STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVE ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 2, 3, 4, 5, 8, 9, and 10, 2014 Facility number: 000039 Provider number: 155685 AIM number: 100275130 Survey Team: Lora Swanson, RN-TC Sharon Ewing, RN Diana McDonald, RN (12/02, 12/04,12/05,2014) Julie Wagoner, RN Census bed type: SNF/NF: 149 Total: 149 Census payor type: Medicare: 10 Medicaid: 111 Other: 28 Total: 149 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on December	F000000	Please accept this plan of correction as our response to the recent state survey that was completed at Golden Living-Elkhart. We would like to request that a desk review for compliance be considered due to the fact there were no alleged deficiencies with actual harm.	

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

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

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	18, 2014, by Brenda Meredith, R.N.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F000157	**F 157** It is the policy of this facility to notify the resident, the	01/09/2015

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	Based on record review and interview, the facility failed to notify a resident's physician of a blood sugar that was outside of the blood sugar monitoring parameters for 1 of 5 residents who met the criteria for unnecessary medications. (Resident #42) Finding includes: On 12/9/14 at 1:57 P.M., the electronic clinical record for Resident #42 was reviewed. The resident's diagnoses included but were not limited to the following: Diab w/o comp type 11/uns not stated uncntrl (Diabetes without complication type2/unspecified not stated uncontrolled). A physicians order written on 11/6/13, indicated the following: "...Novolog [a medication used to lower blood sugar] [Insulin Aspart] Inject [a method to give the medication] as per sliding scale: if 0-109=0 units, < [below] 60, Notify MD[physician]; 110-125 = 1 unit; 126-140 = 2 units; 141-160 = 3 units; 161-180= 4 units; 181-200 = 5 units; 201-240 = 6 units; 241-280 = 7 units; 281-320 = 8 units; 321-360 = 9 units; 361+ = 10 units 361+ Notify MD, subcutaneously [a layer of skin the medication is injected into] before meals and at bedtime...."		physician and the resident's legal representative of changes in the resident's condition. **Corrective Action taken for residents found to be affected by alleged deficient practice:** Resident #42 suffered no ill effects failure to notify physician of blood glucose above 360 as written in the POC. The physician was notified of blood glucoses that were above 360. Attachment P **Identification of other residents with potential to be affected by alleged deficient practice:** 100% audit was conducted of all residents who have blood glucose orders with parameters. No other residents were identified as being affected. **Measures put into place to ensure alleged deficient practice does not recur:** Licensed Nurses will receive in-service training regarding physician notification with a focus on blood sugar parameters.Attachment: N **How corrective action will be monitored to ensure alleged deficient practice does not recur:** Blood glucose documentation will be audited by the DON/Designee 3 times/wkly. Audit results will be reported at QAPI meetings for 6 months, then the team will determine the need for additional auditing until a threshold of 100% is achieved. attachment: Q**Corrective Date: 1-9-15**	

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	Resident # 42's capillary blood glucose monitoring tool and progress notes indicated a lack of physician notification for the following blood sugar levels: *11/3/14 at 5:00 P.M., blood glucose documented 382. Physician notification not documented. *11/3/14 at 10:00 P.M., blood glucose documented 391. Physician notification not documented. *11/5/14 at 11:00 A.M., blood glucose documented 361. Physician notification not documented. *11/6/14 at 11:00 A.M., blood glucose documented 396. Physician notification not documented. *11/7/14 at 11:00 A.M., blood glucose documented 368. Physician notification not documented. *11/15/14 at 8:00 A.M., blood glucose documented 364. Physician notification not documented. *11/17/14 at 5:00 P.M., blood glucose documented 361. Physician notification not documented. On 12/9/14 at 3:00 P.M., an interview was conducted with LPN #14. LPN #14 indicated the following: "... The doctor was probably not notified because we don't notify unless the resident's blood glucose level is over 400...."			

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	On 12/9/14 at 3:06 P.M., an interview was conducted with the East Unit Manager. The Unit Manager indicated the following: "...The doctor should be notified according to the doctor's order and the doctor's order says to notify at 361...." On 12/9/14 at 3:10 P.M., a current policy, provided by the East Unit Manager and titled "...Notification of Change in Resident Health Status Guideline # CLIN 102...." was reviewed. The policy indicated but was not limited to the following: "... The center will consult the resident's physician, nurse practitioner, or physician assistant, and if known notify the resident's legal representative or an interested family member when there is:...(B). Acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications.)" 3.1-5(a)(3)			
F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each			

