order) Clindamycin (an antibiotic) 300 mg q (every) 6 hr (hours) for 10 days. PT/INR (blood test for bleeding time) q 3 days while on ATB (antibiotic). Pharmacy faxed. Resident/Family aware...."</p> <p>-On 5/21/14 at 5:45 p.m., "...Resident's spouse picked up the Resident to go to ER per MD per Spouse...."</p> <p>-On 5/21/14 at 8:30 p.m., "...Resident return from ER (Emergency Room). N.O. for Econazole 1% cream (an antifungal medication) apply topically BID(2 times a day) for 4 weeks. Continue ATB, T (temperature) - 98.6 degrees F. (Fahrenheit, a measurement of temperature), Pharmacy faxed. Resident/Family aware. Resident needs bathed/bed bath once per shift to help with Candidiasis...."</p> <p>-On 5/22/14 6 a.m., "...Continues on ATB, T- 98.4 degrees F. No reaction to medication. Abdomen red with edema</p>			

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	<p>(fluid retention). Denies pain/discomfort...."</p> <p>-On 5/22/14 at 1:45 p.m., "...T - 100.5 degrees F. Continue on ATB for cellulitis of abdomen. No reaction noted. Abdomen red and has edema. PRN (as needed) Vicodin (a pain medication) given at 10 am for c/o (complaint of) general pain and helpful for c/o general pain...."</p> <p>-On 5/23/14 at 2:30 p.m., "...Continue on ATB for cellulitis to abdominal area. Continue with increased edema and light redness....No adverse effect from ATB T-98.6 degrees F.. Encouraged to keep feet elevated...."</p> <p>-On 5/24/14 at 2 p.m., "...98.0 degrees F. Continue on ATB therapy r/t (related to) cellulitis in abdomen with no adverse effects noted. Treatment continue to abdominal folds. Redness remains. Seen by MD review and noted to do PT/INR today. Resident/POA (Power of Attorney) aware...."</p> <p>-On 5/26/14 at 11 p.m., "...No c/o pain. Abdominal fold red. Resident compliant with care...."</p> <p>-On 5/27/14 at 6 a.m., "...Continues on ATB therapy r/t cellulitis of abdomen</p>			

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	<p>with no adverse effects noted. Slight redness remains. No c/o voiced...."</p> <p>-On 5/28/14 at 4 p.m., "...Returned from wound clinic...N.O. continue with orders...."</p> <p>A review of the CNA Flow Sheet Record on 6/4/14 at 2:00 p.m., indicated Resident #9's shower days were on Wednesdays and Saturdays. Also indicated peri care every shift and as needed. The June 2014 CNA flow sheet indicated Peri care was not documented on 6/1/14 1st shift, 6/3/14 3rd and 2nd shifts.</p> <p>An interview with DON on 6/4/13 at 2:40 p.m., indicated Resident #9 was seen at (local Wound clinic) on 5/21/14 and indicated the Resident's abdominal cellulitis was dx at wound appointment and the MD ordered Clindamycin (an antibiotic). She indicated he finished the Clindamycin on 6/2/14. She indicated Dr [Name] wanted Resident to be seen in ER and Resident's wife took him to the ER (Emergency Room). She also indicated the Physician ordered Econazole Topical Cream 1% (an antifungal) to be applied to the affected areas (Resident #9's abdominal fold). The DON indicated Resident #9 had a History of cellulitis in his abdominal fold and legs. She also indicated a history of MRSA (methacillin</p>			

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	<p>resistant staphylococcus Aurous, a multi drug resistant bacteria), and indicated today, 6/4/14 the lab results show MRSA again in the diabetic toe wound and the Resident was being moved to a private room and placed on isolation and started on Doxycycline 100 mg (milligrams) orally every 12 hours for 14 days. The DON indicated the Resident was not always compliant with treatments.</p> <p>An interview with DON on 6/5/14 at 10:30 a.m., indicated the CNA's are to assist Resident #9 with bed bath or peri care every shift. She indicated Resident #9 often refuses. She reviewed the June 2014 CNA Care Flow Sheets and indicated she could not determine if care was missed or refused because nothing was documented on the flow sheet for peri care on 6/1/14, 1st shift and 6/3/14, 3rd and 2nd shifts. She indicated the CNA should have documented if peri care was refused and it should have been reported to the nurse.</p> <p>Review of Resident #9's March, April and May 2014, CNA Flow Sheet Records provided by the DON on 6/5/14 at 11:16 a.m., indicated Peri care was not documented for 22 shifts in March 2014, 1 shift in April 2014, and 2 shifts in May 2014.</p>			

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	<p>An observation of LPN #30 providing MD ordered Treatment to skin for Resident # 9 on 6/5/14 at 1:10 p.m. included the following: LPN #30 cleansed Resident #9's skin under abdominal fold. Skin washed gently with soap and water, rinsed and patted dry. The nurse then applied Nystatin Powder to the skin under the abdominal fold. Resident #9's skin was pink without open areas in skin. An interview with LPN #30 indicated skin was much improved, she indicated the skin was very red and sore and an interview with Resident #9 indicated as long as the area was washed and the powder was applied every shift the skin will stay good. The LPN then indicated there was not an end date to Nystatin Powder treatment and they will continue to apply as long as needed and as a preventive treatment.</p> <p>Review of the Nursing Care Plans on 6/4/14 at 2:30 p.m. indicated, "...Problem of Non Pressure Skin deficit.... Approaches indicated the following: Weekly skin assessment; Follow MD orders for skin care and treatment; Monitor for signs and symptoms of infections; Assess pain/comfort level...."</p> <p>3.1-37(a)</p>			

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the beauty shop door was locked and the beauty shop chemicals were secured while unattended. This affected the safety of 11 confused and independently mobile residents of 55 who resided in the facility.</p> <p>Findings include:</p> <p>1. During the initial tour of the facility on 6-2-2014 at 9:50 a.m., the beauty shop door was unlocked and the beauty shop was unattended. The beauty shop had products sitting on the counter next to the</p>	F000323	<p>F 323 –E It is the intent of the facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility Beauty Shop was secured on 06/05/2014 and door knob replaced with self-locking mechanism and no residents were injured.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	07/06/2014

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	<p>shampoo bowl which included the following, shampoo, conditioner, hair spray, disinfectant cleaner, a can of cool care blue for clippers, 3 unlabeled bottles-one with blue liquid inside and 2 bottles with clear liquid inside. An unlocked drawer contained 4 pair of scissors, an unlocked door contained barbicide and an unlocked cart contained another bottle of barbicide.</p> <p>2. An observation on 6-2-2014 at 11:42 a.m., indicated the beauty shop was unlocked and unattended. The following items were out on the counter:</p> <ul style="list-style-type: none"> <li>- A 33.8 ounce bottle of styling gel.</li> <li>- A 128 ounce container of salon care professional shampoo sparkling apples and pears with a caution printed on the label: "use only as directed...keep out of reach of children...."</li> <li>- A 34.5 ounce bottle of super setting lotion with a caution on the label: "...keep out of reach of children...."</li> <li>- A 13.5 ounce of conditioner.</li> <li>- An 11 ounce spray can of hairspray with a warning printed on the label indicated, "...Flammable...keep out of reach of children...use only as directed...intentional misuse by deliberately concentrating and inhaling contents can be harmful or fatal..."</li> <li>- A 33.8 ounce bottle of tea tree oil</li> </ul>		<p>action will be taken; All resident had the potential to be affected. Doors will be secured at all times when Beauty Shop is not in use and/or staff is not present.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; CEO and/or designee will perform daily round check list in the facility to ensure that doors are locked that contain any potential hazard to residents. Additionally, CEO/DON will randomly monitor secured to ensure resident safety. All staff educated regarding securing all locked doors when not in use/supervised.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Maintenance to perform door security checks daily x7 days, weekly x 3 and then monthly x 3 and report compliance to Performance Improvement Committee. Door security will be placed on the Safety Committee Agenda for review monthly x3 to ensure compliance. (See Exhibit #13)</p> <p>1.CEO is responsible to ensure compliance by July 6, 2014.</p>	

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	<p>shampoo.</p> <ul style="list-style-type: none"> <li>- A 33.8 ounce bottle of daily conditioner.</li> <li>- A 15.5 ounce spray can of cool care plus coolant, disinfectant, lubricant, cleaner rust preventative for clipper blades with a warning on the label "...keep out of reach of children...hazards to humans and animals...causes eye irritation...do not get in eyes...avoid contact with skin...prolonged or frequently repeated skin contact may cause allergic reactions in some individuals...avoid contamination of foodstuff..."</li> <li>- A spray bottle of disinfectant cleaner with a label which indicated "...caution!...may cause eye, skin, nose and throat irritation...keep out of reach of children...avoid eye and skin contact...avoid breathing vapor mist or spray...do not ingest...use only with adequate ventilation...wash thoroughly after handling...."</li> <li>- 2 spray bottles (one with a black sprayer with 1/2 full of clear liquid and one with a purple sprayer and 13 ounces of clear liquid) of unidentified liquid.</li> <li>- 1 unidentified squirt bottle with 6 ounces of blue liquid.</li> <li>- Inside an unlocked drawer was a small tube 1/4 of an ounce of lubricating oil for electric clippers with a label that indicated "...Caution...Keep out of reach</li> </ul>			

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	<p>of children...harmful or fatal if swallowed...."</p> <p>- Another tube of .33 ounce clipper oil was in the unlocked drawer and had a label which indicated "...danger...harmful or fatal if swallowed...keep out of reach of children..."</p> <p>- Inside an unlocked cabinet were 3 pairs of scissors and 1 pair of switch-blade shears.</p> <p>- Inside another unlocked cabinet was a 16 fluid ounce bottle of barbicide with a label which indicated, "...Danger...Keep out of Reach of Children...corrosive...causes irreversible eye damage, and skin burns...harmful if swallowed...avoid contamination of food, wear eye protection (face shield and or goggles), protective clothing, and rubber gloves when handling...wash thoroughly with soap and water after handling and before drinking or using tobacco...."</p> <p>- In an open, upper cabinet, the following products were located on the shelves, a box each of an extra body and variable action perms with a safety warning which indicated "keep out of reach of children", 2 - 10.14 ounce bottles of color protect daily conditioner, a 16 fluid ounce bottle of extra lift volume crème with a label warning which indicated, "...Keep out of reach and sight of children...." The label also indicated "...contains hydrogen peroxide...."</p>			

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	<p>- A 9 ounce bottle of fanci-full temporary hair color 23 frivolous fawn with a label that indicated "...Warning "...this product contains ingredients which may cause skin irritation on certain individuals...must not be used for dyeing eyelashes or eyebrows; to do so may cause blindness...."</p> <p>- A 16 ounce bottle of fanci-full rinse (51 demure mist) with a label which indicated "...Caution this product contains ingredients which may cause skin irritation on certain individuals...must not be used for dyeing eyelashes or eyebrows; to do so may cause blindness...."</p> <p>- An opened box of color (light brown 51) with a label which indicated "warning...keep out of reach of children...."</p> <p>- In an unlocked cart by the hair dryer , the following products were located inside, a 16 ounce bottle of barbicide, a 16 ounce bottle of dissolve floor cleaner with a label which indicated to "keep out of reach of children", 2 boxes of color brilliance (dark intense blond and medium intense blond) with a label which indicated to "...keep out of reach of children...", and an orange spray bottle with an unidentified liquid.</p> <p>3. An observation on 6-2-2014 at 4:40</p>			

