

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State licensure survey.</p> <p>Survey dates: February 15, 16, 17, 18, 19 and 22, 2016</p> <p>Facility Number: 000476</p> <p>Provider Number: 155446</p> <p>AIM Number: 100290870</p> <p>Census bed type: SNF/NF: 89 Total: 89</p> <p>Census payor type: Medicare: 8 Medicaid: 64 Other: 17 Total: 89</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on February 26, 2016 by 17934.</p>	F 0000	<p>This plan of correction constitutes the facility's written credible allegation of compliance. 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 the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>A. Based on interview and record review, the facility failed to notify the POA (Power of Attorney) of the addition of a psychotropic medication for his</p>	F 0157	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? POA for resident #127 was notified on 6/15/15. The</p>	03/23/2016	

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	<p>family member. (Resident #127)</p> <p>B. Based on interview and record review the facility failed to notify the physician of a possible drug allergy for an Opioid Analgesic medication for 1 of 1 residents reviewed for hospitalization. (Resident #35)</p> <p>Findings include:</p> <p>A. Review of the clinical record for Resident #127 on 2/17/16 at 3:55 p.m., indicated the following: diagnoses included, but were not limited to, old myocardial infarction, hypertension, cognitive communication deficit, dementia without behavioral disturbance, and generalized anxiety disorder.</p> <p>A family member of Resident #127 was interviewed on 2/16/16 at 9:36 a.m. During the interview, he indicated he was not notified when his loved one was started on the medication of Seroquel (psychotropic medication). He also indicated he had read information on Seroquel and was concerned its use was contraindicated in patients with cardiovascular disease and with dementia.</p> <p>A physician's order for Resident #127, dated 4/29/15, indicated Seroquel 50 mg</p>		<p>consent for the use of Seroquel was signed on this date. Resident #35 no longer resides at facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Resident's charts, with a psychotropic medication order, were audited for signed consents with no issues found. Resident's medication and allergies were reviewed by DON and NP with no abnormalities found. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Unit Manager/DON will bring new orders for all residents to clinical meeting (M-F). Each new order will be checked against the progress notes for documentation of notification when appropriate. Allergy alerts from PCC will be monitored by the Unit Manager/DON and followed upon M-F during the clinical meeting. An in-service for staff will be held March 15, 2016. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Monitoring will be done daily (M-F) by the DON/UM using the appropriate QA form with findings presented at monthly QA meeting</p>		

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	<p>(milligrams) daily.</p> <p>Social Service #1 and Social Service #2 were interviewed on 2/18/16 at 9:34 a.m. During the interview, they indicated it was the responsibility of nursing to notify family concerning the addition of a medication, any change in medication, or a discontinuation in medication.</p> <p>The Director of Nursing (DON) was interviewed on 2/18/16 at 1:34 p.m. During the interview she indicated the only documentation she could locate when Resident #127's family was notified of the Seroquel was dated 6/10/15.</p> <p>A current facility policy "Managing Change of Condition within PCC (Point Click Care), dated October 2015 and provided by the DON on 2/18/16 at 3:28 p.m., indicated "...To appropriately assess, document, and communicate changes of condition (COC)...Notify the Patient and/or responsible party of current status and subsequent actions/orders...."</p> <p>B. On 2/18/16 at 11 a.m., the clinical record of Resident #35 was reviewed. Diagnoses included, but were not limited to, the following: Acute cholecystitis, Peripheral Vascular Disease, hypertension, hypertensive heart disease,</p>		times 6 months. By what date the systemic changes will be completed. March 23, 2016		

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	<p>stage 5 chronic kidney disease/end stage renal disease, asthma, sleep apnea, morbid obesity, bilateral below the knee amputations, generalized muscle weakness, muscle wasting, anxiety, chronic pain, Diabetes Mellitus type 2, pneumonia and atrophy.</p> <p>The profile form indicated the resident was admitted to the facility on 12/30/15. This form included, but was not limited to, the following allergies: Codeine (opioid analgesic). The severity documented for all the above allergies was "unknown."</p> <p>Nurse's notes, dated 1/18/16 at 3:16 p.m. indicated the following: "The system has identified a possible drug allergy for the following order: Embeda (Opioid Analgesic) capsule...*Narcotic* give 1 capsule by mouth one time a day for chronic pain."</p> <p>Review of the January 2016 MAR (Medication Administration Record) indicated the resident was administered the medication Embeda on 1/20/16 and 1/21/16.</p> <p>A nurse's note, dated 1/22/16 at 9:52 a.m., indicated "Embeda...held due to lethargy...."</p>			

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	<p>A history and physical performed by the Nurse Practitioner, was dated 1/22/16 at 11:28 a.m. This included, but was not limited to, the following: " Acute visit per (name of LPN) request for altered LOC (level of consciousness) d/t (due to) Embeda request per patient...Reassessment...History:...asleep, difficult to arouse...LPN held the Embeda dose d/t altered LOC today...plan to DC (discontinue) Embeda..."</p> <p>A nurse's note, dated 1/22/16 at 1:24 p.m., "The system has identified a possible drug allergy for the following order: Embeda Capsule Extended Release...Narcotic...."</p> <p>Documentation was lacking in the clinical record to indicate the physician had been notified of the possible drug allergy for Embeda prior to the resident having received it for 2 days on 1/20/16 and 1/21/16.</p> <p>On 2/22/16 at 1:50 p.m., the Regional Director of Clinical Operations was interviewed. She indicated the facility did not have a policy and procedure in regard to how the possible allergy alerts, which were documented in the nurses notes, were to be addressed.</p> <p>3.1-5(a)(3)</p>			

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F 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to honor the sleeping routine preference by 1 resident (Resident #107) of 7 residents who met the criteria for choices.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #107 on 2/16/16 at 8:31 a.m., indicated the following: diagnoses included, but were not limited to, Type 1 diabetes, heart failure, atrial fibrillation, asthma, and gastro-esophageal reflux disease with esophagitis.</p> <p>Resident #107 was interviewed on 2/16/16 at 10:29 a.m. During the interview, she indicated she would like to</p>	F 0242	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #107 has been discharged from facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>Residents were interviewed to insure preferences are being met. Care plans were updated as needed. On 2/22/16, the medication time for Levothyroxine Sodium was changed to HS. No other medication time changes were needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Resident preferences/choices will be discussed at admission, the</p>	03/23/2016

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	<p>sleep longer in the morning. She also indicated staff woke her up at 6:00 a.m. every morning to give her thyroid medication before breakfast and then she couldn't get back to sleep. She indicated she did not usually eat her breakfast until 7:30 a.m. to 7:45 a.m., so she wondered why she could not have her medication an hour later.</p> <p>Facility meal times indicated the breakfast service of the East Hall trays began at 7:20 a.m.</p> <p>A physician's order for Resident #107, with a start date of 1/15/16, indicated Levothyroxine Sodium 125 mcg (micrograms) one time daily.</p> <p>A Minimum Data Set assessment for Resident #107, dated 1/21/16, indicated a score of 15 out of 15 on the Brief Interview for Mental Status, indicating she was cognitively intact.</p> <p>A Medication Administration Record (MAR) for Resident #107, dated for the month of January 2016, indicated she received her Levothyroxine Sodium 125 mcg at 5:45 a.m.</p> <p>A MAR for Resident #107, dated for the month of February 2016, indicated she received her Levothyroxine Sodium 125</p>		<p>initial IDT walking rounds and quarterly with care plan meeting. Medications times will be adjusted if indicated. Care plans will be updated as needed by MDS. An audit was completed for residents with early am medications A staff in-service will be held on 3/15/16. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The guardian angel will round M-F asking if individual preferences are being met using the room monitoring form with results to the monthly QA meeting times 6 months. By what date the systemic changes will be completed. March 23, 2016</p>	

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	<p>mcg at 5:45 a.m.</p> <p>LPN #3 was interviewed on 2/19/16 at 5:40 a.m. During the interview she indicated she started passing medications at 5:00 a.m.</p> <p>LPN #4 was interviewed on 2/19/16 at 9:20 a.m. During the interview, she indicated some medications were given on flex time, but if a medication had a specific time listed under the hours on the MAR, that is when the medication was given.</p> <p>The Director of Nursing was interviewed on 2/22/16 at 9:20 a.m. During the interview, she indicated thyroid medication had to be given prior to a meal and it had always been given at 5:45 a.m.</p> <p>A facility care plan for Resident #107, with a review date of 2/10/16, indicated the focus area of preferences. Resident states she would like to choose her own sleeping routine. Interventions to the focus included, but were not limited to, provide resident's care in accordance with (his/her) wishes.</p> <p>A current undated facility policy "Indiana Bill of Resident's Rights", provided by Medical Records on 2/19/16 at 1:40 p.m.,</p>			

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F 0244 SS=E Bldg. 00	<p>indicated "...You have the right to be treated with consideration, respect, recognition of your dignity and individuality...."</p> <p>3.1-3(u)(1)</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 respond to resident council concerns with implementation of measures to address resident council concerns effectively.</p> <p>Findings include:</p> <p>1. On 2/18/16 at 2:40 p.m., a review of the Resident Council Minutes indicated during the meeting on January 2016, residents indicated ice water was not always offered on the halls.</p>	F 0244	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident grievances will be addressed following Resident Council by Social Services and resolved at the next Resident Council meeting. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents were interviewed for concerns with the call light wait time and receiving fresh water</p>	03/23/2016

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	<p>The Resident Council President was interviewed on 02/19/2016 at 1:09 p.m. During the interview, she indicated there had been complaints from residents concerning ice water not being passed. She also indicated she had problems with receiving ice water herself. She further indicated the ice cooler had been sitting in the hallway and residents were helping themselves, but now the ice cooler was locked.</p> <p>2. A review of the Resident Council Minutes provided by Social Services #12 on 2-18-2016 at 2:43 p.m., indicated the following: The January 2016 minutes indicated "...Residents mentioned that call lights are not being answered promptly...." The November 2015 minutes indicated "...3rd shift call light response has been an issue at times...residents feel staff are talking, texting and sitting at nurses stations...." The September 2015 minutes indicated "one resident stated that some residents are left in the assisted dining rooms too long after they are done with their breakfast...she stated that these residents require a push back to their room and that they do not get a push back until they have to wait...." The August 2015 minutes indicated "...one resident stated that they had to</p>		<p>daily. Resident Council meeting held with grievances written and followed up on for concerns. Protocol reviewed for ice water pass and answering call lights with no changes needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The SS director will complete a grievance for any concern voiced at Resident Council and for ward to the appropriate department for resolution. Meetings will be held monthly. A staff in-service will be held on 3/15/16. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Guardian Angels will monitor M-F each occupied room. Grievances will be completed for concerns. The grievance will be given to the SS director at the clinical meeting and forwarded to appropriate department for resolution. SS will log each grievance and monitor for resolution. Results will be presented to monthly QA times 6 months. By what date the systemic changes will be completed. March 23, 2016</p>	

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	<p>wait a little while--15 minutes--on their call light...."</p> <p>The July 22, 2015 minutes indicated "...one resident stated that they felt the units were understaffed...."</p> <p>The April 2015 minutes indicated "...residents mentioned that staff turnover and a non-consistent schedule is a concern to residents...."</p> <p>Copies of the responses to the resident concerns were provided by Social Services #12 on 2-19-2016 at 3:08 p.m. and indicated since the last annual survey, responses for 12-21-15 and 1-27-2016 were the only two provided. An interview with Social Services #12 indicated those were the only ones he had. The contents of the responses concerned the dietary and a facelift for the activity lounge and the previous assisted dining rooms.</p> <p>An interview with the Resident Council President on 2-19-2016 at 1:36 p.m., indicated getting the call lights answered was dependent upon who was on and how many aides were working. She indicated she has had to wait 30 minutes with no one answering her light. Further interview with the Resident Council President, indicated a resident came to her and indicated she went to her bathroom during the night and it was</p>				

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F 0258 SS=D Bldg. 00	<p>soiled and wet on the floor. The aide came and would not clean it up and told her that someone would be here in a couple of hours and they would do it.</p> <p>3.1-3(1)</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to ensure comfortable sound levels for 3 of 22 residents in 2 of 5 units reviewed for comfortable sound levels (Resident #116, #6 and #61.)</p> <p>Findings include:</p> <p>1. An interview with Resident #116 on 2-15-2016 at 2:38 p.m., indicated the "noise is so bad all the time...she feels like she will have a nervous breakdown..." and "...some of the TVs were so loud, it's ridiculous..." The resident indicated she is sound sensitive and had told "...people it bothered her..." The Resident indicated she had "tried earplugs and earphones and nothing drowns it out."</p>	F 0258	<p>· Guardian Angels interviewed interviewable residents asking if they have any concerns with noise (Dept. managers/ADM) 03-23-2016 · Concerns from Resident Council meeting will be followed up on by appropriate manager prior to next scheduled meeting with resolutions discussed at next meeting (SSD/Dept. managers/ADM) – 03-23-2016 · Daily M-F monitoring of interviewable residents during Guardian Angel rounds regarding noise issues. If issues identified, a resident concern/grievance form will be completed and forwarded to SSD. (Dept. managers/ADM) 03-23-2016 · Results of noise/comfortable sound level grievance concerns will be submitted to QAA Committee monthly times 6 months. (SSD/QAA Committee)</p>	03/23/2016

