

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2015
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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00183942.</p> <p>Complaint IN00183942 - Substantiated. Federal/State deficiency related to the allegations is cited at F323.</p> <p>Survey dates: October 25, 26, 27, 28, 29, & 30, 2015</p> <p>Facility number: 004945 Provider number: 155756 AIM number: 200814400</p> <p>Census bed type: SNF: 36 SNF/NF: 105 Total: 141</p> <p>Census payor type: Medicare: 25 Medicaid: 76 Other: 40 Total: 141</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after November 29th, 2015.</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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F 0241 SS=E Bldg. 00	<p>16.2-3.1.</p> <p>QR completed on November 4, 2015 by 17934.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review the facility failed to promote each resident's dignity by providing food appropriate for a resident who ate with her fingers (Resident #53), protecting a resident's private area from exposure, and ensuring staff were seated when feeding residents.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #53 on 10/30/15 at 11:19 a.m., indicated the following: diagnoses included, but were not limited to, anorexia, glaucoma, dysphagia, weakness, unspecified dementia without behavioral disturbance, and delirium due to known physiological condition.</p>	F 0241	<p>F241 Dignity and Respect of Individuality, It is the practice of this facility to ensure that the residents have an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: -The diet care plan for resident #53 has been modified for foods such as soup and oatmeal, she has a handled cup to assist her in eating those foods of her preference. She continues to be on a mechanical soft diet. Staff will assist with utensils when she wants to eat foods with her fingers. -All staff was in-serviced on or before November 29th, on dignity and</p>	11/29/2015

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	<p>An RD (Registered Dietitian) Review for Resident #53, dated 6/17/15, indicated she received a Mechanical Soft Diet due to being edentulous. The review also indicated she ate her meals in the assist dining room and received assistance as needed.</p> <p>A Dietary Progress Note for Resident #53, dated 9/2/15 and written by the Certified Dietary Manager (CDM), indicated she remained in the assisted dining room all meals and was drinking fortified milk all meals to prevent significant weight loss. The note also indicated Resident 53 remained on a Mechanical Soft Diet.</p> <p>A Progress Note for Resident #53, dated 10/20/15 and written by the RD, indicated the resident was spilling liquids from her cups, The recommendation was made for a 2 handled cup with a lid for her beverages to decrease spillage.</p> <p>During an observation in the Assist dining room on 10/25/15 at 12:10 P.M., Resident #53 was seated in her wheelchair along the outside of a kidney shaped dining table with three other residents. A Certified Nursing Assistant (CNA) was observed seated in the inside curve of the kidney shaped dining table. Resident #53 was observed to receive the</p>				<p>ensuring residents private areas are covered up when assisting residents down the hallways and in public areas. -LPN #5 was educated on not standing while assisting residents with feeding.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> - All residents have the potential to be affected by the alleged deficient practice. - DNS/Designee will review residents and staff interactions during meals and in the hallway on an on-going basis to determine if any staff are standing while feeding, have residents exposed, or any residents eating with their fingers that are not on a finger food diet. -The facility will inservice all nursing staff and IDT members on dignity and respect of individuality including meal service observation on or before November 29th, 2015. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur - DNS/Designee will review residents and staff interactions during meals and in the hallway on an on-going basis to determine if any staff are standing while feeding, have residents exposed, or any residents eating with their fingers that are not on a finger food diet. - The facility will inservice all 		

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	<p>lunch meal of: ground Salisbury steak, whipped potatoes with gravy, green beans, and a chocolate peanut butter square, which had been pureed (blended to a smooth consistency). She was observed to eat her lunch meal with her fingers, including the mashed potatoes and pureed chocolate peanut square. There was a spoon on her plate, but she was not observed to use it. Staff seated in the inside curve of the kidney were not heard to encourage Resident #53 to use her spoon.</p> <p>Modified Spread Sheets for the meal for the week of the survey were provided by the CDM on 10/30/15 at 11:30 a.m. The spread sheets for the lunch meal on 10/25/15 indicated a Finger Food Diet consisted of Salisbury steak on bun, hashbrown patty, gravy, green beans, and a chocolate peanut butter square. The spread sheet also indicated a Mechanical Soft diet consisted of a chocolate peanut butter square.</p> <p>During an observation in the Assist dining room on 10/27/15 at 12:22 p.m., Resident #53 was seated in the same place at the kidney shaped dining table. Resident #53 was observed to receive the lunch meal of: ham loaf, scalloped potatoes, peas, and cherry delight dessert. She was observed to feed herself with her</p>		<p>nursing staff and IDT members on dignity and respect of individuality including meal service observation on or before November 29th, 2015.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> -A CQI monitoring tool, Meal Service Observation and Dignity and Privacy, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT. -Data will be collected by Administrator and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. -Non-compliance with facility procedure may result in disciplinary action up to and including termination. <p>Completion date: November 29th, 2015. Reason for IDR: Reduce Scope and Severity of tag. The observation of an unidentified male resident being pushed in a wheelchair and being exposed. There are several residents are care planned for wearing casual clothes, even underclothes at times, but we are unable to determine if this was one of those residents. Another resident was observed in the 300 dining hall with her sweatshirt up on her right side. There are several residents who are care planned for clothing that will be</p>	

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	<p>fingers, including the dessert. Staff were observed to attempt to feed her, but she would not accept any food from them.</p> <p>A Modified Spread Sheet for the lunch meal on 10/27/15 indicated a Finger Food Diet consisted of ham loaf (cut in pieces), oven browned potatoes, sugar snap peas, and a strawberry shortcake bar.</p> <p>During an observation in the Assist dining room on 10/28/15 at 8:15 a.m., Resident #53 was seated in the same place at the kidney shaped dining table. Resident #53 was observed to receive the breakfast meal of: pancake with syrup, ground sausage patty with gravy, and hot cereal. When the surveyor first entered the dining room, she had three flo-control cups with beverages at her place setting. She was observed drinking orange juice from a glass. She was also observed eating her pancake with syrup and hot cereal with her fingers. The surveyor stepped out of the Assist dining room into the Main dining room, and returned to the Assist dining room moments later. The glass of orange juice Resident #53 had been drinking had been transferred into a flow control cup. For the next 10 minutes, Resident #53 attempted to drink her orange juice from the wrong side of the flow control cup. She was not re-directed by staff and staff were not</p>		<p>out of place due to resident frequently scratching or adjusting their own clothing. This resident was not identified.</p>				

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	<p>observed to assist her to turn the cup around so she would be able to place the drinking spout into her mouth.</p> <p>A Modified Spread Sheet for the breakfast meal on 10/28/15 indicated a Finger Food Diet consisted of dry cereal, pancake, sausage patty, and syrup on the side.</p> <p>During an observation in the Assist dining room on 10/29/15, Resident #53 was seated in the same place at the kidney shaped dining table. Resident #53 was observed to receive the breakfast meal of: oatmeal, scrambled egg, sausage link with gravy and a cinnamon roll. There was a spoon inside the bowl of oatmeal, but she was observed to eat the hot cereal with her fingers.</p> <p>A Modified Spread Sheet for the lunch meal on 10/29/15, indicated a Finger Food Diet consisted of dry cereal and a hard cooked egg.</p> <p>During an observation in the Assist dining room on 10/29/15, Resident #53 was seated in the same place at the kidney shaped dining table. Resident #53 was observed to receive the lunch meal of: ground honey chicken with gravy, oven browned potatoes, French style green beans, and strawberry ice cream.</p>			

