

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2015
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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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F 000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: March 2, 3, 4, and 5, 2015</p> <p>Facility number: 000368 Provider number: 15E187 AIM number: 100275220</p> <p>Survey team: Lara Richards, RN-TC Janet Adams, RN Janelyn Kulik, RN (3/2-3/3/15) Caitlyn Doyle, RN (3/4-3/5/15)</p> <p>Census bed type: NF: 21 Total: 21</p> <p>Census payor type: Medicaid: 20 Other: 1 Total: 21</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on March 13, 2015, by Brenda Meredith RN.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 221 SS=D Bldg. 00	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was free from physical restraints for 1 of 3 residents reviewed for restraints of the 6 who met the criteria for restraints related to a resident being placed in a geri chair (reclining chair on wheels) without a medical diagnosis and reassessing the resident after he attempted to get up from his geri chair with a lap tray. (Resident #19)</p> <p>Finding includes:</p> <p>On 3/2/15 at 2:56 p.m., Resident #19 was observed in the dining room sitting in a geri chair with a lap tray in place.</p> <p>On 3/3/15 at 7:15 a.m., the resident was observed in bed. His head was on the pillow and his legs were hanging off the right side of the bed. At this time, CNA #2 indicated the resident was not in his</p>	F 221	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Resident #19 restraint assessment was updated when geri-chair with tray was implemented and the physical therapist has reassessed the resident several times to find an appropriate chair to keep him properly positioned. Resident # 19 has a diagnosis of Huntington's Chorea which is causing deterioration in residents muscular and motor coordination. The physical therapist had recommended pillows, cushions, dycem and tray to help maintain his position because he was no longer able to sit in a wheelchair without sliding forward. D.O.N. reviewed course of treatment and statement that resident had previously got out of the geri-chair with lap tray with physical therapist. Physical therapist stated that he had instructed the C.N.A. staff to</p>	04/04/2015

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	<p>bed. She indicated he gets up and walks and lays down.</p> <p>On 3/3/15 at 8:08 a.m., Resident #19 was observed in his geri chair with no lap tray. CNA #1 put a gait belt on the resident and stood him up and walked the resident out of the dining room. CNA #1 was only holding the gait belt.</p> <p>On 3/3/15 at 10:51 a.m., Resident #19 was observed in the dining room, sitting in the geri chair asleep. The chair was in the upright position. The resident's left arm was hanging over the side of the chair with his hand dangling toward the floor. His feet were hanging down not touching the floor. There was a pillow wedged into the right side of the chair. There was a lap tray attached to the geri chair. The resident woke up and grabbed the lap tray with his left hand. He then leaned to the left with his left hand hanging over the side of the chair and his head was leaning to the left and was not resting on the back of the chair.</p> <p>On 3/3/15 at 11:13 a.m., Resident #19 was observed in the dining room sleeping in his geri chair with the lap tray in place. The chair was slightly reclined, the resident was leaning to the left with his head laying on the left arm rest. At 11:59 a.m., the resident was observed in the</p>		<p>position him in the upright position because when he reclines he can maneuver through opening of between his body and the tray top. On 3/3/15 Physical therapist reassessed the resident again and placed 2 cushions in his geri-chair with the tray and positioning pillows on bilateral sides. On 3/4/15 resident had scooted his body where he had moved the chair cushions up to his back and was attempting to try and come out of the geri-tray so at that point the tray was discontinued. Resident #19 restraint assessment was updated to geri-chair without tray and monitored by nursing staff.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents in geri-chairs and specialized wheelchairs for proper positioning were reassessed by Physical Therapist. Restraint Assessments were reviewed by the D.O.N.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Staff was in-serviced on proper</p>				

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	dining room in a geri chair slightly reclined with the lap tray in place. The resident's legs were pulled up under the lap tray. The resident was sleeping and his head was laying on the right arm rest of the chair. At 12:59 p.m., the resident was observed in the dining room. He was moving his arms and legs. The lap tray was removed from the geri chair at this time and he was moved to an upright position. CNA #1 was assisting him with eating. At 1:13 p.m., CNA #1 put the lap try back on the geri chair and reclined the geri chair. The CNA left the dining room. At 1:20 p.m., the resident was moving his arms and legs. He pulled his leg up to his cheek under the lap tray. He then put his legs over the lap tray, turned in the geri chair until he had both of his legs over the right arms of the chair. At this time, his back was against the left arm of the chair. Staff arrived and removed the lap tray and repositioned the resident. The resident was then transported to his room in the geri chair. CNA #1 positioned the geri chair in an upright position and had the resident stand. She then walked the resident to the bathroom. She returned the resident to the geri chair and put the lap tray back on. Interview with CNA #1 at this time, indicated there was no set schedule for Resident #19 to go walking it was just when he wanted to walk. Sometimes he		positioning and the importance of reporting resident's response to changes in plan of care and reported during 24 hour report. Charge Nurse will continue to monitor wheelchair, geri-chair, chair cushion and restraint use on daily monitoring log for each shift. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Charge Nurse is responsible for monitoring proper positioning and proper restraint use. This is monitored 12A, 3A, 5A, 8A, 11A, 2P, 4P, 6P, 9P daily by the charge nurse during nurse rounds and recorded on the log sheet. D.O.N. will monitor round sheets bi-weekly for 1 month then monthly thereafter ongoing. Q.A. Committee will meet and monitor logs and determine if further monitoring is needed and discuss any concerns about restraint use.	

