

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 04/18/2016
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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 Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 2/22/16.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00196840, IN00196987, and IN00197471.</p> <p>Complaint IN00196840 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Complaint IN00196987- Substantiated. Deficiencies related to the allegations are cited at F157, F282, and F309.</p> <p>Complaint IN00197471- Substantiated. Deficiency related to the allegations is cited at F353.</p> <p>Survey dates: April 15 & 18, 2016</p> <p>Facility number: 000476 Provider number: 155446 AIM number: 100290870</p> <p>Census bed type: SNF/NF: 88 Total: 88</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>Census payor type: Medicare: 19 Medicaid: 56 Other: 13 Total: 88</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on April 20, 2016 by 17934.</p> <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</p>			

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	<p>complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review the facility failed to notify the physician of an unavailable medication to begin treatment for 1 of 3 residents reviewed with new treatments in a sample of 8. (Resident #Y)</p> <p>Findings include:</p> <p>Resident #Y's record was reviewed 4-15-2016 at 2:03 PM. Resident #Y's diagnoses included, but were not limited to, high blood pressure, end stage kidney disease, and anemia.</p> <p>A physician's order dated 3-24-2016</p>	F 0157	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #Y's physician has been notified of the delay in treatment for Silver Sulfadiazine by nursing. (03/27/16) An order was obtained by nursing to discontinue the treatment as an alternate treatment was already ordered. How the facility will identify other residents having the potential to be affected by	05/10/2016

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	<p>indicated to apply Silver Sulfadiazine cream every day shift and every night shift to a burn on Resident #Y's left hip.</p> <p>A review of Resident #Y's Treatment Administration Record dated March 2016 indicated the Silver Sulfadiazine cream was not available for Administration on 3-24 and 3-25-2016.</p> <p>On 3-25-2016 at 11:10 AM, the physician was notified the cream was not available for administration, delaying treatment of the burn for another day.</p> <p>In an interview on 4-18-2016 at 1:07 PM, the Director of Nursing indicated the physician should be notified if a medication is not available to begin treatment.</p> <p>This Federal tag is related to Complaint IN00197471.</p> <p>3.1-5(a)(3)</p>		<p>the same deficient practice; For other residents having the potential to be affected, a treatment audit was conducted by the DON/Designee 04/28/16 and completed on 04/29/16, to ensure treatment supplies were available for ordered treatments, and that only one treatment order existed for each site/wound. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; Reeducation was initiated by the DSD on 4/26/16 with nurses covering: 1. Ensuring treatment supplies and/or meds are available for ordered treatments, and if not available the physician must be notified and an alternate treatment order obtained. 2. Ensuring one treatment order is in place per site/wound. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: An audit of medications not</p>	

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician's orders for treatments for 2 of 3 residents reviewed with treatment orders in a sample of 8. (Resident #Y and Resident #D)</p> <p>Findings include:</p> <p>1. Resident #Y's record was reviewed 4-15-2016 at 2:03 PM. Resident #Y's diagnoses included, but were not limited to, high blood pressure, end stage kidney</p>	F 0282	<p>administered due to lack of medication availability via the med admin audit report, will be conducted by DON/designee 5 times per week x's 2 weeks, 3 times per week x's 2 weeks, weekly for 8 weeks, then monthly for 3 months. Negative findings will be corrected immediately and reviewed monthly in the QA committee meeting times 6 months for further review and/or recommendations.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The MAR/TAR for Residents Y was reviewed by DON/Designee and a skin assessment was completed for Resident Y on 4/26/16 to identify all active wounds. The MAR/TAR for Residents D was reviewed</p>	05/10/2016

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	<p>disease, and anemia.</p> <p>A physician's order dated 4-11-2016 indicated to apply Xeroform gauze and a dry dressing to Resident #Y's left lateral thigh every day shift.</p> <p>A review of Resident #Y's Treatment Administration Record (TAR) dated April 2016 indicated no documentation for the dates of 4-12 and 4-14.</p> <p>In an interview on 4-15-2016 at 10:09 AM, LPN #1 indicated there was not enough staff to complete treatments in a timely manner. If the documentation was not completed, then the treatment was not completed.</p> <p>In an interview on 4-18-2016 at 1:07 PM, the Director of Nursing (DON) indicated that although there was no specific policy for following physician orders, it was a nursing standard to follow physician orders.</p> <p>2. A review of the MDS quarterly assessment completed on 2-10-2016 for Resident D, indicated the BIMS (Brief inventory of mental status) was 15/15, which indicated the resident was cognitively intact.</p> <p>A TAR (Treatment Administration</p>		<p>by DON/Designee and a skin assessment was completed for Resident D on 4/24/16 to identify all active wounds. Physician was notified of current wounds and treatment orders were reconciled on 4/26/16 by DON/Designee. How the facility will identify other residents having the potential to be affected by the same deficient practice; An audit of residents with skin/wound issues was conducted by the DON/Designee on April 29, 2016 to identify documentation omissions on MARs/TARs. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; Nurses were reeducated by DON/Designee on 4/29/16 regarding following physicians orders and documentation of treatments. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:</p>	