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	resident. Based on observation, record reviews, and interviews, the facility failed to ensure activities were provided as assessed for 1 of 3 residents reviewed for activities. (Resident #97) Finding includes: During an interview, on 12/05/14 at 10:43 A.M., Resident #97's family member indicated she had not noted the facility to involve her mother in activities either on or off the unit. She indicated her mother "got bored." The clinical record for Resident #97 was reviewed on 12/4/14 at 4:30 P.M. Resident #97 was admitted to the facility on 09/11/14 with diagnosis, including but not limited to, dementia, hypothyroidism, history of urinary tract infections, peripheral vertigo, hypertension, anxiety, hyperlipidemia and depressive disorder. The Recreation Services Assessment, completed on 10/14/14, indicated the resident had interests in puzzles and trivia, exercise/sports on television and various television movies and shows, enjoyed various music, liked premeal discussion groups, liked visiting with her family, sitting outdoors, going to parties on her nursing unit, liked religious music,	F000248	**F 248** It is the policy of this facility to provide ongoing program of activities designed to meet the interests and psychosocial well-being of each resident.. **Corrective Action taken for residents found to be affected by alleged deficient practice:** Resident 97 was reassessed with family involvement on 12-30-14 to ensure activity preferences are current. Activity calendar posted at the resident bedside to alert staff to assist resident to attend her choice activities..Attachment: A, B, C__ **Identification of other residents with potential to be affected by alleged deficient practice:** 100% audit of resident recreational assessments to identify resident interests and choices. Activity Calendar updated to reflect resident current interest. **Measures put into place to ensure alleged deficient practice does not recur:** Staff will be trained to assist and direct activity program as scheduled on the calendars. Staff will sign off on the activity log . Program Director will monitor activities on 5 days/wk to ensure that they occur and are as scheduled.**How corrective action will be monitored to ensure alleged deficient practice does not recur:** Program Director will be responsible to complete daily	01/09/2015

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	preferred small and large group activities, and in and out of room activities. The care plans included a plan for "life's simple pleasures" which indicated the resident liked to visit with family and friends and drink hot tea with cream and sugar. The plan was initiated on 09/11/14. Resident #97 was observed, on 12/05/14 at 2:15 P.M., seated in her wheelchair at a dining room table in the lounge/dining room finishing her lunch meal. There was another resident rearranging bean bags across the table from Resident #97 and 6 other residents seated in front of the nurse's station with no activity. There were a few residents who had been taken off the unit to a Bingo game in another part of the building. A Music in Motion activity was scheduled but was not observed to have been conducted. Resident #97 was observed, on 12/08/14 from 9:30 A.M. through 11:30 A.M., in her bed asleep. Resident #97 observed, on 12/08/14 at 2:00 P.M., ambulating out the restroom in her room, she was dressed, and was pushing her wheelchair. There was no activity being conducted on the unit. The scheduled activity on the unit was 2:15		audit forms times 5 days for 4 weeks and turn in to Administrator for review. Administrator will observe random activity functions wkly for 90 days to ensure compliance. Results of the audits/observations will be reported to the QPI team monthly for action steps as necessary. Program Director will be responsible to ensure that activities are offered at scheduled times. Attachment: Will use copy of current activity calendar with signatures after each activity. **Corrective Date: 1-9-14**	

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	P.M. - 2:45 p.m. was supposed to be Music and Motion. Resident #97 was observed, on 12/08/2014 2:30 P.M., seated in her wheelchair in her darkened room, talking to her roommate. She had now not been given breakfast or lunch. She was then observed eating her lunch in the dining room/lounge at 3:00 P.M. Resident #97 was observed, on 12/09/14 at 9:26 A.M., seated in her wheelchair in the hallway intersection. There were no activities being conducted on the dementia unit at the time. There was music playing in the background. At 9:36 A.M. on 12/09/14, the unit director was noted to be in the dining/lounge reading the newspaper to residents who were in the room, but Resident #97 remained seated in her wheelchair in the hallway intersection and was not invited nor assisted into the dining/lounge so she could participate in the activity. At 9:45 A.M. on 12/09/14, a nursing assistant gave Resident #97 a snack and then walked away from her. At 10:10 A.M. on 12/09/14, there were 11 residents seated and/or standing			

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	around the intersection of the hallways just in front of the nurse's station, including Resident #97 who was awake in her wheelchair, holding her empty wrapper and cup from a snack. There were also 8 residents in the lounge/dining room. No activity was being conducted and the unit coordinator was not visible anywhere on unit. At 10:50 A.M. on 12/09/14, Resident #97 and 7 other residents were seated around the hallway intersection with no activity. There were 6 other residents in the dining/lounge and a CNA was braiding the hair of Resident #70. There were no other activities being provided. Resident #97 was still holding the trash from the snack she had eaten earlier. There was no activity scheduled form 10:00 A.M. - 11:00 A.M. on the activity schedule. Resident #97 was observed, on 12/09/14 at 2:25 P.M., seated in her wheelchair in the intersection of the hallways on the unit. No activities were being conducted on the unit. The resident indicated she was "Not doing nothing." There was supposed to be a Music in Motion activity scheduled from 2:15 P.M. - 2:45 P.M. Resident #97 observed, on 12/09/14 at 3:00 P.M., in her bathroom in her room			

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	with her brief on and her outside pants off. She indicated she did need help but now she just needed someone to help her put her outside pants on. Staff alerted, unaware of concern. Resident #97 then observed 5 minutes later in the intersection of the hallways eating crackers and drinking juice. No other activities were noted. Review of the Activity schedule indicated there should have been a Music and Motion activity daily between 2:15 P.M. and 2:45 P.M. In addition, on Tuesday 12/09/14 the only morning activities, which were scheduled on a daily basis, was morning care and breakfast from 6 - 8:45 A.M., coffee and news with snack from 9:30 - 10:00, and Pre-meal and Lunch from 11:00 A.M. - 12:30 P.M. The daily afternoon and evening scheduled activities were Quiet Time (lights low and quiet music) from 12:45 P.M. - 1:30 P.M., Music and Motion from 2:15 - 2:45 P.M., Snack at 3:00 P.M., Sensory from 3:45 P.M. - 4:15 P.M., Premeal and dinner from 5:00 P.M. - 6:30 P.M., evening care and social hour (music and television) from 6:30 - 8:00 P.M., and Evening Snack at 8:30 P.M. There had been no follow up note regarding the resident's activity needs and no further individualized care plan			