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	<p>would walk to the dining room for meals. She further indicated this was not the first time he had gotten out from under the lap tray.</p> <p>On 3/4/15 at 10:05 a.m., Resident #19 was observed sitting in his geri chair with the lap tray in place by the window in his room. There were no staff present. The geri chair was reclined and the door to the room was open about one foot. At 10:18 a.m., the resident was observed sitting on the side of his roommate's bed. There were no other residents in the room and no staff was present in the room. The geri chair was in the same spot it was at 10:05 a.m. and the lap tray was secured to the geri chair. Interview with CNA #1 at this time, indicated the last time she saw the resident he was in his geri chair with the lap tray in place.</p> <p>The record for Resident #19 was reviewed on 3/3/15 at 10:58 a.m. The resident's diagnoses included, but were not limited to, Huntington's Chorea, agitation with aggressive behaviors, anxiety and muscle spasm.</p> <p>The Physician's Order Statement (POS) for 3/2015, indicated the resident may have a tray on the geri chair for poor trunk control. This order was initiated on 2/11/15.</p>			

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	<p>A Physician's order, dated 2/3/15, indicated regular recliner chair while up to prevent falls.</p> <p>The Nursing progress notes, from 12/24/14 to 3/3/15, indicated the resident had no falls nor indications of positioning problems.</p> <p>A Nursing progress note, dated 1/5/15 at 6:10 a.m., indicated the resident was seen pacing in the hallway throughout the night and he required multiple redirection. The resident's gait was unsteady.</p> <p>The care plan for Resident #19 indicated the resident used a physical restraint (tray on geri chair) related to wandering into other resident's rooms. This care plan was initiated on 2/11/15. The interventions included to ensure the resident was positioned correctly with proper body alignment while restrained. A care plan for the resident which indicated he had a geri chair related to poor trunk control was initiated on 2/11/15. The intervention was for staff to assist resident with ambulation.</p> <p>A restraint assessment, dated 2/11/15, indicated the reason for the restraint was unsteady gait and agitated behavior. The</p>			

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	<p>resident had an increased risk of sliding related to progressive degenerative medical condition that facilitated an increase in involuntary muscle movement. The resident was unable to maintain a position for more than 30 seconds unless he was asleep. Alternative attempts were 1:1 observations, recliner, 1:1 activities, directed/supervised ambulation, regular toileting, and anticipating hunger, pain, hot and cold. The decision to restrain was from the Physician and the resident could have a tray on the geri chair for poor trunk control to maintain positioning due to spastic muscular movement.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 2/1/15, indicated the resident could be understood and understands. He was an extensive assist with one person physical assist for walking. He had no limitations to range of motion.</p> <p>Further review of the resident's record indicated there was no therapy assessment of the resident related to positioning.</p> <p>A fall assessment, completed on 2/1/15, indicated a score of 75. This score indicated the resident was high risk for</p>			

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	<p>falls.</p> <p>The current policy for Restraint Devices, Physical was provided by the Director of Nursing (DON) on 3/3/15 at 3:10 p.m. The policy indicated the purpose was: "To restrict movement to protect the resident during treatment and diagnostic procedures. To prevent the resident from injuring himself or others. Restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff. To improve the resident's mobility and independent function. To treat resident's medical symptoms."</p> <p>Interview with CNA #2 on 3/3/15 at 1:57 p.m., indicated she had never seen the resident bring his legs up over the lap tray but he does slide down. She indicated he should not be left alone when he was in the geri chair with the lap tray.</p> <p>Interview with the Social Service Designee on 3/3/15 at 12:10 p.m., indicated the resident was unable to control his posture when sitting in a wheel chair. Sliding devices had been tried but were ineffective. He was evaluated by PT (Physical Therapy) for the recliner.</p>						

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F 241 SS=E Bldg. 00	<p>Interview with the DON on 3/3/15 at 2:15 p.m., indicated she was not aware of the resident getting out of the restraint. If he had, then he should have been re-evaluated. She provided a dietary consult for the resident but no therapy consult. Further interview at 3:30 p.m., indicated therapy had been back into the facility and re-evaluated the resident. Therapy made adjustments to the resident's recliner and lap tray.</p> <p>Interview with the DON on 3/4/15 at 3:00 p.m., indicated therapy had been called to re-evaluate the resident. The facility would not be using the lap tray at this time and the physician had made medication changes.</p> <p>3.1-3(w)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and</p>	F 241	1. Describe what the facility did	04/04/2015

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	<p>interview, the facility failed to ensure each resident's dignity was maintained related to standing and assisting residents with their meals as well as having residents who could have nothing by mouth in the dining room at meal times for 5 of 5 meals observed. (Residents #3, #8, #9, and #19)</p> <p>Findings include:</p> <p>1. On 3/2/15 at 9:05 a.m., the breakfast meal was observed in the Main dining room. Resident #19 was seated in a geri chair recliner and in view of the residents eating around him. At 9:30 a.m., the resident had not received a breakfast tray. At 9:40 a.m., staff started cleaning off the tables. The resident still had not received a breakfast tray. At 9:45 a.m., the resident still had not received a breakfast tray.</p> <p>When interviewed on 3/2/15 at 9:50 a.m., the Social Service Designee, indicated the resident was NPO (received nothing by mouth) and had a feeding tube.</p> <p>On 3/4/15 at 8:42 a.m., the resident was observed in the dining room seated in his geri chair with a tray table in place. Breakfast trays were being served and other residents were eating around him. At 9:07 a.m., the resident became</p>		<p>to correct the deficient practice for each client cited in the deficiency. D.O.N. met with thenursing staff and informed them to remove all residents not able to eat duringmeal times. D.O.N. also informed C.N.A.who had fed the residents over the feeding table to positon the residentsproperly in the upright position and feed them sitting down. If the C.N.A. feels she cannot reach farenough to feed residents in the sitting position then she should move her seatand position herself next to the resident and feed each resident properly.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No other residents affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-Service held on Feeding Policy with all nursingstaff and do not stand while feeding residents was added to the policy. PROCEDURE 1. Taketray to resident. 2. Placetray directly in front of resident. 3. Assistresident to proper sitting</p>				

