

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and Sate Licensure Survey completed on June 13, 2014.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaints IN00149714 and IN00149804 completed on June 5, 2014.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00152292, IN00151165, and IN00152141.</p> <p>Survey Dates: July 16, 17, 18, 21 &amp; 22, 2014</p> <p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey team: Gwen Pumphrey, RN-TC Gloria Reisert, MSW (July 17, 21 &amp; 22, 2014) Jennifer Sartell, RN (July 21 &amp; 22, 2014)</p> <p>Census Bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type:</p>	F000000	Preparationand/or execution of this plan of correction in general, or this correctiveaction in particular, does not constitute an admission of agreement by thisfacility of the facts alleged or conclusions set forth in this statement ofdeficiencies. The plan of correction andspecific corrective actions are prepared and/or executed in compliance withState and Federal Laws.	

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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F000241 SS=D	<p>Medicare: 10 Medicaid: 60 Other: 4 Total: 74</p> <p>These deficiencies reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on July 30, 2014, by Brenda Meredith, R.N.</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, facility failed to ensure urinary catheter bags were covered for 1 of 1 resident reviewed for urinary catheters. (Resident #9)</p> <p>Findings include:</p> <p>The Clinical Record for Resident #9 was reviewed on 7/21/14 at 10:40 a.m. Diagnoses included, but were not limited to, quadriplegia, neurogenic bladder, anemia, hypertension and osteoporosis.</p> <p>On 7/21/14, at 11:00 a.m., The Minimum Data Set Assessment, dated 4/15/14.</p>	F000241	<p><u>F241-Dignity and Respect of Individuality</u> It is the practice of this facility and its' staff to promote at all times the practices and care that enhance the individuality and dignity of our residents. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> Resident#9 had his catheter bag re-hung on the side of his bed, and a dignity cover was placed over the catheter bag as well to promote dignity. <i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective</i></p>	08/21/2014			

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	<p>indicated Resident #9 was alert and oriented, required extensive assist of 2 persons with Activities of Daily Living, which included toileting due to resident with both a suprapubic catheter and colostomy.</p> <p>On 7/21/14, at 11:15 a.m., Resident #9's suprapubic catheter bag was observed to be half full of urine, lying on the floor facing the door and not covered.</p> <p>On 7/21/14, at 2:00 p.m., Resident #9's suprapubic catheter bag was observed to be full of urine, lying on the floor facing the door and not covered.</p> <p>On 7/22/14 at 9:03 a.m., Resident #9's suprapubic catheter bag was observed to be half full of urine, lying on the floor facing the door and not covered.</p> <p>On 7/22/14 at 11:00 a.m., Resident #9's suprapubic catheter bag was observed to be empty, lying on the floor facing the door and not covered.</p> <p>During an interview on 7/22/14 at 1:00 p.m., CNA #1 indicated she did not know what the policy was on Foley/suprapubic catheters.</p> <p>During an interview on 7/22/14 at 1:30 p.m., QMA #1 indicated the following</p>		<p><i>actions will be taken? Any resident that requires a Foley catheter has the potential to be affected. An audit of all residents that utilize a Foley catheter was performed, and new catheter bags with built in dignity covers will be purchased and utilized for any resident utilizing a Foley catheter. In addition, all nursing staff was re-educated on the policy and procedures involved in the care and maintenance of Foley Catheters. What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur? An audit of all residents that utilize a Foley catheter was performed, and new catheter bags with built in dignity covers will be purchased and utilized for any resident utilizing a Foley catheter. In addition, all nursing staff was re-educated on the policy and procedures involved in the care and maintenance of Foley Catheters. 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? The DON will perform audits 5 times weekly of those individuals with Foley Catheters for 2 weeks, then 3 times per week for 2 weeks. The results of these audits will be submitted to the administrator daily for review, then submitted with the decreased frequency when the audit is performed.</i></p>	

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	<p>regarding care for a resident with a Foley/suprapubic catheter: catheter care every shift; don't let the bag overflow; report to nurse if there is no urinary output; report odors; be careful when turning residents not to pull out catheter.</p> <p>During an interview on 7/22/14 at 1:45 p.m., CNA #2 indicated the following regarding care for a resident with a Foley/suprapubic catheter: we empty them and make sure they are not leaking, that is all we do.</p> <p>The Policy titled, Catheterization, Suprapubic Catheter Insertion/Suprapubic Catheter Care, provided by the Assistant Director of Nursing on 7/22/14 at 10:26 a.m., included, but was not limited to, "Policy: A Suprapubic bladder drainage system is utilized to establish drainage from the bladder by introducing a catheter through the anterior abdominal wall into the bladder. Responsibility: Licensed Nursing Personnel. Equipment...Procedure...18. Maintain the system on a daily basis by keeping the drainage system free of kinks in the tubing, maintain below the level of the bladder and keep drainage system off the floor...."</p> <p>This deficiency was cited on June 13, 2014. The facility failed to implement a</p>		<p>With the purchase of the catheter bags that have built in dignity covers, this will virtually eliminate any dignity concerns arising from the bags not being covered. The results of these audits will be submitted to the monthly and quarterly QA &amp; A committee for further review and reassessment for further ongoing monitoring.</p>		

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F000279 SS=D	<p>systematic plan of occurrence to prevent recurrence.</p> <p>3.1-3(t)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop care plans which addressed care of a resident's surgical wounds to leg and non-compliance with dressing changes and keeping legs wrapped. This deficient practice affected 1 of 2 residents reviewed for surgical wounds. (Resident #C).</p>	F000279	<u>F279-Develop Comprehensive Care Plans</u> It is the policy of this facility to be constantly and consistently utilizing the results of our assessments to develop, review and revise each resident's individual care needs, so that their plan of care can be adjusted accordingly to promote the highest functional status possible. <i>What corrective action(s) will</i>	08/21/2014

