

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2015
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NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 16, 17, 18, 19, 20, & 23, 2015.</p> <p>Facility number: 000015 Provider number: 155041 AIM number: 100273750</p> <p>Survey team: Lora Brettnacher, RN-TC Kewanna Gordon, RN Megan Burgess, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 105 Total: 109</p> <p>Census Payor type: Medicare: 17 Medicaid: 70 Other: 22 Total: 109</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 3/27/15 by</p>	F 000		
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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 248 SS=D Bldg. 00	<p>Brenda Marshall, RN.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well being for 1 of 3 residents reviewed for activities (Resident #131).</p> <p>Findings include:</p> <p>Resident #131 was observed on the following dates:</p> <p>a. 3/17/2015 at 10:41 a.m. - in bed with his eyes open and the television on.</p> <p>b. 3/19/15 at 10:00 a.m. - in bed on his right side with his eyes closed. No music or television on in the room.</p> <p>c. 3/19/2015 at 11:03 a.m. - in bed with his eyes open and the television on.</p> <p>d. 3/19/2015 at 1:03 p.m. - in bed with</p>	F 248	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by the provisions of federal and state law. F248 I)Resident #131 was watching television which is one of his documented activities of interest. The resident was following his 12/8/14 care plan of, "...preferred most of the time to watch television in his room...". II) Resident's activities of interest are reviewed with each MDS assessment. III) The Activity Director developed a new tracking form that lists the results of each resident's activity of interest on a Activity Level of Participation list (In room 1:1,</p>	04/22/2015

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	<p>his eyes open and the television on.</p> <p>e. 3/19/2015 at 1:27 p.m. - in bed with his eyes closed and the television on.</p> <p>f. 3/19/2015 at 2:17 p.m. - in bed on his right side facing the privacy curtain with his eyes closed and the television on.</p> <p>g. 3//20/15 at 8:30 a.m. - in bed on his back with his eyes open and the television on.</p> <p>h. 3/20/2015 at 9:43 a.m. - in bed on his back with his eyes closed and the television on.</p> <p>i. 3/20/2015 at 10:49 a.m. - in bed on his back with his eyes open and the television on.</p> <p>j. 3/20/2015 at 11:46 a.m. - in common area seated in a wheel chair pushed up to a table watching television in a large group setting.</p> <p>k. 3/20/2015 at 1:53 p.m. - In bed on his back with his eyes open and the television on.</p> <p>l. 3/23/15 at 9:30 a.m. - in bed on his back with his eyes open and the television on.</p> <p>During a family interview on 3/17/15 at 2:30 p.m., Resident #131's wife indicated she visited him several times a week. She indicated staff did not encourage him or provide assistance to him to attend activities.</p> <p>During an interview on 3/23/2015 at 1:02</p>		<p>Independent/Active, Cognitive/Dementia & Passive) comparing to daily census to ensure all residents are reflected on the list. The Activity Director developed a new tracking form that lists the results of each resident's activity of interest on a Activity Interest list (In room 1:1 specific interests, Bingo, shopping, exercise, crafts, etc) comparing to daily census to ensure all residents are reflected on the list. Resident's responsible party will be involved in the activities of interest assessment as appropriate.</p> <p>IV) The Activity Director will report new residents added to the Master Resident Activity list daily in the morning meeting (M-F). The Activity Director will report new residents added to the Master Activity Interest list daily in the morning meeting (M-F). The Activity Director will submit the most current Activity Level of Participation list and the Activity Interest list to the Administrator weekly for 90 days, monthly for 3 months and quarterly for 2 quarters. These processes will be reported to the QAPI committee to review and give direction as appropriate.</p>	