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	<p>restless. LPN #1 approached the resident and asked him what was wrong. The resident indicated, "hungry" and "eat." The LPN left the dining room at this time. At 9:50 a.m., the resident was taken out of the dining room. The resident did not receive any food or drink prior to leaving the dining room.</p> <p>The record for Resident #19 was reviewed on 3/5/15 at 10:25 a.m. A Physician's order, dated 3/2/15, indicated the resident was to have a pureed pleasure feed, 4 ounces twice a day at lunch and dinner.</p> <p>When interviewed on 3/5/15 at 11:50 a.m., the Director of Nursing indicated the resident should not have been in the dining room when meals were being served.</p> <p>2. On 3/2/15, at 9:05 a.m., the breakfast meal was observed in the Main dining room. Resident #3 was seated in a chair and in view of the residents eating around her. At 9:30 a.m., the resident had not received a breakfast tray. At 9:40 a.m., staff started cleaning off the tables. The resident still had not received a breakfast tray. At 9:45 a.m., the resident still had not received a breakfast tray.</p> <p>When interviewed on 3/2/15 at 9:50 a.m.,</p>		<p>position unless contraindicated.</p> <p>4. Protectresident's gown and bed with napkin. 5. If the resident cannot see the tray, tellhim/her the position of each item on the tray. 6. Cut or divide food into small portions andgive resident a small amount at a time. Do not force the resident to eat.Select foods according to resident's appetite and preference. 7. Donot discuss unpleasant subjects while the resident is eating. 8. Never make the resident feel that the mealmust be hurried, but that the procedure is pleasant. Give him/her your completeattention. Sit so you are at the same level as the resident when possible. NEVER STAND AND FEED RESIDENT</p> <p>9. Hold the glass in one hand and the straw inthe other when serving liquids with a straw. 10. Give liquids slowly. Be sure liquid is nottoo hot. Test temperature by feeling container or dropping small amount on yourinner wrist. 11. Alternatesolid food and liquid. 12. Washresident's hands and face after meals. 13. Removetray. 14. Leave resident in a comfortable positionwith call light and water in reach.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Charge Nurse will monitorproper feeding technique during</p>				

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	<p>the Social Service Designee indicated the resident was NPO (received nothing by mouth) and had a feeding tube.</p> <p>At 12:55 p.m., on 3/2/15, the resident was observed in the dining room. Lunch was being served at this time and the other residents were eating in front of the resident.</p> <p>On 3/3/15 at 9:00 a.m. and 12:27 p.m., the resident was in the dining room while the breakfast and lunch meals were being served. The resident was in view of the residents eating around her.</p> <p>On 3/4/15 at 8:42 a.m., the resident was again in the dining room while breakfast was being served.</p> <p>The record for Resident #3 was reviewed on 3/4/15 at 9:14 a.m. The resident's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), peptic ulcer disease and gastritis.</p> <p>The 2/7/15 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was severely impaired for daily decision making.</p> <p>When interviewed on 3/5/15 at 11:50 a.m., the Director of Nursing indicated the resident should not have been in the</p>		<p>mealtimes. EatingSupport U = Unsatisfactory. S = Satisfactory. Steps of Procedure Date: _____ Date: _____</p> <ol style="list-style-type: none"> 1. Taketray to resident..... U / S 2. Ifdentures are worn, make sure they are in place..... U / S 3. Placetray directly in front of resident..... U / S U / S 4. Assist resident toproper sitting position unless contraindicated..... U / S U / S 5. Protectresident's gown and bed with napkin..... U / S U / S 6. Ifthe resident cannot see the tray, tell him/her the position..... U / S U / S of each item on the tray. (Referring to face of a clock, meat is at 9 o'clock, peas are at 3 o'clock). 7. Cutor divide food into small portions and give resident a U / S U / S small amount at a time. Do not force the resident to eat. Select foods according to resident's appetite and preference. 8. Do not discuss unpleasantsubjects while the resident is eating..... U / S U / S 9. Nevermake the resident feel 	

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	<p>dining room when meals were being served.</p> <p>3. The breakfast meal was observed on 3/2/15 at 9:05 a.m. Resident #8 was seated in a geri chair at a table in the Dining Room. The resident was served her breakfast tray at 9:24 a.m. CNA # 2 was seated behind the table and began feeding the resident. The CNA was observed standing up from her chair and reaching over the table to feed the resident several times during the breakfast meal.</p> <p>On 3/3/15 at 8:36 a.m., Residents #8 and #9 were observed sitting at a table in the Dining Room. CNA #2 was observed seated behind the table feeding the residents. The CNA stood up and reached over the table several times to assist both residents with their food and beverages.</p> <p>The record for Resident #8 was reviewed on 3/5/15 at 8:00 a.m. The resident's diagnoses included, but were not limited to, arthritis, cataracts, dementia, depression, and anorexia.</p> <p>The 1/7/15 Quarterly Minimum Data Set (MDS) assessment, indicated the resident's cognitive skills for decision making were severely impaired. The</p>		<p>that the meal must be hurried,..... U / S U / S but that the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible.</p> <p>10.Hold the glass in one hand and the straw in the other when..... U / S U / S serving liquids with a straw.</p> <p>11.Give liquids slowly. Be sure liquid is not too hot. Test U / S U / S temperature by feeling container or dropping small amount on your inner wrist.</p> <p>12.Alternate solid food and liquid..... U / S U / S</p> <p>13.Wash resident's hands and face after meals..... U / S U / S</p> <p>14.Remove tray..... U / S U / S</p> <p>15.Leave resident in a comfortable position with U / S U / S Call light and water in reach.-</p> <p>16.Document procedure in medical record..... U / S U / S</p> <p>17.Staff is properly positioned during feeding..... U / S U / S</p> <p>COMMENTS: _____</p>	

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F 272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS 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;</p>		Currently we have 1resident NPO who will remain in their room during mealtime. The other resident can have 2 pleasurefeedings of 4oz. of food and 4oz. thickened liquids two times per day. This resident will remain by the nursesstation when NPO for the meal and will be brought into the dining room when he hispleasure feeding is ready for his food consumption.	

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	<p>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 observation, record review and interview, the facility failed to ensure ongoing restraint assessments were completed for 1 of 3 residents reviewed for restraints of the 6 residents who met the criteria for restraints. (Resident #1)</p> <p>Finding includes:</p> <p>On 3/3/15 at 8:23 a.m., Resident #1 was observed sitting in his wheel chair. A seat belt was fastened around the resident's waist area.</p> <p>On 3/4/15 at 7:35 a.m., the resident was seated in his wheel chair in his room. CNA #3 was in the room at this time. The CNA buckled the residents seat belt at this time and then took the resident out of the room.</p> <p>On 3/5/15 at 8:00 a.m., the resident was observed sitting in his wheel chair in the Dining Room. The resident's seat belt was in place.</p> <p>On 3/5/15 at 9:12 a.m., the resident was</p>	F 272	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Restraint of Resident #1 was completed. Resident #1 is in need of his specialized wheelchair which has a seat belt attached to the side of the chair and due to his diagnosis of Cerebral Palsy, Down's Syndrome, Mental Retardation and Osteoporosis. The diagnosis of this resident contributes to his inability to maintain a safe and proper positioning without the use of his specialized wheelchair with seat belt. The restraint is used more for positioning but because of it having a seat belt it is also considered a restraint.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents requiring restraints were assessed by the Physical Therapist and no other seat belts are used in the facility except for Resident #1. MDS was reviewed</p>	04/04/2015