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	<p>Findings included:</p> <p>Review of the clinical record for Resident #C on 7/17/14 at 12:35 p.m., indicated the resident had had 2 re-admissions from the hospital, on 6/30/14 and 7/12/14, due to vascular wounds on legs which required surgical intervention. Diagnoses included, but were not limited to Left femoral/popiteal bypass, diabetes mellitus and dementia.</p> <p>Hospital records indicated the resident was sent to the hospital, on 6/19/14, for a Left femoral/popiteal bypass surgery due to worsening vascular wounds and returned on 7/12/14.</p> <p>The records also indicated the resident again was sent to the hospital on 7/8/14 due to an infection in his groin surgical site and subsequently returned back to the facility on 7/12/14.</p> <p>Nursing and Social Service Notes between 6/30/14 and 7/17/14 indicated the following entries: - "7/1/14 7:37 a.m. - upon entering room to give resident his HS [evening] meds, observed resident picking at legs and removing dressing. There were dressings thrown on the floor by resident, staples in left LE [lower extremity] were however</p>		<p><i>beaccomplished for those residents found to have been affected by the deficient practice?</i> Resident#3 had his care plan immediately corrected and updated to reflect and address this resident's non-compliance with his wound treatments and staple placement. <i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i> Any resident receiving a surgical procedure outside of the facility has the potential to be affected. A 100% audit was performed of all surgical wound patients. No other resident was found to be affected by this deficient practice. All residents receiving a surgical procedure outside of the facility will have their orders reviewed and new orders updated by the charge nurse re-admitting the resident. The IDT and clinical team will review the discharge orders, in addition to the admission record entered by the charge nurse to ensure all careplans are updated and as accurate as possible based on review of their surgical assessment 5 times per week. <i>What measures or what systemic changes will be made to ensure that the deficient practice does not occur?</i> The DON will ensure that these results are tracked, monitored and maintained whenever there is an outside procedure performed</p>		

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	<p>intact...Applied new dressings to cover staples only to have observed resident removing it shortly afterwards."</p> <p>- "7/5/14 3:08 a.m. - ...Staples intact to left surgical area is red with swelling noted and some drainage noted. Resident does pick at areas and surgical incision."</p> <p>- "7/5/14 1:18 p.m. - ...Res [Resident] cont [continues] to pick at staple area as well as other leg..."</p> <p>- "7/5/14 5:54 p.m. - resident pulled drsg [dressing] off of left leg where staples are from surgery. Res picked at staple area to the left upper thigh, area had a steady stream of blood coming from area. Leg was re-wrapped..."</p> <p>- "7/7/14 10:16 a.m. - ...resident has been having behaviors and picking at legs and refusing to elevate them."</p> <p>- "7/14/14 2:19 a.m. - Attempted to do skin assessment resident refused kept yelling to leave him alone. resident had all his bandages off and had picked areas on his legs open."</p> <p>- "7/14/14 2:30 a.m. - Resident pulled off dressings picking at skin...."</p> <p>- "7/14/14 2:06 p.m.- ...Cont to pick at</p>		<p>through review in weekly skin meetings. The DON will review these results weekly with the IDT team, as well as the administrator to ensure all care plans are up to date. <i>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?</i> The DON will review these results weekly with the IDT team, as well as the administrator to ensure all care plans are up to date and any concerns or complications are immediately addressed. The administrator will monitor this along with the IDT team, and will audit results monthly. The results of these audits will be submitted to the monthly and quarterly QA &amp; A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>skin, dsq [dressing] intact at this time..."</p> <p>- "7/15/14 10:28 a.m. - Psych [psychiatric] eval [evaluation] 7/14/14 new orders to increase klonopin [an anti-anxiety medication] due to anxiety and picking at skin. care plan and log updated."</p> <p>- "7/17/14 4:40 a.m. - Resident is NPO [nothing by mouth] due to fem pop [femoral popiteal] in a.m., dressings changed x 2 resident keeps picking and pulling them off..."</p> <p>Review of the current care plans as presented by the Medical Records Clerk on 7/21/14 at 2:00 p.m. included an Interdisciplinary care plan for at risk for increased anxiousness related to anxiety and picks skin dated 5/7/14. A 7/15/14 additional approach to reflect the new order for Klonopin was listed, but the care plan failed to address the resident's picking at his skin, and especially at his surgical incisions and refusal to keep legs bandaged.</p> <p>A care plan which addressed the resident's new surgical sites and care related to these wounds was also lacking.</p> <p>During an interview on 7/22/14 at 10:30 a.m., the MDS (Minimum Data Set</p>						

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F000282 SS=D	<p>assessment) Coordinator indicated that some issues with residents, such as new wounds should be care planned right away.</p> <p>On 7/22/14 at 11:00 a.m., the Director of Nursing presented a copy of the facility's current policy titled "Care Plans." Review of this policy at this time included, but was not limited to: "Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Responsibility: All members of the interdisciplinary team. Coordinated by the MDS Coordinator...Procedure:...3. The Initial Care Plan will be completed as soon as possible after admission..."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on record review and interview, the facility failed to provide a complete physician order for care of a</p>	F000282	<p><u>F282-Services by a Qualified Persons/Per Care Plan</u> It is our policy to always follow orders given by qualified persons,</p>	08/21/2014

