

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2015
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NAME OF PROVIDER OR SUPPLIER BLAIR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 269 MEADOWVIEW DR PERU, IN 46970
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: September 14, 15, 16, 17, 18 and 21, 2015</p> <p>Facility number: 012565 Provider number: 155791 AIM number: 201021970</p> <p>Census bed type: SNF: 30 SNF/NF: 24 Residential: 28 Total: 82</p> <p>Census payor type: Medicare: 21 Medicaid: 14 Other: 19 Total: 54</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 14454 on September 29, 2015.</p>	F 0000	<p>R 000</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on September 21, 2015. Please accept this Plan of Correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interviews, the facility failed to ensure a thorough assessment was completed related to wounds for 1 of 3 residents reviewed for</p>	F 0272	<p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: 1) Resident #28 has had thorough</p>	10/21/2015

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	<p>pressure ulcers (Resident #96). In addition, the facility failed to ensure thorough bladder incontinence assessments were completed for 1 of 3 residents reviewed for urinary incontinence. (Resident #28)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #28 was reviewed on 09/16/15 at 2:36 P.M. Resident #28 was admitted to the facility, on 03/27/15, with diagnoses, including but not limited to iron deficiency anemia, osteoarthritis, chronic pain syndrome, weakness, anxiety state, depressive disorder, edema, hypothyroidism, glaucoma, and esophageal reflux.</p> <p>An Admission Nursing Assessment, completed on 03/27/15, indicated Resident #28 was occasionally incontinent of her bladder, used a panty liner and used the bathroom. The resident was unable to recognize the need to void, had stress and urge incontinence and dribbled. The resident took diuretic medications. In addition, the assessment indicated she voided upon rising, after meals, and before bed. The assessment indicated the resident was only toe touch weight bearing and needed the extensive assistance of two for toileting needs but was able to sit on a toilet. An attached</p>		<p>bladder assessment with updated care plan. 2) Resident #96 has been discharged. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1) All residents have the potential to be affected by this alleged deficient practice. 2) All residents have been reviewed for completed bladder assessments. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1) A thorough bladder assessment will be completed at least quarterly or when a change in status is identified through the daily CCM meeting review of residents and care plans updated accordingly. 2) A thorough wound assessment will be completed at least weekly for all identified residents with wounds-all documentation is done on a continuous event circumstance and will not include repeat of identification of area as it is identified upon initial assessment. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: 1) DHS and/or designee will review 5 residents weekly for proper documentation of pressure</p>	

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	<p>care plan indicated the resident was to be toileted upon rising, before/after meals, before bedtime, was to be toileted every shift.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 04/03/15, indicated the resident scored a 12 out of 15 on the BIMS (Brief Interview for Mental Status), moderately impaired. The resident required extensive staff assistance for transfers and toileting needs and was frequently incontinent of her urine and always continent of her bowels.</p> <p>A quarterly MDS assessment, completed on 06/26/15, indicated the resident scored a 11 of 15 on the BIMS, moderately impaired. The resident required extensive assistance of one staff for transfers and toileting needs, and was now always incontinent of her bowels and bladder function.</p> <p>An Individual Plan Report, current until 06/2015, indicated the resident was to be checked for incontinence q (every) 2 hours and prn (as needed). The resident was to be offered toileting during incontinence checks.</p> <p>A care plan, initiated on 07/07/15, indicated the resident had experienced</p>		<p>assessments x 4 weeks then monthly times 5 months to ensure documentation compliance and</p> <p>2) DHS and/or designee will review 5 residents weekly for change of urinary continence x 4 weeks then monthly times 5 months to ensure identification of bladder continence status/change</p> <p>3) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations.</p> <p>Completion Date: October 21, 2015</p>	

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	<p>bowel and bladder incontinence related to general weakness and required assistance with ADLs (activities of daily living). The goal was for the resident to maintain current level of bladder continence. The only intervention on the plan was to provide incontinence care after each incontinent episode.</p> <p>During an interview, on 09/17/2015 at 1:39 P.M., the DON (Director of Nursing) indicated the bladder incontinence assessments were completed on a monthly basis with the monthly nursing assessments. Review of the monthly nursing assessment indicated there was only a place to indicate if the resident was continent, occasionally incontinent, frequently incontinent, or totally incontinent of her bladder. There was no thorough assessment of the resident's bladder incontinence.</p> <p>During an interview, on 09/18/15 at 9:10 A.M., CNA #26 indicated Resident #28 was able to tell staff if she had been incontinent and/or ask for the bedpan when she was awake, was very consistent about the awareness or sensation to void but was not always able to control her bowels and/or bladder. She indicated the resident refused to sit on the toilet. She indicated the resident could not side on a toilet. CNA #26 was unsure if it was a</p>			

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	<p>balance issue or if she would be able to sit on a bedside commode. She indicated Resident #28 had informed her before she was admitted she had utilized a bedpan at home. CNA #26 indicated the resident was to be checked and/or changed every 2 hours while in bed and then per request when she was up in her wheelchair.</p> <p>During an interview, on 09/17/15 at 4:30 P.M., the MDS coordinator, LPN #27, indicated she looked at the elimination record and care plan when she was completing the MDS assessments. She indicated she did not complete any supplemental assessments regarding bladder incontinence.</p> <p>2. On 9/16/15 at 12:08 P.M., a review of the clinical record for Resident #96 was conducted. The record indicated the resident was admitted on 7/2/15. The resident's diagnoses included, but were not limited to: diabetes, anxiety, depression, below the knee amputation (BKA) and a-fibrillation. The resident discharged from the facility on 9/15/15.</p> <p>A 14 day Minimum Data Set (MDS) Assessment, dated 7/16/15, indicated the resident had no pressure ulcers, diabetic foot ulcers or other open lesions. The assessment indicated the resident had a surgical wound. The 30 day MDS</p>			

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	<p>Assessment, dated 7/30/15, a significant change MDS assessment, dated 8/20/15, and the 60 day MDS Assessment, dated 8/27/15, indicated the resident had no pressure ulcers, diabetic foot ulcers or other open lesions.</p> <p>A Skin Integrity Event note, dated 7/10/15, indicated resident had an area of blisters to his left shin area, measuring 7 cm. (centimeters) x 6.5 cm. and 3 cm x 3.5 cm. The blisters were fluid filled. The interventions were: pressure reducing device for chair and bed and encourage fluids. The form further indicated on 7/12/15, the "...blisters no longer intact seeping fluid..." The form indicated on 7/13/15, the resident returned to facility after a physician's visit with new orders for an antibiotic for 10 days for blistered area and post-op incision wound of amputated leg.</p> <p>A Nursing Progress Note, dated 7/27/15 at 9:42 A.M., indicated "... blisper [sic, blister] popped and area measuring 6 x 5...new order for culture and keflex...." Another Nursing Progress Note, dated 7/27/15 at 9:44 A.M., indicated "...resident blister no longer intact. Area red in color measuring 4.5 x 4.5...." There were no indications as to where these wounds were located.</p>			

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	<p>A Nursing Progress Note, dated 8/10/15 at 1:06 A.M., indicated "...Skin: area measures 5 x 6..." A Nursing Progress Noted at 1:08 A.M., on the same date, indicated "...Skin: area measures 6.5 x 7..." Neither note addressed the area of the wound or what type of wounds were assessed. Another Nursing Progress Note, dated 8/10/15 at 1:16 A.M., indicated "...When doing res [resident] skin measurements, res[resident] noted to have a blister to outside of left foot near little toe. Small area of drainage noted...."</p> <p>A Physician Orders (Wound Care) form from the local wound clinic, dated 8/3/15, indicated 2 wounds, but did not specify the location or type of wound. The treatment order was for Aquacel AG (wound dressing) and a conform dressing. A Wound Clinic form, dated 8/10/15, indicated #2 wound was located on the left distal lower leg, #3 wound was located on the left lower leg, #4 wound was the BKA incision site and wound #5 was located on the left lateral foot. The form had no documentation of the type of wound (except for the incision wound) or it's size. Treatments were indicated for #2, #3 and #5. The last Wound Clinic form, dated 9/14/15, indicated the wounds on the left distal lower leg, the proximal left leg, the left lateral foot and the right BKA wound were cleansed and</p>			

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	<p>treatments were provided.</p> <p>A Wound Clinic Note/Multi Wound Chart Details form, faxed to the facility upon request, dated 9/14/15, indicated wound #2 was a diabetic wound/ulcer of the left distal lower extremity. The date acquired was 7/4/15 and the wound status was open and measured 6.5 x 2.6 x 0.1 cm. Wound #3 was a diabetic wound/ulcer of the left proximal lower extremity. The date acquired was 8/4/15 and the wound status was open and measured 2 x 4 x 0.1 cm. Wound #4 was a surgical wound on the incision of the right below the knee amputation. The date acquired was 6/24/15. Wound status was open and measured 3.7 x 9 x 0.3 cm. Wound #5 was a diabetic wound/ulcer of the left lateral foot. The date acquired was 8/6/15 and the wound status was open and measured 2.1 x 1.6 x 0.2 cm.</p> <p>During an interview, on 9/16/15 at 3:10 P.M., the MDS Coordinator indicated she was only aware of the incision wound.</p> <p>During an interview, on 9/18/15 at 2:35 P.M., the Wound Care Nurse/Assistant Director of Nursing (ADON) indicated she had not done skin assessments on the wounds as they were opened blisters and the wound care clinic were dressing and taking care of the wounds. She further</p>						

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F 0279 SS=D Bldg. 00	<p>indicated the nursing staff were documenting in the progress notes on the wounds. The Wound Care Nurse/ADON had never requested further information from the wound clinic.</p> <p>3.1-31(c)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 interview and record review, the facility failed to create a comprehensive care plan to address a pressure ulcer for 1 of 3 residents</p>	F 0279	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1) Resident #46</p>	10/21/2015

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	<p>reviewed for pressure ulcers and the use of an anti-anxiety medication for 1 of 6 residents reviewed for unnecessary medications. (Resident #46 and Resident #91)</p> <p>Findings include:</p> <p>1. On 9/16/15 at 8:28 A.M., a review of the clinical record for Resident #46 was conducted. The record indicated the resident was admitted on 6/24/15. The resident's diagnoses included, but were not limited to: acute respiratory failure, dysphasia, weakness, congestive heart failure, anxiety, dementia, anemia, pressure ulcer and atrial fibrillation.</p> <p>An Admission Assessment, dated 7/12/15, indicated the resident was at risk for pressure ulcers.</p> <p>A skin integrity event note, dated 7/17/15, indicated the resident had an "unable to stage" (full thickness tissue loss in which the base of the ulcer was covered by slough and/or eschar) pressure ulcer on his left lower buttock. The pressure ulcer measured 1.2 x 1.7 centimeters (cm) was red and blanchable. The left buttock upper area had a 2.5 x 3.4 cm unstageable, non blanchable, pressure ulcer with with brown edges (area not open) this measurement</p>		<p>comprehensive care plan has been revised to reflect interventions for pressure ulcer prevention; 2) Resident # 91 care plan has been developed to include interventions for use of antianxiety medication (Clonazepam). Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>1) All residents at risk for pressure ulcers and residents with antianxiety medications have the potential to be affected by this alleged deficient practice. 2) All residents at risk for pressure ulcers have been reviewed for comprehensive care plan updates. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: 1) Licensed nursing staff were re-educated regarding the campus guidelines for development of interdisciplinary care plans and appropriate interventions by DHS / clinical nursing support. 2) MDS nurse re-educated by DHS on responsibility of maintaining and updating care plans as resident needs require; 3) Review all residents that are currently on antianxiety medication and update/revise care plan How the corrective measures will be monitored to ensure the alleged deficient practice does</p>		