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	<p>Record) for Resident D for April 2016 was provided by the Director of Nursing (DON) on 4-18-2016 at 1:07 p.m.</p> <p>A review of the April TAR 2016 indicated the following:</p> <p>There were 5 orders for different wound sites dated 3-31-2016 to "monitor dressing every day to ensure adequate adhesion and to evaluate drainage or leakage; observe the area around the dressing for s/s (signs symptoms) of infections...every day shift..." The 5 sites to monitor included the left buttock distal, left buttock proximal, right buttock distal, right buttock, and the right thigh. The TAR indicated no documentation for wound care for the following April 2016 dates, the 1st, 3rd, 5th ,8th, 10th, 14th, 16th and 17th.</p> <p>There were 4 orders for treatments for the different wound sites dated 4-5-2016, to "...cleanse with Normal Saline, apply medihoney, apply bordered gauze every day shift every other day for wound..." The 4 sites for wound care included the left buttock distal, the left buttock proximal, the right buttock distal and the right buttock. The TAR indicated no documentation for wound care for the following April 2016 dates, the 8th,10th and 14th (a Friday, Sunday and a</p>		<p>MAR/TARs will be audited for documentation omissions by DON/Designee 5 times per week x's 2 weeks, 3 times per week x's 2 weeks, weekly for 8 weeks, then monthly for 3 months. Negative findings will be corrected immediately and reviewed monthly in the QA committee meeting times 6 months for further review and/or recommendations.</p>		

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	<p>Thursday).</p> <p>There was an order for the right thigh wound dated 4-9-2016 to "...cleanse with normal saline, apply medihoney, apply foam dressing with tape every day shift every other day for wound..." The TAR was initialed on 4-12-2016 (a Tuesday), but documentation for care was done on the 10th (Sunday) or the 14th (Thursday).</p> <p>An interview with LPN #20 on 4-18-2016 at 2:12 p.m., indicated if the treatments were not documented on the TAR, it would look like the wound care was not done. The LPN indicated Resident D went to dialysis on Tuesdays, Thursdays and Saturdays at 10:30 a.m., and if the dressings were not changed prior to the resident leaving, then the day shift would not have documented on the TAR that the dressings were changed.</p> <p>An interview with the West hall Unit Manager on 4-18-2016 at 2:16 p.m., indicated the dressing times for Resident #D were changed to the night shift due to day shift being too busy to get the dressings changed prior to dialysis.</p> <p>This Federal Tag is related to Complaint IN00197471.</p> <p>3.1-35(g)(2)</p>			

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F 0309 SS=D Bldg. 00	<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 begin treatment for a burn in a timely manner for 1 of 3 residents reviewed with new treatments in a sample of 8. (Resident #Y)</p> <p>Findings include:</p> <p>Resident #Y's record was reviewed on 4-15-2016 at 2:03 PM. Resident #Y's diagnoses included, but were not limited to, high blood pressure, end stage kidney disease, and anemia.</p> <p>In an interview on 4-15-2016 at 1:57 PM, Resident #Y indicated he had spilled coffee on himself during transport to</p>	F 0309	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician was notified that Silvadene/treatment was not available for Residents #Y on 3/27/16 by nursing. An order was obtained by nursing to discontinue treatment as an alternate treatment was already ordered. How the facility will identify other residents having the potential to be affected by the same deficient practice; An audit	05/10/2016