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	<p>colostomy for 2 of 3 residents reviewed who had a colostomy. (Resident #A)</p> <p>B. Based on record review and interview, facility failed to follow dietician recommendations and facility care plan for 1 of 1 resident reviewed for readmission and 1 of 1 resident reviewed colostomy. (Resident #9)</p> <p>Findings included:</p> <p>A.1. Review of the clinical record for Resident #A on 7/21/14 at 10:10 a.m., indicated the resident had diagnoses which included, but were not limited to: diabetes mellitus, hemiplegia, ileostomy and traumatic brain injury due to motor vehicle accident.</p> <p>The physicians orders for the month of July 2014 failed to list orders for care of and changing of the resident's ileostomy.</p> <p>A 7/8/13 care plan indicated "Focus: resident requires an ileostomy. Goal: Will have no complications daily. Interventions: Bowel sounds as indicated; change colostomy bag and appliances as needed; Meds per order; Monitor stoma site; Observe stool."</p> <p>During an interview with RN #2 at 1:45 p.m. on 7/22/14, she indicated "The</p>		<p>and to document properly any medication administration, as well as removing any orders as directed to do so by qualified persons.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident# A had his colostomy care orders added to the TAR Resident#9 had his colostomy care orders added to the TAR. Resident#9 had his nutritional orders clarified from the wound clinic to ensure they coordinate with the nutritional recommendations of the facility's Registered Dietician moving forward. This will ensure there will be no orders written regarding the nutritional needs of our residents without the confirmation from the facility's Registered Dietician prior to writing the order. Licensed nursing staff were re-educated on ileostomy/colostomy care, as well as the documentation procedures and order requirements associated with care.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>Any resident that requires the use of an ileostomy/colostomy could be affected. Any resident receiving nutritional orders from the wound clinic could be affected.</p>		

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	<p>resident has his colostomy bag changed on almost a daily basis due to him pulling it off. It's not a daily thing but does it quite frequently. He's not in pain but has a lot of anxiety and then just picks at things and will pull it off. We don't have any specific orders - we just change it." We don't document it anywhere, we just replace it it whenever the girls tell us he had pulled it off."</p> <p>B.1. The Clinical Record for Resident #9 was reviewed on 7/21/14 at 10:40 a.m. Diagnoses included, but were not limited to, quadriplegia, neurogenic bladder, anemia, hypertension and osteoporosis.</p> <p>The Admission Minimum Data Set Assessment, dated 1/20/14, indicated Resident #9 was admitted with three stage 4 pressure ulcers. The Minimum Data Set Assessment, dated 4/15/14, indicated Resident #9 was alert and oriented, required extensive assist of 2 persons with bed mobility and transfers, and extensive assist of 1 with toileting due to resident has both a suprapubic catheter and colostomy.</p> <p>Record review indicated Resident #9 readmitted to the facility, on 7/15/14, after plastic and reconstructive surgery to pressure ulcers. The Hospital Initial Nutritional Assessment, dated 7/15/14,</p>		<p>Only 1resident currently visits the area wound clinic. 100%audit was completed on any resident that requires ileostomy/colostomy care toensure that the ostomy care orders are reflected on the TARs. Licensednursing staff were re-educated on ileostomy/colostomy care, as well as thedocumentation procedures and order requirements associated with ostomy care. <i>What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?</i> Licensednursing staff were re-educated on ileostomy/colostomy care, as well as thedocumentation procedures and order requirements associated with ostomy care. The DONor designee will complete TAR audits weekly to ensure those residents receivingostomy care have their orders reflected, as well as the care performed. Thereadmit/admit audit tool will be updated by the DON / designee to reflectchanges in orders on residents with ileostomy or colostomy care needs on theirTARs. <i>How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?</i> The DON/Designee will audit the</p>				

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	<p>indicated the following recommendations to increase nutrient needs related to wound healing: Juven twice daily (BID); Zinc Sulfate 220 milligrams (mg) daily; Vitamin C 500 mg BID.</p> <p>Resident #9's care plan indicated resident requires a colostomy. It also indicated change colostomy bag and appliance as needed and monitor stoma site.</p> <p>The clinical record of Resident #9's readmission Medication Administration Record, dated 7/15/14, did not include the hospital's initial nutrition assessment recommendations. Review of the readmission Treatment Administration Record (TAR), dated 7/15/14, did not include colostomy orders.</p> <p>On 7/22/14 at 8:15 a.m., nurse's note dated 7/16/14 at 7:00 a.m. (late entry entered on 7/21/14 at 5:38 p.m.) indicated the physician was aware of the hospital nutrition assessment and will discuss with facility nutritionist before making any decisions.</p> <p>On 7/22/14 at 9:00 a.m., RN #1 indicated the late entry nurse's note was put in because the order was not followed up on when Resident #9 returned from the hospital on 7/15/14.</p>		<p>TARs weekly for our residents receiving ostomy care. Any and all discrepancies will be documented and resolved. The results of the TAR audits will be provided to the administrator upon completion for review. The results of these audits will be submitted to the monthly and quarterly QA &amp; A committee for further review and reassessment for further ongoing monitoring.</p>				

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F000431 SS=E	<p>On 7/22/14 at 9:00 a.m., RN #1 indicated Resident #9 had a colostomy and nurses document colostomy care on the TAR . RN #1 could not find colostomy orders for Resident #9 and indicated that no orders were put on when resident returned from the hospital on 7/15/14.</p> <p>On 7/22/14 at 9:33 a.m., review of the Policy and Procedure titled, Colostomy Care/Ileostomy Care, included, but was not limited to, "Policy...Responsibility: All Licensed Nursing Personnel...Procedure...14. Document on treatment sheet that care was done...."</p> <p>This deficiency was cited on June 13, 2014. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>						