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	<p>included a red area just above the non-staged area. Interventions were pressure relieving device for chair and bed. apply wound cleanser, apply xeroform and cover with optifoam. The wound was to be monitored weekly.</p> <p>A Physician's Order, dated 7/17/15, indicated to cleanse the left buttock with wound cleanser, apply xeroform and optifoam.</p> <p>A Clinically At Risk (CAR) report, dated 7/21/15, indicated the pressure area identified from a skin integrity event, was a stage 2 (a partial thickness loss of dermis, or an intact or open/ruptured serum filled blister), and measurements were the same as the skin integrity events had described. A CAR report, dated 7/28/15, indicated the wound measured 1.6 x 1.0 x 0.1 cm. A subsequent measurement on 8/4/15 indicated the wound measured 0.4 x 0.6. On 8/25/15 the area was documented as healed/closed.</p> <p>A 14 day Minimum Data Set (MDS) Assessment, dated 7/30/15, indicated the resident had an unstageable pressure ulcer with wound bed covered by slough and/or eschar. A 30 day MDS Assessment, dated 8/13/15, indicated the resident had a Stage 2 pressure ulcer. The</p>		<p>not reoccur: 1) Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, open events/observations and new orders in the daily clinical meeting 5 days a week, ongoing. The review is to ensure the care plan have been initiated/updated as necessary. 2) The Daily Clinical Report will be completed to document the review of the above stated reports/forms. Audits and/or observations related to care plans will be conducted by the DHS or designee weekly times 4 weeks for 5 residents; then monthly times 5 months to ensure compliance. 3) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: October 21, 2015</p>		

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	<p>interventions for both assessments were pressure ulcer care and pressure reducing device for the chair and bed.</p> <p>A copy of the complete care plan was received, on 9/16/15 at 11:35 A.M., from the Director of Nursing. An at risk for pressure care plan, dated 9/1/15, indicated the resident was at risk due to incontinence, limited bed mobility and history of skin breakdown. The interventions included but were not limited to: keep clean/dry, assist/remind resident to turn when in bed, provide pressure relieving mattress, assess skin weekly and provide moisture barrier as ordered. The care plans did not contain a pressure ulcer care plan to address interventions to treat and close a pressure ulcer.</p> <p>During an interview, on 9/16/15 at 12:20 P.M., the Facility Consultant indicated she did not have a care plan to address the resident's pressure wound. The consultant could not explain why the at risk for pressure care plan was not developed until 9/1/15.</p> <p>On 9/16/15 at 3:35 P.M., an interview was conducted with the DON (Director of Nursing) and MDS Coordinator. The MDS Coordinator indicated she was not responsible for the care plans regarding</p>			

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	<p>wounds. The DON indicated the Skin Impairment Circumstance form, dated 7/17/15, had interventions included on it; however, a care plan was not implemented.</p> <p>On 9/16/15 at 3:49 P.M. a review of the Skin Impairment Circumstance form, dated 7/17/15, indicated interventions were a pressure reducing device for the bed and treatment implemented.</p> <p>On 9/16/15 at 1:55 P.M., the Director of Nursing provided a policy titled "Guidelines for Care Plan Development," undated and indicated the policy was the one currently used by the facility. The policy indicated "...Purpose: to ensure care plans are developed to communicate resident preferences and care needs...5. The care plan shall...include the problem area, resident goal, approaches/interventions and a goal date...."</p> <p>2. The clinical record for Resident #91 was reviewed on 9/17/15 at 2:12 P.M. Resident #91 was admitted to the facility on 5/7/15, with diagnoses, including but not limited to, anxiety, depressive disorder, insomnia, diabetes type II and urinary tract infection.</p> <p>A Social Service note, dated 5/8/15,</p>			

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	<p>indicated "...resident admitted to facility on 5/7/15 from hospital. Resident has a dx [diagnosis] anxiety and is currently taking clonazepam 1 mg tab po [oral] 2 x [times] dly [daily]...."</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 5/12/15, indicated Resident #91's active diagnoses was anxiety disorder and depression with a BIMS (Brief Interview for Mental Status) score of 10 indicating the resident was moderately cognitively impaired.</p> <p>A physician order, dated 5/12/15, indicated "...Clonazepam [a medication used for anxiety] 1 mg [milligram] twice a day diagnosis: anxiety state...."</p> <p>A nurse note, dated 5/13/15 at 10:03 P.M., indicated "...res [resident] has had several hallucinations this evening. Res thought his deceased brother was sitting on his bed...."</p> <p>A Social Service note, dated 6/15/15 at 10:45 A.M., indicated "...resident received n.o. [new order] on 6/12/15 to dc [discontinue] clonazepam dx anxiety per family request...."</p> <p>A nurse note, dated 6/17/15 at 2:03 A.M., indicated "...res [resident] noted to have increase in behaviors, res upset and</p>			

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	<p>thinking someone had been in and out of his room, he was looking for her, becoming upset, yelling out loud awaking other res, staff reassured res, res wanting to call police, several attempts to redirect, res toileted, offered something for discomfort...ua [urinalysis] to be sent out with lab, conts [continues] with atb [antibiotic] therapy for UTI [urinary tract infection] with end date of 6/17/15, md [medical doctor] updated cont [continue] to monitor...."</p> <p>A Social Service note, dated 6/18/15 at 9:56 A.M., indicated "...resident received new order on 6/17/15 for clonazepam 1 mg po HS [hours sleep] dx anxiety...."</p> <p>A nurse note, dated 6/19/15 at 9:51 P.M., indicated "...res continues to be confused and agitated. Res. refused to get washed up for bed and lay down. Res. hallucinating on and off throughout shift...."</p> <p>A nurse note, dated 6/21/15 at 12:50 P.M., indicated "...pt [patient] continues to have behaviors. He was very confused upon rising asking where he was, how long he has been here...He is hallucinating and paranoid stating...we are trying to kill him...."</p> <p>The current health care plans for Resident</p>			

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	<p>#91 included but were not limited to: A care plan, dated 5/8/15, indicated the resident received an antidepressant medication r/t [related to] depression dx[diagnosis]. A care plan, dated 7/9/15, indicated the resident had a diagnosis of insomnia and I am currently taking a sleep aid. A care plan, dated 7/27/15, indicated the resident had a memory/recall problem r/t dementia. There was no care plan documentation regarding hallucinations or the use of an antianxiety medication.</p> <p>On 9/16/15 at 1:55 P.M., record review of the current policy titled "Guidelines for Care Plan Development" received from the MDS Coordinator indicated "...To ensure care plans are developed to communicate resident preferences and care needs...Procedure: 4. A care plan shall be developed no later than 21 days after admission, and no later than 7 days after the date in V0200B2 [MDS Care Area Assessment Process completion date], addressing the resident preferences, MDS triggers, diagnoses, risk factors and other applicable care needs...."</p> <p>During an interview on 9/18/15 at 11:59 A.M., the MDS Coordinator indicated if a resident had a diagnosis of anxiety or was on an antianxiety medication a care plan should be developed.</p>			

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F 0282 SS=D Bldg. 00	<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 interviews, the facility failed to follow a care plan related to incontinence for 1 of 3 residents reviewed for bladder incontinence (Resident #48) In addition, the facility failed to follow a plan of care to address constipation for 1 of 1 residents reviewed for constipation. (Resident #63)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #63 was reviewed on 09/17/2015 9:48 A.M. Resident #63 was admitted to the facility on 02/26/13, with diagnoses, including but not limited to dementia, dysphagia, history of urinary calculi, hypothyroidism, anxiety state, hypertension, atrial fibrillation, history of venous thrombosis, esophageal reflux, osteoarthritis, weakness, altered mental state, constipation and coronary artery disease.</p>	F 0282	<p>What corrective actions will be accomplished for residents found to have been affected by the alleged deficient practice: Resident #48 has had his Urinary Incontinence care plan updated Resident # 63 does have Bowel Protocol in place and bowel movements have been monitored to ensure BM has occurred How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1) All residents residing at the campus have the potential to be affected by the alleged deficient practice 2) All residents have been reviewed for urinary incontinence and bowel movement monitoring. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1) Nursing staff received re-education by the DHS / clinical</p>	10/21/2015	

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	<p>The Nursing progress notes, dated 09/15/15 at 12:27 A.M., indicated the resident was exhibiting signs of distress, moaning, having abdominal pain and distention. The resident was sent to the acute care facility emergency room.</p> <p>A CT (computerized tomography) scan, completed on 09/15/15, at the hospital, indicated a 10 x 11 cm (centimeter) ball of stool in the rectal vault and the resident was diagnosed with a fecal impaction.</p> <p>The computerized Vitals record, which included bowel movement documentation, indicated the resident was not documented to have had a bowel movement from 09/07/15 to 09/15/15.</p> <p>The Resident #63's physician orders, dated 5/17/15, for medication included an order to administer a Bisacodyl (laxative) suppository 10 mg (milligram) rectally as needed for constipation. If the resident had no bowel movement in 72 hours, the resident was to receive 2 Tablespoons of a "Natural Laxative." If there were no results in 24 hours from the Natural Laxative, the resident was to receive 30 cc (cubic centimeters) of Milk of Magnesia (laxative). If the resident had no results fro the Milk of Magnesia in 12</p>		<p>support on following care plan interventions and audits to be completed; 2) Different staff members on varying shifts and units will be observed to ensure following of care plan interventions.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: 1) Per the campus guidelines, the Nursing Leadership Team will review the Resident Messages in the daily clinical meeting 5 days a week, ongoing. The review is to ensure Ineffective Bowel Pattern Circumstance has been started andthe bowel protocol has been initiated and results obtained. 2) The Daily Clinical Report will be completed to document the identified residents with Bowel concerns . Audits and/or observations will be conducted by the DHS or designee 5 times a week for 4 weeks, then monthly times 5 months to ensure compliance. 3) DHS and/or designee will observe 5 residents weekly x4 weeks, then monthly times 5 months to ensure compliance of urinary incontinence care plan; 4) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further</p>	

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	<p>hours, the resident was to receive a Dulcolax (laxative) suppository. If no results from the suppository in 2 hours then the resident was to receive a Fleets enema.</p> <p>The September 2015 Medication Administration Record (MAR) indicated from September 1-15, before she went to the acute care facility, the resident did not receive any of the medications to treat constipation ordered by the physician on an as needed basis.</p> <p>During an interview, on 09/18/2015 at 9:00 A.M., the DON (Director of Nursing) indicated the facility's computer system generated a "resident message" regarding no bowel movements documented for 3 days and these were to be reviewed for the CCM (Clinical Care Meetings) by Department heads and addressed. She also indicated the staff nurses received the messages and were supposed to take action but they were waiting on the CCM meeting to "catch" the issues. In addition, she indicated the bowel movement documented while the resident was out of the building had occurred just before she was transported but was not documented timely or appropriately. She did not know if there were any other bowel movements "missed" on the documentation or why</p>		<p>recommendations. Completion Date: October 21, 2015</p>	

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	<p>the nurses did not realize the lack of bowel movements and implement the ordered medications.</p> <p>2. The clinical record for Resident #48 was reviewed on 9/16/15 at 9:17 A.M. Resident #48 was admitted to the facility on 4/26/13, with diagnoses, including but not limited to, aphasia, cerebrovascular accident, weakness, anxiety, depressive disorder and urinary tract infection.</p> <p>The quarterly Minimum Data Set (MDS) assessment, completed on 8/10/15, indicated the resident was moderately cognitively impaired, required extensive staff assistance of two staff for bed mobility and transfers, and extensive assistance of one staff for toilet use. The bowel and bladder assessment indicated the resident was always incontinent of urine.</p> <p>A Monthly Nursing Assessment, dated 9/2/15, indicated the resident required a 2 person assist for transfers with the use of a mechanical lift, was incontinent and unable to recognize the need to void.</p> <p>During an interview, on 9/16/15 at 9:39 A.M., CNA #31 indicated the resident was always incontinent of bowel and bladder and wore a brief. She further indicated the resident was checked and</p>			