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	<p>An interview with Resident #116 on 2-22-2016 at 9:42 a.m., indicated the resident was in her room and the door was opened. The resident indicated the TV noise goes on all night long and she has told the nurses several times and nothing has changed. At this time, it was observed that a very loud TV was on and was coming from a room across the hall.</p> <p>2. An interview with Resident #6 on 2-16-2016 at 2:21 p.m., indicated "...other residents' TVs were up too loud..." The resident indicated he did report this to staff, but he indicated those staff were no longer here. During the interview, with Resident #6's room quiet and the door closed, it was observed that 2 different TVs could be heard blaring and some music could also be heard. The resident indicated there had been a nurse that would get the TVs turned down about 10:30 p.m. and close those resident's doors, but he indicated that nurse was no longer here.</p> <p>An observation outside Resident #6's room on 2-18-2016 at 4:15 p.m., indicated a loud TV and a loud radio from 2 other rooms could be easily heard in the hallway as both room doors were open. Another loud TV could be heard in the hall from a different room, even</p>		03-23-2016	

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	<p>though the room door was opened just a crack.</p> <p>An observation outside Resident #6's room on 2-19-2016 at 9:22 a.m., indicated a TV and radio from a room could be heard in the hallway and a TV from another room could also be heard in the hallway.</p> <p>An observation outside Resident #6's room on 2-22-2016 at 9:40 a.m., indicated 3 different TVs could be heard in the hall from 3 different rooms around Resident #6's room.</p> <p>3. An interview with Resident #61 on 2-15-2016 on 12:15 p.m., indicated she was awakened at night as she hears loud voices in the hallway. She indicated the noise kept her from going back to sleep.</p> <p>A review of the Resident Council Minutes provided by Social Services #12 on 2-18-2016 at 2:43 p.m., indicated in the June 24, 2015 minutes "...one resident stated that noise at nighttime is an issue around 9:00 - 10:00...."</p> <p>The March 25, 2015 notes indicated "...quiet time for staff was suggested from 9:00 - 10:00 for the start time, throughout the night...other residents televisions and radios being loud at nighttime...."</p>			

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F 0282 SS=E Bldg. 00	<p>An interview with LPN #11 on 2-19-2016 at 10:00 a.m., indicated she was not aware residents had complained about it being noisy during the evening and night shift.</p> <p>An interview with the Administrator and DON (Director of Nursing) on 2-22-2016 at 2:00 p.m., indicated they were not aware of the noise issue in the 100 and 200 hall.</p> <p>The current "Indiana Bill of Resident's Rights" which was undated and provided by Medical Records #13 on 12-19-2016 at 1:40 p.m. indicated "...you have the right to be treated with consideration, respect, recognition of your dignity and individuality...."</p> <p>3.1-19(f)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on observation, interview and</p>	F 0282	Resident #107 discharged from	03/23/2016

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	<p>record review, the facility failed to ensure 2 of 3 residents reviewed for ADLs (Activities of Daily Living) personal care received oral care. (Resident #100 and #136)</p> <p>B. Based on observation, interview and record review the facility failed to follow the care plan for access to cold water for 2 residents (Resident #107 and Resident #116) of 2 residents who met the criteria for hydration.</p> <p>Findings include:</p> <p>A.1. An observation of Resident #100 on 2-15-2016 at 2:40 p.m., indicated the resident was in her wheelchair in her room watching TV with the call light attached to the bed rail.</p> <p>An observation of Resident #100 on 2-16-2016 at 1:30 p.m., indicated the resident was in her room in her wheelchair with a splint on her right hand and a tray table attached to the right side of her wheelchair.</p> <p>An interview with Resident #100 on 2-15-2016 at 2:46 p.m., indicated she did not get a "...toothbrush very often...."</p> <p>An interview with Resident #100 on 2-22-2016 at 11:04 a.m., indicated she</p>		<p>facility · Resident #116 and 136 – ice water is being passed according to protocol on a daily basis · Resident #136 is offered oral care on a daily basis by CNA. · Interviewable residents were interviewed for water pass and oral care with no additional concerns identified. · Daily monitoring M-F during Guardian Angel rounds asking residents if there are any concerns with oral care and ice water pass with appropriate resident concern/grievance form completed and submitted to SSD. (Dept. managers/ADM) 03-23-2016 · Daily M-F report will be run/reviewed during clinical meeting regarding missed ADL charting with results forwarded to appropriate unit manager for follow up with resident/staff. ongoing (MDS/UM/DON) 03-23-2016 · Monthly times 6 months monitoring of resident concerns/grievances specifically related to oral care and ice water pass through QAA committee (SSD/Dept. managers/ADM) 03-23-2016</p>		

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	<p>didn't have her teeth brushed today.</p> <p>An interview with CNA #14 on 2-19-2016 at 4:01 p.m., indicated the resident required extensive assistance and he would provide her nighttime care per the resident's request. CNA #14 indicated if the resident wants her teeth brushed, he would do it and document in the system.</p> <p>The record review for Resident #100 began 2-19-2016 at 12:19 p.m. Diagnoses included but were not limited to Alzheimer's disease, chronic atrial fibrillation, hypertension (high blood pressure), muscle wasting, dysphagia (difficulty swallowing), cerebral vascular disease (stroke), hemiplegia (weakness) and hemiparesis (paralysis), affecting the dominant side-right.</p> <p>A review of the physician's orders indicated on 2-12-2016, "...the MD (Medical Doctor) determined the Resident had the Mental Capacity to make healthcare decisions as per the history & physical or transfer orders or preferred intensity of care...."</p> <p>A care plan for ADLs (Activities of Daily Living) dated 8-18-2015 and provided by the Administrator on 2-22-2016 at 11:14 a.m., indicated Resident #100 "...needs</p>			

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	<p>extensive assistance with ADLs...." The interventions for "...Oral/Dental Care - One person physical assist required...."</p> <p>Further review of the ADL care plan indicated "...Oral Care: The resident has (SPECIFY: own teeth, upper/lower dentures, broken teeth, carious teeth, sore gums, bridgework). The resident requires oral inspection (SPECIFY FREQ) Report changes to the Nurse...."</p> <p>A review of the annual MDS (Minimum Data Set) assessment dated 12-10-2016 indicated Resident #100's BIMS (Brief Interview for Mental Status) was a 13/15 which indicated the resident was cognitively intact. The assessment indicated there were no problems in the oral/dental care section and the resident required an extensive assist of one person for personal hygiene which included combing hair and brushing the teeth. Further review of the assessment indicated the resident had an upper and lower extremity impairment on one side.</p> <p>A review of the "Bedside Kardex Report printed on 2-18-2016 provided by LPN #15 on 2-18-2016 at 3:45 p.m., indicated under personal hygiene/oral care section "...Oral/Dental Care - one person physical assist required...."</p> <p>A review of the February 2016 task</p>			

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	<p>documentation which was provided by the Administrator on 2-22-2016 at 8:20 a.m., indicated documentation was to be done every shift for personal hygiene. Documentation was lacking for February 3, 5, and 10. Documentation for 2 shifts were marked on February 1, 4, 11, 12, 15, 16, and 18 and documentation for one shift was marked on February 8, 9, 13, 14 and 17.</p> <p>A review of the dental exam for 12-15-2015 and provided by the Administrator on 2-22-2016 at 11:14 a.m., indicated the following, "...Oral hygiene: Fair, Gingival Tissue: Slight Inflammation, and Debris Level: Moderate...." An attachment to the dental exam titled "Oral Care Tips For Older Adults" with Resident 100's name and date of exam indicated "...brush your teeth and tongue twice a day for two minutes using fluoride toothpaste...clean between your teeth daily with floss or other between-the-teeth cleaner...."</p> <p>A.2. An interview with Resident #136 on 2-16-2016 at 1:41 p.m., indicated the resident had not brushed his teeth since he had been in this room, which had been prior to Christmas 2015. The resident indicated the mirror in the bathroom was not low enough for him to see to brush his teeth. Resident #136 took a</p>			

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	<p>toothbrush which was in a sealed plastic wrap and a small tube of un-used toothpaste out of his shirt pocket and indicated it had not been used.</p> <p>An interview with CNA #14 on 2-19-2016 at 4:02 p.m., indicated the staff try to get Resident #136 to do as much as he possibly can for himself.</p> <p>An interview with Resident #136 on 2-22-2016 at 9:40 a.m., indicated his teeth had still not been brushed and staff had not assisted him to brush his teeth. The resident was observed to open his mouth and his teeth were discolored and stained.</p> <p>An interview with Social Services #12 on 2-22-2016 at 8:20 a.m., indicated Resident #136 has a follow up appointment with the dentist on 2-24-2016 at 10:30 a.m.</p> <p>The record review began on 2-19-2016 at 2:47 p.m. Diagnoses for Resident #136 included but were not limited to transient alteration of awareness, chest pain, cerebellar stroke syndrome, hemiplegia and hemiparesis following other CVA (cerebral vascular accident - stroke) affecting left non-dominant side, flaccid hemiplegia affecting right dominant side, muscle weakness, COPD (chronic</p>			

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	<p>obstructive pulmonary disease), hypertension, diabetes, cardiomegaly (enlarged heart), dissociative and conversion disorders, and heart failure.</p> <p>A review of the physician orders dated 2-12-2016 indicated "...the MD (Medical Doctor) determined the Resident had the Mental Capacity to make healthcare decisions as per the history & physical or transfer orders or preferred intensity of care...."</p> <p>A review of the care plan for ADLs dated 2-9-2016 and provided by the Administrator on 2-22-2016 at 11:14 a.m., indicated Resident #136 "...needs extensive assist with ADLs related to right sided hemiparesis..." The interventions indicated the resident would like to be woken up at 8 a.m. daily including weekends, two person physical assist for bed mobility, transfers, bathing and mechanical lift, and one person assist for eating and dressing. Additional interventions included encourage resident to use call bell and encourage resident to participate to the fullest extent with each interaction.</p> <p>A review of the MDS quarterly assessment dated 2-1-2016 indicated the BIMS was 14/15, which indicated the resident was cognitively intact. Further</p>			

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	<p>review of the MDS, indicated Resident #163 required extensive assistance of 2 persons for personal hygiene which included brushing teeth and there was a functional limitation in range of motion in the upper and lower extremity with impairment on one side.</p> <p>A review of the "Bedside Kardex Report printed on 2-18-2016 provided by LPN #15 on 2-18-2016 at 3:45 p.m., indicated under personal hygiene/oral care section "...would like to be woken up at 8 AM daily including weekends...."</p> <p>A review of the February 2016 task documentation which was provided by the Administrator on 2-22-2016 at 8:20 a.m., indicated documentation was to be done every shift for personal hygiene. Documentation was lacking for February 8, 2016. Documentation for 2 shifts were marked on February 4, 12, 16 and 18 and documentation for 1 shift was marked for February 3, 5, 7, 9, 10, 11, 13, 14, 15, 17 and 19.</p> <p>A review of the dental exam for 1-26-2016 and provided by the Administrator on 2-22-2016 at 11:14 a.m., indicated the following, "...Oral hygiene: Fair, Gingival Tissue: Slight Inflammation, and Debris Level: Minimal...." An attachment to the dental</p>			

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	<p>exam titled "Oral Care Tips For Older Adults" with Resident 136's name and date of exam indicated "...brush your teeth and tongue twice a day for two minutes using fluoride toothpaste...clean between your teeth daily with floss or other between-the-teeth cleaner...."</p> <p>An interview with LPN #11 on 2-22-2016 at 9:36 a.m., indicated she hadn't seen the printed aide task sheets for the documentation of the ADLs. She indicated with the personal hygiene every shift on the task sheet, she would expect to see documentation every shift for care. LPN #11 indicated without the documentation, the personal hygiene task would not have been done.</p> <p>A current policy "Operating Standards Guidelines Interdisciplinary Walking Rounds" dated April 2015 and provided by the Administrator on 1-22-2016 at 8:20 a.m., indicated "...key areas of IDT walking rounds include...review of ADL documentation for accuracy of coding vs. patient functional ability...."</p> <p>B. 1. Review of the clinical record for Resident #107 on 2/9/16 at 8:31 a.m., indicated the following: diagnoses included, but were not limited to, Type 1 diabetes, heart failure, atrial fibrillation, asthma, and gastro-esophageal reflux</p>			

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	<p>disease with esophagitis.</p> <p>Resident #107 was interviewed on 2/16/16 at 10:43 a.m. During the interview, she indicated staff did not routinely pass fresh ice water. She also indicated she had not received any fresh ice water since the evening of 2/15/16.</p> <p>Resident #107 was again interviewed on 2/18/16 at 3:30 p.m. During the interview, she indicated the passing of ice water had not improved much since 2/15/16. She also indicated she had not received any fresh ice water since early in the morning, indicating the passing of ice water was particularly bad on the 2nd shift. When observing her water mug, there was no ice inside the mug and the outside of the mug was warm to the touch. She further indicated she often had to go to the nurses station herself and ask staff for ice water, but staff would tell her to wait while they were seated at the nursing station "playing with their cell phones."</p> <p>A physician's order for Resident #107, with a start date of 1/14/16, indicated she received Furosemide (diuretic) 20 mg (milligrams) BID (twice a day) related to heart failure.</p> <p>Review of the Resident Council Minutes</p>			