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	interventions to ensure Resident #97 received activities while she was awake. 3.1-33(a)			
F000279 SS=D	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. 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. 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). Based on record review and interviews, the facility failed to ensure there were interventions to address behaviors and/or medical symptoms care planned for 1 of 5 residents reviewed for medications. (Resident #97) Finding includes:	F000279	It is the policy of this facility to ensure there are interventions to address behaviors and/or medical symptoms care planned. . **Corrective Action taken for residents found to be affected by alleged deficient practice:** Resident #97: Care plan reviewed and updated to include specific interventions and target behaviors for the use of psychotropic/mood	01/09/2015

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	The clinical record for Resident #97 was reviewed on 12/4/14 at 4:30 P.M. Resident #97 was admitted to the facility on 09/11/14 with diagnosis, including but not limited to, dementia, hypothyroidism, history of urinary tract infections, peripheral vertigo, hypertension, anxiety, hyperlipidemia and depressive disorder. The current medication orders for Resident #97 included orders for the resident to receive the mood stabilizing medication, Divalproex Sodium 125 mg (milligrams) once a day for Alzheimer's disease. The resident also received the antianxiety medication, Lorazepam 0.5 mg at bedtime for anxiety. The health care plans related to the use of psychoactive medications, current through 12/20/14, had interventions to monitor the side effects of the medications she received, observe for the changes in the resident's mood/behavior and report to the physician, and an intervention to talk to the resident if she appeared anxious or down to see what was wrong and resolve it if possible. There were no specific interventions other than to talk to the resident if she was anxious or down (sad). The target behavior for which the resident received Divalproex Sodium was not identified.		stabilizing medications. Attachment: (D) **Identification of other residents with potential to be affected by alleged deficient practice:** 100% care plan review complete on residents receiving a psychotropic medication. Behavior interventions will be added specific to the residents as needed. **Measures put into place to ensure alleged deficient practice does not recur:** Licensed nursing and social service staff will receive in-service training regarding facility protocols/policies regarding the care planning process of psychotropic medications. Care plans of the residents receiving psychotropic medications will be reviewed quarterly by the behavior team to ensure behavior interventions are in place and specific to the residents. **How corrective action will be monitored to ensure alleged deficient practice does not recur:** The social service director will audit care plans of 5 residents per week times 90 days, that receive psychotropic medications. Results of those audits will be reviewed monthly during the QAPI meeting by the team times 90 days to ensure 100% compliance. Any concerns will be addressed with the team including the need for additonal auditing or training. Attachment: (EI) **Corrective Date: 1-9-15**	

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	Interview with the Director of Nursing, on 12/10/14 at 9:00 A.M., indicated the resident's physician had prescribed the medication prior to her admission for organic brain syndrome. The Director of Nursing did not know what behavioral symptoms the resident might have been exhibiting prior to her admission. The resident had only exhibited one episode of yelling and cursing at a new roommate when she her sleep was disturbed in September 2014. The Director of Nursing indicated any behavior was "tracked" and documented but there was no plan of which interventions were to be attempted and exactly which target behavior was supposed to be improved by the use of the antipsychotic medication. 3.1-35(b)(1)			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other			

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	appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on record review and interviews, the facility failed to ensure the medical symptom which required the use of an antipsychotic medication was care planned for 1 of 5 residents reviewed for unnecessary medications. (Resident #65) In addition, the facility failed to ensure there was documentation of an attempt to involve the family of 1 of 1 residents reviewed for care plan participation. (Resident #97) Findings include: 1. The clinical record for Resident #65 was reviewed on 12/08/14 at 2:34 P.M. Resident #65 was admitted to the facility on 08/23/10 and readmitted on 10/17/14 with diagnosis, including but not limited to, vascular dementia, urinary tract infection, psychosis, dementia with behavioral disturbances, anxiety, and Alzheimer's disease. The current medication orders for Resident #65 included the antipsychotic medication, Seroquel 25 mg (milligrams) in the AM and 50 mg in the PM related	F000280	**F 280** It is the policy of this facility to include residents and families in care plan participation. It is also the policy of the facility to include medical symptoms on the care plan for any resident who requires the use of anti-psychotic medications . **Corrective Action taken for residents found to be affected by alleged deficient practice:** The Serroquel for Res #65 was dc'd. and care plan was updated to include change. A care plan conference will be held with res #97 and the family. **Identification of other residents with potential to be affected by alleged deficient practice:** 100% audit of care plans for those residents who receive psychotropic medications to ensure the medical condition for the medication is listed and that the family has had opportunity to participate in care plan meetings. **Measures put into place to ensure alleged deficient practice does not recur:** Licensed nursing and social service staff will receive in-service training regarding policies/protocols for appropriate use and documentation of psychotropic medications. Psychotropic medication log will	01/09/2015