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	<p>She was observed to grasp a clump of French style green bean with her fingers and place them in her mouth. She was also observed to eat the strawberry ice cream with her fingers.</p> <p>A Modified Spread Sheet for the lunch meal on 10/29/15, indicated a Finger Food Diet consisted of honey chicken in strips, green beans, and an ice cream sandwich.</p> <p>CNA #8 was interviewed on 10/29/15 at 2:00 p.m. During the interview she indicated Resident #53 would not use her eating utensils to eat, but would feed herself with her fingers. She also indicated Resident #53 usually would not let staff feed her. She further indicated she thought Resident #53 had not been placed on a Finger Food Diet due to receiving fortified foods.</p> <p>The Consultant RD was interviewed on 10/30/15 at 10:30 a.m. During the interview she indicated Resident #53 only received fortified milk at all meals. She also indicated the facility did not have a Mechanical Soft Finger Food Diet.</p> <p>2. During an observation on 10/27/15 at 11:28 a.m., an un-identified nursing personnel was observed pushing a male resident in a wheelchair around the</p>			

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	<p>nursing station and down the 500 Hall. The male resident was observed to be wearing a white T-shirt and a pair of plaid boxer shorts. His boxer shorts were up very high on his thighs with the leg opening close to the inside of his leg exposing his private area.</p> <p>The Director of Nursing Services (DNS) and the DNS Specialist were interviewed on 10/30/15 at 10:35 a.m. During the interview they indicated all private areas of residents should be protected from exposure.</p> <p>3. Observations during evening meal in Auguste Cottage on 10-25-2015 indicated the following:</p> <p>At 6:18 p.m., LPN (Licensed Practical Nurse) #5 was observed standing next to a seated resident and began feeding the resident her fruit.</p> <p>At 6:20 p.m., LPN # 5 was observed standing next to another resident seated in her wheelchair and began feeding the resident her meal.</p> <p>At 6:25 p.m., LPN #5 was observed standing next to a third seated resident and began feeding the resident her fruit.</p> <p>4. An observation in the 300 hall dining</p>			

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F 0323 SS=D Bldg. 00	<p>room during the lunch meal on 10-28-2015 at 12:10 p.m., indicated a resident was in her high backed wheelchair and her sweatshirt was up on her right side which exposed her right side abdomen and hip.</p> <p>The DNS and the DNS Specialist were interviewed on 10/30/15 at 10:35 a.m. During the interview they indicated staff were not to stand when feeding residents.</p> <p>The facility "Resident Handbook, Residents' Rights and Advanced Directives", revised September 2014, indicated "...The resident has a right to a dignified existence...."</p> <p>3.1-3(t)</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.</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent falls for 2 of 5 residents reviewed for</p>	F 0323	<p>F323 Free of Accident Hazards/Supervision/Devices, It is the practice of this facility to ensure that the residents environment remains as free of</p>	11/29/2015

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	<p>falls. (Resident H and Resident B)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #H on 10/30/15 at 9:51 a.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's disease, dementia, and history of falling.</p> <p>Resident #H was admitted to the facility on 2/19/15.</p> <p>A Minimum Data Set (MDS) assessment, dated 5/26/15, indicated a score of 5 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The MDS also indicated he required extensive assistance with the physical assistance of 2 staff for bed mobility and transfers, and required limited assistance with the physical assistance of 1 staff for locomotion. The MDS further indicated he was not steady, only able to stabilize with human assistance, when moving from a seated to standing position and walking. The MDS also indicated he was not on a toileting program.</p> <p>Review of the clinical record for Resident H indicated he experienced falls on: 5/16/15, 5/21/15, 5/27/15, 5/30/15,</p>		<p>accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-Resident H's fall care plans and environment were reviewed to ensure adequate fall interventions and supervision were in place.</p> <p>-Resident B's fall care plans and environment were reviewed to ensure adequate fall interventions and supervision were in place.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>- All residents have the potential to be affected by the alleged deficient practice.</p>	

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	<p>6/9/15, 6/13/15, 6/14/15, 6/18/15, 6/24/15, 7/2/15, 7/3/15, 7/11/15, 8/3/15, 8/23/15, 8/26/15, 9/11/15, 9/23/15, 9/29/15, 10/21/15, 10/22/15, and 10/25/15.</p> <p>Review of the Resident Profile for Resident #H indicated the following fall interventions prior to 8/3/15: hipsters on at all times, offer to lay resident down after meals, autolock brakes on wheelchair, tilted wheelchair seat, hi-low bed with bed in lowest position, winged mattress, non-skid strips in front of the toilet, patient helper to toilet, floor mat next to bed, and staff to walk resident with walker in afternoon after lunch.</p> <p>An Event Report for Resident #H, dated 8/3/15 at 9:44 a.m., indicated he was seated in his wheelchair at a dining room table in Auguste's Cottage (secured unit) when he got up unassisted and took steps, tripping over another resident's wheelchair falling to the ground on his left side. The report also indicated he incurred a skin tear to his left knee. The report further indicated the resident stated he got up because he had to use the restroom. He was incontinent of his bladder at the time of the fall. The IDT (Interdisciplinary Team) indicated Resident #H had a toileting plan in place and staff were educated to toilet him</p>		<p>- DNS/Designee will review residents with falls and fall care plans on an on-going basis to determine if any fall interventions or increased supervision is necessary to keep residents as free of accidents hazards as is possible.</p> <p>-The facility will inservice all nursing staff and IDT members on falls interventions and supervision on or before November 29th, 2015.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>- DNS/Designee will review residents with falls and fall care plans on an on-going basis to determine if any fall interventions or increased supervision is necessary to keep residents as free of accidents hazards as is possible.</p>		