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	<p>p.m., indicated the beauty shop door was unlocked and unattended.</p> <p>4. An observation on 6-3-2014 at 8:59 a.m., indicated the beauty shop door was unlocked and unattended.</p> <p>5. An observation on 6-4-2014 at 9:25 a.m., indicated the beauty shop door unlocked and unattended.</p> <p>6. An observation on 6-5-2014 at 9:58 a.m., indicated the beauty shop door unlocked and unattended.</p> <p>7. During an interview with the Administrator on 6-5-2014 at 10:00 a.m., the Administrator indicated the beauty shop door was to be locked at all times except when housekeeping was to clean the beauty shop. The Administrator indicated housekeeping cleaned the beauty shop everyday. During the interview with the Administrator, there was not a housekeeping cart observed in the vicinity of the the beauty shop. The Administrator indicated she was not aware the beauty shop door had been unlocked while unattended. The Administrator indicated 11 residents who resided in the facility were independently mobile and were confused.</p> <p>A policy, "Beautician/Barber" dated</p>			

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F000325 SS=G	<p>10-31-2006 and provided by the Administrator on 6-5-2014 at 10:29 a.m., indicated "...store chemicals in a safe secured cabinet...."</p> <p>3.1-45(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to re-assess, develop, and implement dietary interventions for 2 residents (Resident #58 and Resident #13 ) of 4 residents who met the criteria for being underweight and/or not</p>	F000325	F 325 – G 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #58 and Resident #13 reside in facility. Physician has	07/06/2014

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	<p>receiving a supplement and/or preventative interventions to prevent further weight loss. This deficient practice resulted in a severe weight loss for Resident #58 and a significant weight loss for Resident # 13.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #58 on 6/4/14 at 2:37 p.m., indicated the following: diagnoses included, but were not limited to, generalized anxiety, depressive disorder, and edema.</p> <p>Resident #58 was admitted to the facility on 1/15/14.</p> <p>Facility weights for Resident #58 indicated the following: 258 pounds on 1/15/14, 258.2 pounds on 1/21/14, 259 pounds on 1/28/14, 258 pounds on 2/22/14, and 259 pounds on 3/7/14.</p> <p>Physician orders for Resident #58, with a start date of 1/15/14, indicated he received a Regular Diet and Lasix 40 mg daily for edema.</p> <p>A Medical Nutrition Therapy Assessment for Resident #58, dated 1/15/14, indicated he received a Regular Diet with an admission weight of 258 pounds.</p>		<p>evaluated both residents and has updated progress notes accordingly. Resident #58 weight loss has been attributed to diuretic use and his weight loss has been determined desirable by the attending physician. Resident #13 weight has been stabilized since May 5th, 2014 and continues on weekly weights with interventions as warranted.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All other residents have the potential to be affected, therefore the facility has hired a contracted Registered Dietician and 100% of residents have been assessed by 6-23-2014 and appropriate recommendations made.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Nursing staff will be educated on the Weight system of Signature Healthcare by DON on 06/26/2014 and on communication between nursing and dietary to ensure order accuracy. New orders will be reviewed in the daily clinical meeting to ensure communication to RD/DM and appropriate physician/ family notification of changes. Maintenance will validate scale calibration weekly through preventative</p>	

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	<p>The assessment also indicated a BMI (Body Mass Index) of 35.9, which indicated he was overweight for his height. The assessment further indicated an average food/beverage intake of 75% to 100%. The nutrition goal for Resident #58 was no significant weight change through next review.</p> <p>Review of the Medicare Documentation Worksheets for Resident #58, dated from 1/16/14 through 3/31/14, indicated he had edema present in his bilateral lower extremities.</p> <p>Review of the Individual Resident Meal Intake Record for Resident #58, dated for January, 2014, February, 2014, and March, 2014, indicated he generally consumed 100% of his meals.</p> <p>Facility weights for Resident #58 indicated the following: 237.5 pounds on 4/15/14 and re-weigh on 4/16/14 ( a loss of 21.5 pounds or 8.3% since 3/7/14), and 234.5 pounds on 4/21/14 ( a loss of 24.5 pounds or 9.45% since 3/7/14).</p> <p>A Medical Nutrition Therapy Assessment Change of Condition for Resident #58, dated 4/9/14 - 4/15/14, indicated a weight of 238 pounds, or a severe weight loss of 8.1% in 1 month. The assessment also indicated his weight</p>		<p>maintenance rounds. Dedicated staff will be assigned to weigh patients and reweights will be done within 24 hours and validated by charge nurse. Dietary manager has reconciled physician orders/supplements to dietary records for validation. RD assessments have been completed by 06/23/2014 and care plans have been updated as appropriate. Facility will conduct weekly Nutrition at Risk meeting, led by the RD to address nutritional needs of resident population.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Weight program performance improvement tool will be reviewed monthly x 3 and then quarterly thereafter with review of plan of correction to ensure compliance. See Exhibit #14)</p> <p>1.RD/ DON/ CEO is responsible to ensure compliance by July 6, 2014.</p>	

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	<p>was down from 259 pounds in 30 days, but still remained above his Ideal Body Weight of 172 pounds to 189 pounds. The assessment further indicated he had edema and was prescribed Lasix. The assessment also indicated his intakes were variable. The assessment recommended if weight loss decreased into May, 2014, would recommend adding supplements at that time.</p> <p>An Individual Resident Meal Intake Record for Resident #58, dated for April, 2014, indicated he consumed between 25% to 100% of his meals.</p> <p>A Patient Weekly Skin Check Sheet for Resident #58, indicated edema was present on the weeks of 4/6/14, the weeks of 4/20/14, and the weeks of 4/27/14.</p> <p>Facility weights for Resident #58 indicated the following: 231.5 pounds on 5/5/14 (a loss of 28 pounds or 10.61% since 3/7/14), 235 pounds on 5/12/14, and 229 pounds on 5/19/14 (a loss of 30 pounds or 11.58% since 3/7/14).</p> <p>A Dietary Progress Note for Resident #58, dated 5/30/14, indicated a current weight of 225.8 pounds on 5/26/14, or a 3.8% loss in 30 days. The note also indicated a BMI of 31.4 which continued to place him as obese, but a significant</p>						

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	<p>weight loss was not desirable. The note further indicated he remained on a Regular diet and continued to receive Lasix for his continuing edema. The note further indicated the recommendation of shakes at breakfast and supper.</p> <p>An Individual Resident Meal Intake Record for Resident #58, dated for May, 2014, indicated he consumed between 25% to 100% of his meals.</p> <p>A Patient Weekly Skin Check Sheet for Resident #58, indicated edema was present on the week of 5/27/14.</p> <p>Observations were made during the lunch meal on 6/2/14, 6/3/14, 6/4/13, and 6/5/13. During each observation Resident #58 was eating his meals in his room in bed. His meal tray was placed on an over-the-bed table. He was observed to eat his meals alone. His appetite was estimated as fair.</p> <p>Based on the facility Individual Resident Weight History, Resident #58 had lost 33.2 pounds or 12.81% from 3/7/14 to 5/26/14, or less than 90 days. Calculations indicated Resident #58 experienced a severe weight loss.</p> <p>A facility care plan for Resident #58, with a start date of 1/24/14 and a revision</p>			

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	<p>date of 4/21/14, indicated the problem area of obesity, intake below 75% of meals, edema to bilateral lower extremities. A goal to the nutrition care plan was for the resident to have no significant weight changes. Approaches to the problem included, but were not limited to, diet per order, weigh resident per MD order or policy, nutritional supplements/snacks per MD order, honor food preferences within reason, and encourage intake of meals.</p> <p>A physician's order for Resident #58, dated 6/3/14, indicated to add Health Shake at breakfast and supper.</p> <p>A meal tray card for Resident #58, provided by the Certified Dietary Manager (CDM) on 6/5/14 at 9:50 a.m., did not indicate he received a Health Shake with breakfast and supper. When queried, she indicated anything special a resident was to receive at mealtime was listed on the meal card.</p> <p>The Director of Nursing was interviewed on 6/5/13 at 11:18 a.m. During the interview she indicated if a resident was on the Skilled Unit, Medicare required charting daily. She also indicated Resident #58 was moved from Skilled on 3/31/14. She further indicated nursing would then chart on the Resident</p>			

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	<p>Progress Notes any conditions of the resident.</p> <p>LPN #30, a nurse on the Center Wing, was interviewed on 6/5/14 at 2:56 p.m. During the interview she indicated Resident #58 was admitted with edema and has continued to have edema since his admission.</p> <p>The Administrator and Director of Nursing were interviewed on 6/5/14 at 3:16 p.m. During the interview they indicated the Registered Dietitian who was with the facility at the time of Resident #58's severe weight loss was no longer under contract with the facility.</p> <p>The CDM was interviewed on 6/6/14 at 10:18 a.m. During the interview she indicated the Registered Dietitian made recommendations for any supplements. She also indicated the Registered Dietitian would then provide the recommendation to nursing who would send the recommendation to the physician for his/her approval. She further indicated nursing would send a communication form to dietary for implementation. When queried, the CDM indicated she had not received any communication form from nursing concerning the order for health shakes for Resident #58.</p>			

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	<p>A current facility policy "Weight Evaluation and Intervention Guide", dated 4/28/13 and provided by the CDM on 6/5/14 at 5:23 p.m., indicated "...Interventions for Unintended significant or insidious weight loss...Assess nutritional status; consider risk factors...Assess food likes/dislikes &amp; make appropriate accommodations...Provide physical assistance, verbal instruction (e.g., curing) and/or social stimulation at meals and snacks...Monitor weight more frequently...Provide additional calories...Increase Caloric density of meals with whole milk, large portions, 7/or fortified foods, etc...Caloric dense medical food supplement (i.e., 2 calories/ml) at med pass...Caloric dense snacks between meals...Caloric dense, medical food supplements between meals...When evaluating weight loss, consider if the patient was edematous when initially weighted and, with treatment, no longer has edema...."</p> <p>2. On 6/5/14 at 2:00 P.M., the clinical record of Resident #13 was reviewed. Diagnoses included, but were not limited to, the following: vascular dementia with depression, depressive disorder, lack of coordination; muscle weakness, esophageal reflux, malaise and fatigue,</p>			

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	<p>generalized pain; hypothyroidism and cerebrovascular accident. An MDS (minimum data set), dated 2/20/14, included, but was not limited to, the following: cognitive status was identified as severe cognitive impairment and was independent with eating.</p> <p>At the time, the weight log in the clinical record indicated the following weights: 1/10/14: 140 lbs (pounds) 2/22/14: 141 lbs 3/17/14: 137.6 lbs 4/7/14: 138 lbs 5/5/14: 131 lbs 5/8/14: 131 lbs</p> <p>A physician order dated 1/20/14 indicated the following: "Healthshake, 1 dly (daily) with lunch for supplement."</p> <p>On 6/5/14 at 4:07 P.M., the FSM (food service manager) was interviewed. She indicated the following: The resident was on a regular diet. She indicated on 1/20/14 the resident was started on health shakes, one daily at lunch. The FSM indicated the resident had a significant weight loss from 4/7/14 to 5/8/14. The FSM indicate the weight loss to be 5.072% in one month.</p> <p>At this time the FSM documented a weight of 131 lbs dated 6/2/14, and for</p>			

