

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2014
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NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: August 18, 19, 20, 21 and 22, 2014</p> <p>Facility Number: 000083 Provider Number: 155166 AIM Number: 100289670</p> <p>Survey Team: Heather Hite, RN - TC Julie Ferguson RN Jennifer Redlin, RN Caitlyn Doyle, RN</p> <p>Census Bed Type: SNF/NF: 135 Total: 135</p> <p>Census Payor Type: Medicare: 18 Medicaid: 109 Other: 8 Total: 135</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 29, 2014, by Janelyn Kulik, RN.</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey desk review on or after September 21, 2014.</p>	

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

TITLE

(X6) DATE

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

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F000156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any</p>			
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	<p>charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>			

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	<p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure the residents were informed of their right to formally complain to the State Department of Health and were given information on how to contact the State Department of Health. This had the potential to affect the 135 residents who resided in the facility. (Resident #112 and #7)</p> <p>Findings include:</p> <p>Interview with Resident #112, the Resident Council President, on 8/22/14 at 11:00 a.m., indicated that she did not know how to contact the State Department of Health, was not aware of where she could find the contact information, and could not remember the information being discussed at the meetings.</p> <p>Resident #112's record was reviewed on 8/22/14 at 11:50 a.m. The Quarterly Minimum Data Set (MDS) Assessment, dated 6/30/14, indicated a BIMS (Brief Interview for Mental Status) score of 15 which indicated the resident was</p>	F000156	<p>F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in</p>	09/21/2014
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	<p>cognitively intact.</p> <p>Interview with Resident #7 on 8/22/14 at 1:08 p.m. indicated he regularly attended resident council meetings. He indicated he was not sure how to contact the State Department of Health and could not remember that information being discussed at the meetings.</p> <p>Resident #7's record was reviewed on 8/22/14 at 1:41 p.m. The Quarterly MDS Assessment, dated 7/10/14, indicated a BIMS score of 15 which indicated the resident was cognitively intact.</p> <p>Review of the monthly Resident Council meeting minutes from December 2013 to July 2014 on 8/22/14 at 1:06 p.m., indicated there was no discussion about the rights of residents to formally complain to the State Department of Health or how to contact the State Department of Health.</p> <p>Interview with the Director of Nursing Services (DNS) and Executive Director on 8/22/14 at 1:30 p.m., indicated information about the State Department of Health was discussed at the meetings and the residents should have been aware of the information. They further indicated Activities staff should have documented the information they</p>		<p>nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or</p>	

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	discussed at the meetings in the minutes. 3.1-4(j)(3)(C)		her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Resident #112 and Resident #7 have received a copy of the At Your Service poster which includes the contact		

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			<p>information for the Indiana State Department of Health. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient practice. · At Your Service posters which include all required information are posted in the main lobby and on both wings as well as in our admissions packet.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · At Your Service posters which include all required information will be presented/reviewed and documented at the monthly resident council meeting. · The Activity Director was inserviced by the Executive Director on 9/9/14 regarding documenting when the At Your Service posters are presented/reviewed at the monthly meeting. 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 · The Executive Director will review the Resident Council minutes monthly ongoing to ensure compliance. · If a 100% threshold is not achieved an action plan will be developed.</p>		

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F000167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on record review and interview, the facility failed to ensure the residents were aware that the State Inspections were available to read and where they were located. This had the potential to affect the 135 residents residing in the facility. (Resident #112, #7, and #76)</p> <p>Findings include:</p> <p>Interview with Resident #112, the Resident Council President, on 8/22/14 at 11:00 a.m., indicated that she did not know where the survey results were and the information had not been discussed at the resident council meetings that she could remember.</p> <p>Resident #112's record was reviewed on 8/22/14 at 11:50 a.m. The Quarterly Minimum Data Set (MDS) Assessment, dated 6/30/14, indicated a BIMS (Brief Interview for Mental Status) score of 15</p>	F000167	<p>F167 RIGHT TO SURVEY RESULTS – READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Resident #112, Resident #7 and Resident #75</p>	09/21/2014			

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	<p>which indicated the resident was cognitively intact.</p> <p>Interview with Resident #7 on 8/22/14 at 1:08 p.m. indicated he regularly attended resident council meetings. He indicated he was not sure where the survey results were and could not remember that information being discussed at the meetings.</p> <p>Resident #7's record was reviewed on 8/22/14 at 1:41 p.m. The Quarterly MDS Assessment, dated 7/10/14, indicated a BIMS score of 15 which indicated the resident was cognitively intact.</p> <p>Interview with Resident #76 on 8/22/14 at 1:18 p.m. indicated she attended resident council meetings. She indicated she was not sure where the survey results were located.</p> <p>Resident #76's record was reviewed on 8/22/14 at 1:41 p.m. The Quarterly MDS Assessment, dated 6/24/14, indicated a BIMS score of 15 which indicated the resident was cognitively intact.</p> <p>Review of the monthly Resident Council meeting minutes from December 2013 to July 2014 on 8/22/14 at 1:06 p.m., indicated there was no discussion about the past survey results.</p>		<p>have been informed of where the Survey Results are located. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · The residents were informed at the Resident Council meeting of the location of the Survey Results. · The Survey Results are located in the front lobby as well as the Cottage nurses station. · "Survey Results are located in the front lobby" signs have been posted on the units. · "Survey Results are located at the nurses station" sign has been posted in the cottage. · The Activity Director was inserviced by the Executive Director on 9/9/14 regarding documenting when the location of the survey results are presented/reviewed at the monthly meeting. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · The location of the Survey Results will be presented/reviewed and documented at the monthly resident council meeting. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>		

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F000246 SS=D	<p>Interview with the Director of Nursing Services (DNS) and Executive Director on 8/22/14 at 1:30 p.m., indicated information about the survey results was discussed at the meetings and the residents should have been aware of the information. They further indicated Activities staff should have documented the information they discussed at the meetings in the minutes.</p> <p>3.1-3(b)(1)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to ensure a dependent, nonverbal resident had access to the call system for 1 of 40 residents observed during Stage 1. (Resident #115)</p> <p>Findings include:</p> <p>On 8/19/14 at 10:45 a.m., Resident #115 was observed lying in his bed. The call light pad was observed lying on the floor. He indicated he was able to use the call</p>	F000246	<p>program will be put into place</p> <ul style="list-style-type: none"> The Executive Director will review the Resident Council minutes monthly ongoing to ensure compliance. If 100% threshold is not achieved an action plan will be developed. <p>F246 REASONABLE ACCOMMODAT ION OF NEEDS/PREFE RENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable</p>	09/21/2014

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	<p>light pad with his right hand when in reach.</p> <p>On 8/21/14 at 10:30 a.m., Resident #115 was observed lying in bed. His call light pad was out of reach hanging over the back of the headboard. The West Wing Evening Supervisor was notified at this time and indicated it needed to be kept within reach and she would monitor for this.</p> <p>On 8/21/14 at 3:00 p.m., a staff nurse was observed leaving Resident #115's room. The resident was then observed lying in bed with the call light pad on the bed next to his flaccid left arm. When asked if he could reach the call light with his right hand, he attempted and indicated he could not. The West Wing Unit Manager and Evening Supervisor were notified at this time and indicated Resident #115's call light needed to be kept within reach of his right hand. They further indicated staff would be inserviced immediately.</p> <p>Resident #115's record was reviewed on 8/20/14 at 8:35 a.m. The resident's diagnoses included, but were not limited to, seizures, history of CVA (stroke) with right & left hemiplegia (partial paralysis), contractures to both hands, tracheostomy (a breathing tube inserted through the neck), and bilateral (both sides) foot</p>		<p>accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Resident #115's call light was placed within his reach. The resident's profile was update to reflect call light is to be placed near his right hand. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient practice. · Nurses during nursing rounds, per shift daily, will check all residents for call light placement. Findings were documented on the Daily Nursing Rounds Checklist and addressed immediately. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · During Customer Care rounds, as well as nursing rounds per shift daily all residents will be reviewed for call light placement. Findings will be documented on the Nursing Rounds Checklist and the Customer Care Rounds Sheets and will be addressed immediately. · Unit</p>	

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F000250 SS=D	<p>drop.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 7/25/14 indicated the resident is cognitively intact. His Functional Status Assessment indicated he was completely dependent for Activities of Daily Living (ADL's) and had a functional deficit in range of motion of impairment on both sides, upper and lower extremities.</p> <p>A care plan for communication (due to a tracheostomy and unable to verbalize) indicated, communicates by mouthing words and gesturing.</p> <p>3.1-3(v)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and</p>	F000250	<p>Managers/charge nurses monitor resident care by making rounds on their units each shift. Concerns are addressed with the nursing aide, as needed. · The Director of Nursing Services is responsible to monitor for facility compliance and reviews the Nursing Rounds Checklists daily. · The Customer Care Rounds Sheets will be reviewed during daily meetings by the ED/designee for compliance. · The CEC/designee will inservice all staff on call light placement by 9/21/4. 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 · The Managers/designee will complete the "Call Light" CQI Tool daily ongoing for at least 6 months. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action</p> <p>F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p>	09/21/2014	

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	<p>interview, the facility failed to provide medically-related social services to attain the highest practicable physical, mental, and psychosocial well being of residents, related to, dental exams and recommendations were not followed up on for 1 of 3 residents reviewed for dental status of the 4 residents who met the criteria for dental status. (Resident #4)</p> <p>Findings include:</p> <p>During an interview on 08/19/14 at 8:54 a.m., Resident #4 indicated he had a missing tooth from his upper dentures and several missing or broken front teeth from his lower dentures. He indicated he had been seen by the dentist "awhile ago" and was supposed to have his dentures fixed, but hadn't heard anything further. He further indicated his teeth were not currently causing any problems eating or chewing, but he was worried about it becoming a problem now that he also had a missing upper tooth.</p> <p>During an observation of Resident #4 on 08/19/14 at 8:54 a.m., the resident had an upper tooth missing and a couple missing and broken lower front teeth. He also had food particles on the front of his shirt and stuck in his beard.</p>		<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · Prior authorization was resubmitted for Resident #4's denture replacement by the dentist. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · All residents receiving dental services were reviewed to ensure prior authorizations were processed by the Social Service Director. 	