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	<p>immediately following meals.</p> <p>An Event Report for Resident #H, dated 8/23/15 at 2:10 p.m., indicated he was observed lying on the carpeted mat on the floor next to his bed. The report also indicated prior to the occurrence, he had eaten his lunch, was toileted, and assisted into bed. The report further indicated he had removed his body pillow and non-skid socks per self while lying in bed. The report also indicated he was placed back into his bed, but continued to be restless so staff assisted him up into his wheelchair in direct sight of staff. The IDT reviewed his fall interventions and considered all were still appropriate and effective and did not recommend any additional fall interventions.</p> <p>An Event Report for Resident #H, dated 8/26/15 at 6:26 a.m., indicated he was found lying on the mat next to his bed on his left hip with his legs bent towards the bed and his back and left shoulder lying on the back of his wheelchair. The wheelchair was lying on it's back with the wheels toward the wall. The report also indicated the bed was in the low position, the mat was on the floor, his hipsters were on, his gripper socks were on, and his body pillow was in position. The report further indicated Resident #H had climbed or rolled over the body pillow.</p>		<p>-The facility will inservice all nursing staff and IDT members on falls interventions and supervision on or before November 29th, 2015.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-A CQI monitoring tool, Fall Management, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT.</p> <p>-Data will be collected by Administrator and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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	<p>The IDT recommended anti-tippers to be added to his wheelchair and for his wheelchair to be placed in the bathroom during the night.</p> <p>An Event Report for Resident #H, dated 9/11/15 at 11:05 a.m., indicated he was in his wheelchair in the hallway, grabbed onto the handrail, and stood up. The report also indicated he went to sit back down, missed the wheelchair, and sat down on the floor in front of the wheelchair. The report also indicated a Certified Nursing Assistant was at the opposite end of the hallway and could not reach him in time. The IDT recommended staff walk with Resident #H between the breakfast meal and the lunch meal.</p> <p>An Event Report for Resident #H, dated 9/23/15 at 5:46 a.m., indicated he was found on the floor at the foot of the roommate's bed, lying on his left side with his left arm under him and his right arm holding the foot of the roommate's bed. His legs were straight out towards his bed. The report also indicated he was wearing hipsters and non-skid socks at the time. The report further indicated his bed was in the lowest position, a carpeted mat was on the floor, and a winged mattress and a body pillow were in place. The IDT indicated Resident #H was not</p>		<p>Completion date: November 29th, 2015.</p>	

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	<p>able to stand up from his bed in the lowest position and likely crawled out of bed. Resident #H had been placed on 15 minute checks, but they were discontinued. All interventions were in place and effective. No additional fall interventions were recommended.</p> <p>An Event Report for Resident #H, dated 9/29/15 at 2:15 p.m., indicated he was observed to ambulate without assistance into the hallway and was witnessed holding onto the handrail. The report also indicated he became weak, lost his balance, and landed on his side on the floor. The report further indicated prior to the occurrence he had been walked following the lunch meal and then requested to lay in bed. The report also indicated his previous fall interventions were in place. The IDT did not recommend any additional fall interventions.</p> <p>An Event Report for Resident #H, dated 10/21/15 at 6:45 p.m., indicated he was in the dining room in his wheelchair and had completed his dinner, moved himself away from the dining table, stood up, moved away from his wheelchair, and fell to the floor on his left side. The IDT recommended for Resident #H to be served in the 1st group of residents receiving their dinner meal so he could</p>			

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	<p>be occupied with eating while staff served the remaining residents. Once he was finished eating staff could assist him to bed if he desired.</p> <p>An Event Report for Resident #H, dated 10/22/15 at 11:47 a.m., indicated he had fallen and was sitting on the dining room floor. The report also indicated he was seated behind another resident's wheelchair with his hand holding the handle on the back of the wheelchair. The report further indicated he was placed on 1:1 supervision due to restlessness.</p> <p>An Event Report for Resident #H, dated 10/26/15 at 10:45 p.m., indicated he was observed lying on his left side on the floor in the hallway in front of his room. The report also indicated he was wearing his hipsters and gripper socks. The report further indicated he complained of pain to his left elbow and left knee. There was soft swelling and pale blue bruising to his left elbow. There was no bruising or deformities noted to his left knee. The report also indicated he was assisted back to bed with more frequent staff monitoring throughout the night.</p> <p>A Progress Note for Resident #H, dated 10/27/15 at 5:50 a.m., indicated he complained of pain to his left elbow and</p>			

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	<p>left knee.</p> <p>A Progress Note for Resident #H, dated 10/27/15 at 8:07 a.m., indicated the IDT met to review the fall on 10/26/15. The note also indicated a new order was received for an x-ray of his left elbow and left knee. The note further indicated he had been awake all day on 10/26/15, walked several times, and allowed to stand with assist for extended periods of time. The note also indicated he had become physically stronger which accounted for him being able to get out of bed per self, but had the diagnosis of dementia resulting in continued decreased safety awareness.</p> <p>A Progress Note for Resident #H, dated 10/27/15 at 9:42 a.m., indicated he recently had an increase in his Buspar (anti-anxiety medication) due to increased anxiety.</p> <p>A Radiology Report for Resident #H, dated 10/27/15, indicated mild arthritic changes and osteopenia to his left knee.</p> <p>A Progress Note for Resident #H, dated 10/27/15 at 4:08 p.m., indicated a new order was received to discontinue Buspar 10 mg (milligrams) daily and to start Buspar 5 mg BID (twice a day). The note also indicated an order for Ativan</p>			

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	<p>(anti-anxiety medication) 0.25 mg TID (three times a day) related to anxiety and restlessness.</p> <p>A Progress Note for Resident #H, dated 10/27/15 at 9:20 p.m., indicated he continued to guard his left knee.</p> <p>A Progress Note for Resident #H, dated 10/28/15 at 10:37 a.m. and written by the Nurse Practitioner (NP), indicated he was seen for an evaluation of his condition per nursing request due to abnormal posture. The resident was leaning forward in his chair and was unable to maintain a normal posture in his chair. The note also indicated the resident had experienced 2 falls in the past few days and after the last fall had complained of left knee pain. The note further indicated Resident #H had multiple falls in the past. The note also indicated due to the resident being a poor historian, abnormal posture, and recent falls, a STAT (immediately) medical work-up was warranted. A x-ray of his spine and bilateral femurs was ordered.</p> <p>A Radiology Report for Resident #H, dated 10/28/15, indicated a suspected fracture involving the neck of the femur with slight displacement.</p> <p>A Progress Note for Resident #H, dated</p>			

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	<p>10/28/15 at 2:35 p.m., indicated the x-rays indicated a suspected fracture of the left hip and right lower lobe infiltrate effusion. The note also indicated a new order was received to sent the resident to the local ER for evaluation and treatment. He returned to the facility at 11:20 p.m.</p> <p>A Progress Note for Resident #H, dated 10/29/15 at 2:31 p.m. and written by the NP, indicated he had been increasingly restless with more falls. The note also indicated a reduction in his Buspar and the addition of a low dose of Ativan. The note further indicated the x-ray following the most recent fall resulted in a fractured hip. The note also indicated the Buspar would be discontinued and the Ativan reduced to 0.25 mg BID. The note further indicated the NP would "start over if needed" with his medications.</p> <p>A Progress Note for Resident #H, dated 10/30/15 at 9:08 a.m., indicated the NP believed the increase in his Buspar may have caused more anxiety which may have contributed to his fall. The note also indicated he was not getting out of bed at this time. The fall interventions of walk to dine, walk between meals, serve first at dinner, and offer to lay down after meals, etc., had been discontinued.</p> <p>A current facility care plan for Resident</p>			

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	<p>#H, with a review date of 10/15/15, indicated the problem area of resident at risk for falls due to: decreased mobility, history of falls, cognition to Alzheimer's disease, and medication regimen. Approaches to the problem included, but were not limited to, call light in reach, hipsters on at all times, hi-low bed with bed in lowest position, winged mattress, floor mat next to bed, and hourly visual rounding during the night. The last fall intervention of hourly visual rounding during the night was started on 10/27/15 following his fall on 10/26/15.</p> <p>A current facility care plan for Resident #H, with a review date of 10/15/15, indicated the problem area of resident has risk for pathological fracture related to diagnosis of osteoporosis and history of fracture. Approaches to the problem included, but were not limited to, administer medications as ordered, assist resident with transfers as needed, encourage/remind resident to ask for help, keep room/pathways free of clutter, and call light within reach.</p> <p>The Director of Nursing Services was interviewed on 10/30/15 at 3:00 p.m. During the interview she indicated the facility was continuously starting new interventions for Resident #H to prevent his falls. She also indicated the</p>			

