STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 10, 11, 14, 15, 16 and 17, 2016. Facility number: 000515 Provider number: 155608 AIM number: 100290820 Census bed type: SNF: 22 SNF/NF: 93 Total: 115 Census payor type: Medicare: 17 Medicaid: 62 Other: 36 Total: 115 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32882 on 3/21/16.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 0282 SS=D Bldg. 00	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. Based on observation, record review and interview, the facility failed to provide services in accordance with a resident's written plan of care related to the lack of an assessment and monitoring of a resident with bruises, and not following a physician's order related to a pressure ulcer treatment not completed as ordered for 2 of 21 residents whose plan of care was reviewed. (Residents #109, #65) Findings include: 1. On 3/10/16 at 1:28 p.m., Resident #109 was observed to have a purple discoloration to the left 4th knuckle on the left hand. She was also observed to have a slightly swollen tip of the right first finger which was a light purple in color. The resident indicated she was unsure how the discoloration on the knuckle happened, but indicated the tip of her finger had been swollen and purple for over a week.	F 0282	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 109 assessed, incident report completed. M.D. notified. No adverse effect from alleged deficiency. Padding was applied to wall where resident reports“bumping” area Resident 65 was assessed, treatment order clarified. MD and hospice agency informed of dressing change omission. Resident had no adverse effect from alleged deficiency. - 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; All resident will have plan of care reviewed and will be assessed during their next shower day. All skin conditions will be assessed and appropriate interventions implemented. All residents with pressure ulcers will have treatments evaluated for complete and accurate transcription. what measures	04/11/2016

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	On 3/14/16 at 3:35 p.m., Resident #109 was observed sitting in her wheelchair in the activity room participating in a painting activity. A dark purple discoloration was noted to the top of the left hand and a greenish yellow discoloration to the 4th knuckle. On 3/16/16 at 3:45 p.m., Resident #109 was lying in her bed. A brown discoloration was observed to the left 4th knuckle, a purple discoloration to the top of the left hand, and the tip of the right first finger was still slightly swollen and light purple in color. The resident indicated she had probably bumped her left hand to get the discolorations. She further indicated she may have pinched her finger on her side rail when she was trying to pull herself up. Record review for Resident #109 was completed on 3/16/16 at 2:23 p.m. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, anxiety and depression. A Care Plan indicated the resident was receiving Coumadin (blood thinner) medication. An intervention included to observe for side effects of the medication such as bruising. Review of the March 2015 Treatment		will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Night shift will complete an audit of orders written on the previous day and verify for complete and accurate transcription of new orders Staff education see exhibit C will be provided on following plan of care and physician order follow through and importance of skin assessments. - 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 Nursing manager will complete a random audit of 5 new physician orders and 5 plans of care per day Licensed nurse will complete a secondary skin check on shower day and sign off on shower skin assessment, the nursing supervisor or designee will audit 5 residents per week see exhibit A. DON to report on audit findings monthly in QA meeting for 6 months	

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	Administration Record indicated a skin assessment was completed on 3/16/16, 3/9/16, and 3/2/16 with no new skin issues noted. Interview with LPN #1 on 3/16/16 at 3:54 p.m., indicated she was unaware the resident had any discolorations to the top of her left hand and knuckle or the swelling and discoloration to the right first finger. She indicated she completed a quick skin assessment on the resident before the resident went out to a doctor appointment that day but did not notice anything. She further indicated staff should have noticed the discolorations by now because the resident needed assistance with daily care. 2. The record for Resident #65 was reviewed on 3/14/16 at 2:17 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, heart failure, depression and peripheral vascular disease (poor lower extremity circulation). Review of a Physician's Order dated 3/14/16, indicated to cleanse the coccyx (tail bone area) with wound wash, apply Cavilion spray (a wound wash) and cover with Allevyn (a wound dressing) daily and as needed. Review of the March 2016 TAR			