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	<p>Resident #4's record was reviewed on 08/19/14 at 2:45 p.m. The resident's diagnoses included, but were not limited to, contracture left hand, chronic kidney disease, reflux, dysphagia, anxiety, depressive disorder, Diabetes Mellitus, and left sided hemiplegia.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment, dated 6/4/14, indicated the resident had no cognitive impairment.</p> <p>A Significant Change MDS Care Area Assessment (CAA) dated 1/9/14 indicated the "Dental Care" area triggered for problems needing attention. "... Resident is alert, able to make needs known, has no natural teeth, wears upper and lower dentures. Resident at risk for choking and poor oral health. Feeds self with staff set up."</p> <p>The Physician's Order Summary (POS) dated August 2014 indicated an order for a regular consistency diet.</p> <p>A Dental Care Plan dated 6/17/12, indicated, "Resident has no natural teeth." Approaches included: "Assist resident with oral care routinely and as needed; dental consult as indicated; observe & document red/ bleeding gums, lesions, sx (symptoms of) pain & notify MD (Physician); observe for decreased ability</p>		<ul style="list-style-type: none"> · Dental prior authorization requests will be logged on a Prior Authorization Request Log and monitored weekly until the authorization or denial is received. · The Prior Authorization Log will be reviewed by the Social Service Director weekly to ensure timely follow through with prior authorization with the dentist. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · Dental prior authorization requests will be logged on a Prior Authorization Request Log and monitored weekly until the authorization or denial is received. · The Social Service Designees will be inserviced on the use of the Prior Authorization Request Log by the Social Service Director by 9/21/14. · The Prior Authorization Log will be reviewed by the Social Service Director weekly to ensure timely follow through with prior authorization with the dentist. 	

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	<p>to chew food; refer to RD (Registered Dietician) as indicated for problems with food consumption; therapy screen quarterly and prn (as needed)."</p> <p>A Dental Consult Note, dated 1/31/14, indicated, "Seen. Pt (patient) requested to be seen today. Pt stated he broke his lower denture in half - denture fell on tile floor. Pt states staff took lower broken denture. Pt is wearing his other lower denture, made back in 1970's according to pt. Pt would like to have his lower denture repaired. Pt states newer lower denture fits better for him."</p> <p>A Dental Consult Note, dated 2/5/14, indicated, "Seen. Pt has broken lower denture and #23, 24, 25, 27 broken out of dentures . Send in PA (payment authorization) for repair/ replace teeth."</p> <p>A Social Service note, dated 2/3/14, indicated, "Res (resident) was seen by Dr. [dentist's name] DDS on 1/31/14. Res lower denture was broken and is in res drawer. Writer informed Dr. [dentist's name] of such and requested res be seen next visit in."</p> <p>A Social Service note, dated 2/6/13 indicated, "Dr. [dentist's name] DDS saw res on 2/5/14. PA to be sent to Indiana Medicaid for repair of lower denture.</p>		<p>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</p> <ul style="list-style-type: none"> · The Social Service Director/designee will complete the "Dental Services" CQI audit tools weekly x 4 weeks, the monthly ongoing thereafter for at least 6 months. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action 	

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	<p>Res is currently wearing an older denture."</p> <p>There was a lack of documentation in the resident's record to indicate the resident had received his new lower dentures or Social Services had followed up with the resident's dentist regarding the status of his new dentures.</p> <p>An interview on 8/20/14 1:10 p.m. with Social Services Assistant (SSA) #1, indicated she was not aware of any follow up results for denture repair for Resident #4 since February 2014 or the current status of Resident #4's dentures.</p> <p>A follow up interview on 8/20/14 at 2:05 p.m. with SSA #1, indicated she had spoken with Resident #4 and she was unaware he was still wearing his old dentures. She further indicated she will leave a message for the dentist to follow up on his new lower dentures and the need to also repair his top dentures.</p> <p>Interview with the Social Service Director (SSD) on 8/21/14 at 1:45 p.m., indicated SSA #1 should have followed up after the February dentist visit for Resident #4's new dentures.</p> <p>3.1-34(a)</p>			

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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop resident care plans, related to medications which can thin the blood (Lovenox, Aspirin, Xarelto, Plavix) for 3 of 4 resident reviewed for skin (non-pressure related) of the 8 who met the criteria for skin (non-pressure related), and 1 of 5 residents reviewed for unnecessary medications. (Residents # 30, #138, #142, #15)</p> <p>Findings include:</p> <p>1. Record review for Resident #30 was</p>	F000279	<p>F279</p> <p>DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's</p>	09/21/2014
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	<p>completed on 8/20/14 at 1:41 p.m. The Quarterly Minimum Data Set (MDS) Assessment completed on 8/12/14 indicated the resident was cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, depression, respiratory failure. The resident was a total 2 person assist for bed mobility, transferring, toileting, personal hygiene and bathing. The resident had a functional limitation in range of motion to bilateral upper and lower extremities.</p> <p>The August 2014 Physician Order Summary (POS) indicated the resident was receiving Lovenox 30 milligrams (mg) subcutaneous daily (blood thinning injection).</p> <p>The record lacked indication the resident had a care plan to inform the staff of the risks of taking Lovenox due to the blood thinning action of the medication.</p> <p>An interview with the West Wing Unit Manager on 8/22/14 at 10:11 a.m., indicated the resident was taking Lovenox and should of had a care plan in place.</p> <p>2. Record review for resident #138 was completed on 8/19/14 at 1:23 p.m. The Quarterly MDS indicated the resident</p>		<p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Residents #30, #138, #142 and #15 care plans were updated to include medications that can thin the blood and cause bleeding and bruising. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient practice. · Care Plans for all residents who currently are on a blood thinner have been reviewed by the Interdisciplinary team for accuracy and updated as indicated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · The Interdisciplinary Team will review care plans for all admissions, readmissions and significant changes during clinical meeting and update as indicated for residents with orders for blood thinners. · The Interdisciplinary Team will review the physician orders at the clinical meeting for all admissions, readmissions and significant changes for residents</p>	

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	<p>was cognitively intact. The diagnoses included, but were not limited to high blood pressure, anxiety, depression, kidney disease, and morbid obesity. The resident was an extensive 2+ person assist for bed mobility, transfers, and toileting. The resident received anticoagulant (blood thinning) medication.</p> <p>The August 2014 POS indicated the resident was receiving Aspirin 81 mg every day and Xarelto (blood thinning medication) 20 mg every evening.</p> <p>The record lacked indication the resident had a care plan to inform the staff of the risks of taking Aspirin and Xarelto due to the blood thinning action of the medications.</p> <p>An interview with the West Wing Unit Manager on 8/20/14 at 8:45 a.m., indicated the resident was taking Aspirin and Xarelto and should of had a care plan in place.</p> <p>3. The record for Resident #142 was reviewed on 8/19/14 at 1:07 p.m. The resident's diagnoses included, but were not limited to, anemia, coronary artery disease, and Alzheimer's disease.</p> <p>Review of the 8/2014 Physician Orders indicated orders for Aspirin 81</p>		<p>with orders for blood thinners. · The Interdisciplinary Team will be educated on updating Care Plans by the CEC/designee by 9/21/14.</p> <p>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 · The MDS Coordinator/designee will complete the "Care Plan Updating" CQI tool weekly x 4 weeks, the monthly ongoing thereafter. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action</p>				

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	<p>milligrams (mg) daily and Plavix (a medication used to prevent blood clots) 75 mg daily.</p> <p>Review of the 8/2014 and 7/2014 Medication Administration Record (MAR) indicated the resident had received the Aspirin and Plavix medications daily.</p> <p>There was lack of documentation to indicate the resident had a care plan to inform the staff of the increased risk for bleeding and/or bruising associated with the Aspirin and Plavix medications.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator and MDS Assistant on 8/20/14 at 9:20 a.m. indicated they usually did not care plan Aspirin or Plavix use. They further indicated residents who receive Aspirin daily are at risk for bleeding and bruising.</p> <p>4. The record for Resident #15 was reviewed on 8/19/14 at 4:10 p.m. The resident's diagnoses included, but were not limited to, peripheral arterial disease, cerebrovascular accident (stroke), and coronary artery disease.</p> <p>Review of the 8/2014 Physician Orders indicated orders for Aspirin 81 mg daily.</p>						