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	<p>5/26/14, she documented a weight of 131 lb. The FSM indicated the resident was reweighed on 5/7/14 and the weight was 131 lb. She indicated the resident was currently on weekly weights. She indicated at this time, she thought the RD (registered dietician) had written the weekly weights in the resident's clinical record, but the RD had not done this. The FSM indicated at the time, the last intervention put in place to address weight loss was the health shake, in January 2014. The FSM indicated there had been no new interventions put into place to address the significant weight loss which had been identified on 5/5/14. The FSM indicated the plan to prevent weight loss was to add another health shake daily for the resident to take. The FSM indicated she thought the Dietician was going to do this the next Monday. Documentation was lacking of weekly weights having been done from 5/8/14 - 5/26/14.</p> <p>The FSM indicated that for the last month the residents weight had been at 131 lbs. The FSM indicated the former Dietician left the facility in April 2014 and the current dietician started at the facility on 5/22/14. The FSM indicated she and the Director of Nursing "took care of the weights during this time."</p>			

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	<p>At the time, the FSM provided a copy of the Dieticians note, dated 5/22/14. The note included, but was not limited to, the following: "Resident (#13) with sig (significant) wt (weight) loss at 30 days. Wkly (weekly) wt 5/8 131#, recently some depression, meds (medications) adjusted...Stable, started on health shakes at lunch...f/u (follow up) with further sig (significant) changes. RD (registered dietician f/t prn (as needed)..Recommendations: Wkly (weekly) weights r/t (related to) sig (significant) loss at 30 days; Resident prefers vanilla and strawberry health shakes..."</p> <p>A plan of care dated 5/22/14 included the following: "addressed problem: "Resident with sig wt loss at 30 days...Goal: wt will remain 131# +/- 5 pounds thru next review. Approaches: healthshake at lunch."</p> <p>A Care Plan Conference Summary dated 6/5/14, included but was not limited to, the following: "Wt (weight) 131 lb. Has had a signif (significant) wt (weight) change x 6 months...Care plan conference discussion:...Res (resident) is on weekly weights, receives healthshakes at lunch, receives reg diet."</p> <p>On 6/6/14 at 12:03 P.M., the</p>			

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F000329 SS=D	<p>Administrator (Adm) and Director of Nursing were interviewed. The Adm indicated the Dietician would come to the facility next week. The DON indicated the resident had been a little depressed as her roommate left the facility right before Christmas.</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review the facility failed to provide clinical rationale for the use of a mood stabilizer and/or</p>	F000329	F 329- D It is the intent of the facility to provide clinical rationale for the use of a mood stabilizer and/or provide documentation of	07/06/2014			

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	<p>provide documentation of an attempted gradual dose reduction for 2 of 5 residents reviewed for unnecessary medication. Resident #49 and Resident #33</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #49 on 6/4/14 at 9:32 a.m., indicated the following: diagnoses included, but were not limited to, anxiety state and depressive disorder.</p> <p>Resident #49 was interviewed on 6/3/14 at 8:39 a.m. During the interview she indicated she was most comfortable staying in her bed.</p> <p>A Minimum Data Set assessment for Resident #49, dated 3/20/14, indicated a score of 15 out of 15 on the Brief Interview for Mental Status, indicating she was cognitively intact.</p> <p>Physician orders for Resident #49, dated for the month of November, 2013, indicated she received Zoloft 75 mg (milligrams) daily for depression (with a start date of 1/24/12), Ativan 0.5 mg q (every) 8 hours PRN (as needed) for anxiety (with a start date of 7/4/12), and Ativan 0.5 mg HS (hour of sleep) for anxiety (with a start date of 8/27/13).</p>		<p>an attempted gradual dose reduction for residents reviewed for unnecessary medication.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents # 49 and #13 have had their medications reviewed by the attending physician and pharmacy consultant for possible of gradual dose reduction. .</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents receiving mood stabilizers have had their medication regimen's reviewed for GDR (gradual dose reduction) on 6-9-2014 by the DON, CEO, Geri-psych Nurse Practitioner, and Pharmacist, recommendations made, and care plans/behavior monitoring tools/care guides have been updated.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Nursing staff will be educated on Behavior Monitoring by Social Service Director and with regards to the documentation of resident behaviors and non-pharmacological interventions. New orders will be reviewed daily in the clinical meeting and will be followed</p>	

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	<p>Monthly Behavior Monitoring Flowsheets for Resident #49, dated for the months of November, 2013, December 2013, January, 2014, February, 2014, and through March 9, 2014, indicated the target behaviors of tearfulness, verbal aggression, and refusing care were being followed. The flowsheets also indicated the diagnoses of anxiety and depression and the psychoactive medications of Ativan and Zoloft. The flowsheets further indicated only one episode of tearfulness and verbal aggression occurred in the month of November, 2013. The flowsheets did not indicate any episodes of tearfulness, verbal aggression or refusing care in December, 2013, January, 2014, February, 2014, and through March 9, 2014.</p> <p>Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review for Resident #49, indicated the following: for November, 2013 - 1 episode of tearfulness and verbal aggression; for December, 2013 - behaviors had decreased; for January, 2014 - behaviors were stable and no changes were recommended; and for February, 2014 - behaviors were stable.</p>		<p>utilizing the "white board" process. Care plan and care guides will be updated as needed to reflect new orders, condition change. Facility will continue with monthly Behavior meeting, and will include the geriatric nurse practitioner and the pharmacy to review medication regimen for unnecessary medications and potential gradual dose reduction.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Pharmacy consultant will report on status of gradual dose reduction as a part of monthly Performance Improvement Committee pharmacy report, which is a regular agenda item. It is important to note, that facility has secured a new pharmacy consultant, who will be engaged with the facility processes going forward. (See Exhibit #15)</p> <p>1.CEO is responsible to ensure compliance by July 6, 2014.</p>				

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	<p>Resident #49 was hospitalized from 3/9/14 through 3/16/14.</p> <p>Physician orders for Resident #49, dated March 17, 2014, indicated Zoloft 75 mg daily for depressive disorder, Ativan 0.5 mg q 8 hours for anxiety, and Ativan 0.5 mg HS for anxiety.</p> <p>A Resident Progress Notes for Resident #49, dated 3/24/14 and written by Social Service, indicated she scored a 15 out of 15 on the Brief Interview for Mental Status, indicating she was cognitively intact. The note also indicated she "...denied any thoughts that she would be better off dead, delusions, or hallucinations. No behavioral symptoms, rejection of care, or wandering...."</p> <p>The Monthly Behavior Monitoring Flowsheets for Resident #49, dated from March 17, 2014 through April 23, 2014 did not indicate any episodes of tearfulness, verbal aggression or refusing care.</p> <p>A Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review for Resident #49, dated 4/14/14, indicated she continued to receive Zoloft 75 mg daily for depressive disorder, Ativan 0.5 mg q 8 hours PRN for anxiety state, and Ativan</p>			

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	<p>0.5 mg HS for anxiety state. The review also indicated she was in the hospital from 3/9/14 to 3/16/14, refused to get out of bed and had a negative attitude. The review further indicated to add Depakote 125 mg for mood disorder, to increase Zoloft to 100 mg daily for depression/anxiety, and to decrease Ativan 0.5 mg to Ativan 0.25 mg 1 x daily PRN. There was no evidence non-pharmacological interventions were tried prior to the addition of the Depakote.</p> <p>A physician's order for Resident #49, dated 4/15/14, indicated the following: start Depakote 125 mg BID for mood disorder, continue Zoloft 75 mg qd (every day) for depression/anxiety, and Ativan 0.5 mg PRN q 8 hours for anxiety.</p> <p>Review of Medicare Documentation Worksheet for Resident #49, dated 3/18/14 through 3/27/14 did not indicate any signs/symptoms of mood/depression. The worksheets only indicated Resident #49 declined to get out of bed.</p> <p>Review of Resident Progress Notes for Resident #49, dated 3/28/14 through June 5, 2014 did not indicate any signs/symptoms of mood/depression. The notes only indicated Resident #49 declined to get out of bed.</p>			

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	<p>A Mood and Behavior Communication Memo for Resident #49, dated 4/24/14, indicated she was loud and rude to staff.</p> <p>The Monthly Behavior Monitoring Flowsheets for Resident #49, dated from April 25, 2014, for the month of May, 2014, and through June 4, 2014, did not indicate any episodes of tearfulness, verbal aggression or refusing care. The flowsheets did not include the target behavior of mood disorder, the diagnosis of mood disorder, or the medication of Depakote.</p> <p>Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review for Resident #49, indicated the following: for April, 2014 - behaviors were stable. The review did not include the addition of Depakote.</p> <p>The Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review for Resident #49 had not been completed for May, 2014.</p> <p>The Behavior/Interventions Monthly Flow Record for Resident #49, did not indicated any tearfulness, verbal aggression, or refusing care on June 1, 2014 through June 4, 2014.</p>			

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	<p>A Medication Administration Record for Resident #49, dated for June, 2013, indicated she received Depakote 125 mg BID for mood disorder, Zoloft 75 mg daily for depressive disorder, Ativan 0.25 mg q HS for anxiety, and Ativan 0.5 mg q 8 hours PRN for anxiety.</p> <p>A facility care plan for Resident #49, with a start date of 6/6/12 and a review dated of 4/10/14, indicated the problem area of resident suffers from chronic anxiety. Approaches to the problem included, but were not limited to, medications as ordered, monitor signs/symptoms of anxiety, and notify family &amp; physician as needed.</p> <p>A facility care plan for Resident #49, with a start date of 12/19/13 and a review date of 4/30/14, indicated the problem area of psychotropic drug use related to diagnosis of anxiety and depression with distressing behaviors of verbally aggressive, resisting/refusing needed care, and tearfulness. Approaches to the problem included, but were not limited to, attempt to address/rule out potential contributing factors, administer medication as prescribed by the physician, monitor for effectiveness of medication, observe for physical and verbal behavioral symptoms, report to</p>			

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	<p>physician any noted side effects or adverse reaction associated with use of drug, and review with IDT (Interdisciplinary Team) for GDR as indicated.</p> <p>The facility drug reference PharMerica 2014, indicated Depakote may be used for mania with bipolar disorder. The drug reference did not indicated the use of Depakote for mood disorder.</p> <p>The Administrator and Director of Nursing were interviewed on 6/5/14 at 3:16 p.m. During the interview they indicated Resident #49 displayed more depression and declined to get out of bed upon her return from the hospital.</p> <p>The Social Service Director was interviewed on 6/6/14 at 9:40 a.m. During the interview she indicated she had only been the social service representative since May, 2014. She further indicated behavior meetings were held every month when the Psych Nurse Practitioner and the team could get together, discuss resident behaviors, and develop plans. When queried she indicated Resident #49 liked to stay in her room and do things her way.</p> <p>The Administrator and Director of Nursing were interviewed on 6/6/14 at</p>				