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	(Treatment Administration Record), indicated the treatment to the coccyx was completed on 3/14/16 and on 3/16/15. The treatment was not signed off on the TAR as completed on 3/15/16. Review of the Nurse's Notes from 3/14/16 at 10:00 a.m. through a late entry on 3/15/16 at 7:00 p.m. lacked an indication that the treatment of the coccyx was completed on 3/15/16. Review of the Hospice Nurse Notes indicated the Nurse had visited the resident on 3/10/16 and 3/14/16. Review of the Hospice Nurse Note dated 3/14/16 at 8:45 a.m., indicated there was a new wound to the coccyx area. The Hospice Nurse Note further indicated there was a new treatment order. The new treatment indicated, Cavilion spray and an Allevyn dressing to be applied to the coccyx daily. Interview with LPN #2 on 3/16/16 at 9:13 a.m., indicated she had completed the treatment to the coccyx area earlier this morning while the Hospice CNA had completed the resident's bed bath. LPN #2 further indicated the dressing that was removed from the coccyx was dated 3/14/16, with a nurse's initials.			

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	Interview with the Director of Health Care Services (DHS) on 3/16/16 at 11:30 a.m., indicated the Physician's Order for the treatment to the coccyx was to be completed daily and it was not completed on 3/15/16. The DHS further indicated there was not a policy for following Physician's Orders. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	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. Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 8 residents who met the criteria for non pressure related skin conditions, and the lack of before and after dialysis	F 0309	- whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; - Resident 109 assessed, incident report completed. M.D. notified. No adverse effect from alleged deficiency. Padding was applied to wall where resident reports“bumping” area - Resident209 assessed and had no adverse effects related to	04/11/2016

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	assessments for 1 of 1 residents reviewed for dialysis of 1 who met the criteria for dialysis. (Residents #109, #209) Findings include: 1. On 3/10/16 at 1:28 p.m., Resident #109 was observed to have a purple discoloration to the left 4th knuckle on the left hand. She was also observed to have a slightly swollen tip of the right first finger which was a light purple in color. The resident indicated she was unsure how the discoloration on the knuckle happened, but indicated the tip of her finger had been swollen and purple for over a week. On 3/14/16 at 3:35 p.m., Resident #109 was observed sitting in her wheelchair in the activity room participating in a painting activity. A dark purple discoloration was noted to the top of the left hand and a greenish yellow discoloration to the 4th knuckle. On 3/16/16 at 3:45 p.m., Resident #109 was lying in her bed. A brown discoloration was observed to the left 4th knuckle, a purple discoloration to the top of the left hand, and the tip of the right first finger was still slightly swollen and light purple in color. The resident indicated she had probably bumped her		alleged deficiency. - 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; - Noother residents receive dialysis - All resident will be assessed during their next shower day. All skin conditions will be assessed and appropriate interventions implemented. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; . - Apolicy review and revision of pre and post dialysis assessment (See exhibit B) with education provided see exhibit C to nurses on action steps and accountability. - 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 - Licensed nurse will complete a secondary skin check on shower day and sign off on shower skin assessment, the nursing supervisor or designee will audit 5 residents perweek see exhibit A. - Nursing manager or designee will audit 5 records per week of dialysis patient pre/post assessment form for completion and follow up See exhibit A - DONto report on audit findings monthly in QA meeting for 6 months	

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	left hand to get the discolorations. She further indicated she may have pinched her finger on her side rail when she was trying to pull herself up. Record review for Resident #109 was completed on 3/16/16 at 2:23 p.m. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, anxiety and depression. The Quarterly Minimum Data Set (MDS) assessment completed on 1/12/16 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 15 which indicated the resident was cognitively intact. The assessment indicated the resident needed an extensive 1 person assist for bed mobility, dressing, and toileting. The assessment indicated the resident had received an anticoagulant (blood thinning) medication. A Care Plan indicated the resident was receiving Coumadin (blood thinner) medication. An intervention included to observe for side effects of the medication such as bruising. Review of the March 2016 Physician's Orders indicated the resident had received Coumadin 3 mg (milligrams) daily until 3/13/16. The order was			

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	changed to hold the Coumadin on 3/14/16, then to start Coumadin 2.5 mg daily on 3/15/16. Review of the March 2015 Treatment Administration Record indicated a skin assessment was completed on 3/16/16, 3/9/16, and 3/2/16 with no new skin issues noted. Interview with LPN #1 on 3/16/16 at 3:54 p.m., indicated she was unaware the resident had any discolorations to the top of her left hand and knuckle or the swelling and discoloration to the right first finger. She indicated she completed a quick skin assessment on the resident before the resident went out to a doctor appointment that day but did not notice anything. She further indicated staff should have noticed the discolorations by now because the resident needed assistance with daily care. 2. The record for Resident #209 was reviewed on 3/15/16 at 1:43 p.m. The resident's diagnoses included, but were not limited to, chronic renal disease, hypertension, and diabetes mellitus. Review of the March 2016 Physician Order Summary (POS) indicated the resident received dialysis six times a week Monday through Saturday.			