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	<p>dialysis. Although Resident #Y indicated he had given information to the transport driver and to the dialysis unit, neither assessed the area. Resident #Y further indicated on his return to the facility, he was in a hurry to see his girlfriend and refused to allow the nurse to do a post dialysis skin assessment.</p> <p>In an interview on 4-18-2016 at 9:33 AM, LPN #2 indicated she was informed by the CNA at 5:30 AM on 3-24-2016 of the burn on Resident #Y's left hip. LPN #2 then indicated she measured the area and described the area as having intact skin with blisters. Further, LPN #2 indicated she notified the physician and received an order for the Silvadene cream.</p> <p>A physician's order, dated 3-24-2016, indicated to apply Silver Sulfadiazine cream every day shift and every night shift to a burn on Resident #Y's left hip.</p> <p>A review of Resident #Y's Treatment Administration Record dated March 2016, indicated the Silver Sulfadiazine cream was not available for Administration on 3-24 and 3-25-2016.</p> <p>On 3-25-2016 at 11:10 AM, the physician was notified the cream was not available for administration, delaying</p>		<p>was conducted by the DON/Designee beginning 4/28/16 of medications/treatments documented as "not administered" and physician notification. Alternate orders were obtained as physician deemed appropriate. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; Reeducation was initiated by the DSD on 4/26/16 covering the proper process to follow when medication is not available including physician notification, obtaining an alternate treatment when needed, and timely administration of medications/treatments. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: and An audit of treatments not administered will be conducted by unit managers/designee to ensure treatments are</p>				

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F 0353 SS=E Bldg. 00	<p>treatment of the burn for another day.</p> <p>In an interview on 4-18-2016 at 1:07 PM, the Director of Nursing indicated the physician should have been notified the medication was not available so orders could have been obtained to begin treatment.</p> <p>This Federal tag is related to Complaint IN00197471.</p> <p>3.1-37(a)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 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</p>		<p>performed/documented timely 5 times per week x's 2 weeks, 3 times per week x's 2 weeks, weekly for 8 weeks, then monthly for 3 months. Negative findings will be corrected immediately and renewed monthly in QAA committee meeting times 6 months for further review and/or recommendations</p>		

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	<p>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 observation, interview, and record review, the facility failed to ensure adequate staff to ensure medications and treatments were administered in a timely manner for 3 of 4 residents reviewed with medications and treatments in a sample of 8. This had the potential to affect all dependent residents residing in the facility. (Resident #D, Resident #E, and Resident #F)</p> <p>Findings include:</p> <p>1. During medication pass observation on 4-15-2016 at 10:47 AM, Resident #E received the following: Ferrous Sulfate 325 mg tablet scheduled for 9:00 AM, and Proazosin 5 mg tablet scheduled for 8:00 AM.</p> <p>Resident #E's record was reviewed 4-18-2016 at 8:41 AM. Resident #E's diagnoses included, but were not limited to, high blood pressure, diabetes, and heart failure.</p> <p>A review of Resident #E's</p>	F 0353	<p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician was notified of late medication administration omissions in MAR/TAR documentation for Residents E, and F on 5/2/16. How the facility will identify other residents having the potential to be affected by the same deficient practice; Staffing levels were reviewed by the Administrator and Nursing Administration on 4/18/16 to ensure sufficient staff to meet the needs of residents. Resident Council and Complaint/Grievances Processes will be used each month to identify residents potentially impacted by staffing concerns, with remediation facilitated as indicated. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; MARs/TARs of residents will be reviewed by DON/designee to evaluate timing concerns and create optimal shift efficiencies with medication and treatment administration; changes will be made as deemed appropriate by physicians. Administrator and DON met on 5/2/16 to review</p>	05/10/2016

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	<p>physician's orders indicated Resident #E was to receive Ferrous Sulfate 325 mg three times per day at 9 AM, 1 PM, and 5 PM. Further, Resident #E was to receive Proazosin 5 mg every 8 hours at midnight, 8 AM, and 4 PM.</p> <p>In an interview on 4-15-2016 at 11:27 AM, Resident #E indicated medications were not given according to any sort of schedule, but when the nurses could get around to it as there were not enough nurses to assure medications were given on a routine basis.</p> <p>2. During medication pass observation on 4-15-2016 at 10:17 AM, Resident #F received the following: Methadone 10 mg scheduled for 9 AM, Gabapentin 300 mg scheduled for 9 AM, and lpratropium/ Albuterol solution for nebulizer scheduled for 8 AM.</p> <p>Resident #F's record was reviewed on 4-18-2016 at 8:52 AM. Resident #F's diagnoses included, but were not limited to, high blood pressure, diabetes, and depression.</p> <p>A review of Resident #F's</p>		<p>number of residents per unit with number of staff allocated to each unit per shift. Staffing/schedule was revised and staff reallocated to ensure sufficient staff to meet needs of the residents. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Random Resident and staff member interviews will be completed 3 times per week x's 4 weeks, weekly for 8 weeks, then monthly for 3 months. Administrator/Designee will discuss daily staffing needs in stand up meeting Monday through Friday to ensure sufficient staff to meet the needs of the residents. Scheduler/DSD will notify Administrator on weekends of staffing concerns for appropriate follow up. Staffing concerns identified through Resident Council, complaint/grievance processes, &/or random interviews will be presented to monthly QA times 6 months for further review and/or recommendations.</p>	