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	<p>3:00 p.m. During the interview they indicated staff had not documented the increase in depression or change in mood for Resident #49.</p> <p>A current facility policy "Antipsychotic/Psychoactive Medication", dated 5/23/13 and provided by the Administrator on 6/6/14 at 2:27 p.m., indicated "...Antipsychotic medications are used for organic mental syndromes with associated psychosis and/or distressing behaviors...The information material concerning psychotherapeutic drug should include:...The reasonable alternative treatment and risks, and why the health professional is recommending this particular treatment,, Gradual dose reductions consist of tapering the patient's daily dose to determine if the patient's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether...Implement a behavior monitoring log or similar mechanisms to document need for an response to drug therapy...Identify evidence for other possible reasons for the patient's distress has been considered and ruled out...Attempt alternative methods to psychoactive drug use and document effectiveness...Consider modifying monitoring approaches when the patient experiences changes, if</p>						

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	<p>necessary...Patient changes may include, but are not limited to: a. Acute onset of signs or symptoms or worsening of chronic disease b. Decline in function or cognition c. Addition or discontinuation of medications and/or non-pharmacological intervention...Document care plan interventions as developed for patient..."</p> <p>2. A review of the clinical record for Resident #33 began on 6-5-2014 at 1:59 p.m., and indicated diagnoses included but were not limited to, atrial fibrillation, coronary artery disease, cerebral vascular accident with left hemiplegia (stroke with left sided paralysis), depression, diabetes, hypertension, hypo-manic with aggression, seizure disorder, vascular dementia with delusions</p> <p>The April 2014 recapitulation was signed on 4-3-2014 by the physician and indicated Resident #33 was prescribed Prozac 20 mg (milligrams)/5 ml (milliliters) liquid and to give 20 mg enteral daily for depressive disorder and anxiety and valproic acid 250 mg/ 5 ml liquid give 5 mls enteral three times daily for mood stabilizer.</p> <p>A review of the "Psychotropic Drug Log" provided by Social Services on 6-6-2014 at 9:32 a.m., indicated Resident #33 was</p>			

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	<p>started on Prozac 20 mg (milligrams) enteral daily on 1-27-2011 for depressive disorder/anxiety and on 1-30-2012 began valproic acid 250 mg/5 ml enteral 3 times daily for mood disorder.</p> <p>A review of the "Monthly Behavior Summary/Psychoactive Gradual Dose Reduction Reviews" for Resident #33 indicated the following:</p> <ul style="list-style-type: none"> <li>- May 2014 review indicated the resident had no behaviors, swearing or rude comments during April 2014 and a referral to the Psych Nurse Practitioner would be made.</li> <li>- April 2014 review indicated the resident had no behaviors and was stable at this time. A GDR (gradual dose reduction) was marked due 5-14 for Prozac and 9-14 for valproic acid.</li> <li>- March 2014 review indicated no physical aggression, no swearing or rude comments.</li> <li>-Feb 2014 review indicated no events for physical aggression, swearing, rude comments and delusional behavior. The notes indicated the aggression was decreased by 4 events, the swearing was decreased by 10 events and the rude comments were decreased by 9 events. A note indicated "stable at this time. The Depakote Sprinkles (valproic acid) contraindicated due to decrease [sic] in behaviors."</li> </ul>			

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	<p>-January 2014 review indicated 4 events of physical aggression, 10 events of swearing, 9 events of rude comments and no delusional behavior. The notes indicated Prozac was increased in November 2013.</p> <p>- December 2013 review indicated no events of physical aggression, swearing or rude comments and no delusional behavior.</p> <p>- November 2013 review indicated 1 event of physical aggression, 3 swearing events and 1 rude comments event and no delusional behaviors. The report indicated the resident was taking 10 mg of Prozac daily.</p> <p>A review of the Psych Nurse Practitioner notes regarding behavior indicated the following:</p> <p>- On 2-11-2014, the NP indicated the behavior meeting notes and chart were reviewed and indicated Resident #33 doing well with occasional physical aggression, swearing and rude comments. The appetite and sleep "ok." The notes indicated the resident was "up ad lib (as much as one desires) in the wheelchair, was pleasant, cursing a lot and unable to redirect-appears to be for attention."</p> <p>- On 1-14-2014, the NP indicated the behavior meeting notes and chart were reviewed and staff reported behaviors had decreased.</p>			

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	<p>-On 11-6-2013, the NP indicated the behavior meeting notes and chart were reviewed with behaviors that included negative statements, false accusations, inappropriate language, combative with staff, prefers to stay in bed with appetite and sleep "ok." The NP completed the assessment and Prozac was increased from 10 mg to 20 mg daily.</p> <p>A review of the Psychotropic Drug use care plan dated 6-8-2013 and updated last on 5-15-2014, indicated the psychotropic drug use related to diagnosis of depression (prozac), seroquel-dc'd (discontinued) - hypo mania with aggression, paranoia and delusions. Approaches included but were not limited to, attempt to address/rule out potential contributing factors, administer medications as prescribed by the physician, monitor for effectiveness of psychotropic drug to address target behavior, pursue psychiatric consultation/follow up as applicable, observe for physical and verbal behavioral symptoms directed toward others and review with IDT (Interdisciplinary Team) for GDR as indicated.</p> <p>A review of the alteration in mood care plan due to history of depression and dated 6-18-2013 was last reviewed on</p>			

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	<p>5-15-2014. Approaches included but were not limited to, document symptoms and any change in mood, monitor response and potential side effects of medications and report to the physician to assess for changes.</p> <p>An interview with Social Services on 6-6-2014 at 2:10 p.m., indicated Resident #33 had a contraindication for the depakote sprinkles (valproic acid) written by the Nurse Practitioner in February 2014 for behaviors.</p> <p>The Social Service Designee or DON (Director of Nursing) were unable to provide documentation of an attempted GDR for Resident #33 for the valproic acid (Depakote Sprinkles) that was prescribed beginning 1-30-2012.</p> <p>The facility drug reference PharMerica 2014, indicated Depakote may be used for mania with bipolar disorder. The drug reference did not indicate the use of Depakote for mood disorder.</p> <p>3.1-48(a)(6)</p>			

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F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review,</p>	F000353	F 353 – E It is the intent of this facility to have sufficient nursing	07/06/2014

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	<p>the facility failed to ensure sufficient staffing to meet the needs of the residents per 13 of 22 anonymous resident interviews and 2 of 3 families interviewed. This deficient practice had the potential to affect the 55 residents who resided in the building.</p> <p>Findings include:</p> <p>1. During the interviews held on 6-2-2014 and 6-3-2014, 13 residents were interviewed about nurse staffing and requested confidentiality regarding their comments. The confidential residents' interviews indicated the following:</p> <p>- On 6-2-2014 at 11:17 a.m., a resident indicated "the facility works short staffed."</p> <p>- On 6-3-2014 at 9:26 a.m., a resident indicated "they are short staffed, have call-offs on weekends, the staff is worn out, the staff ends up quitting" and the facility had "lost a lot of staff since the 1st of the year." Further interview with the resident at 10:36 a.m., indicated "there needs to be another CNA (Certified Nursing Assistant) to answer call lights" as the resident "waited 35 minutes last night and have had to wait up to an hour...." An additional interview with the resident indicated "the nurses work 2 halls, work 12 hours shifts" and</p>		<p>staff.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility is unable to address specific residents/ families identified due to anonymity.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All other residents have the potential to be affected; therefore every effort is being made to ensure that staffing is adequate to meet the needs of the patient population. Staffing patterns /scheduling are being evaluated by DON/CEO, in collaboration with SCC (Signature Care Consultants) and open positions are being reviewed for accuracy. Nursing staff is being educated on staffing requirements as well as perceptions being communicated to customers. White boards will be placed on each unit so that residents and family members are able to identify staff on duty and nursing hours will be displayed at the main entrance. Nursing staff will be educated by the DON/designee regarding the "call in" procedure/ policy; weekend make-up policy, as well as the facility call light policy.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure</p>				

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	<p>"no one wants to work here..."</p> <p>- On 6-2-2014 at 3:28 p.m., a resident indicated there was "not enough help" and "had a 20 minute wait" for help. Further interview with the resident on 6-5-2014 at 12:18 p.m., indicated the aide usually provided her with the bedpan and the resident used the call light when she needed toileting assistance. The resident indicated there were times she had an incontinent episode due to waiting on staff to answer the call light.</p> <p>- On 6-3-2014 at 3:06 p.m., the resident indicated the facility was "always short staffed." The resident indicated he had to wait 1 and 1/2 hours for help and that was why many residents "yell out."</p> <p>- On 6-3-2014 at 10:37 a.m., a resident indicated the "facility needs more staff", "sometimes has had to wait for a long time for the call light to be answered" which had resulted in an incontinence "accident."</p> <p>- On 6-3-2014 at 9:18 a.m., the resident indicated there was "not enough staff on 2nd and 3rd shifts, but 3rd shift is terrible." The resident indicated "wait times were 15 - 20 minutes for staff to get to the roommate and the roommate tries to get up on her own." The resident indicated she was afraid her roommate was going to get "hurt."</p> <p>- On 6-3-2014 at 11:02 a.m., a resident indicated she had to "wait for an hour to</p>		<p>that the deficient practice will not recur;</p> <p>White boards will be placed on each unit so that residents and family members are able to identify staff on duty and nursing hours will be displayed at the front nurses station. CEO will educate all Department Managers and all staff on the Grievance policy and procedure and will ensure that Grievance/concern forms are easily accessible to all residents/visitors and staff. Grievance forms will be turned in to the CEO for review, logging and given to appropriate Department Manager for resolution. Completed grievance form will be returned to the CEO within 24 hours and follow up completed. Education will also address facility Call light policy with regards to all staff being responsible for answering and expected response time. Call light audits will be performed daily x 7 days, weekly x 3, monthly x 2 and quarterly thereafter until substantial compliance achieved according to Resident Council. Additionally, Social Service Director will interview 5 residents and 2 family members weekly x 3, then monthly x2 and then quarterly thereafter to ensure that residents/families are secure in facility staffing. SSD will report any concerns to the DON/ CEO for immediate resolution. Concerns and Grievances will be a standard agenda item for the monthly Performance</p>	