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	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were stored properly. This deficient practice affected 2 of 3 medication carts observed.</p> <p>Findings include:</p> <p>1. On 7/17/14 at 8:34a.m., the medication cart on Emerald unit was observed to have an open vial of Haldol, an antianxiety medication, in the top drawer of the cart next to a bottle of eye drops. The vial had approximately 1/2 of the medication in the vial.</p>	F000431	<p><u>F431-Drug Records, Label/Store Drugs and Biologicals</u></p> <p>It is the policy of this facility to properly manage and audit our medication carts to ensure no expired medications are available for use, and they are discarded per policy.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>An initial audit of all medication and treatment carts has been performed by the DON or designee. An additional audit was performed by our outside Pharmacy team from United RX.</p>	08/21/2014

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	<p>RN #1 indicated, she did not use that medication and she did not know where it came from. She removed the vial and disposed of it in the sharps container on the side of the medication cart.</p> <p>2. On 7/18/14 at 12:18p.m., Haldol, an antianxiety medication, and Flucinosone, a nasal spray, was observed on the nurses station desk. The nurse was observed assisting residents with meals. At 12:26p.m., the nurse left the unit and the medications were still on the nurses station desk. At 12:54p.m., the nurse returned to the unit and medications were still stored at the nurses station desk.</p> <p>At 1:45p.m., LPN #3 indicated, "I was sending that medication back to the pharmacy."</p> <p>3. On 7/18/14 at 1:33p.m., the medication cart on the Onyx unit was observed to have the following:</p> <ul style="list-style-type: none"> <li>-an unopened vial of insulin</li> <li>-an opened vial of lidocaine with a discard date of 7/14/14</li> <li>-a lantus flex pen with no physician order attached.</li> <li>-a humalog flex pen with no physician order attached</li> <li>-a bottled of artificial tears with no physician order attached</li> </ul>		<p>Any expired medications or supplies were immediately removed from the cart and discarded appropriately, per policy.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>All residents have the potential to be affected by the alleged deficient practice. An initial audit of all medication and treatment carts has been performed by the DON or designee. Any expired medications or supplies were immediately removed from the cart and discarded appropriately, per policy. An additional audit was performed by our outside Pharmacy consultant, as well as cart audits performed by external staff to get extra and new eyes on the carts to ensure there are no expired medications, or no medications located in the inappropriate storage area.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Nurses were re-educated on drug records, label/store of drugs. 100% audit of all carts was performed by the DON/designee daily for 4 weeks. These audits will continue on all carts 5 times a week for 3 weeks, then 3 times a week for 3 weeks, then 2 times a</p>		

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F000465 SS=E	<p>LPN #3 indicated, the expired medication should be disposed of from the cart and the insulin should be stored in a plastic bag with the physicians order attached.</p> <p>A copy of the policy titled, Medication Storage and Labeling, was provided by the DoN on 7/22/14 at 10:08a.m. The policy stated.....All drugs classified as Schedule II of Controlled Substances Act will be stored under double locks.....outdated, contaminated or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock.</p> <p>This deficiency was cited on June 13, 2014. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-25 (j) 3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on record review, observation and</p>	F000465	<p>weekfor 2 weeks, then monthly thereafter. <i>How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?</i> DON/Designee will do daily cart audits for 4 weeks, then 2 times a week for 2 weeks. Any andall discrepancies will be reeducated and resolved. Theadministrator or designee will monitor these audits. The results of these audits will be submittedto the monthly and quarterly QA &amp; A committee for further review andreassessment for further ongoing monitoring.</p> <p><u>465-</u> <u>Safe/Functional/ComfortableEnvir</u></p>	08/21/2014	

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	<p>interviews, the facility failed to ensure a clean and functional environment was maintained for residents on 4 of 4 halls and 1 of 1 Main Dining rooms in that dead flies were on windowsills and in light coverings, chandelier and fluorescent light bulbs were missing and/or burned out; flooring and resident bedside mats had food and stains on them, light coverings were cracked/dirty, and door frames to resident rooms were marred with chipped paint. (Sapphire Stream, Onyx, Emerald Brook and Ruby Bay).</p> <p>Findings included:</p> <p>1. During a tour of the halls on 7/17/14, the following was observed between 8:10 a.m. and 9:30 a.m.:</p> <ul style="list-style-type: none"> <li>- The mat on the right side of Resident #A's bed in Room 126 was observed to have numerous dried yellow and white splatters on it.</li> <li>- The floor in Room 115 was observed to have multiple brown and red dried spots on it.</li> <li>- The floor in Room 111 was observed to have multiple pieces of brown food-like chunks on the floor underneath the overbed table where the resident was sitting in his wheelchair.</li> </ul>		<p><u>onment</u> It is the policy of this facility to provide the safest, most comfortable, functional, home like environment possible. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> The flooring in room 115 was cleaned. The food observed from breakfast on the floor of room 111 was swept up and disposed of. All light bulbs have been replaced by the maintenance supervisor. While replacing light bulbs, the maintenance director also cleaned the fixtures. These are to be inspected weekly moving forward. 10 of 10 resident room door frames on Ruby hall were either sanded down, resurfaced and scheduled to be replaced by 2/1/2015. 1 of 1 linen closet door frames was repaired. 1 of 1 old dining room door frame repaired. 4 ceiling tiles leading into Onyx hall were replaced. All stained ceiling tiles that could not be cleaned appropriately were replaced. The 2 hooyer lifts mentioned at the end of Sapphire Hall were cleaned and stored appropriately. New scale was purchased to replace the worn and dirty scale. Rooms 146, 148, 150, and 151 on Onyx hall were in the process of having their calllights replaced. This project was completed, and all wires were back in place once the new call lights were installed. The covebase outside of rooms 137</p>		