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F000282 SS=E	<p>Review of the 8/2014 and 7/2014 MAR indicated the resident had received the Aspirin medication daily.</p> <p>There was lack of documentation to indicate the resident had a care plan to inform the staff of the increased risk for bleeding and/or bruising associated with the Aspirin medication.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator and MDS Assistant on 8/20/14 at 9:20 a.m. indicated they usually did not care plan Aspirin use. They further indicated residents who receive Aspirin daily are at risk for bleeding and bruising.</p> <p>3.1-35(a)</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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure Physician's orders and care plans were followed as written related to skin discolorations not assessed and monitored for 3 of 4 resident's reviewed for skin (non-pressure related), of the 8 who met the criteria for skin</p>	F000282	<p>F282 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>	09/21/2014

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	<p>(non-pressure related), assessment upon return from dialysis for 1 of 1 resident's reviewed for dialysis of the 2 who met the criteria for dialysis, provision of dental services for 1 of 3 resident's reviewed for dental services of the 4 who met the criteria for dental services, failing to apply splints for 1 of 4 resident's reviewed for Range of Motion out of the 4 who met the criteria for Range of Motion, and ensuring fall interventions were in place for 1 of 1 residents reviewed for accidents, of the 1 resident who met the criteria for accidents. (Residents #30, #138, #142, #60, #4, #115, #143)</p> <p>Findings include:</p> <p>1. During an observation on 8/18/14 at 3:06 p.m., Resident #30 was observed to have a green/brown discoloration to the right forearm.</p> <p>During an observation on 8/21/14 at 2:12 p.m., Resident #30 was observed to have multiple green/brown discoloration to bilateral lower legs, right forearm and left forearm.</p> <p>Record review for Resident #30 was completed on 8/20/14 at 1:41 p.m. The Quarterly Minimum Data Set (MDS) Assessment completed on 8/12/14</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · Resident #30's physician was notified and the areas were noted are Ecomosis and he doesn't want to follow those areas with weekly measurements. A care plan has been developed addressing the resident's Ecomosis. · Resident #138's physician and family were notified and the areas are being tracked with weekly measurements and the care plan has been updated. · Resident #60's blood pressure will be taken and documented upon return from dialysis and his care plan has been updated. · A skin event was completed for Resident #142 on 8/19/14. Physician notified and care plan updated. · Prior authorization was resubmitted for Resident #4's denture replacement by the dentist. · Therapy re-evaluated Resident #115. The physician was notified and the current plan of care was continued. Splints/Boots will be 				

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	<p>indicated the resident was cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, depression, respiratory failure. The resident was a total 2 person assist for bed mobility, transferring, toileting, personal hygiene and bathing. The resident had a functional limitation in range of motion to bilateral upper and lower extremities.</p> <p>The August 2014 Physician Order Summary (POS) indicated the resident was receiving Lovenox 30 milligrams (mg) subcutaneous daily (blood thinning injection).</p> <p>A care plan dated, 9/14/12, indicated the resident had potential for further skin breakdown related to impaired mobility. An approach was for the CNA to do skin checks with care and notify the nurse of any abnormalities.</p> <p>An interview with the Wound Nurse and the West Wing Unit Manager on 8/22/14 at 10:11 a.m., indicated any new skin conditions including bruising should have been brought to the attention of the nurse and should have an event put into the computer and then monitored. They further indicated no events were put into place for the multiple discolorations to the residents bilateral lower legs, and</p>		<p>applied as ordered.</p> <ul style="list-style-type: none"> Resident #143 no longer resides at the facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. Physician's orders and Care Plans for all residents who currently are receiving dialysis, have skin discolorations, needing dental services, requiring splints, and have fall interventions have been reviewed by the Interdisciplinary team for accuracy and updated as indicated. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> The Interdisciplinary Team will review care plans and 	

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	<p>discoloration to bilateral forearms. They further indicated the resident was admitted on 8/1/14 from the hospital with the discolorations and they were being monitored but no documentation was completed.</p> <p>2. During an observation on 8/18/14 at 3:29 p.m., Resident #138 was observed to have a large purple discoloration to the left upper arm.</p> <p>Record review for resident #138 was completed on 8/19/14 at 1:23 p.m. The Quarterly MDS indicated the resident was cognitively intact. The diagnoses included, but were not limited to high blood pressure, anxiety, depression, kidney disease, and morbid obesity. The resident was an extensive 2+ person assist for bed mobility, transfers, and toileting. The resident received anticoagulant (blood thinning) medication.</p> <p>The August 2014 POS indicated the resident was receiving Aspirin 81 mg every day and Xarelto (blood thinning medication) 20 mg every evening.</p> <p>A care plan dated, 11/11/13, indicated the resident was at risk for skin breakdown due to obesity. An approach was to assess and document skin condition</p>		<p>physician's orders for all admissions, readmissions, and significant changes during clinical meeting and update as indicated.</p> <ul style="list-style-type: none"> The Interdisciplinary Team and nurses will be educated on Admission/Readmission procedures, Care Plan updating, Assessments and following Physicians Orders by the CEC/designee by 9/21/14. <p>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</p> <ul style="list-style-type: none"> The MDS Coordinator/designee will complete the "Care Plan Updating" CQI tool weekly x 4 weeks, the monthly ongoing thereafter. The Unit Managers will complete the "Dialysis Care", "Fall Program", "Adaptive Devices" and "Assessments" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter for at least 6 months. The Social Service Director/designee will complete the "Dental Services" CQI audit tools weekly x 4 weeks, the monthly ongoing thereafter for at least 6 	

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	<p>weekly and as needed and to notify the physician of any abnormal findings.</p> <p>Interview with LPN #1 on 8/19/14 at 3:00 p.m., indicated they did weekly skin observations of residents. When CNAs did resident care, they should notify the nurse of any new skin areas that are noticed. She further indicated staff should have noticed the discoloration during resident care and brought it to the attention of the nurse. She further indicated the resident is on blood thinning medications.</p> <p>3. Interview with Resident #60 on 8/21/14 at 1:20 p.m., indicated when he returns to the facility after dialysis the nurse was to check his access site and vital signs. He further indicated the nurse did not always check his vital signs when he returns from dialysis.</p> <p>The record for Resident #60 was reviewed on 8/20/14 at 9:18 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, hypertension, and congestive heart failure.</p> <p>Review of the 8/2014 Physician Orders indicated orders to record blood pressure after return from dialysis Tuesday, Thursday, and Saturday.</p>		<p>months.</p> <ul style="list-style-type: none"> · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action 		

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	<p>Review of the 8/2014 Medication Administration Record (MAR) indicated the resident's blood pressure had not been monitored upon return from dialysis.</p> <p>Review of the Electronic Medical Record (EMR) Vital Signs section indicated the resident's blood pressure had not been monitored upon return from dialysis.</p> <p>Review of the Dialysis Appointment Assessments lacked indicated the resident's blood pressure had not been monitored upon return from dialysis.</p> <p>Resident #60 had a care plan for risk for complications related to hemodialysis. The nursing interventions included "...tx (treatment) as indicated..."</p> <p>Interview with RN #2 on 8/21/14 at 1:50 p.m., indicated when the resident returned from dialysis she would check his fistula for bruit and thrill and obtain vital signs. She further indicated just the resident's pulse was to be checked and documented in the MAR.</p> <p>Interview with the East Wing Unit Manager on 8/21/14 at 2:14 p.m., indicated the resident's vital signs should be assessed upon return to the facility following dialysis. She further indicated the vital signs should be documented in</p>			

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	<p>the MAR or the vital signs section in the computer.</p> <p>4. On 8/18/14 at 11:35 a.m. Resident #142 was observed to have a dark purple discoloration noted to the back of her right hand. The resident was unable to say how she received the discoloration.</p> <p>On 8/19/14 at 3:53 p.m. Resident #142 was sitting in her wheelchair in the common area. The resident was noted to have a dark purple discoloration to the back of her right hand that was observed 8/18/14.</p> <p>The record for Resident #142 was reviewed on 8/19/14 at 1:07 p.m. The resident's diagnoses included, but were not limited to, anemia, coronary artery disease, and Alzheimer's disease.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed 6/24/14 indicated Resident #142 was cognitively impaired. The resident was an extensive 2+ person assist for bed mobility and transfers.</p> <p>Review of the 8/2014 MAR indicated the resident received Aspirin 81 milligrams (mg) daily and Plavix (a medication used to prevent blood clots) 75 mg daily.</p> <p>Review of the Weekly Skin Assessments</p>						

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	<p>for August 2014 indicated a skin assessment was completed on 8/11/14 and 8/18/14 and there were no areas of skin integrity alteration noted.</p> <p>Review of the Non Pressure Wound Skin Evaluation Reports on 8/19/14 at 3:50 p.m., lacked documentation of a non-pressure related skin condition for the right hand discoloration.</p> <p>Resident #142 had a care plan for risk for skin breakdown. The nursing interventions included to assess and document skin condition weekly and as needed and notify the physician of abnormal findings.</p> <p>Interview with LPN #3 on 8/19/14 at 3:55 p.m., indicated she could not find documentation of the discoloration to Resident #142's right hand. She further indicated the discoloration should have been noticed by staff during daily care and reported to her.</p> <p>A new Skin Event was completed 8/19/14 at 8:44 p.m. for a bruise to the top of the right hand. The area was dark purple in color and measured 5.5 centimeters (cm) x 2.6 cm x < (less than) 0.01 cm.</p> <p>The resident's record lacked an</p>			

