

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155767	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN RD GREENFIELD, IN 46140
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 20, 21, 22, 25, 26, 27, and 28, 2014</p> <p>Facility number: 005954 Provider number: 155767 AIM number: 201068810</p> <p>Survey team: Karina Gates, Generalist, TC Beth Walsh, RN Tom Stauss, RN Angie Stallsworth, RN (August 25, 26, 27, and 28, 2014) Cheryl Fielden, RN (August 20, 2014)</p> <p>Census bed type: SNF: 51 SNF/NF: 10 Residential: 53 Total: 114</p> <p>Census payor type: Medicare: 28 Medicaid: 8 Other: 78 Total: 114</p> <p>Residential Sample: 10</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey on August 28, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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

TITLE

(X6) DATE

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

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F000157 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 and 410 IAC 16.2-5.</p> <p>Quality review completed on September 2, 2014 by Cheryl Fielden, RN.</p> <p>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).</p> <p>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</p>			

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	<p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a Physician of lab values in a timely manner for 1 of 1 dialysis residents reviewed for nutrition. (Resident #66)</p> <p>Findings include:</p> <p>The clinical record for Resident #66 was reviewed on 8/25/14 at 1:35 p.m. The diagnoses for Resident #66 included, but was not limited to, end stage renal disease, diabetes, and depression.</p> <p>A review of a document titled, Treatment Sheet for Facility (a communication tool from Resident #66's dialysis center), dated 7/30/14 (print date 8/6/14), indicated an elevated level of phosphorus of 5.8 mg/dL (milligrams/deciliter) that was drawn on 7/28/14. The normal range for phosphorus was 2.6-4.5 mg/dL. There was no review date on the Treatment Sheet by the Facility or the Physician. The Treatment Sheet for Facility document was located in the</p>	F000157	<p>F 157</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #66 has been discharged from the campus.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review the following for the past 14 days: 1. All residents with ordered labs to ensure MD was notified of the results. 2. All dialysis center communication tools / treatment sheets for any abnormal labs to ensure MD was notified of the results.</p> <p>Measures put in place and systemic changes made to</p>	09/27/2014

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	<p>clinical record.</p> <p>During an interview with the Facility Registered Dietician (RD), on 8/26/14 at 11:30 a.m., she indicated she needed to review the labs from the dialysis center to ensure Resident #66 was on the correct diet. The Facility RD further indicated she will contact the dialysis center to retrieve those labs.</p> <p>On 8/26/14, at 1:25 p.m., the Facility RD indicated she reviewed the labs that were just received from the dialysis center, at 1:15 p.m. and the 7/28/14 labs indicated an elevated level phosphorus of 5.8 mg/dL, as indicated above. The RD further indicated she left a message with the Dialysis Center RD for a review of Resident #66's diet order, due to the elevated level of phosphorus.</p> <p>A review of the labs the Facility RD received, on 8/26/14 at 1:15 p.m., were the exact same 7/28/14 labs that were on the Treatment Sheet for Facility document that was listed above found in the clinical record.</p> <p>A review a document, dated 8/27/14, received from Resident #66 dialysis center indicated a new diet recommendation of no added salt, extra protein, limited potassium foods, limit</p>		<p>ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1. Physician Notification Guidelines 2. Dialysis Provider Communication</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 5 months to ensure compliance: 1. Ordered labs to ensure MD was notified of the results. 2. Dialysis center communication tools / treatment sheets for any abnormal labs to ensure MD was notified of the results.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>high phosphorus foods, and a fluid restriction of 1500 cc/ml (milliliters). Resident #66's current diet was a regular diet with a fluid restriction of 1200 ml.</p> <p>On 8/27/14, at 1:50 p.m., Unit Manager #2 indicated the facility did speak with the Dialysis Center RD and the Dialysis Center RD recommended a change based on the information the Facility RD sent to her.</p> <p>During an interview with Campus Support Clinician (CSC) , on 8/27/14 at 2:03 p.m., she indicated the facility did not know the 7/28/14 labs were already in the clinical record and the labs would've been helpful in determining the appropriate diet for Resident #66. The CSC indicated if there wasn't a date/initials on the Treatment Sheet for Facility, the Physician did not review the 7/28/14 labs.</p> <p>A document titled, Skilled Nursing Assessment and Data Collection, dated 8/27/14, indicated a note at 1:09 p.m. that the 7/28/14 labs were just sent to the Physician for review. The document also indicated a note, on 8/28/14 at 9:55 a.m., that indicated the Physician was just notified again that day to review the 7/28/14 labs and recommended diet orders.</p>						

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F000280 SS=D	<p>At 10:20 a.m., on 8/28/14, the Director of Health Services (DHS) and Unit Manager #2 indicated the facility was unaware of the 7/28/14 labs in the clinical record since 8/6/14 and the Physician was not notified of the 7/28/14 labs until the labs were faxed to him on 8/27/14 with the recommendation to change the diet order. They also indicated it would've been helpful to know the 7/28/14 labs were already in the chart so the Facility could've provided the information to the Physician sooner than 8/27/14 for a possible diet change.</p> <p>As of final exit, on 8/29/14, no further information regarding a diet change due to the elevated phosphorus levels, was provided.</p> <p>3.1-5(a)(2)</p> <p>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.</p>			

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	<p>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 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.</p> <p>Based on observation, interview, and record review, the facility failed to update a dialysis care plan and falls care plan for 2 of 24 residents reviewed for care plans. (Residents #66 and #87)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #66 was reviewed on 8/25/14 at 1:35 p.m. The diagnosis for Resident #66 included, but was not limited to, end stage renal disease, diabetes, and depression.</p> <p>A review of the care plans for Resident #66, including an Acute Care Needs, ADL (activities of daily living), and General Information care plans, did not include an intervention of communication between the dialysis center and the facility.</p>	F000280	<p>F 280</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #66 has been discharged. Resident #87 care plan interventions were reviewed and updated related to fall risk.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review and update all care plan interventions related to the following: 1. dialysis care / communication 2. fall risk</p>	09/27/2014