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	<p>- Lounge on Ruby Bay - the room appeared very dark with little lighting. Upon observation, 2 of 2 chandeliers had missing and/or burned out light bulbs - 1 had only 1 of 8 lit bulbs; the other only had 2 of 8 light bulbs. In an interview with Activities #2 at this time, she indicated the room was going to be turned into a mini theater but agreed that the room was very dark. A resident deemed alert and oriented by Activities #2, was observed in the room trying to read his bible. She indicated the resident came into this room every day after breakfast to read and that other residents came in to watch tv. She was unable to account for how long the bulbs in the chandeliers had been missing or burned out.</p> <p>- Ruby Bay hall - 10 of 10 resident room door frames to the hall, 1 of 1 linen closet door frames and 1 of 1 to the locked old dining room door had marred and chipped paint door frames extending up half way from the floor.</p> <p>- 4 ceiling tiles to the left corner of the hall entrance to Onyx hall were observed to be bulging with brown stains and were cracking. 2 ceiling tiles between the nursing station and the entrance to Onyx hall had brown stains on them - 1 was the</p>		<p>and 138 was installed. The butterpacket was picked up and disposed of in room 113. All overhead fluorescent ceiling lights on Emerald Brook were replaced with new fixtures. All overhead fluorescent ceiling lights on Ruby Bay were replaced with new fixtures. All window sills are checked daily to ensure no dead insects are found. Resident A and resident #41 had their bedside mats deep cleaned. <i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i> All residents have the potential to be affected by the alleged deficient practice. All window sills were immediately checked and cleaned. All light bulbs have been replaced by the maintenance supervisor. While replacing light bulbs, the maintenance director also cleaned the fixtures. <i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i> A new housekeeping supervisor was recruited and hired. A new, increased housekeeping budget was implemented, and staff has been hired to fill these extra shifts. We have had outside housekeeping department heads conducting orientation for the new housekeeping supervisor and their staff. This includes, but is not limited to: A deep cleaning</p>		

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	<p>size of a serving plate and was by the light and the 3 others surrounding this tile had multiple brown stains ranging in dime size to quarter size.</p> <p>2. During random observations on 7/17/14 between 11:15 a.m. and 1:25 p.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- At the end of Sapphire hall, the weight scale's entire frame had a heavy accumulation of black/brown dirt on it; the black mat at the base had several worn areas which exposed the frame beneath; the mat was also heavily soiled with dirt particles. 2 of 2 hoyer lifts also located here had a moderate accumulation of dust and brown spots on the metal frame.</li> <li>- The Main Dining Room floor had numerous black scuff marks and appeared dirty and dull.</li> <li>- Room 111 - floor remained the same as previously observed at 8:30 a.m..</li> </ul> <p>3. During an environmental observation on 7/21/14 between 8:50 a.m. and 10:00 a.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- Rooms 146, 148, 150 and 151 on Onyx hall was observed to have the hall cover and call light system wires hanging down from the wall.</li> </ul>		<p>schedule, a regular cleaning schedule, daily cleanliness checklist, and cleanliness standards. New housekeeping team receiving ongoing, thorough inservice training. The main dining hall flooring was replaced. Quotes to repair the drywall throughout the facility have been secured, and we have a tentative completion date of 10/1/2014. Guardian Angel rounds. These rounds/audits are conducted 5 times per week, and reviewed 5 times per week by the management team, and the administrator. Thus, any negative observations can be addressed. <i>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?</i> Sanitation/Cleanliness rounds/audits will be conducted by the New Housekeeping Supervisor 5 days a week for 4 weeks, then 3 days per week for 4 weeks, then weekly thereafter. The results of these inspections will be provided to the administrator daily, and audited a minimum of one time weekly. The administrator or designee will monitor these audits. The results of these audits will be submitted to the monthly and quarterly QA &amp; A committee for further review and reassessment for further ongoing monitoring.</p>	

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	<p>- the weight scale and 2 hoyer lifts previously identified on 7/17/14 at 11:15 a.m. remained with the same dirt and worn places.</p> <p>- The hall cover baseboard was missing outside Rooms 137 and 138.</p> <p>- Room 113 - a butter packet was on the floor by the resident's wheelchair.</p> <p>- Emerald Brook hall: the last 3 ceiling lights at the end of the hall were missing a light bulb and/or had dead bugs inside and were cracked with brown splatters on them.</p> <p>- Ruby Bay hall - the ceiling light cover at the entrance had a 6 inch crack in it with dead bugs inside. The first light cover upon entering the unit had a 4 inch crack in it with multiple areas of chipping plaster around it. This same crack was again observed on 7/22/14 at 4:15 p.m. during the environmental tour with the Administrator and the Director of Maintenance. The next 8 ceiling light covers had cracks and dead bugs in them. The 8th light was burned out. The 10th light was missing the bulbs and the light cover.</p> <p>- During an observation on 7/21/14 at 2:10 p.m., the covering to Resident #41's</p>			