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	<p>changed every two hours because he does not know and cannot tell staff when when he needs to go to the bathroom. She indicated the staff also knew when he was wet because he became very fidgety in his chair.</p> <p>The following observations of Resident #48 indicated:</p> <p>On 9/14/15 from 9:30 A.M.-10:30 A.M., the resident was sitting in his wheelchair in the dining room attending an activity. From 10:30 A.M.-11:25 A.M. the resident was in the resident lounge in front of the television asleep. At 11:36 A.M. the resident was assisted in his wheelchair from the lounge back into the dining room and his wheelchair was pushed up to a dining room table, he was not observed to be checked or changed during this time.</p> <p>On 9/15/15 from 8:00 A.M.-10:15 A.M., the resident was observed sitting in his wheelchair at the dining room table. The resident was not checked or changed during this time.</p> <p>On 9/16/15 from 9:18 A.M.-10:05 A.M., the resident was observed sitting in his wheelchair attending an activity in the dining room. At 10:05 A.M. a Certified Nursing Assistant (CNA) transported the</p>			

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	<p>resident in his wheelchair from the activity to the resident lounge and seated him at the table with another resident. At 11:30 A.M. the resident remained in the resident lounge at the table. The resident was not observed to be checked or changed during this entire time. At 11:40 A.M., the CNA transferred the resident in his wheelchair into the dining room to his table. The resident was not taken to his room to be checked or changed.</p> <p>On 9/17/15 from 8:30 A.M.-9:14 A.M., the resident was observed sitting at the dining room table eating his breakfast. At 9:14 A.M., the resident was pushed in his wheelchair to an activity in the dining room, he attended the activity from 9:14 A.M.-10:33 A.M. At 10:33 A.M., the resident was pushed in his wheelchair by a CNA from the dining room and taken into the resident lounge and placed in front of the television. He was not taken to his room to be checked or changed. The resident stayed in the lounge area until 11:45 A.M. At 11:45 A.M., the resident was pushed in his wheelchair from the lounge to the dining room and placed at the table by a CNA. He was not checked or changed prior to lunch. At 12:15 P.M., the resident was at the dining room table eating his lunch. At 12:41 P.M., the resident was finished with his lunch and remained at the dining</p>			

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	<p>room table. At 1:01 P.M., a CNA transferred the resident to his room, another CNA assisted to transfer the resident into his bed with the use of the maxi lift (a mechanical lift).The residents brief was removed, the brief was heavily saturated with urine and the resident had a large bowel movement in his brief.</p> <p>During an interview, on 9/17/15 at 1:10 P.M., CNA #32 indicated the resident was checked and his brief was changed at 11:00 A.M. that morning.</p> <p>A Vitals Report, dated 9/10/15-9/17/15, indicated on 9/14/15, the residents brief was changed at 3:34 A.M., 5:39 A.M., 11:23 A.M., then again at 9:20 P.M. On 9/15/15 the residents brief was changed 12:18 A.M., 2:35 A.M., and 5:07 A.M., there was no more documentation for 9/15/15. There was no documentation for 9/16/15 on any shift. On 9/17/15, the residents brief was changed at 2:49 A.M. and 5:20 A.M., there was no more documentation for the rest of 9/17/15.</p> <p>The care plans indicated the following: #1 Date, initiated 6/2/15 with no revision date, indicated the problem: Functional urinary incontinence R/T (related to dementia, BPH (benign prostatic hyperplasia), requires assistance with adls (activities of daily living). Interventions</p>						

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	<p>included but were not limited to "...apply moisture barrier to skin, check for incontinent episodes at least every 2 hours, ensure adequate bowel elimination, provide incontinence care after each incontinent episode and report any signs of skin breakdown...."</p> <p>#2 Date initiated 9/11/15 with no revision date, indicated the problem: Resident is at risk for pressure ulcers r/t incontinence, requires assistance with adls. Interventions included but were not limited to "...history of pressure ulcers, keep clean and dry as possible...provide incontinence care after each incontinent episode...."</p> <p>#3 Date initiated 7/27/15 with no revision date, indicated the problem: Resident is limited in ability to transfer self R/T hx (history) of CVA (cerebrovascular accident). Interventions included but were not limited to "...keep call light within reach, provide 2 assist for transferring with use of maxi move lift, use maxi move large sling for transferring...."</p> <p>3.1-35(g)(2)</p>			

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F 0309 SS=G Bldg. 00	<p>483.25 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 of care.</p> <p>Based on record review and interviews, the facility failed to ensure bowel movements were monitored and a bowel protocol was implemented to treat constipation for 1 of 1 residents reviewed for bowel incontinence. This deficient practice resulted in severe abdominal pain, the need for transport to an acute care facility and treatment for a fecal impaction. (Resident #63)</p> <p>Finding includes:</p> <p>The clinical record for Resident #63 was reviewed on 09/17/2015 9:48:03 A.M. Resident #63 was admitted to the facility on 02/26/13, with diagnoses, including but not limited to dementia, dysphagia, history of urinary calculi, hypothyroidism, anxiety state, hypertension, atrial fibrillation, history of venous thrombosis, esophageal reflux, osteoarthritis, weakness, altered mental state, constipation and coronary artery disease.</p> <p>A Nursing progress note, dated 09/15/15</p>	F 0309	<p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: Resident # 63 has Bowel Protocol in place and bowel movements have been monitored with no further concerns related to bowel function. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1) All residents residing at the campus have the potential to be affected by the alleged deficient practice; 2) All residents have been reviewed to ensure Bowel Movement protocol is in place as needed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1) Nursing staff received re-education on following physician orders, review of electronic health system reports, and care plan interventions by DHS / clinical support staff. How the corrective action will be</p>	10/21/2015

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	<p>at 12:27 A.M., indicated the resident was exhibiting signs of distress, moaning, having abdominal pain and distention. The resident was sent to the acute care facility emergency room.</p> <p>A CT (computerized tomography) scan, completed on 09/15/15, indicated a 10 x 11 centimeter (cm) ball of stool in the rectal vault and the resident was diagnosed with a fecal impaction.</p> <p>The computerized Vitals record, which included bowel movement documentation, indicated the resident was not documented to have had a bowel movement from 09/07/15 to 09/15/15.</p> <p>The physician's medications orders, dated 5/17/15, for Resident #63 indicated to administer a Bisacodyl (laxative) suppository 10 milligrams (mg) rectally as needed for constipation. If the resident had no bowel movement in 72 hours, the resident was to receive 2 Tablespoons of a "Natural Laxative." If there were no results in 24 hours from the Natural Laxative, the resident was to receive 30 cc (cubic centimeters) of Milk of Magnesia (laxative). If the resident had no results from the Milk of Magnesia in 12 hours, the resident was to receive a Dulcolax (laxative) suppository. If no results from the suppository in 2 hours</p>		<p>monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>1) Per the campus guidelines, the Nursing Leadership Team will review the Resident Messages in the daily clinical meeting 5 days a week, ongoing. The review is to ensure Ineffective Bowel Pattern Circumstance has been started and the bowel protocol has been initiated and results obtained. 2) The Daily Clinical Report will be completed to document the identified residents with Bowel concerns and follow up as indicated. Audits and/or observations will be conducted by the DHS or designee 5 times a week for 4 weeks, then monthly times 5 months to ensure compliance. 3) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations. Completion Date: October 21, 2015</p>				

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	<p>then the resident was to receive a Fleets enema.</p> <p>The September 2015 Medication Administration Record (MAR) indicated from September 1 - 15, before she went to the acute care facility, the resident did not receive any of the medications to treat constipation ordered by the physician on an as needed basis.</p> <p>During an interview, on 09/18/2015 at 9:00 A.M., the Director of Nursing (DON) indicated the facility's computer system generated a "resident message" regarding no bowel movements documented for 3 days and these were to be reviewed for the CCM (Clinical Care Meetings) by Department heads and addressed. She also indicated the staff nurses received the messages and were supposed to take action but they were waiting on the CCM meeting to "catch" the issues. In addition, she indicated the bowel movement documented while the resident was out of the building had occurred just before she was transported but was not documented timely or appropriately. She did not know if there were any other bowel movements "missed" on the documentation or why the nurses did not realize the lack of bowel movements and implement the ordered medications.</p>			

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	<p>The current facility policy and procedure, provided on 09/18/15 at 8:30 A.M., included the following: "...5. The Bowel and Bladder Circumstance form or Ineffective Bowel Pattern form shall be initiated for any resident not having a BM with 72 hours (unless this has been determined to be a usual bowel pattern for the individual).</p> <p>a. The 72 Hour follow up on the B and B Circumstance form should be completed until the resident has a BM or the bowel pattern returns to normal for the resident.</p> <p>b. The Ineffective Bowel Pattern form should be completed each shift until the resident has a BM or bowel pattern has returned to "normal" for the resident.</p> <p>c. The assessment of the abdomen shall be completed each shift that includes abdominal distention, pain and bowel sounds.</p> <p>6. Nursing staff shall assess for effectiveness within 24 hours of the first step before proceeding to the next level...."</p> <p>The current Guidelines for Use of Care Tracker for Bowel and Bladder Documentation policy, provided on 09/18/15 at 8:30 A.M., included the following: "...18. Completion of Bowel and Bladder services will be validated</p>			

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F 0314 SS=G Bldg. 00	<p>through the use of the Care Tracker Bowel and Bladder reports. This will be accomplished by the DHS [Director of Health Services] or designee. The Care Tracker Compliance Report and "No BM in the last 3 days cross tab report" will be reviewed and utilized during the morning stand-up interdisciplinary team meeting to assure provision of services...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interviews, the facility failed to ensure interventions were implemented to prevent pressure ulcer development on a lower extremity for 1 of 3 residents reviewed for pressure ulcers. This deficient practice resulted in the development of an unstageable pressure</p>	F 0314	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #62 skin assessment conducted by wound nurse, physician and dietary consult, reveal wounds to left lateral foot are arterial in nature. Angiogram has been scheduled.</p>	10/21/2015

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	<p>ulcer. (Resident #62)</p> <p>Finding includes:</p> <p>The clinical record for Resident #62 was reviewed on 09/16/2015 at 9:51 A.M. Resident #62 was admitted to the facility on 07/10/15, with diagnoses, including but not limited to status post traumatic fracture of the lower leg, history of above knee amputation, end stage renal disease with dialysis, history of falls, peripheral vascular disease, atrial fibrillation, neuropathy, hypertension, chronic kidney disease, constipation, esophageal reflux, gout, edema, diabetes mellitus and pain.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 07/17/15, indicated the resident was at risk for the development of pressure ulcers but did not have any pressure ulcers.</p> <p>The care plan related to the resident's risk for pressure ulcers, initiated on 07/22/15, included the following interventions: " Avoid shearing resident's skin during positioning, transferring, and turning, keep clean and dry as possible. Minimize skin exposure to moisture, keep linens clean, dry, and wrinkle free, maintain the head of the bed at the lowest degree of elevation possible, provide incontinence care after each incontinent episode...,</p>		<p>Appropriate revisions were made to the care plan to reflect all wound interventions. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1) All residents have the potential to be affected by this alleged practice.2) All residents have had a skin assessment completed and interventions implemented as needed.Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: 1) Nurses re-inserviced on correct classification of wounds, weekly skin checks and documentation by DHS / nursing clinical support; 2) All new admissions will have skin risk assessments, interventions, and care plans reviewed within 72 hours with appropriate follow-up;How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: 1) Per the campus guidelines, the Nursing Leadership Team will review skin documentation, interventions, and care plans on all new admissions in the daily clinical meeting Mon-Fri 2) Residents with skin impairment will be discussed in weekly CAR meeting; 3) Audits and/or observations will be conducted of new admissions by</p>	