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	to Anxiety State. The resident also received the antianxiety medication, Klonopin 0.25 mg once a day for dementia with behavioral disturbances and anxiety state. Interview with the Director of Nursing, on 12/10/14 at 9:00 A.M., indicated the resident had been admitted to the facility, in 2010 already receiving 200 mg of Seroquel. She indicated by January 2014, the resident's Seroquel dose had been reduced to 50 mg a day at bedtime. Documentation was provided which indicated on February 06, 2014 the resident had been evaluated by the psychiatric nurse practitioner and a 12.5 mg dose of Seroquel in the mornings had been added to her drug regimen due to "meanness to staff and other residents." The resident was evaluated, on 04/22/14, by the psychiatric nurse practitioner and the morning dose of Seroquel was increased to 25 mg due to "increased delusions and agitations." The health care plans for Resident #65, current through 02/12/15, included a plan for the Potential for Drug Related Complications associated with the use of psychotropic medications. The interventions were to observe for		be kept by the Social Service Director for residents currently receiving psychotropic medications that retain information that supports necessary requirements of the medications, A care plan invitation log will be kept in the receptionist office that will include information regarding the date the invitation was mailed out and who it was mailed to. The social service director will record the information in the progress note section of the resident's chart. Attachments: (F) **How corrective action will be monitored to ensure alleged deficient practice does not recur:** The psychotropic and care plan logs will be reviewed 1 time wkly for 90 days, by the Administrator for compliance . Audit results will be taken to the QAIP committee monthly for 3 months, who will be responsible to review and make recommendations, including additional monitoring or termination of monitoring once facility reaches 100% compliance. **Corrective Date:** 1-9-15	

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	behavior changes, observed for side effects of antidepressant, antianxiety, and psychotropic medications, provide non-pharmacological interventions to reduce target behaviors, anxiety, or depression, and to refer to the psychologist/psychiatrist for medication and behavioral interventions. There was no specific documentation regarding the target behaviors or specific interventions to utilize to address the resident's behaviors. There was also a plan to address the resident's short and long term memory issues with interventions to redirect the resident and remind her of time, schedules, etc. There was also a plan to address the resident's behaviors of refusing showers and personal hygiene care, agitation when other resident's entered her room, making inappropriate (rude) comments about others, and hoarding soiled underwear in her room. The interventions focused on the refusal of care and hoarding soiled underwear and indicated she was to be "talked to" about inappropriate comments. There was no care plan to address the resident's delusions. 2. The clinical record for Resident #97 was reviewed on 12/4/14 at 4:30 P.M. Resident #97 was admitted to the facility on 09/11/14 with diagnosis, including but			

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	not limited to, dementia, hypothyroidism, history of urinary tract infections, peripheral vertigo, hypertension, anxiety, hyperlipidemia and depressive disorder. Interview with the family of Resident #97 on 12/05/14 at 11:40 A.M., indicated she was not invited to participate in a care plan meeting. Review on 12/09/2014 at 10:27 A.M., both the Resident's hard chart and electronic chart, indicated there was no documentation regarding the date and manner in which Resident #97's family had been invited to the last care plan meeting, which was held on 09/30/14, and only attended by a facility nurse and the dementia unit coordinator. Interview with the Administrator, on 12/09/14 at 10:36 A.M., indicated the receptionist was given a list of resident's due for a care plan meeting and the receptionist then mailed out a form letter with a scheduled time for the care plan meeting in the middle of the form. There was no other method to ensure family's were notified of care plan meetings and there was no documentation kept regarding who had been on the list for September 30, 2014. Interview, on 12/10/2014 at 1:57 P.M.,			

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	with RN #4, the MDS (Minimum Data Set) coordinator, indicated she gave the receptionist a care plan meeting schedule every 6 weeks and the receptionist then would send a letter to the POA (Power of Attorney) or HCR (Health Care Representative) with the date and time of the resident's scheduled health care plan meeting. She indicated a copy was also placed on each resident's units mail box. No copies were kept for list for September 30, 2014 and Employee #4 indicated the resident's copy was probably not kept. She confirmed there was also no documentation in clinical record regarding notification of resident's and family's of the care plan meeting schedule. 3.1-35(b)(1) 3.1-35(C)(2)(c)			
F000282 SS=D	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 record review and interview, the facility failed to follow the plan of care regarding physician notification of a resident with a blood sugar that was outside of the blood sugar monitoring	F000282	**F 282** It is the policy of this facility to follow the plan of care regarding physician notification of changes with residents.	01/09/2015

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	parameters for 1 of 5 residents who met the criteria for unnecessary medications. (Resident #42) Finding includes: On 12/9/14 at 1:57 P.M., the electronic clinical record for Resident #42 was reviewed. The resident's diagnoses included but were not limited to the following: Diab w/o comp type 11/uns not stated uncntrl (Diabetes without complication type2/unspecified not stated uncontrolled). A physicians order written on 11/6/13 indicated the following: "...Novolog [a medication used to lower blood sugar] [Insulin Aspart] Inject [a method to give the medication] as per sliding scale: if 0-109 = 0 units, < (below) 60, Notify MD[physician]; 110-125 = 1 unit; 126-140 = 2 units; 141-160 = 3 units; 161-180 = 4 units; 181-200 = 5 units; 201-240 = 6 units; 241-280 = 7 units; 281-320 = 8 units; 321-360 = 9 units; 361+ = 10 units 361+ Notify MD., subcutaneously [a layer of skin the medication is injected into] before meals and at bedtime...." Resident # 42's capillary blood glucose monitoring tool and progress notes indicated a lack of physician notification		**Corrective Action taken for residents found to be affected by alleged deficient practice:** Resident #42 suffered no ill effects failure to notify physician of blood glucose above 360 as written in the POC. The physician was notified of blood glucoses that were above 360. **Identification of other residents with potential to be affected by alleged deficient practice:** 100% audit was conducted of all residents who have blood glucose orders with parameters. No other residents were identified as being affected. **Measures put into place to ensure alleged deficient practice does not recur:** Licensed Nurses will receive in-service training regarding physician notification with a focus on blood sugar parameters. **How corrective action will be monitored to ensure alleged deficient practice does not recur:** Blood glucose documentation will be audited by the DON/Designee 3 times/wkly. Audit results will be reported at QAPI meetings for 6 months, then the team will determine the need for additional auditing until a threshold of 100% is achieved.	