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	<p>physician's orders indicated Resident #F was to receive Methadone 10 mg every 12 hours at 9 AM, and 9 PM; Gabapentin 300 mg three times per day at 9 AM, 1 PM and 5 PM; and Ipratropium/ Albuterol solution as a nebulized dose every 4 hours at midnight, 4 AM, 8 AM, Noon, 4 PM, and 8 PM.</p> <p>In an interview on 4-15-2016 at 11:25 AM, Resident #F indicated his medications, especially his nebulizer were always late as there were not enough nurses to ensure medications were received at the right times.</p> <p>In a confidential interview on 4-15-2016 at 10:37 AM, Nurse #3 indicated there was not enough staff to complete med pass in a timely manner as medications were scheduled for a multitude of times for one resident. Further, Nurse #3 indicated she had requested help to complete the med pass in a timely manner, but none was given.</p> <p>3. A confidential interview with a Resident with a BIMS (Brief Interview for Mental Status, to indicate cognitive level) score of 15/15 (cognitively intact), indicated the following: the Resident had to wait 2 hours for</p>			

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	<p>the call light to be answered to be assisted to re-position.</p> <p>4. An interview with Resident D on 4-18-2016 at 10:25 a.m., indicated the facility was understaffed. Resident D indicated the little things get over looked and the staff were ready to "drop". Resident D indicated the medications were not on time and the dressings for wounds were not getting done. Resident D indicated it was over a week without dressing changes or medication on the wounds.</p> <p>A review of the MDS quarterly assessment completed on 2-10-2016 for Resident D, indicated the BIMS was 15/15, which indicated the resident was cognitively intact.</p> <p>A TAR (Treatment Administration Record) for Resident D for April 2016 was provided by the Director of Nursing (DON) on 4-18-2016 at 1:07 p.m.</p> <p>A review of the April TAR 2016 indicated the following: There were 5 orders for different wound sites dated 3-31-2016 to "monitor dressing every day to ensure adequate adhesion and to</p>			

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	<p>evaluate drainage or leakage; observe the area around the dressing for s/s (signs symptoms) of infections...every day shift...." The 5 sites to monitor included the left buttock distal, left buttock proximal, right buttock distal, right buttock, and the right thigh. The TAR indicated no documentation for wound care for the following April 2016 dates, the 1st, 3rd, 5th ,8th, 10th, 14th, 16th and 17th. There were 4 orders for treatments for the different wound sites dated 4-5-2016, to "...cleanse with Normal Saline, apply medihoney, apply bordered gauze every day shift every other day for wound...." The 4 sites for wound care included the left buttock distal, the left buttock proximal, the right buttock distal and the right buttock. The TAR indicated no documentation for wound care for the following April 2016 dates, the 8th,10th and 14th (a Friday, Sunday and a Thursday). There was an order for the right thigh wound dated 4-9-2016 to "...cleanse with normal saline, apply medihoney, apply foam dressing with tape every day shift every other day for wound...." The TAR was initialed on 4-12-2016 (a Tuesday), but documentation for</p>			

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F 0371	<p>care was done on the 10th (Sunday) or the 14th (Thursday).</p> <p>An interview with LPN #20 on 4-18-2016 at 2:12 p.m., indicated if the treatments were not documented on the TAR, it would look like the wound care was not done. The LPN indicated Resident D went to dialysis on Tuesdays, Thursdays and Saturdays at 10:30 a.m., and if the dressings were not changed prior to the resident leaving, then the day shift would not have documented on the TAR that the dressings were changed.</p> <p>An interview with the West hall Unit Manager on 4-18-2016 at 2:16 p.m., indicated the dressing times for Resident #D were changed to the night shift due to day shift being too busy to get the dressings changed prior to dialysis.</p> <p>This Federal tag is related to Complaint IN00197471.</p> <p>3.1-17(a)</p>				
	483.35(i)				