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	<p>During an interview with the Campus Support Clinician (CSC), on 8/27/14 at 2:03 p.m., she indicated there should be communication between the dialysis center and the facility to ensure appropriate care was provided for the resident. She further indicated she was unable to locate an intervention on Resident #66's care plans regarding communication between the dialysis center and the facility. The CSC indicated there should be an intervention that indicates communication between the dialysis center and facility was needed.</p> <p>A policy titled, Guideline for Dialysis Provider Communication, no date, was received from the CSC on 8/27/14 at 2/21 p.m. The policy indicated, "...4. A report (may be written or verbal) shall be requested from the Dialysis Provider that will alert the campus regarding: a. tolerance to procedure, [sic] b. vital signs, [sic] c. medications administered d. other information deemed necessary for ongoing provision of care....6. A care plan shall be developed containing the necessary information for ongoing care interventions and approaches regarding Dialysis [sic] services...."</p> <p>2. Resident #87's record was reviewed on 8/20/14 at 1:41 p.m. The resident's diagnoses included, but were not limited</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Care Plan Team on the following guidelines: 1. Dialysis Provider Communication 2. Interdisciplinary Team Care Plan</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Review of care plan to ensure interventions for dialysis care / communication are in place. 2. Review of care plan to ensure interventions for fall risk are in place.</p> <p>The results of the audit observations will be reported,</p>	

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	<p>to, Alzheimer's Dementia, senile dementia, depressive disorder, osteoporosis, and hypertension. The resident's medications included, but were not limited to, morphine sulfate, ativan, depakote, metoprolol, trazodone, and melatonin.</p> <p>The clinical record indicated Resident #87 received hospice services.</p> <p>An 8/17/14 nursing progress note indicated Resident #87 grabbed a door frame as she was being assisted through a facility entrance by her daughter and the resident fell out of the wheelchair. The record indicated the resident did not sustain an injury from the fall. The progress note indicated a wheelchair alarm, from Resident #87's wheelchair, was heard by staff. As they responded to the alarm, they observed Resident #87 seated on the floor with her daughter present.</p> <p>Resident #87's care plans did not include a risk for falls care plan with related fall interventions.</p> <p>On 8/26/14 at 1:24 p.m., during an interview, the MDS Coordinator indicated Resident #87 did not have a fall risk care plan in place at the time of Resident #87's 8/17/14 fall. She</p>		<p>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F000282 SS=D	<p>indicated based on the initial MDS assessment, dated 6/8/14, Resident #87 was a fall risk due to factors such as the resident's diagnosis of Alzheimer's dementia, and impaired mobility factors.</p> <p>A 6/8/14 MDS assessment indicated Resident #87's care plan was updated with interventions to reduce fall risk.</p> <p>On 8/26/14, during an interview, the DHS indicated any interventions for fall risk prevention should be updated on a resident's care plans. She indicated Resident #87's care plan was not updated to include fall risk interventions after 7/10/14.</p> <p>A facility policy titled "Interdisciplinary Team Care Plan Guideline" and dated January, 2008, indicated "...The care plan should be reviewed and revised as needed with each MDS assessment..."</p> <p>3.1-35(b)(2) 3.1-35(c)(1) 3.1-35(d)(2)(b)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>						

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	<p>Based on interview and record review, the facility failed to follow Physician's Orders for 2 of 5 residents reviewed for unnecessary medications. (Resident #94 & #85)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #94 was reviewed on 8/25/14 at 1:55 p.m. The diagnoses for Resident #94 included, but was not limited to, Parkinsons, asthma, depression, anxiety, and, insomnia.</p> <p>A review of a Consultant Pharmacist's Medication Regimen Review, dated 5/21/14, indicated a recommendation to consider obtaining blood pressure and pulse hold parameters for metoprolol ER 25 mg (blood pressure medication/milligrams) that was ordered daily.</p> <p>A Physician's Order, dated 5/24/14, indicated a clarification for metoprolol ER 25 mg. The order indicated to call/hold the medication if the blood pressure was less than 100/50 or the pulse was less than 50.</p> <p>A review of the June and July MARs (medication administration record)</p>	F000282	<p>F 282</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #94 MAR reviewed to ensure blood pressure and pulse are being obtained/documented on the MAR prior to administering ordered medications and that hold parameters are being followed as ordered. Resident #85 MAR reviewed to ensure the correct amount of insulin is administered/documented as ordered according to the blood sugar readings.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review the following: 1. All residents with orders for vital signs and / or hold parameters prior to medication administration to ensure complete / documented as ordered on the MAR. 2. All residents with ordered sliding scale insulin to ensure the correct amount is administered / documented on the MAR according to the results of the blood sugar reading.</p>	09/27/2014			

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	<p>copied indicated the blood pressure and pulse were only obtained/documentated on the following days:</p> <p>6/24/14, 6/28/14, 6/29/14, 7/5/14, 7/6/14, 7/9/14, 7/12/14, 7/13/14, 7/26/14, 7/27/14, & 7/7/28/14.</p> <p>During an interview with Director of Health Services (DHS), on 8/25/14 at 2:18 p.m., she indicated the facility was unable to locate the blood pressures and pulses for the missing dates above in June and July. The DHS further indicated the vital signs should've been documented on the MAR to ensure the medication was not given outside of the parameters ordered. The DHS also indicated she was unable to verify the vital signs were done as ordered.</p> <p>A policy titled, Specific Medication Administration Procedures dated 9/1/13, was received from the Campus Support Clinician on 8/27/14 at 2:05 p.m. The policy indicated, "...M. Obtain and record any vital signs or other monitoring</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1. Specific Medication Administration Procedures 2. Blood Sugar Monitoring</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 5 times per week times 8 weeks, then weekly times 4 months to ensure compliance: 1. Orders for vital signs and / or hold parameters prior to medication administration are complete / documented as ordered on the MAR. 2. Orders for sliding scale insulin are complete and the correct amount is administered / documented on the MAR according to the results of the blood sugar reading.</p> <p>The results of the audit observations will be reported, reviewed and trended for</p>	