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	<p>get a breathing treatment on nights." The resident indicated the wait resulted in her having a "panic attack."</p> <p>- On 6-2-2014 at 2:18 p.m., a resident indicated the facility "works short staff every day and has had to wait up to 2 hours for staff to answer her call light, which resulted in an incontinence accident." Further interview with the resident indicated she was to receive a breathing treatment QID (4 times per day) but sometimes only received it BID (2 times per day)."</p> <p>- On 6-2-2014 at 2:57 p.m., a resident indicated "one aide was assigned to too many residents" and she "had to wait an hour and a half for her nighttime pill." The resident indicated she had a history of anxiety and nervousness and relied on the nurse to give her medication at a specific time. The resident indicated it upset her when they didn't come and she waited and waited. The Resident indicated she put on her call light, but no one even came to check on her.</p> <p>- On 6-3-2014 at 10:18 a.m., a resident indicated the "facility was short staffed."</p> <p>- On 6-3-3014 at 9:43 a.m., a resident indicated 1st shift was "short staffed."</p> <p>The Resident indicated she has had to wait for staff to go to the bathroom and had trouble waiting. The resident indicated she had an incontinent accident since she had to wait.</p>		<p>Improvement Committee. Regional Quality of Life Director will educate Quality of Life staff about appropriate interactions with the residents and professional behavior and will educate staff on how to handle/document resident concerns and interact with the resident council.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Concern/ Grievance log will be reviewed monthly in Performance Improvement Committee for any trends and will continue as a standard agenda item. (See Exhibit #6) Call light response audit tool will be reviewed monthly x 3 and then quarterly thereafter until substantial compliance has been achieved according to the Resident Council. (See Exhibit #7) CEO will monitor activity calendar monthly x 3 and then quarterly thereafter. CEO will review findings with the Resident Council president monthly x3 and then quarterly thereafter, until Resident Council feels that substantial compliance has been achieved. (See Exhibit #16)</p> <p>1.CEO is responsible to ensure compliance by July 6, 2014.</p>				

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	<p>- On 6-3-2014 at 8:40 a.m., a resident indicated the facility was short staffed all the time.</p> <p>-On 6-2-2014 at 11:50 a.m., a resident indicated she has "had to wait 30 minutes to an hour to get the call light answered," indicated the "girls are all overworked," "are mostly short staffed on weekends" and "has been like this since they changed hands."</p> <p>- On 6-5-2014 at 10:51 a.m., a resident indicated there was not enough staff to answer the call lights and the call lights were left unanswered too long. The resident indicated the CNAs (Certified Nursing Assistants) were working way too much, "12 hours and sometimes 16 hours" and indicated "how do they have time for their families." The Resident indicated the CNAs "get too tired" and "when they call in, they were being fired". Further interview with the anonymous resident indicated the facility was losing good help, thus making the resident feel "awful" and "worried." The resident indicated "the facility just doesn't have enough help."</p> <p>2. Two family interviews were conducted and the families requested confidentiality. The interviews indicated the following:</p> <p>- On 6-3-2014 at 11:43 a.m., the family member of a resident indicated "there</p>						

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	<p>was just not enough staff."</p> <p>- On 6-2-2014 at 4:02 p.m., the family member of a resident indicated there was not enough staff "on the weekends and it has been this way forever." The family member indicated "people call in and others just don't show up," and stated "there are no cars in the back parking lot where staff parks." The family member indicated the call lights "are going off and takes a long time to answer, sometimes the resident waits 30 minutes..." The family member indicated her concerns were shared at every care conference with the last conference being on 5-15-2014 and the facility indicated "they schedule people but they just don't show up."</p> <p>3. Confidential interviews with facility staff indicated the following:</p> <p>- LPN #35 indicated there were not enough staff to meet the needs of the residents. LPN #35 indicated there were only 2 nurses working on most evenings and nights.</p> <p>- LPN #22 indicated LPN #35 came in at 9 am and was working until 10 p.m. tonight. LPN #22 indicated nurses will work late or come in early, "especially if someone calls in so we don't have to work with 2 nurses." LPN #22 indicated Center hall could use more help.</p>			

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	<p>- LPN #24 indicated she worked days and every other weekend and indicated there were not enough nurses on the weekends...only 2 in the building and 1 nurse would take the South Hall and half of center hall and the other nurse would take half of center hall, the rooms between center and north hall and north hall. LPN #24 indicated there were not enough aides to take care of the residents.</p> <p>CNA #36 indicated there was not enough staff to get the call lights answered and the CNA indicated when residents put on their call light to go to the bathroom, staff cannot get there in time before residents had incontinence episodes.</p> <p>LPN #29 indicated having enough staff depends on the day. The LPN indicated there was not enough nursing on 1st and night shifts as there were usually 2 nurses. The LPN indicated that it was difficult to get medications and treatments to the residents on time. Further interview with the LPN indicated there was not enough aides to answer the call lights timely.</p> <p>CNA #25 indicated she worked days and she indicated another CNA would help in Center hall during lunch, because that</p>			

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	<p>hall had 2 CNAs and during meals 1 CNA would go to the dining room which would leave only 1 to answer the lights..</p> <p>RN #32 indicated sometimes there was not enough staff and it depended what was going on the with residents. The LPN indicated there would be times the medications would not get to the residents on time.</p> <p>LPN #31 indicated the problem with staffing was when there were call-ins, no staff could be found to come to work at the facility.</p> <p>A review of the Nurse Staff Posting provided by the Corporate Nurse on 6-6-2014 at 2:40 p.m. and the Daily Staffing Sheet for actual hours worked provided by the Corporate Nurse on 6-5-2014 at 2:14 p.m. indicated the following:</p> <ul style="list-style-type: none"> <li>- On Saturday, May 3, 2014, the Nurse Staff Posting indicated 2 LPNs were scheduled for 8 hours for each shift (days, evenings and nights) for 57 residents.</li> <li>- On Saturday, May 3, 2014, the Daily Staffing Sheet indicated 1 LPN worked the day shift for 8.5 hours, 1 LPN worked the day shift and the first half of the 2nd shift for 11.75 hours, one 2nd shift LPN "called off", one 2nd shift LPN worked 8</li> </ul>			

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	<p>hours and 1 LPN worked 4 hours for the later half of 2nd shift. The 3rd shift had 2 LPNs work 7.5 and 8 hours.</p> <p>- On Tuesday, May 6, 2014, the Nurse Staff Posting indicated 3 LPNs were working for a total of 16 hours...resulting in 2 LPNs being in the facility for 1st shift for a census of 57.</p> <p>- On Tuesday, May 6, 2014, the Daily Staffing Sheet indicated 1 LPN worked 6 a.m. to 2 p.m., 1 LPN worked 6 a.m. to 10 a.m. and the last LPN worked from 10 a.m. to 10 p.m.</p> <p>- On Saturday, May 10, 2014, the Nurse Staff Posting was not provided as requested.</p> <p>- On Saturday, May 10, 2014, the Daily Staffing Sheet indicated 1 LPN worked 6 a.m. to 10 a.m., 1 LPN worked 12 hours and 1 RN worked 6.75 hours on 1st shift, leaving 2 nurses in the building for 1st shift. During 2nd shift, 1 LPN called in and that left 2 LPNs to work the 2nd shift for a 4 hour time period. The resident census according to the nurse staff posting for 5-9-2014 was 57.</p> <p>- On Saturday, May 17, 2014, the Daily Staffing Sheets indicated 2 LPNs worked the day shift for a census of 56 residents.</p> <p>- On Friday, May 23, 2014, the Nurse Staff Posting indicated 5 CNAs worked the day shift and 4 CNAs worked the 2nd shift.</p> <p>- On Saturday, May 24, 2014, the Daily</p>			

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	<p>Staffing Sheets indicated 2 nurses worked a 4 hour time period from 6 a.m. to 10 a.m. for a census of 58 residents.</p> <p>-On Monday, May 26, 2014, the Daily Staffing Sheet indicated 1 LPN worked the night shift for a census of 58 residents. The other LPN name was marked out.</p> <p>- On Sunday, June 1, 2014, the Daily Unit Assignment (form name changed) indicated 2 LPNs were scheduled for day shift for a census of 57 residents.</p> <p>-On Monday, June 2, 2014, the Daily Unit Assignment indicated a nurse WMBI (would not be in) on 1st shift and 2 LPNs were left to work 1st shift for a census of 57 residents. The "as worked" Daily Unit Assignment was not updated to reflect additional nurse staffing for June 2nd. There was not a Nurse Staff Posting provided for Monday, June 2, 2014.</p> <p>An interview with the DON (Director of Nursing) on 6-6-2014 at 9:10 a.m., indicated 3 nurses were scheduled in the building for 1st and 2nd shift and 2 nurses were scheduled on 3rd shift. The DON indicated 1 nurse on each shift was on the bubble, which meant if a nurse call would call in, the nurse on the bubble would work over or a nurse would come in early to cover the nurse that called in. The DON indicated 6 CNAs were</p>			

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F000371 SS=F	<p>scheduled to work 1st and 2nd shift and 3 CNAs were scheduled on 3rd shift. The DON indicated they are short staffed and the CNAs were working more hours.</p> <p>A policy on Nurse Staffing was requested from the DON during the 6-6-2014, 9:10 a.m. interview, but not provided by the exit conference held on 6-6-2014 at 4:00 p.m.</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p>	F000371	F 371 – F It is the intent of this	07/06/2014

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	<p>A. Based on observation, interview and record review the facility failed to ensure staff washed their hands for the recommended amount of time and also failed to ensure staff washed their hands immediately before assisting/feeding residents with meals and after their hands touched soiled surfaces. The facility further failed to protect food from potential contamination during meal service in the dining room and during the transportation of room trays potentially affecting 55 of 55 residents who ate meals prepared by the facility kitchen.</p> <p>B. The facility failed to keep the snack and beverage refrigerators temperatures in the medication rooms within the correct temperature range per facility policy for 3 of 3 refrigerators observed. The facility also failed to keep logs (recording) of the nourishment refrigerators in the medication rooms for 3 of 3 refrigerators observed, potentially affecting all residents who received food from the nourishment refrigerators.</p> <p>Findings include:</p> <p>A.1. During an observation of the lunch meal in the dining room on 6/2/14 the following was observed:</p> <p>- At 12:00 p.m., Certified Nursing</p>		<p>facility to store, prepare, distribute and serve food under sanitary conditions.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Hand-washing education, with return demonstrations were required for all staff and 100% compliance to be achieved by 06/26/2014. All refrigerators have temperature logs in place and are being checked daily. Additionally, each refrigerator has been validated by Maintenance to ensure proper working order, and placed on preventative maintenance check list for routine validation.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Mandatory hand-washing education, with return demonstration to validate competency has been performed by the DON and/or designee by 06/26/2014. All new employees will be educated on Hand-washing during orientation and at least annually, with performance reviews. Nutrition/ dietary refrigerator temperature logs will be checked daily by the dietary manager and/or designee and will be reviewed weekly by the CEO to ensure compliance. The medication room refrigerators will be checked,</p>	

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	<p>Assistant (CNA) # 33 was observed to pull up a dining room chair to the table where a resident was seated. She was observed to start feeding her without washing her hands.</p> <p>- At 12:15 p.m., CNA #25 was observed seated at a dining room table feeding lunch to a resident. She was observed to get up from the chair and move around the table to another placing her bare hand on top of his hand encouraging him to eat. She then returned to the first resident and continued to feed him lunch. She was not observed to wash her hands.</p> <p>A.2. During an observation of the lunch meal on 6/4/14, the following was observed:</p> <p>- At 11:30 a.m., CNA #21 was observed to carry a room tray from the dining room through the 600 Hall to the room of a resident. Her room tray contained a glass of lemonade and a cup of hot tea which were not covered to protect them from potential contamination.</p> <p>- At 11:45 a.m., LPN #24 was observed to move a chair up to a dining room table where three residents were seated. She was observed to help re-position a resident in her geri-chair and also adjusted her clothing protector. She then</p>		<p>twice daily and logged by assigned nurses and DON will review weekly to ensure compliance. CNA #28 will be educated regarding hand-washing, infection control principals. Nursing and Dietary staff will be educated regarding the process for delivery of meal trays and pick up, covering of food and beverages during transportation and infection control principals as they apply to food service.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Mandatory hand-washing education, with return demonstration to validate competency has been performed by the DON and/or designee by 06/27/2014. All new employees will be educated on Hand-washing during orientation and at least annually, with performance reviews. Nutrition/ dietary refrigerator temperature logs will be checked daily by the Dietary Manager and/or designee and will be reviewed weekly by the CEO to ensure compliance. The medication room refrigerators will be checked twice daily and logged by the assigned nurse and DON will review weekly to ensure compliance. CNA #28 will be educated regarding hand-washing, infection control principals and tray handling.</p>				