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	<p>observed sitting in his wheel chair in his room. The resident's seat belt was in place. CNA #3 was present in the room at this time. The CNA indicated the resident wore the seat belt "just about all the time."</p> <p>The record for Resident #1 was reviewed on 3/4/15 at 1:20 p.m. The resident's diagnoses included, but were not limited to, Cerebral Palsy, Down's Syndrome, mental retardation, and osteoporosis.</p> <p>The 1/9/15 Minimum Data Set (MDS) quarterly assessment, indicated the resident's cognitive skills were severely impaired. The assessment also indicated the resident was dependent on staff for bed mobility, transfers, dressing, and personal hygiene. The assessment also indicated a trunk restraint and a chair that prevented rising were both used daily.</p> <p>There were no Physical Restraint assessments completed in 2014 or 2015.</p> <p>When interviewed on 3/4/15 at 7:50 a.m., RN #1 indicated the resident required total staff assistance for ADL's (Activities of Daily Living). The RN also indicated the resident's seat belt was to be in place when he was in the wheel chair.</p>		<p>and even though it is used more to help positioning it is also arestraint since the resident cannot remove the device. All residents with use of geri-chairs, withor without tray and specialty chairs with seatbelts were reviewed.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>Staff was in-serviced onproper positioning and the importance of reporting resident's response tochanges in plan of care and reported during 24 hour report. ChargeNurse will continue to monitor wheelchair, geri-chair, chair cushion andrestraint use on daily monitoring log for each shift.</p> <p>MDS wasreviewed and even though it is used more to help positioning it is also arestraint since the resident cannot remove the device. All residents with use of geri-chairs, withor without tray and specialty chairs with seatbelts were reviewed.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Charge Nurse is responsible for monitoring proper positioningand proper restraint use. This is monitored12A, 3A, 5A, 8A,</p>				

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F 282 SS=D Bldg. 00	<p>When interviewed on 3/4/15 at 2:04 p.m., the Director of Nursing indicated the resident had a specialty wheel chair and the seat belt had been on the wheel chair since the resident was admitted to the facility. The Director of Nursing indicated the seat belt was used for the resident's safety.</p> <p>When interviewed on 3/5/15 at 9:45 a.m., the Director of Nursing indicated there were no current restraint assessments for Resident #1. The Director of Nursing indicated the seat belt was coded as a trunk restraint on the MDS and ongoing Physical Restraint assessments should have been completed.</p> <p>3.1-31(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. Based on observation, record review and interview, the facility failed to ensure Physician orders and the plan of care were followed for 1 of 3 residents</p>	F 282	<p>11A,2P, 4P, 6P, 9P daily by the charge nurse during nurse rounds and recorded on the log sheet. D.O.N. will monitor round sheets bi-weekly for 1 monthly then monthly thereafter ongoing. MDS will be monitored by D.O.N. upon admission, quarterly and upon changes. Q.A. Committee will meet and monitor logs and MDS of residents with restraint and determine if further monitoring is needed and discuss any concerns about restraint use.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #19</p>	04/04/2015			

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	<p>reviewed for restraints of the 6 who met the criteria for restraints related to the position of the resident with a restraint. (Resident #19)</p> <p>Finding includes:</p> <p>On 3/3/15 at 7:15 a.m., Resident #19 was observed in bed. His head was on the pillow and his legs were hanging off of the right side of the bed. At this time, CNA #2 indicated the resident was not in his bed. She indicated he gets up and walks and then lays down.</p> <p>On 3/3/15 at 8:08 a.m., Resident #19 was observed in his geri chair with no lap tray. CNA #1 put a gait belt on the resident and stood him up and walked the resident out of the dining room. CNA #1 was only holding the gait belt.</p> <p>On 3/3/15 at 10:51 a.m., Resident #19 was observed in the dining room, sitting in a geri chair asleep. The chair was in the upright position. The resident's left arm was hanging over the side of the chair with his hand dangling toward the floor. His feet were hanging down not touching the floor. There was a pillow wedged into the right side of the chair. There was a lap tray attached to the geri chair. The resident woke up and grabbed the lap tray with his left hand. He then</p>		<p>restraintassessment was updated when geri-chair with tray was implemented and thephysical therapist has reassessed the resident several times to find anappropriate chair to keep him properly positioned. Resident # 19 has a diagnosis ofHuntington's Chorea which is causing deterioration in residents muscular andmotor coordination. The physicaltherapist had recommended pillows, cushions, dycem and tray to help maintainhis position because he was no longer able to sit in a wheelchair withoutsliding forward. D.O.N. reviewed course oftreatment and statement that resident had previously got out of the geri-chairwith lap tray with physical therapist. Physical therapist stated that he had instructed the C.N.A. staff toposition him in the upright position because when he reclines he can maneuverthrough opening of between his body and the tray top. On 3/3/15 Physical therapist reassessed theresident again and placed 2 cushions in his geri-chair with the tray andpositioning pillows on bilateral sides. On 3/4/15 resident had scooted his body where he had moved the chaircushions up to his back and was attempting to try and come out of the geri-trayso at that point the tray was discontinued. Resident #19 restraint assessment was updated to geri-chair without</p>		