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	<p>Auguste's Cottage was alarm free. She further indicated there was no pattern to his falls. She also indicated she did not think he was was able to get up out of bed on his own, but he had become stronger and was able to get up from his bed in the lowest position. She further indicated it was trial and error for Resident #H as his dementia increased and his safety awareness decreased.</p> <p>2. A review of the Event Reports for Resident B provided by the Director of Nursing on 10-29-2015 at 11:50 a.m., indicated Resident B had 30 falls reported from 7-3-2015 through 10-13-2015. Twenty-seven of the 30 falls were unwitnessed.</p> <p>Nine unwitnessed falls were recorded in July 2015 on the 3rd, 5th, 9th, 11th, 14th, 16th, 17th, 18th, and 20th. All falls occurred in Resident B's room with the bed alarm sounding during 6 of the 9 falls. Interventions put into place after the falls included increased monitoring, continuous monitoring, one on one supervision, frequent bed checks and increased check and change for incontinence.</p> <p>Ten falls were recorded in August of 2015 with 2 of the 10 falls witnessed. The 8 unwitnessed falls occurred on the 1st, 9th, 15th, 17th, 20th, 24th, 26th and</p>			

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	<p>the 29th and happened in the resident's room. Interventions put in place after those falls included increased visual bed checks each hour, staff to remain in with resident in bathroom at all times, one on one, 3 day bowel and bladder assessment, toileting, brought to nurses station for one on one, need to check on resident every hour while in bed, bed monitor and resident needs to be with staff all the time.</p> <p>The 2 witnessed falls occurred on the 13th and the 27th. A review of the 8-13-2015 event report indicated Resident B was sitting in her wheelchair in the 300 hall near the nurses station and stood up with the assistance from the rail in the hallway. The resident was observed by another nurse and CNA (Certified Nursing Assistant) who were unable to get to the resident before she lowered herself to the floor. The Event Report indicated the intervention put in place to prevent another fall was "...keep in close proximity at all times...."</p> <p>A review of the 8-27-2015 event report indicated Resident B was in the activity room in her wheelchair while another staff member heard the alarm sounding and was unable to get to the resident in time. The staff witnessed Resident B stand from her wheelchair and slide to</p>			

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	<p>the floor.</p> <p>Ten falls were recorded in September 2015, with 1 of the 10 witnessed. The 9 unwitnessed falls occurred on the 3rd, 8th, 9th, 11th, 13th, 14th, 16th, 17th and the 20th. The falls occurred in the front lobby, another resident's room, the bird room, the lounge behind the nurse's station and 5 of the falls occurred in the resident's room. Interventions put into place included dycem to the wheelchair, monitor resident, sit resident inside nurse's station next to nurse, monitor frequently, 2 hour toileting, be by staff when up in chair, need to be by staff when up in wheelchair, resident to go to activities, need to be with staff at all times and place resident in her wheelchair and put in her in the hallway to be observed by staff.</p> <p>The witnessed fall occurred on 9-9-2015 at 8:45 p.m., in the 300 hall as Resident B was in her wheelchair and attempted to transfer herself to a chair. The Event Report indicated staff observed but was unable to get to the resident in time to prevent the fall. The Event Report indicated the intervention after the fall was to put Resident B in front of the nurse's station.</p> <p>One fall was recorded for October 2015</p>			

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	<p>as an unwitnessed fall in the dining room. A review of the IDT note for the 10-13-2015 fall, indicated Resident B was sitting in the hallway with a nurse. The note indicated the nurse left the resident and entered another room to give medications. Resident B propelled herself to the dining room. An alarm was sounding and Resident B was found sitting on her buttocks on the floor. No additional interventions were implemented to prevent another fall.</p> <p>An observation of Resident B on 10/26/2015 at 9:09 a.m., indicated Resident B was in her room in bed. The call light was observed on the wall near the center curtain and not in reach of the resident.</p> <p>An observation of Resident B on 10/26/2015 at 11:08 a.m., indicated Resident B was in her bed. An interview with Resident B at this time indicated she did not know how to get the nurse. The call light was observed to be draped on the wall and not in reach of the resident. A sign at the head of the bed was posted on the wall and indicated, "Don't stand up without help. Push call button...." The resident would not see the sign due to her position in the bed as she would be looking to the wall opposite the sign. Resident B would have to sit up</p>			

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	<p>and turn her head greater than 90 degrees in order to see the sign.</p> <p>An observation and interview with Resident B on 10-27-2015 at 4:30 p.m., indicated the resident was in her bed with the body pillow on her right side and her feet hanging over the edge of the bed. The call light button was observed to be under the resident's left shoulder. Resident B was asked where her call light was and she indicated it was on her foot and pointed to the white band around her left ankle (which was the wanderguard). When the resident was asked how she could get help from the nurse or aide, Resident B indicated she would call out.</p> <p>An observation of Resident B on 10/29/2015 at 2:01 p.m., indicated the resident was in her room in bed and the call light was hanging on the wall.</p> <p>The record review for Resident B began on 10-29-2015 at 3:00 p.m. Resident B was admitted to the facility on 6-20-2015 with diagnoses that included but were not limited to diabetes, venous thrombosis (blood clot), dysphagia (difficulty swallowing), multifactorial encephalopathy (disorder of the brain), dementia with behavioral disturbances, anxiety and history of falling.</p>			

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	<p>A review of the admission nursing assessment dated 6-20-2015, indicated the resident was alert, had a fall during the last month but no falls were indicated in the 2 to 6 months prior. The assessment indicated the resident was unable to move from a seated to a standing position, walk or transfer self. A nurse's note indicated the resident required a maximum of 2 assists for activities of daily living and turning.</p> <p>A review of the MDS (Minimum Data Set) assessment for the BIMS (Brief Interview for Mental Status) score, which was a measure of cognitive status indicated the following: The admission BIMS score dated 6-27-2015 was 3/15. (with 15 being cognitively intact). The 30 day BIMS score dated 7-16-2015 was 4/15. The 60 day BIMS score dated 8-17-2015 was 2/15. All scores indicated Resident B was severely cognitively impaired. Further review of the MDS for the previous dates indicated Resident B required extensive assistance of 2+ persons for bed mobility, transfers, toileting, personal hygiene and bathing.</p> <p>A review of the current physician orders indicated the following:</p>			