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	<p>p.m., the Activity Director (AD) indicated Resident #131 was non verbal, could not consume food by mouth, stayed to himself and preferred to be in small group settings.</p> <p>During an interview on 3/23/15 at 1:51 p.m., Unit Manager #2 indicated Resident #131 enjoyed "listening" to people, small group activities, music, and television.</p> <p>During an interview on 3/23/2015 at 1:02 p.m., the Activity Director (AD) indicated Resident #131 was non verbal, could not consume food by mouth, stayed to himself and preferred to be in small group settings. She indicated he was provided one on one activities.</p> <p>During an interview on 3/23/15 at 1:51 p.m., Unit Manager #2 indicated Resident #131 enjoyed "listening" to people, small group activities, music, and television.</p> <p>During an interview on 3/23/15 at 2:30 p.m., the Activity Director indicated Resident #131 had not been provided one on one activity and indicated she had not tracked participation in small group activities. She indicated she began taking Resident #131 to small group activities "this week."</p> <p>Resident #131's record was reviewed on</p>				

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	<p>3/20/15 at 2:44 p.m. Resident #131 had diagnoses which included, but were not limited to, a stroke, aphasia (inability to speak), and depression. An admission Minimum Data Set (MDS) assessment tool, dated 12/9/14, indicated Resident #131 was cognitively impaired and a Brief Interview of Mental Status Score could not be obtained, he had long and short term memory problems, he was unable to respond to questions regarding activity preferences, he required physical assistance from staff for locomotion, and his family was not interviewed to obtain input regarding activity preferences.</p> <p>Resident #131's current care plans were reviewed on 3/20/2015 at 2:44 p.m., a mood alteration care plan indicated as of 12/8/14, Resident #131 was at risk for "reoccurring depression symptoms" related to a diagnosis of depression. A goal indicated the facility would attempt to minimize the symptoms of depression by encouraging him to participate in social activities of his choice. An activity care plan dated 12/8/14, indicated he was unable to speak and did not like to participate in large group activities. preferred most of the time to watch television in his room and needed cues and reminders for activities. A goal indicated he would participate in one activity of his choice weekly in his</p>				

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F 282 SS=D Bldg. 00	<p>room/or a small group activity. Interventions included: country music, television, reading, one on one visits, small group activities, assistance to and from activities, and visits from his wife.</p> <p>Activity attendance records from December 2014 through March 23, 2015, were reviewed on March 23, 2015 at 2:30 p.m. The records indicated Resident #131 was taken to two large group activities in December 2014, six large group activities in January 2015, two large group activities in February 2015, and three large group activities in March 2015. The activity attendance records lacked indication Resident #131 had been provided one on one activities or small group activities.</p> <p>3.1-33(a) 3.1-33(b)(8)</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. Based on observation, record review, and</p>	F 282	F282 1)Resident #131 was watching television which is one	04/22/2015

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	<p>interview, the facility failed to ensure residents were provided with activities according to their plan of care for 1 of 3 residents reviewed for following activity care plans (Resident #131).</p> <p>Findings include:</p> <p>Resident #131 was observed on the following dates:</p> <p>a. 3/17/2015 at 10:41 a.m. - in bed with his eyes open and the television on.</p> <p>b. 3/19/15 at 10:00 a.m. - in bed on his right side with his eyes closed. No music or television on in the room.</p> <p>c. 3/19/2015 at 11:03 a.m. - in bed with his eyes open and the television on.</p> <p>d. 3/19/2015 at 1:03 p.m. - in bed with his eyes open and the television on.</p> <p>e. 3/19/2015 at 1:27 p.m. - in bed with his eyes closed and the television on.</p> <p>f. 3/19/2015 at 2:17 p.m. - in bed on his right side facing the privacy curtain with his eyes closed and the television on.</p> <p>g. 3//20/15 at 8:30 a.m. - in bed on his back with his eyes open and the television on.</p> <p>h. 3/20/2015 at 9:43 a.m. - in bed on his back with his eyes closed and the television on.</p> <p>i. 3/20/2015 at 10:49 a.m. - in bed on his back with his eyes open and the television on.</p>		<p>of his documented activities of interest. The resident was following his 12/8/14 care plan of, "...preferred most of the time to watch television in his room...".</p> <p>II) Resident's activities of interest are reviewed with each MDS assessment. The resident's activities of interest are reflected in their care plans and followed accordingly. III) The Activity Director will track a new tracking form that lists the results of each resident's activity of interest which are care planned on a Activity Level of Participation list (In room 1:1, Independent/Active, Cognitive/Dementia & Passive) comparing to daily census to ensure all residents are reflected on the list.</p> <p>The Activity Director developed a new tracking form that lists the results of each resident's activity of interest on a Activity Interest list (In room 1:1 specific interests, Bingo, shopping, exercise, crafts, etc) comparing to daily census to ensure all residents are reflected on the list.</p> <p>Resident's responsible party will be involved in the activities of interest assessment and care planned as appropriate. Resident activity participation log will reflect the frequency of attendance of activities which has been care planned. IV) The Activity Director will report new residents activity interest added to the Activity Level of Participation</p>		