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	<p>assessment of the discoloration to the right hand until brought to the facility's attention.</p> <p>5. During an interview on 08/19/14 at 8:54 a.m., Resident #4 indicated he had a missing tooth from his upper dentures and several missing or broken front teeth from his lower dentures. He indicated he had been seen by the dentist "awhile ago" and was supposed to have his dentures fixed, but hadn't heard anything further. He further indicated his teeth were not currently causing any problems eating or chewing, but he was worried about it becoming a problem now that he also had a missing upper tooth.</p> <p>During an observation of Resident #4 on 08/19/14 at 8:54 a.m., the resident had an upper tooth missing and a couple missing and broken lower front teeth. He also had food particles on the front of his shirt and stuck in his beard.</p> <p>Resident #4's record was reviewed on 08/19/14 at 2:45 p.m. The resident's diagnoses included, but were not limited to, contracture left hand, chronic kidney disease, reflux, dysphagia, anxiety, depressive disorder, Diabetes Mellitus, and left sided hemiplegia.</p> <p>A Quarterly Minimum Data Set (MDS)</p>			

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	<p>Assessment, dated 6/4/14, indicated the resident had no cognitive impairment.</p> <p>A Significant Change MDS Care Area Assessment (CAA) dated 1/9/14 indicated the "Dental Care" area triggered for problems needing attention. "... Resident was alert, able to make needs known, has no natural teeth, wears upper and lower dentures. Resident at risk for choking and poor oral health. Feeds self with staff set up."</p> <p>A Dental Care Plan dated 6/17/12, indicated, "Resident has no natural teeth." Approaches included: "Assist resident with oral care routinely and as needed; dental consult as indicated; observe & document red/ bleeding gums, lesions, sx (symptoms of) pain & notify MD (Physician); observe for decreased ability to chew food; refer to RD (Registered Dietician) as indicated for problems with food consumption; therapy screen quarterly and prn (as needed)."</p> <p>A Dental Consult Note, dated 1/31/14, indicated, "Seen. Pt (patient) requested to be seen today. Pt stated he broke his lower denture in half - denture fell on tile floor . Pt states staff took lower broken denture. Pt is wearing his other lower denture, made back in 1970's according to pt. Pt would like to have his lower</p>			

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	<p>denture repaired. Pt states newer lower denture fits better for him."</p> <p>A Dental Consult Note, dated 2/5/14, indicated, "Seen. Pt has broken lower denture and #23, 24, 25, 27 broken out of dentures. Send in PA (payment authorization) for repair/ replace teeth."</p> <p>A Social Service note, dated 2/3/14, indicated, "Res (resident) was seen by Dr. [dentist's name] DDS on 1/31/14. Res lower denture was broken and is in res drawer. Writer informed Dr. [dentist's name] of such and requested res be seen next visit in."</p> <p>A Social Service note, dated 2/6/13 indicated, "Dr. [dentist's name] DDS saw res on 2/5/14. PA to be sent to Indiana Medicaid for repair of lower denture. Res is currently wearing an older denture."</p> <p>There was no indication in the resident's record to indicate the resident had received his new lower dentures or Social Services had followed up with the resident's dentist regarding the status of his new dentures.</p> <p>During an interview on 8/20/14 1:10 p.m. with Social Services Assistant (SSA) #1, indicated she was not aware of any follow up results for denture repair for</p>			

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	<p>Resident #4 since February 2014 or the current status of Resident #4's dentures.</p> <p>A follow up interview on 8/20/14 at 2:05 p.m. with SSA #1, indicated she had spoken with Resident #4 and she was unaware he was still wearing his old dentures. She further indicated she will leave a message for the dentist to follow up on his new lower dentures and the need to also repair his top dentures.</p> <p>Interview with the Social Service Director (SSD) on 8/21/14 at 1:45 p.m., indicated SSA #1 should have followed up after the February dentist visit for Resident #4's new dentures.</p> <p>6. Resident #115's record was reviewed on 8/20/14 at 8:35 a.m. The resident's diagnoses included, but were not limited to, seizures, history of CVA (stroke) with right & left hemiplegia (partial paralysis), contractures to both hands, tracheostomy (a breathing tube inserted through the neck), and bilateral (both sides) foot drop.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 7/25/14 indicated the resident is cognitively intact. His Functional Status Assessment indicated he was completely dependent for Activities of Daily Living (ADL's) and</p>			

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	<p>had a functional deficit in range of motion of impairment on both sides, upper and lower extremities.</p> <p>The Physician's Order Summary (POS), dated August 2014 indicated orders written on 4/29/14 for left elbow and left resting hand splints for 6 hours from 9 p.m. to 3 a.m. and bilateral podus boots, may remove for bathing. The POS diagnosis list also indicated, "bilateral foot drop with cushion to maintain proper body alignment and upright position."</p> <p>On 8/19/14 at 11:15 a.m., the West Wing Unit Manager indicated Resident #115 was not currently seeing Occupational Therapy (OT), and was not on the facility's Restorative program or FIT (Functional Independence Training) program for Range of Motion (ROM).</p> <p>A care plan for ADL's indicated, "Dependent with ADL's - dx. (diagnosis) contractures, impaired mobility. Approaches: Passive (done by staff) ROM during ADL care (initiated 7/21/14); ST (speech therapy) (initiated 7/21/14); ... bilateral podus boots at all times as tolerated. May remove for bathing then reapply (initiated 8/13/13); left hand resting splint (on at 9:00 p.m. and off 3:00 a.m.) and left elbow splint (on at 9 pm - off at 3 am) as tolerated</p>				

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	<p>(initiated 8/13/13); ... refer to therapies as indicated (initiated 2/12/13)."</p> <p>The Medication Administration Record (MAR) for August 2014 indicated the left hand and arm splints and bilateral podus boots had been applied daily as ordered. A picture and instructions for splint devices was included in the MAR as follows: "L resting hand splint & L elbow splint. Both splints for L upper extremity on at the same time. L ankle boot to L foot - on at all times, as tolerated, may remove for bathing/ hygiene & reapply."</p> <p>During an observation and interview with Resident #115 on 8/29/14 at 10:45 a.m., he was lying in his bed and was not wearing any splints or podus boots. One foam boot was lying on the bed between his feet. He shook his head "no" when asked if the boot had been bothering him. His arm and hand splints were hanging in a bag over his bed. He also shook his head "no" when asked if staff ever applied his arm and hand splints or did exercises with his left arm and hand.</p> <p>Resident #115 was observed on 8/20/14 at 1:05 p.m. sitting in his Geri-chair in the hallway. He was wearing a boot on his right foot and no boot was present to his left foot. He indicated his left arm and hand splints had not been applied the</p>			

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	<p>night before.</p> <p>On 8/20/14 at 9:10 p.m., Resident #115 was observed lying in bed watching TV. There was a boot present to his right foot and only a sock on his left foot. No splints were present to his left arm or hand and they were hanging in a bag above his bed. He indicated by nodding that staff only puts on one boot and hasn't applied the splints to his left arm or hand today.</p> <p>On 8/20/14 at 10:10 p.m. The Medication Administration Record (MAR) showed the left elbow and hand splints for Resident #115 signed off by the nurse as having been applied for 8/20/14 as well as bilateral podus boots every shift on 8/20/14. Resident #115 remained resting in bed with a boot remaining only to his right foot and no splints to his left hand or arm. The splints remained hanging in a bag over the bed.</p> <p>An interview with LPN #2 on 8/20/14 at 10:40 p.m., indicated Resident #115 had no evening treatments or medications which had not already been done. LPN #2 then confirmed the splints had been signed out on the MAR as applied, but indicated he had not actually applied them. LPN #2 further indicated he had cared for Resident #115 the prior evening</p>			
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	<p>and had not applied them, even though the MAR indicated the splints were applied. LPN #2 further indicated the resident had podus boots ordered bilaterally and didn't know what happened to the second boot.</p> <p>During an interview on 8/21/14 at 10:30 a.m., the Director of Nursing Services (DNS) indicated staff should be following Resident #115's Physician's orders for splints and should not be signing off treatments on the MAR until actually completed. The DNS further indicated she would request an Occupational Therapy evaluation immediately to make sure splints still fit correctly and will also have therapy look for second podus boot.</p> <p>7. The record for Resident #143 was reviewed on 8/19/14 at 3:12 p.m. The resident's diagnoses included, but were not limited to, dementia, muscle weakness, anemia (iron deficiency), osteoporosis, renal failure, anxiety, and depression.</p> <p>Review of the Nursing progress notes indicated the resident had a witnessed fall on 8/16/14 at 2:00 p.m. The resident self transferred from her wheelchair to the couch. Two staff members assisted the resident onto the couch. The resident indicated pain to her left hip, no other</p>			

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	<p>injuries were noted.</p> <p>Review of the "Fall Event" completed on 8/16/14 indicated the resident was observed lacking non skid footwear.</p> <p>The Nursing progress note dated 8/16/14 2:55 p.m., indicated the resident's doctor was notified and the resident was sent to the emergency room for an evaluation.</p> <p>On 8/16/14 at 6:30 p.m., the Nursing progress note indicated the resident returned from the hospital with no fractures and denied pain.</p> <p>The Nursing progress noted dated 8/18/14 at 12:17 p.m. indicated the resident was observed by nursing staff to stand and bear weight with a one person transfer.</p> <p>Review of the IDT (Interdisciplinary Team) progress note on 8/1/8/14 at 9:15 a.m., indicated the resident's care plan and profile was reviewed and updated.</p> <p>A MDS (Minimum Data Set) assessment Significant Change assessment completed on 7/29/14 indicated Resident #143 was cognitively impaired. The resident's functional status on both assessments indicated a two person assist with transfers, toileting, personal hygiene</p>			