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	<p>leaned to the left with his left hand hanging over the side of the chair and his head was leaning to the left and was not resting on the back of the chair.</p> <p>On 3/3/15 at 11:13 a.m., Resident #19 was observed in the dining room sleeping in his geri chair with the lap tray in place. The chair was slightly reclined, the resident was leaning to the left with his head laying on the left arm rest. At 11:59 a.m., the resident was observed in the dining room in the geri chair. The chair was slightly reclined with the lap tray in place. The resident's legs were pulled up under the lap tray. The resident was sleeping and his head was laying on the right arm rest of the chair. At 12:59 p.m., the resident was observed in the dining room. He was moving his arms and legs at this time. The lap tray was removed from the geri chair at this time and he was moved to an upright position. CNA #1 then proceeded to assist him with eating. At 1:13 p.m., CNA #1 put the lap tray back on the geri chair and reclined the geri chair. The CNA left the dining room. At 1:20 p.m., the resident was moving his arms and legs. He pulled his leg up to his cheek under the lap tray. He then put his legs over the lap tray and turned in the geri chair until he had both of his legs over the right arm of the chair. At this time, his back was against the left</p>		<p>tray and monitored by nursing staff. Currently Resident #19 position is all over the geri-chair with legs being put on the side of the chair, scooting down in the geri-chair but resident is able to reposition self when instructed to. He is able to ambulate and still wanders and takes peers food items and drinks from the sink faucets even though he is on a 4oz. pureed diet with 4oz. thicken liquids BID only.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents in geri-chairs and specialized wheelchairs for proper positioning were reassessed by Physical Therapist. Restraint Assessments were reviewed by the D.O.N.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Staff was in-serviced on proper positioning and the importance of reporting resident's response to changes in plan of care and reported during 24 hour report. Charge Nurse will continue to monitor wheelchair, geri-chair,</p>				

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	<p>arm of the chair. Staff arrived and removed the lap tray and repositioned the resident. The resident was then transported to his room in the geri chair. CNA #1 positioned the geri chair in an upright position and had the resident stand. She then walked the resident to the bathroom. She returned the resident to the geri chair and put the lap tray back on.</p> <p>On 3/4/15 at 10:05 a.m., Resident #19 was observed sitting in his geri chair with the lap tray in place by the window in his room. There were no staff present. The geri chair was reclined and the door to the room was open about one foot. At 10:18 a.m., the resident was observed sitting on the side of his roommate's bed. There were no other residents in the room nor were staff present. The geri chair was in the same place it was at 10:05 a.m. and the lap tray was secured to the geri chair.</p> <p>The record for Resident #19 was reviewed on 3/3/15 at 10:58 a.m. The resident's diagnoses included, but were not limited to, Huntington's Chorea, agitation with aggressive behaviors, anxiety and muscle spasm.</p> <p>The Physician's Order Statement (POS) for 3/2015, indicated the resident may</p>		<p>chair cushion and restraint use ondaily monitoring log for each shift.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Charge Nurse is responsible for monitoring proper positioningand proper restraint use. This ismonitored 12A, 3A, 5A,8A, 11A, 2P, 4P, 6P, 9P daily by the charge nurse during nurse rounds andrecorded on the log sheet. D.O.N. will monitor round sheetsbi-weekly for 1 monthly then monthly thereafter ongoing. Q.A. Committee will meet and monitorlogs and determine if further monitoring is needed and discuss any concernsabout restraint use.</p>		

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	<p>have a tray on the geri chair for poor trunk control. This order was initiated on 2/11/15.</p> <p>The care plans for Resident #19, indicated the resident used a physical restraint (tray on geri chair) related to wandering into other resident rooms. This care plan was initiated on 2/11/15. The interventions included to ensure the resident was positioned correctly with proper body alignment while restrained. A care plan for the resident indicated he had a geri chair related to poor trunk control. The care plan was initiated on 2/11/15. The intervention was for staff to assist resident with ambulation.</p> <p>Interview with the Social Service Designee on 3/3/15 at 12:10 p.m., indicated the resident was unable to control his posture when sitting in a wheel chair. Sliding devices had been tried but were ineffective. He was evaluated by PT (Physical Therapy) for the recliner.</p> <p>3.1-35(g)(2)</p>			

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F 311 SS=D Bldg. 00	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review and interview, the facility failed to ensure assistance for nail care was provided related to nails not trimmed for 2 of 3 residents reviewed for Activities of Daily Living of the 4 residents who met the criteria for Activities of Daily Living. (Residents #12 and #14)</p> <p>Findings include:</p> <p>1. On 3/2/15 at 10:31 a.m., Resident #12 was observed in bed. The resident's finger nails on both of his hands were long.</p> <p>On 3/3/15 at 11:07 a.m., the resident was observed sitting in a chair in his room. The resident's finger nails on both of his hands were long. The resident indicated he did not remember when the staff last cut his nails. The resident also indicated the staff had not offered to cut his nails in the past few days. The resident also indicated he preferred his nails short.</p> <p>The record for Resident #12 was reviewed on 3/3/15 at 11:56 a.m. The</p>	F 311	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident#12 nails were cut on 3/3/14 by C.N.A. staff Resident#14 nails were cut by the Charge Nurse</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All resident's nails were checked and no one else was affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All nursing staff was in-serviced on nail cutting and policy given. Nails trimmed column has been added to the daily tub surveillance log which is completed by the licensed nurse daily. If a resident refuses nail care it is to be reported to the charge nurse during 24 hour report.</p>	04/04/2015			

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	<p>resident's diagnoses included, but were not limited to, hemiplegia (weakness on one side), congestive heart failure and convulsions.</p> <p>Review of the 11/28/14 Minimum Data Set (MDS) assessment, indicated the resident required limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non weight bearing support) of one staff member for personal hygiene.</p> <p>When interviewed on 3/4/15 at 10:10 a.m., CNA # 2 indicated the resident needed assistance with nail care. The CNA also stated "I just did his nails last night."</p> <p>2. On 3/2/15 at 12:12 p.m., Resident #14's right hand thumb fingernail was observed to be long and jagged.</p> <p>On 3/4/15 at 8:30 a.m., Resident #14 was seated at a table in the main dining room eating breakfast. His right hand thumb fingernail was observed to be long and jagged. All of his other fingernails were observed to be long and thick. The top part of his left hand index finger had been amputated.</p> <p>On 3/5/15 at 9:43 a.m., the resident was observed standing in the doorway to his room. His right hand thumb fingernail</p>		<p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Charge Nurse will complete the nail trimmed log on the tub surveillance sheet daily and monitor the nail condition of each resident daily during med pass. D.O.N. will monitor tub surveillance sheet bi-weekly to ensure every resident's nails are trimmed then weekly times 1 month. D.O.N. will monitor resident's nails during her monitoring rounds monthly thereafter, for 6 months. Q.A. Committee will review tub surveillance logs for frequency of resident's nails being trimmed quarterly and determine whether further monitoring is needed or can be stopped.</p>				