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	<p>j. 3/20/2015 at 11:46 a.m. - in common area seated in a wheel chair pushed up to a table watching television in a large group setting.</p> <p>k. 3/20/2015 at 1:53 p.m. - In bed on his back with his eyes open and the television on.</p> <p>l. 3/23/15 at 9:30 a.m. - in bed on his back with his eyes open and the television on.</p> <p>During a family interview on 3/17/15 at 2:30 p.m., Resident #131's wife indicated she visited him several times a week. She indicated staff did not encourage him or provide assistance to him to attend activities.</p> <p>During an interview on 3/23/2015 at 1:02 p.m., the Activity Director (AD) indicated Resident #131 stayed to himself and preferred to be in small group settings.</p> <p>During an interview on 3/23/15 at 1:51 p.m., Unit Manager #2 indicated Resident #131 enjoyed "listening" to people, small group activities, music, and television.</p> <p>During an interview on 3/23/2015 at 1:02 p.m., the Activity Director (AD) indicated Resident #131 was non verbal, could not consume food by mouth, stayed to himself and preferred to be in small</p>		list daily and care plans in the morning meeting (M-F). The Activity Director will submit the most current Master Activity Interest list/Activity Level of Participation list/care plans/participation logs to the Administrator weekly for 90 days. The Administrator will randomly validate activity care plans/participation logs with the Activity Level of Participation list monthly for 3 months and quarterly for 2 quarters. These processes will be reported to the QAPI committee to review and give direction as appropriate.	

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	<p>group settings. She indicated he was provided one on one activities.</p> <p>During an interview on 3/23/15 at 1:51 p.m., Unit Manager #2 indicated Resident #131 enjoyed "listening" to people, small group activities, music, and television.</p> <p>During an interview on 3/23/15 at 2:30 p.m., the Activity Director indicated Resident #131 had not been provided one on one activity and indicated she had not tracked participation in small group activities. She indicated she began taking Resident #131 to small group activities "this week."</p> <p>Resident #131's record was reviewed on 3/20/15 at 2:44 p.m. Resident #131 had diagnoses which included, but were not limited to, a stroke, aphasia (inability to speak), and depression. An admission Minimum Data Set (MDS) assessment tool, dated 12/9/14, indicated Resident #131 was cognitively impaired and a Brief Interview of Mental Status Score could not be obtained, he had long and short term memory problems, he was unable to respond to questions regarding activity preferences, he required physical assistance from staff for locomotion, and his family was not interviewed to obtain input regarding activity preferences.</p>			

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	<p>Resident #131's current care plans were reviewed on 3/20/2015 at 2:44 p.m., a mood alteration care plan indicated as of 12/8/14, Resident #131 was at risk for "reoccurring depression symptoms" related to a diagnosis of depression. A goal indicated the facility would attempt to minimize the symptoms of depression by encouraging him to participate in social activities of his choice. An activity care plan dated 12/8/14, indicated he was unable to speak and did not like to participate in large group activities. preferred most of the time to watch television in his room and needed cues and reminders for activities. A goal indicated he would participate in one activity of his choice weekly in his room/or a small group activity. Interventions included: country music, television, reading, one on one visits, small group activities, assistance to and from activities, and visits from his wife.</p> <p>Activity attendance records from December 2014 through March 23, 2015, were reviewed on March 23, 2015 at 2:30 p.m. The records indicated Resident #131 was taken to two large group activities in December 2014, six large group activities in January 2015, two large group activities in February 2015, and three large group activities in March 2015. The activity attendance records</p>			