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SS=E Bldg. 00	<p>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 and failed to maintain clean microwaves. This deficient practice had the potential to affect the 88 residents who received food and beverages stored in the facility pantries and kitchenettes.</p> <p>Findings include:</p> <p>1. An observation of the pantry and kitchenette in the Bed and Breakfast Memory Care unit on 4-15-2016 at 9:50 a.m., indicated the following:</p> <p>The locked pantry area had a loaf of wheat bread on the wire shelf with a best by date of 4-12-2016.</p> <p>A gallon zip locked plastic bag of coffee had a 30 ml (milliliter) plastic cup stored inside the bag of coffee. The bag of coffee was not dated.</p>	F 0371	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The pantries and kitchenettes have been cleaned on 4/26/16 by housekeeping staff with outdated items discarded. Opened items were dated with date opened. Cleaning included the refrigerator and microwave. How the facility will identify other residents having the potential to be affected by the same deficient practice; The facility will add to the refrigerator temperature log to ensure compliance with the completion of daily kitchenette/pantry storage and cleanliness. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not	05/10/2016

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	<p>A gallon zip locked plastic bag of thickener powder was dated 4-11-2016 and a 30 ml plastic cup used as a scoop was stored inside the bag.</p> <p>The floor had dried coffee spills on it and the floor was sticky.</p> <p>In the kitchenette, on the middle shelf of an upper cabinet was an opened and partially used package of mini cinnamon sugar donuts with a sell by date of 3-3-2016. There was not an opened date written on the bag. An unopened bag of mini cinnamon sugar donuts had a sell by date of 3-3-2016.</p> <p>In the freezer, there was an opened and unsealed package of smoked sausage without a name or date opened on the package.</p> <p>Inside the refrigerator was the following:</p> <p>A 1/2 gallon of whole milk was without an opened date written on the container.</p> <p>An opened, unsealed 4 pound bag of sugar was on the top shelf of the refrigerator without an opened date written on the package.</p> <p>A 32 ounce bottle of lemon juice was without an opened date.</p> <p>There were 2 sandwiches wrapped in clear plastic wrap without a name, date or</p>		<p>recur; Housekeeping Staff were re-educated on keeping pantries/kitchenette and microwaves clean, as well as discarding expired food items. Former key pads were changed to key locks on 4/29/16 by maintenance director to gain greater control over the placement of food contents. Staff were reeducated on dating and appropriately discarding open food items. Activities included an education article in the monthly newsletter (May) for residents and families advising them of pantry/kitchenette rules. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Unit Mangers will monitor updated refrigerator temperature logs and make random spot checks to evaluate compliance with storage and sanitation practices 3 times per week x's 4 weeks, weekly for 8 weeks, then monthly for 3</p>	

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	<p>contents written on them.</p> <p>An opened 16 ounce bottle of ranch dressing had an unreadable best by date and no opened date written on the container.</p> <p>An opened 24 ounce bottle of chocolate syrup did not have an opened date written on the container.</p> <p>An opened 30 ounce jar of mayonnaise did not have an opened date written on the jar.</p> <p>An opened 16.5 ounce bottle of relish did not have an opened date written on the container.</p> <p>An opened zip locked package of honey roasted turkey did not have an opened date written on the package.</p> <p>Inside the microwave oven were light red splatters on the sides and top of the microwave and the glass plate had dried spills on it.</p> <p>2. An observation in the activity room kitchen on 4-15-2015 at 3:49 p.m., indicated a large tray of corn chips with caramel was observed on top of the stove to cool for at least an hour without being covered.</p> <p>3. An observation of the pantry and kitchenette in the Bed and Breakfast Memory Care unit on 4-18-2016 at 8:52 a.m., indicated the following:</p>		<p>months, with negative findings presented to monthly QA times 6 months for further review and/or recommendations.</p>	