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	<p>and bed mobility.</p> <p>The care plan dated 6/27/14 indicated the resident was at risk for falls. The nursing interventions included "... 2 person assist with gait belt for transfers...non skid footwear...."</p> <p>Interview with CNA #2 on 8/20/14 at 2:06 p.m. indicated the resident was to wear rubber soled slippers when out of the bed or slippers with gripper socks, and a one person assist with toileting, dressing, grooming, transfers and showering.</p> <p>On 8/18/14 at 10:51 a.m. the resident was observed lacking non skid footwear while she propelled herself with her feet, in her wheelchair, in the main dining room.</p> <p>On 8/19/14 at 9:11 a.m. the resident was observed lacking non skid footwear in the main dining room while the resident was sitting in her wheelchair during group exercise.</p> <p>An interview with the East Unit Manager on 8/20/14 at 3:49 p.m. indicated the resident was a two person assist with transfers and indicated the resident's profile was not updated. The East Unit Manager also indicated the resident's profile sheet lacked non skid footwear</p>			

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F000309 SS=E	<p>and had "...Assist of one with transfers...."</p> <p>Interview with RN #1 on 8/20/14 at 4:02 p.m. indicated the resident was a one person assist with transfers.</p> <p>Interview with CNA #1 on 8/20/14 at 4:03 p.m. indicated the resident should wear non skid footwear and she had just transferred the resident by herself from the wheelchair to her bed.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to assessment upon return from dialysis for 1 of 1 residents reviewed for dialysis of the 2 residents who met the criteria for dialysis and related to the monitoring and assessment of bruises for 3 of 4 residents reviewed for non pressure related skin</p>	F000309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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</p>	09/21/2014

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	<p>conditions of the 8 residents who met the criteria for non pressure related skin conditions. (Resident #60, #142, #138 and #30)</p> <p>Findings include:</p> <p>1. Interview with Resident #60 on 8/21/14 at 1:20 p.m., indicated when he returns to the facility after dialysis the nurse was supposed to check his access site and vital signs. He further indicated the nurse does not always check his vital signs when he returns from dialysis.</p> <p>The record for Resident #60 was reviewed on 8/20/14 at 9:18 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, hypertension, and congestive heart failure.</p> <p>Review of the 8/2014 Physician Orders indicated orders to record blood pressure after return from dialysis Tuesday, Thursday, and Saturday.</p> <p>Review of the 8/2014 Medication Administration Record (MAR) indicated the resident's blood pressure had not been monitored upon return from dialysis.</p> <p>Review of the Electronic Medical Record (EMR) Vital Signs section indicated the</p>		<p>of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · Resident #60's blood pressure will be taken and documented upon return from dialysis. · A skin event was completed for Resident #142 on 8/19/14 to monitor the discolored area. · Resident #138's physician and family were notified and the areas are being tracked and monitored with weekly measurements. · Resident #30's physician was notified and an order was received and the areas were noted are Ecomosis and he doesn't want to follow those areas with weekly measurements. The discolored with be monitored and assessed by licensed nursing staff. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p>	

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	<p>resident's blood pressure had not been monitored upon return from dialysis.</p> <p>Review of the Dialysis Appointment Assessments indicated the resident's blood pressure had not been monitored upon return from dialysis.</p> <p>Resident #60 had a care plan for risk for complications related to hemodialysis. The nursing interventions included "...tx (treatment) as indicated..."</p> <p>Interview with RN #2 on 8/21/14 at 1:50 p.m., indicated when the resident returned from dialysis she would check his fistula for bruit and thrill and obtain vital signs. She further indicated just the resident's pulse was to be checked and documented in the MAR.</p> <p>Interview with the East Wing Unit Manager on 8/21/14 at 2:14 p.m., indicated the resident's vital signs should be assessed upon return to the facility following dialysis. She further indicated the vital signs should be documented in the MAR or the vital signs section in the computer.</p> <p>A facility policy, titled Dialysis Care, dated 9/2012, and received from the Executive Director as current on 8/18/14, indicated "...8. An assessment of the</p>		<ul style="list-style-type: none"> · All residents that reside at the facility have the potential to be affected by the alleged deficient practice. · Nurses will be educated on Dialysis Care Policy and Skin Assessments by the CEC/designee by 9/21/14. · All residents who receive dialysis were reviewed to ensure residents vital signs are taken and documented upon return from dialysis. · All residents with bruises were reviewed to ensure skin was assessed and monitored per policy. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · Nurses will be educated on Dialysis Care Policy and Skin Assessments by the CEC/designee by 9/21/14. · DNS/designee will complete a chart review for residents who attend dialysis to ensure vital signs are taken and documented upon return. 	

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	<p>resident will be completed upon return from each dialysis visit to include vital signs and assessment of the site including bruit and thrill, drainage, and general condition. Documentation of the assessment will be recorded in EMR and dialysis flow sheet or MAR..."</p> <p>2. On 8/18/14 at 11:35 a.m. Resident #142 was observed to have a dark purple discoloration noted to the back of her right hand. The resident was unable to say how she received the discoloration.</p> <p>On 8/19/14 at 3:53 p.m. Resident #142 was sitting in her wheelchair in the common area. The resident was noted to have a dark purple discoloration to the back of her right hand that was observed 8/18/14.</p> <p>The record for Resident #142 was reviewed on 8/19/14 at 1:07 p.m. The resident's diagnoses included, but were not limited to, anemia, coronary artery disease, and Alzheimer's disease.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed 6/24/14 indicated Resident #142 was cognitively impaired. The resident was an extensive 2+ person assist for bed mobility and transfers.</p> <p>Review of the 8/2014 MAR indicated the</p>		<ul style="list-style-type: none"> · Charge nurses will observe all residents skin on a weekly basis any alterations will initiate a skin event. <p>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</p> <ul style="list-style-type: none"> · The Unit Managers will complete the "Dialysis Care" and "Assessments" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter for at least 6 months. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action. 				

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	<p>resident received Aspirin 81 milligrams (mg) daily and Plavix (a medication used to prevent blood clots) 75 mg daily.</p> <p>Review of the Weekly Skin Assessments for August 2014 indicated a skin assessment was completed on 8/11/14 and 8/18/14 and there were no areas of skin integrity alteration noted.</p> <p>Review of the Non Pressure Wound Skin Evaluation Reports on 8/19/14 at 3:50 p.m., indicated no issues of a non-pressure related skin condition for the right hand discoloration.</p> <p>Resident #142 had a care plan for risk for skin breakdown. The nursing interventions included to assess and document skin condition weekly and as needed and notify the physician of abnormal findings.</p> <p>Interview with LPN #3 on 8/19/14 at 3:55 p.m., indicated she could not find documentation of the discoloration to Resident #142's right hand. She further indicated the discoloration should have been noticed by staff during daily care and reported to her.</p> <p>A new Skin Event was completed 8/19/14 at 8:44 p.m. for a bruise to the top of the right hand. The area was dark</p>			

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F000318 SS=D	<p>purple in color and measured 5.5 centimeters (cm) x 2.6 cm x < (less than) 0.01 cm.</p> <p>The resident's record indicated the discoloration to the right hand had not been addressed or assessed until brought to the facility's attention.</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a dependent resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion, related to hand, arm, and foot splints not applied as ordered for 1 of 3 residents reviewed for range of motion of the 4 who met the criteria for range of motion. (Resident #115)</p> <p>Findings include:</p> <p>Resident #115's record was reviewed on 8/20/14 at 8:35 a.m. The resident's diagnoses included, but were not limited</p>	F000318	<p>F318 INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the</p>	09/21/2014

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	<p>to, seizures, history of CVA (stroke) with right & left hemiplegia (partial paralysis), contractures to both hands, tracheostomy (a breathing tube inserted through the neck), and bilateral (both sides) foot drop.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 7/25/14 indicated the resident was cognitively intact. His Functional Status Assessment indicated he was completely dependent for Activities of Daily Living (ADL's) and had a functional deficit in range of motion of impairment on both sides, upper and lower extremities.</p> <p>The Physician's Order Summary (POS), dated August 2014 indicated orders written on 4/29/14 for left elbow and left resting hand splints for 6 hours from 9 p.m. to 3 a.m. and bilateral podus boots, may remove for bathing. The POS diagnosis list also indicated, "bilateral foot drop with cushion to maintain proper body alignment and upright position."</p> <p>On 8/19/14 at 11:15 a.m., the West Wing Unit Manager indicated Resident #115 was not currently seeing Occupational Therapy (OT), and was not on the facility's Restorative program or FIT (Functional Independence Training) program for Range of Motion (ROM).</p>		<p>deficient practice</p> <ul style="list-style-type: none"> · Resident #115 was reassessed and the current plan of care was continued. Splints/Boots will be applied as ordered. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · Therapy has verified that all resident's splint schedules are being followed for residents that have a physicians order for splints. · DNS/designee conducted an audit to ensure that residents with contractures are receiving range of motion and/or appropriate splints. · The nursing staff will be educated on donning/doffing of resident's splint usage by the RSM/SDC/designee by 9/21/14. 	