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F 315 SS=D Bldg. 00	<p>lacked indication Resident #131 had been provided one on one activities or small group activities.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure a interventions to sustain/improve urinary function for 1 of 1 residents reviewed for urinary function.</p> <p>Findings include:</p> <p>During an observation on 3/21/2015 at 2:14 p.m., Resident #124 told RN #32 he was, "about to wet myself." The RN administered medications to the resident, then provided 1 person assistance to the bathroom. The resident indicated he</p>	F 315	<p>F315</p> <p>I)Resident #124 was admitted to the facility in October of 2014 with a diagnosis of Urinary Incontinence.</p> <p>He was referred to therapy to assess his urinary function. He is currently participating in the therapy urinary incontinence program.</p>	04/22/2015

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	<p>began urinating before he got to the bathroom.</p> <p>During an interview on 3/21/2015 at 2:22 p.m., RN # 32 indicated Resident #124 was continent when he was admitted to the facility in October of 2014. She indicated he needed lots of reminders and direction for toileting. RN #32 indicated a urinal was placed at the resident ' s bedside in case he remembered to use it.</p> <p>During an interview on 3/24/2015 at 1:36 p.m., Unit Manager (UM) #30 indicated residents were usually put on a 3 day toileting plan upon admission or if a decline in urinary continence is noted. She indicated residents with a decline were referred to physical therapy to restore or maintain their level of continence. She indicated Resident #124 had not been on a toileting plan nor had he been seen by therapy related to his urinary incontinence.</p> <p>During an interview on 3/24/2015 2:07 p.m., CNA #33 indicated Resident #124 required limited assistance for toileting and most of the time informed staff when he needed to go to the bathroom.</p> <p>During an interview on 3/24/15 at 2:15 p.m., Resident #124 indicated he was</p>		<p>Nurses were inserviced on the nursing re/admission assessment (update), the three (3) day bladder pattern and Continency Status: Assessment and Approaches policy & procedures.</p> <p>II) All residents that are currently incontinent have been/will be assessed by the three (3) day bladder pattern.</p> <p>Residents are assessed for urinary function upon admission, with each MDS assessment and as appropriate.</p> <p>Nurses were inserviced on the nursing re/admission assessment (update), the three (3) day bladder pattern and Continency Status: Assessment and Approaches policy & procedures.</p> <p>III) The nursing admission assessment has been updated removing the in/continent question.</p>	

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	<p>able to get to the bathroom in time to prevent incontinence when he first arrived at the facility. He indicated he currently had difficulty making it to the bathroom on time.</p> <p>Resident #24 's record was reviewed on 3/20/2015 at 10:40 a.m. Diagnosis included but was not limited to BPH (benign prostatic hyperplasia). An admission assessment, dated 10/2/2014, indicated Resident #124 was continent of urine with nocturia (excessive urinating at night), and needed assistance of 1 staff for toileting.</p> <p>A care plan, dated 10/3/14, indicated the resident was at risk for urinary tract infection related to a urinary obstruction and was to be monitored for bladder distention and discomfort and allowed adequate time to urinate. The care plan did not indicate a toileting program for scheduled toileting, prompted voiding, or bladder training.</p> <p>The CNA (Certified Nursing Assistant) Care Delivery Guide, dated 10/2/14, indicated the resident was full weight bearing and fully ambulatory with 1 assist and a walker. The guide also indicated the resident was continent of both bowel and bladder and was oriented with some confusion. The book contained a tab</p>		<p>The first three (3) days of each new re/admission and residents with urinary incontinence concerns during the MDS assessment and as appropriate will have a three (3) day bladder pattern completed.</p> <p>After the bladder pattern is established the Unit Manager will review and complete the bladder pattern assessment in the (electronic) medical record. If urinary incontinence is established the Unit Manager will refer the resident to therapy for evaluation for the urinary incontinence program.</p> <p>If the resident is not a candidate for the urinary incontinence program therapy will refer to nursing for the (possibility) of a scheduled toileting program.</p> <p>IV) The Unit Manager will monitor the bladder pattern results for re/admission residents and for residents within the MDS assessment period/as appropriate via the schedule provided by the MDS</p>	