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	<p>indicated during the meeting on January 2016, residents indicated ice was not always offered on the halls.</p> <p>The Resident Council President was interviewed on 02/19/2016 at 1:09 p.m. During the interview, she indicated there had been complaints from residents concerning ice water not being passed. She also indicated she had problems with receiving ice water. She further indicated the ice cooler had been sitting in the hallway and residents were helping themselves, but now the ice cooler was locked.</p> <p>A facility care plan for Resident #107, with a review date of 2/15/16, indicated the focus area of the resident was dehydration or potential fluid deficit related to diuretic use. Interventions included, but were not limited to, ensure resident has access to cold water whenever possible.</p> <p>The Administrator was interviewed on 2/22/16 at 9:20 a.m. During the interview, she indicated ice water was to be passed on each shift.</p> <p>The Administrator was interviewed on 2/22/16 at 1:11 p.m. During the interview, she indicated the facility did not have a policy concerning the passing</p>			

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	<p>of ice water or following care plans.</p> <p>B. 2. On 2/18/16 at 11 a.m. the clinical record of Resident #116 was reviewed. Diagnoses included, but were not limited to, the following: lymphedema in bilateral lower extremities, diabetes and hypertension. The MDS (minimum data set) assessment, dated 12/11/15 included, but was not limited to, the following: independent cognition; extensive assist for bed mobility and transfer and ambulation in room didn't occur.</p> <p>A care plan, dated 12/15/15, addressed the focus of "...has risk for dehydration or potential fluid deficit r/t bacterial pneumonia with antibiotic..." Interventions included, but were not limited to, the following: "Encourage...to drink fluids of choice...Ensure...has access to water pitcher in her room..."</p> <p>On 2/15/16 at 2:45 p.m. the resident was interviewed. She indicated the staff do not routinely pass fresh ice water to her. She indicated due to her diagnosis of renal insufficiency and failure, it is important for her to drink water. She indicated "you have to beg for water here."</p> <p>On 2/18/16 at 1:55 p.m., the resident was observed in her bed. She was</p>			

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	<p>interviewed and indicated there have been times that she has not had ice water from early morning until second shift. She indicated she asks for it but does not always get it.</p> <p>On 2/18/16 at 3:45 p.m. a copy of the resident's Kardex (form which specified resident's care to be received) was received from LPN #24. This form included, but was not limited to, the following: "Encourage (resident name) to drink fluids of choice."</p> <p>On 2/19/16 at 10:03 a.m. the resident was observed in her room in bed. She indicated she had not had fresh ice water passed to her since before supper last night. At this time, both of the resident's uncovered water pitchers were observed. One was completely empty and the other was 3/4 empty.</p> <p>On 2/19/16 at 11:22 a.m., CNA #23 was interviewed. She indicated she was caring for Resident #116 today. She indicated she tries to pass water right after breakfast, once a shift.</p> <p>On 2/19/16 at 11:26 a.m., Resident #116 was observed sitting in her bed with two water pitchers at her bedside. Both were empty. Resident #116 was interviewed and indicated she had not received any</p>			

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F 0309 SS=D Bldg. 00	<p>fresh ice water yet today.</p> <p>On 2/19/16 at 1:40 p.m. the LPN #11 provided a current copy of the CNA (certified nursing assistant) sheet. These sheets included, but were not limited to, the following: First shift, ice water passed by 9:00 a.m.; second shift, ice water passed by 3 p.m.; 3rd shift was lacking documentation of guidelines for passing water.</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> <p>Based on interview and record review, the facility failed to ensure assessments for a resident with a change in condition were completed and contained current information. The facility further failed to ensure the physician or nurse practitioner was notified of one possible drug allergy for 1 of 1 resident reviewed for</p>	F 0309	<ul style="list-style-type: none"> · Resident #35 discharged from facility · Daily M-F ongoing review of 24 hour report during clinical meeting by DON/UM with followup as indicated. (UM/DON) 03-23-2016 · Daily M-F ongoing review of Change of condition/SBAR assessments with follow up as 	03/23/2016

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	<p>hospitalization. (Resident # 35)</p> <p>Findings include:</p> <p>On 2/18/16 at 11 a.m., the clinical record of Resident #35 was reviewed. Diagnoses included, but were not limited to, the following: Acute cholecystitis, Peripheral Vascular Disease, hypertension, hypertensive heart disease, stage 5 chronic kidney disease/end stage renal disease, asthma, sleep apnea, morbid obesity, bilateral below the knee amputations, generalized muscle weakness, muscle wasting, anxiety, chronic pain, Diabetes Mellitus type 2, pneumonia and atrophy.</p> <p>The profile form indicated the resident was admitted to the facility on 12/30/15. This form included, but was not limited to, the following allergies: Codeine (opioid analgesic). The severity documented for all the above allergies was "unknown."</p> <p>Physician orders, dated 12/30/15, included but were not limited to, the following order: "Oxycodone (opioid analgesic) HCL (hydrochloride)...every 4 hours as needed for pain..."</p> <p>Nurse's notes, dated 1/15/16 at 11:04</p>		<p>indicated. (UM/DON) 03-23-2016</p> <ul style="list-style-type: none"> · Daily M-F ongoing review of PCC clinical alerts during clinical meeting with follow up as indicated. (UM/DON) 03-23-2016 · In-service nursing staff regarding Change of Condition/SBAR and appropriate assessment follow up. · Daily monitoring with monthly times 6 months report submitted to QAA committee for review (UM/DON/QAA Committee) 03-23-2016 	

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	<p>p.m. included, but were not limited to, the following: "...Alert, orientation to person, place, time and situation; Res (resident) does frequently doze off when in bed even while nurse is doing care...."</p> <p>Nurse's notes, dated 1/18/16 at 3:16 p.m. indicated the following: "The system has identified a possible drug allergy for the following order: Embeda (Opioid Analgesic) capsule...*Narcotic* give 1 capsule by mouth one time a day for chronic pain."</p> <p>A Nurse's note, dated 1/18/16 at 4 p.m. included, but was not limited to, the following information: "...Res (resident) has chronic pain and takes routine and prn (as needed) pain medicine. The med (medicine) has limited effect. Res (resident) did receive new orders for stronger pain med when it becomes available to pharmacy since they do not carry there."</p> <p>Review of the January 2016 MAR (Medication Administration Record) indicated the resident was administered the medication Embeda on 1/20/16 and 1/21/16.</p> <p>Medicare documentation, from the clinical record which was dated 1/20/16 at 8:00 p.m., included, but was not</p>			

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	<p>limited to, the following: alert, oriented to person, place, time and situation; notable changes in LOC (level of consciousness) and orientation and/or cognition: Resident has frequent episodes of being lethargic.</p> <p>Medicare Documentation, from the clinical record which was dated 1/21/16 at 9:20 p.m., included but was not limited to, the following: "vital signs: most recent: temperature 98.3 oral (1/20/16 1 a.m.); pulse 78 (1/20/16, 3:03 p.m.); respirations 18 (1/20/16 at 8:01 p.m.); blood pressure 101/64 (1/21/16 at 8:02 a.m.)...alert...res (resident) has frequent episodes of being lethargic..."</p> <p>A nurse's note, dated 1/22/16 at 9:52 a.m., indicated "Embeda...held due to lethargy...."</p> <p>A history and physical performed by the Nurse Practitioner, was dated 1/22/16 at 11:28 a.m. This included, but was not limited to, the following: " Acute visit per (name of LPN) request for altered LOC (level of consciousness) d/t (due to) Embeda request per patient...Reassessment...History:...asleep, difficult to arouse...LPN held the Embeda dose d/t altered LOC today...Appears very lethargic and slow moving...mental capacity...unable to obtain...most recent</p>			

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	<p>vital signs:...temperature: 98.3 oral (1/20/16)...pulse 78 (1/20/16); blood pressure 106/78 (1/22/16); blood sugar: 171.0 mg/dl (milligrams/deciliter) (1/22/16 at 7:44 a.m.); oxygen saturation: 98% (1/17/16)...lethargic, sleepy, in WC (wheelchair), jerking movements noted per NP...neurological: lethargic; summary of findings: altered LOC...plan to DC (discontinue) Embeda..."</p> <p>On 1/22/16 at 1:08 p.m., a pharmacy review indicated the following: "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's regimen contained no new irregularities..."</p> <p>A nurse's note, dated 1/22/16 at 1:24 p.m., "The system has identified a possible drug allergy for the following order: Embeda Capsule Extended Release...Narcotic...."</p> <p>Documentation was lacking in the clinical record to indicate the possible drug allergy for Embeda had been addressed prior to the resident having received it for 2 days on 1/20/16 and 1/21/16.</p>			

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	<p>A nurses note, dated 1/22/16 at 2:23 p.m., indicated "...Lyrica capsule...held due to lethargy..."</p> <p>Medicare Documentation, dated 1/22/16 at 3:04 p.m. from the clinical record included, but was not limited to, the following: Most recent temperature: 98.3, oral (1/20/16); most recent pulse: 78 (1/20/16); most recent respirations 18 (1/20/16), most recent blood pressure 106/78 (1/22/16 at 7:44 a.m.), not alert, oriented to person, place, time, situation (sic); resident has frequent episodes of being lethargic; notable changes in mood and behavior "Resident started on Embeda 2 days ago, very lethargic."</p> <p>A nurse's note, dated 1/22/16 at 3:24 p.m., "...Resident lethargic today. Embeda started 2 days ago. NP (Nurse Practitioner) titrating down Embeda and dcing (discontinuing) after 4 days. V/S (vital signs) WNL (within normal limits)..."</p> <p>A nurse's note, dated 1/22/16 at 7:00 p.m., "(name of resident) is experiencing a possible change in condition. The following areas of concern are noted: Altered mental status, food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts). Functional decline (worsening function and/or</p>			

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	<p>mobility). Unresponsiveness. MD notified...1/22/16 at 8:00 p.m. See SBAR (Situation, Background, Assessment, Recommendation) for further information."</p> <p>A "Change in Condition Evaluation" form dated 1/22/16 at 7 p.m. included, but was not limited to, the following: "...change in condition...I am calling about is...altered mental status...food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts), functional decline (worsening function and/or mobility)...unresponsiveness...This started on 1/21/16...time of day did this start...[sic] morning...additional pertinent diagnosis...chronic renal failure...are the most recent vital signs taken after the change in condition occurred...Yes...most recent BP 106/78 date (1/22/16 at 7:44 a.m.); most recent pulse 78...date (1/20/16 at 3:03 p.m.), most recent respiration: 18, date (1/20/16 at 8:01 p.m.), most recent temperature 98.3, oral, date (1/20/16 1:01 a.m.)...most recent O2 SATs (saturation) 98 %, date (1/17/16) mental status evaluation: unresponsiveness, decreased level of consciousness (sleepy, lethargic)...other symptoms or signs of delirium...specify the decreased level of consciousness: sudden change in level of consciousness</p>			

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	<p>or responsiveness...Describe the functional status signs or symptoms: SE (side effect) new pain medication...change in level of consciousness is: sudden change in level of consciousness or responsiveness...s/s over medicated and N.P. to reassess in person...date and time clinician notified 1/22/16 at 8 p.m..."</p> <p>A nurses note, dated 1/22/16 at 8:00 p.m. "Res has been lethargic and is responding to verbal stimuli but then goes back to sleep. Reported that she was seen by N.P. earlier today and is to be monitored. New pain med Embeda d/cd...Res...and v/s have been wnl. N.P. (nurse practitioner name) was contacted regarding the res not eating, drinking et (and) not responding appropriately. Informed writer that she had got [sic] report from N.P. (a different N.P.) and we were to monitor. N.P. (name of first NP) to have res reassessed by herself or day N.P. Will continue to monitor."</p> <p>Nurse notes, dated 1/22/16 at 9:01 p.m., indicated "...Unable to waken res enough to safely swallow meds."</p> <p>An SBAR COC (change of condition) 911 Transfer form, dated 1/23/16 at 6:45 a.m., included, but was not limited to, the following: Change of condition type:</p>			
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	<p>mental change...change of condition...I am calling about is [sic]...Res not responding appropriately, no food or fluid in last 48 hours, no voiding in last 24 hrs (hours)...This started on 1/21/16...since this started has it gotten...worse...this condition has occurred before...no...other pertinent history...DM (diabetes Mellitus), COPD (chronic obstructive pulmonary disease)...Medication alerts, changes in the last week...Blood pressure (BP) 77/45 (1/23/16 at 6:30 a.m.)..pulse 89 (same time and date as BP); respirations: 26 (same time and date as BP); temperature 101.1 Maxilla (same time and date as BP)...mental changes...decreased consciousness (sleepy,lethargic), unresponsiveness...cannot open her eyes, slurred speech...labored breathing...Resp (respirations) 26, O2 (oxygen) SATs (saturation) 88% and need O2 per n/c (nasal cannula)...no food or intake last 48 hours...no voiding in last 24 hours...Full CPR (Cardiopulmonary Resuscitation)...Nurse. I think the problem may be...s/s (signs and symptoms) infection, s/s sepsis...."</p> <p>An "Emergency Department Chart" dated 1/23/16 at 7:20 a.m. indicated the chief complaint was "possible sepsis."</p> <p>On 2/18/16 at 8:25 a.m., the DON</p>			