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	<p>parameters ordered or deemed necessary prior to medication administration...."</p> <p>2. The clinical record for Resident #85 was reviewed on 8/65/14 at 11:55 a.m. The diagnoses for Resident #85 included, but was not limited to, diabetes mellitus, Parkinsons, Alzheimers, and depression.</p> <p>A review of the July 2014 Physician's Orders indicated an order for Sliding Scale Novolog (insulin) before meals and before bedtime. The Novolog Sliding Scale was ordered as the following, after a blood sugar reading was obtained: 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units....</p> <p>A review of the July MAR indicated the following blood sugar readings and units given: 7/2/14-11 a.m.=157, symbol for zero units given, 7/5/14-bedtime=156, symbol for zero units given, 7/6/14-bedtime=180, symbol for zero units given, 7/7/14-bedtime=185, symbol for zero units given, 7/8/14-bedtime=155, symbol for zero units given, 7/9/14-bedtime=234, symbol for zero</p>		<p>compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>units given, 7/12/14-4 p.m.=154, symbol for zero units given, 7/12/14-bedtime=255, symbol for zero units given, 7/18/14-bedtime=211, symbol for zero units given, 7/19/14-bedtime=284, symbol for zero units given, 7/20/14-bedtime=170, symbol for zero units given, 7/22/14-4 p.m.=230, 2 units given, 7/22/14-bedtime=233, symbol for zero units given, 7/26/14-7 a.m.=159, symbol for zero units given, 7/26/14-4 p.m.=155, symbol for zero units given, 7/26/14-bedtime=262, symbol for zero units given, 7/27/14-4 p.m.=194, symbol for zero units given, 7/28/14-bedtime=170, symbol for zero units given.</p> <p>An ADL (Activities of Daily Living) Care Plan, dated 2/7/14 and remained current at the time of review, indicated an intervention of, "...Administer my insulin as ordered-see current orders..."</p> <p>During an interview with Unit Manager #7, on 8/26/14 at 1:35 p.m., she indicated the MAR was the only location for</p>			

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F000323 SS=E	<p>insulin dosages given for blood sugar readings.</p> <p>The Director of Health Services (DHS) indicated on 8/26/14 at 149 p.m., the MAR was the only location for blood sugar readings and the amount of insulin given to a resident. The DHS further indicated staff were expected to follow Physician's Orders as ordered/written.</p> <p>On 8/26/14, at 2:20 p.m., the Campus Support Clinician indicated the facility was unable to locate any other documentation that the correct amount of insulin was provided to Resident #85 on the above dates.</p> <p>3.1-35(g)(1)</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, interview, and record review, the facility failed to provide the appropriate fall interventions</p>	F000323	F 323	09/27/2014

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	<p>to a resident for 1 of 3 residents reviewed of 5 who met the criteria for accidents (Resident #17), and to ensure medication carts, containing potentially harmful medications and other items, were kept locked while unattended by nursing staff with the potential to affect 5 cognitively impaired, ambulatory residents of 21 residents on the 200 hall.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #17 was reviewed on 8/21/14 at 2:00 p.m. The diagnoses for Resident #17 included, but were not limited to, muscle weakness.</p> <p>An interview was conducted with LPN #10 on 8/21/14 at 2:24 p.m. LPN #10 indicated Resident #17 had a fall approximately 3 weeks prior.</p> <p>The 7/3/14 Nurse's Note indicated, "CRCA (Clinical Resident Care Associate) was toileting res (resident). When she tried to stand up, her ft (foot) was slipping, so she sat back down on toilet. Res sat down hard, knocking the tank lid off. (Symbol for "no") bruising noted. Denies pain @ this (symbol for "time"). Will monitor."</p> <p>The 7/3/14 Change of Condition Form</p>		<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1. Resident #17 fall interventions reviewed to ensure they were appropriate. 2. All residents have the potential to be affected by the alleged deficient practice of the medication cart being left unlocked / unattended.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1. Review of all falls for the past 14 days to ensure appropriate fall prevention interventions, fall circumstance form and 72 hour follow up are in place. 2. All residents have the potential to be affected by the alleged deficient practice of the medication cart being left unlocked / unattended.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1. Fall Management Program 2. Circumstance and Reassessment Form 3. Medication</p>				

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	<p>indicated, "Res standing up from toilet. Ft slipping. She sat down pretty hard on toilet seat.... Will f/u (follow up) 72 (symbol for "hours"). The Physician order/ response section of the form, completed on 7/7/14, indicated, "OK. Cont (continue) to monitor." No verification of continued 72 hour follow up was found in the clinical record.</p> <p>The 7/5/14, 10:00 a.m., nurses note indicated, "3 x 5 purple bruise now noted to RT (right) (symbol for "lower") back. Family aware & skin assessment completed."</p> <p>An interview was conducted with LPN #10 on 8/25/14 at 11:00 a.m., regarding 72 hour follow up after Resident #17's fall. LPN #10 indicated, "There should be a fall circumstance (Fall Circumstance and Reassessment Form) filled out for the 7/3 (7/3/14) incident. It was considered a fall." LPN #10 looked through Resident #17's clinical record and indicated, "It doesn't look like there was a fall circumstance filled out. I don't see verification of the monitoring for 72 hours after the fall. I would consider that a fall. When I came back from vacation, I was told by the night shift nurse, she (Resident #17) fell, and that's why she became a 2 person assist for toileting. Now she's back down to one person."</p>		<p>Administration - General Guidelines</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Review of falls to ensure appropriate fall prevention interventions, fall circumstance form and 72 hour follow up are in place. 2. Observation of medication carts on all hallways to ensure the cart is locked while unattended.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>An interview was conducted with Resident #17 on 8/25/14 at 11:28 a.m., regarding her 7/3/14 fall. She indicated, "I just fell down too fast, and broke the toilet lid. It was shattered afterward. One of the aides was helping me to get off the commode. I didn't have full grip on the rod, and I fell back. I stand up by pulling on the rod. I don't understand why I didn't have a higher commode. They (aides) have to give me a little boost to get up from the commode every time I use it. One of those higher toilet seats would be helpful." Regarding whether the facility tried a higher toilet seat, she indicated, "They've never tried one of those higher seats." Regarding whether she'd like to try one, she indicated, "It's possible to try it, but I hope to go home soon. After it happened, they recommended 2 people to help me. I don't know if I always need it though, or if they have the extra people to help. I have the higher seat at home." Regarding whether a higher commode seat would benefit her in the future, as well as at the time of her 7/3/14 fall, she indicated, "Yes."</p> <p>An observation of Resident #17's restroom was made on 8/25/14 at 11:56 a.m. No high toilet seat was observed.</p>			