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	<p>"...Activity level: Up Ad Lib (as desired) w/assist (with assist) in w/c (wheelchair)...positioning devices: carpeted mat next to bed every shift...hi low bed in lowest position every shift...positioning/devices: body pillow on left side of bed...every shift...wanderguard - check for placement and function every shift...wheelchair alarm - check placement and function every shift...auto lock brakes to wheelchair...hipsters on only while up in w/c every shift...dycem to w/c...fall prevention every shift...winged mattress to bed...non-skid strips in front of toilet...patient helpers to toilet...."</p> <p>A review of the updated Resident Profile dated 10-29-2015 and provided by the Corporate Nurse on 10-29-2015 at 2:34 p.m., indicated the following for falls:</p> <p>"...7-6-2015 w/c (wheelchair) alarm 7-2-2015 carpeted mat by bed and hi low bed, bed in lowest position 8-27-2015 hipster when up 7-15-2015 body pillow left side...head and foot board padded 7-16-2015 resident to have frequent bed checks 7-15-2015 provide resident with an activity apron and different extenuated cloths 8-3-2015 visual checks every 1 hours during night</p>			

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	<p>8-14-2015 offer scheduled activity in activity room following lunch meal</p> <p>8-17-2015 3rd shift to get up and place in visible area</p> <p>8-27-2015 auto lock brakes on w/c...offer snack when 3rd shift gets up for the day</p> <p>9-4-2015 dycem to w/c</p> <p>9-19-2015 winged mattress to bed</p> <p>9-21-2015 staff to ensure environment is safe for resident to crawl on floor.</p> <p>10-28-2015 non skid strips in front of toilet...pt (patient) helper to toilet...."</p> <p>A risk for fall care plan dated 7-2-2015 and provided by the Director of Nursing Service Supervisor on 10-29-2015 at 2:34 p.m., indicated the same approaches as the profile and the following additional approaches, call light in reach, non-skid footwear, personal items in reach and therapy screen.</p> <p>A confidential interview with CNA #2 indicated Resident B's safety measures in the room included a hi/low bed, a tab alarm which was placed on the shoulder that was up and a body pillow under the fitted sheet. CNA #2 indicated when Resident B was up in her wheelchair, the tab alarm was placed and Resident B was to be constantly checked. When CNA #2 was asked what the definition of constantly checked meant, CNA #2 indicated the resident was with someone</p>			

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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804
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	<p>at all times, like a one on one but when the CNA had to take care of another resident, Resident B would be placed in the doorway of the other resident's room. CNA #2 indicated during the time she would be taking care of the other resident, she would be asking Resident B if she was doing ok.</p> <p>A confidential interview with CNA #6, indicated Resident B had a tab alarm for her wheelchair. CNA #6 indicated when Resident B was up in her wheelchair, she was to be with staff at all times. CNA #6 indicated if another resident needed care, she had to find another aide to watch Resident B. While providing care for other residents, CNA #6 indicated there were staff members sitting at the nurses station while the Resident B's alarm was sounding and no one came to assist Resident B.</p> <p>A confidential interview with CNA #3 indicated when the resident was up, the resident had to be with a staff member. CNA #3 indicated when the staff were to provide care for another resident, another staff member needed to be summoned to watch the Resident B.</p> <p>An interview with the DNS (Director of Nursing Services) on 10-30-2015 at 1:25 p.m., indicated there was not any</p>			

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	<p>documentation of the resident checks by the staff. The DNS indicated the customary times for the aides to do bed checks at night was at 12:00 a.m., 2:00 a.m. and 4:00 a.m., but there was no documentation for the bed checks. The DNS indicated Resident B was to be checked visually frequently as she had been known to crawl on the floor in her room, but there was no documentation in place for the visual checks.</p> <p>A current policy, "Fall Management Program" dated 2/2015 and provided by the DNS on 10-30-2015 at 9:49 a.m., indicated "...it is the policy...to ensure residents residing within the facility will maintain physical functioning through the establishment of physician, environmental, and psychosocial guidelines to prevent injury related to falls...Fall risk will be assessed upon admission or re-admission...care plan will be developed at time of admission specific to each resident's fall risk factors...The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile...interdisciplinary team will discuss new residents on the 1st morning after the day of admission in the clinical meeting...fall risk will be discussed at this time, including appropriate interventions...All falls will be discussed</p>			

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F 0371 SS=E Bldg. 00	<p>by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls...."</p> <p>This Federal tag relates to complaint IN00183942.</p> <p>3.1-45(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, interview and record review the facility failed to maintain clean microwaves and refrigerators in hall kitchenettes and in the Activity Room and also failed to ensure food and beverages were labeled and dated in the hall kitchenettes refrigerators and freezers and lounge areas in 4 of 5 dining room kitchenettes and lounge areas and 1 Activity room.</p> <p>Findings include: During an initial tour of the facility</p>	F 0371	<p>F371 Food Procure, Store/Prepare/Serve - Sanitary, It is the practice of this facility to ensure that 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.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>	11/29/2015

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	<p>dining room kitchenettes on 10/15/15, the following was observed:</p> <p>On the 300 hall kitchenette at 4:28 p.m., a dried, red sticky substance was observed under the lower drawers in the refrigerator. There was also an opened package of York Minis in the freezer section of the refrigerator, not re-sealed, and not labeled or dated.</p> <p>On the 100 hall kitchenette at 4:31 p.m., a dried, red sticky substance was observed in the bottom of the refrigerator, a covered bowl of Mandarin oranges and a covered bowl of red gelatin with whipped topping were not labeled or dated, a 12 ounce bottle of diet pepsi was not labeled or dated, a covered plate containing a chicken leg, green beans, and cornbread was not labeled or dated, a 7.5 ounce can of cream of mushroom soup with the seal broken was in the door, a 46 ounce bottle of tomato juice was not dated, and a paper bag containing food for a resident on the 100 hall was not dated. An 18.5 ounce bottle of Pure Leaf sweet tea was not labeled or dated and a container of Culver's ice cream identified with the resident's name had an enjoy date stamped on the container of 10/4/15 in the freezer section of the refrigerator. The microwave was soiled with food particles.</p>		<p>practice:</p> <p>-The 300 Hall kitchenette was cleaned thoroughly including the refrigerator and microwave and all unlabeled or dated food was removed.</p> <p>-The 100 Hall kitchenette was cleaned thoroughly including the refrigerator and microwave and all unlabeled or dated food was removed.</p> <p>-The Activity Room kitchenette was cleaned thoroughly including the refrigerator and microwave and all unlabeled or dated food was removed.</p> <p>-The Auguste's Cottage kitchenette was cleaned thoroughly including the refrigerator and microwave and all unlabeled or dated food was removed.</p> <p>-The 400 Hall kitchenette was cleaned thoroughly including the refrigerator and microwave and</p>	