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	<p>(Director of Nursing) and Unit Manager #21 were interviewed. They indicated the resident had been in pain management for years. They indicated soon after the Embeda was started, the resident began to decline, became very lethargic and had slurred speech. The resident could be aroused but then would drift right back to sleep. Unit Manager #21 indicated the nurse's note "Physician's Order Note: The System has identified a possible drug allergy for the following order: "Embeda...", "pops up from pharmacy." The DON indicated the facility would contact pharmacy regarding the note as to how to proceed with the medication. Unit Manager #21 indicated that on 1/22/16, the resident started to deteriorate even more, so an SBAR was completed on 1/22/16 at 7 p.m.</p> <p>On 2/18/16 at 9:30 a.m., the manager at (name of pharmacy) was interviewed. She was made aware of the nurses note entry on 12/30/15 at 10:30 a.m.. She indicated this note had been generated from the facility computer system due to the resident having had a codeine allergy. She indicated codeine was considered a "cross sensitivity" to Oxycodone, so there was a possibility it may have required monitoring. The manager at (name of pharmacy) indicated it was the responsibility of the facility to "follow up</p>			

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	<p>with the prescriber" in regards to the entry in the nurses notes, which referenced the possible drug allergy.</p> <p>On 2/18/16 at 9:20 a.m., the (name of pharmacy) pharmacists was interviewed. She indicated morphine and codeine have a similar chemical structure which could lead to possible cross sensitivities, in reference to the allergy of codeine and the medication Embeda. She indicated the comment in the nurses notes about the possible drug allergy should be generated from the facility program. She indicated (name of pharmacy) did flag Embeda as a potential allergy. She indicated the order was processed on 1-18-16 and an allergy alert came up on their system on 1-18-16 as "non significant." The (name of pharmacy) pharmacists indicated the facility was to address this allergy alert from their side by notifying the physician of the alert and also to get a physician order regarding continuation or changes of the medication. The pharmacist indicated the (name of pharmacy) doesn't have documentation the facility called the pharmacy at any time regarding this possible allergy alert.</p> <p>On 2/22/16 at 11:32 a.m., Unit Manager #21 was interviewed. She indicated there should have been additional assessment</p>			

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	<p>and documentation of monitoring the resident's condition from 1/22/16 at 7 p.m. to the time of the transfer on 1/23/16 at 6:45 a.m. She indicated the follow up of the nurse practitioner having been notified of the resident's change in condition on 1/22/16 at 8 p.m. was for the nurse practitioner to reassess the resident in the morning. She also indicated the documentation of the "most recent vital signs" on the facility computerized charting, was self populated as the computer would automatically pull the most recently documented vital signs to be plugged into the documentation. Unit Manager #21 indicated the resident's signs and symptoms of lethargy began on 1/21/16 at 9:20 p.m.</p> <p>On 2/22/16 at 1 p.m., the DON provided a copy of the current facility policy and procedure for "Managing Change of Condition within PCC (Point Click Care)." This policy was dated October 2015 and included, but was not limited to, the following: "...If the change in condition does not require an Immediate 911 transfer, the following steps may be followed:...document assessment findings and communications..."</p> <p>On 2/22/16 at 1:40 p.m., the DON was interviewed. She indicated the resident</p>			
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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F 0323 SS=E Bldg. 00	<p>had a urinary tract infection which involved VRE (Vancomycin Resistant Enterococcus) around 1/15/16 and also experienced some tiredness during that time.</p> <p>On 2/22/16 at 1:50 p.m., the Regional Director of Clinical Operations was interviewed. She indicated the facility did not have a policy and procedure in regard to how the possible allergy alerts, which were documented in the nurses notes, were to be addressed.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure hand sanitizer, beauty shop supplies, alcohol prep pads, and shower cleaner disinfectant were stored securely and safely from mobile and confused residents. This deficient practice had the</p>	F 0323	<p>· Resident #37 – seat belt replaced – 02-19-2016 · One bathroom on B&B unit registered 120 degrees – hot water heater turned off, line was bled to lower temperature and all bathroom water temperature was rechecked and within normal levels. · Beautician was in</p>	03/23/2016

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	<p>potential to affect 6 confused and mobile residents of the 73 residents who resided outside the Bed and Breakfast Memory Care Unit in the facility.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure the hot water temperatures were 120 degrees Fahrenheit or less in the Bed and Breakfast, which had the potential to affect the 8 confused and independently mobile residents of the 16 residents who resided in the Bed and Breakfast Memory Care Unit. (Rooms 401, 405, 406, 410, 414)</p> <p>C. Based on observation, interview and record review, the facility failed to ensure a safety belt was replaced timely for 1 of 1 resident reviewed for malfunctioning safety equipment and with a history of falls. (Resident #37)</p> <p>Findings include:</p> <p>A. An observation of the shower room in the Rehabilitation unit on 2-15-2016 at 9:47 a.m., indicated the door could be opened by pushing down on the door handle. A key pad was observed on the door as the means to unlock the door. Inside the shower room in the left cabinet above the sink on the 3rd shelf were 2 boxes of tub and shower repair kit with a</p>		<p>serviced on 02-16-2016 on appropriate storage of all chemicals by DSD. · Three residents identified with seatbelts. All seatbelts checked for functionality with no issues noted.</p> <p>· Locked doors were checked for appropriate function by maintenance director.</p> <p>· Medication carts and locked areas were checked for proper storage of chemicals with no abnormalities found. · Staff was in serviced to discuss proper storage of chemicals and ensuring appropriate doors are locked. Beautician in serviced as above along with appropriate water temperature and proper functioning of resident equipment. Works orders were also presented to staff and protocol for use explained. · Three identified residents with seat belts will be interviewed M-F by guardian Angels to insure proper function.</p> <p>· Daily monitoring of water temperatures in identified rooms (Maintenance) 03-23-2016 · Daily monitoring of locked doors for proper function (Maintenance) 03-23-2016 · Beauty shop will be monitored one time during each visit for proper storage of chemicals (Admissions Coordinator) 03-23-2016 · Daily monitoring of above will occur x 60 days and then weekly x 6 months with results submitted to QAA Committee.</p>	

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	<p>warning on the label "...Danger...Keep Out of Reach of Children...Catalyst hardener causes severe burns...may be fatal if swallowed...vapor harmful..." An unlabeled spray bottle with a very light blue tinted liquid inside was in a plastic compartment with a lock, but the cover was missing, allowing the spray bottle to be accessible. It was located on the left side of the shower.</p> <p>An observation of an unattended medication cart in the 300 hall on 2-15-2016 at 9:55 a.m., indicated a 4 ounce bottle of hand sanitizer was out on top of the cart.</p> <p>An observation of the unattended and accessible nurse's station on 2-15-2016 at 10:01 a.m., indicated at least 5-6 alcohol prep pad packets were in an open container.</p> <p>An observation of an unattended medication cart parked by room 312 on 2-15-2016 at 10:05 a.m., indicated a 4 ounce bottle of hand sanitizer was out on top of the cart.</p> <p>An observation of an unattended, unlocked janitor closet on 2-15-2016 at 10:06 a.m., indicated a large bottle of rug doctor cleaner on the shelf and the automatic dispenser of cleaning products</p>			

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	<p>was on the wall.</p> <p>An observation of an unattended medication cart parked by room 312 on 2-15-2016 at 10:08 a.m., indicated there were 2 bottles of hand sanitizer out on top of the cart.</p> <p>An observation of an unattended medication cart parked by room 112 on 2-15-2016 at 3:50 p.m., indicated a 4 ounce bottle of hand sanitizer was out on top of the cart.</p> <p>An observation of an unattended medication cart parked by room 104 on 2-17-2016 at 11:48 a.m., indicated a 4 ounce bottle of hand sanitizer was out on top of the cart.</p> <p>An observation of an unattended medication cart parked between rooms 103 and 105 on 2-18-2016 at 9:09 a.m., indicated a 4 ounce bottle of hand sanitizer was out on top of the cart.</p> <p>An observation of the unattended Beauty Shop on 2-18-2016 at 10:09 a.m., indicated one resident was under the hair dryer. The following products were observed out on the counter, shampoo, hair spray, binding gel, hand sanitizer and a glass container of barbicide. At 10:10 a.m., Hair Stylist #16 returned with a</p>			

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	<p>resident from the Bed and Breakfast Memory Care Unit. At 10:25 a.m., an interview with Hair Stylist #16 indicated she will go and get her clients from their rooms and return them to their rooms. She indicated she does leave the Beauty Shop door open and will only leave a resident in the shop that is not confused, or does not have a risk of falling or bolting. She indicated the facility will sometimes bring the residents to the shop. All the products except the shampoo had keep out of reach of children on the labels.</p> <p>An observation of the Rehabilitation unit shower room on 2-18-2016 at 10:14 a.m., indicated the shower room was able to be entered by pushing down on the handle of the door. The key pad was not used for entry. An observation of an unlabeled spray bottle with a very light blue tinted liquid inside was in a plastic compartment with a lock. The cover was missing which allowed the spray bottle to be accessible. An unlocked cabinet on the wall to the left of the shower indicated the 2 boxes of tub and shower repair kits were still on the 3rd shelf.</p> <p>An interview with LPN #17 on 2-18-2016 at 10:15 a.m., indicated the shower room should have been locked. The nurse indicated she usually would</p>			

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	<p>push the keypad to unlock the door. It was observed that LPN #17 was able to push the handle and open the door without using the keypad. Further interview with LPN #17, indicated she did not know what the unlabeled spray bottle contained. LPN #17 went to her Unit Manager, LPN #18 and asked her about the contents of the spray bottle. LPN # 18 indicated she did not know what was in the spray bottle. LPN #18 found Housekeeper #19 and she indicated the spray bottle contained a disinfectant which was used for cleaning the shower. LPN #18 was observed to try to open the shower room door with turning the lock on the inside to the lock position and the door would still not lock.</p> <p>A copy of the "Safety Data Sheet"" for "brand" instant hand sanitizer dated 5-29-2015 and provided by Medical Records #13 on 2-19-2016 at 1:40 p.m., indicated hazard statements "...causes eye irritation...flammable liquid and vapor...may be harmful if swallowed...may be harmful in contact with skin...may cause an allergic skin reaction.... First aid measures for ingestion indicated "...if swallowed, call a physician immediately...."</p> <p>A copy of the alcohol antiseptic prep pad package provided by Medical Records</p>			

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	<p>#13 on 2-19-2016 at 1:40 p.m., indicated "...Keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>A copy of the "brand" hand sanitizer label provided by Medical Records #13 on 2-19-2016 at 1:40 p.m., indicated "...Keep out of reach of Children...."</p> <p>A copy of the "brand" gel label provided by Medical Records #13 on 2-19-2016 at 1:40 p.m., indicated "...caution...for external use only...in case of eye contact flush thoroughly with water...keep out of reach of children...."</p> <p>A copy of the "Safety Data" Sheet for barbicide concentrate dated 3-6-2015 and provided by Medical Records #13 on 2-19-2016 at 1:40 p.m., indicated "...flammable liquid and vapor...causes skin irritation...causes serious eye irritation...if swallowed immediately call a poison center/physician...rinse mouth...."</p> <p>A copy of the "brand" disinfectant label provided by Medical Records #13 on 2-19-2016 at 1:40 p.m., indicated "...keep out of reach of children...this product may be irritating to skin or eyes...if such contact occurs, flush immediately with plenty of water...."</p>			

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	<p>A current list of residents provided by Medical Records #13 on 2-19-2016 at 1:40 p.m., indicated there were 6 confused and independently mobile residents who resided outside the Bed and Breakfast (400 hall).</p> <p>A current policy "Safety" dated 8-2014 and provided by Medical Records #13 on 2-19-2016 at 1:40 p.m., indicated "...ensure all chemical and cleaning agents are properly stored to prevent misuse or accidental ingestion...container labeling...no container of hazardous substances will be released for use until the following label information is verified: contents of container...appropriate hazard warnings...the name of the manufacturer...."</p> <p>A current policy "Beautician/Barber Services" dated 2012 and provided by Medical Records on 2-19-2016 at 1:40 p.m., indicated "...chemicals will be secured to prevent misuse or accidental ingestion...."</p> <p>B. An observation of the hot water temperature in room 405 on 2-16-2016 at 10:18 a.m., indicated the hot water was 122.0 degrees Fahrenheit (F) after 30 seconds.</p>			