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	<p>An interview was conducted with the DHS on 8/26/14 at 10:20 a.m. She indicated the Fall Circumstance and Reassessment Form from Resident #17's 7/3/14 fall could not be found, and it contained verification of the 72 hour follow up. She indicated the fall was reviewed in a peer review meeting a few weeks prior. Regarding a root cause determination for the 7/3/14 fall, she indicated, "I'm almost certain they were assisting her, and the CRCA left out of the bathroom, and the resident attempted to get up without her assistance, and that caused the fall. Regarding interventions implemented afterwards, she indicated therapy and a 2 person assist with toileting. Regarding whether a higher toilet seat was considered or discussed with Resident #17, she indicated, "We didn't think about a high seat. I think it would have been a good idea. With it, she wouldn't have to sit so low."</p> <p>Regarding whether anyone was aware she had a higher toilet seat when she was at home, prior to entering the facility, the DHS indicated, "None of us were aware she had a higher seat at home. I'm sure we didn't discuss it at a care plan meeting, or she would have one."</p> <p>Regarding whether she was aware Resident #17 needed a boost every time she gets up from the commode, the DHS indicated, "No, we didn't."</p>			

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	<p>The Falls Management Program Guidelines was provided by the DHS on 8/26/14 at 1:15 p.m. It indicated, "Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form". The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT (interdisciplinary team) to evaluate thoroughness of the investigation and appropriateness of the interventions."</p> <p>2. On 8/20/14 at 2:02 p.m., during an observation, a medication cart immediately next to the 200 hall nursing station was observed to be unlocked. Inside the cart, medications for resident #'s 71 and 163. LPN #9 was taking the blood pressure for an unidentified resident across the activity room with her back turned to the two med carts. There were two medication carts in the area near the nursing station, with one being unlocked. At the time of the observation, Resident #28 was observed pulling on the second drawer of the locked medication cart.</p> <p>On 8/20/14 at 2:05 p.m., during an</p>			

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	<p>interview, LPN #9 indicated she should not have left the medication cart unlocked while she was assessing the unidentified resident. She indicated it was not consistent with facility policy to leave medication carts unlocked as there were several cognitively impaired residents on the 200 hall, including Resident #28.</p> <p>A 7/29/14 MDS (Minimum Data Set) assessment indicated Resident #28's BIMS (Brief Interview for Mental Status) score was "3". On 8/25/14, at 9:49 a.m., during an interview, RN #20 indicated Resident #28 was cognitively impaired.</p> <p>On 8/25/14 at 9:26 a.m., during an observation, a medicine cart (med cart) on the 200 hall was outside room 208. The medication cart was observed to be unlocked. No facility staff was observed to be visible in the immediate area near the medication cart. Inside the med cart, some of the medications were: risperidone, sertraline, and depakote for Resident #49, clopidogrel for Resident #95, cymbalta for Resident #91, furosemide for Resident #'s 91 and 97, lidocaine hcl 1% injectable solution for Resident #84, warfarin sodium and isosorbide mononitrate for Resident #28.</p> <p>Inside the top drawer of the medication</p>			

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	<p>cart were unopened insulin syringes. Unit manager #7 saw the unlocked medication cart at the time of the observation. She indicated the cart should not have been left unlocked without a nurse near the cart, 4 residents, including Resident #28, were in the area near the medicine cart.</p> <p>On 8/25/14 at 9:32 a.m., during an interview with LPN #9 , who identified herself as in charge of the unlocked medication cart, she indicated an unlocked medication cart could pose a potential harm to a cognitively impaired resident. She indicated a resident could also have been injured by a needle stick from an insulin syringe. LPN #9 indicated she was in a resident's room providing resident care. She indicated she should not have left the cart unlocked. 2 of the 4 residents in the area of the medication cart were identified by the "200 hall" unit manager as "cognitively impaired" Unit Mgr #7 indicated the residents' as "Resident #97 and Resident #28.</p> <p>On 8/25/14 at 10:02 a.m., during an interview, the DHS indicated the items in the unlocked medication cart, such as insulin needles, warfarin, isosorbide, and lasix, among other medications, could potentially harm any cognitively impaired</p>			

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F000325 SS=D	<p>resident who may accidentally or intentionally go into the medication cart. The DHS indicated nursing staff should always lock all med carts when the staff is not going to be immediately near the med cart.</p> <p>A facility policy, dated June, 2012 and titled "Med Pass Procedures & Error Prevention" indicated "...keep carts (medication carts) locked at all times..."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <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.</p> <p>Based on observation, interview, and record review, the facility failed to provide nutritional supplements, as ordered and recommended, to 2 of 3 residents reviewed of 3 who met the criteria for nutrition. (Residents #28 and #93)</p> <p>Findings include:</p>	F000325	<p>F 325 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #29 and #93 are receiving nutritional supplements as ordered. Identification of other residents having the potential to be affected by the same alleged</p>	09/27/2014

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	<p>1. The clinical record for Resident #93 was reviewed on 8/22/14 at 11:00 a.m. The diagnoses for Resident #93 included, but were not limited to, Alzheimer's dementia.</p> <p>The 7/7/14 individualized care plan for Resident #93 indicated, "Maintenance of my weight and skin integrity are also impaired as my nutritional needs are not anticipated to be met or maintained.</p> <p>The weights for Resident #93 were as follows:</p> <p>3/7/14 - 140 lbs. 4/7/14 - 120 lbs. 6/2/14 - 122 lbs. 7/3/14 - 125 lbs. 8/19/14 - 121 lbs.</p> <p>The 4/11/14 Nutrition Assessment indicated, "Res (resident) adm (admitted) to hospice. Up today for brkfst (breakfast). First time in past wk (week). (Symbol for "nothing" ate but drank beverage. Nutrition Interventions - offer ensure plus tid (3 times daily) as tol (tolerated)."</p> <p>The 8/19/14 Nutrition Progress Note indicated, "...[name of nutritional supplement] plus tid b/t (between)</p>		<p>deficient practice and corrective actions taken: DHS or designee will review all residents with ordered nutritional supplements to ensure they have been transcribed to the MAR timely and are administered as ordered. DHS or designee will review RD nutritional recommendations for past 30 days to ensure MD was notified and orders were received and implemented. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following guidelines: 1. Nutritional Recommendations 2. Medication Orders How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Ordered nutritional supplements are transcribed to the MAR timely and administered as ordered 2. MD notified timely of RD recommendations and orders are received and implemented The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for</p>		