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	for the following blood sugar levels: *11/3/14 at 5:00 P.M., blood glucose documented 382. Physician notification not documented. *11/3/14 at 10:00 P.M., blood glucose documented 391. Physician notification not documented. *11/5/14 at 11:00 A.M., blood glucose documented 361. Physician notification not documented. *11/6/14 at 11:00 A.M., blood glucose documented 396. Physician notification not documented. *11/7/14 at 11:00 A.M., blood glucose documented 368. Physician notification not documented. *11/15/14 at 8:00 A.M., blood glucose documented 364. Physician notification not documented. *11/17/14 at 5:00 P.M., blood glucose documented 361. Physician notification not documented. On 12/9/14 at 3:00 P.M., an interview was conducted with LPN #14. LPN #14 indicated the following: "... The doctor was probably not notified because we don't notify unless the resident's blood glucose level is over 400...." On 12/9/14 at 3:06 P.M., an interview was conducted with the East Unit Manager. The Unit Manager indicated the following: "...The doctor should be		- attachment: (Audit Form) **Corrective Date:** - **1-9-15**	

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	notified according to the doctor's order and the doctor's order says to notify at 361...." On 12/9/14 at 3:10 P.M., a current policy, provided by the East Unit Manager and titled "...Notification of Change in Resident Health Status Guideline # CLIN 102...." was reviewed. The policy indicated but was not limited to the following: "... The center will consult the resident's physician, nurse practitioner, or physician assistant, and if known notify the resident's legal representative or an interested family member when there is:...(B). Acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications.)" 3.1-35 (g)(2)			
F000329 SS=D	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			

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	combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interviews, the facility failed to ensure there were adequate indications to support the increase in an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication use. (Resident #65) Finding includes: The clinical record for Resident #65 was reviewed on 12/08/14 at 2:34 P.M. Resident #65 was admitted to the facility on 08/23/10 and readmitted on 10/17/14 with diagnosis, including but not limited to, vascular dementia, urinary tract infection, psychosis, dementia with behavioral disturbances, anxiety, and Alzheimer's disease. The current medication orders for Resident #65 included the antipsychotic medication, Seroquel 25 mg (milligrams)	F000329	**F 329** It is the policy of this facility to ensure there adequate indications to support increases in anti-psychotic medications. **Corrective Action taken for residents found to be affected by alleged deficient practice:** Resident #65's psychotropic medications were reviewed by the nurse practitioner in February, 2014 and were appropriate at that time. On 12-11-14, they were reviewed again and a decrease was made to the Seroquel. The resident suffered no ill effects from the changes. **Attachment: H Identification of other residents with potential to be affected by alleged deficient practice:** Residents with new psychotropic medications or an increase in the current psychotropic medication were reviewed and target behaviors were compared to the anticedent behavior logs to determine if any drugs are unnecessary. There were none noted. **Measures put**	01/15/2015

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	in the AM and 50 mg in the PM related to Anxiety State. The resident also received the antianxiety medication, Klonopin 0.25 mg once a day for dementia with behavioral disturbances and anxiety state. Interview with the Director of Nursing, on 12/10/14 at 9:00 A.M., indicated the resident had been admitted to the facility, in 2010 already receiving 200 mg of Seroquel. She indicated by January 2014, the resident's Seroquel dose had been reduced to 50 mg a day at bedtime. Documentation was provided which indicated on February 06, 2014, the resident had been evaluated by the psychiatric nurse practitioner and a 12.5 mg dose of Seroquel in the mornings had been added to her drug regimen. The January and early February 2014 nursing progress notes indicated on 02/05/14 at 2:54 P.M., the resident was very agitated with a nurse because she had desired a television left from an expired resident and it was given to a different resident. The resident remained upset for a long time, calling the nurse she felt was responsible names and "hitting her on the arm and stated 'Thanks for nothing'." There was no intervention documented in the nurse's note on		**into place to ensure alleged deficient practice does not recur:** Recommendation of psychotropic medication changes will be referred to the behavior team who will be responsible to review the antecedent logs/nurses notes that have been completed to determine if the changes are necessary prior to the change. The DON/ADON will be notified prior to any requested changes in psychotropic medications to ensure appropriateness. Staff will be in-serviced to the facility protocol regarding request for changes. It will include documenting behaviors and ensuring adequate indications to support the increase in a ant-psychotic medication.. **How corrective action will be monitored to ensure alleged deficient practice does not recur:** All physician orders are reviewed daily (Mon-Friday) as part of the facility's clinical meeting. The social service director will be responsible to follow up with any changes in psychotropic medications to ensure that they are appropriate for the resident's needs and that appropriate documentation is present. A log will be kept that will list any changes identified and will be reviewed wkly with the Director of Nursing.ADON. Results of the audits will be reviewed by the QAPI committee monthly for 90 days. The team members will be	