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	<p>A zip locked package of honey roasted turkey was in the bottom drawer of the refrigerator without a name or opened date written on it.</p> <p>An opened 30 ounce jar of mayonnaise did not have an opened date written on the jar.</p> <p>An opened 16.5 ounce bottle of relish did not have an opened date written on the container.</p> <p>In the kitchenette, on the middle shelf of an upper cabinet was an opened and partially used package of mini cinnamon sugar donuts with a sell by date of 3-3-2016. There was not an opened date written on the bag. An unopened bag of mini cinnamon sugar donuts had a sell by date of 3-3-2016.</p> <p>There was a loaf of wheat bread with a best by date of 4-17-2016 in the cabinet.</p> <p>There was an opened, 10 ounce package of strawberry bars with an opened date of 4-15-2016 written on the package. The package was not sealed.</p> <p>An interview with RN #21 on 4-18-2016 at 9:00 a.m., indicated the strawberry bars should have been placed in a sealed bag</p>			

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	<p>An observation of the microwave indicated there were reddish splatters on the sides and top of the microwave and the round glass plate was not clean.</p> <p>In the pantry, a zip locked gallon bag of thickener powder had a 30 ml plastic cup stored inside the bag.</p> <p>An opened loaf of wheat bread with a best by date of 4-11-2016 on the label was stored on the wire shelf.</p> <p>Dried coffee color splatters were observed on the side of the wall next to the coffee pot and there were dried coffee spills on the floor under the coffee pot which covered 1/2 of a 12 inch square of the floor tile.</p> <p>A review of the Pantry Audits for March and April 2016 indicated there were not audits marked for the Bed and Breakfast Memory Care unit.</p> <p>An interview with the Director of Environmental Services on 4-18-2016 at 2:20 p.m., indicated housekeeping was responsible for the cleaning of the pantries, refrigerators, freezers and microwaves and for checking food for expiration dates.</p> <p>The Director of Environmental Services</p>			

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	<p>indicated the Bed and Breakfast did have pantry audits done and should have been placed in the plan of correction book. Further interview with the Director of Environmental Services, indicated housekeeping should be cleaning the pantries and microwaves in all of the units.</p> <p>An interview with the DON (Director of Nursing) on 4-18-2016 at 2:46 p.m., indicated the Activity Director was responsible to monitor the kitchenette/pantry in the Bed and Breakfast Memory Care unit. Further interview with the DON, indicated there were no paper pantry audits completed for the Bed and Breakfast unit in the plan of correction book.</p> <p>An interview with the Activity Director on 4-18-2016 at 2:55 p.m., indicated it was her responsibility to check and clean the refrigerator, freezer, cabinets and microwave in the Bed and Breakfast Memory Care unit. The Activity Director indicated she did not get it done this past Friday as she was here only a couple hours. She indicated she did not check the pantry in the Bed and Breakfast.</p> <p>During an observation with the Activity Director in the Bed and Breakfast Memory Care unit's kitchenette and</p>			

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	<p>pantry on 4-18-2016 at 2:58 p.m., the following was observed:</p> <p>The refrigerator had a subway sack with a sandwich inside and without a label, name or date on it.</p> <p>A zip locked package of honey roasted turkey was in the bottom drawer without a name or opened date written on the package.</p> <p>There were 2 brown bananas in the other bottom drawer. The Activity Director was observed to discard the meat and bananas.</p> <p>The microwave had splatters of reddish color on the top and sides of the inside of the microwave and the round glass tray was not clean. The Activity Director indicated she did not clean the microwave this past Friday or today.</p> <p>In the upper left cabinets, the Activity Director was unaware of the 2 packages of mini cinnamon sugar donuts which had a sell by date of 3-3-2016, were even in the cabinet. The Activity Director was observed to discard the two packages of donuts.</p> <p>The pantry was observed to have dried coffee stains on the floor. The Activity</p>			

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	<p>Director indicated housekeeping was to clean the kitchenette/pantry floors.</p> <p>A zip locked plastic bag of thickener powder with an opened date of 4-11-2016 had a 30 milliliter plastic cup stored inside the bag. The Activity Director was unaware the "scoop" could not be left in the powdered thickener.</p> <p>A sealed plastic container labeled "brand name" cereal did not have an opened date on it.</p> <p>The Activity Director indicated there was not an audit form completed for the Bed and Breakfast kitchenette/pantry.</p> <p>4. During an observation of the West Hall Pantry on 4/15/16 at 9:40 a.m., the following was observed:</p> <p>In the refrigerator there was: one opened bottle of [Brand] salad dressing not labeled with an opened date and a use by date of 12/30/15; one opened bottle of [Brand] ketchup not labeled with an opened date; one opened bottle of pickle relish not labeled with an opened date.</p> <p>In the freezer there was: a white coffee cup with a dark brown frozen substance, not covered and not labeled with a name or a date; an opened box of popsicles not labeled or dated; an opened box of</p>			