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	<p>A care plan for ADL's indicated, "Dependent with ADL's - dx. (diagnosis) contractures, impaired mobility. Approaches: Passive (done by staff) ROM during ADL care (initiated 7/21/14); ST (speech therapy) (initiated 7/21/14); ... bilateral podus boots at all times as tolerated. May remove for bathing then reapply (initiated 8/13/13); left hand resting splint (on at 9:00 p.m. and off 3:00 a.m.) and left elbow splint (on at 9 pm - off at 3 am) as tolerated (initiated 8/13/13); ... refer to therapies as indicated (initiated 2/12/13)."</p> <p>A care plan for communication (due to a tracheostomy and unable to verbalize) indicated, communicates by mouthing words and gesturing.</p> <p>The Medication Administration Record (MAR) for August 2014 indicated the left hand and arm splints and bilateral podus boots had been applied daily as ordered. A picture and instructions for splint devices was included in the MAR as follows: "L (left) resting hand splint & L elbow splint. Both splints for L upper extremity on at the same time. L ankle boot to L foot - on at all times, as tolerated, may remove for bathing/ hygiene & reapply."</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · All residents are screened at least quarterly to determine the need for formal therapy and/or continued use of splints. · Unit Managers and charge nurses monitor resident care for the use of splints and receipt of range of motion by making rounds on their units daily per shift. Findings are documented on the Nursing Rounds Checklists. Concerns are addressed with the nursing aide, as needed. · Rounds are completed each shift by the charge nurse and/or by department heads, to monitor resident care and the use of splints. Concerns are addressed and documented on the Nursing Rounds Checklist and Customer Care Rounds Sheets and discussed with the resident's charge nurse. · The Director of Nursing Services is responsible to monitor for facility compliance and will review the Nursing Rounds Checklists daily. · The Customer Care Rounds Sheets will be reviewed during daily meetings by the ED/designee for compliance. 		

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	<p>During an observation and interview with Resident #115 on 8/29/14 at 10:45 a.m., he was lying in his bed and was not wearing any splints or podus boots. One foam boot was lying on the bed between his feet. He shook his head "no" when asked if the boot had been bothering him. His arm and hand splints were hanging in a bag over his bed. He also shook his head "no" when asked if staff ever applied his arm and hand splints or did exercises with his left arm and hand.</p> <p>Resident #115 was observed on 8/20/14 at 1:05 p.m. sitting in his Geri-chair in the hallway. He was wearing a boot on his right foot and no boot was present to his left foot. He indicated his left arm and hand splints had not been applied the night before.</p> <p>On 8/20/14 at 9:10 p.m., Resident #115 was observed lying in bed watching TV. There was a boot present to his right foot and only a sock on his left foot. No splints were present to his left arm or hand and they were hanging in a bag above his bed. He indicated by nodding that staff only puts on one boot and hasn't applied the splints to his left arm or hand today.</p> <p>On 8/20/14 at 10:10 p.m. The Medication Administration Record (MAR) showed</p>		<p>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</p> <ul style="list-style-type: none"> · The Unit Managers/designee will complete the "Accommodation of Needs" CQI Tool weekly x 4 weeks and then monthly ongoing thereafter for at least 6 months. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action 	

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	<p>the left elbow and hand splints for Resident #115 signed off by the nurse as having been applied for 8/20/14 as well as bilateral podus boots every shift on 8/20/14. Resident #115 remained resting in bed with a boot remaining only to his right foot and no splints to his left hand or arm. The splints remained hanging in a bag over the bed.</p> <p>During an interview with LPN #2 on 8/20/14 at 10:40 p.m., indicated Resident #115 had no evening treatments or medications which had not already been done. LPN #2 then confirmed the splints had been signed out on the MAR as applied, but indicated he had not actually applied them. LPN #2 further indicated he had cared for Resident #115 the prior evening and had not applied them, even though the MAR indicated the splints were applied. LPN #2 further indicated the resident had podus boots ordered bilaterally and didn't know what happened to the second boot.</p> <p>During an interview on 8/21/14 at 10:30 a.m., the Director of Nursing Services (DNS) indicated staff should be following Resident #115's Physician's orders for splints and should not be signing off treatments on the MAR until actually completed. The DNS further indicated she would request an</p>			

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F000323 SS=D	<p>Occupational Therapy evaluation immediately to make sure splints still fit correctly and will also have therapy look for second podus boot.</p> <p>On 8/20/14 at 2:50 p.m. COTA #1 indicated Resident #115 had not been seen by OT since 2013. She further indicated the procedure for residents who have contractures if for OT to initially do all splinting evaluations and fittings. OT then trains floor staff on each resident's devices before releasing from OT, so then floor staff are responsible to work with splints as ordered.</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure adequate supervision for fall interventions for 1 of 1 resident reviewed for accidents of f the 1 resident who met the criteria for accidents. (Resident #143)</p> <p>Findings include:</p>	F000323	<p>F323 FREE OF ACCIDENTS/HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents</p>	09/21/2014

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	<p>The record for Resident #143 was reviewed on 8/19/14 at 3:12 p.m. The resident's diagnoses included, but were not limited to, dementia, muscle weakness, anemia (iron deficiency), osteoporosis, renal failure, anxiety, and depression.</p> <p>Review of the Nursing progress notes indicated the resident had a witnessed fall on 8/16/14 at 2:00 p.m. The resident self transferred from her wheelchair to the couch. Two staff members assisted the resident onto the couch. The resident indicated pain to her left hip, no other injuries were noted.</p> <p>Review of the "Fall Event" completed on 8/16/14 indicated the resident was observed lacking non skid footwear.</p> <p>The Nursing progress note dated 8/16/14 2:55 p.m., indicated the resident's doctor was notified and the resident was sent to the emergency room for an evaluation.</p> <p>On 8/16/14 at 6:30 p.m., the Nursing progress note indicated the resident returned from the hospital with no fractures and denied pain.</p> <p>The Nursing progress noted dated 8/18/14 at 12:17 p.m. indicated the resident was observed by nursing staff to</p>		<p>This tag is being disputed.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · Resident #143 no longer resides at the facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · All residents who are at risk for falls were reviewed by the DNS/designee to ensure fall interventions were in place per plan of care. · The CEC/designee will complete Inservice for staff on Fall Prevention Interventions and the use of Mechanical Lifts by 9/21/14. 	

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	<p>stand and bear weight with a one person transfer.</p> <p>Review of the IDT (Interdisciplinary Team) progress note on 8/1/8/14 at 9:15 a.m., indicated the resident's care plan and profile was reviewed and updated.</p> <p>A MDS (Minimum Data Set) assessment Significant Change assessment completed on 7/29/14 indicated Resident #143 was cognitively impaired. The resident's functional status on both assessments indicated a two person assist with transfers, toileting, personal hygiene and bed mobility.</p> <p>The care plan dated 6/27/14 indicated the resident was at risk for falls. The nursing interventions included "... 2 person assist with gait belt for transfers...non skid footwear...."</p> <p>Interview with CNA #2 on 8/20/14 at 2:06 p.m. indicated the resident was to wear rubber soled slippers when out of the bed or slippers with gripper socks, and a one person assist with toileting, dressing, grooming, transfers and showering.</p> <p>On 8/18/14 at 10:51 a.m. the resident was observed lacking non skid footwear while she propelled herself with her feet, in her</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · Unit Managers and charge nurses monitor resident care by making rounds on their units to ensure fall interventions are in place per plan of care. Concerns are addressed with the nursing aide, as needed. · The Director of Nursing Services is responsible to monitor for facility compliance. · Unit Managers are responsible to ensure residents receive the necessary fall prevention measures they require. <p>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</p> <ul style="list-style-type: none"> · Observations will be 	

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	<p>wheelchair, in the main dining room.</p> <p>On 8/19/14 at 9:11 a.m. the resident was observed lacking non skid footwear in the main dining room while the resident was sitting in her wheelchair during group exercise.</p> <p>During an interview with the East Unit Manager on 8/20/14 at 3:49 p.m. indicated the resident was a two person assist with transfers and indicated the resident's profile was not updated. The East Unit Manager also indicated the resident's profile sheet lacked non skid footwear and had "...Assist of one with transfers...."</p> <p>Interview with RN #1 on 8/20/14 at 4:02 p.m. indicated the resident was a one person assist with transfers.</p> <p>Interview with CNA #1 on 8/20/14 at 4:03 p.m. indicated the resident should wear non skid footwear and she had just transferred the resident by herself from the wheelchair to her bed.</p> <p>3.1-45(a)(2)</p>		<p>documented on the "Nursing Rounds Checklist" and "Fall Program" CQI tools weekly x 4, then monthly thereafter for at least 6 months.</p> <ul style="list-style-type: none"> · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action. 		