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	<p>was observed to be long and jagged. All of his other fingernails were observed to be long and thick.</p> <p>During an interview on 3/5/15 at 9:43 a.m., Resident #14 indicated his fingernails were pretty long and sharp but he wasn't sure if they needed to be cut. He further indicated someone usually helped him with trimming his nails.</p> <p>Resident #14's record was reviewed on 3/4/15 at 2:35 p.m. The resident's diagnoses included, but were not limited to, frostbite, cellulitis of the hands, and hypertension.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/15, indicated the resident was cognitively impaired and required a limited assist of one person with personal hygiene.</p> <p>A care plan, dated 8/31/14, indicated the resident had an ADL (activities of daily living) self-care performance deficit and required staff assistance.</p> <p>Interview with CNA #1 on 3/5/15 at 1:31 p.m., indicated the resident required minimum to moderate assistance with his ADL's. She further indicated she was not sure when nail care had last been provided to the resident because staff</p>			

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F 323 SS=D Bldg. 00	<p>were nervous about working with the resident's hands. She further indicated the resident's nails had always been long and staff was going to complete nail care today.</p> <p>3.1-38(a)(3)(E)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure residents were free of hazards, related to water temperatures above 120 degrees in 2 of 19 resident hand sinks checked for water temperatures. This had the potential to affect four residents who resided on the East Hall. (Room 103 and Room 105)</p> <p>Finding includes:</p> <p>During a resident room observation on 3/2/15 at 11:08 a.m., the water temperature in East Room 103's vanity sink felt hot to the touch. A thermometer check indicated a water temperature of 123.9 F (degrees Fahrenheit).</p> <p>During a resident room observation on</p>	F 323	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>The maintenance supervisor had been maintaining his weekly water temperature logs. The surveyor informed the D.O.N. of water temp. the hot water was shut off and tagged out in rooms 102 & 103. The maintenance supervisor returned and adjusted the mixing valves and recorded the temps. Water was in within normal limits. The charge nurse was informed to keep a water temp log on those 2 rooms to ensure the temp remained between 100-120 degrees. The maintenance supervisor used a new thermometer and compared it with his previous thermometer and noticed that it was off a few degrees. It was determined that</p>	04/04/2015

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	<p>3/2/15 at 11:07 a.m., the water temperature in East Room 105's vanity sink felt hot to the touch. A thermometer check indicated a water temperature of 122.6 F.</p> <p>The Director of Nursing was notified of the hot water temperatures.</p> <p>During the environmental tour on 3/5/15 at 1:00 p.m. through 1:15 p.m., with the Director of Maintenance, the following hot water temperatures were obtained: Room 103-102 F Room 105-106 F</p> <p>During an interview with the Director of Maintenance on 3/5/15 at 1:05 p.m., indicated he had been made aware of the hot water temperatures earlier in the week and had taken care of it. He further indicated he checked the water temperatures weekly.</p> <p>3.1-45(a)(1)</p>		<p>the thermometers have to be recalibrated to maintain accuracy. Proper readings were obtained within normal limits of 102 degrees in room 103 and 106 degrees in room 105.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No other rooms were affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-service was held with maintenance staff and policy was updated to include recalibration of thermometer on the 1st and 16th of each month. The procedure for thermometer recalibration was given to staff and updated log sheet was reviewed to include date of recalibration.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Maintenance Supervisor is responsible for monitoring water temp logs. Administrative Designee will be responsible for</p>	

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F 325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to ensuring the Registered Dietitian (RD) was notified of a resident's NPO (nothing by mouth) status after readmission to the facility for 1 of 4 residents reviewed for nutrition of the 5 residents who met the criteria for nutrition. (Resident #3)</p> <p>Finding includes: The record for Resident #3 was reviewed on 3/4/15 at 9:14 a.m. The resident's diagnoses included, but were not limited</p>	F 325	<p>monitoring that recalibration is done on the 1stand the 16th of each month. Water temp logs will be monitored weekly times one month then monthlythereafter. Q.A. Committee willreview water temp. logs and determine if further monitoring is needed.</p> <p>1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Resident#3 returned NPO but primary source of nutritional intake is through the pegtube. The Resident received the weightloss due to hospitalizations starting in October. She was in the facility for 8 days inNovember, 6 days in December, 6 days in January and 18 days in February. Residenthad cookie swallow on March 10, 2015 and she remains NPO and on the same Jevityfeeding. DieticianProgress Note as of March 14, 2015 states: Readmissionnote: Resident readmitted back to facility with TF</p>	04/04/2015	

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	<p>to, dysphagia (difficulty swallowing), peptic ulcer disease and gastritis.</p> <p>The February 2015 Physician's order summary (POS), indicated the resident was to receive Pureed pleasure feedings with nectar thick liquids. The resident was also receiving Jevity 1.2, one can (8 ounces) by the way of a peg (percutaneous endoscopic gastrostomy) tube twice a day at 6:00 a.m. and 10:00 p.m.</p> <p>The 2/7/15 Registered Dietitian (RD) note completed at 4:15 p.m., indicated a significant weight change was noted. Review of the February weight indicated the resident weighed 32 pounds, showing a 10% decrease from August 2014 which was 36.5 pounds and November 2014 which was 36 pounds. A 7.5% decrease in 90 days. Decrease secondary to hospitalization. Current tube feed order provides 41.4 kilocalories (kcal) per kilogram (kg) of bodyweight for weight gain (with puree pleasure feed and nectar thick liquids) Continue tube feed, puree pleasure feed and water flush as ordered, monitor weight and tolerance to tube feed.</p> <p>An entry in the Nursing progress notes dated 2/15/15 at 8:00 a.m., indicated the resident was in bed and was observed to</p>		<p>order Jevity 1.2 1 can bid.and 50 ml water flush tid. Returned withNPO status. Had cookie swallow (T.O 3.7.15) but remains as NPO 3.11.15status Nutrient content of TF = 600 calories, 28 gm protein, 407 ml free water and 150 mlfree water = 557 ml. Plan. CPM of TF andwater flush order. f/u as needed. F/u toprevious 3.14.15 note. Obtained wt = 30pounds, 2 pounds decrease from February, indicating a 5% wt loss in 30 days,secondary to hospitalization. TFproviding 44 kcal per kg body weight for promotion of wt. continue TF asordered.</p> <p>2.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected. No oneaffected from this finding.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>D.O.N. consulted withdietician and NPO status was added to the Dietary Communication Sheet alongwith time dietician was notified and if new orders were received. Nurses will call the dietician upon newadmissions, re-admissions, diet change and</p>		