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	<p>meals. Accepts = 50% of [name of nutritional supplement]. Res cont (continues) (symbol for "with") hospice tx (treatment). 1) change [name of nutritional supplement] to between meals 2) mvi (multivitamin) with minerals to assist healing 3) fort (fortified) foods (symbol for "with") meals."</p> <p>The 8/21/14 Physician Telephone Order indicated, "Dietary recommendation - d/c (discontinue) [name of nutritional supplement] Plus (symbol for "with") meals - only between meals. Multi vitamin po (by mouth) dly (daily). Fortified foods (symbol for "with") meals."</p> <p>The August, 2014 MAR (medication administration record) indicated the first attempted administration of the multivitamin was on 8/26/14. It indicated [name of nutritional supplement] was not given or refused on the following dates/meals: breakfast on 8/4/14, 8/6/14, 8/19/14, 8/24/14, and 8/25/14, and supper on 8/4/14, 8/5/14, and 8/9/14.</p> <p>An interview was conducted with LPN #11 on 8/26/14 at 11:43 a.m., regarding the [name of nutritional supplement] on the above dates/meals, and the delay in attempted administration of Resident</p>		a minimum of 6 months then randomly thereafter for further recommendation.				

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	<p>#93's daily multivitamin. LPN #11 indicated, "I saw the multivitamins in the medication cart this morning, so I asked (name of Unit Manager #7) about it, because I didn't see it on the MAR. She (Unit Manager #7) said it was ordered on 8/21 (8/21/14), and didn't get transcribed onto the MAR. As far as the blanks on the MAR, I'd guess she refused, because she has in the past, but it's not documented either way. The verification of receiving or refusing [name of nutritional supplement] may be in the nurses notes, but most likely, on the back of MAR, and it's not there."</p> <p>An observation of Resident #93's multivitamins in the medication cart was made on 8/26/14 at 11:50 a.m. with LPN #11. The packet of multivitamins was dated 8/21/14. LPN #11 indicated, "8/21 (8/21/14) is the day the med (medication) came out. I transcribed it onto the MAR this morning."</p> <p>An interview was conducted with the DHS on 8/26/14 at 1:45 p.m. She indicated, "I couldn't find any verification she (Resident #93) refused or was given the [name of nutritional supplement] on those dates."</p> <p>2. Resident # 28's record was reviewed on 8/21/14 at 10:44 a.m. The resident's diagnoses included, but were not limited</p>			
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	<p>to, dysphagia, urinary tract infection, muscle weakness, diabetes mellitus, hypertension. The resident's medications included, but were not limited to, coumadin, xanax, methotrexate, and folic acid.</p> <p>Resident #28's weight record indicated the following weights for the resident: 6/5/14 108 lbs., 7/3/14 102 lbs., 7/24/14 96 lbs., 8/14/14 95 lbs. Previous weights for Resident #28 were: 6/28/13 109 lbs., 8/2/13, 110 lbs., 11/4/13 113 lbs.</p> <p>On 8/22/14 at 12:19 p.m., Resident #28 was observed in the main dining room eating lunch at a table with other residents. Her meal ticket did not include a nutritional supplement and no nutritional supplement was observe on her meal tray.</p> <p>A nutrition assessment and progress note, dated 7/28/14 indicated Resident #28 lost 9.8 lbs. in the 30 days prior to, and including, the 7/28/14 assessment. The note indicated the 9.8 lbs. of weight loss was a "...9%..." weight loss over a 30 day period.</p> <p>On 8/25/14 at 1:42 p.m., during an interview, the Registered Dietitian (RD) indicated she wrote two recommendations to start Resident #28</p>			

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	<p>on "[name of nutritional supplement]" due to the resident's need for higher caloric intake due to recent weight loss. She indicated the first recommendation for Resident #28 to have the [name of nutritional supplement] was written on 7/28/14 and the second recommendation for the same intervention was written on 8/12/14. The RD indicated the 9% weight loss noted on 7/28/14 was a "significant weight loss."</p> <p>A 7/28/14 facility document titled "Nutrition Recommendations" indicated for Resident #28 to receive "120 ml [name of nutritional supplement] BID(twice daily)"</p> <p>An 8/12/14 Nutrition recommendation indicated the RD recommended to have Resident #28 take an "[name of nutritional supplement]" and indicated "2nd rec (recommendation) (7/28/14)"</p> <p>On 8/26/14 at 9:01 a.m., during an interview, the DHS indicated the facility did not secure an order from Resident #28's physician for an [name of nutritional supplement] as recommended by the RD on 7/28/14 and 8/12/14. She indicated facility records did not indicate Resident #28 received [name of nutritional supplement] prior to 8/25/14. A physician's order for [name of</p>			

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F000329 SS=D	<p>nutritional supplement] , dated 8/25/14, was observed in the resident's record on 8/25/14. The DHS indicated Resident #28 "probably did not receive the [name of nutritional supplement] " supplement as recommended by the RD between the dates of 7/28/14 and 8/25/14.</p> <p>On 8/26/14 at 10:07 a.m., during an interview, the DHS indicated she could not verify according to Resident #28's if the resident had received [name of nutritional supplement] , prior to 8/25/14, as recommended by the RD. She also indicated Resident #28's physician was not notified of the RD recommendations to begin the [name of nutritional supplement] supplement until 8/25/14.</p> <p>A care plan for potential weight loss, dated 6/17/14, indicated Resident #28's weight "...should remain at a healthy range for me and be without any unwarranted significant weight change..."</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for</p>						