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	Review of the Treatment Administration Record (TAR) for March 2016 indicated the resident's dialysis catheter was assessed for signs and symptoms of infection every shift but lacked documentation the resident was assessed before or after dialysis. Review of the Nurse's Notes for March 2016 lacked documentation the resident had been assessed before and after dialysis. Interview with RN #1 on 3/17/16 at 1:33 p.m. indicated her routine was to check the resident's vital signs and assess his pain before he went to dialysis and when he returned from dialysis. Interview with the Director of Health Services (DHS) on 3/16/16 at 8:56 a.m. indicated the resident had a communication book he was to take back and forth to dialysis. She further indicated the book was not currently at the facility. She indicated she had spoken with the resident and he indicated he just leaves the book at dialysis because the dialysis center does not look at it anyway. She further indicated the dialysis communication forms had not been completed. A facility policy, titled "Dialysis			

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	Interfacility Transfer Communication", dated 8/30/2011, and received from the DHS as current, indicated "...1. The Dialysis Communication Record will be completed by the licensed nurse when sending and receiving the individual undergoing outpatient dialysis. The information will include: Pre-dialysis and post-dialysis weights, vascular access site condition, mental status, vital signs, and pertinent laboratory results..." 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview, observation and record review, the facility failed to provide Activities of Daily Living (ADL) assistance to a dependent resident related to providing hair grooming for 1 of 2 residents reviewed for ADL's of the 2 residents who met the criteria for ADL's. (Resident #228) Finding includes:	F 0312	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Resident hair was combed and resident demonstrated no adverse effects related to the alleged deficiency. - 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; - All residents will be assessed for grooming and hygiene - what	04/11/2016

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	Resident #228's daughter was interviewed on 3/10/16 at 2:20 p.m., and she indicated she felt the resident's hair was unkempt by staff. On 03/14/2016 at 4:12 p.m., the resident was observed sitting in her wheelchair in the 700 hallway waiting for the dining room doors to open for dinner. The resident's hair in the back was unkempt and messy. On 3/15/16 at 8:23 a.m., the resident was observed in the 700 hallway being pushed by a CNA to the resident's room. Staff indicated the resident had returned from the dining room from breakfast. The resident's hair, in the back, was observed as unkempt and messy. Interview with CNA #1 on 3/16/16 at 11:03 a.m., indicated the resident was a one person assist with personal hygiene, and her hair was combed in the morning before breakfast and in the evening before bed time. On 3/17/16 at 8:25 a.m., the resident was observed in the 700 hallway therapy room, and the resident indicated she had just returned from breakfast. The back of the resident's hair was observed as unkempt and messy.		measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Staff education see exhibit C will be provided to facility staff on ADL's and grooming - 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 - Facility leadership will audit residents for grooming and hygiene in the dining room 5 times per week during meal manager rotation and report findings See exhibit A - Audit findings will be presented in QA monthly for 6 months	

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	On 3/17/16 at 9:28 a.m., the resident was observed sitting in her wheelchair, in her room, watching TV. The back of the resident's hair was still unkempt and messy. On 03/17/2016 at 11:22 a.m., Resident #228 was observed in the dining room sitting at a table with 3 other residents. The back of the resident's hair was unkempt and messy. Interview with CNA #1 on 03/17/2016 at 11:26 a.m., indicated that the resident's hair was brushed this morning, but not before being taken to lunch today. CNA #1 further indicated the resident's hair was not brushed before lunch or before going to dinner. Resident #228's record was reviewed on 3/17/16 at 11:32 a.m. The resident's diagnoses included, but were not limited to, dementia, Parkinson's Disease and anemia. Review of the resident's 14 day MDS (Minimum Data Set) assessment dated 3/1/16, indicated the resident had some cognitive impairments, was an extensive one person assist with personal hygiene and an extensive two person assist with dressing.			