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	<p>reduce friction injuries by using lubricants, protective films, protective dressing, and/or protective padding as needed, report any signs of skin breakdown, use lifting device as needed, and use moisture barrier product to perineal area."</p> <p>A skin assessment of Resident #62's left lower leg, completed on 08/31/15, indicated there were intact sutures in the left lower leg, one plus edema in his foot, and an ace wrap was applied to his left leg. There was no impaired skin noted on the assessment.</p> <p>A skin assessment, completed on 09/01/15, indicated the incision was intact and there was an abrasion on his left great toe which had been present prior to his discharge on 08/24/15.</p> <p>A skin assessment in progress note, dated 09/02/15, indicated there was a scabbed area to the left lateral ankle measuring 1 cm (centimeter) by 1 cm with no redness, edema, or discomfort.</p> <p>A nursing note, dated 09/03/15, indicated "redness" to left lateral ankle continued.</p> <p>A nursing note, dated 09/04/15 at 3:56 P.M., indicated : "Left lateral leg: 5 cm x 6 cm. Abdomen: 1.5 cm by 2 cm. There</p>		<p>the DHS or designee 5 times a week for 4 weeks, then monthly times 5 months to ensure compliance. 4) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations</p> <p>Completion Date: October 21, 2015</p>	

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	<p>was no explanation as to exactly what areas the measurements were assessing.</p> <p>A pressure ulcer wound assessment, completed on 09/04/15, indicated the physician was notified on 09/04/15.</p> <p>A nursing note, dated 09/05/15 at 12:57 A.M., indicated "Pressure area to left lateral foot cont. [continues]. Heel floating. HOB [Head of Bed] elevated for comfort et [and] call light within reach."</p> <p>A wound assessment, dated 09/08/15 at 3:16 P.M., indicated there was an unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the ulcer bed) black/purple wound on the left outer ankle (sic) the wound measured 2 cm by 1.5 cm with irregular wound edges, no tunneling or drainage, no signs of infection, periwound skin pink and blanchable. Resident stated the area was made by his shoe.</p> <p>Nursing note, dated 09/08/15 at 10:13 A.M., indicated the physician and family were notified of the wound.</p> <p>A physician's order, dated 9/10/15, indicated the treatment for the residents pressure ulcer was sure prep (skin protectant) tid (three times a day). A</p>						

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F 0315 SS=D Bldg. 00	<p>physician's order, dated 9/11/15, indicated the resident must have blue heel protector when up.</p> <p>An observation of the pressure area for Resident #62, completed on 09/17/2015 at 1:52 P.M., indicated the resident had a dime sized black dry unstageable pressure ulcer on his left outer ankle bone. The skin directly surrounding the black area was dry and peeling. There was slight edema of the foot noted. The nurse wiped the area with sure prep and put his sock and a blue heel protector back onto his foot.</p> <p>There were no specific interventions implemented regarding protecting the resident's foot until after the pressure ulcer on the resident's ankle developed.</p> <p>3.1-40(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder</p>						

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	<p>receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interviews, the facility failed to ensure bladder incontinence was thoroughly assessed and individualized interventions implemented to prevent bladder continency decline in 1 of 3 residents reviewed for bladder incontinence. (Resident #28 and #48)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #28 was reviewed on 09/16/15 at 2:36 P.M. Resident #28 was admitted to the facility on 03/27/15, with diagnoses, including but not limited to iron deficiency anemia, osteoarthritis, chronic pain syndrome, weakness, anxiety state, depressive disorder, edema, hypothyroidism, glaucoma, and esophageal reflux.</p> <p>An admission Nursing assessment, completed on 03/27/15, indicated she was occasionally incontinent of her bladder, used a panty liner, used the bathroom, was unable to recognize the need to void, had stress and urge incontinence, dribbled, and took diuretic medications. In addition, the assessment indicated she voided upon rising, after meals, and before bed. The assessment</p>	F 0315	<p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: 1) Resident #28 has had thorough bladder assessment with updated care plan 2) Resident #48 has had his Urinary Incontinence care plan updatedHow other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1) All residents have the potential to be affected by this alleged deficient practice.2) All residents have been reviewed to ensure a bladder assessment is in place, and if needed, care plans updated and in place.What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1) A thorough bladder assessment will be completed at least quarterly or when a change in status is identified through the daily CCM meeting review of residents and care plans updated accordingly. 2) Random staff will be observed by DHS / Designee to ensure following of care plan interventions.How the corrective action will be monitored to ensure the deficient practice</p>	10/21/2015

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	<p>also indicated the resident was only toe touch weight bearing and needed the extensive assistance of two for toileting needs but was able to sit on a toilet. An attached care plan indicated the resident was to be toileted upon rising, before/after meals, before bedtime and was to be toileted q (every) shift,</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 04/03/15 indicated the resident scored a 12 out of 15 on the BIMS (Brief Interview for Mental Status), moderately cognitively impaired. The resident required extensive staff assistance for transfers and toileting needs. The resident was frequently incontinent of her urine and always continent of her bowels.</p> <p>A quarterly MDS assessment, completed on 06/26/15, indicated the resident scored a 11 of 15 on the BIMS, moderately cognitively impaired. The resident required extensive assistance of one staff for transfers and toileting needs. The resident was now always incontinent of her bowels and bladder function.</p> <p>A Individual Plan Report which was current until 06/2015, indicated the resident was to be checked for incontinence q 2 hours and as needed. The resident was to be offered toileting</p>		<p>will not recur, i.e. what quality assurance program will be put into place: . 1) DHS and/or designee will review 5 residents weekly for change of urinary contience x 4 weeks then monthly times 5 months to ensure identification of bladder contience status/change 2) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations. Completion Date: October 21, 2015</p>				

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	<p>during incontinence checks.</p> <p>A care plan, initiated on 07/07/15, indicated the resident had experienced bowel and bladder incontinence related to general weakness and required assistance with ADLs (Activities of Daily Living). The goal was for the resident to maintain current level of bladder continence but the only intervention was to provide incontinence care after each incontinent episode.</p> <p>During an interview, on 09/17/2015 on 1:31 P.M., with the DON (Director of Nursing), she indicated she thought the bladder incontinence assessments were completed on a monthly basis with the monthly nursing assessments.</p> <p>During an interview, on 09/18/15 at 9:00 A.M., the Assistant DON indicated the monthly assessment only indicated if the resident was continent of their bladder, occasionally incontinent, frequently incontinent or totally incontinent. There was no assessment further assessment of the incontinence for residents on the monthly nursing assessments.</p> <p>During an interview, on 09/17/15 and 4:30 P.M., the MDS coordinator, LPN #27, indicated she looked at the elimination record and care plan when</p>			

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	<p>she was completing the MDS assessments. She indicated she did not complete any supplemental assessments regarding bladder incontinence.</p> <p>On 09/17/15, Resident #28 was observed lying in her bed from 8:15 A.M. - 11:27 A.M. At 11:27 A.M., CNA #26 and CNA #29 entered her room, changed her soiled incontinent brief, dressed the resident and transferred her to her wheelchair. The resident was not offered a bedpan, toileting, and the resident did not request to be toileted. The resident's legs were noted to be bent at abnormal angles at the ankles and she could not bear much weight during the transfer.</p> <p>During an interview, on 09/18/15 at 9:10 A.M., CNA #26 indicated Resident #28 was able to tell staff if she had been incontinent and/or ask for the bedpan when she was awake. The CNA further indicated the resident was not always able to control her bowels and bladder but seemed to know when she needed to void or could at least tell staff that she had been incontinent when she was awake. The CNA indicated the resident refused to sit on the toilet but had informed staff she had been using a bedpan prior to her admission to the facility. CNA #26 indicated she did not know if the resident was capable of</p>			

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	<p>sitting on a bedside commode or toilet because they had never attempted to toilet her in that manner</p> <p>There was no documentation presented regarding Resident #28's to acknowledge her decline in bladder continence and no thorough assessment to determine any causative factors and no interventions implemented to assist the resident to maintain her bladder continency.</p> <p>2. The clinical record for Resident #48 was reviewed on 9/16/15 at 9:17 A.M. Resident #48 was admitted to the facility on 4/26/13, with diagnoses, including but not limited to, aphasia, cerebrovascular accident, weakness, anxiety, depressive disorder and urinary tract infection.</p> <p>The quarterly Minimum Data Set (MDS) assessment, completed on 8/10/15, indicated the resident was moderately cognitively impaired, required extensive staff assistance of two staff for bed mobility and transfers, and extensive assistance of one staff for toilet use. The bowel and bladder assessment indicated the resident was always incontinent of urine.</p> <p>A Monthly Nursing Assessment, dated 9/2/15, indicated the resident required a 2 person assist for transfer with the use of a</p>			

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	<p>mechanical lift, was incontinent, and unable to recognize the need to void.</p> <p>During an interview, on 9/16/15 at 9:39 A.M., CNA #31 indicated the resident was always incontinent of bowel and bladder and wore a brief. She further indicated the resident was checked and changed every two hours because he cannot tell staff when when he needs to go to the bathroom. She indicated the staff also know when he was wet because he became very fidgety in his chair.</p> <p>The following observations of Resident #48 indicated:</p> <p>On 9/14/15 from 9:30 A.M.-10:30 A.M., the resident was sitting in his wheelchair in the dining room attending an activity. From 10:30 A.M.-11:25 A.M. the resident was in the resident lounge in front of the television asleep. At 11:36 A.M. the resident was assisted in his wheelchair from the lounge back into the dining room and his wheelchair was pushed up to a dining room table, he was not observed to be checked or changed during this time.</p> <p>On 9/15/15 from 8:00 A.M.-10:15 A.M., the resident was observed sitting in his wheelchair at the dining room table. The resident was not checked or changed</p>			

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	<p>during this time.</p> <p>On 9/16/15 from 9:18 A.M.-10:05 A.M., the resident was observed sitting in his wheelchair attending an activity in the dining room. At 10:05 A.M., a Certified Nursing Assistant (CNA) transported the resident in his wheelchair from the activity to the resident lounge and seated him at the table with another resident. At 11:30 A.M., the resident remains in the resident lounge at the table. The resident was not observed to be checked or changed during this entire time. At 11:40 A.M., the CNA transferred the resident in his wheelchair into the dining room to his table. The resident had not been taken to his room to be checked or changed.</p> <p>On 9/17/15 from 8:30 A.M. - 9:14 A.M., the resident was observed sitting at the dining room table eating his breakfast. At 9:14 A.M., the resident was pushed in his wheelchair to an activity in the dining room, he attended the activity from 9:14 A.M. - 10:33 A.M. At 10:33 A.M., the resident was pushed in his wheelchair by CNA#32 from the dining room and taken into the resident lounge and placed in front of the television. He was not taken to his room to be checked or changed. The resident stayed in the lounge area until 11:45 A.M. At 11:45 A.M., the resident was pushed in his</p>			