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	<p>poured her liquids into glasses with her bare fingers touching the outside rims of the glasses and started to feed her. She did not wash her hands after touching soiled surfaces.</p> <p>- At 11:48 a.m., CNA #21 was observed to move a chair up to a dining room table where two residents were seated. She was observed to start feeding a resident without washing her hands.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 6/6/14 at 10:21 a.m. During the interview she indicated staff were to wash their hands for 20 seconds and were to wash their hands after touching any object or resident prior to assisting/feeding residents their meals. She also indicated everything on a resident's meal tray needed to be covered when being transported to their rooms. She further indicated the open tiered cart containing room trays for residents on the 500 Hall and the 600 Hall were arranged in the order they were to be served from the open tiered cart, with the lower tiers of the cart containing the first trays to be served so the plastic cover could be rolled up from the bottom of the cart to the top of the cart. The open tiered cart was completely covered prior to leaving the kitchen. Nursing staff were to move the cart to each door of each resident</p>		<p>Dietary Manager will be replacing lids with plastic wrap to ensure proper covering. Department managers have been assigned dining room duties to assist with meal service Monday- Friday and the week-end manager will assist with meal service on the weekend for at least one meal. Dietary Manager/ RD will be checking refrigerators for properly dated/ stored/ labeled items per monitoring check list. Nursing and Dietary staff will be educated regarding the process for delivery of meal trays and pick up, covering of food and beverages during transportation and infection control principals as they apply to food service.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Dietary manager/ DON to monitor temperature logs weekly x 3 and then monthly x2 and report findings to the Performance Improvement Committee monthly x 3 until substantial compliance is obtained. Observations will be made by the CEO and/or designee weekly x 3 and then monthly x 2 until compliance has been achieved by the Performance Improvement committee. Dietary rounds will be performed by the RD and reviewed by the CEO on a weekly basis to ensure food sanitation requirements are met. (See Exhibits # 17, 18, 19)</p> <p>1.CEO is responsible to ensure</p>				

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	<p>when their meals were served. The open tiered cart was to remain covered until the Nursing staff was ready for that tray and not transported through the hallway with the trays exposed.</p> <p>A current facility policy "Hand Hygiene/Handwashing", dated 8/31/11 and provided by the CDM on 6/6/14 at 11:10 a.m., indicated "...Handwashing is the single most important procedure for preventing the spread of infection...After handling soiled equipment or utensils...between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments...Rub hands together with vigorous friction for 20 seconds..."</p> <p>A current facility policy "Dining Standards", dated 1/5/12 and provided by the CDM on 6/6/14 at 11:10 a.m., indicated "...Foods transported to patient rooms are appropriately covered...Staff completes hand hygiene according to procedure at the beginning of meal service and as needed throughout the meal service...."</p> <p>A. 3. During an observation on 6-5-2014 at 11:20 a.m., CNA #25 passed lunch trays to residents in the North Hall. The bowl of salad on each resident's tray was</p>		compliance by July 6, 2014.	

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F000431 SS=F	<p>covered with a plastic cup lid which did not cover the salad completely. One bowl of salad was not covered at all. The tall tray cart was open on each side and the plastic trash bag was pushed up to the top of the cart.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and 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</p>			

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	<p>drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review the facility failed to maintain the proper temperature for the storage of medications for 3 of 3 refrigerators observed for medication storage, potentially affection all 55 residents in the facility.</p> <p>Findings include:</p> <p>1. During observation of the medication refrigerators in medication rooms on 6/5/14 the following was observed:</p> <p>-At 12:08 p.m., the South Hall medication refrigerator temperature was 45 degrees F. (Fahrenheit) and was confirmed by LPN #29. The June 2014 temperature log indicated the refrigerator temperature was only recorded 1 day, on 6/4/14 and the refrigerator temperature was 43 degrees F. During an interview with LPN #29 on 6/5/14 at 12:10 p.m., she indicated the night shift nurse was to monitor and record the temperatures of the refrigerators in the medication rooms every night.</p> <p>-At 4:05 p.m., the North Hall medication refrigerator temperature was 44 degrees</p>	F000431	<p>F 431- F It is the intent of this facility to maintain the proper temperature for the storage of medications.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All medication room refrigerators have been validated by the Director of Maintenance to be found in proper working order OR have been replaced.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Refrigerators have been validated to be in proper working order or have been replaced. Temperature logs have been placed on all refrigerators. Nursing staff has been educated with regards to the taking of refrigerator temperatures and with regards to the reporting of temperatures outside of acceptable range. They have also been educated by the DON and/or designee regarding medication storage, labeling, dating of medications stored in the refrigerator.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur;</p>	07/06/2014

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	<p>F. and was confirmed by LPN #22. The June 2014 temperature log indicated the refrigerator temperature was only recorded on June 1st, 2nd, and 3rd, 2014. There was no documentation the temperature was checked the remainder of the month.</p> <p>-At 4:45 p.m., the South Hall medication refrigerator temperature was rechecked and the temperature was 46 degrees F. and was confirmed by LPN # 31.</p> <p>-At 5:35 p.m. the Center Hall medication refrigerator temperature was 44 degrees F. and was confirmed by RN # 32. The refrigerator was full of medications which included multiple vials of unopened Insulin, suppositories, Aplisol (Mantoux test for tuberculosis) vials, and a Pharmacy EDK (Emergency Drug Kit).</p> <p>During observations of the medication refrigerators in the medications rooms on 6/6/14 the following was observed.</p> <p>-At 9:15 a.m., the North Hall medication refrigerator was observed with the DON (Director of Nursing) and the temperature was 40 degrees F. The DON indicated the nurse was to check the refrigerator's temperatures every night and record the temperatures on the Refrigerator Temperature Log. She indicated she</p>		<p>The medication room refrigerators will be checked twice daily and logged by the nurse and DON will review weekly to ensure compliance. Refrigerator temperature logs will be kept for 6 months and will be evaluated monthly.</p> <p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Refrigerator temperature logs will be reviewed monthly x3 and then quarterly x 2 in the Performance Improvement Committee or until substantial compliance has been achieved. (See Exhibit #17)</p> <p>1.CEO is responsible to ensure compliance by July 6, 2014</p>	

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	<p>would need to refer to the facility policy about the correct temperature ranges for the refrigerators. During a review of the North Hall's Refrigerator/Freezer Temperature Log for June 2014, the DON confirmed missing documentation of temperatures on June 4th, 5th and 6th. The DON also indicated the non-dated Guidelines for Refrigerator Temperatures were on the Temperature Log Sheet which indicated, "...Refrigerator Temperature: 34 degrees to 38 degrees..." The DON indicated the recorded and current temperatures of 40 degrees was too warm.</p> <p>-At 9:30 a.m. the South Hall medication refrigerator was observed with the DON, the temperature was 40 degrees F, and the hand written refrigerator temperature logs for June 2014 indicated no recorded temperature on June 1st, 2nd or 3rd. The documentation on the temperature log indicated on 6/4/14 a temperature of 43 degrees F., on 6/5/14 a temperature of 40 degrees F. and on 6/6/14 a temperature of 40 degrees F..</p> <p>-At 9:30 a.m., during an interview with the DON, she indicated the night nurse was to adjusted the temperature of the refrigerator and re-check the temperature to see if it was with in the correct range. She also indicated the nurse was to report</p>			

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	<p>if the refrigerator temperature was out of range to her and also to maintenance. She indicated she did not know why the Refrigerator/Freezer Temperature Logs were hand written and not documented on the facility's form. She indicated the night nurse was new and she must not be aware of the proper temperature ranges for the refrigerators.</p> <p>-At 9:35 a.m. the South Hall medication refrigerator's contents were observed with the DON which included the following: -Bisacodyl Suppositories for 6 Residents. -Acetaminophen 650 mg Suppositories for 1 Resident. -1 Prescription bottle of Acidophilus for 1 Resident.</p> <p>-At 9:45 a.m. the Center Hall's hand written medication refrigerator log was observed with the DON and 4 of the six temperatures recorded were out of the correct range, On 6/2/14 the refrigerator temperature was 42 degrees F. and on 6/4, 5 and 6/14 the refrigerator temperature was 40 degrees F.</p> <p>-At 9:50 a.m., during an observation of the content of the Center Hall medication refrigerator with LPN #30. was found to contain the following: - 14 vials of un-opened Insulin. -13 Insulin Pens.</p>			

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	<p>-1 box of Oxycodone (pain medication) pre-filled syringes</p> <p>- 5 prescription bottles of acidophilus (supplement for yeast).</p> <p>-Tylenol (for pain or fever) Suppositories for 1 resident.</p> <p>-Bisacodyl (for bowel irregularity) Suppositories for 4 resident.</p> <p>-Phenergan (for nausea) Suppositories for 1 resident.</p> <p>-6 vials of Engerix-B (vaccine for hepatitis B), facility stock.</p> <p>-3 vials of Procrit (to treat anemia) for 1 resident.</p> <p>-6 vials of Aplisol (for Mantoux testing for tuberculosis), facility stock.</p> <p>-2 prescription bottles of liquid Omeprazol ( treatment of gastric reflux) for 1 resident.</p> <p>-1 prescription bottle of liquid Lorazepam (for anxiety) for 1 resident.</p> <p>-1 box of per-fill syringes of Lorazepam for 1 resident.</p> <p>-1 Pharmacy EDK (Emergency Drug Kit) not expired.</p> <p>None of the medications observed in the Center Hall medication refrigerator were expired.</p> <p>-At 1:10 p.m., the North Hall medication refrigerator contents were observed with LPN #24. and contained the following:</p> <p>- 2 un-opened Insulin Pens for 2 residents.</p>			

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	<p>- 3 vials of un-opened insulin for 3 residents.</p> <p>- Acetaminophen Suppositories for 1 resident</p> <p>- Bisacodyl Suppositories for 3 residents.</p> <p>- 1 vial of Aplisol with an open date of 5/14/14, facility stock.</p> <p>- Pharmacy EDK (Emergency Drug Kit) not expired.</p> <p>During a interview on 6/6/14 at 3:55 p.m. the DON indicated she could not locate the Refrigerator/Freezer Temperature Logs for May 2014 for the North and South Halls. She provided copies of the Center Hall May 2014 Refrigerator/Freezer Temperature Log. The medication refrigerator log indicated the temperature was out of the indicated range of 34 degrees to 38 degrees F. on 4 days of the 30 days recorded, the temperatures documented were at 40 degrees F. on 5/ 8, 18, 29 and 30/2014.</p> <p>The facility did not provide a policy for Refrigerated Medication Storage. On 6/6/14 at 11:10 a.m., the Administrator provided the the Facility's policy titled, Monitoring Refrigerator/Freezer Temperatures, dated August 2013, which indicated, "...Procedure...Post a temperature log for each refrigerator and freezer at the beginning of each month....Check and record temperature</p>			