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	<p>In the Activity Room on at 4:34 p.m., the microwave was soiled with food particles.</p> <p>On Auguste's Cottage at 4:38 p.m., a bag of fruit for a resident in the Cottage was not dated and a cardboard box containing 2 slices of pepperoni and sausage pizza was not labeled or dated. A 16 ounce plastic squeeze bag of whipped topping was not re-sealed or dated in the freezer section of the refrigerator.</p> <p>On the 400 hall kitchenette at 4:47 p.m., two 8 ounce individual frozen meals were not labeled or dated.</p> <p>The Consultant Registered Dietitian (RD) was interviewed on 10/30/15 at 10:30 a.m. During the interview she indicated dietary staff were responsible to check the hall kitchenettes on a daily basis.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 10/30/15 at 11:30 a.m. During the interview she indicated the dietary evening supervisor completed a checklist before leaving for the evening. During the interview the CDM provided a copy of the checklist. The checklist indicated all refrigerators must be clean and organized, and everything must be dated and labeled. This included all</p>		<p>all unlabeled or undated/misdated food was removed.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>- All residents have the potential to be affected by the alleged deficient practice.</p> <p>- The Dietary Clinician/Designee will round the facility and check all kitchenettes including but not limited to the 400 Hall Kitchenette, 100 Hall Kitchenette, the Auguste's Cottage, and 300 Hall Kitchenette for cleanliness as well as unlabeled or undated/misdated food or beverages.</p> <p>-The facility will inservice all staff on Food Procurement, Storage, Prepare and Serve with Sanitary Conditions on or before November 29th, 2015.</p>	

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	<p>dining rooms, including the cottage and nourishment room.</p> <p>A current facility policy "Infection Control", revised on July 2015 and provided by the RD on 10/30/15 at 10:48 a.m., indicated "...The refrigerators will be kept clean. Spills...will be wiped up as they are noticed...."</p> <p>A current facility policy "Labeling and Dating", dated August 2014 and provided by the RD on 10/30/15 at 10:48 a.m., indicated "...All opened and leftover items need to be labeled with the date of opening...."</p> <p>3.1-21(i)(2)</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>- The Dietary Clinician/Designee will round the facility and check all kitchenettes including but not limited to the 400 Hall Kitchenette, 100 Hall Kitchenette, the Auguste's Cottage, and 300 Hall Kitchenette for cleanliness as well as unlabeled or undated/misdated food or beverages.</p> <p>-The Dietary Clinician/Designee will inservice Department Heads who serve as weekend managers to ensure rounding and checking of all kitchenettes occurs 7 days a week.</p> <p>-The facility will inservice all staff on Food Procurement, Storage, Prepare and Serve with Sanitary Conditions on or before November 29th, 2015.</p>	

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F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-A CQI monitoring tool, Labeling and Dating Food as Cleanliness of Kitchenettes, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT.</p> <p>-Data will be collected by Administrator and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>Completion date: November 29th, 2015.</p>	

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	<p>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review the facility failed to ensure clean clothing and linens were protected from potential contamination.</p>	F 0441	F441 Infection Control, Prevent Spread, Linens, It is the practice of this facility to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable	11/29/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation of the 500 Hall on 10/25/15 at 6:16 p.m., an un-identified laundry staff was observed delivering clean laundry to residents' rooms. The laundry cart was covered on 3 sides and the front cover flap was draped up over the top of the cart. Folded clean laundry was observed on the top of the front flap which had been draped over the top of the cart. The laundry staff pushed the laundry cart down the hall without replacing the front flap so the front of the cart was closed or protecting the clean folded laundry on the top of the cart. The clean folded laundry on the top of the laundry cart was delivered to a resident's room. 2. During an observation of the 200 Hall on 10/28/15 at 3:35 p.m., CNA #9 was observed to carry a stack of clean linen through the hallway uncovered into a resident's room. The linen was carried up against her uniform top. 3. An observation on 10/27/2015 at 12:20 p.m., indicated the Customer Care Coordinator was pushing an uncovered cart with a resident's clean clothing hanging from the cart and folded clothing was observed stacked on the base of the cart. The Customer Care Coordinator was observed to push the cart down the 		<p>environment and to help prevent the development and transmission of disease and infection.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-The laundry staff was inserviced on ensuring that all flaps of the laundry cart are down and draped over the clean linen during distribution and no laundry is to be stacked on top of the cart.</p> <p>-All Nursing staff was inserviced on how to properly carry clean linen so it does not touch the uniform.</p> <p>-The Customer Care Coordinator was inserviced to ensure during a room move all clean linen is covered while in the hallway and until delivered to the new room.</p> <p>How will you identify other residents having the potential to be affected by the same</p>	

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	<p>100 hall through the main lounge and down to the end of the 500 hall. An interview at this time with the Customer Care Coordinator indicated she was transferring the clothing of a resident from one room to another room.</p> <p>An interview with Laundry #4 on 10-30-2015 at 10:12 a.m., indicated all clean laundry delivered to the units and to the residents should be covered when transported in the hallways.</p> <p>An interview with CNA (Certified Nursing Assistant) #1, CNA #2 and CNA #3 on 10-30-2015 at 10:20 a.m., indicated linens should be carried in the hands and away from the body.</p> <p>An interview with the Customer Care Coordinator on 10-30-2015 at 1:12 p.m., indicated she moves a resident's personal belongings and clothing when the resident moves to another room. The Customer Care Coordinator indicated she did not cover the resident's clean clothing that she gets from their closet or dresser drawers when moving from one room to another room.</p> <p>A current policy "Laundry/Linen" dated 02/2012 and provided by the Director of Nursing on 10-29-2015 at 5:00 p.m., indicated "...clean linen must be</p>		<p>deficient practice and what corrective action will be taken:</p> <p>- All residents have the potential to be affected by the alleged deficient practice.</p> <p>- DNS/Designee will monitor all nursing staff on an on-going basis to ensure staff does not carry clean linen next to their body where it may come in contact with their uniform.</p> <p>-Housekeeping Supervisor/Designee will monitor laundry staff and any staff involved with room moves to ensure all clean linen and clean clothes are covered while transporting in the hallway.</p> <p>-The facility will inservice all staff on Infection Control and Linens on or before November 29th, 2015.</p> <p>What measures will be put into place or what systemic changes you will make to</p>	

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	protected from soiling or contamination...clean linen should be carried away from body to prevent contamination...carts/racks must be covered...." 3.1-19(g)(1)(2)(3)		<p>ensure that the deficient practice does not recur</p> <p>- DNS/Designee will monitor all nursing staff on an on-going basis to ensure staff does not carry clean linen next to their body where it may come in contact with their uniform.</p> <p>-Housekeeping Supervisor/Designee will monitor laundry staff and any staff involved with room moves to ensure all clean linen and clean clothes are covered while transporting in the hallway.</p> <p>-The facility will inservice all staff on Infection Control and Linens on or before November 29th, 2015.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-A CQI monitoring tool, Linen</p>	

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F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. A. Based on observation, interview and	F 0465	Transfers and Infection Control Review, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT. -Data will be collected by Administrator and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. -Non-compliance with facility procedure may result in disciplinary action up to and including termination. Completion date: November 29th, 2015. Reason for IDR: Facility does not believe the frequency of the observations meets the definition of a pattern and is asking for a reduction in scope and severity.	11/29/2015	