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	<p>wheelchair from the lounge to the dining room and placed at the table by a CNA #32. He was not checked or changed prior to lunch. At 12:41 P.M., the resident was finished with his lunch and remained at the dining room table. At 1:01 P.M., CNA#32 transferred the resident to his room, another CNA assisted to transfer the resident into his bed with the use of the maxi lift (a mechanical lift). The residents brief was removed, the brief was saturated with urine and the resident had a large bowel movement in his brief.</p> <p>During an interview, on 9/17/15 at 1:10 P.M., CNA #32 indicated the resident was checked and his brief was changed at 11:00 A.M. that morning.</p> <p>A Vitals Report, dated 9/10/15 - 9/17/15, indicated on 9/14/15, the residents brief was changed at 3:34 A.M., 5:39 A.M., 11:23 A.M., then again at 9:20 P.M. On 9/15/15, the residents brief was changed 12:18 A.M., 2:35 A.M., and 5:07 A.M., there was no more documentation for 9/15/15. There was no documentation for 9/16/15 on any shift. On 9/17/15 the residents brief was changed at 2:49 A.M. and 5:20 A.M., there was no more documentation for the rest of 9/17/15.</p> <p>During an interview, on 9/17/15 at 3:45</p>			

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	<p>P.M., The MDS (Minimum Data Set) Coordinator indicated the facility does not have a separate bladder assessment, the nursing staff complete a monthly nursing assessment, which included bowel and bladder information. She further indicated if she could not get all of the information she needed from the monthly nursing assessment she interviewed staff members. If she could not get the information she needed from the staff interviews and the monthly assessments she looked at the plan of care to complete her 7 day look back period.</p> <p>On 9/17/15 at 3:04 P.M., a review of care plans was conducted. A care plan, dated 6/2/15, indicated the resident had functional urinary incontinence R/T (related to) dementia, BPH (benign prostatic hyperplasia), requires assistance with ADLs (activities of daily living). Interventions included but were not limited to "...apply moisture barrier to skin, check for incontinent episodes at least every 2 hours, ensure adequate bowel elimination, provide incontinence care after each incontinent episode and report any signs of skin breakdown...." A care plan, dated 9/11/15, indicated the resident was at risk for pressure ulcers r/t incontinence, requires assistance with ADLs. The interventions included but</p>				

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F 0329 SS=D Bldg. 00	<p>were not limited to "...history of pressure ulcers, keep clean and dry as possible...provide incontinence care after each incontinent episode..." A care plan ,dated 7/27/15, indicated the resident had limited ability to transfer self R/T hx (history) of CVA (cerebrovascular accident). The interventions included but were not limited to "...keep call light within reach, provide 2 assist for transferring with use of maxi move lift, use maxi move large sling for transferring..."</p> <p>3.1-41(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to</p>			

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	<p>treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to ensure there were adequate indications for use of an antipsychotic medication for 2 of 6 residents reviewed for unnecessary medications (Resident #44 and 60). In addition, the facility failed to ensure there were non-pharmalogical interventions initiated prior to the use of an antianxiety medication for 1 of 6 residents reviewed for unnecessary medications. (Resident #60) The facility failed to ensure there was adequate monitoring of antipsychotic medication use for 1 of 6 residents reviewed for unnecessary medications. (Resident #44) Finally, the facility failed to ensure a Gradual Dose Reduction was attempted timely for 1 of 6 residents reviewed for unnecessary medications. (Resident #63)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #60 was reviewed on 09/16/2015 at 8:28 A.M. Resident #60 was admitted to the facility, on 08/26/14, with diagnoses, including but not limited to: history of</p>	F 0329	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>1) Resident #60 has been discharged from facility</p> <p>2) Resident #44 MAR updated with space for documentation of Intervention tried prior to prn administration</p> <p>3) Resident # 63 has had a recent medication review with reccommendation/GDR</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur :</p> <p>1) All residents who are receiving</p>	10/21/2015

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	<p>urinary tract infections, weakness, atrial fibrillation, dementia with delirium, osteoarthritis, diabetes mellitus and hypertension. On 08/11/15, a diagnosis of anxiety, constipation, acute pain with nausea/vomiting and abnormal weight loss was added.</p> <p>The current medication orders for Resident #60 included the following: Haldol (antipsychotic) 0.5 mg (milligrams) every 6 hours as needed (prn) anxiety state (ordered 09/10/15). Lorazepam (anxiolytic) 0.5 mg one tablet every 4 hours prn anxiety (ordered 08/12/15).</p> <p>The most recent MDS (Minimum Data Set) assessment, completed on 06/08/15, indicated Resident #60 had no behaviors documented.</p> <p>The care plan related to PRN anxiety medication, current through 12/15/15, included the following interventions: "Assess if the resident's behavior/mood symptoms present a danger to the resident and/or others. Intervene as needed, Assess resident's functional status prior to initiation of drug use or serve as a baseline, attempt non-pharmalogical interventions, monitor for drug use effectiveness and adverse consequences, and monitor resident's</p>		<p>psychoactive medications have had their medications reviewed by Consultant Pharmacist (10/5/15-10/6/15) with reccommendations as appropriate.</p> <p>2) Indications for continued use of the medication reviewed (Diagnosis)</p> <p>3) All PRN psychoactive medications have had updated space for documentation of Interventions tried prior to prn administration on MAR</p> <p>4) Nursing staff have been educated to document interventions prior to administration of PRN psychoacitve medication.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur:</p> <p>1) DHS and/or designee will review 5 residents prn medication administrations weekly for proper documentation x 4 weeks then monthly times 5 months to ensure documentation compliance, and</p> <p>2) DHS and/or designee will review 5 residents weekly for psychoactive medication, its indication for use and last GDR x 4 weeks then monthly times 5 months to ensure identification of indications for use.</p>	

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	<p>mood and response to medication." The care plan related to the resident's antipsychotic medication use, also current through 12/15/15, had very similar interventions as the antianxiety medication care plan except for the monitor for EPS (extrapyramidal symptoms) was an additional intervention. And "try non-pharmalogical interventions before initiating drug therapy" was one of the interventions.</p> <p>The Medication Administration Record (MAR) for September 2015 indicated the resident received an antipsychotic dose of Haldol on 09/15/15 at 6:07 P.M.</p> <p>The resident received doses of the antianxiety medication, Lorazepam on 09/03/15 at 7:05 P.M. and 09/04/15 at 4:59 A.M.</p> <p>Nursing Progress Notes for September 2015 indicated there was no specific behavior documentation on 09/03, 09/04 or 09/15/15, regarding the need to administer antianxiety and/or antipsychotic medication.</p> <p>At the bottom of the electronic MAR for the Haldol administration, "agitation" was documented.</p>		<p>3) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations.</p> <p>Completion Date: October 21,2015</p>		

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	<p>At the bottom of the electronic MAR for the Lorazepam administrations, "restless" was documented for 09/03/15, and "restless and anxiety" were documented on 09/04/15.</p> <p>During an interview, on 09/16/15 at 9:00 A.M., LPN #27 indicated there was a report on which interventions attempted prior to medication administration were documented. She further indicated surveyors were not given access to that particular report.</p> <p>During an interview, on 09/16/2015 at 9:37 A.M., LPN #28, the Medical Records/Staffing Coordinator, indicated there were no interventions attempted prior to any of the medication administrations on the report and there was no progress note and no other documentation.</p> <p>2. The clinical record for Resident #63 was reviewed on 09/17/2015 at 9:48 A.M. Resident #63 was admitted to the facility, on 02/26/13, with diagnoses, including but not limited to dementia, dysphagia, history of urinary calculi, hypothyroidism, anxiety state, hypertension, atrial fibrillation, history of venous thrombosis, esophageal reflux, osteoarthritis, weakness, altered mental state, and coronary artery disease.</p>			

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	<p>The medication orders for Resident #63, current for September 2015, included the antianxiety medication, Alprazolam 0.125 mg (milligram) per gastrostomy tube twice a day.</p> <p>The most recent MDS Quarterly Assessment, completed on 08/02/15, indicated the resident had moderately impaired cognition, poor appetite and had exhibited no behaviors.</p> <p>The care plan related to antianxiety medication, initiated on 05/21/15 and current through 11/2015, had a goal for the resident not to exhibit any adverse side effects from the medication use. The interventions included attempting a GDR (gradual dose reduction) quarterly or as needed.</p> <p>There were no nursing progress note from August through September 2015 related to any anxiety issues.</p> <p>During an interview, on 09/17/15 at 2:00 P.M., the Assistant Director of Nursing (ADON) indicated the resident had not exhibited any anxiety behaviors for the past year. In addition, she indicated the resident had received the antianxiety medication since her original admission to the facility on 02/26/14. The ADON</p>			

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	<p>indicated in July 2014 the dose of Alopazolam (anxiolytic) was reduced from 0.25 mg BID (twice a day) to 0.125 mg BID.</p> <p>A pharmacy request, dated 04/14/15 and 05/28/15, indicated a request to the physician was made to recommend attempting a GDR on the Alopazolam medication. The physician agreed to the recommendation from April 2015 on 05/01/15, but written at the bottom was "family requests we do not change the dose." On the May pharmacist recommendation, the physician signed it on 06/02/15, and asked for the facility to talk to the resident's family and let them know it was the pharmacist recommendation. Another handwritten note at the bottom of the recommendation indicated the writer had spoken with the resident's daughter and the resident's family again declined the dose reduction and indicated they had attempted a dose reduction without success. However, there was no evidence of an unsuccessful dose reduction since the resident had been admitted to the facility in 2013. In addition, there was no documentation from the physician clarifying why a GDR was contra-indicated and not in the resident's best interest.</p> <p>3. On 9/16/15 at 9:25 A.M., a record</p>			

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	<p>review indicated, Resident # 44 was admitted to the facility on 1/21/15, with diagnoses included, but were not limited to, "...dementia with delusions, chronic pain, edema, anemia and hypertension...."</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 7/14/15, indicated Resident #44 was severely cognitively impaired.</p> <p>The physician admission orders, dated 1/21/15, indicated the resident was on Seroquel (an antipsychotic) 50 mg (milligrams) twice a day and 75 mg at bedtime for dementia with senile delusions.</p> <p>A nursing admission assessment, dated 1/21/15, indicated under the mood and behavior assessment no behaviors were present. In addition, the box for delusions was unmarked.</p> <p>A nursing skilled charting evaluation, dated 1/22/15, indicated under the cognition/mental status section "other" was marked and hand written was the word "wandering." There were no other mood or behavior issues documented.</p> <p>An initial psychosocial assessment, dated 1/28/15, completed by the Social Service Director, indicated under "Cognitive</p>			

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	<p>Pattern: Delirium" the resident had difficulty focusing attention. The resident was easily distracted. The resident seemed out of touch. The resident seemed to have difficulty keeping track of what was said.</p> <p>A Behavior Analysis report, indicated: on 5/9/15 at 8:32 P.M., the resident intruded on the privacy or activity of others. The intervention was utilized to redirect and was effective.</p> <p>The Nursing progress notes, indicated the following: On 5/19/15 at 9:57 P.M., the resident refused a shower x (times) 3.</p> <p>On 6/28/15 at 7:37 A.M., "Resident came to dining room for breakfast this morning seeming like normal self. At 6:45 A.M. res (resident) began to have seizure activity which lasted 5 minutes."</p> <p>On 7/8/15 at 3:39 P.M., "Resident refused to get vitals taken for monthly assessment."</p> <p>On 7/31/15 at 11:54 A.M., "Pt (patient) continues to refuse dentures, has not had them in since they were removed."</p> <p>On 8/5/15 at 12:10 A.M., "[resident name] has no skin impairment or noted</p>			