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	<p>[Brand] Turtle pie, not labeled or dated; an opened box of [Brand] croissant sandwiches not labeled or dated.</p> <p>5. During an observation of the Rehabilitation Unit's Kitchenette and Pantry on 4/15/16 at 10:00 a.m., the following was observed:</p> <p>In the kitchenette cabinets in the dining room there were 6 large plastic containers containing dry cereal, and 2 (rice krispies and corn flakes) of the 6 were not dated.</p> <p>In the pantry's refrigerator there was: an opened plastic package of [Brand] chicken deli meat, not labeled or dated; a brown paper bag, taped shut, not labeled or dated; a medium size plastic container containing what appeared to be potato salad, not labeled or dated; a medium plastic container of noodle soup tied inside of a grocery type plastic bag with a name and room number written on a piece of paper in the bag, but was not dated; a small plastic container containing noodles, not labeled or dated; a sealed store prepared lettuce salad, not labeled with a best if used by date of 4/11/16.</p> <p>6. During an observation of the West Hall Pantry on 4/15/16 at 4:55 p.m., the following was observed:</p>			

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	<p>In the freezer the uncovered white coffee mug had been removed.</p> <p>In the refrigerator the opened bottle of [Brand] salad dressing with a use by date of 12/30/15, the opened ketchup bottle and opened pickle relish bottles remained in the refrigerator door and were not labeled with opened dates.</p> <p>7. During an observation of the Rehabilitation Unit's Kitchenette/Pantry on 4/18/16 at 1:25 p.m., the following was observed:</p> <p>In the kitchenette cabinets in the dining room were 6 large plastic containers containing dry cereal and 2 (rice krispies and corn flakes) of the 6 containers remained un-dated.</p> <p>In the pantry refrigerator was: a slice of wheat bread and a pat of butter in a wax paper bag not labeled or dated; 3 small individual plastic containers containing sour cream not labeled or dated; 1 covered bowl of tomato soup not labeled or dated; one bowl of noodles covered with plastic wrap, not labeled or dated; a half full clear plastic pitcher containing white liquid, appeared to be milk, not dated with an opened date.</p>			

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F 0520 SS=E Bldg. 00	<p>During an interview with the West Hall Unit Manager on 4/18/16 at 2:20 p.m., she indicated the staff putting the food item in the refrigerator or freezer was responsible to make sure the food item was labeled with a resident's name and a date.</p> <p>A current policy titled "Resident Room and Bathroom Cleaning" dated 8/14 and provided by the Director of Environmental Services on 4-18-2016 at 2:38 p.m., indicated "...Daily Routine Cleaning procedure...clean microwave...."</p> <p>3.1-21(i)(2) 31.-21(i)(3)</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 identify issues with respect to which quality</p>			

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	<p>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 QAA (Quality Assessment and Assurance) committee failed to implement an effective plan of correction for concerns identified on the recertification survey to ensure physician notification of a change in treatment, medications were passed according to physician orders, assessments and treatments were completed as ordered, and food and beverages kept in the pantry and kitchenette freezers/refrigerators and cabinets were properly sealed, labeled, and dated, and failed to maintain a clean microwave. This had the potential to affect 88 of 88 residents who resided in the facility.</p> <p>Findings include:</p> <p>The Administrator was interviewed on 4/18/16 at 12:40 a.m. During the interview she indicated she was hired as</p>	F 0520	<p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Facility Administration was able to clear 8 federal tags upon re-visit due to good faith Quality Management Program remediation efforts. The remaining issues that were not cleared have been addressed through alternate plans of action submitted to the state. How the facility will identify other residents having the potential to be affected by the same deficient practice; Issues identified by the department from annual and re-visit surveys have been added as standard monthly agenda items to prompt Quality Management Committee review and oversight. Monitoring plans associated with these tags will be reviewed each month to evaluate compliance status and identify additional remediation needs. What measures will be put into place, or systemic changes</p>	05/10/2016