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	<p>bedside floor mat had multiple brownish spots on it ranging from 1/2 dollar size to dime size. Area surrounding the spots had a moisture appearance. Room 130 was observed to have dead flies on the window sill. These same flies were again observed at 4:10 p.m. on 7/22/14 during the environmental tour with the Administrator and the Director of Maintenance.</p> <p>During an interview with the Director of Maintenance on 7/21/14 at 11:40 a.m., he indicated that he had run out of screws and had to go buy some more before he could hang up and secure the call lights hanging out from the wall.</p> <p>On 7/22/14 at 4:00p.m., the Administrator indicated the residents observed wandering around the loose wires on the Onyx unit were confused.</p> <p>Requests were made to the administrator on 7/16, 7/17, 7/21, and 7/22 for estimates, potential completion dates, and detailed plans related to the environment concerns. On 7/22/14 at 4:49p.m. the following estimates were obtained after the plan of correction date:</p> <ul style="list-style-type: none"> <li>-Rooms 137, 138, 149, and 150 insulated glass units dated 7/16/14.</li> <li>-remove and set toilet, remove tile, remove cove base, and install new</li> </ul>						

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F000469 SS=F	<p>flooring for 15 bathrooms dated 7/15/14. -ceiling panels, stop strips, and flourescent lights dated 7/15/14. -resident room doors and door frames dated 7/18/14.</p> <p>This deficiency was cited on June 13, 2014. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(f)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on record review, observation and interviews, the facility failed to maintain an effective pest control program on 2 of 4 halls, 1 of 1 Main Dining room, and 6 of 51 resident rooms in that flies were observed on residents' bodies, linens and tables and flying around the facility during 3 of 5 survey days. (Onyx and Sapphire Stream halls and Rooms 111, 113, 115, 119, 126 and 130)</p> <p>Findings included:</p> <p>1. During lunch meal observation on 7/16/14 between 11:50 a.m. and 12:30</p>	F000469	<p><u>F469-Maintains Effective Pest Control Program</u> It is the policy of this facility to maintain an environment that is free and clear of pests and insects. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> A new Pest Control company has been contracted as our vendor for our pest and insect remediation and control. New Vendor made initial visit with treatment for flies specifically, on 7/25/2014. 9 Flylights have been placed throughout the facility in strategic</p>	08/21/2014

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	<p>p.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- 11:55 a.m. - a fly was observed flying around the man dining room tables while residents were in the dining room.</li> <li>- 12:27 p.m. - 1 fly was observed flying around the Sapphire Stream hall.</li> </ul> <p>2. During the medication pass observation on 7/17/14 between 8:15 a.m. and 9:30 a.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- 8:22 a.m. - several flies were observed in the dayroom either flying around or sitting on the furniture.</li> <li>- 8:46 a.m. - 2 flies were observed in Room 119 - on the bedside table and 1 on the overbed table.</li> <li>- 9:04 a.m. - 1 fly was observed flying around Emerald Brooks hall and 5 flies were observed in Room 111 on the resident's pillow, bedding and his body.</li> </ul> <p>3. During tour on 7/17/14 between 8:10 a.m. and 9:30 a.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- 8:10 a.m. -Resident #A was observed in bed in his room #126 swiping at a fly. He was also observed to have 2 fly swatters on his bed with 2 additional flies observed flying around him. In an interview with the resident at this time,</li> </ul>		<p>areas.</p> <p>An aircurtain and a mesh screen were added to the highest traffic door as well as amesh screen added to the service entrance.</p> <p><i>How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?</i></p> <p>Allresidents could be affected by the alleged deficient practice. A newPest Control company has been contracted as our vendor for our pest and insectremediation and control.</p> <p>Newvendor made initial visit with treatment for flies, specifically, on 7/25/2014.</p> <p>9 Flylights have been placed throughout the facility in strategic areas.</p> <p>An aircurtain and a mesh screen was added to the highest traffic door as well as amesh screen added to the service entrance.</p> <p><i>What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?</i></p> <p>A newPest Control company has been contracted as our vendor for our pest control. Pestcontrol reports will be generated from each vendor service call. Those reports will be reviewed by theMaintenance Supervisor and any and all vendor recommendations will be discussedwith the Administrator.</p> <p><i>How the corrective action(s) willbe monitored to ensure the</i></p>	

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	<p>he indicated that the flies were always in his room bothering him keeping him awake, especially at night and that was why he had a fly swatter.</p> <p>An interview with CNA #1 at 8:20 a.m. indicated that she did not think the flies were too bad.</p> <p>- 8:25 a.m. - observation of Room 115 indicated 3 flies were observed in this room - 1 sitting on a resident's pillow on the overbed table and 2 others flying around landing off and on on the resident's bed and curtains. No resident was observed in Bed 1 at this time.</p> <p>In an interview with the Administrator at 8:50 a.m., he indicated that no flies or other bug issues were seen when the pest control company came in for their visit in April and May. Review of the Pest Control logs for April, May and June 2014 confirmed no issues had been noted.</p> <p>- 9:25 a.m. - 1 fly was observed sitting on Bed 2 in Room 130. In an interview with Resident #B at this time, he indicated the flies have been an issue for awhile, especially over the past weekend and even before that. He indicated that in the last couple of days, they had not been too much of a problem, but the there was one</p>		<p><i>deficient practice will not recur, i.e. what quality assurance program will be put into place?</i></p> <p>Monthly service calls will be made by New Pest Control vendor for the first 3 months. Ongoing, they will then make their service calls on a quarterly or as-needed basis. Pest control service call reports will be provided to the administrator following each visit. All results of the Pest Control reports will be taken to the monthly and Quarterly QA meeting for review and reassessment for further ongoing monitoring.</p>	