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	<p>injuries d/t (due to) altercation this evening. No additional hostility or attempts have been made. I do not believe pt has any recall of situation. I think the patient was overwhelmed by all the stimuli. Also pt may be more irritable d/t increased and frequent pain which is being investigated further."</p> <p>On 8/11/15 at 7:27 A.M., "Broken dentures. Staff attempting to put res lower dentures in when res hit staff hand knocking dentures to floor causing dentures to break in half."</p> <p>On 9/2/15 at 5:59 A.M., "res was wondering around intruding the privacy of another res. Res. was immediately removed from the res. room."</p> <p>On 9/11/15 at 1:00 A.M., "no behaviors displayed on noc (night) shift."</p> <p>On 9/12/15 at 5:41 A.M., "No behaviors present on night shift."</p> <p>On 9/15/15 at 6:01 A.M., At 0610 (6:10 A.M.) pt had seizure which lasted approx (approximately) 45 sec. (seconds). Pt fell face first into table and onto floor. Pt nose bleeding profusely.</p> <p>A Nursing Monthly Assessment, dated 8/6/15, indicated: Behavior: Potential</p>			

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	<p>indicators of psychosis: none of the above was checked. The box for hallucinations and delusions was unmarked.</p> <p>A Note To the attending Physician/Prescriber, dated 8/24/15, indicated "...[resident name] receives Seroquel (antipsychotic) 50 mg bid [twice a day] and 75 mg hs [hours sleep] for dementia with delusions. She is due for dose reduction consideration of this regimen. Of concern is the recent seizure activity reported on 6/28/15. Family indicated she has had a couple of seizures prior to this but no reasons were found as to why. Seroquel has potential to reduce seizure threshold and result in additional seizure activity. No recent delusions are documented in nursing notes or weekly nursing summary. Physician response, dated 9/10/15, indicated "Agree. Reduce Seroquel to 50 mg TID [three times a day] x 2 weeks then 50 mg bid...."</p> <p>A Gradual Dose Reduction Circumstance form, dated 9/10/15, indicated the diagnosis for use of the Seroquel was delusional disorder. The date the medication was started was on 1/22/15, and the last reduction attempt was unknown and no prior reductions had been attempted.</p>			

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	<p>During an interview, on 9/16/15 at 9:23 A.M., CNA #31 indicated the resident is resistant to care at times but other than that she did not have any other behaviors.</p> <p>On 9/16/15 at 12:30 P.M., review of a care plan, initiated on 6/29/15, indicated the problem: "I am at risk for adverse consequences R/T (related to) receiving an antipsychotic medication for treatment of Dementia with Delusions." Interventions included but were not limited to "...Assess my behavioral symptoms if present and are a danger to the resident and/or others. Intervene as needed. Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extra pyramidal symptoms. Attempt a gradual dose reduction. Attempt to give the lowest dose possible. Monitor my behavior and response to medication. Pharmacy consultant review monthly. Review for continued need at least quarterly...."</p> <p>During an interview, on 9/16/15 at 2:09 P.M., the Director of Nursing indicated the resident was not followed by psych services but her family physician follows her medications. She further indicated the first and only GDR (gradual dose reduction) since admission in January</p>			

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F 0363 SS=E Bldg. 00	<p>2015 was just done on 9/10/15.</p> <p>3.1-48(a)(6)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review and interviews, the facility failed to serve fortified foods to 15 of 52 residents for whom the physician had ordered these foods. In addition, the facility failed to follow the menu consistently for 7 of 52 residents who required a sodium restricted diet.</p> <p>Finding includes:</p> <p>1. During observation of the breakfast meal, conducted on 09/14/15 from 7:10 A.M. - 8:00 A.M., Cook #21 was not observed to utilize a spreadsheet or any recipes to make her and/or serve breakfast to residents.</p> <p>During observation of the noon meal,</p>	F 0363	<p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: Resident 21 was not identified on the sample and resident #60 has been discharged from the facility.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1) All residents have the potential to be affected by this alleged deficient practice.2) All residents have been reviewed to ensure they are receiving the proper diet.What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1. New spreadsheets, recipes and menus were implemented on 9/21/15 2.</p>	10/21/2015	

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	<p>conducted on 09/14/15 from 11:45 A.M. - 12:50 P.M., Cook #21 was not observed to utilize a spreadsheet or any recipes to serve lunch to residents. She was observed to serve almost all residents in healthcare a macaroni and cheese and ham casserole, carrots, watermelon and a fruit cobbler.</p> <p>A spreadsheet with therapeutic diet menus and portions, approved by the Dietician was requested for the meals served on 09/14/15; however, this was not provided.</p> <p>During an interview, on 09/15/15 at 10:00 A.M. with the Food Service Supervisor (FSS), he indicated he thought the facility had therapeutic diet orders. A list of diet orders was provided and indicated there were 15 residents with fortified food orders, 3 residents with a 2 gram (gm) / NAS (no added salt) diet order, 9 residents with a controlled carbohydrate diet, 8 residents with mechanical soft and/or chopped meat diet orders, 4 residents with a pureed diet order, 1 residents with renal diet restrictions, and 3 residents with a NAS (no added salt) diet order. When queried regarding how fortified foods were determined and served to those residents whom required the therapeutic diet, the FSS indicated health shakes were always</p>		<p>Dining Services Support to provide education on fortified foods, spreadsheets and therapeutic diets on 10/12/15; 3. Fortified Food Best Practice updated / revised 10/6/2015; How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>1) DFS and/or designee will review 5 meals weekly for proper use of spreadsheets, provision of therapeutic diets and fortified foods, x 4 weeks then monthly x 5 months to ensure compliance;</p> <p>2) The results of the audits and/or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations. Completion Date: October 21, 2015</p>	

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	<p>available and residents on those diets could "ask" for the item. He also indicated the oatmeal in the mornings was fortified with extra butter and sugar. When asked how the sodium restricted diets were determined he indicated again that residents could "choose" their menu and their choices were honored. It was unclear if food items on their ordered diets were pointed out to them or if they were made aware of the consequences of choosing food items not on their therapeutic diets. When asked if the dietician had menued macaroni and cheese with ham casserole for the 2 gm Na (Sodium) and the Renal and NAS diets the FSS indicated he would "check" with the dietician.</p> <p>On 09/16/2015 at 8:42 A.M. the breakfast tray for Resident #21 was observed. The meal ticket on the room tray indicated she was to receive fortified foods. Her breakfast tray consisted of coffee, a red colored juice, toast and scrambled eggs. There were no particular food items which had been "fortified" served to Resident #21.</p> <p>On 09/16/2015 at 8:48 A.M. the breakfast tray for Resident #60 was observed. She had been served cut up pieces of watermelon, a Danish and a red colored drink. Her meal ticket indicated</p>			

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	<p>she was to have been served "fortified" foods.</p> <p>During an interview, on 09/16/15 at 11:20 A.M., with the Assistant FSS, she indicated she had checked with the dietician and the macaroni and cheese with ham casserole should not have been served to those residents on a NAS or 2 GmNa diet. She also indicated the oatmeal at breakfast had been fortified.</p> <p>Observation of the noon meal service on 09/16/15 at 11:20 A.M. - 12:20 P.M. indicated a spread sheet was still not consistently being utilized. Review of the spreadsheet, provided by request by the Assistant FSS indicated there were still no guidance for fortified foods. The assistant FSS indicated she had instructed the Cook to fortify all of the macaroni and cheese for everyone by using evaporated milk instead of regular milk. The spreadsheet was pointed out to Cook #25 after she had already started serving residents in the main dining room and had already sent food to the secured Dementia unit. Residents requiring a 2 gm/Na diet served before she was made aware of the menued items were served an Italian sausage link and a side serving of macaroni and cheese but they were supposed to have received french fries instead of the macaroni and cheese.</p>			

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	<p>The assistant FSS provided a corporation guideline which indicated the therapeutic diets, the diet orders that corresponded to each diet and the total calories, grams of protein, and sodium provided by each diet. There were no indications as to how the extra 700 calories and extra 14 grams of protein were to be provided for those residents requiring a fortified foods diet.</p> <p>A policy and procedure, provided by the AFSS (Assistant Food Services Supervisor) on 09/17/15 at 9:30 A.M., dated as revised on March 2012, included the following: "...High Calorie/High Protein This diet is designed to provide additional calories and protein through foods that are normally served on the Regular Diet. This is accomplished by fortifying beverages, soups, hot cereals, puddings, mashed potatoes, and gravy with modular powder supplements that have calories/protein. Occasionally, whole milk will be menued In place of 2 % [percent] milk. All recipes for these are indicated with the acronym HC meaning High CalorieReduced Carbohydrate. The Reduced Carbohydrate Diet is intended for individuals with diabetes that required and/or request reduced amounts of sugar. It is carbohydrate controlled with an average of 1800 kcals [kilocalories] /day.</p>			

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	<p>This diet contains sugar-free condiments, ½ portions of high-sugar/high calorie desserts and/or reduced calories versions of desserts, 4 oz [ounce] juice, skim milk, and low-fat/low-cholesterol eggs and other reduced calorie/fat foods as needed. ...2 Gram Sodium Any sodium-restricted diet is used to prevent and treat high blood pressure, cardiovascular disease, congestive heart failure, kidney disease, and some other liver diseases. In the case of an advanced disease state, debilitated or malnourished individuals, oral intake may be so poor that optimizing oral intake should take priority over dietary sodium restriction. This diet is built using the Regular Diet and the actual nutritional analysis of each menu items; efforts were made to keep this diet as similar to the Regular Diet as possible to provide higher quality meals. The diet limits the use of very high sodium foods and eliminates the use of salt at the table and salt packets on trays. Many recipes include the abbreviation " RS " to indicate Reduced Sodium or " NAS " to indicated No Added Salt...."</p> <p>3.1-20(i)(1) 3.1-20(i)(4)</p>			

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F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interviews, the facility failed to ensure food was stored, prepared and served in a sanitary manor in 1 of 1 healthcare kitchens. The deficiency related to handwashing, utensils, equipment, shelves, hair covering, glove use, a clock, dishwasher temperatures, sanitation water, and trash cans. This potentially affected 52 of 54 residents who consumed food in the healthcare.</p> <p>Findings include:</p> <p>1. During the initial kitchen sanitation tour and observation of the breakfast meal service, conducted on 09/14/15 from 7:10 A.M. - 8:00 A.M., the following was noted: - Dietary staff member #20 entered the kitchen from outside through a side door, carrying a box of coffee packets. She walked through the kitchen, into the dining room, then reentered the kitchen and proceeded to put away frozen food without washing her hands. - Two of 5 scoops, put away as clean,</p>	F 0371	<p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p> <p>No residents were directly affected, however all items have been addressed and cleaned</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>Dining Services Support to provide education on 10/12/15 related to the following:</p> <ol style="list-style-type: none"> 1) Handwashing / glove usage 2) Cleaning list 	10/21/2015