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	02/05/14 regarding the resident's behaviors. An "Antecedent Behavior Monitoring Log" for February 2014 documented the resident has having behaviors on 02/05/14 during the second shift of agitation, combative, yelling/cursing, and delirium. The only interventions was "1:1" and the resident "calmed temporarily." There was no specific description of what the delirium was related to or what the behaviors were about. The nursing progress notes for April 2014 for Resident #65 indicated a note from both activities and social services, date 04/10/14 and 04/11/14, which did not indicate any recent increase in behavioral. On 04/18/14 at 3:42 P.M., a nursing note indicated the resident had been wandering in the building and had made a comment to the receptionist that she needed a gun to harm herself because she could not locate way out of the building. Social services was notified and upon interviewing the resident, she indicate she did not desire to harm herself and had no recollection of having made the statement. The Social Services note indicated the resident had been noted to be more confused and nursing was asked to get an order for a urinalysis test for Resident #65.		responsible to make recommendations for any concerns/compliance issues, including recommendation to stop auditing after maintaining threshold of 100% compliance in this area.. Attachment: (I) **Corrective Date: 1-9-15**	

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	A nursing progress note, dated 04/20/14 at 4:58 P.M., indicated the resident was "sexual towards male patients, becomes upset frequently over nothing, cusses and was verbally abusive towards others." The comments were part of a summary note and there was no additional information regarding the times, frequency, and interventions attempted to address the resident's behaviors. The April 2014 "Antecedent Behavior Monitoring Log" indicated on 04/15/14, the resident was cursing and yelling, 1:1 was given. There was no information regarding the specific behaviors or the outcome of the interventions. On 04/18/14, in the lobby, the resident was documented as having demonstrated increased confusion and suicidal ideation, 1:1 was given and the resident was redirected. On 04/20/14, during 1st and 2nd shift the resident was documented as being agitated, cussing, and sexually inappropriate. 1:1 was given for all three behaviors and "redirected" was documented as the response. There was no specifics given regarding the behaviors and there was no documentation that the 1:1 given was not successful in addressing the resident's behaviors. The resident was evaluated by the			

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	psychiatric nurse practitioner and the morning dose of Seroquel was increased to 25 mg due to "increased delusions and agitations." The health care plans for Resident #65, current through 02/12/15, included a plan for the Potential for Drug Related Complications associated with the use of psychotropic medications. The interventions were to observe for behavior changes, observed for side effects of antidepressant, antianxiety, and psychotropic medications, provide non-pharmacological interventions to reduce target behaviors, anxiety, or depression, and to refer to the psychologist/psychiatrist for medication and behavioral interventions. There was no specific documentation regarding the target behaviors or specific interventions to utilize to address the resident's behaviors. There war also a plan to address the resident's short and long term memory issues with interventions to redirect the resident and remind her of time, schedules, etc. Finally, there was a plan to address the resident's behaviors of refusing showers and personal hygiene care, agitation when other resident's entered her room, making inappropriate (rude) comments about others, and hoarding soiled underwear in her room. The interventions focused on the refusal			

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	of care and hoarding soiled underwear and indicated she was to be "talked to" about inappropriate comments. There was no plan specific to the resident's target behavior of delusions and no clear interventions to address the resident's agitation issues. 3.1-48(a)(4)			
F000371 SS=F	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 manner in one of one kitchens. In addition, the facility failed to serve food in a sanitary manner in 1 of 3 dining rooms. This deficient practice potentially affected 145 of 149 residents who consumed food in the facility. Findings include: 1. During the Kitchen Sanitation tour, conducted on 12/02/14 at 10:37 A.M., accompanied by the FSS (Food Service	F000371	**F 371** It is the policy of this facility to provide to store, prepare, distribute and serve food under sanitary conditions . **Corrective Action taken for residents found to be affected by alleged deficient practice:** The kitchen, storage area, and dish room were deep cleaned on December 10th. Trash cans were replaced with Ft. petal operational lids. The stove hood was professionally cleaned as scheduled in December. Also, all serving carts were sanitized and rust removed. All storage shelves used for storing cooking utensils/pans were cleaned during the deep cleaning of the	01/09/2015

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	Supervisor), the following was noted: The trash can near the handwashing sink required staff to touch the lid in order to throw away the paper towels after washing their hands. There were open packages of drink mix and chocolate chips stored in open boxes on open shelves in the dry storage. There was a 1/2 flat of pasteurized eggs stored on top of boxes of waffles. A large mixer was stored uncovered with cake batter on the mixer. The FSS was unsure when it had been last used. The outside of the stove and tilt griddle was visibly dirty with a heavy amounts of a greasy film, dust, and food splatters. A shelf above the stove was also dirty with a greasy, dust covered film. The outside and inside of metal cabinets, used to store steam table pans, was dirty with dust, food crumbs, and a greasy film that smeared when touched. The overhead stove hood had a visible layer of dust by light fixtures. Interview with the FSS indicated the hood was due to be cleaned in December 2014 and had last been documented as cleaned in		kitchen and dish room area. Test strips for dishwater temps were purchased on 12-10. Dietary staff received training on the protocol to test temperatures and to log results appropriately. Dietary staff in-service on new cleaning schedules and routines and infection control protocols in regards to working in the dietary department. Attachment: (J) **Identification of other residents with potential to be affected by alleged deficient practice:** All residents have potential to be affected by alleged deficient practices. **Measures put into place to ensure alleged deficient practice does not recur:** The facility has implemented daily cleaning schedules and audit tools for dietary staff to address all cleaning areas of the dietary department. In addition, all dietary employees have been assigned specific areas that they are responsible to monitor and clean as necessary. Increased monitoring of the temp logs and test strip supplies to 3 times/wk by the dietary manger to ensure that supplies are available and temps are being logged appropriately. Attachments: (K) **How corrective action will be monitored to ensure alleged deficient practice does not recur:** sanitation audits completed per the Dietary Manager/Asst. Manager daily times 5 days/wk. Immediate	