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	<p>entitled toileting program however, lacked information regarding a toileting program for resident #124.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 10/9/14, indicated Resident #124 was occasionally incontinent of urine and indicated a trial of a toileting program (scheduled toileting, prompted voiding or bladder training) had not been attempted.</p> <p>A MDS assessment, dated 11/3/14, indicated Resident #124 was frequently incontinent, needed 1 person assistance for toileting, and a urinary toileting plan had not been attempted.</p> <p>A MDS assessment, dated 1/9/15, indicated Resident #124 was frequently incontinent of urine and indicated a trial of a toileting program had not been attempted. The assessment indicated a BIMS (Brief Interview for Mental Status) score of 11 out of 15, indicating moderately impaired cognition.</p> <p>A policy entitled, "Toileting Programs," dated 5/10/10, received from the Executive Director (ED) on 3/24/15 at 3:43 p.m., indicated the purpose was, "Reducing episodes of incontinence."</p> <p>3.1-41(a)(1)</p>		<p>Coordinator. The Unit Manager will report the results of the three (3) day bladder pattern in the daily clinical meeting (M-F). The Director of Nursing will monitor for the completion of the three (3) day bladder pattern and subsequent referrals weekly for 90 days, monthly for 3 months and quarterly for 2 quarters. These processes will be reported to the QAPI committee to review and give direction as appropriate.</p>		

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F 456 SS=F Bldg. 00	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure the kitchen's dishwasher maintained the manufacturer's safe wash cycle temperatures while operated for 2 of 4 kitchen observations. This practice had the potential to affect 106 of 109 residents.</p> <p>During the initial observation of the kitchen on 3/16/2015 at 10:20 a.m., a rack of dirty plates was observed to be cleaned by the high temperature dishwasher, and the temperature reached 136 degrees Fahrenheit during the wash cycle.</p> <p>During an observation on 3/16/2015 at 10:44 a.m., the maintenance supervisor was observed to manually obtain a dishwasher wash cycle temperature of</p>	F 456	<p>F456</p> <p>I)The dishwasher safe wash cycle temperature while in operation meets/exceeds the manufacturer's temperature of 155 degrees Fahrenheit.</p> <p>Dietary employees were inserviced on the manufacture's safe wash cycle temperature of 155 degrees Fahrenheit.</p> <p>II) Dietary employees were inserviced on the manufacture's safe wash cycle temperature of 155 degrees Fahrenheit.</p>	04/22/2015

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	<p>146 degrees Fahrenheit with a digital thermometer.</p> <p>During an interview on 3/16/2015 at 10:40 a.m., the Dietary Manager indicated the manufacturer instructions for the dishwasher indicated the wash cycle should have reached a temperature of 155 degrees Fahrenheit, which had been printed on the side of the dishwashing machine.</p> <p>During an interview on 3/17/2015 at 9:23 a.m., the Administrator indicated the dietary staff should have monitored wash cycle temperatures of the dishwasher.</p> <p>A Temperature Chart, dated March 2015, had been provided by the Dietary Manager on 3/16/2015 at 10:49 a.m. This document indicated wash cycles temperatures of the dishwasher had not been monitored and documented.</p> <p>On 3/23/2015 at 11:07 a.m., the Dietary Manager provided the "High Temperature Straight or Corner Single Rack Dishwasher" document, dated 2012, and indicated this was the manufacturer's instructions for the facility's high temperature dishwasher. This document indicated "...Operating Temperature: Wash cycle minimum of 155 to 160 degrees Fahrenheit..."</p>		<p>III) The policy, titled "Dishwashing Procedure" has been updated to reflect manufacture's safe temperature of 155 degrees Fahrenheit and the recording of the wash cycle temperature after the last cycle of each meal.</p> <p>The dish machine temperature record sheet was updated to include the wash cycle temperature which is recorded after the last cycle of each meal.</p> <p>IV) The Dietary Manager, Registered Dietician and/or designee will review the dish machine temperature record sheet daily for 90 days. Maintenance will randomly validate the dish machine temperature weekly for 90 days, monthly for 3 months and quarterly for 2 quarters. The Dietary Manager will submit the dish machine temperature record sheet to the Administrator weekly for 90 days, monthly for 3 months and quarterly for 2 quarters. These processes will be reported to the QAPI committee to review</p>	