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	<p>were soiled with dried food particles.</p> <ul style="list-style-type: none"> - The top of the steamer, on which a microwave was sitting, was visibly dirty with a build up of food debris. - The shelf above the stove top, used to store a container of butter, cans of nonstick spray and a pepper shaker was dirty with a build up of a greasy film and dust. - A open metal shelf, beneath a food preparation counter, used to store large baking sheets, metal bowls, and small appliances such as a milkshake blender had a build up of gritty debris and grime. - There was a plastic bag, dated 08/15/15, which contained four small meat patties. - Employee #23, a housekeeping employee was noted to enter the kitchen, walked through the kitchen to obtain a banana and a small stack of serving bowls. She did not wash her hands and did not have her hair covered. - A stack of dinner plates, utilized by Cook #21 was sitting on an open grill. The grates of the grill were heavily coated with black and/or brown colored build up of debris. - Dietary employee #20, donned a pair of gloves, handled the plastic packaging on a box of Danishes, and then placed the individual Danishes onto a plate with her contaminated gloved hands. - A shelf, located under the stove griddle 		<ul style="list-style-type: none"> 3) Proper storage of plates 4) Temp log 5) Using test strips 6) Proper use of robo coupe <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: .</p> <ul style="list-style-type: none"> 1) DFS and/or designee will audit sanitation 3 times weekly x 4weeks; then monthly x 5 months to ensure compliance; 2) DFS and/or designee will audit cleaning list that includes all items identified on F-371 3 times weekly x 4 weeks; then monthly x 5 months to ensure compliance; 3) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations. <p>Completion Date: October 21, 2015</p>	

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	<p>area, utilized to store stock pots, was dirty with food debris.</p> <ul style="list-style-type: none"> - A visible dusty, dirty radio was sitting on top of a plastic bucket of season salt in the middle of Cook #21's counter, with open items she was using to prepare breakfast, such as eggs and pancake batter and open pancake mix. - Dietary Employee #22 entered the kitchen through the side door to the outside, removed two large gray bins from the clean dishes side of the dishwasher and placed them onto a black cart. She then proceeded to wash her hands for 5 seconds before proceeding to food preparation. - There was an undated, opened bag of sliced lunch meat in the small refrigerator beside the food preparation counter. - Cook #21, who was preparing pureed food, had donned gloves and then touched a toaster, paper menus, and a spatula hands before she reached into the food processor to adjust the blade with her contaminated gloved hands. - Dietary employee #20 exited the kitchen through the outside, side door and reentered through the same door carrying two bunches of bananas. She placed the bananas onto a visibly dirty sink counter with other fruit items, then without washing her hands, donned gloves, handled a refrigerator hands and the outside of a plastic container of 			

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	<p>strawberries. She then handled individual strawberries with her contaminated gloved hands, sliced them with a knife without washing them, and served them to a resident in the dining room.</p> <p>- Cook #21 placed three cooked scrambled eggs into the food processor, touched the blade of the food processor with her bare hands to adjust it, and pureed the eggs. She poured the mixture onto a divided plate. Without washing the food processor, she placed french toast into it and touched the blade with her contaminated hands. She donned a pair of gloves, touched the outside of a bread package and placed slices of bread into a toaster with a pair of tongs. Next, she changed her gloves, obtained a large serving plate, used tongs to put some already cooked sausage patties from a pan on a warming shelf onto the plate, then utilized her contaminated gloved hands to scoop up a large amount of cooked bacon slices onto the large plate beside the sausage patties. She then removed her gloves, went back over to the food processor, reached in and pulled out the blade from the pureed french toast.</p> <p>- The shelf above the warming element, used to store containers of foil, plastic wrap and baggies was dirty with dried food splatters and dust.</p>			

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	<p>- The dishwasher temperature gauge was not functioning and Dietary employee #20 indicated the maintenance staff came in every morning to "check the temperature" of the dishwasher. There was a food temperature log, which had a place to document the dishwasher temperature, which was noted to be blank for several days worth of documentation.</p> <p>- The food surface sanitizer water, tested by Dietary employee #20 was not registering on the test strips she utilized.</p> <p>The following was noted during the noon meal service, conducted on 09/14/15 at 11:45 A.M.:</p> <p>- During an interview with Dietary Employee #20, on 09/14/15 at 12:00 P.M. she indicated all of the testing strips were expired and she did not know if there were any non-expired strips available.</p> <p>- There were two trash cans full of trash with no lids on them and noted to be pushed towards the side door to the kitchen and not in constant use.</p> <p>- Cook #21, placed 5 heaping large spoonfuls of a ham and macaroni and cheese casserole into the food processor and poured an unmeasured amount of hot water into the container and pureed them together. Then, with contaminated gloved hands, she reached into the food processor and removed the blade before</p>			

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	<p>scraping the mixture into divided plates for service.</p> <p>During an interview with the Maintenance supervisor and observation of the dishwasher, on 09/15/15 at 9:00 A.M., he indicated the dishwashing machine was actually a hot water sanitizing machine but the hot water booster had broken so they had changed the machine to a low temperature chemical sanitation machine and had ordered a new machine. The Maintenance supervisor indicated he was utilizing the hot water temperature gauge to "check the dishwasher." When asked how he verified the chemical aspect of the sanitation process he indicated he had no chemical test strips.</p> <p>An interview was conducted on 09/15/15 at 9:45 A.M., with the Maintenance Supervisor and the contracted dishwashing service person. The Maintenance supervisor indicated they were working on the machine. The contracted employee indicated the machine was not testing properly and he had replaced an "injector" and felt the chemical was getting into the machine but the temp on the machine was too "hot" and was "burning" the chemical off and it was not testing at the correct dose.</p>			

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	<p>During an interview, on 09/15/15 at 11:00 A.M., the Administrator indicated the new dishwasher was to be installed on 09/16/15, and the facility would utilized paper products for meal service and wash the pans in the residential kitchen's dishwasher.</p> <p>During an observation of the noon meal service, conducted on 09/16/15 from 11:20 A.M. - 12:40 P.M. the following was noted:</p> <ul style="list-style-type: none"> - Chef #24 donned a pair of gloves, touched the refrigerator door and the outside of a baggie. He then reached into the baggie and retrieved a hot dog with his contaminated gloved hand and placed it on a grill. <p>A current Policy and Procedure - Titled, " Guidelines for Handwashing " , provided by the Administrator on 09/18/15 at 11:00 A.M., included the following: " 3. Health Care Workers shall wash hands at times such as: ...d. After removing gloves ...5. HCW (Health Care Workers) ' s are to only use liquid soap ...8. Wash well for 20 seconds "</p> <p>The following current Policies and Procedures were provided by the Administrator on 09/18/15 at 11:00 A.M.</p>			

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	<p>The " Proper glove use Fact Sheet " included the following: " Wash your hands before putting them on (gloves) and when changing to a fresh pairChange them when necessary. You should change them at the following times: As soon as they become soiled or torn, before beginning a different task, at least every four hours during continual use, after handling raw meat, fish, or poultry and before handling cooked or ready - to - eat food."</p> <p>The " Food Prep Surfaces " included the following procedure: " Dispense sanitizer into red sani-bucket or as per local health department regulations. Per label directions, use Quat test papers to check proper concentration of minimum of 200 ppm [parts per million] at room temperature " " Oven " - procedure " Use eye and hand protection when handling chemicals. Clean weekly or as needed "</p> <p>For use with the " Robot Coupe: " " When handling blade use Blade Blocker Cut resistant glove. "</p> <p>3.1-21(i)(2)</p>			

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F 0425 SS=E Bldg. 00	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observations, interviews and record reviews, the facility failed to ensure physician's orders were transmitted to the pharmacy through their electronic system and failed to ensure the medication label reflected the current physician's order for 1 of 9 resident's reviewed during a Medication Administration Observation. (Resident #19)</p> <p>Finding includes:</p> <p>During a Medication Administration Observation, on 9/17/15 at 8:28 A.M.,</p>	F 0425	<p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: Resident # 19 has been discharged from facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1) All resident have the potential to be effected by the alleged deficient practice;2) All medications have been reviewed to ensure all medications are available and have the proper medication label.What measures will be put into place or what systemic changes will be made</p>	10/21/2015			

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	<p>RN#9 was observed administering bystolic (medication for hypertension) 10 milligrams (mg) and senexon (laxative) 8.6/50 mg orally to Resident #19. The directions on the medication cards indicated both medications were to be given twice a day (BID).</p> <p>On 9/17/15 at 10:15 A.M., a comparison of medication orders and medications observed being administered was conducted. The physician orders, dated 8/11/15, indicated Resident #19 was to receive Senexon 8.6/50 mg once a day. Another physician's order for Resident #19, dated 8/11/15, indicated Resident #19 was to receive bystolic 10 mg once a day.</p> <p>During an interview, on 9/17/15 at 10:25 A.M., RN #9 indicated her electronic Medication Administration Record (MAR) was correct and Resident #19 was receiving both medications once a day.</p> <p>During an interview, on 9/17/15 at 11:45 A.M., the Director of Nursing (DON) indicated the orders were sent electronically as the transmission status stated "Change Order ePrescription." She could not explain why the medication cards indicated the resident was to have received the medications BID.</p>		<p>to ensure the deficient practice does not recur: Nurses re-inserviced by DHS / designee on using direction change stickers for medication cards/bottles when orders change;How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: 1) DHS and/or designee will perform random audit of orders 5 orders per week for 4 weeks then monthly times 5 months to ensure medication label matches medication order; 2) DHS and/or designee will perform random audit of order sources for 5 orders per week for 4 weeks then monthly times 5 months to ensure proper order transmission to pharmacy; 3) The results of the audit and / or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% complinace is achieved; then randomly thereafter for further recommendations.Completion Date: October 21,2015</p>				

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	<p>On 9/17/15 at 2:35 P.M., a telephone interview was conducted with the DON and the Pharmacy Manager. The Pharmacy Manager indicated the orders were not received and therefore the medication cards still indicated Resident #19 should receive the medications BID. The DON indicated the MAR was correct and Resident #19 was receiving the medications once a day as ordered. The Pharmacy Manager indicated the MAR was changed with the electronic system when the nurse put the order in, however the physician must be set up in the system's data base for the new order to be received by the pharmacy and the medication card directions for use to be changed. The Pharmacy Manager further indicated the electronic order indicated the "order source was written" and pharmacy was expecting a written order. The Pharmacy Manager indicated with the electronic system, the pharmacy did not print the monthly medication lists, however the facility was instructed to print one monthly and review it for accuracy just as they had done with the paper MAR's. The DON indicated the monthly reviews were conducted by two nurses and was compared to the orders received to make sure the MAR was correct.</p>			

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F 0514 SS=B Bldg. 00	<p>On 9/17/15 at 2:45 P.M., the DON provided a policy titled "Guidelines for Telephone Orders," dated 6/15/15, and indicated the policy was the one currently used by the facility. The policy indicated "...The entry shall contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. (Electronic system will automatically date/time and add signature of the entry person.)..."</p> <p>3.1-25(j)(5)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record reviews and interview the facility failed to have the physician's orders signed and dated, by the physician,</p>	F 0514	What corrective action will be accomplished for those residents found to have been affected by the	10/21/2015			

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	<p>for 5 of 9 residents reviewed for the medication pass. (Resident #19, #33, #36, #49 and #91)</p> <p>Finding includes:</p> <p>A Physician's Order Report for July and August of 2015, indicated the physician had not reviewed and approved the orders for Resident #19. The physicians' signature and date space was left blank.</p> <p>A Physician's Order Report for July, August and September of 2015, indicated the physician had not reviewed and approved the orders for Resident #33. The physician's signature and date space was left blank.</p> <p>A Physician's Order Report for June, July, August and September of 2015, indicated the physician had not reviewed and approved the orders for Resident #36. The physician's signature and date space was left blank.</p> <p>A Physician's Order Report for June and August of 2015, indicated the physician had not reviewed and approved the orders for Resident # 91. The physician's signature and date space was left blank.</p> <p>A Physician's Order Report, dated 6/28/2015 - 7/28/2015, indicated the</p>		<p>deficient practice?</p> <p>All residents monthly physician order summaries (June-Sept 2015) have been reviewed and "lookback" order with signature obtained from attending physicians.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents residing at the campus have the potential to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>1) All attending physicians and NP have been entered into Matrix, educated by the DHS/designee in how to remotely sign orders, and timeline for required review and signature;</p> <p>2) Non Attending (consulting) physicians will be educated by 10/21/15 by the DHS/designee and required to provide order review and signature within guideline timeframe.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur?</p>	