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	<p>the Administrator of the facility on 2/6/16, received 3 weeks of training, and then came to the facility. She also indicated the QAA committee met quarterly with the Medical Director, the Pharmacist, the Administrator, the Director of Nursing (DON) and all the department heads. She further indicated the QAA committee reviewed the Resident Council Meeting minutes, facility audits, the results of the State Survey and the Life Safety Code survey. She also indicated the QAA team would discuss any concerns brought to the committee and the team would collaborate and develop a plan of action for each concerns.</p> <p>The Plan of Correction, with a completion date of 3/23/16, for the recertification and state licensure survey, indicated the following corrective action(s) would be monitored to ensure the deficient practices would not recur: monitoring with findings presented at monthly QAA meetings, on-going review of 24 hour report during clinical meeting with follow-up as indicated, ongoing review of Change of Condition assessments with follow-up as indicated, daily (M-F) ongoing review of Point Click Care alerts during clinical meetings with follow-up as indicated, in-service nursing staff regarding Change of</p>		<p>made, to ensure that the deficient practice will not recur; Quality Assurance Committee Members will be in-serviced by the Director of Quality Management (or designee) on facilitating effective quality assessment and assurance activities; including responsibilities for developing, implementing, and monitoring action plans to correct quality deficiencies. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Each quarter for the next 2 quarters, the Director of Operations, or designee will review and sign off on facility Quality Assurance Committee Meeting minutes to monitor compliance with conducting effective Quality Assurance Committee Activities to address State Department and facility concerns. The Director of Operations will be responsible for directing and coordinating Administrator compliance with facility Quality Assurance Programs.</p>	

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	Condition and appropriate assessment follow-up, monitor assigned daily staffing pattern for accuracy, appropriate staffing level based on census, adjust staffing patterns as appropriate based on concerns/trends through grievance process, resident communication providing timely assistance of resident requests, monitor resident concerns through daily Guardian Angel rounds and IDT (Interdisciplinary Team) walking rounds, monitor concerns through monthly Resident Council meetings with appropriate follow-up, monitor concerns through ABAQIS (survey readiness tool) survey completion and resident and family questionnaires, review resident concerns/grievances daily (M-F) during department director meetings, monthly review of grievances with track/trend analysis submitted to QAA Committee for review and appropriate follow-up, refrigerators/freezers checked for cleanliness/appropriate temperatures and labeling of food, microwaves cleaned with schedule for cleaning posted, food in freezer/refrigerators checked daily for appropriate labeling, staff in-serviced on proper labeling of food/drinks and cleanliness of microwaves, and daily monitoring of pantries and refrigerators with report submitted for review to the monthly QAA Committee.			

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	<p>An In-Service Training/Attendance Record, dated 3/15/16, indicated all staff were in-serviced on survey compliance and the Plan of Correction.</p> <p>The Administrator was interviewed on 4/18/16 at 3:49 p.m. During the interview she indicated the facility did not consider the kitchenette in the Bed and Breakfast as a pantry, so the facility did not complete any monitoring forms. She also indicated food items were being thrown away during the daily monitoring by the Unit Manager. She did not indicate why food and beverages were found not labeled or dated during the survey. She further indicated the DON read the orders and the progress notes during the clinical meeting and she was aware of several instances where the physician had not been notified. She also indicated the facility would be making changes so the deficiencies cited would not be re-cited.</p> <p>A current undated facility policy "Quality Management Policy", provided by the Administrator on 4/18/16, indicated "...It is the policy that a functional Quality Management Program is maintained to monitor and evaluate the quality of resident care and services...A functional QA&A Program is maintained...The committee reviews and assesses quality</p>			

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	<p>data and develops and implements appropriate plans of action to correct identified quality deficiencies...The QA&A Committee shall consist of the Executive Director, the Director of Nursing Services, the Medical Director (required to attend quarterly) and minimally three additional facility staff members...These additional members should represent various service departments within the facility...The Executive Director shall serve as the Committee Chairman and the Director of Nursing Services shall serve as the Co-Chairman...The QA&A committee meets monthly to review and assess quality data and to determine if established standards are being met...Facility quality data will be collected and trended to identify shortfalls...The committee is responsible for taking immediate action for issues that reflect sub-standard quality of care and/or have the potential for increased risk...The QA&A committee will initiate quality improvement action plans to address identified shortfalls and negative outcomes...."</p> <p>These deficiencies were cited on the annual recertification survey on 2/22/16 and the facility failed to implement a plan to correct the deficiency.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-52(a)(2)				