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	<p>record review, the facility failed to maintain a clean and sanitary assisted dining room and couches in the locked dementia unit lounge area. This deficient practice had the potential to affect the 13 residents who ate in the assisted dining room and 32 residents who resided on the locked dementia unit.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure resident wheelchairs were maintained in a clean manner for 8 residents who resided on 2 of 6 units in the facility. Resident #82, Resident #147, Resident #9, Resident #63, Resident #65, Resident #2, Resident #84, Resident #85</p> <p>Findings include:</p> <p>A. 1. On 10/25/15 at 4:10 p.m., during the initial tour of the facility, the assisted dining room for the 400 and 500 hall was observed. At this time, there were no residents in the dining room. The baseboards on all four walls in the dining room were observed to have dried white splatters scattered throughout the perimeter of the room. The bases of the 3 wheeled chairs, which were positioned for the staff to sit on while feeding the resident's, were observed to also have dried white splatters on them around the base and the pedestal as well as on the</p>		<p>Safe/Functional/Sanitary/Comfortable Environment, It is the practice of this facility to ensure that the environment is safe, functional, sanitary, and comfortable for all residents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-The wheelchairs for residents #82, #147, #9, #63, #65, #2, #84, #85 were thoroughly cleaned.</p> <p>-The couches on the Auguste's Cottage were cleaned thoroughly as well as the baseboards in the assisted dining room along with the base of the cabinet and the staff wheeled chairs.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>- All residents have the potential to be affected by the alleged</p>		

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	<p>table legs. The bottom half of a wooden cabinet was observed to have dried red spills on the outer side and front door portions of the cabinet.</p> <p>An observation in Auguste Cottage in the dining room/lounge area on 10-25-2015 at 6:30 p.m., indicated a brown smear was on the seat of a sofa close to a dining table. The brown color smear was 1.5 inches long and 1 inch wide.</p> <p>On 10/26/15 at 11 a.m. and 10/27/15 at 9:40 a.m., the assisted dining room was observed. The table legs, chair base, baseboards and lower cabinet were in the same condition as was observed on 10/25/15 at 4:10 p.m.</p> <p>During an observation in the Auguste's Cottage on 10/28/15 at 12:02 p.m., paper wrappers, dirt, and debris were observed around the legs of the couches in the seating area, along the wall, and next to the fish aquarium. There was also dried food and debris observed at the edges of the seat cushions of the couches underneath the arm rests.</p> <p>On 10/28/15 at 11 a.m., and 10/29/15 at 5 p.m., the assisted dining room was again observed and remained in the same condition as observed on 10/25/15 at 4:10 p.m.</p>		<p>deficient practice.</p> <p>-Environmental Supervisor/Designee will round the facility on a daily basis to ensure cleaning standards are being met including but not limited to resident wheel chairs, couches, baseboards, cabinets, and staff wheeled chairs.</p> <p>-The Environmental Supervisor/Designee will inservice all housekeeping staff and nursing staff on cleaning standards including but not limited to cleaning wheel chairs, couches, baseboards, cabinets, and staff wheeled chairs. The inservice will be on or before November 29th, 2015.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>-Environmental Supervisor/Designee will round the facility on a daily basis to ensure cleaning standards are being met including but not limited to resident wheel chairs,</p>		

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	<p>On 10/30/15 at 11:40 a.m., the assisted dining room for the 400 and 500 halls was observed with the Administrator. The dining room remained as observed on 10/25/15 at 4:10 p.m. In addition to the above observations, an overbed table, which a resident had been observed to eat on for the breakfast meal had dried red splatters on the base of the table frame and also crumbs.</p> <p>On 10/30/15 at 11:30 a.m., the dementia unit lounge area was observed. All of the 6 couches in the area were observed to have one and or more of the following observations on the visible surfaces: accumulation of dust and debris in the corners of the couch where the cushions intersected with the frame of the couch; the trim skirt was observed to have stains and/or dark accumulation of soilage; dried red and/or white spatters were observed on the surfaces of the couches; area of liquid, which contained what appeared to be food particles, was observed to have run down the side of the couch and dried; dark stains on the base of the seat cushions.</p> <p>On 10/30/15 at 1:30 p.m., the Housekeeping Supervisor was interviewed. He indicated since the condition of the couches in the dementia</p>		<p>couches, baseboards, cabinets, and staff wheeled chairs.</p> <p>-The Environmental Supervisor/Designee will inservice all housekeeping staff and nursing staff on cleaning standards including but not limited to cleaning wheel chairs, couches, baseboards, cabinets, and staff wheeled chairs. The inservice will be on or before November 29th, 2015.</p> <p>-The Administrator/designee will conduct rounds daily to ensure environmental standards are being met.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-A CQI monitoring tool, Environment and Resident Care Rounds, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT.</p>	

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	<p>unit was brought to his attention, he had cleaned them and all the stains and dried splatters observed on the couches were able to be removed. The Housekeeping Supervisor indicated there was a resident on the dementia unit who "spits a lot on things." He also indicated the facility did not maintain logs to indicate when an area had been cleaned. He indicated there was no set schedule for cleaning the couches but the cleaning was "done on an as needed basis. "</p> <p>On 10/30/15 at 12:15 p.m., the Administrator provided a copy of the current policy and procedure for "Housekeeping." This policy was dated 5/2012 and included, but was not limited to, the following: "The Housekeeping department shall maintain a clean...environment within the facility...clean up all spills and debris promptly...Resident Equipment: Know what equipment housekeeping is responsible for cleaning, such as...furniture, etc..."</p> <p>On 10/30/15 at 1:26 p.m., the Director of Nursing (DON) provided a copy of the current undated facility policy and procedure for "Cleaning Guidelines." These Guidelines included, but were not limited to, the following: "...Weekly Schedule...Common areas...dining</p>		<p>-Data will be collected by Administrator and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>Completion date: November 29th, 2015.</p>	

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	<p>rooms...:dust/disinfect horizontal surfaces..."</p> <p>B. On 10/25/15 at 4:10 p.m., Resident #82 was observed to be sitting in her wheelchair (wheelchair) in the 500 hall. The resident was observed to be sitting on an antipressure cushion. The visible areas of the cushion had dried spills and splatters of a white and red substance along with food particles. The wheelchair was also observed to have food particles on the area of the wheelchair tires, which came in contact with the floor. An accumulation of dust was observed on the criss cross bars on the underside of the wheelchair and also on both sides of the spokes of the wheels.</p> <p>On 10/26/15 at 2:42 p.m., Resident #65 was observed in her wheelchair. Visible dust and accumulation of dried splatters were observed on the base of the wheelchair seat. The cross bars on the bottom of the wheelchair also had a visible accumulation of dirt and dust. There was a dried piece of lettuce on the resident's wheelchair brake on the right side of the wheelchair. The flat horizontal surfaces on the wheelchair all had visible dust and dirt. The condition of the resident's wheelchair was observed on 10/27/15 at 11:30 a.m. 10/28/15 at 11:20 a.m. and remained the same as</p>			

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	<p>observed on 10/26/15 at 2:42 p.m.</p> <p>On 10/26/15 at 3:19 p.m., a confidential family interview was conducted. The family member of a resident indicated the resident's wheelchair was not maintained in a clean manner and had been observed to have food particles on the wheelchair and not be clean.</p> <p>On 10/29/15 at 11:15 a.m., Resident #2, #84 and #85 were observed in their wheelchairs. The wheelchairs had an accumulation of dust along the flat sides of the spokes of the wheels, the cross bars underneath the seat of the wheelchairs and along the flat edges of the wheelchairs.</p> <p>On 10/29/15 at 4:50 p.m., Resident #9 and Resident #63 were observed in their wheelchairs. Both wheelchairs had dried splatters on the seat base and sides, dust and dried splatters accumulated on the spokes of the wheelchair, and on the sides and surfaces underneath the wheelchairs.</p> <p>On 10/30/15 at 10:58 a.m., Resident #82 was observed in her wheelchair. The wheelchair remained in the same condition as observed on 10/25/15 at 4:10 p.m. At this time, Resident #147 was observed in her wheelchair. There</p>			