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	<p>An observation of the hot water temperature in room 406 on 2-16-2016 at 10:58 a.m., indicated the hot water was 121.6 degrees F within 15 seconds.</p> <p>An observation of the hot water temperature in room 401 on 2-16-2016 at 12:12 p.m., indicated the hot water was 120.4 degrees F after running for 20 seconds.</p> <p>An observation of the hot water temperature in room 414 on 2-16-2016 at 12:12 p.m., indicated the hot water was 122.9 degrees F.</p> <p>An observation on 2-17-2016 of the hot water temperatures in the following rooms of the Bed and Breakfast Memory Care Unit indicated the following: at 11:51 a.m., 124 degrees F in room 406 which shared the bathroom with 404 at 11:54 a.m., 122.9 degrees F in room 405 which shared the bathroom with 407 at 11:56 a.m., 123.6 degrees F in room 410 which shared the bathroom with 408 at 11:59 a.m., 123.3 degrees F in room 414 which shared the bathroom with 412</p> <p>An interview with CNA #20 on 2-17-2016 at 12:00 p.m., indicated there were 16 residents in the Bed and Breakfast Memory Care Unit.</p>			

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	<p>An interview with the Maintenance Supervisor on 2-17-2016 at 1:51 p.m., indicated the water temperatures in resident rooms should range between 105 and 120 degrees Fahrenheit. The Maintenance Supervisor indicated one room's water temperature in the building was checked daily with each unit being checked at least weekly. The Maintenance Supervisor provided a log for 2016 with the date, room and temperature listed from 1-3-2016 thru 2-12-2016 with the lowest temperature being 105 degrees F in room 207 on 2-9-2016 and the highest temperature of was 117 degrees F obtained in several rooms on several days. The Maintenance Supervisor provided a "daily room round sheet that indicated "...water temp (temperature) - patient room 105 - 120 degrees...."</p> <p>An observation of the storage room outside the Bed and Breakfast with the Maintenance Supervisor on 2-17-2016 at 1:58 p.m., indicated the room housed the hot water heater that served the Bed and Breakfast unit. The Maintenance Supervisor indicated he adjusted the mixing valve after he was notified of the hot water temperatures in the Bed and Breakfast unit. There was not a thermometer observed on the hot water</p>			

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	<p>heater or after the mixing valve to indicate the temperature of the water that flows to the Bed and Breakfast Memory Care unit.</p> <p>A current list of residents provided by Medical Records on 12-19-2016 at 1:40 p.m., indicated there were 8 confused and independently mobile residents in the Bed and Breakfast Memory Care unit.</p> <p>C. An observation of Resident #37 on 2-16-2016 at 9:51 a.m., indicated the Velcro seat belt on the wheelchair was not secured. An interview with the Resident at this time indicated the seat belt broke yesterday and she told staff and they were getting her another one.</p> <p>An observation and interview with Resident #37 on 2-18-2016 at 9:10 a.m., indicated the seat belt had not been replaced yet. Resident #37 indicated she did not fall out of her wheelchair yesterday or today so far. Resident #37 was observed without the seatbelt secured and with involuntary extremity movements due to her disease process.</p> <p>An interview with Resident #37 on 2-19-2016 at 9:18 a.m., indicated the seat belt was not fixed and she was told it would be fixed today. An observation at this time indicated one side of the seat</p>			

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	<p>belt was on the resident's left side under the wheelchair cushion.</p> <p>An interview with the Maintenance Man #30 on 2-19-2106 at 2:14 p.m., indicated he could not remember when he received the work order for the seat belt for Resident #37. Maintenance #30 indicated the work order was sometime earlier in the week and a new seat belt was ordered at that time. He indicated in the meantime, a seat belt was found here in the facility and he put it on Resident #37's wheelchair today.</p> <p>An observation of Resident #37 on 2-19-2016 at 4:00 p.m., indicated the resident was in the 100 hallway in her wheelchair with the seatbelt secured around her waist. An interview with the resident indicated the seatbelt was fixed today.</p> <p>An observation of Resident #37 on 2-22-2016 at 9:00 a.m., indicated the resident was sitting in her wheelchair by the 100/200 hall nurse station with the seat belt secured around her waist</p> <p>A review of the "Bedside Kardex Report" for Resident #37 was printed on 2-18-2016 and provided by LPN #15 on 2-18-2016 at 3:45 p.m., indicated "...safety/monitors...has consented to a</p>			

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F 0325 SS=D Bldg. 00	<p>self releasing seat belt for her W/C (wheelchair)...."</p> <p>A review of Resident #37's progress notes dated 2-16-2016 at 9:57 a.m. and provided by the Administrator on 2-19-2016 at 3:00 p.m., indicated "...resident reported that wheelchair safety belt is missing...work order submitted to maintenance...."</p> <p>A review of the IDT (Interdisciplinary Team) Post-Occurrence Assessment dated 2-17-2016 at 10:36 a.m. and provided by the Administrator on 2-22-2016 at 11:42 p.m., indicated the resident fell 2 times on 2-16-2016. Fall #1 indicated the resident was found on the floor in the bathroom and fall #2 indicated the resident slid out of her wheelchair in the hallway. The self-releasing device was not marked as being in place.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive</p>			

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	<p>assessment, the facility must ensure that a resident -</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to provide interventions to address the low albumin level present on admission of 1 resident (Resident #96). The facility further failed to assess, develop and revise dietary interventions to prevent continuing weight loss for 2 residents (Resident #91 and Resident #132) of 4 residents who met the criteria for weight loss since admission.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #96 on 2/17/16 at 12:25 p.m., indicated the following: diagnoses included, but were not limited to, muscle weakness, localized edema, heart failure, chronic kidney disease, and anemia.</p> <p>Resident #96 was admitted to the facility on 11/10/15.</p> <p>A Laboratory Report for Resident #96, dated 11/11/15, indicated an Albumin level of 1.9 g/dl (grams per deciliter),</p>	F 0325	<ul style="list-style-type: none"> · Resident #96 discharged from facility · Resident #91 discharged from facility · Resident #32 current plan of care reviewed with no changes indicated (UM/DON) 03-01-2016 · Monthly review of all weights identifying significant gains/losses during clinical meeting with appropriate IDT walking round, if indicated. (UM/DON) – 03-07-2016 - ongoing · Weekly review of all weekly weights identifying significant gains/losses during clinical meeting with appropriate IDT walking round, if indicated. (UM/DON) 03-07-2016 - ongoing · Daily M-F review of 24 hour report noting any triggered weight gain/loss during clinical meeting. (UM/DON) 03-07-2016 - ongoing · Schedule IDT walking rounds specific to weight changes identified daily, weekly, and/or monthly. (IDT) 03-07-2016 - ongoing · Weekly follow up of dietician recommendations during clinical meeting. (UM/DON) 03-07-2016 - ongoing · Daily review of physician orders/labs insuring follow up with NP/MD during clinical meeting. 03-07-2016 - ongoing · In-service 	03/23/2016

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	<p>with a reference range of 3.4-5.0 g/dl.</p> <p>A Nutritional Assessment for Resident #96, dated 11/11/15, indicated she was at normal nutritional status.</p> <p>A Dietary Progress Note for Resident #96, dated 12/7/15, indicated she received a Regular Diet with oral intakes noted as 0-50%. The note also indicated she had experienced a significant weight loss x (times) 30 days related to recently being in the hospital. The note did not refer to the low Albumin level of 1.9 g/dl on 11/11/15, or if her protein needs were being met through her diet. The recommendation was made to consider starting Suplena (a nutritional supplement for chronic kidney disease) 1 can daily to provide additional calories and protein. The note did not indicate the additional amount of protein the supplement would provide.</p> <p>A Nutritional Assessment for Resident #96, dated 12/9/15, indicated she was at risk of malnutrition.</p> <p>A Physician's order for Resident #96, dated 12/11/15, indicated Suplena 1 can daily. The order also indicated a dietary consult for an Albumin level of 1.9 related to chronic kidney disease.</p>		<p>nursing staff regarding weight gain/loss, lab follow up, completion of SBAR/COC for weight gain/loss, notification of physician. (DSD/DON) 03-23-2016 · Monthly review times 6 months with clinical indicator report specific for weight loss with submission of results to QA committee (DON) 03-01-2016 – ongoing</p>		

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	<p>Review of the Medication Administration Record for Resident #96, dated for December 2015, indicated the Suplena 1 can daily was not started until 12/13/15.</p> <p>A facility care plan for Resident #96, with a review date of 12/8/15, indicated the focus area of altered nutrition and hydration. Interventions to the focus included, but were not limited to, Regular Diet as ordered, snacks/supplements as ordered, monitor weight, notify MD of significant weight change, labs as ordered, and RD (Registered Dietitian) evaluation as needed.</p> <p>Resident #96 was admitted to the hospital on 12/17/15.</p> <p>The Director of Nursing was interviewed on 2/19/16 at 1:39 p.m. During the interview, she indicated the Registered Dietitian was notified of any consult orders during her visits to the facility.</p> <p>Dietitian consulting dates, provided by the Administrator on 2/18/16 at 2:55 p.m., indicated the Registered Dietitian was in the facility on 11/11/15, 11/12/15, 11/20/15, 11/30/15, 12/3/15, 12/7/15, 12/11/15, and 12/22/15. The dietary consult for the low Albumin level was not completed prior to the resident being admitted to the hospital.</p>			

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	<p>The Director of Nursing was interviewed on 2/22/16 at 9:30 a.m. During the interview, she indicated Resident #96 previously had a lower Albumin level when she was in the hospital prior to coming to the facility. She also indicated the Nurse Practitioner was addressing her elevated TSH (thyroid stimulating hormone) level before she addressed the low Albumin level.</p> <p>2. Review of the clinical record for Resident #91 on 2/17/16 at 10:35 a.m., indicated the following: diagnoses included, but were not limited to, dysphagia (difficulty swallowing), dementia, atrial fibrillation, hypertension, edema, and acute kidney failure.</p> <p>Resident #91 was admitted to the facility on 10/29/15.</p> <p>A physician's order for Resident #91, dated 10/29/15, indicated a Regular Diet.</p> <p>A Nursing Admission Assessment for Resident #91, dated 10/29/15, indicated a height of 64 inches and a weight of 149 pounds.</p> <p>A Nutrition Screening and Assessment for Resident #91, dated 10/30/15 and completed by the Dietary Manager and</p>			

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	<p>Registered Dietitian, indicated he received a Regular Diet. The assessment did not indicate his height, weight, BMI (Body Mass Index), calorie needs, protein needs, or fluid needs. The Registered Dietitian indicated she would request his height and weight to be obtained and would finish the assessment once obtained.</p> <p>Facility weights for Resident #91 indicated a weight of 145.4 pounds on 11/5/15 and 140.2 pounds on 11/12/15, a loss of 5.9% since his admission on 10/30/15.</p> <p>A Change of Condition Progress Note for Resident #91, dated 11/12/15, indicated the MD was notified of his weight loss.</p> <p>A Progress Note for Resident #91, dated 11/13/15, indicated he had poor/inadequate food and fluid intake.</p> <p>A physician's order for Resident #91, dated 11/14/15, indicated Ensure Plus (nutritional supplement) 240 ml (milliliter)/day.</p> <p>Facility weights for Resident #91 indicated a weight of 136 pounds on 11/18/15, a loss of 8.7% since his admission on 10/30/15.</p>			

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	<p>A Nutritional Risk Assessment for Resident #91, dated 11/20/15, indicated a weight loss of 12.6 pounds or 8.4% since weight recorded on 10/30/15. Estimated calorie needs were calculated at 1860 to 2480 Calories/day. The assessment also indicated oral intake noted as 26-100%. The assessment further indicated he received 1 can of Ensure Plus daily, which was not generally consumed. The recommendation was made to discontinue the Ensure Plus and offer health shakes 120 ml TID (three times a day) with meals for increased calories and protein.</p> <p>A Dietary Progress Note for Resident #91, dated 11/20/15, indicated may also consider adding nutritional treats with lunch and dinner to see if resident will accept as this would also provide additional calories/protein.</p> <p>A physician's order for Resident #91, dated 11/20/15, indicated to discontinue the Ensure Plus and to start Health Shake 120 ml TID with meals. The order also indicated to start Magic Cup BID (twice a day) with lunch and dinner.</p> <p>Facility weights for Resident #91 indicated a weight of 133.6 pounds on 11/25/15, a loss of 10.3% since his admission on 10/30/15.</p>			

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	<p>A facility care plan for Resident #91, with a start date of 10/30/15, indicated the focus area of altered nutrition and hydration triggered a weight loss. Interventions to the focus included, but were not limited to, pureed diet as ordered, snacks/supplements as ordered, monitor weight, notify MD of significant weight change, and RD evaluation as needed.</p> <p>The Administrator was interviewed on 2/18/16 at 10:23 a.m. During the interview, she indicated the dietitian for the facility came weekly.</p> <p>Dietitian consulting dates, provided by the Administrator on 2/18/16 at 2:55 p.m., indicated the Registered Dietitian was in the facility on 11/11/15, 11/12/15, 11/20/15, 11/30/15, 12/3/15, 12/7/15, 12/11/15, and 12/22/15.</p> <p>The Director of Nursing was interviewed on 2/22/16 at 9:20 a.m. During the interview, she indicated interventions to the continuing weight loss prior to 11/20/15, included a referral to Speech Therapy and downgrading his diet from a Soft Texture with ground meats to a Pureed consistency and the addition of Ensure Plus. She also indicated the additional interventions of Healthshakes</p>			