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	Resident #228 was observed on 3/17/16 11:43 a.m. in Dining Room #2 with the Director of Health Care Services (DHS). Interview with the DHS at that time indicated the back of the resident's hair looked messy and needed to be combed. 3.1-38(a)(3)(B)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on record review and interview, the facility failed to ensure a treatment was completed as ordered for a pressure ulcer for 1 of 5 residents reviewed for pressure ulcers. (Resident #65) Finding includes: The record for Resident #65 was	F 0314	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Resident 65 was assessed, treatment order clarified. MD and hospice agency informed of dressing change omission. Resident had no adverse effect from alleged deficiency - how other residents having the potential to be affected	04/11/2016

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	reviewed on 3/14/16 at 2:17 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, heart failure, depression and peripheral vascular disease (poor lower extremity circulation). Review of a Physician's Order dated 3/14/16, indicated to cleanse the coccyx (tail bone area) with wound wash, apply Cavilion spray (a wound wash) and cover with Allevyn (a wound dressing) daily and as needed. Review of the March 2016 TAR (Treatment Administration Record), indicated the treatment to the coccyx was completed on 3/14/16 and on 3/16/15. The treatment was not signed off on the TAR as completed on 3/15/16. Review of the Nurse's Notes from 3/14/16 at 10:00 a.m. through a late entry on 3/15/16 at 7:00 p.m. lacked an indication that the treatment of the coccyx was completed on 3/15/16. Review of the Hospice Nurse Notes indicated the Nurse had visited the resident on 3/10/16 and 3/14/16. Review of the Hospice Nurse Note dated 3/14/16 at 8:45 a.m., indicated a new		by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents with pressure ulcers will have treatments evaluated for complete and accurate transcription. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Staff education see exhibit C will be provided to all nursing staff regarding following physician orders and licensed nurse order checks on the night shift. - 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 - Nursing manager or designee will complete a random audit of 5 treatment orders per week see exhibit A - DON to report on audit findings monthly at QA for 6 months	

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	wound to the coccyx area. The Hospice Nurse Note further indicated there was a new treatment order. The new treatment indicated, Cavilion spray and an Allevyn dressing to be applied to the coccyx daily. Interview with LPN #2 on 3/16/16 at 9:13 a.m., indicated she had completed the treatment to the coccyx area earlier this a.m. while the Hospice CNA had completed the resident's bed bath. LPN #2 further indicated the dressing that was removed from the coccyx was dated 3/14/16, with a nurse's initials. Interview with the Director of Health Care Services (DHS) on 3/16/16 at 11:30 a.m., indicated the Physician's Order for the treatment to the coccyx was to be completed daily and it was not completed on 3/15/16. The DHS further indicated there was not a policy for following Physician's Orders. 3.1-40(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive			

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	dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to a lack of non-pharmacological interventions attempted before the administration of antianxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Residents #214) Finding includes: The record for Resident #214 was reviewed on 3/16/16 at 8:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and hyperlipidemia. Review of the March 2016 Physician Order Summary (POS) indicated an order	F 0329	Facility wishes to complete an IDR of this alleged deficiency. The facility maintains that the one and only affected resident affected by alleged deficiency was receiving hospice care and the regulation states non-pharmacological intervetions are to be considered when INDICATED. The following plan of correction in no way indicates Wittenberg's admittance of alleged deficiency. - whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; - residentwas assessed and had no adverse effect related to alleged deficiency. - howother residents having the potential to be affected by the same	04/11/2016

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	for lorazepam (Ativan, an antianxiety medication) 1 mg (milligram) at bedtime as needed. Review of the February 2016 Medication Administration Record (MAR) indicated the resident had received the lorazepam medication on 2/23/16, 2/24/16, and 2/28/16. The record lacked documentation of any non-pharmacological interventions attempted prior to administering the lorazepam medication on 2/23/16, 2/24/16, and 2/28/16. Review of the March 2016 MAR indicated the resident had received the lorazepam medication on 3/2/16 and 3/10/16. The record lacked documentation of any non-pharmacological interventions attempted prior to administering the lorazepam medication on 3/2/16 and 3/10/16. Interview with the Director of Health Services (DHS) on 3/16/16 at 10:25 a.m. indicated any non-pharmacological interventions that were attempted prior to PRN (as needed) medication administration should have been charted on the back of the MAR. 3.1-48(a)(6)		deficientpractice will be identified and what corrective action(s) will be taken; - Allresidents with prn psychotropic medications will have medication administrationrecords checked for documented interventions and any deficiencies will beaddressed - whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; - Educationsee exhibit C will be provided to nursing staff regarding interventionsto attempt prior to medication administration. Hospice policy will be reviewed(see attached) - howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and - 5residents per week receiving prn psychotropic medication will have theirmedication admiration record reviewed by social service for utilization of interventionsprior to medication administration see exhibit A - DONt o report on audit findings monthly in QA for 6 months	