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	<p>fly who continued to pest him, especially when he was eating.</p> <p>- 9:30 a.m. - 1 fly was observed sitting on the soiled linen barrel outside of Room 113. Observation inside the room noted 1 fly sitting on the resident's blanket while he was up in his wheelchair that continued to fly back and forth on him. He indicated there were flies in his room.</p> <p>In an interview with CNA #5 on 7/17/14 at 11:35 a.m., she indicated that she had seen the residents on Sapphire Stream hall shoo the flies the most and were especially more prevalent during meal times.</p> <p>In an interview with Activities #1 at 11:45 a.m., she indicated that there had been flies in the building occasionally.</p> <p>4. During a meal observation on 7/17/14 between 11:50 a.m. and 12:35 p.m., the following was observed:</p> <p>- 11:55 a.m. - Room 111 - 2 flies were observed on the overbed table where the resident was sitting at. These flies were observed to fly and then land on the resident every time he moved.</p> <p>- Main Dining Room: 12:00 p.m. - 2 flies were observed on the resident's table (3 residents observed at this table) and 1</p>			

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	<p>was sitting on the resident's bib on the table.</p> <p>- 12:10 p.m. - after a staff member placed a tray on this table for a resident, the 2 flies flew up and returned to land back onto the bib and another resident's shoulder.</p> <p>- 12:15 p.m. - 1 fly was observed to be flying back and forth landing on a resident who sat in front of an overbed table by the door. The fly landed not only on the blanket around the resident's shoulders but also on his food until the resident went to take a bite.</p> <p>- 2:20 p.m - 1 fly observed on Room 111's resident's back while up in wheelchair. Whenever the resident moved, the fly would also but then re-land back onto the resident's body.</p> <p>Review of the resident Council Minutes from January 2014 to July 2014 indicated that on 7/9/14, the residents voiced concerns about flies and gnats in residents' room. The Director of Nursing and the Administrative Assistant were documented to have been present at this meeting also.</p> <p>On 7/9/14, the Housekeeping Director responded to the Resident Council</p>						

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F000514 SS=D	<p>concern by indicated the fly and gnat problem had been taken care of the previous week by spraying. She also indicated that fly curtains will be installed 7/14/14.</p> <p>Review of the follow-up concern forms indicated the Resident Council concerns had been reported to the Department Heads by the Director of Nursing on 7/9/14 and the Morning QA (Quality Assurance) stand up meeting on 7/11/14 for a finalized plan of action.</p> <p>In an interview with the Administrator on 7/22/14 at 9:53 a.m., he indicated the new fluorescent bug lights and the fly curtain had been ordered on 6/6/14 and were received on 6/10/14. Review of the invoices provided by the Administrator at this time confirmed the order and when received.</p> <p>During an interview with the Administrator on 7/22/14 at 6:20 p.m. during the final exit meeting, he indicated that the curtains were never installed as previously planned on 7/14/14 as other things took priority.</p> <p>3.1-19(f)(4)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE</p>			

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	<p><b>SSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure residents' clinical records were complete and accurate for 2 of 19 residents' reviewed for complete and accurate clinical records. (Resident #9 and Resident A)</p> <p>Findings include:</p> <p>1. The Clinical Record for Resident #9 was reviewed on 7/21/14 at 10:40 a.m. Diagnoses included, but were not limited to, quadriplegia, neurogenic bladder, anemia, hypertension and osteoporosis.</p> <p>On 7/21/14, at 11:00 a.m., The Admission Minimum Data Set Assessment, dated 1/20/14. indicated Resident #9 was admitted with three stage 4 pressure ulcers. The Minimum Data Set Assessment, dated 4/15/14. indicated Resident #9 was alert and oriented, required extensive assist of 2</p>	F000514	<p><u>514-Resident Records-Complete/Accurate/Accessible</u></p> <p>It is the policy of this facility to follow any and all physician orders to maintain the utmost wellbeing for our residents. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident# A had his colostomy care orders added to the TAR Resident#9 had his colostomy care orders added to the TAR. Resident#9 had his nutritional orders clarified from the wound clinic to ensure they coordinate with the nutritional recommendations of the facility's Registered Dietician moving forward. This will ensure there will be no orders written regarding the nutritional needs of our residents without the confirmation from the facility's Registered Dietician prior to writing the order. Licensed nursing staff were</p>	08/21/2014	

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	<p>persons with bed mobility and transfers, and extensive assist of 1 with toileting due to resident has both a suprapubic catheter and colostomy.</p> <p>On 7/21/14 at 11:30 a.m., record review indicated Resident #9 readmitted to the facility on 7/15/14 after plastic and reconstructive surgery to pressure ulcers. The Hospital Initial Nutritional Assessment, dated 7/15/14, indicated the following recommendations to increase nutrient needs related to wound healing: Juven twice daily (BID); Zinc Sulfate 220 milligrams (mg) daily; Vitamin C 500 mg BID.</p> <p>On 7/21/14 at 12:00 p.m., Resident #9's careplan indicated resident requires a colostomy. It also indicated change colostomy bag and appliance as needed and monitor stoma site.</p> <p>On 7/21/14 at 3:30 p.m., clinical record review of Resident #9's readmission Medication Administration Record, dated 7/15/14, did not include the hospital's initial nutrition assessment recommendations. Review of the readmission Treatment Administration Record (TAR), dated 7/15/14, did not include colostomy orders.</p> <p>On 7/22/14 at 8:15 a.m., nurse's note</p>		<p>re-educated on ileostomy/colostomy care, as well as the documentation procedures and order requirements associated with care.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</i></p> <p>Any resident that requires the use of an ileostomy/colostomy could be affected. Any resident receiving nutritional orders from the wound clinic could be affected.</p> <p>Only 1 resident currently visits the area wound clinic.</p> <p>100% audit was completed on any resident that requires ileostomy/colostomy care to ensure that the ostomy care orders are reflected on the TARs.</p> <p>Licensed nursing staff were re-educated on ileostomy/colostomy care, as well as the documentation procedures and order requirements associated with ostomy care.</p> <p><i>What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur?</i></p> <p>Licensed nursing staff were re-educated on ileostomy/colostomy care, as well as the documentation procedures and order requirements associated with ostomy care.</p> <p>The DON or designee will complete TAR audits 3 times per</p>	