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	<p>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 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 observation, interview, and record review, the facility failed to follow up with a psychiatric recommendation to discontinue an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #97)</p> <p>Findings include:</p> <p>The clinical record for Resident #97 was reviewed on 8/22/14 at 11:30 a.m. The diagnoses for Resident #97 included, but were not limited to, dementia with behavior disturbance.</p> <p>The August, 2014 Physician's Orders for Resident #97 indicated a 2.5 mg tablet of Zyprexa (antipsychotic medication) to be given daily at 5:00 p.m. effective 1/7/14.</p>	F000329	<p>F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #93 psychiatric recommendation was reviewed and follow up was complete. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will obtain a list and progress notes from psychiatric MD of the residents reviewed for the past 30 days and review their psychiatric recommendations to ensure follow up was complete. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or</p>	09/27/2014

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	<p>The 4/28/14 Nursing Home Psychiatric Subsequent Visit Form for Resident #97 was provided by the Campus Support Clinician on 8/27/14 at 12:23 p.m. It indicated, "Treatment Plan: Patient is on hospice, and having in (sic) general decline, both with cognition and physical health....Patient continues to be minimally responsive, confused and disoriented. She is pleasant, and no longer having episodes of tearfulness. This is probably improved due to her overall decline and decreased level of functioning. She has tolerated the reduction in Zyprexa from 5 mg to 2.5 mg without problem. No return of behavioral issues are noted. We will go ahead and try a discontinuation of patient's Zyprexa altogether, monitoring her for an increase in behavior issues. Follow up with patient in 2-3 months to reassess her behaviors and mood without Zyprexa. Also, patient has had a gradual decline in weight, which is now significantly low. If this continues, we may confer with hospice, and consider starting Remeron as an appetite stimulant if they agree."</p> <p>The April, May, June, July, and August, 2014 MAR's (medication administration records) indicated Resident #97 continued to receive 2.5 mg of Zyprexa</p>		<p>designee will re-educate the Interdisciplinary team on the following guideline: Reviewing and transcribing orders from physician progress notes How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for all residents reviewed by the psychiatric MD will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. A list from the psychiatric MD was obtained of the residents reviewed during his/her visit 2. All progress notes for those residents reviewed were received timely 3. All recommendations noted in the progress notes were complete with follow up The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>daily, after the 4/28/14 psychiatric treatment plan to "try a discontinuation of patient's Zyprexa altogether".</p> <p>The 7/2/14 Nursing Home Psychiatric Subsequent Visit Form for Resident #97 indicated, "Patient is no longer on hospice, though she continues to have a gradual decline in weight. I am going to start her on Remeron 7.5 mg h.s. (at night) for an appetite stimulant....I had thought that the Zyprexa order was discontinued at the last visit, however it is still listed on the patient's current medication list. Rather than discontinue it at the same time as starting Remeron, I'm going to wait and see how patient does with Remeron. We will continue the zyprexa and reassess that at the next visit...."</p> <p>An interview was conducted with the Campus Support Clinician on 8/27/14 at 12:23 p.m. She indicated, "We just got the notes (4/28/14 Nursing Home Psychiatric Subsequent Visit Form for Resident #97). No one knew about the 'try a discontinuation of patient's Zyprexa altogether'....If we'd seen this, we would have called him and asked if he wanted the zyprexa dc'd (discontinued)."</p> <p>An interview was conducted with the SSD (Social Services Director) on</p>			

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F000371 SS=F	<p>8/27/14 at 12:38 p.m. She indicated, "I did not receive the 4/28 (4/28/14) progress note." Regarding whether the facility had a system in place to ensure they received psychiatric progress notes timely and followed through with any recommendations or treatment plans, she indicated, "I don't know of a system to double check the progress notes against the residents seen."</p> <p>3.1-48(a)(2)</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 and interview, the facility failed to ensure a vendor wore a hairnet in the kitchen during meal preparation. This had the potential to affect 61 residents residing in the facility.</p> <p>Findings include:</p> <p>During an observation, on 8/25/14 at 11:45 a.m., a [name of company] food/drink vendor was observed without a hairnet on. The vendor was near the food preparation area.</p>	F000371	<p>F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Observation of employees / vendors in the kitchen area to ensure hair nets are completely covering their hair. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes</p>	09/27/2014			

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F000441 SS=F	<p>During an interview with the Dietary Manager on 8/25/14 at 11:46 a.m., he indicated the vendor should have a hairnet on in the area the vendor was observed standing. The Dietary Manager indicated he already told the vendor's partner that they need to put on a hairnet if they were going to be in the food preparation area.</p> <p>A policy titled, Food Production Guidelines-Sanitation & Safety, dated 2009, was received from the Administrator on 8/25/14 at 1:50 p.m. The policy indicated, "...3. Approved hairnets, caps or other effective hair restraints shall be used...in the preparation and service of food...."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>		<p>made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team and visiting vendors on the following campus guideline: Sanitation and Safety - related to the requirement of use of hair nets in the food preparation area. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Observation of employees and vendors in the kitchen area to ensure hair nets are in place in the food preparation area. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident that tested positive for Clostridium difficile (C.diff) was in contact isolation, as needed. This had the potential to affected 61 residents that resided in the facility. The facility also failed to ensure an infection control/Contact Isolation policy followed</p>	F000441	<p>F 441 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #140 has been discharged Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will audit / observe the following: 1. Review</p>	09/27/2014