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview the facility failed to ensure a medication error rate of less than 5% was maintained for the 2 of 7 residents observed during medication pass. Two errors were observed during the 33 opportunities of error during medication administration. This resulted in a medication error rate of 6.06%. (Resident #55 and #51)</p> <p>Findings include:</p> <p>1. During an observation on 8/20/14 at 9:47 a.m. with RN #2, washed hands, donned gloves and had shaken the inhaler Symbicort, administered one puff to resident #55, waited one minute before administering the next puff at 9:48 a.m. The inhaler Dulera was shaken and administered at 9:50 a.m.</p> <p>During the observation, an interview with RN #2 indicated to wait 1 minute between separate inhalers.</p> <p>The record for Resident #55 was reviewed on 8/20/14 at 12:30 p.m. The</p>	F000332	<p>F332 Medication Errors</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Resident #55 is administered medications per MD order and facility policy. · Resident #51 is administered medications per MD order and facility policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · Residents who receive medication have the potential to be affected by the alleged deficient practice. · Licensed nurses and QMA's will be re-educated to following physician orders for medication administration by the CEC/designee by 9/21/14. · A Medication Administration Skills Validation (Medication Pass</p>	09/21/2014
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	<p>resident's diagnoses were included, but not limited to, COPD (Chronic Obstructive Pulmonary Disease-difficulty in breathing).</p> <p>The Physician's Order Summary dated 8/13/14 through 8/31/14 indicated Mometasine-Formoterol (Dulera, an inhaler for breathing easier) 200 mcg-5 mcg (micro milligrams) 2 puffs every 12 hours, DX (diagnosis) COPD and Symbicort 160 mcg-4.5 mcg 2 puffs every 12 hours, DX COPD.</p> <p>Interview with the DNS (Director of Nursing Services) on 8/20/14 at 1:29 p.m., indicated the nurse should have waited five minutes in between the two different inhalers.</p> <p>On 8/20/14 at 12:55 p.m., the DNS provided the policy for "Metered Dose Inhaler" and indicated this document was current. This policy indicated "...13. When using more than one inhaler wait 5 minutes in-between...."</p> <p>2. On 8/20/14 at 12:02 p.m. with RN #3, the following was observed: RN #3 crushed the gabapentin 800 mg tablet in a plastic packet, then poured the gabapentin powder in a 200 cc metered cup medication cup, she then washed her hands, and in another 200 cc metered</p>		<p>observation) was completed for all nurses and QMA's by the DNS/designee by 9/21/14. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Licensed nurses and QMA's will be re-educated to following physician orders for medication administration by the CEC/designee by 9/21/14. · The Director of Nursing Services, and/or designee, will monitor compliance with medication administration requirements. · The DNS/designee will conduct rounds on all shifts utilizing the skills validation check sheet to ensure medications are administered as ordered. · A Medication Administration Skills Validation (Medication Pass Observation) will be completed for all nurses and QMA's by the DNS/designee to encompass all shifts. 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 · A "Medication Pass" CQI tool will be utilized weekly x 4, monthly x 3, then quarterly thereafter. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.</p>	

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	<p>plastic cup RN #3 placed 200 cc of water from the resident's bathroom sink and placed the cup of water on the resident's bedside table. RN #3 then donned gloves, placed a towel under resident's peg-tube, placed some of the water from the 200 cc metered cup into the powdered medication cup, checked the peg tube for residual, then removed the plunger and administered the medication/water solution into the open syringe and flushed the remaining of the 200 cc slightly warm water by gravity, removed syringe and recapped tubing.</p> <p>After observation, an interview with RN #3 at 12:16 p.m. indicated she did not flush with 30 cc of water before and after medication.</p> <p>The record for Resident #51 was reviewed on 8/20/14 at 12:13 p.m. The resident's diagnoses included, but were not limited to, paralysis, peg-tube(port into stomach for nutrition and medications), trach (trachea), chronic respiratory failure, peripheral neuropathy(leg nerve pain) and seizure disorder.</p> <p>The Physician Order Summary dated August 2014 indicated to flush the peg tube with 30 cc(cubic centimeter) of water before and after each medication,</p>			

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F000412 SS=D	<p>H2O (water) flush per G-tube (peg tube) 200 cc every 6 hours, gabapentin 800 mg(milligrams)(for seizures and nerve pain) take 1 tablet per G-tube every hours.</p> <p>Interview with the DNS (Director of Nursing Services) on 8/20/14 at 1:29 p.m., indicated there should have been two 30 cc cups of water in addition to the 200 cc cup of water for the flush before and after giving the medication.</p> <p>On 8/20/1 with at 1:42 p.m., the ADNS (Assistant Director of Nursing Services) provided the "Enteral Tube-Medication Administration" policy. This current policy indicated "...10. Flush tubing with 30 cc of water 11. Administer each medication, as ordered...13. Upon completion flush tubing with 30 cc of water...."</p> <p>3.1-48(c)(1)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments;</p>			

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	<p>and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dental services were completed for a resident who had missing/broken dentures for 1 of 3 residents reviewed for dental care of the 4 residents who met the criteria for dental care. (Resident #4)</p> <p>Finding includes:</p> <p>During an interview on 08/19/14 at 8:54 a.m., Resident #4 indicated he had a missing tooth from his upper dentures and several missing or broken front teeth from his lower dentures. He indicated he had been seen by the dentist "awhile ago" and was supposed to have his dentures fixed, but hadn't heard anything further. He further indicated his teeth were not currently causing any problems eating or chewing, but he was worried about it becoming a problem now that he also had a missing upper tooth.</p> <p>During an observation of Resident #4 on 08/19/14 at 8:54 a.m., the resident had an upper tooth missing and a couple missing and broken lower front teeth. He also had food particles on the front of his shirt and stuck in his beard.</p>	F000412	<p>F412 ROUTINE/EMEGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>· Prior authorization was resubmitted for Resident #4's denture replacement by the dentist.</p>	09/21/2014

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	<p>Resident #4's record was reviewed on 08/19/14 at 2:45 p.m. The resident's diagnoses included, but were not limited to, contracture left hand, chronic kidney disease, reflux, dysphagia, anxiety, depressive disorder, Diabetes Mellitus, and left sided hemiplegia.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment, dated 6/4/14, indicated the resident had no cognitive impairment.</p> <p>A Significant Change MDS Care Area Assessment (CAA) dated 1/9/14 indicated the "Dental Care" area triggered for problems needing attention. "... Resident is alert, able to make needs known, has no natural teeth, wears upper and lower dentures. Resident at risk for choking and poor oral health. Feeds self with staff set up."</p> <p>The Physician's Order Summary (POS) dated August 2014 indicated an order for a regular consistency diet.</p> <p>A Dental Care Plan dated 6/17/12, indicated, "Resident has no natural teeth." Approaches included: "Assist resident with oral care routinely and as needed; dental consult as indicated; observe & document red/ bleeding gums, lesions, sx (symptoms of) pain & notify MD</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · All residents receiving dental services were reviewed to ensure prior authorizations were processed by the Social Service Director. · Dental prior authorization requests will be logged on a Prior Authorization Request Log and monitored weekly until the authorization or denial is received. · The Prior Authorization Log will be reviewed by the Social Service Director weekly to ensure timely follow through with prior authorization with the dentist. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · Dental prior authorization requests will be logged on a Prior Authorization Request Log and 	

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	<p>(Physician); observe for decreased ability to chew food; refer to RD (Registered Dietician) as indicated for problems with food consumption; therapy screen quarterly and prn (as needed)."</p> <p>A Dental Consult Note, dated 1/31/14, indicated, "Seen. Pt (patient) requested to be seen today. Pt stated he broke his lower denture in half - denture fell on tile floor. Pt states staff took lower broken denture. Pt is wearing his other lower denture, made back in 1970's according to pt. Pt would like to have his lower denture repaired. Pt states newer lower denture fits better for him."</p> <p>A Dental Consult Note, dated 2/5/14, indicated, "Seen. Pt has broken lower denture and #23, 24, 25, 27 broken out of dentures. Send in PA (payment authorization) for repair/ replace teeth."</p> <p>A Social Service note, dated 2/3/14, indicated, "Res (resident) was seen by Dr. [dentist's name] DDS on 1/31/14. Res lower denture was broken and is in res drawer. Writer informed Dr. [dentist's name] of such and requested res be seen next visit in."</p> <p>A Social Service note, dated 2/6/13 indicated, "Dr. [dentist's name] DDS saw res on 2/5/14. PA to be sent to Indiana</p>		<p>monitored weekly until the authorization or denial is received.</p> <ul style="list-style-type: none"> · The Social Service Designees will be inserviced on the use of the Prior Authorization Request Log by the Social Service Director by 9/21/14. · The Prior Authorization Log will be reviewed weekly to ensure timely follow through with prior authorization with the dentist. <p>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</p> <ul style="list-style-type: none"> · The Social Service Director/designee will complete the "Dental Services" CQI audit tools weekly x 4 weeks, the monthly ongoing thereafter for at least 6 months. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility 	

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	<p>Medicaid for repair of lower denture. Res is currently wearing an older denture."</p> <p>There was a lack of documentation in the resident's record to indicate the resident had received his new lower dentures or Social Services had followed up with the resident's dentist regarding the status of his new dentures.</p> <p>During an interview on 8/20/14 1:10 p.m. with Social Services Assistant (SSA) #1, indicated she was not aware of any follow up results for denture repair for Resident #4 since February 2014 or the current status of Resident #4's dentures.</p> <p>A follow up interview on 8/20/14 at 2:05 p.m. with SSA #1, indicated she had spoken with Resident #4 and she was unaware he was still wearing his old dentures. She further indicated she will leave a message for the dentist to follow up on his new lower dentures and the need to also repair his top dentures.</p> <p>Interview with the Social Service Director (SSD) on 8/21/14 at 1:45 p.m., indicated SSA #1 should have followed up after the February dentist visit for Resident #4's new dentures.</p> <p>3.1-24(a)(3)</p>		procedures may result in disciplinary action		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and</p>	F000441	F441 INFECTION CONTROL,	09/21/2014