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	<p>and Magic Cups were started on 11/20/15.</p> <p>Resident #91 discharged from the facility on 12/23/15.</p> <p>3. Review of the clinical record for Resident #132 on 2/17/16 at 2:57 p.m., indicated the following: diagnoses included, but were not limited to, dehydration, acute kidney failure, heart failure, hypertension, and dysphagia.</p> <p>Resident #132 was admitted to the facility on 11/19/15.</p> <p>Facility weights for Resident #132 indicated an admission weight of 111.8 pounds on 11/19/15.</p> <p>A physician's order for Resident #132, dated 11/19/15, indicated a Regular Soft Texture Diet.</p> <p>A physician's order for Resident #132, dated 11/20/15, indicated daily weights. The order also indicated Ensure Plus 240 ml BID (twice a day) as a supplement.</p> <p>A Nutritional Assessment for Resident #132, dated 11/21/15, indicated she was at risk of malnutrition.</p> <p>A Nutritional Assessment for Resident</p>			

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	<p>#132, dated 11/30/15, indicated a weight loss since admission, but did not indicate her current weight. The assessment also indicated she received a Soft diet and was started on Ensure Plus 1 can BID on 11/20/15. The assessment further indicated her estimated needs of 1410-1880 Calories/day. The assessment recommended if weight loss continued, may consider increasing supplement to TID for additional calories and protein. The assessment indicated she was at "high risk for nutrition."</p> <p>Facility weights for Resident #132 indicated a weight of 102.8 pounds on 12/1/15, a loss of 8% since her admission on 11/19/15.</p> <p>A Dietary Progress Note for Resident #132, dated 12/11/15, indicated a weight of 103 pounds, a significant weight loss x 30 days. The note also indicated a weight of 111.8 pounds on 11/19/15. The note further indicated her weight range had been 102-105 pounds. The note also indicated she received a Regular Soft Texture Diet with oral intakes averaging 50-75% and she also received Ensure Plus 1 can BID for additional calories and protein. The note further indicated her estimated needs of 1410-1880 Calories/day and 47 grams protein/day, should be met with diet, intakes and</p>				

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	<p>supplement.</p> <p>A Dietary Progress Note for Resident #132, dated 12/22/15, indicated her oral intakes noted as 51-75%. The note also indicated she continued to receive Ensure Plus 1 can BID. The note further indicated her weights ranged from 101-102 pounds.</p> <p>Facility weights for Resident #132 indicated a weight of 101.8 pounds on 12/25/15, a loss of 8.9% since her admission on 11/19/15.</p> <p>A Dietary Progress Note for Resident #132, dated 1/2/16, indicated a weight of 99.6 pounds, a significant weight loss x 30 days. The note also indicated she remained on a Regular Soft Texture Diet with Ensure Plus 1 can BID. Oral intakes noted as 26-75%. The note further indicated the writer met with the resident to discuss weight/intakes/supplement. The resident reported she was drinking the supplement and had some snacks in her room. She requested to have ice cream at dinner.</p> <p>Facility weights for Resident #132 indicated a weight of 99.5 pounds on 1/5/15, a loss of 11% since her admission on 11/19/15.</p>			

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	<p>An IDT (Interdisciplinary Team) Assessment & Progress Note for Resident #132, dated 1/12/16, indicated a weight of 102.8 pounds on 1/11/16. The assessment and progress note also indicated she would be offered ice cream x 3 a day, pudding x 3 a day, and snacks x 3 a day.</p> <p>Facility weights for Resident #132 indicated a weight of 97.3 pounds on 2/17/16, a loss of 12.9% since her admission on 11/19/15.</p> <p>Dietitian consulting dates, provided by the Administrator on 2/18/16 at 2:55 p.m., indicated the Registered Dietitian was in the facility on 11/11/15, 11/12/15, 11/20/15, 11/30/15, 12/3/15, 12/7/15, 12/11/15, 12/22/15, 1/2/16, and 1/9/16</p> <p>The DON was interviewed on 2/19/16 at 1:56 p.m., and indicated residents were identified with weight loss and were reviewed every week.</p> <p>The DON was interviewed on 2/19/16 at 3:05 p.m. During the interview, she was unable to provide any information on why the Ensure Plus for Resident #132 had not been increased from BID to TID with her continuing weight loss.</p> <p>A facility care plan for Resident #132,</p>			

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	<p>with a start date of 11/20/15, indicated the focus area of altered nutrition and hydration due to diagnosis of heart failure and acute kidney failure. Has shown weight loss since admission.</p> <p>Interventions to the focus included, but were not limited to, diet as ordered, snack/supplements as ordered, offer HS snacks, monitor weight, and notify MD of significant weight change.</p> <p>A current facility policy "Weight Management Standard", updated October 2011 and provided by the Regional Director of Clinical Operations on 2/19/16 at 2:00 p.m., indicated "...Residents identified to be at risk for weight variance, will have routine assessment and care plan interventions...The objective of this process is to assess, and manage weight variances, to determine appropriate referrals and/or interventions to achieve the best possible clinical outcomes...Licensed nurse to review electronic weight reports and schedule re-weights within 24 hours for significant weight variance: A five pound weight loss from original weight...A 5% weight (loss/gain) in one month, a 7.5% in three months, or 10% in six months...A three pound loss in one month for those weighing less than 100 pounds...Dietary Services Manager/designee will complete</p>			

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F 0353	<p>weight review and determine significant changes...Re-evaluate on a regular basis to ensure compliance and positive outcomes...."</p> <p>A current facility policy "Interdisciplinary Walking Rounds", updated April 2015 and provided by the Administrator on 2/22/16 at 8:20 a.m., indicated "...Monthly and/or weekly weights are reviewed to determine a need for weekly weights or if the weight is stable enough to remove from weekly assessment...Patients with weight loss need to have the Operating Standard for Nutrition Management initiated. Refer to dietary if appropriate, for double portions, enhanced fortified food items or specialized nutritional products, Speech for swallowing difficulties...Add patients to weekly weights as needed or if there is a loss of 2% in seven (7) days, 5% in thirty days, 7.5% in ninety (90) days, and/or 10% in one hundred and eighty (180) days...Review any other issues care planned for interventions and effectiveness...."</p> <p>3.1-46(a)(1)</p> <p>483.30(a)</p>			

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SS=E Bldg. 00	<p>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, the facility failed to ensure sufficient nursing staff provided the necessary care and services timely and safely, to meet the needs of the 89 residents who resided in the building.</p> <p>Findings include:</p> <p>A confidential interview with the family member of a resident indicated there were very few staff in the facility this past Saturday (2-13-16).</p> <p>A confidential interview with a family</p>	F 0353	<ul style="list-style-type: none"> · Daily staffing pattern reviewed with no changes indicated (DSD/DON) – 03-01-2016 · Monitor assigned daily staffing pattern for accuracy, appropriate staffing level based on census/PPD (DSD/DON) 03-01-2016 – ongoing · Adjust staffing patterns as appropriate based on concerns/trends identified through grievance process (DSD/DON) 03-01-2016 – ongoing · In-service nursing staff on appropriate call light response, resident communication, providing timely assistance of resident 	03/23/2016	

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	<p>member of a resident indicated the facility was short staffed.</p> <p>A confidential interview with a family member of a resident indicated "...there was not enough staff to get the resident up and the resident was in bed a lot...clothing has a strong urine odor and the resident sits in wet depends...."</p> <p>Confidential interviews were conducted with residents and indicated the following comments about staffing: A resident indicated "...had an accident while waiting for the bedpan about a week ago...sometimes it takes over an hour to get the call light answered...."</p> <p>A resident indicated "...when you fell, you had to go get help as they did not answer the call lights...."</p> <p>A resident indicated the "...facility needs more staff on evenings and weekends...."</p> <p>A resident indicated the facility was "...short staffed on weekends...."</p> <p>A resident indicated "...will turn the call light on and no one comes to answer it...sometimes at least 30 minutes if not longer before anyone comes to help...been this way for 6 months...."</p>		<p>requests – (DSD/DON) 03-23-2016</p> <ul style="list-style-type: none"> · Monitor resident concerns through daily Guardian Angel rounds (Dept. managers/ADM) 03-07-2016 – ongoing · Monitor concerns through monthly Resident Council meeting with appropriate follow up (SSD/ADM) - 03-23-2016 – ongoing · Monitor concerns through ABAQIS survey completion – resident and family questionnaires (Dept. managers/ADM) - 03-07-2016 – ongoing · Monitor concerns through IDT walking rounds (IDT/ADM) · Review resident concerns/grievances daily during department director meeting (Dept. managers/ADM) – Daily M-F x 6 months. · Monthly review of grievances with track/trend analysis submitted to QAA Committee for review and appropriate follow up (SSD/QAA Committee) – 03-23-2016 – ongoing. 	

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	<p>A resident indicated "...there is a big hole in the staffing...during the day too many people to care for in this wing for the staff working...during the 1st shift has 2 aides and there needs to be more...the only time they get to work is when the state is here...after last year's survey, they just had meetings about it and nothing really changed...cut hours back is all that is heard for the last month...staff talking on the phone while providing care...."</p> <p>A resident indicated "...3rd shift short on staff...has had to wait for staff to answer call light...pressed call light and staff entered room stating she would be right back to help...needed to use the restroom immediately and then transferred self to the toilet...staff finally came back and told the resident she should have waited for her to come back and help...."</p> <p>A resident indicated "...waited for over 2 hours during the night from 2 a.m. to almost 5 a.m...if they are busy passing trays or medications, that comes first before the lights...needed help to the bathroom...asked staff to check her every 2 hours at least and it never happened...."</p> <p>A resident indicated "...the staff indicated they cut hours...was incontinent 3 times while waiting for assist...not enough help in the morning and evenings when</p>			

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	<p>getting ready for bed...."</p> <p>A resident indicated "...has to wait...."</p> <p>A resident indicated "...waited 1 and 1/2 hours on Saturday night (2-20-2016) for someone to assist her to bed and today she had waited an hour and 15 minutes for someone to come and change her soaked pad...she indicated she had a sore on her bottom and it hurts...."</p> <p>A resident indicated "... had to wait for over an hour for a bedpan on Sunday evening (2/21/16)...."</p> <p>A confidential interview with Staff #31, indicated there were not enough staff in the unit for the residents they have as some residents require 2 assists and that leaves no one to assist other residents.</p> <p>A confidential interview with Staff #32 indicated there was no one to cover for either of them for their break. Further interview with Staff #32 indicated there was just not enough help with the residents needing the 2 assists.</p> <p>A confidential interview with Staff #33 indicated there were not enough staff to meet the needs of the residents during her shift in the 100-200 halls.</p>			

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	<p>A confidential interview with Staff #34 indicated there was not enough aides working to answer the lights, give the showers, pass ice, get the beds made and pass meal trays in the 100-200 halls.</p> <p>A confidential interview with Staff #35 indicated "...there were 2 CNAs in the 300 hall and that works...but in the 100-200 halls, 3 CNAs were not enough when you have showers and everything else...as it was a much more difficult unit...."</p> <p>A review of the Resident Council Minutes provided by Social Services #12 on 2-18-2016 at 2:43 p.m., indicated the following: The January 2016 minutes indicated "...Residents mentioned that lights are not being answered promptly...." The November 2015 minutes indicated "...3rd shift call light response has been an issue at times...residents feel staff are talking, texting and sitting at nurses stations...." The September 2015 minutes indicated "one resident states that some residents are left in the assisted dining rooms too long after they are done with their breakfast...she stated that these residents require a push back to their room and that they do not get a push back until they have to wait...."</p>			

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	<p>The August 2015 minutes indicated "...one resident stated that they had to wait a little while--15 minutes--on their call light..."</p> <p>The July 22, 2015 minutes indicated "...one resident stated that they felt the units were understaffed..."</p> <p>The April 2015 minutes indicated "...residents mentioned that staff turnover and a non-consistent schedule is a concern to residents..."</p> <p>Copies of the responses to the resident concerns were provided by Social Services #12 on 2-19-2016 at 3:08 p.m. and indicated since the last survey, responses for 12-21-15 and 1-27-2016 were the only two provided. An interview with Social Services #12 indicated those were the only ones he had. The contents of the responses concerned the dietary and a facelift for the activity lounge and the previous assisted dining rooms.</p> <p>An interview with the Resident Council President on 2-19-2016 at 1:36 p.m., indicated getting the call lights answered was dependent upon who was on and how many aides were working. She indicated she has had to wait 30 minutes with no one answering her light. Further interview with the Resident Council President, indicated a resident came to</p>						

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	<p>her and indicated she went to her bathroom during the night and it was soiled and wet on the floor. The aide came and would not clean it up and told her that someone would be here in a couple of hours and they would do it.</p> <p>A list of the residents that needed staff assistance of 2 for transfers or for Hoyer lifts was provided by Social Services #12 on 2-22-2016 at 11:55 a.m., and indicated there were 20 of 89 residents that needed 2 assists for transfers and lifts.</p> <p>A review of the Resident Census and Conditions of Residents signed and provided by the DON (Director of Nursing) on 2-15-2016, indicated there were 82 of 89 residents that required 1 or 2 assists for Bathing and Dressing, 80 of 89 who required the assists of 1 or 2 staff for transferring, 78 of 89 who required 1 or 2 assists for toileting and 74 of 89 residents required 1 or 2 assists for eating. Further review indicated 4 residents were dependent for bathing, dressing, transferring and eating while 6 residents were dependent for toileting.</p> <p>An interview with the Administrator and DON (Director of Nursing) on 2-22-2016 at 2:00 p.m., indicated the facility did not have a policy for staffing.</p>			