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	September 2014. Three of three steam table pans, stored as clean, had a greasy film on the inside and outside of the pans. The outside of the convection oven was dirty with a greasy buildup, dust, and food crumbs. The outside of 3 large bins on wheels ,used to store flour, sugar, and bread crumbs, was dirty on the outside and lids with dust and food splatters. Four of 6 food scoops, put away as clean, had food smears on them. The dish room floor was noted to have pooled water and a black substance underneath the dishwasher and along the wall. The FSS indicated the floor was not properly sloped and the water from the dishwasher puddled and sat on the floors. There was also a large amount of splattered white and dusty buildup on the dishwasher and the counters legs and shelving in the dish room. Interview with the FSS indicated the dishwasher was a low temperature, chemical sanitizing dishwasher but there were no test strips available to check the sanitizer levels of the dishwasher. The		action taken toward any areas/concerns identified. 1 time wkly sanitation audits will be completed by the Administrator . All audit results will be reviewed by the QAPI team monthly times 3 months, Any trends/concerns will be identified and action steps taken as appropriate including additional cleaning and staffing discipline actions._ Attachment: (L)__	

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	FSS indicated she did not know how to check the chemical level and did not realize they were out of strips. (test strips) Review of the daily log documentation of the dishwasher temperatures and test strip readings indicated staff were consistently marking one temperature reading, all the same for the wash, rinse, and ppm (parts per million) chemical sanitizer section of the log. The ceiling in dish room was dusty around the vents, which also had rust on them. The outside of the dishwashing machine was dirty and there was a dusty, grimy buildup on the plumbing pipes in the dish room. During the observation of the meal service, conducted on 12/05/14 at 11:15 A.M., food debris was noted on the storage cupboard for pitchers/coffee thermos's. There was rust and food debris on the carts utilized to hold the insulated plate lids. The assistant cook, Employee #2, who was serving the vegetables and pureed food, was noted to reach for a plate of food from the main cook and pull the plate towards herself by holding onto a			

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	double portion of fish with her gloved hands which she had been touching plates, trays and various utensils. 2. On 12/02/14 at 2:30 P.M., the Assistant Food Service Supervisor, Employee #3, was observed attempting to assess the chemical sanitizing level of the dishwasher with test strips which had been obtained during the noon meal service. Employee #3 was unclear on the correct procedure to utilize to test the dishwasher. A poster, on the wall to the left of the dishwasher, had instructions for a high temperature dish machine and the section of the poster for low temperature machines had been worn off and was barely visible. Employee #3 was noted to attempt to run a test strip into the dishwasher on a tray while the machine was running. After two attempts, Employee #3 was cued as to the proper technique for checking the sanitization of the dish machine. The test strip tested between 50 - 100 ppm (parts per million) but Employee #3 indicated it should read 200 ppm. A sticker, which was dilapidated and barely legible, located on the dishwasher, was pointed out to Employee #3. The sticker indicated the chemical level was supposed to be 50 ppm. 3. On 12/8/14 at 12:20 P.M., during an			

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	observation of the Rosewood dining room, Employee #12 was observed serving multiple residents' their food with her fingers and hand over the top of bowls of fruit. On 12/8/14 at 12:23 P.M., during an observation of the Rosewood dining room, Employee #13 was observed serving multiple residents' their food with her fingers and hand over the top of bowls of fruit. On 12/10/14 an interview was conducted with the Infection Control Nurse. The Infection Control Nurse indicated glasses and bowls should be handled from the side during food service. On 12/10/14 at 1:30 P.M., a current policy, titled "...[facility name] dining services policies and procedures manual...." was reviewed. The policy and procedure indicated but was not limited to the following: "...Cross-Contamination...Handling plates...Handle plates by the bottom or the edge, and avoid touching areas where food will be placed. Keep thumbs and fingers away from food on plates or in bowls...." 3.1-21(i)(2)			

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interviews, the facility failed to ensure	F000441	**F 441** It is the policy of this facility to establish and maintain	01/09/2015

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	resident clothing and clean linens were transported in a sanitary manner on 3 of 5 nursing units. In addition, the facility failed to ensure 2 nursing staff members washed their hands appropriately before providing resident care during 2 of 2 observations. The facility also failed to ensure disposable straws were handled appropriately on 1 of 4 nursing units. Findings include: 1. On 12/09/14 at 2:57 P.M. CNA #1 was observed walking down the southwest unit hallway carrying a stack of clean washrag's and hand towels against his uniform. 2. On 12/10/14 at 9:50 A.M., an unknown resident was observed sitting in his wheelchair beside the medication cart at the nurses station located on the East hallway. The resident was observed pulling paper covered straws out of a plastic holder on the side of the medication cart, he then threw the straws onto the floor. The resident left the area and the straws were observed on the floor for 10 minutes. LPN #21 observed the straws on the floor beside the medication cart and proceeded to pick them up and place them back into the plastic holder on the med cart for resident use.		an infection control program designed to provide a safe, sanitary and comfortable environment.. **Corrective Action taken for residents found to be affected by alleged deficient practice:** CNA #1 received education regarding proper linen handling. LPN #21 received education regarding hand washing policy with specific focus on when to wash her hands. Also received education regarding throwing things away once it hits the floor. LPN #22 received hand washing education. Laundry department received education on proper procedures for laundry and distribution of linen and personal clothing. Attachment: (M). **Identification of other residents with potential to be affected by alleged deficient practice:** All residents residing in the facility have the potential to be affected by alleged deficient practice. **Measures put into place to ensure alleged deficient practice does not recur:** Staff will be inserviced by Clinical Director of Education regarding Hand washing and infection control. Laundry carts with Covers have been purchased for laundry personnel to use to deliver personal clothing and linen throughout the facility.Attachment: Located under M **How corrective action will be monitored to ensure alleged deficient practice does not recur:** Random Infection control	