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	<p>interview, the facility failed to ensure infection control practices and standards were maintained related to an exposed needle from a Lovenox (blood thinner) syringe for 1 of 1 observations of injections. This had the potential to affect 43 residents in the facility who receive injectable medications. (Resident #55)</p> <p>Findings include:</p> <p>On 8/20/14 at 9:28 a.m., RN #2 was observed to have administered Lovenox injections to Resident #55 with no concerns, then recapped the syringe lid on the bed side table and then administered the resident's inhalers.</p> <p>During this observation and interview on 8/20/14 at 9:28 a.m., RN #2 indicated that she did recap the needle and did not place it into the sharps container until she was finished administering all of the resident's medications.</p> <p>Interview with the DNS (Director of Nursing Services) on 8/20/14 at 1:29 p.m., indicated the nurse was not to recap needles.</p> <p>On 8/20/14 at 12:55 p.m., the DNS provided the "Subcutaneous-Injection" policy and indicated this document was current. This policy indicated "...16. Do</p>		<p>PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · RN #2 was educated by the DNS on recapping needles immediately. · There is no corrective action for residents since the alleged deficiency was in the past. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be effected by the alleged deficient 				

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	no re-cap needle, place needle and syringe in sharps container...." 3.1-18(b)(1)		<p>practice.</p> <ul style="list-style-type: none"> Nurses will be educated as to proper procedure for administering injections by the CECC/designee by 9/21/14. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> The CEC/designee will conduct skills validations all nurses providing injections. <p>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</p> <ul style="list-style-type: none"> Observations will be documented on the "Subcutaneous Injection" skills validation tool weekly x 4, then monthly thereafter by the DNS/designee. Data will be submitted to the CQI Committee for review and follow up. Noncompliance with facility 	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to gouged walls, marred doors and walls, chipped paint, missing closet door handles, loose or missing base molding, cracked and buckled bathroom tiles, stained and marred floors, standing water around toilets, and ripped wheelchair pads on 6 of 8 hallways throughout the facility. (Rehab, Cottage, West Front, Vent, Viking, and South).</p> <p>Findings include:</p> <p>An environmental tour was conducted on 8/22/14 at 10:20 a.m. with the Maintenance Director and the Executive Director.</p> <p>1. Rehab hallway</p> <p>a. Room 124: The white molding behind the bed was chipped. One resident resides</p>	F000465	<p>procedures may result in disciplinary action.</p> <p>F465 Other Environmental</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>· There were no residents cited under this regulation, however, the following sanitation areas have been cleaned and/or addressed:</p> <p>o The molding was repaired in Room 124.</p> <p>o The bathroom walls were painted for Rooms 139 and 141.</p> <p>o The bathroom walls were painted</p>	09/21/2014

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	<p>in this room.</p> <p>2. Cottage</p> <p>a. Rooms 139 & 141: The bathroom walls were marred in the shared bathroom. Three residents used this bathroom.</p> <p>b. Rooms 143 & 145: The bathroom walls were marred in the shared bathroom. Three residents used this bathroom.</p> <p>3. West Front hallway</p> <p>a. Room 203: The walls by bed 1 were marred and there were mars to the bathroom door & walls. Two residents resided in this room and three residents used this bathroom shared with Room 205.</p> <p>4. Vent hallway</p> <p>a. Room 211: The bottom outside of the bathroom door was marred and the wall by the closet was gouged and the paint chipped. Two residents resided in this room.</p> <p>b. Room 215: The wall was gouged and paint chipped between the bathroom and bed 1. Two residents resided in this</p>		<p>for Rooms 143 and 145.</p> <ul style="list-style-type: none"> o The wall was repaired for Room 203 and the bathroom doors and walls were painted for Rooms 203 and 205. o The walls were repaired and painted for Room 211 and 215. o The bathroom for Room 216 was repaired and the sink was caulked. o Room 219 bathroom door was repaired and painted. o The walls in Room 223 were repaired and molding was replaced. o The bathroom door, walls and molding were repaired as well as the flooring in Room 224. o The closet door handle was replaced, the bathroom door and walls were repaired for Room 225. o The wall tile in the bathroom was replaced for Rooms 228 and 231. o Room 234's bathroom and the room walls were repaired and painted. The toilet was repaired, loose molding was replaced and his wheelchair pad was fixed. o The wall by the bathroom in Room 241 was repaired. The bathroom that is shared with Room 239 was also repaired. 	

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	<p>room.</p> <p>c. Room 216: The bathroom had gouges to the walls and inside doors and the sink caulk was cracking. There was a large gouge and missing molding between the bathroom and bed 1. One resident resided in this room.</p> <p>d. Room 219: The outside of the bathroom door had gouged and chipped paint. Two residents resided in this room.</p> <p>e. Room 223: The bottom of the wall between the door and closet had a gouged wall and missing molding. Two residents resided in this room</p> <p>f. Room 224: The outer bathroom door was gouged and had chipped paint. The wall by the closet was chipped & missing molding and the floor under bed 1 had large black marks. Two residents resided in this room.</p> <p>5. Viking hallway</p> <p>a. Room 225: The closet door was missing a handle, the outer bathroom door was gouged and the wall between the bathroom and bed 1 was gouged. Two residents resided in this room.</p> <p>b. Room 228: The bathroom had cracked</p>		<p>o The marred walls, flooring and sink caulk was repaired for the shared bathroom for Rooms 240 and 242.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be effected by the alleged deficient practice. · ED/designee inspected all resident rooms to ensure rooms are functional and safe. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · All staff will be educated on the use of the Maintenance Request Form by the CEC/designee by 9/21/14. · Customer Care Reps will document on the Customer Care Rounds Sheet daily areas needing repairs. The sheets will be reviewed 	

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	<p>wall tile & missing molding. Two residents resided in this room.</p> <p>c. Room 231: The bathroom had cracked and buckled wall tiles and the bedroom wall was marred by the bathroom door. One resident resided in this room.</p> <p>d. Room 234: The wall by the bathroom and the wall by the closet had large gouges and missing molding. Resident #4 had a rip in the left upper pad of his wheelchair. The shared bathroom repeatedly had standing water at the base of the toilet, holes in the walls, marred doors and loose molding. Two residents resided in this room and four residents shared the bathroom.</p> <p>6. South hallway</p> <p>a. Room 241: The wall by the bathroom had a hole. The shared bathroom with Room 239 had mars to the inner doorway. One resident resided in this room and three residents shared this bathroom</p> <p>b. Room 240 and Room 242: The shared bathroom had marred walls and marred inner doors, a brownish stain on the floor under the sink, and cracking caulk to the sink. Three residents used this bathroom.</p>		<p>daily in the morning and afternoon meetings to ensure repairs are completed.</p> <ul style="list-style-type: none"> · The Preventative Maintenance schedule will be utilized by the Maintenance Director. Documentation on room repairs will be noted in the Preventative Maintenance book. <p>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</p> <ul style="list-style-type: none"> · The Executive Director will review the Preventative Maintenance Book monthly to ensure compliance. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action. 		

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F000520 SS=E	<p>At the time of the tour, the Maintenance Director indicated all of the above areas were in need of repair and the larger areas would be given priority. He further indicated that he had a rotating painting schedule and the facility planned to replace the molding and floors in 2015 on the West Front hallway, East Front hallway, Rehab hallway and therapy areas. A log based on floor plans was also kept of areas & rooms painted and corresponding dates.</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 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</p>			

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	<p>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 failed to identify and implement plans of action to correct quality deficiencies related to dental care for 1 of 3 residents reviewed for dental care (Resident #4) and skin assessments for 3 of 4 residents reviewed for non-pressure related skin conditions. (Residents # 138, #142 and #30) This had the potential to affect 135 of the 135 residents who reside in the facility.</p> <p>Findings include:</p> <p>The facility failed to ensure residents were being monitored for bruising, had care plans in place for anticoagulant medications, and received follow up dental care for Residents #138, #142, #30, #15, and #4.</p> <p>During an interview with the Executive Director (ED) on 5/22/14 at 2:15 p.m., indicated the Corporate Office sends out a set schedule for audits to be done. He further indicated skin assessments, including anticoagulant care plans, had been audited in June & July of 2014 with a 98% result and dental services had been done in February, March & April 2014 with results of 96%, 94% & 93.6%</p>	F000520	<p>F520 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 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</p>	09/21/2014

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	<p>respectively. In response to the below-threshold results for dental, the QA committee implemented a log sheet for Social Services (SS) to use to check follow ups. "It was being audited & our SS just missed it."</p> <p>3.1-52(b)(2)</p>		<p>quality deficiencies will not be used as a basis for sanctions.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · Dental Care and Skin Assessments are part of the CQI program. · Prior authorization was resubmitted for Resident #4's denture replacement by the dentist. · Residents #30, #138, #142 and #15 care plan was updated to include medications that can thin the blood. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. 	

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			<ul style="list-style-type: none"> · Continuous Quality Improvement Committee will address bruising, anticoagulant medications and dental prior authorizations. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · The Continuous Quality Improvement schedule has been updated and will be educated to all members by the ED/designee by 9/21/14. · The Continuous Quality Improvement audits will be completed per the schedule and discussed at the monthly meeting. · Action plans will be written and staff educated when thresholds are not met. · The Executive Director will monitor for compliance monthly ongoing. How the corrective action(s) will be monitored to ensure the 	

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			<p>deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · The Executive Director will monitor the CQI schedule monthly ongoing to ensure compliance. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action 		