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	<p>have a large amount of dark brown emesis. Upon assessment, the resident's lungs were congested and she had a non-productive cough. A dark brown substance was observed in the peg tube. The Physician was notified and orders were received to send the resident to the Emergency room for evaluation. The resident was admitted to the hospital and returned to the facility on 2/25/15.</p> <p>A Physician's order, dated 2/25/15, indicated readmit with previous meds and treatment. Continue Jevity peg tube feedings. NPO (nothing by mouth) until cookie swallow is done.</p> <p>There was no documentation to indicate the RD had been notified of the resident's readmission on 2/25/15 and her NPO status. The last documented entry by the RD was on 2/7/15.</p> <p>The 2/7/15 Significant change Minimum Data Set (MDS) assessment, indicated the resident had a weight loss, a feeding tube and was receiving a mechanically altered diet.</p> <p>The plan of care, dated 2/7/15, indicated the resident required a tube feeding for dysphagia. The interventions included, but were not limited to, RD to evaluate quarterly and as needed.</p>		<p>NPO however dietician will not benotified if resident's NPO for medical testing. Communication will beindicated on 24 hour report and in nurses documentation.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Charge Nurse will beresponsible for calling dietician and completing the dietary communicationsheet. D.O.N. will review allDietary communication sheets as they occur. D.O.N. will review alldiet orders monthly. Dietician will review allpeg tube residents monthly and diet orders monthly. Q.A. will review DietaryCommunication Sheets and determine if further need of monitoring is needed.</p>		

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F 329 SS=D Bldg. 00	<p>Interview with LPN #1 on 3/4/15 at 11:05 a.m., indicated the resident's cookie swallow was scheduled for 3/10/15. She also indicated that she was not sure if the RD had been notified of the resident's readmission and NPO status.</p> <p>Interview with the Director of Nursing on 3/5/15 at 2:15 p.m., indicated that she notified the RD via phone of the resident's readmission but did not document anything.</p> <p>3.1-46(a)(1)</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 treat a specific condition as diagnosed and</p>			

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	<p>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 interview, the facility failed to develop resident care plans for monitoring related to medications which can thin the blood (aspirin), for 1 of 5 residents reviewed for unnecessary medications. (Resident #18)</p> <p>Finding includes:</p> <p>Resident #18's record was reviewed on 3/4/15 at 9:14 a.m. The resident's diagnoses included, but were not limited to, hypertension and hypercholesterolemia.</p> <p>The Physician's Order Summary, dated 3/2015, indicated an order for aspirin low tab 81 mg (milligrams) ec (enteric coated) daily.</p> <p>Review of the March 2015 and February 2015 Medication Administration Record (MAR), indicated the resident had received the aspirin medication daily.</p> <p>There was a lack of documentation to indicate the resident had a care plan to inform the staff of the risks of taking aspirin related to the blood thinning</p>	F 329	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #18 care plan was updated to include monitor for bleeding and bruising due to ASA use.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents receiving ASA and blood thinners care plans were reviewed and monitoring for bleeding and bruising due to ASA and Xarelto use.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-service held with nursing staff and it was discussed the need to add the use of Xarelto and ASA to care plan and monitor for side effects of bleeding and bruising.</p> <p>4. Describe how the corrective action(s) will be monitored to</p>	04/04/2015

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F 371 SS=F Bldg. 00	<p>action of the medication.</p> <p>During an interview on 3/5/15 at 10:08 a.m., the Director of Nursing (DON) indicated there was not a care plan for the aspirin. She indicated she usually does not write a care plan for the medication because it is a low dose. She further indicated a resident who took aspirin daily would be at risk for bleeding and bruising.</p> <p>3.1-48(a)(3)</p> <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 interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions related to dust, grease and debris on the floor pipes for 1 of 1 kitchens located in the facility. The facility also failed to ensure hand sanitation was completed during the preparation of meal trays in 1 of 1 kitchens located in the facility. The facility also failed to ensure foods stored in the freezer were maintained at the proper temperature in 1 of 1 kitchens</p>	F 371	<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. D.O.N. will monitor careplans quarterly of residents on blood thinners and ensure side effects arenoted. Q.A. Committee willreview the list of residents on blood thinners and determine if monitoring isadequate.</p> <p>1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Thesoap spillage on the wall by the hand washing sink was cleaned by themaintenance staff. Thekitchen white floor pipes under 3 compartment sink to dishwasher wereimmediately cleaned of the dust, grease and debris by maintenance staff. The onefloor corner of the kitchen floor was cleaned of a small amount of floor debrisby maintenance staff. Theplastic</p>	04/04/2015

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	<p>located in the facility. This had the potential to affect 20 of 21 residents who resided in the facility and received oral diets. (The Main Kitchen) (Dietary Manager).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the Initial Kitchen Sanitation Tour on 3/2/15 at 9:35 a.m., with the Dietary Manager, the following was observed: <ol style="list-style-type: none"> a. There was spillage on the wall by the hand washing sink. b. There was an accumulation of grease, dirt, and dust on the white pipes under the dishwasher. c. The pipes under the counter of the three compartment sink were dirty and there was debris on the floor in the corner. d. There was an accumulation of dust and grease on a container of sanitizing solution under the three compartment sink. e. The temperature in the freezer registered 2 degrees Fahrenheit. 2. During the Kitchen Sanitation Tour on 		<p>sanitizing solution container under 3 compartment sink was cleaned of dust and grease by maintenance staff. On 3/5/15 Surveyor informed D.O.N. of freezer temp was 2 degrees and that she checked it and it was 6 degrees. D.O.N. was unaware that the temp was over a 3 day period. On 3/5/15 D.O.N. informed dietary staff to move all items from the walk-in freezer and place them in the downstairs freezers. D.O.N. was informed of the deficiency on the tray line with dietary manager on 3/5/15 at the end of meal serving of lunch. In-service was reviewed with dietary personnel about avoid bare hand contact with food at meal service glove technique was included along with proper hand washing technique.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No other deficient practices noted at this time. Freezer temp logs reviewed by Administrator and conference called made to Dietician. Administrator reviewed proper freezer temp with dietary manager and dietary staff. Freezer temp should remain 0 degrees or below not 3-4 stated by Dietary Manager. New thermometer placed in</p>	