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F000441 SS=E	<p>readings for refrigerators and freezers at least twice daily (am and pm)....Collect the temperature logs at the end of each month. Keep a minimum of 6 months or per state guidelines....Evaluate results and initiate performance improvement processes if warranted...."</p> <p>3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>			

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	<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>A. Based on observation, interview and record review, the facility failed to ensure hand hygiene and/or adequate cleaning of nonessential equipment was performed by direct care staff of a resident in contact isolation for 1 of 1 residents observed in contact isolation. Resident #77</p>	F000441	<p>F 441- E It is the intent of this facility to establish and maintain an Infection Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>1.What corrective action(s) will be accomplished for those</p>	07/06/2014

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	<p>B. Based on interview and record review, the facility failed to ensure tuberculin tests (TB) were performed and read in a timely manner for 3 of 5 resident's reviewed for TB skin tests.</p> <p>Resident #79, #78, #77</p> <p>Findings include:</p> <p>A.1. On 6/3/14 at 11:15 A.M., CNA (certified nursing assistant) #20 was observed passing meal trays in the 500 hall. CNA #20 was observed to push the tray cart down the hall and stopped in front of Resident #77's room which was observed with supplies of gloves, gowns and masks, hanging on the outside of the closed door. The door to the room was observed to have multi pocketed holders attached to the door. The door and/or room did not have a manner to indicated and/or to alert the general public to see nursing staff prior to entering the room. The pockets included the following items: boxes of disposable gloves, masks, gowns. CNA #20 was observed to open the door with ungloved hands and take the meal tray into the room without gown or gloves on. CNA #20 was observed to come and and out of the room several times to obtain various items from the meal cart. She was observed to come out of the isolation</p>		<p>residents found to have been affected by the deficient practice; Resident #22 isolation order is being re-evaluated by attending physician. Resident #77, #78 and #79 have had PPD applied and read and brought into compliance.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All other residents have the potential to be affected; therefore staff has been educated regarding Hand-washing, Isolation policy and procedure, protective equipment, equipment cleaning, basic infection control principles. Nurses have also been educated on the requirement for TB testing /policy and procedure.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; New admission charts will be reviewed in the daily clinical meeting to ensure that admission TB testing has been performed as required. 100% audit of TB skin testing/ results will be done by 06/27/2014 and reviewed monthly by the DON for compliance. New hires will be educated regarding hand-washing, infection control, use of protective equipment, basic infection control practices and isolation policies.</p>		

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	<p>room and still with no gloves or gown on, was observed to open a pouch type cooler and removed an individual carton of ice cream. CNA #20 was observed to touch the resident's bedside table with ungloved hands while in the isolation room. CNA #20 came out of the isolation room and without handwashing continued to pass meal trays (take meal trays off the meal cart and take them into resident rooms) down the 500 hall. She was observed to go in and out of resident rooms while passing the meal trays, including opening and closing the cooler pouch to take out ice cream, without sanitizing her hands .</p> <p>At the time, CNA #20 was interviewed. She indicated she had passed room trays to "about 9 residents" on the 500 and 600 halls.</p> <p>On 6/3/14 at 11:55 A.M., CNA #20 was observed to walk into the isolation room in the 500 hall, without gloves and/or gown on, and removed the meal tray from the bedside table. CNA #20 then walked out of the isolation room and placed the tray on the meal cart and without sanitizing her hands continued picking up meal trays from resident rooms in the 600 hall.</p> <p>On 6/5/14 at 2:55 P.M. CNA #21 was observed going into room of contact</p>		<p>1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; CEO/DON will perform rounds 3x daily x 7 days to observe for proper hand-washing, adherence to infection control policy/ procedure, then daily x 3 weeks and then randomly to ensure compliance with plan of correction and will report findings and/or opportunity for improvement to the Performance Improvement Committee monthly x 3 and then quarterly until substantial compliance achieved. (See Exhibits #20 and 19)</p> <p>1.CEO is responsible to ensure compliance by July 6, 2014</p>				

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	<p>isolation person in 500 hall, without gown or gloves on. She was observed to come out of the room without gloves on and/or sanitizing her hands and was holding the resident's water pitcher. CNA #21 then took the multi use scoop from the ice cart and scooped ice, from the multi use cooler, into the resident's pitcher and took it back into the resident's room. CNA #21 was observed to walk out of the resident's room, again without sanitizing her hands.</p> <p>At 2:57 P.M., CNA #21 was interviewed. She indicated she didn't observe any special precautions for the resident is isolation as she "didn't touch the resident."</p> <p>On 6/6/14 at 4 P.M., the clinical record of Resident #79 was reviewed. A history and physical, dated 5/21/14, included, but was not limited to, the following: "...has a 2 week history of legs sores which when cultured turned positive for MRSA (methacillin resistant staphylococcus aureus)..." Web MD defined MRSA as a type of bacteria which is resistant to many antibiotics which is spread from person to person through casual contact or through contaminated objects.</p> <p>On 6/6/14 at 12:10 P.M. the DON (Director of Nursing), ADM (Administrator) and the Regional</p>			

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	<p>Consultant Nurse were interviewed. The DON indicated the resident was admitted to the facility with cellulitis to both legs, which tested positive for MRSA. She indicated the resident had been in contact isolation since admission and remained in contact isolation. The DON indicated when staff members go into an isolation room with a meal tray, they should put on at least a gown and gloves and when they come out of the room, remove the gown, gloves and wash their hands. The DON when the staff pass ice water to an isolation room, they should do the same regarding the gown, gloves and handwashing. The DON indicated it was the protocol of the facility to have a sign displayed on rooms of isolation resident directing anyone entering the room to "see nursing before entering."</p> <p>A.2. On 6/5/14 at 3:17 P.M. LPN #22 was interviewed regarding her preparation to change the dressing for Resident #79. LPN #22 indicated Resident #79 was in contact isolation. She indicated whenever she goes into the room, she puts a gown and gloves on because "we don't know what he (the resident) has touched." She indicated she puts a gown and gloves on regardless if she touches the resident or not. She indicated the resident had MRSA on the wounds on his bilateral lower legs. LPN</p>						

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	#22 was observed to remove the outer kerlix layer of dressing to the resident's left lower extremity (LLE), while the resident was lying in bed. She was observed to remove the Xerofoam dressing from the resident's leg with gloved hands. She then picked up a bottle of normal saline (NS), squirted it on the leg wounds and wiped it with a dry gauze square. She removed her gloves and immediately applied new gloves without sanitizing hands. She then used the scissors to cut squares of xerofoam dressing and applied it with her hands to the resident's legs. LPN #22 indicated there were 4 open areas to the resident's leg. She opened the tube of Bactroban ointment, still with the gloves she touched the wounds with, and applied the Bactroban ointment to the resident's leg with her gloved hands. She then removed this pair of gloves and put new pair of gloves on without sanitizing her hands. At the time, LPN #22 realized she needed kerlix dressing and she took her gloves and gown off and left the room, without sanitizing her hands. When she returned to the room, the resident had sat up on the side of the bed. She donned new gloves and applied the remainder of the dressings to the left leg. LPN #22 removed the gloves and applied new gloves without sanitizing hands. She then touched the small bedside trash can						

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	<p>and positioned it so the resident could prop his leg on it. Without changing gloves, LPN #22 squirted the normal saline onto the right leg and blotted the resident's leg with a dry gauze square. She then applied the Bactroban ointment (from the tube) to the dressing and placed it on the right leg. She then applied the Kerlix dressing and used the scissors to cut the Kerlix dressing. She used a roll of tape to secure the Kerlix. LPN #22 placed the used scissors and tape on the bedside table top. LPN #22 had placed a dry washcloth on the resident's bedside table, but the scissors and tape were not placed on the dry washcloth. With gloved hands, LPN #22 used the scissors to cut off kerlix from the resident's right leg. She then poured NS over the leg and dried with a dry gauze square. She then changed her gloves without sanitizing hands and applied the Bactroban (from the tube) to the dressings, which were applied to the resident's leg. She used the scissors to cut the Kerlix dressing and the dressing was secured with tape. She then put the Xerofoam dressing back in the foil pouch and the tube of Bactroban back in the box. She placed the Xerofoam dressing package into a clear zip lock baggie. LPN#22 removed her gloves and without handwashing she left the room carrying the baggy and unclean scissors. She went down the hall to the multi use</p>			

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	<p>shower room. One in the shower room, the paper towel dispenser over the sink was observed to be open with no paper towel roll in place and/or no way to dry hands in the shower room. LPN #22 was observed to leave the shower room and went to her medication cart. She placed the baggie on the top of her cart and put a glove on her hand to hold the unclean scissors. With the ungloved hand, she opened her cart and grabbed a bleach wipe to clean the scissors with, and also wiped off the Bactroban tube.</p> <p>LPN#22 was interviewed on 6/5/14 at 5 07 p.m. She stated she didn't wash her hands in the shower room because there was no paper towel in the shower room but she did go to the med room and wash her hands there.</p> <p>On 6/6/14 at 8:40 A.M., the Administrator provided a copy of the facility policy and procedure for "Hand Hygiene/Handwashing" dated 8/31/11. The policy included, but was not limited to, the following: "Handwashing is the single most important procedure for preventing the spread of infection...hand hygiene is to be performed:...between tasks and procedures on the same patient when contaminated with body fluids to prevent cross contamination of different body sites...after removal of</p>			

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	<p>medical/surgical or utility gloves; intermittently after gloves are removed, between patient contacts and when otherwise indicated to avoid transfer of microorganisms to other patients or environments..."</p> <p>At the time, the Administrator also provided a copy of the facility policy and procedure for "Transmission Based Precautions" dated 8/31/13. This policy included but was not limited to, the following: "Transmission-based precautions are for patients with documented...infections or colonization with highly transmissible or epidemiologically important pathogens for which additional precautions are need to prevent transmission...Three types of transmission-based precautions are: contact...Contact precautions is a method designed to reduce the risk of transmission of micro-organisms by direct or indirect contact...Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment...Procedure...communicate to staff isolation interventions; instruct staff on good handwashing and use the appropriate personal protective equipment...Post the appropriate precaution notice immediately visible</p>			

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	<p>location outside the room...hand hygiene is the most important method of control to prevent transmission...Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails)...Dedicate use of noncritical patient care equipment for the patient in contact precautions; if this is not possible, then the equipment should be cleaned and disinfected before use on another patient...items are to be cleaned in the patient's room, then brought out and left to air dry...gloves should be worn with removing the tray from the room and placing on the tray cart..."</p> <p>On 6/6/14 at 12:10 P.M., the DON was interviewed. She indicated she would expect the nurse to clean her equipment before leaving the isolation room. The DON also indicated staff should sanitize hands between glove changes.</p> <p>B. On 6/6/14 at 12:22 P.M., the DON (Director of Nursing) was interviewed. She indicated if residents were admitted from the hospital, the TB (tuberculosis test) test results would be documented on the immunization record and/or the admission notes. The DON indicated at this time, the initial TB test should be done "right away" after admission. The DON indicated the resident is given the</p>			