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	On 12/10/14 at 10:16 A.M., LPN #22 was observed coughing, sneezing and then blowing her nose. She then proceeded to pick up and look at charts and answer the phone without washing her hands or using hand sanitizer. On 12/10/14 at 11:22 A.M., LPN #21 was observed at the medication cart on the East hallway drawing up insulin into a syringe for a resident. The nurse was not observed to wash her hands or use hand sanitizer prior to preparing the medication. On 12/10/14 at 1:15 P.M., record review of the current policy titled "Handwashing/Hand Hygiene" received from the Director of Nursing indicated "...5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:...p. After blowing or wiping nose...s. After handling soiled equipment or utensils...." 3. On 12/3/14 at 9:27 A.M., an observation was made of a Laundry Attendant on the East unit, pushing a large uncovered rolling cart that contained 2 blue shirts and 1 pair of jeans.		rounds will be completed 3 times a wk by the Director of Clinical Education, which will include observations of hand washing and distributing of the personnel laundry and linen. Results of the rounds will be shared with the DON/Administrator 1 time a week as part of the morning meeting. Any compliance issues will be addressed immediately. The Administrator will be responsible to review the results of the audit with the QAIP committee who will be responsible to make recommendations for further auditing, and/or stopping after 100% thresehold is acheived.. Attachment(N)	

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	On 12/3/14 at 12:02 P.M., a Laundry Attendant was observed distributing clean laundry to resident's rooms on the East Unit. The laundry was hanging on a large rolling cart that was partially covered with a small sheet, however, not all of the clean laundry was covered by the sheet. On 12/8/14 at 10:02 A.M., a Laundry Attendant #11 was observed distributing clean laundry to resident's rooms on the East Unit. The laundry was hanging on a large rolling cart that was partially covered with a small sheet, however, not all of the clean laundry was covered by the sheet. On 12/8/14 at 10:05 A.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated the clean laundry should be covered while being transported and delivered to resident's rooms. On 12/8/14 at 10:52 A.M., an interview was conducted with the Administrator. The Administrator indicated the facility did not have a policy regarding linen transportation and distribution related to those services were contracted outside of the facility. On 12/8/14 at 10:54 A.M., a current			

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	procedure, provided by the Administrator and titled "... [Corporate Name] Processing Resident Personal Clothing...." was reviewed. The procedure indicated but was not limited to the following: "... Delivery of Personal Clothing...The rack of hung clothing and folded clothing should be delivered daily, either by the Nursing or Laundry staff. If Laundry personnel are making deliveries, be sure to knock on the resident's door before entering and announce yourself as Laundry there to deliver clothing...." 3.1-18(l) 3.1-19(g)			
F000463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a resident's emergency call light, in her bathroom, was functioning properly for 1 of 40 resident's in a sample of 40. (Resident #145) Finding include: On 12/10/14 between 3:00 P.M. and 3:30 P.M., an environmental tour was	F000463	**F 463**It is the policy of this facility to ensure resident call lights are functioning properly.. **Corrective Action taken for residents found to be affected by alleged deficient practice:** Resident #145's call light was fixed immediately when found to be not working.. **Identification of other residents with potential to be affected by alleged deficient practice:** 100% audit of resident call lights was completed. All lights were found to be in working	01/09/2015

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	conducted with the Maintenance Director and the Administrator and the following was observed: The emergency call light, in the bathroom, of Room #529 did not come on when the cord was pulled. An interview with the 500 Unit Manager, at that time, indicated it had been repaired recently and was functioning at that time. On 12/10/14 at 4:34 P.M., an interview was conducted with the Administrator. The Administrator indicated the call lights in the resident's room were checked during a preventative maintenance check of the resident's room that are assigned by the corporate office on a Monthly, Weekly and Daily basis. If at any time a repair of a resident's room needed to be made a work order is placed and the repair was made right away. Documentation indicated Resident #145's room had a preventative maintenance check on 11/25/14 and that it was functioning at that time. The Administrator indicated there was not a policy for the maintenance of call lights. 3.1-19(u)(2)		condition.. **Measures put into place to ensure alleged deficient practice does not recur:** The maintenance department has increased number of times that call lights are being checked 5 times/wk during facility rounds. This will be ongoing as call lights can dysfunction at any time. **How corrective action will be monitored to ensure alleged deficient practice does not recur:** The Administrator will review the call light logs wkly to ensure compliance of the system. Results of the audits will be reviewed by the QAPI committee monthly for 3 months. The QAPI committee will be responsible to recommend additional auditing or to stop current auditing once threshold of 100% is maintained. Attachment: (0)	