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	<p>was an accumulation of dust on the cross bars beneath the wheelchair seat and on the spokes of the wheels. Dried food was observed on the spokes of the wheel.</p> <p>On 10/30/15 at 10:40 a.m., Housekeeper #1 was interviewed. Housekeeper #1 indicated if wheelchairs were soiled, housekeeping would disinfect them.</p> <p>On 10/30/15 at 10:45 a.m., CNA #7 was interviewed. She indicated everyone was to clean the wheelchairs and if something was spilled on them, it should be clean when the spill occurred.</p> <p>On 10/30/15 at 10:50 a.m., the DON was interviewed. She indicated the 3rd shift nursing staff had a cleaning schedule for wheelchairs but the wheelchairs were also cleaned on an as needed basis, and when a spill happened, it should have been cleaned up at that time. She indicated once the resident was back in their room and out of their wheelchairs, any food particles should be removed from the wheelchair.</p> <p>On 10/30/15 at 10:56 a.m. the DON provided a copy of the "Chair cleaning schedules" for the "400 Hall night shift" and "500 hall night shift." The schedule specified daily which resident room wheelchairs were scheduled to be</p>			

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F 0520 SS=E Bldg. 00	<p>cleaned. The DON indicated she was unable to find a completed checklist for each hall which would have documented the wheelchairs had been cleaned.</p> <p>On 10/30/15 at 1:26 p.m., the Director of Nursing provided an undated copy of the current facility "Cleaning Guidelines." This copy included, but was not limited to, the following: "...weekly dining: clean dining room chairs and table bases; clean dining areas (sic) walls and cove (sic) base as needed..."</p> <p>On 10/30/15 at 1:30 p.m. the Housekeeping Supervisor was interviewed. He indicated there was no documentation when the assisted dining room was cleaned but the floor baseboards, chair and table legs were to be cleaned weekly.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p>			

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	<p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility QAA (Quality Assessment and Assurance) Committee failed to identify and implement an action plan to correct and monitor the identified concerns of cleanliness of couches in the dementia unit; cleanliness of resident wheelchairs and the assisted dining room; dignity of residents; and lack of cleanliness in 4 of 5 kitchenette/lounge areas and 1 Activity Room.</p> <p>Findings include:</p> <p>On 10/20/15 at 3:35 p.m. the Administrator and Director of Nursing Services (DNS) were interviewed. They indicated the facility QAA (Quality</p>	F 0520	<p>F520 QAA Committee-Members/Meet Quartely/Plans, It is the practice of this facility to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-The wheelchairs for residents #82, #147, #9, #63, #65, #2, #84,</p>	11/29/2015

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	<p>Assurance and Assessment) committee met on a monthly basis and included the following representatives: Administrator, DNS, ADNS (Assistant Director of Nursing Services), all Unit Mangers, Clinical Educator, all IDT (Interdisciplinary Team) members, Department Heads, Medical Director, MDS (minimum data set) nurse, Medical Records supervisor, therapy staff, Dietary Supervisor, Business Office Manager, Environmental/Housekeeping Supervisor, Activities supervisor, Social Service, Memory Care Manager and Pharmacy consultant. The Administrator and DON indicated the QAA committee had not identified the unclean kitchenettes, any dignity concerns, unclean assisted dining rooms and the unclean wheelchairs as problem areas to be addressed by the committee. They indicated they had an internal environmental inspection several weeks ago and the inspection had not identified any concerns with the wheelchairs and couches not being clean. They were also not made aware of any concerns with the kitchenettes from the internal environmental audit. The Administrator indicate the kitchenettes were cleaned frequently.</p> <p>The Administrator indicated the facility audits themselves. He indicated there were different audits, some were</p>		<p>#85 were thoroughly cleaned.</p> <p>-The couches on the Auguste's Cottage were cleaned thoroughly as well as the baseboards in the assisted dining room along with the base of the cabinet and the staff wheeled chairs.</p> <p>-All staff was inserviced on Dignity on or before November 29th, 2015.</p> <p>-All kitchenette/lounge areas and Activity room were thoroughly cleaned.</p> <p>-The QAA committee is adding monitoring tools called Environment and Resident Care Rounds, Dignity, Food Labeling and Dating, Kitchenette Cleanliness, and will be a permanent part of the QAA committee audits.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p>	

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	<p>monthly, some quarterly, it just depended on the concern. He indicated upon review, the audits would be changed on an as needed basis. He indicated the staff, residents and families can complete forms to notify the facility of any grievances and/or concerns. The Administrator indicated these forms were reviewed daily. He indicated these forms go to Social Services and are discussed in the morning meetings the next work day, Monday - Friday. He indicated the facility tries to get a plan to resolve the concern/issue within 24 hours. He indicated they don't always have resolution in that time frame but they should have a plan. He indicated the plan is implemented and there was follow up from the facility to evaluate the plan. He indicated, depending on the department involved, the facility would notify the resident, family or whoever is involved of the outcome or resolution of the issue/concern. The Administrator indicated he signs off on all the concerns and if education and/or inservicing is needed, that is provided as well by the appropriate staff.</p> <p>On 10/30/15 at 1:26 p.m., the DON provided a copy of the current undated "Policy Statement." The statement included, but was not limited to, the following: "It is the standard of...that</p>		<p>- All residents have the potential to be affected by the alleged deficient practice.</p> <p>-The QAA committee is adding monitoring tools called Environment and Resident Care Rounds, Dignity, Food Labeling and Dating, Kitchenette Cleanliness, and will be a permanent part of the QAA committee audits.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>- All residents have the potential to be affected by the alleged deficient practice.</p> <p>-The QAA committee is adding monitoring tools called Environment and Resident Care Rounds, Dignity, Food Labeling and Dating, Kitchenette Cleanliness, and will be a permanent part of the QAA</p>		

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	<p>each facility actively participates in a formalized and documented Quality Improvement Process. The process is comprehensive (involving all departments and key facility practices) and includes monitoring, evaluation and appropriate follow up action to continually improve and provide excellence inservice. Quality improvement is an ongoing process designed to improve present levels of care and services and to provide optimal health opportunity to the residents..."</p> <p>3.1-52(a)(2)</p>		<p>committee audits.</p> <p>-The Administrator will inservice all QAA committee members on the newly added monitoring tools including Environment, Resident Care Rounds, Dignity, Food Labeling and Dating, Kitchenette Cleanliness on or before November 29th, 2015.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-A CQI monitoring tool, QAA Monitoring Tools, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT.</p> <p>-Data will be collected by Administrator and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in</p>	

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			disciplinary action up to and including termination. Completion date: November 29th, 2015.		