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	<p>dated 7/16/14 at 7:00 a.m. (late entry entered on 7/21/14 at 5:38 p.m.) indicated the physician was aware of the hospital nutrition assessment and will discuss with facility nutritionist before making any decisions.</p> <p>On 7/22/14 at 9:00 a.m., RN #1 indicated the late entry nurse's note was put in because the order was not followed up on when Resident #9 returned from the hospital on 7/15/14.</p> <p>On 7/22/14 at 9:00 a.m., RN #1 indicated Resident #9 had a colostomy and nurses document colostomy care on the TAR . RN #1 could not find colostomy orders for Resident #9 and indicated that no orders were put on when resident returned from the hospital on 7/15/14.</p> <p>On 7/22/14 at 9:33 a.m., review of the Policy and Procedure titled, Colostomy Care/Ileostomy Care, included, but was not limited to, "Policy...Responsibility: All Licensed Nursing Personnel...Procedure...14. Document on treatment sheet that care was done...."</p> <p>2. Review of the clinical record for Resident #A on 7/21/14 at 10:10 a.m., indicated the resident had diagnoses which included, but were not limited to: diabetes mellitus, hemiplegia, illeostomy</p>		<p>week to ensure those residentsreceiving ostomy care have their orders reflected daily, as well as the careperformed. These audits will continuedaily for 2 weeks; then the following 2 weeks, the audits will be performed 3times weekly; then monthly thereafter.</p> <p>Thereadmit/admit audit tool will be updated by the DON / designee to reflectchanges in orders on residents with ileostomy or colostomy care needs on theirTARs and reviewed 5 times per week.</p> <p><i>How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?</i></p> <p>TheDON/Designee will audit the daily TARs for our residents receiving ostomycare. Any and all discrepancies will beidentified and resolved.</p> <p>Theresults of the TAR audits will be provided to the administrator upon completionfor review. The results of these auditswill be submitted to the monthly and quarterly QA &amp; A committee for furtherreview and reassessment for further ongoing monitoring.</p>	

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	<p>and traumatic brain injury due to motor vehicle accident.</p> <p>The physicians orders for the month of July 2014 failed to list orders for care of and changing of the resident's illeostomy.</p> <p>A 7/8/13 care plan indicated "Focus: resident requires an illeostomy. Goal: Will have no complications daily. Interventions: Bowel sounds as indicated; change colostomy bag and appliances as needed; Meds per order; Monitor stoma site; Observe stool."</p> <p>During an interview with RN #2 at 1:45 p.m. on 7/22/14, she indicated "The resident has his colostomy bag changed on almost a daily basis due to him pulling it off. It's not a daily thing but does it quite frequently. He's not in pain but has a lot of anxiety and then just picks at things and will pull it off. We don't have any specific orders - we just change it. We don't document it anywhere, we just replace it it whenever the girls tell us he had pulled it off."</p> <p>This deficiency was cited on June 13, 2014. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-50(a)(1)</p>			

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F009999 SS=D	<p>3.1-50(a)(2)</p> <p>3.1-14(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia training within six (6) months of initial employment, to within thirty (30) days for personnel assigned to the Alzheimer's and dementia specialty care units, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidence by:</p> <p>Based on record review and interview, the facility failed to ensure 2 of 9 staff reviewed had evidence of dementia training.</p> <p>Finding includes:</p> <p>On 7/16/14 at 10:00a.m., certificates were provided of the staff who completed dementia training.</p> <p>On 7/22/14 at 9:05 a.m., nine (9)</p>	F009999	<p><u>F9999-Final Observations</u> A 100%audit was made of active employee records to identify any employees lacking therequired Dementia training and the corresponding verification of that trainingincluding proof of testing. Allemployees lacking in their Dementia training have now met their dementiatraining requirements. They have allattended the required course, and all have certificates of completion, signedverification of classroom attendance, and post-tests to confirm thiseducational requirement has been met. Theorientation process for new employees has been altered to encompass the initialrequirement of dementia training to ensure new hires receive their trainingwithin the required time frame. Thereafter,Dementia classes will be conducted to ensure all employees receive the requiredongoing training. Staff completion ofthis required training will be monitored by assigned staff. The overall program will be monitored by theAdministrator for appropriate completion. Therresults of these reviews will be submitted to the monthly and quarterly QA&amp; A committee for further review and reassessment</p>	08/21/2014	

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	<p>employee personnel files were reviewed. Two (2) of the 9 staff did not have evidence of receiving dementia training.</p> <p>On 7/22/14 at 11:23a.m., the Dementia Educator was interviewed. She indicated she provided the inservice training to all the staff. She stated the post test from the training should be placed in the employee files. She was unable to provide requested documentation of which staff met the dementia training requirements, which staff still needed to have the training, or when the newly hired staff would have their training. She indicated some staff have not received the training.</p> <p>This deficiency was cited on June 13, 2014. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p><b>3.1-14(u)</b></p>		for further ongoing monitoring.		