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F 0371 SS=D Bldg. 00	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 Based on observation, interview and record review, the facility failed to ensure proper hand hygiene was maintained during the lunch meal service for the 600 Dining Room. This had the potential to affect 3 of the 4 residents who received a regular textured diet. (600 Dining Room) Finding includes: A continuous observation was made on 3/10/16 from 11:17 a.m. through 12:00 p.m. in the 600 Dining Room: At 11:20 a.m., Cook #1 placed the food containers on the steam table with appropriate scoops and spoons, and the dinner rolls were observed to be the original bag, opened. Cook #1 prepared 2 room trays, the first one at 11:43 p.m. a pureed meal plate, the second a regular textured diet plate, Cook	F 0371	1. What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice: Residents assessed and zero adverse effects noted from the alleged deficient practice 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All resident seating in this dining room have the potential to be effected by the alleged deficient practice. Zero adverse effects identified. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficit practice doesn't not recur: All Culinary staff have been educated and have signed to attest to that fact. Education was completed by all culinary staff on 3-18-16. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;	04/11/2016

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	#1 was observed to touch the meal ticket, 3 serving scoops (one from each food), then placed a dinner roll from the bag onto the plate. Then Cook #1 prepared the 7 pureed meal plates, which did not receive a dinner roll. After completing the pureed meal plates, at 11:48 a.m., Cook #1 received a meal ticket, used the same gloved hand to accept the meal ticket, proceeded to touch 3 serving spoons to place food onto a plate, then used same gloved hand again to retrieve a dinner roll from the bag and place it onto the resident's plate. The plate was then served to the resident. For the last regular textured diet plate, Cook #1 received the meal ticket, used the same gloved hand to touch 3 serving spoons, and then placed a dinner roll from the bag onto the resident's plate, which was then served to the resident. Cook #1 did not change gloves or wash hands at any time during the observation. Interview with Cook #1 at 11:54 a.m., indicated he should have used tongs to serve the dinner rolls. The policy titled, "Culinary Services, Use		and by what date the systemic changes will be completed. The deficiency will be added to the Culinary Audit Checklist which is completed by culinary director or designee, which is completed twice a week. This audit will include meal observation of rotating meals. Date of completion of the audits will be 9-2016	

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	of Gloves," was provided by the Dietetic Technician on 3/10/16 at 3:15 p.m. This current policy indicated, "...3. Disposable gloves worn to handle ready to eat food shall be single use gloves used only for one task...." 3.1-21(i)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility			

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	must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and interview, the facility failed to ensure infection control practices and standards were maintained related to an unidentified resident's toothbrush uncovered in the bathroom. (Room #312) Finding includes: During an observation on 3/10/16 at 12:05 p.m. of Room #312's bathroom, an unidentified toothbrush was uncovered and on the ledge above the sink. During the Environmental Tour on 3/17/16 at 1:20 p.m., in Room #312's bathroom, an unidentified toothbrush was observed to be uncovered on the ledge above the sink. Interview with the Manager of Plant Operations at 2:00 p.m., indicated the	F 0441	- whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; - Toothbrushplaced in a labeled bag in the bathroom - howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken; - Allbathrooms checked for presence of uncovered personal hygiene items - whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; - Education See exhibit C will be provided tonursing staff regarding importance of infection control measures including butnot limited to: hand washing and protected hygiene items. - howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be	04/11/2016