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	<p>3/5/15 at 9:20 a.m., the following was observed:</p> <p>a. The temperature in the freezer registered 6 degrees Fahrenheit.</p> <p>When interviewed as this time, the Dietary Manager indicated freezer temperatures should be between 3-4 degrees Fahrenheit.</p> <p>3. The March 2015 logs for the freezer temperature were reviewed on 3/5/15 at 10:20 a.m. The logs indicated the temperatures were recorded three times a day (no times listed). The following temperatures were recorded:</p> <p>3/1/15: 10 degrees Fahrenheit, 19 degrees Fahrenheit, and 11 degrees Fahrenheit</p> <p>3/2/15: 9 degrees Fahrenheit, 18 degrees Fahrenheit, and 10 degrees Fahrenheit</p> <p>3/3/15: 4 degrees Fahrenheit, 13 degrees Fahrenheit, and 8 degrees Fahrenheit</p> <p>3/4/15: 11 degrees Fahrenheit</p> <p>When interviewed on 3/5/15 at 10:28</p>		<p>freezer. She also informed them that signs are placed in the kitchen for proper temperatures for everything in dietary department. The proper temp is also recorded on the temp log and the problem should have been reported to her immediately especially when the repairman had just come on for and serviced the freezer on 1/8/15 and unit had low pressure and unit was recharged and Freon filled. Administrator met with maintenance staff and discussed with them that she had assigned them to clean the pipes and corner of the kitchen when she did rounds on Friday. Discipline time was given off to the maintenance staff.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-services held with dietary and maintenance department held. Dietary In-Service: Avoid Bare Hand Contact With Food At Meal Service, Hand washing, Sanitizer Use, Glove Use, Hair and Nail Care, Temperatures for Food Safety, Freezer Battery Maintenance Log, Walk-in Cooler Battery Maintenance Log, New temp log form for freezer and walk-in cooler form. Dietician will in-service the staff on survey findings upon her next visit and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/05/2015
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407		
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	<p>a.m., the Dietary Manager indicated the freezer temperatures were to be checked three times a day.</p> <p>4. The tray line service breakfast meal was observed on 3/3/15 at 8:17 a.m. The Dietary Manager was preparing the meal trays at this time. The Dietary Manager washed his hands and put on a pair of disposable gloves and began the tray line. The Dietary Manager used tongs to pick up the french toast sticks from the steam table and placed them on individual resident plates. The Dietary Manger would then hold the french toast sticks with one hand and cut them with the other. The Dietary Manager continued to prepare other plates with the same gloves he had touched the french toast sticks with. The Dietary Manager did not change gloves before touching the food. The Dietary Manager also was observed pouring syrup from a bottle and then touching the food with the same gloves on.</p> <p>When interviewed on 3/4/15 at 2:30 p.m., the Director of Nursing indicated the Dietary Manager should not have touched the food items while wearing the same gloves worn while touching tongs, plates, and other items.</p> <p>3.1-21(i)(3)</p>		<p>complete Dietary Safety and Sanitation Form for Administrator review. Maintenance-In-Service: Daily cleaning log for kitchen which was updated to include cleaning pipes, sanitizing solution containers, and wall of employee hand washing sink. Freezer and Walk-In Cooler Battery Maintenance log reviewed and maintenance staff responsible for keeping proper functioning batteries in thermostat.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Administrative Designee will monitor freezer temps daily and report any readings above 0 degrees Fahrenheit to Administrator immediately. Freezer Temp Log and Trayline will be monitored daily times 1 week by Administrative Designee and log form completed. Freezer Temp Log and Tray Line Audit Tool will be completed 3 times a week for one week then weekly for 6 months. Q.A. Committee will review Audit Tools and determine frequency of further monitoring. Administrative Designee will monitor custodial cleaning log of kitchen daily and check for dust, grease and debris in the cited areas and throughout entire kitchen area. Dietician will complete Dietary Safety and</p>		

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F 463 SS=D Bldg. 00	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to ensure residents were provided a functioning call system device at the bedside for 1 of 19 residents whose call lights were observed. (Resident #18)</p> <p>Finding includes:</p> <p>On 3/2/15 at 11:20 a.m., an observation was made in Room East 19 of Resident #18's bedside call light. The bedside call light system failed to function properly.</p> <p>On 3/3/15 at 7:15 a.m., an observation was made in Room East 19 of Resident</p>	F 463	<p>Sanitation Form upon each visit and notify Administrator of concerns. Battery Maintenance Log for Freezer and Walk-In Cooler will be reviewed monthly by Administrative Designee. Q.A. Committee will review all logs from Dietary Logs (Freezer Log, Tray Line Audit Log), Dietician Report (Dietary Safety and Sanitation Form) and Maintenance Log (Custodial Daily Log For Kitchen and Battery Maintenance Logs For Freezer and Walk-In Cooler) and determine frequency of further monitoring.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #18 call light was replaced by maintenance supervisor.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No one else was affected.</p> <p>3. Describe the steps or systemic changes the facility has made or</p>	04/04/2015			

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	<p>#18's bedside call light. The bedside call light system failed to function properly.</p> <p>Staff was not aware Resident #18's call light system was not working properly. On 3/3/15 at 7:15 a.m. CNA #2 attempted to use the bedside call light and indicated the system failed to function properly.</p> <p>During the Environmental tour, on 3/5/15 from 1:00 p.m. through 1:15 p.m., the Director of Maintenance indicated he had been informed by staff the call light wasn't functioning properly and had replaced the call light cord.</p> <p>3.1-19(u)(1)</p>		<p>will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made.</p> <p>Maintenance department will continue to monitor call light system weekly and record results on log sheet.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance supervisor is responsible for ensuring call light system is working properly. Nursing staff will continue to fill our repair slip and report any problems with call light to maintenance supervisor. Administrator designee will monitor repair logs as they occur and check for accuracy in completing repairs. Q.A. will monitor repair logs and completion of repairs quarterly and determine if any problems with current monitoring system.</p>		