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F 0371 SS=E Bldg. 00	<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> <p>Based on observation, interview and record review the facility failed to ensure food and beverages kept in the pantry and kitchenette freezers/refrigerators and cabinets were properly sealed, labeled, and dated, failed to maintain clean microwaves, and failed to ensure a refrigerator door was kept sealed to maintain the appropriate temperature. This deficient practice had the potential to affect 85 of 89 residents who received food and beverages stored in the the facility pantries and kitchenettes.</p> <p>Findings include:</p> <p>1. During an observation of the Bed & Breakfast Memory Care Unit kitchenette on 2/15/16 at 9:52 a.m., the following was observed:</p>	F 0371	<ul style="list-style-type: none"> · Refrigerators/freezers were checked for cleanliness/appropriate temperatures/thermometers, and labeling of food · Microwaves were cleaned with schedule for cleaning posted · Ice machines were cleaned · A schedule was implemented for daily cleaning of microwaves, ice machines, and refrigerators (Housekeeping/ADM) · The temperature log for all refrigerators in pantries will be completed daily (Housekeeping) · Food in freezer/refrigerators will be checked daily for appropriate labeling (CDM) · Staff was in serviced on proper labeling of food/drinks, and temperatures and cleanliness of microwaves/ice machines (CDM) · Policy and procedure reviewed 03-01-2016 with no changes indicated · Daily monitoring of pantries, 	03/23/2016	

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	<p>In the refrigerator there was: a small zip-lock package of lunch meat, not labeled or dated; a small plastic bag containing part of a sandwich wrapped in foil, not labeled or dated; and an opened half-gallon of whole milk, not dated when opened. There was no thermometer visible in the refrigerator.</p> <p>In the freezer there was an opened 12 ounce bottle of pop, not labeled or dated.</p> <p>The microwave was extremely soiled with dried food debris and food splatter on all of the interior surfaces.</p> <p>2. During an observation of the Rehabilitation Unit kitchenette on 2/15/16 at 10:12 a.m., the following was observed:</p> <p>The microwave was soiled.</p> <p>In the freezer there was: 4 dishes of chocolate of ice cream, not dated; and 5 cups of strawberry ice cream, with 1 dish not covered, not dated.</p> <p>In the refrigerator there was: 1 small zip lock plastic bag containing broccoli florets, not dated; an opened 1/2 gallon of chocolate milk was not dated when opened; and 1 small plastic deli container</p>		ice machines, and refrigerators will continue for a period of 6 months with report submitted for review to the monthly QAA Committee.	

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	<p>from a local grocery store containing cranberry salad, not labeled or dated.</p> <p>The water channel on the bottom of the ice machine had standing rust colored water.</p> <p>3. During an observation of the West Hall pantry on 2/16/16 at 12:25 p.m., the following was observed:</p> <p>The microwave was soiled with spills and food splatter on all surfaces.</p> <p>In the freezer there was: a 9 ounce frozen microwaveable meal of three cheese ziti marinara, not labeled or dated; an 8 ounce frozen microwaveable meal of beef and peppers, not labeled or dated; a small cup of thick chocolate shake-like drink from a local restaurant, not labeled or dated; a 5 ounce Jamaican style beef patty, not labeled or dated; an opened 1 gallon plastic container of Neopolitan ice cream, not completely re-sealed, labeled or dated; an opened box of 12 junior popsicles, not labeled or dated; and three covered dishes of strawberry ice cream, not dated.</p> <p>In the refrigerator there was: an opened 12 ounce box of chocolate truffles, not labeled or dated; a plastic bag containing three 4 ounce containers of yogurt and a</p>			

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	<p>partially un-covered dish of chocolate pudding, not dated; an opened 2 liter bottle of pop, not labeled or dated; 2 bowls of vanilla pudding, not dated; 2 plastic containers labeled with a resident's name containing a casserole and side vegetables, not dated; a plastic container of macaroni & cheese, not labeled or dated; a large red plastic container labeled with a resident's name containing 5 pieces of fried chicken and 2 pieces of fish, not dated; and a plastic bag containing a Styrofoam container of Chinese food, not labeled or dated.</p> <p>In upper cabinets there was: a plastic bread sleeve containing 4 moldy slices of bread, with best by date of 1/3/16; an opened 10.5 ounce box of baked snack mix, not labeled or dated; and a 10.5 ounce bag of snack chips, not labeled or dated.</p> <p>4. During an observation of the East Hall pantry on 2/16/16 at 1:40 p.m., the following was observed:</p> <p>In the freezer there was: an opened 28 ounce box of turtle pie, not dated; a plastic bag containing 5 boxes with a microwaveable breaded chicken sandwich, not labeled or dated; and a plastic bag containing 2 boxes with a microwaveable breaded chicken</p>			

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	<p>sandwich and a 12 ounce can of processed meat, not labeled or dated.</p> <p>In the refrigerator there was: a small plastic bag containing a partially eaten meat sandwich, not labeled or dated; a 5.3 ounce container of Greek yogurt, not labeled or dated; a plastic bag containing a small bag of potatoes chips and a 4 ounce container of applesauce, not labeled or dated; a small plastic bag with a partially eaten meat sandwich, not labeled or dated; a plastic bag containing an 8 ounce container of Greek yogurt and 4 ounce container of applesauce, not labeled or dated; a small plastic zip lock bag containing 1/2 of a meat spread sandwich, not labeled or dated; a box of chicken from a local restaurant, labeled with the residents name, containing chicken, a biscuit, mashed potatoes & green beans, not dated; a covered dinner size Styrofoam plate containing meat spread, not labeled or dated; and an 8 pack box of thawed popsicles.</p> <p>5. During an observation of the East Hall pantry on 2/22/16 at 8:24 a.m., the following was observed:</p> <p>The microwave was soiled.</p> <p>The door to the refrigerator was not closed properly, leaving a gap of</p>			

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	<p>approximately 1/2 inch allowing room temperature air to enter the refrigerator. There was no light on in the refrigerator and the thermometer in the refrigerator read 44 degrees.</p> <p>In the freezer, the opened 29 ounce box of turtle pie remained, not dated.</p> <p>6. During an observation of the Bed & Breakfast kitchenette on 2/22/16 at 8:30 a.m., the following was observed:</p> <p>The microwave remained extremely soiled with baked on food debris and food splatter on all the interior surfaces.</p> <p>In the refrigerator there was an opened 1/2 gallon of whole milk, not dated when opened.</p> <p>7. During an observation of the Rehab Unit kitchenette on 2/22/16 at 8:36 a.m., the following was observed:</p> <p>The water channel on the bottom of the ice machine had standing rust colored water.</p> <p>In the refrigerator there was an opened 2 liter bottle of pop, not labeled or dated.</p> <p>8. During an observation of the West Hall pantry on 2/22/16 at 8:45 a.m., the</p>			

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	<p>following was observed:</p> <p>In the freezer there was: a 9 ounce frozen microwaveable meal of three cheese ziti marinara remained, not labeled or dated; an 8 ounce frozen microwaveable meal of beef and peppers remained, not labeled or dated; a Jamaican style beef patty remained, not labeled or dated; an opened 1 gallon plastic container of Neopolitan ice cream remained, not labeled or dated; 1 covered dish of strawberry ice cream remained, not dated; two 16.0 ounce bottles of water, not labeled; and a 32 ounce bottle of low calorie grape beverage, not labeled.</p> <p>In the refrigerator there was: a 16.0 ounce bottle of cherry pop, not labeled; an opened 2 liter bottle of pop, not labeled; a wax paper bag of un-identified food, not labeled or dated; and a plastic bag containing a Styrofoam container of blueberry pancakes, dated 1/29/16.</p> <p>In upper cabinets there was: a plastic bread sleeve containing 4 moldy slices of bread, with best by date of 1/3/16; an opened 10.5 ounce box of baked snack mix, not labeled or dated; and a 10.5 ounce bag of snack chips, not labeled or dated.</p> <p>The microwave was soiled.</p>			

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	<p>The Administrator was interviewed on 2/22/16 at 9:20 a.m. During the interview she indicated Housekeeping was responsible for the pantries. She also indicated the facility just had a recent change in the housekeeping supervisor.</p> <p>The Dietary Manager was interviewed on 2/22/16 at 1:00 p.m. During the interview she indicated the temperature of the refrigerator should be 41 degrees or lower.</p> <p>A paper attached to the refrigerators in the kitchenettes and pantries, provided by the Dietary Manager on 2/22/16 at 11:11 a.m., indicated "Staff please remember that refrigerators are for residents use only! All items must be dated and have the residents name on it. Any items not marked or outdated will be discarded."</p> <p>The Administrator was interviewed on 2/22/16 at 1:11 p.m. During the interview she indicated the facility did not have a schedule for the cleaning of the pantries/kitchenettes and the microwaves.</p> <p>A current undated facility policy "Personal Resident Refrigerator Policy and Procedure", indicated "...It is the policy...to make sure that all food in the</p>			

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	<p>facility is stored safely and in proper conditions whether it is in a pantry refrigerator or a resident's personal refrigerator...All food in pantry and personal refrigerators must be stored at or below 36 degrees...Each refrigerator will have a working thermometer...All food items must be properly stored in proper containers and have a date opened date on them or they will be discarded...For purposes of keeping foods stored safely...food in the residents personal and pantry refrigerators to be stored, once opened for a maximum of three days...All pantry and personal refrigerators will be monitored for outdated food by Housekeeping...Housekeeping will discard any outdated or unlabeled food..."</p> <p>3.1-21(i)(2) 31.-21(i)(3)</p>						
F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure</p>	F 0465	<p>Residents #80 and #100 arm rests of wheelchairs were</p>	03/23/2016			

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	<p>a clean, comfortable, sanitary environment for 15 of the 35 residents' rooms observed for a clean room; furthermore, the facility failed to ensure wheelchairs were clean and in good repair for 5 residents in 2 of the 5 units of the facility. (Residents #80, #37, #136, #100 and #21)</p> <p>Findings include:</p> <p>1. An observation in room 112B on 2-16-2016 at 9:22 a.m., indicated the following, the bathroom had dust with dirt, hair and debris noted on all floor surfaces along the edges of the bathroom. There were dried, dark splashes and spills scattered on the lower half of the bathroom walls. The floor around the toilet had missing or non-existent caulk with dark, rusty surfaces noted around the entire circumference of the toilet base. The area of the floor between the resident's bedroom and the bathroom, had 4 strips of duct tape that were rolling up on the edges from the direction of the resident's bedroom.</p> <p>An observation of room 114A on 2-15-2016 at 2:36 p.m., indicated the top drawer on her bedside table did not close. There were 13 various size holes in the wall by the resident's bed. There were crumbs, hair and debris in a pile behind</p>		<p>replaced (Maintenance) 03-23-2016 · Residents # 21, 37, 80, 100, and 136 wheelchairs were cleaned(Maintenance) 03-23-2016 · Room #112-B – bathroom was cleaned(Maintenance) 03-23-2016 · Room 114 – A – Bedside table was replaced. Holes in wall repaired (Maintenance) 03-23-2016 · Room 118-A – Bed remote was cleaned (Maintenance) 03-23-2016 · Rooms 208-B, 411-B, 403, 414, 405-B, 404, and 406 – vents were cleaned (Maintenance) 03-23-2016 · Room 120-A, 204-B, 201, and 208-B – doors and jambs painted (Maintenance) 03-23-2016 · Room 203-A – toilet replaced (Maintenance) 03-23-2016 · Room 217 – toilet replaced, door and jambs painted, blinds replaced, carpet cleaned, vent cleaned and replaced. (Maintenance) 03-23-2016 · Carpet was checked for spots and cleaned as needed. (Maintenance) 03-23-2016 · Rooms/bathrooms were checked for cleanliness and cleaned as needed. (Maintenance) 03-23-2016 · Residents wheelchairs were cleaned (Maintenance) 03-23-2016 · Bedside tables were checked for proper function during guardian angel rounds. (Maintenance) 03-23-2016 · Resident room walls were checked for holes and repaired. (Maintenance)</p>	