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	toothbrush should have been covered or not stored in the bathroom. 3.1-18(a)		put into place;and - Nursingleadership will monitor for covered and separated personal hygiene items inresident bathrooms in 5 resident rooms per week see exhibit A DON to report on findings in QA for 6 months	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the resident's environment and safety equipment was clean and in good repair related to marred and gouged walls and closet doors, dirty bathroom floors and chipped paint for 6 of 7 hallways in the facility. (700, 600, 500, 400, 300 and 100 Hallways) Findings include: During the Environmental Tour on 3/17/16 from 1:20 p.m. through 2:00 p.m. with the Manager of Plan Operations and the Executive Director, the following was observed: 1. 700 Hallway: a. In Room #714, the closet door was	F 0465	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - all items from the “punch” list have been corrected and toilet seat grab bars have been modified to ensure proper hand grip. - 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; - A review by maintenance staff of every resident room has been completed all similar alleged deficiencies have been corrected. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Education will be provided during facility staff meeting to review expectations and notification process for areas of concern. Formal tracking process	04/11/2016

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	gouged and in the bathroom, the toilet riser's handle was against the wall, having left no space for the resident's hand to grasp the handle. There was one resident who resided in this room. b. In Room #713, the closet door was gouged. There was one resident who resided in this room. 2. 600 Hallway: a. The outside of Room 615's bathroom door was gouged near the knob. There were two residents who resided in this room. b. Room #613's closet door was marred and the baseboard in the bathroom by the toilet had pulled away from the wall. There were two residents who shared this bathroom. c. In Room #607, there were black marks on the floor next to bed B and the toilet riser's handle was against the wall, having left no space for the resident's hand to grasp the handle. There were two residents who resided in this room. d. The inside of Room #605's bathroom door was gouged and the toilet riser handles had a brown discoloration. There were two residents who shared this		will be developed and occur on a weekly basis to ensure repairs occur timely. - 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 - Maintenance director or designee will inspect 20 rooms per week for environmental concerns including but not limited to: hand rails too close to the wall, marred and gouged doors, soiled floors, loose base boards. Plant operations will complete audit for 6 months.	

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	bathroom. e. Room #603's bathroom door was splintered and gouged near the knob. There were two residents who shared this bathroom. f. In Room 601, the closet door near the entrance door was gouged and the toilet riser's handle was against the wall, having left no space for the resident's hand to grasp the handle. There were two residents who resided in this room. 3. 500 Hallway: a. In Room #512, by bed A, there were black marks on the wall by the head of the bed. There were two residents who resided in this room. 4. 400 Hallway: a. Room #413's outer room door skin was gouged. There were two residents who resided in this room. b. In Room 410's bathroom, the walls were gouged and the door frame had chipped paint. There were two residents who shared this bathroom. c. In Room #409's bathroom, the walls were gouged. There was one resident			

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	who resided in this room. d. In Room #408's bathroom, the walls were gouged and the door frame had chipped paint. There were two residents shared this bathroom. e. In Room #406, one of the residents that resided in this room,in this room wrote her last name on the bathroom wall and on the closet door. At 2:35 p.m., the resident's roommate indicated the name written on things bothered her. There were two residents who resided in this room. Interview with the Executive Director and the Manger of Plant Operations at the time of the Environmental Tour, indicated they were aware the resident the resident wrote her name on the wall and closet, was territorial and having a hard time adjusting to her environment. 5. 300 Hallway: a. In Room #312's bathroom, the door frame had chipped paint and the floor was dirty with a build up of debris in the corners. The register in the room next to bed B had chipped paint. There were two residents who resided in this room. b. In Room #311's bathroom, the inside			

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	of the wood door was chipped. There were two residents who shared this bathroom. c. In Room #304, the closet door skin had peeled away from the door and was gouged. In the bathroom, the walls were gouged, the base molding had come away from the wall, and the door frame had chipped paint. There were two residents who resided in this room. d. In Room #303, the bathroom door skin had peeled off. There were two residents who resided in this room. e. In Room #302's bathroom, there were black mars on the wall, and the floor had dirt and debris built up in the corners. There were two residents who shared this bathroom. 6. 100 Hallway: a. In Room #106, the wall was marred near the bed. One resident resided in this room. b. In Room #101, the closet door was splintered and gouged. One resident resided in this room. Interview with the Manager of Plant Operations at end of tour at 2:00 p.m.,			

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	indicated all of the above were in need of cleaning and repair. 3.1-19(f)			