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	<p>the Centers for Disease Control (CDC) guidelines regarding Clostridium difficile (C.diff) isolation precautions. This also had the potential to affect 61 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During the initial facility tour on 8/20/14, at 11:15 a.m., of the 400 Hall/Kipling Court, no "isolation" signs were noted on any of the doors in the hallway.</p> <p>During an interview with LPN #1, on 8/20/14 at 11:16 a.m., she indicated none of the residents residing on the 400 hall were in isolation.</p> <p>The clinical record for Resident #140 was reviewed on 8/20/14 at 1:30 p.m. The diagnosis for Resident #140 included, but was not limited to, C. diff.</p> <p>A (Name of Lab) Final Report, dated 8/16/14, indicated Resident #140 had a positive lab for C. diff (Clostridium difficile). The Report also indicated Contact Precautions were required. The Report indicated the results of the lab was called to the MD (Medical Doctor) on 8/16/14 by LPN #1.</p> <p>A Physician's Order, dated 8/19/14,</p>		<p>all residents recent labs / stool samples to ensure isolation is implemented for C-Diff if applicable. 2. Review all residents in isolation for C-Diff to ensure the Contact Isolation policy follows the Centers for Disease Control (CDC) guidelines regarding Clostridium Difficile (C.Diff) isolation precautions related to the following: a. ensure the infected or colonized area of the resident's body are contained and covered when it is determined medically necessary to bring a resident out of their room b. use of designated equipment (i.e. scales for weight) for a resident in isolation c. visitors taught how to gown and glove before entering a resident's room d. staff to gown / glove when entering a resident's room to provide care and these precautions are to continue until diarrhea ceases Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the staff and family members, when applicable, on the following guideline: 1. Contact Precautions 2. CDC Recommendations and Guidance on How can clostridium difficile infections be prevented in hospitals and other healthcare settings 2. CDC Recommendation and Guidance for Isolation Precautions: Preventing Transmission of</p>		

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	<p>indicated to discontinue the contact isolation.</p> <p>A Physician's Order, dated 8/20/14 at 11:40 a.m., indicated to start contact isolation for C. diff.</p> <p>LPN #1 indicated on 8/20/14 at 2:05 p.m., she called the MD to clarify the isolation status for Resident #140. LPN #1 further indicated she was unsure why the contact precautions were discontinued. LPN #1 indicated Resident #140 was not on isolation when she came in for her shift that morning around 7 a.m.</p> <p>On 8/20/14 at 2:19 p.m., during an interview with Unit Manager #2, she indicated there was some miscommunication regarding Physician's Orders and lab results for Resident #140. Unit Manager #2 further indicated LPN #1 did not properly notify Nursing Administration that Resident #140 tested positive for C. diff and needed contact isolation. Unit Manager #2 also indicated Resident #140 did not have contact isolation for 2 shifts on 8/19/14 and 8/20/14 due to the miscommunication.</p> <p>CRCA (Clinical Resident Care Associate) #3 indicated, on 8/20/14 at</p>		<p>Infectious Agents in Healthcare Settings How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Review all residents recent labs / stool samples to ensure isolation is implemented for C-Diff if applicable. 2. Review all residents in isolation for C-Diff to ensure the Contact Isolation policy follows the Centers for Disease Control (CDC) guidelines regarding Clostridium Difficile (C.Diff) isolation precautions related to the following: a. ensure the infected or colonized area of the resident's body are contained and covered when it is determined medically necessary to bring a resident out of their room b. use of designated equipment (i.e. scales for weight) for a resident in isolation c. visitors taught how to gown and glove before entering a resident's room d. staff to gown / glove when entering a resident's room to provide care and these precautions are to continue until diarrhea ceases The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for</p>	

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	<p>2:30 p.m., Resident #140 was still having diarrhea that day.</p> <p>During an observation, on 8/21/14 at 10:38 a.m., CRCA #5 was observed taking Resident #140 out of their room and off of the unit, without any gowns or gloves on herself or the Resident. Resident #140 and CRCA #5 were observed on the other side of the Facility in the Beauty Shop near Dickinson Drive. Activity Assistant #4 and Resident #33 were observed in the Beauty Shop, when Resident #140 was in the Beauty Shop. CRCA #5 and Resident #140 then returned to Resident #140's room.</p> <p>During an interview with CRCA #5, on 8/21/14 at 10:52 a.m., she indicated she took Resident #140 over to the Beauty Shop to get weighed. CRCA #5 further indicated the scale on the 400 hall/Kipling Court was in the medication/nursing storage area, so they (CRCAs) were trying to stay away from using that scale.</p> <p>During an observation, on 8/21/14 at 11:30 a.m., two family members were observed entering Resident #140's room. CRCA #5 watched the family members enter Resident #140's room and put down their belongings. Neither family member was observed putting on a gown or</p>		a minimum of 6 months then randomly thereafter for further recommendation.				

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	<p>gloves.</p> <p>A policy titled, Guidelines for Contact Precautions, no date, was received from the Director of Health Services (DHS), on 8/21/14 at 12:16 p.m. The policy indicated, "...9. Visitors a. Visitors must be taught how to properly gown and glove by facility staff. Evidence of consistent non-compliance should be documented in the resident's chart along with any follow-up activity...."</p> <p>CRCA #5 indicated on 8/21/14 at 12:50, that Resident #140 was still having loose stools.</p> <p>The Director of Health Services (DHS) indicated during an interview, on 8/21/14 at 12:55 p.m., weighing a resident might be medically necessary, depending on the Resident's status. The DHS further indicated there have been some recent weight concerns regarding Resident #140, but she was unsure if weighing the Resident was medically necessary. The DHS also indicated she was unaware of the staff not utilizing the scale on the 400 hall/Kipling Court and Resident #140 should've been weighed over there, instead of on the other side of the Facility.</p> <p>At 1:49 p.m., on 8/21/14, the DHS</p>			

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	<p>indicated the Family Members that entered Resident #140's room, should have donned gowns and gloves when they entered the room. The DHS further indicated it was the Facility's policy that all Visitors don gowns and gloves before entering a Resident's room that was in contact isolation.</p> <p>During an interview with Unit Manager #2, on 8/22/14 at 11:30 a.m., she indicated staff do not like to utilize the scale on the 400 hall/Kipling Court because it was inconvenient since the scale was in the medication storage closet and a Nurse needs to be with a CRCA when a CRCA weighs a resident in there. Unit Manager #2 further indicated the Facility had not considered utilizing separate scales for residents in contact isolation.</p> <p>At 2:15 p.m., on 8/27/14, the CSC indicated Resident #33 was in the beauty shop on 8/21/14 around 10:30 a.m., when Resident #140 was taken in there to weigh her.</p> <p>2. A policy titled, Guidelines for Contact Precautions, no date, was received from the Director of Health Services (DHS), on 8/21/14 at 12:16 p.m. The policy indicated, "...Contact Precautions are indicated to prevent and control</p>			