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	<p>the door and along the wall baseboard edges.</p> <p>An observation in room 118A on 2-16-2016 at 9:02 a.m., indicated the bed remote was caked with a dark residue in the crevices of the bed remote control. There were crumbs and debris observed along the edges of the room.</p> <p>An observation of room 120A on 2-16-2016 at 10:39 a.m., indicated the door jams were banged up with paint missing and bare metal exposed beneath.</p> <p>An observation of room 201 on 2-15-2016 at 12:13 p.m., indicated the bathroom door was scraped the width of the door about 12 inches from the bottom and exposing the bare metal.</p> <p>An observation of room 203A on 2-15-2016 at 3:41 p.m., indicated the inside of the toilet bowl and the interior rim of the stool was stained and dark in color.</p> <p>An observation of room 204B on 2-15-2016 at 2:53 p.m., indicated the paint from the door frames to the bathroom were scraped with the bare metal exposed.</p> <p>An observation of room 208B on</p>		<p>03-23-2016 · Bed remotes were cleaned (Maintenance)</p> <p>03-23-2016 · Vents were cleaned (Maintenance) 03-23-2016 · Door and jams were checked for painting needs. (Maintenance) 03-23-2016 · Toilets were checked for the need to replace. (Maintenance) 03-23-2016 · Blinds were checked for repairs needed and repaired/ordered replacement. (Maintenance) 03-23-2016 · Daily rounds to be completed by Guardian Angels to check rooms for cleanliness M-F and complete work order as needed to maintain clean rooms, checking vents, walls, furniture, remotes, doors, jams, and blinds (Dept. Managers/ADM) - 03-23-2016 – ongoing. · Wheelchair cleaning schedule was made for each unit. Wheelchairs will be cleaned on night shift by CNA's and on an as needed basis. 03-23-2016 – ongoing. · Daily monitoring to be done with Guardian Angel room rounds x 6 months with results presented monthly to QAA Committee. 03-23-2016 – ongoing.</p>	

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	<p>2-15-2016 at 3:23 p.m., indicated the paint from the door frames in the bathroom were scraped with the bare metal exposed and the ceiling vent had accumulated dust on the vent slats.</p> <p>An observation of room 217 on 2-15-2016 at 3:35 p.m., indicated the paint on the bathroom and entry door frames were scraped with the bare metal exposed. The paint on the wall on the right just inside the room door was scraped with the white drywall exposed. The bathroom floor corners were dirty with grit and debris and could be felt and removed with a damp paper towel. The wall to the left of the sink had water drip stains that ran down the wall and the toilet had brown stains on the bowl and rust stains from the rim down. The blinds had 2 slats broken and 3 other slats cracked. The carpet had several stains in the middle of the carpet. The ceiling vent had dust buildup on the vent slats and the door threshold to bathroom had dark stains on it and did not appear clean.</p> <p>An observation in room 403 on 2-16-2016 at 11:04 a.m., indicated the bathroom ceiling vent was covered with dust that had collected on the vent slats.</p> <p>An observation in room 405B on 2-16-2016 at 10:20 a.m., indicated the</p>			

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	<p>bathroom ceiling vent was covered with dust that had collected on the vent slats. This bathroom was shared by room 407.</p> <p>An observation in the bathroom that was shared by rooms 404 and 406 on 2-16-2016 at 10:57 a.m., indicated the ceiling vent was covered with dust that had collected on the vent slats.</p> <p>An observation in room 411B on 2-16-2016 at 10:50 a.m., indicated the ceiling vent was covered with dust that had collected on the vent slats.</p> <p>An observation in room 414 on 2-16-2016 at 12:10 p.m., indicated the ceiling vent was covered with dust that had collected on the vent slats.</p> <p>An observation in the 100 hall outside rooms 110 and 114 and 119 on 2-16-2015 at 9:11 a.m., indicated white ceiling vents with the slats dotted with rust and with dust accumulated on the vent slats. The ceiling vent over the scale across from the 100/200 hall nurse station was observed with rust and dust on the vent slats and dried leaves were laying on the vent slats. A ceiling tile outside room 117 was half discolored with a brown color and was protruded outward.</p>			

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	<p>An observation of the 200 hall ceiling vents outside rooms 201 and 205 on 2-16-2016 at 2:14 p.m., indicated the vents had dust and rust on the vent slats.</p> <p>A confidential interview with a resident during the survey, indicated "...they only clean since the survey team was here...and they never clean the toilet..."</p> <p>A confidential interview with a resident during the survey, indicated "...the hallways need stripping...sees dirt and dust...watched a flower petal on the floor for 3 days before it was cleaned...and trash not emptied for 2 days last week...."</p> <p>A confidential interview with a family member during the survey indicated his loved one "...used to live on the 100 Hall, but now lives on the 400 Hall...stated the 100 Hall was extremely dirty...."</p> <p>An interview with Housekeeping #36 on 2-22-2016 at 9:30 a.m., indicated he used 2 products to clean the toilets. He indicated he has tried and tried to get the brown/black stains out of the toilets but he indicated they came from a older brush and the areas were scratches that he can't get out. He indicated he had submitted work orders for some rooms with really badly stained toilets. Further interview with Housekeeper #36</p>			

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	<p>indicated the rooms were deep cleaned monthly and some rooms were deep cleaned twice a month due to odor or other issues. He indicated he does try to scrape the grime off of the floor in the bathrooms, but some bathrooms have vinyl and he has to be careful with that.</p> <p>An interview with Housekeeper #19 on 2-22-2016 at 9:36 a.m., indicated the toilets with the stains on them, they cannot get clean. The housekeeper indicated they are old and need replaced. Further interview with Housekeeper #19 indicated the vents should be cleaned monthly, but should always be checked during the heating season as they tend to get dust on them more often.</p> <p>An interview with the Maintenance Supervisor on 2-22-2016 at 10:35 a.m., indicated he just got the housekeeping and laundry department assigned to him 2 weeks ago along with the building maintenance that he came here to do. He indicated he went room by room and listed what the room needed which could have included carpet, flooring, painting, toilets and one room needed a new sink. He indicated he has a plan but it is going to take him a while to complete. He indicated the stains in some of the toilets won't come out and the toilets need replaced. He indicated the vents in the</p>			

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	<p>halls were on his list. Further interview with the Maintenance Supervisor indicated there was not a policy for cleaning rooms or the vents as he just hasn't updated them yet. He indicated the building has had several years of neglect and will take some time and approval of a plan to get it to where he wants it to be.</p> <p>2. An observation of Resident #80's wheelchair on 2-16-2016 at 10:40 a.m., indicated dried spills and splatters were on the wheelchair base. Both arm rests were observed to have the vinyl worn off with the foam inside exposed. This would be on the area that the resident's arms would be placed.</p> <p>An observation of Resident #80's wheelchair on 2-22-2016 at 9:28 a.m., indicated the resident's wheelchair was cleaner but the arm rests still had torn vinyl on them.</p> <p>An observation of Resident #37's wheelchair on 2-16-2016 at 9:51 a.m., indicated the wheelchair had dirt and dust on the frames and wheels of the chair. An interview with Resident #37 at this time indicated "...they do not clean it..."</p> <p>An observation of Resident #37's wheelchair on 2-22-2016 at 9:35 a.m., indicated the wheelchair had dust/dirt on</p>			

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	<p>the wheelchair spokes.</p> <p>An observation of Resident #136's wheelchair on 2-16-2016 at 1:55 p.m., indicated the wheelchair had dried food on the frame on the left side and there was dust on the wheel spokes. An interview with Resident #136 at this time, indicated the staff did not clean his wheelchair.</p> <p>An observation of Resident #100's wheelchair on 2-22-2016 at 11:04 a.m., indicated there was dust on the spokes of the wheels and the armrest vinyl was cracked.</p> <p>An observation of Resident #21's wheelchair on 2-22-2016 at 1:33 p.m., indicated the wheelchair had dust and grit buildup on the spokes.</p> <p>An interview with the Resident Council President on 2-19-2016 at 1:09 p.m., indicated wheelchairs were supposed to be cleaned weekly and it was not being done.</p> <p>An interview with LPN #11 from the 100/200 unit on 2-19-2016 at 1:37 p.m., indicated the wheelchairs were supposed to be cleaned on 3rd shift and per the CNA (Certified Nursing Assistant) assignment sheet. LPN #11 indicated</p>			

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F 0520 SS=E Bldg. 00	<p>there was not a place to document that the wheelchair cleaning was completed.</p> <p>A copy of the "CNA Assignment Sheet - 3rd Shift" for the 100/200 hall residents was provided by LPN #11 on 2-19-2016 at 1:40 p.m. The sheet indicated a wheelchair cleaning schedule as follows, "...Monday: 101A-104B...Tuesday: 105A-108B...Wednesday: 109A-112B...Thursday: 114A-120B...Friday: 123A-204B...Saturday: 205A-208B...Sunday: 209A-217...."</p> <p>An interview with the Administrator on 2-22-2016 at 2:00 p.m., indicated there was not a policy for wheelchair cleaning.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to</p>			

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	<p>identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility's QA& A (Quality Assessment and Assurance) Program failed to implement and revise action plans for identified concerns regarding ensuring comfortable sound levels were maintained; failed to ensure water temperatures were maintained at safe and comfortable levels; failed to ensure hazardous chemicals were out of reach of confused, self-mobile residents; failed to ensure the environment was clean and was maintained in good repair; failed to ensure wheelchairs were maintained in a clean and sanitary manner; failed to assure adequate staffing levels were maintained to meet resident needs timely and safely; failed to address Resident Council Concerns regarding keeping fresh ice water available at the resident's bedsides; and failed to ensure unit microwaves were cleaned, pantry</p>	F 0520	<ul style="list-style-type: none"> · Action plans written and implemented regarding comfortable sound levels, water temperature maintenance, hazardous chemical storage, environment maintenance, wheelchair cleaning, staffing levels, resident council concerns, ice water passing, cleaning of pantry microwaves, proper labeling of pantry items (Dept. managers/ADM) 03-23-2016 · Daily M-F monitoring through Guardian Angel rounds (Dept. managers/ADM) 03-23-2016 · Monthly monitoring through ABAQIS resident and family interviews (Dept. managers/ADM) 03-23-2016 · Monthly monitoring through Resident Council meeting/minutes (SSD/Dept. managers/ADM) 03-23-2016 · Monitoring through submission of resident concerns/grievances (SSD/Dept. managers/ADM) 03-23-2016 · Action plans 	03/23/2016

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	<p>items were properly labeled with resident's name and date and identified.</p> <p>Findings include:</p> <p>On 2/23/16 at 3:30 p.m. the Administrator was interviewed. She indicated she was the contact person for the QA & A committee. She indicated the QA & A committee consisted of the following members: Administrator, Director of Nursing, Director of Rehabilitation, MDS (Minimum Data Set) Coordinator, Business Office Manager, Sales and Marketing Staff, Medical Director and other staff as needed, depending on the issues identified. She indicated the QA & A committee met monthly and failed to identify and/or implement and or adjust actions plans for the identified concerns listed above.</p> <p>The Administrator indicated during the Quarterly QA & A Committee meetings, the committee reviewed prior data and made decisions regarding identified concerns which needed actions plans developed or adjusted, determine goals and monitoring and audits of the action plans. She indicated they look at various areas of the facility and if there were issues, they track and trend to do an action plan and then monitor. She indicated sometimes, they assigned a</p>		<p>submitted to QAA Committee for review/approval (Dept. managers/ADM) 03-23-2016 · Plans to be reviewed weekly by QA Committee (Dept. managers/ADM) 03-23-2016 · Plans/progress to be submitted to QA committee monthly for review and amendment, if indicated (Dept. managers/ADM) 03-23-2016</p>		

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	<p>charter and would have a subcommittee work on a specific problem. The subcommittee would bring it back to the committee with possible resolutions. The Administrator indicated when goals were met, the QA & A committee would monitor for at least 6 months for compliance. She indicated concerns of residents, families, staff are brought to the QA & A Committee in various ways; through the department managers, Concern/Grievance forms available in the facility which could be placed in a secure box and also from the Resident Council and Social Services. She indicated she has an open door policy. She indicated these concerns were taken to Social Service and then to the appropriate department, with the Administrator then signing off on it. She indicated these are tracked and trended. When a problem is identified, they develop an action plan and then have tools in place for monitoring.</p> <p>The Administrator indicated at the time of this interview, she was not aware of the following concerns: comfortable sound levels not maintained; the hot water temperatures (the Administrator indicated the hot water checks were being done as they were supposed to); unsecured chemicals; The Administrator indicated they were</p>			

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	<p>aware of the following concerns: the cleanliness of the environment. She indicated they had been trying very hard and they had put a plan in place for this concern in the middle of December 2015. She indicated the facility had had a change in management with housekeeping in mid January or the first of February. She indicated they are in the middle of regrouping and putting a new plan in place to move forward. For sufficient nurse staffing, the Administrator indicated the facility had an action plan of call light audits as residents had identified this as a concern. She indicated the facility had been doing 5 random call light audits and they determined the call lights weren't getting answered in a timely manner. The Administrator indicated she was unaware of the pantries not being maintained in a clean and sanitary manner.</p> <p>On 2/22/16 at 3 p.m. the Administrator provided a current copy of the undated, facility policy and procedure for "Quality Management Policy." This policy included, but was not limited to, the following: " It is the policy that a functional Quality Management Program is maintained to monitor and evaluate the quality of resident care and services, pursue methods to improve quality and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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	<p>all areas of organizational functioning, and to promote safety by using a systematic problem identification and resolution process." The Quality Management Program includes an active Quality Assessment and Assurance (QA & A) program and a strategic focus on Continuous Quality Improvement (CQI). A functional QA & A program is to meet all regulatory requirements. The committee reviews and assesses quality data and develops and implements appropriate plans of action to correct identified quality deficiencies..."</p> <p>3.1-52(a)(2)</p>			