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F 9999 Bldg. 00	<p>physician had not reviewed and approved the orders for Resident #49</p> <p>During an interview, on 9/17/15 at 3:04 P.M., the Director of Nursing (DON) indicated the physician had not signed monthly medication reviews (also call Physician Order Report) for resident #19, #33, #36, #91 and #49.</p> <p>3.1-50(a)(1)</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>(g) The Administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by</p>	F 9999	<p>1) DHS and/or designee will perform random audit of 5 resident's orders per week for 4 weeks then monthly times 5 months to ensure timeliness of physician review and signature;</p> <p>2) The results of the audit and / or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations.</p> <p>Completion Date: October 21,2015</p> <p>F-9999 – Reportables What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #42 had been discharged from facility prior to survey; How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents residing at the campus have the potential to</p>	10/21/2015

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	<p>telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including but not limited to, any: (D) major accidents.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to report to the Indiana State Department of Health (ISDH), a bruise of unknown origin, per the facility's policy. This affected 1 of 6 residents reviewed for unnecessary medication use. (Resident #42)</p> <p>Finding includes:</p> <p>On 9/17/15 at 2:52 P.M., a review of the clinical record for Resident #42 was conducted. The record indicated the resident was admitted on 5/1/15. The resident's diagnoses included, but were not limited to: chronic airway obstruction, hypertension, atrial fibrillation, morbid obesity and congestive heart failure.</p> <p>A care plan, dated 5/5/15, indicated the resident had a care plan for using a blood thinner (coumadin) related to atrial fibrillation and cardiomyopathy.</p>		<p>be affected by the alleged practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1) The DHS and Administrator were provided inservice by clinical support staff on guidelines for reportables including appropriate timeframes fro reporting. 2) An inservice education program was conducted by the Director of Health Services and the Administrator with direct care staff addressing circumstances that require reporting including appropriate timeframes. How the corrective action will be monitored to ensure the deficient practice will not recur? 1) The DHS and/or designee will conduct a random audit of 5 residents , residents will be assessed and interviewed, to ensure that any injuries are identified, properly investigated and reported, weekly for 4 weeks then monthly times 5 months to ensure reporting of incidents in the appropriate time frame; 2) Results of audits will be reported by the DHS/designee to the campus Quality Assurance Committee for 6 months or until 100% compliance is achieved; and randomly thereafter for further recommendations. Completion Date: October 21,2015 F-9999 – TB Screening What corrective action will be accomplished for</p>	

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	<p>Interventions to the plan included, but were not limited to: monitor lab work per my physician's order, administer blood thinner/anticoagulants as per current physician order, monitor for abnormal bruising and review medication list quarterly for medications which may affect blood levels.</p> <p>A Resident Coag (Coagulation) Testing Record form, dated 5/4/15, indicated "2.4" under results column. The form did not explain what the 2.4 represented. The physician orders column indicated "...therapeutic re check in 1 month...."</p> <p>A Physician's Order, dated 5/4/15, indicated "...continue current coumadin [a blood thinner] 10 mg [milligrams] po [orally] every Monday and Coumadin 7.5 mg po all other days...Recheck in 1 month due 6/8/15...."</p> <p>A Skin Integrity Event form, dated 6/4/15 at 8:43 A.M., indicated the resident had a bruise measuring 18 cm (centimeters) by 8 cm. on her right inner wrist. The form further indicated the bruise was painful as voiced by the resident. The root cause determined was "...possibly hit on bed rail res [resident] on coumadin...." The form indicated the physician and family was notified of the bruise.</p>		<p>those residents found to have been affected by the alleged deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? 1) All residents residing at the campus have the potential to be affected by the alleged deficient practice. 2) All new employees have been reviewed to ensure TB testing was completed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1) New Hire TB Process reviewed / revised to provide for and monitor compliance with new hire TB testing. This process added to new hire checklist as well for follow up; 2) AP/Payroll clerk inserviced by Exective Director on revised process. How the corrective action will be monitored to ensure the deficient practice will not recur. ED will review all new hire paperwork checklist/TB testing prior to new employees being added to facility schedules weekly for 4 weeks; then monthly x 5 months to ensure TB testings are completed in the appropriate time frame and will report findings to QAA Committee for 6 months or until 100% compliance is</p>				

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	<p>During an interview, on 9/18/15 at 9:24 A.M., the DON indicated the bruise was not reported to the State Department of Health.</p> <p>On 9/18/15 at 11:15 A.M., the DON provided a policy titled, "Reportable Event Procedural Guidelines," dated 11/2010, and indicated the policy was the one currently used by the facility. The policy indicated "...Occurrences to be reported include..."Large lacerations or contusions (of unknown origin or requires hospitalization <23 hrs.)..."</p> <p>3.1-13(g)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment, The examination shall include for each employee a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradurmal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom</p>		<p>achieved. Completion Date: October 21,2015</p>		

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	<p>administered. The tuberculin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within (1) month prior to employment, and a least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure 3 of 5 employees reviewed received a Tuberculin skin test (PPD) prior to working at the facility. (Employee #1, #2 and #3).</p> <p>Findings include:</p> <p>An employee record review was conducted on 9/16/2015 at 2:00 P.M. and indicated the following:</p>			

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	<p>Employee #1's hire date was 8/5/2015 and the employee did not receive a PPD until 9/16/2015.</p> <p>Employee #2's hire date was 8/18/2015 and the employee did not receive a PPD until 09/15/2015.</p> <p>Employee #3's hire date was 8/18/2015 and the employee did not receive a PPD until 09/19/2015.</p> <p>During an interview, on 09/16/2015 at 2:00 P.M., the Corporate Nurse indicated there were no other PPD (Tuberculin Test) records available for the three employees.</p> <p>On 09/16/2015 at 3:45 P.m., the Corporate Nurse provided the a policy titled "Guidelines for TB [Tuberculin] Results Summary Documentation: Staff," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Upon hire each employee shall receive a Two Step Mantoux PPD test to ensure they are free of tuberculosis...."</p> <p>3.1-14(t)(1)</p>			

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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 28 Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>			R 0000	<p>R 000</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on September 21, 2015. Please accept this Plan of Correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>		
R 0268 Bldg. 00	<p>410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. Based on observation and interview the</p>			R 0268	<p>What corrective actions will be</p>		10/21/2015

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	<p>facility failed to ensure that only residents who had physicians orders for fortified diets, received them. This had the potential to affect 27 of 28 residents who consumed food from the residential kitchen.</p> <p>Finding includes:</p> <p>On 09/17/2015 at 11:30 A.M., observation of the noon meal indicated the mashed potatoes to be served to all residents were fortified.</p> <p>During an interview, on 09/17/2015 at 11:30 A.M., the FSS (Food Service Supervisor) indicated the fortified mashed potatoes were to be served to all the residents who eat from the facility kitchen. He further indicated that only one resident had a physician order to receive fortified foods.</p> <p>On 09/18/2015 at 11:00 A.M., the Administrator provided the dining services policy titled "Fortified Foods Guideline" and indicated the policy was the one currently used by the facility. The policy indicated "...The supplement program will continue to be implemented with a physician approved diet order and will be served at each meal. The diet order will be communicated to Dining Services in the diet order communication</p>		<p>accomplished for residents found to have been affected by the deficient practice: The resident in question is now being offered options for fortified foods per facility policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1) All residents have the potential to be affected by this alleged deficient practice. 2) All residents have been reviewed to ensure they are receiving the proper diet. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1) New spreadsheets, recipes and menus implemented on 9/21/15 2) Dining Services Support to provide education on fortified foods, spreadsheets and therapeutic diets on 10/12/15 3) Fortified Food Best Practice updated/revised 10/6/2015. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: 1) DFS and/or designee will review 5 meals weekly for proper use of spreadsheets, provision of therapeutic diets and fortified foods, x 4 weeks then monthly x 5 months to ensure compliance 2) The results of the audit and or observations will be reported,</p>	

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R 0273 Bldg. 00	<p>form. Weight and food intake will be monitored by the Clinical Nutrition Support (CNS) team to assess program effectiveness. The intake of the fortified food items is not included in the MAR [Medication Administration Record] as it is a diet order. Fortified Food is not a separate diet listing on the menu as the Fortified Food item can vary with each resident at each meal...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food was stored, prepared and served in a sanitary manner in 1 of 1 Residential kitchens. This related uncovered and undated foods, soiled equipment, storage of clean equipment and serving food. This had the potential to affect 28 of 28 residents who consumed food from the residential kitchen.</p> <p>Findings include: During a kitchen tour on 09/17/2015 at 11:20 A.M., the following was observed:</p>	R 0273	<p>reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations. Completion Date: October 21, 2015</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: No residents were directly affected, however all items have been addressed and cleaned How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1. Dining</p>	10/21/2015

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	<p>Uncovered waffles were located in a small refrigerator and were undated. A metal pan, uncovered which contained french fries and chicken tenders was located in the freezer.</p> <p>Food particles and a bread tie were observed to be covering the surface of the salad chilling/serving bar.</p> <p>Several cutting boards were stored on an unclean shelf which was visibly soiled with food debris</p> <p>Four of 12 large pans, stacked together were put away wet.</p> <p>Three of 6 hood vents, located above the stove top and open grill were heavily soiled with a thick brown substance.</p> <p>The emergency foam dispensers, located above the stove top, griddle, and grill had a thick brown substance on them.</p> <p>The open grill, which had food on it, had a heavy accumulation of a thick brown and black colored substance.</p> <p>The inside of the oven had several black and brown, raised splatters on the walls and bottom of the oven.</p> <p>A large square, open, uncovered</p>		<p>Services Support to provide education on 10/12/15 related to the following: a. Handwashing/glove useage b. Cleaning list c. Proper storage of plates d. Temp log e. Using test strips f. Proper use of roto coupe</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: . 1) DFS and/or designee will audit sanitation 3 times weekly x 4 weeks; then monthly x 5 months to ensure compliance; 2) DFS and/or designee will audit cleaning list that includes all items identified on R273 three times weekly , x 4 weeks then monthly x 5 months to ensure compliance; 3) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved; then randomly thereafter for further recommendations.</p> <p>Completion Date: October 21, 2015</p>	

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	<p>container, located on the floor under the grill contained a thick brown and black liquid. The FSS identified the liquid as "grease."</p> <p>Clean cooking pans and skillets were observed hanging on a pot/pan ceiling rack. The height of the pans were just above a 2 compartment sink where pans were noted to be soaking. There were beige colored splatters noted all over the wall behind the clean pans.</p> <p>Employee # 4 donned gloves and touching the plastic packaging, opened a bag of chicken tenders. She then reached into the bag and grabbed out some of the chicken tenders with her contaminated gloved hand.</p> <p>Employee #5 was observed to put unopened packets of butter on dishes of food. She then served the food dishes to residents.</p> <p>On 09/18/2015 at 11:00 A.M., the Administrator provided the current dining services policy titled "Assisted Living Guidelines Dining Services" and indicated the policy was the one currently used by the facility. The policy indicated "...12. The campus shall ensure food is procured, stored, prepared and distributed in a manner that protects it against</p>			

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	contamination and spoilage" On 09/18/2015 at 11:00 A.M., the Administrator provided the current dining services policy titled "Leftover Food Storage" and indicated the policy was the one currently used by the facility. The policy indicated "...2. Date all food and use or discard within three days..."				