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F 514 SS=D Bldg. 00	<p>An undated policy, titled "Dishwashing Procedure," identified by the Administrator as current, was provided on 3/23/2015 at 3:44 p.m. The policy indicated "...Dishwashing machines must reach a specific wash and rinse temperature in order to sanitize dishes properly. The required temperature is generally printed on the machine or temperature gauge...Employees should check the temperature gauge regularly during a dishwashing cycle to be sure that the water is at the correct temperature...Any problems should be reported to the Food Service Director...."</p> <p>3.1-19(bb)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of</p>		and give direction as appropriate.				

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	<p>care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review the facility failed to ensure clinical information regarding the residents hospice services were readily accessible for resident care. This deficient practice had the potential to affect 1 of 1 resident reviewed for hospice services (Resident 40).</p> <p>Findings include:</p> <p>Resident #40's record was reviewed on 3/20/2015 at 12:44 p.m. The record lacked clinical information regarding the residents hospice services after July of 2014.</p> <p>During an interview on 3/21/2015 at 11:02 a.m., Unit Manager (UM) #30, indicated the hospice service provider had completely computerized their charting. She indicated the hospice service communicated information with the facility verbally and that there was no specific system in place for staff to record the information into the residents clinical record. She indicated her staff were expected to verbally communicate the information to each other.</p> <p>During an interview on 3/24/2015 at</p>	F 514	<p>F514</p> <p>I)Resident #40 hospice services clinical information is readily accessible for resident care.</p> <p>Nurses were inserviced on Communication with Hospice staff and record documentation and the (electronic) Hospice Nurse Visit documentation tab policy & procedures.</p> <p>II) All residents receiving hospice services has their clinical information readily accessible for resident care.</p> <p>Nurses were inserviced on Communication with Hospice staff and record documentation and the (electronic) Hospice Nurse Visit documentation tab policy & procedures.</p>	04/22/2015

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	<p>12:48 p.m., Registered Nurse (RN) #31 indicated report from hospice was verbal and there was no way to retrieve the information other than calling hospice to get it.</p> <p>During an interview on 3/24/2015 2:30 p.m., the Director of Nursing (DoN), indicated hospice information should have been in the nursing notes because it is a consultation.</p> <p>A policy entitled, "Hospice Program," indicated "Our facility contracts for hospice services for residents who wish to participate in such programs."</p> <p>3.1-50(a)(3)</p>		<p>III) A (electronic) Hospice Nurse Visit documentation tab has been added to the facility (electronic) medical record.</p> <p>The facility charge nurse will document in (electronic) medical record under the Hospice Nurse Visit documentation tab.</p> <p>The hospice company will provide note of encounter for the residents (electronic) medical record as soon as available.</p> <p>IV) The Unit Manager will monitor the receipt of the hospice documentation and report weekly in the morning meeting (M-F). The Unit Manager will report documentation written under the (electronic) Hospice Nurse Visit documentation tab for residents receiving hospice service daily in the morning meeting (M-F). The Director of Nursing will randomly monitor the receipt of the hospice documentation and report and report documentation written under the (electronic) Hospice Nurse Visit documentation tab for residents receiving hospice service weekly for 90 days,</p>	

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			monthly for 3 months and quarterly for 2 quarters. These processes will be reported to the QAPI committee to review and give direction as appropriate.		