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	<p>noscomial transmission of infection with any of the following:...b. Clostridium difficile [C. diff]....5. Personal Protective Equipment:...b. Wear a clean [sic] non-sterile, fluid resistant gown when entering the room if it is anticipated clothing will have substantial contact with the resident or environmental surface [sic] or when there is likelihood that organisms from blood, urine, stool, or wound drainage may be on surfaces or items in the resident's rooms. c. Substantial contact is defined when the worker can anticipate that his/her clothing will be directly in contact with the resident, resident's linen or bed....10. Transferring Residents/Allowing Residents out of Rooms: a. Residents in Contact Precautions may come out of their room as long as the contaminant requiring isolation is contained. (i.e. dressing, catheters, brief, etc)...."</p> <p>"How can Clostridium difficile Infection Be Prevented in Hospitals and Other Healthcare Settings," (last updated 3/6/12) was retrieved on 8/21/14 at 12:20 p.m., from the Centers of Disease Control (CDC) website. The guidance indicated to, "...use gowns when entering patient's rooms and during care....continue these precautions until diarrhea ceases...."</p> <p>Another article titled, Guidelines for Isolation Precautions: Preventing</p>			

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	<p>Transmission of Infectious Agents in Healthcare Settings (last updated 1/13/14) was retrieved on 8/21/14 at 12:20 p.m., from the CDC website. The article indicated on page 85, "...V.B. Patient Transport V.B.4.a. In acute care hospitals and long-term care and other residential settings, limit transport and movement of patients outside of the room to medically-necessary purposes.</p> <p>V.B.4.b. When transport or movement in any healthcare setting is necessary, ensure that infected or colonized areas of the patients body are contained and covered...."</p> <p>During an interview with the Director of Health Services (DHS), on 8/21/14 at 1:49 p.m., she indicated the Facility's Corporation was in the process of revising their policy regarding contact isolation/C. diff and the Corporation was aware that the policy did not follow CDC guidelines.</p> <p>On 8/22/14, at 11:00 a.m., the Campus Support Clinician (CSC) indicated she directed the Facility's Corporation that the CDC recommended to only transport residents out of their room when it was medically necessary. The CSC further indicated the Facility's Corporation plan to revise their policy to match the CDC recommendations regarding</p>			

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F009999	<p>transportation of residents out of their room.</p> <p>3.1-18(b)(2) 3.1-18(a)</p> <p>State Findings</p> <p>3.1-14 PERSONNEL</p> <p>(b) A facility must not use any individual working in the facility as a nurse aide for more than four (4) months on a full-time, part-time, temporary, per diem, or other basis unless that individual:</p> <p>(1) is competent to provide nursing and nursing related services, and:</p> <p>(2) has completed a:</p> <p>(A) training and competency evaluation program; or</p> <p>(B) competency evaluation program approved by the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure a CNA</p>	F009999	<p>F 9999 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: CNA #12 has a current certification on file.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all employed CNA's to ensure they have a current certification on file. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing Leadership team on the following regulation: 3.1-14 PERSONNEL (b) A facility must not use any individual working in the facility as a nurse aide for more than four (4) months on a full-time, part-time, temporary, per diem, or other</p>	09/27/2014	

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	<p>(Certified Nursing Assistant) received her Indiana certification within 120 days of her hire date for 1 of 53 CNA's reviewed for appropriate certification. (CNA #12)</p> <p>Findings include:</p> <p>The Employee Records form and CNA certifications were reviewed on 8/28/14 at 11:00 a.m. CNA #12 had a start date of 11/19/13. Upon review of CNA certifications, no Indiana nurse aide certification was found for CNA #12.</p> <p>The CNA/QMA Testing Form for CNA #12 was provided by the ADHS (Assistant Director of Health Services) on 8/28/14 at 12:45 p.m. It indicated CNA #12 passed her written/oral test on 8/15/14.</p> <p>An interview was conducted with the ADHS on 8/28/14 at 12:45 p.m. The ADHS indicated CNA #12 was from out of state, and that CNA #12 informed her she had until 8/4/14 to get her Indiana certification, even though her start date was 11/19/13. Regarding the ADHS's understanding of the time requirement for obtaining certification in the state of Indiana, the ADHS indicated, "I have no understanding of what the requirement is for out of state people. I was going off her word."</p>		<p>basis unless that individual: (1) is competent to provide nursing and nursing related services; and: (2) has completed a: (A) training and competency evaluation program; or (B) competency evaluation program approved by the division. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 CNAs will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review certification on file to ensure it is current. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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R000000	The following state residential findings are cited in accordance with 410 IAC 16.2-5.	R000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey on August 28, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.			

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	<p>Based on observation and interview, the facility failed to ensure a vendor wore a hairnet in the kitchen during meal preparation. This had the potential to affect 26 of 53 residents residing in the assisted living facility.</p> <p>Findings include:</p> <p>During an observation, on 8/25/14 at 11:45 a.m., a [name of company] food/drink vendor was observed in the kitchen, without a hairnet on. The vendor was near the food preparation area.</p> <p>During an interview with the Dietary Manager, on 8/25/14 at 11:46 a.m., he indicated the vendor should have a hairnet on in the area the vendor was observed standing. The Dietary manager indicated he already told the vendor's partner that they need to put on a hairnet if they were going to be in the food preparation area.</p> <p>A policy titled, Food Production Guidelines-Sanitation & Safety, dated 2009, was received from the Administrator on 8/25/14 at 1:50 p.m. The policy indicated, "...3. Approved hairnets, caps or other effective hair restraints shall be used...in the preparation and service of food...."</p>	R000273	<p>R 273 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Observation of employees / vendors in the kitchen area to ensure hair nets are completely covering their hair. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team and visiting vendors on the following campus guideline: Sanitation and Safety - related to the requirement of use of hair nets in the food preparation area. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Observation of employees and vendors in the kitchen area to ensure hair nets are in place in the food preparation area. The results</p>	09/27/2014			

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			of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.		