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	<p>first TB test at the facility and if the resident had not had another TB test prior to that, the TB test will be repeated 2 weeks later.</p> <p>On 6/6/14 at 2:27 P.M., the Administrator provided a current copy of facility policy and procedure for "Mantoux Tuberculin Skin Test", dated 8/22/13. The policy included, but was not limited to, the following: "Baseline testing for...Tuberculosis infection is recommended for...newly admitted patients...If a patients...skin test...is not read between 48 and 72 hours after administration, reschedule for another skin test..."</p> <p>On 6/6/14 at 2:45 P.M., the DON was interviewed. She indicated the staff nurses are responsible to ensure the newly admitted resident's have their TB tests administered and read. She indicated the nurses document the TB test administration and the date it is to be read on the MAR (medication administration record). She indicated the TB testing has not had adequate follow through in monitoring it's compliance.</p> <p>On 6/6/14 at 3:15 P.M., the Administrator (ADM) was interviewed. She provided the following information:</p>			

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	<p>Resident #77 had a TB test administered at (hospital) on 5/20/14. There was no documentation on the immunization record this TB test was read.</p> <p>Resident #78 was admitted to the facility on 5/1/14 from a hospital. The immunization record indicated the resident had the first TB test administered at the facility on 5/7/14, 6 days later.</p> <p>Resident #79 was admitted to the facility on 5/27/14 from (name of hospital). The Immunization Record for the facility indicated the first TB test was administered to the resident on 5/29/14, 2 days later.</p> <p>3.1-18(b(2))</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review the facility failed to maintain accurate and complete documentation of the treatment for a skin tear and/or personal care completed on 3 residents who met the criteria for skin related problems. Resident #19, Resident #9, Resident #22</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #19 on 6/4/14 at 1:39 p.m., indicated the following: diagnosis included, but was not limited to, ischemic heart disease, muscle weakness, and edema.</p> <p>Resident #19 was interviewed on 06/03/2014 at 20:23 a.m. During the</p>	F000514	<p>F 514 – D It is the intent of the facility to maintain clinical records on each resident in accordance with accepted professional standards of practice that are complete, documented accurately, readily accessible and systematically organized.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #19- Skin tear to left wrist immediately assessed by DON and proper treatment applied, documented and transcribed to TAR. Area healed on 06/20/2014 Resident #9 - immediately offered and accepted shower with peri care provided by staff. DON assessed abdomen to assure no signs/symptoms of infection and that peri-care was completed and adequate. and</p>	07/06/2014			

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	<p>interview a very large skin tear was noted on the interior of his left wrist. The area was dark red in color with some very noted. There were also areas of dry crusted skin.</p> <p>A Resident Progress Notes for Resident #19, dated 5/26/14 as a late entry for 5/25/14, indicated an area noted on his left wrist approximately 2 cm (centimeters) in length. The notes also indicated steri-strips were on with a Kerlix wrap when found. The notes further indicated an order for a dry dressing BID (twice a day) until healed in place.</p> <p>A Resident Progress Notes for Resident #19, dated 5/26/14 as a late entry for 5/25/14, indicated he had a skin tear on his left wrist. The notes also indicated steri strip and dressing applied.</p> <p>A Resident Weekly Skin Check Sheet for Resident #19, dated 5/27/14, indicated there were no new skin issues. The check sheet did not identify the skin tear on his left wrist.</p> <p>A physician's order for Resident #19, dated 5/25/14, indicated to apply dry dressing to area on left wrist BID until healed.</p>		<p>Resident #22 immediately assessed and peri- care offered.</p> <p>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All other residents have the potential to be affected. Nursing staff have been educated with regards to documentation requirements as related to physician orders, Nursing progress notes, assessments, Medication/ treatment administration records, care flow records and care plans. They have also been educated on the importance of documenting/ care planning of refusals and non-compliance.</p> <p>1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; 100% skin sweep was performed with no additional skin issues identified. New orders will be reviewed in the daily clinical meeting and "white board" process utilized to ensure follow up of issues until they are resolved. DON/designee will monitor MAR/TAR/Flow records/ documentation to ensure completion. Education has also been done with nursing staff regarding the difference between a "nursing measure" that can be appropriately care planned and a physician's order requiring</p>				

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	<p>A physician's order for Resident #19, dated 5/26/14, indicated steri strips to skin tear on left wrist, wrap with Kerlix, and change wrap daily.</p> <p>The Medication Administration Record for Resident #19, dated for the month of May, 2014, indicated to change wrap daily to left wrist on day shift. Initials were only documented on 5/26/14, indicating the treatment was done.</p> <p>A Resident Progress Notes for Resident #19, dated 5/29/14, indicated left wrist was healing well with dressing intact.</p> <p>The Treatment Administration Record for Resident #19 for the month of June, 2014, did not include the order for the wrap daily to left wrist.</p> <p>There was no physician order to discontinue the treatment to the skin tear on his left wrist.</p> <p>During an observation on 6/3/14 at 11:30 a.m., Resident #19 was observed seated in his wheelchair in the dining room. The skin tear on his left wrist was not observed to be covered.</p> <p>Resident #19 was interviewed on 6/4/14 at 3:50 p.m. During the interview he indicated staff had just put a dressing on</p>		<p>supporting documentation.</p> <p>1. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; DON/designee will perform 5 record reviews per week x 3 weeks, then 5 records monthly x 3 months. Clinical Record review is a part of the Signature Care Consultant visit report and will be reviewed monthly, as part of quality assurance. These audits will be reviewed in the Performance Improvement committee monthly x 3 and then quarterly thereafter until substantial compliance has been achieved, as determined by the committee. (See Exhibit #22)</p> <p>1.CEO is responsible to ensure compliance by July 6, 2014</p>				

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	<p>his skin tear after lunch on 6/3/14.</p> <p>During an observation on 6/5/14 at 8:35 a.m., Resident #19 was observed in his wheelchair in the dining room. The skin tear on his left wrist was not observed to be covered.</p> <p>During an observation on 6/5/14 at 1:45 p.m., Resident #19 was observed resting in bed. The skin tear on his left wrist was not observed to be covered. During the observation he indicated the skin tear had been seeping on 6/4/14.</p> <p>The Administrator and DON were interviewed on 6/5/14 at 3:16 p.m. During the interview they indicated nursing personnel were to write their initials in the box on the MAR each time a treatment was given. They also indicated if a treatment was not completed, nursing was to write their initials with a circle surrounding them and then document on the back of the MAR why the treatment was not done.</p> <p>The Director of Nursing was interviewed on 6/6/14 at 10:14 a.m. During the interview she indicated the skin tear for Resident #19 actually measured 5 cm.</p> <p>A current undated facility policy "Documentation Do's and Don'ts</p>			

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	<p>Reference Guide", provided by the Administrator on 6/6/14 at 3:07 p.m., indicated "...Do not leave fields or blocks blank...."</p> <p>2. Review of the clinical record for Resident #9 on 6/4/14 at 1:20 p.m., indicated the following: diagnoses included, but was not limited to, cellulitis of abdomen and legs, diabetes, diabetic foot wounds, peripheral neuropathy, CHF (congestive heart failure), HTN (hypertension or high blood pressure) Atrial Fibrillation, COPD (chronic obstructive pulmonary disease), obesity and gout.</p> <p>Resident #9 was interviewed on 06/03/2014 at 2:49 p.m., and indicated he had cellulitis and a yeast infection under his abdomen fold and indicated he had to go to the emergency room a few weeks ago because it became blood red. He indicated the nursing staff does not always wash under his abdomen or peri area every shift as they are suppose too. He indicated he does not need assist to go to the bathroom, but he does need assist to clean these areas.</p> <p>A review of the CNA Flow Sheet Record on 6/4/14 at 2:00 p.m., indicated Resident #9's shower days were on Wednesdays</p>			

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	<p>and Saturdays. Also indicated peri care every shift and as needed. The June 2014 CNA flow sheet indicated Peri care was not documented on 6/1/14 1st shift, 6/3/14 3rd and 2nd shifts.</p> <p>An interview with DON on 6/5/14 at 10:30 a.m., indicated the CNA's are to assist Resident #9 with bed bath or peri care every shift. She indicated Resident #9 often refuses. She reviewed the June 2014 CNA Care Flow Sheets and indicated she could not determine if care was missed or refused because nothing was documented on the flow sheet for peri care on 6/1/14, 1st shift and 6/3/14, 3rd and 2nd shifts.</p> <p>Review of the March, April and May 2014, CNA Flow Sheet Records provided by the DON on 6/5/14 at 11:16 a.m., indicated Peri care was not documented for 22 shifts in March 2014, 1 shift in April 2014, and 2 shifts in May 2014.</p> <p>Review of the Nursing Care Plans on 6/4/14 at 2:30 p.m. indicated a problem of Non Pressure Skin deficit. Approaches indicated the following: Weekly skin assessment; Follow MD orders for skin care and treatment; Monitor for signs and symptoms of infections; Assess pain/comfort level....</p>			

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	<p>3. Review of the clinical record for Resident #22 on 6/6/14 at 10:00 a.m., indicated the following: diagnoses included, but were not limited to, Multiple Sclerosis progressed to paraplegia, history of sacral pressure ulcers, status post flap graft repair of sacral pressure ulcer, History of MRSA (an infection)</p> <p>On 6/6/13 at 10:40 a.m., a review of Resident #22's Nursing Care Plans indicated the following: "...Problem: Skin at risk: r/t contractures, immobility, refuses to get out of bed, pressure ulcers, redness on buttocks, does not like to turn...Approaches: monitor skin, do all skin care for resident...."</p> <p>On 6/6/17 at 1:30 p.m., a review of the CNA Flow Sheet Records indicated Resident #22 provided by the DON on 6/6/14 at 1:27 p.m. indicated Resident #22 was to have Peri Care every shift. The March, May and June 2014, CNA Flow Sheet Records indicated the following: -Peri Care was not documented for 33 shifts in March 2014. -Resident was hospitalized from 5/8/14 to 5/23/14. The Resident returned to the facility on 5/23/14 and the Peri Care was not documented for 10 shifts after</p>			

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	<p>5/23/14. -Peri Care documentation was lacking for 4 shifts in June 2014.</p> <p>On 6/5/14 10:30 a.m., an interview with the DON indicated she could not determine if care was given or refused because documentation was missing. She indicated the CNA should have documented if peri care was given or refused and if refused it should have been reported to the nurse.</p> <p>Review of the non-dated facility's policy provided by the DON on 6/6/14 at 3:07 p.m. titled, Documentation Do's and Don'ts reference Guide, indicated the following, "...Record all of the facts and chart promptly...record all car given, including resident's response to treatment...Document resident refusals or noncompliance...."</p> <p>3.1-50(a)(1)(2)</p>						