

#107

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 155200	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/10/2011
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 247	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 18 residents interviewed regarding roommate changes in the total Stage 1 sample of 40 residents received notification of the placement of a roommate. (Resident #49)</p> <p>Findings include:</p> <p>Resident #49 reported during interview on 2/8/11 at 11:30 A.M., he had a roommate brought into his room in the last 9 months, and he had not been told before the resident came into the room.</p> <p>The clinical record of Resident #49 was reviewed on 2/9/11 at 2:46 P.M., and indicated the resident was admitted to the facility on 2/6/09 and was his own responsible party.</p> <p>There was nothing in Social Service notes regarding having a roommate or notification of same. Interview with Social Service Director (SSD) #1 on 2/9/11 at 2:52 P.M., indicated she let the resident know verbally of the impending roommate's arrival.</p> <p>She indicated she always let the resident and family know if a roommate was going to be coming, and let them know the time, if it was known. She indicated she did so verbally and did not make note unless the resident did not want the roommate.</p> <p>SSD #2, Corporate Social Service staff, who was present during the interview with SSD #1, indicated there was a policy for notification of a resident of a roommate coming, but there was no form. She indicated the SSD should document the notes of the notification in the social service notes.</p> <p>The policy, Intrafacility Transfers, provided on 2/9/11 at 3 P.M. indicated "Social Service staff will notify the current and new roommates and their families of the change and document in the medical record."</p> <p>3.1-3(v)(2)</p>

*Approved
KF 3/9/11*

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

The above isolated deficiencies pose no actual harm to the residents

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**RIGHT TO NOTICE BEFORE
ROOM/ROOMMATE CHANGE**

1. Resident #49 does not have a roommate at the current time and will be given advanced notice of receiving a roommate as indicated. The notification will be documented in the resident's clinical record.
2. All residents have the potential to be affected. If a resident will be getting a roommate, the resident will be given advanced notice and the notification will be documented in the resident's clinical record.
3. The facility's policy for roommate notification has been reviewed and no changes are

indicated at this time. The Social Service Director has been re-educated on notification and documentation requirements. A Resident Interview and Observation Form has been implemented to ensure compliance.
(See Attachment F)

4. The Social Service Director or designee will be responsible for interviewing 3 alert and oriented residents and completing the Resident Interview Form on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective action will be completed on or before March 12, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

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F 000 INITIAL COMMENTS

F 000

This visit was for a Recertification and State Licensure Survey.

Survey Dates: February 7, 8, 9, 10, 2011

Facility number: 000107
Provider number: 155200
AIM number: 100290330

Survey team:
Donna Downs, RN, TC
Brenda Buroker, RN
Debbie Barth, RN
Lois Corbin, RN

Census bed type:
55 SNF/NF
55 Total

Census payor type:
07 Medicare
40 Medicaid
08 Other
55 Total

Sample: 31

These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.

Quality review completed on February 16, 2011 by Bev Faulkner, RN

F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and

Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.

Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.

The Plan of Correction is prepared and submitted because of requirements under State and Federal law.

Please accept this Plan of Correction as our credible allegation of compliance.

RECEIVED

MAR - 4 2011

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

F 156

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Michael Jay Nelson ADMINISTRATOR 3/3/2011

A 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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regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including

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the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

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A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

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The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:

A. Based on observation and interview, the facility failed to ensure the posting of names, addresses, and telephone numbers of pertinent state advocacy groups, including the state survey and certification agency, was posted in a manner that was accessible to residents who were wheelchair bound and were in a font that was easily readable for residents. The facility also failed to post information on how to apply for Medicare and/or Medicaid. This had the potential to affect all 55 residents residing in the facility.

B. Based on record review and interview, the facility failed to ensure 3 of 3 residents reviewed for discharge from Medicare services received notification two days prior to the termination of services and specific reasons why the services were to be terminated.
(Resident #28, #13, #67)

Findings include:

A. On 2/9/11 at 1:30 p.m., a frame containing important telephone numbers was observed displayed in the front lobby. The bottom of the frame was approximately 5 feet from the floor, making it inaccessible to wheelchair-bound

**F 156
NOTICES OF RIGHTS, RULES,
SERVICES, CHARGES**

1A. All postings were updated with the correct information including how to apply for Medicare and/or Medicaid, retyped in larger font to make them easier to read, and lowered to provide easy access to residents who may be chair-bound.

1B. Resident # 28, #13, and #67 have been notified of the specific reasons as to why Medicare services were terminated.

2A. See 1A Above

2B. All residents receiving Medicare services have the potential to be affected. Any resident who is discharged from Medicare services will receive notification 2 days prior to the termination of services with specific reasons as to why the services were terminated.

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residents. A table and two chairs was sitting to the left of the frame, with one of the chairs pulled into the area in front of the frame, making access to the numbers difficult to residents with impaired mobility. The telephone numbers to the state survey agency contained only the long-distance telephone number and did not include information on how to file a complaint with the agency. The telephone numbers were in small font, making it difficult to read them unless standing close to the frame.

Another frame was displayed in the hallway, and this frame contained telephone numbers for Medicare and Medicaid agency with instructions that Social Services would assist residents on how to apply for Medicare/Medicaid. The information did not include how the resident could access benefits and/or how to receive refunds for previous payments.

On 2/10/11 at 7:00 a.m., the Social Service Director was interviewed. She indicated Medicare/Medicaid information on how to apply is given to residents on admission, but she doesn't know if additional information is available in the facility. At this time, the Business Office Manager checked and indicated the information located in the frame says to see Social Service director on how to apply and there are phone numbers for each of the entities.

B. During a 2/10/11, 8:30 A.M., interview and review of Non-Coverage of Medicare Services, the Business Office Manager [B.O.M.] indicated three residents had been discharged from Medicare Services and received notification.

Resident #28 was to be discharged on 1/26/11 and there was an OMB [Office of Management

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3A. The business office manager was re-educated on the posting regulations and will be responsible for updating all postings as indicated to comply with state and federal regulations. An Environmental Observation form has been implemented to ensure compliance with facility postings. (See Attachment A)

3B. The facility's policy for notification for Medicare services was reviewed and no changes are indicated at this time. The Business Office Manager was re-educated on notification and reasoning of termination. A Liability Notices and Beneficiary Appeal Rights Review form has been implemented to ensure compliance with notification of termination of services. (See Attachment B)

4A. The Maintenance Director or designee will be responsible for doing environmental rounds and completing the Environmental Observation Form on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly

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and Budget] Approval No. 0938-0953, Notice of Medicare Provider Non-Coverage form signed by the resident on 1/24/11. "Your provider has determined that Medicare probably will not pay for your current skilled nursing services after the effective date indicated above. You may have to pay for any SNF services you receive after the above date."

There was no specific information regarding why the services were to be ending.

The OMB Approval No. 0938-0953 form for Resident #13 indicated a family member had signed the notice on 12/10/10 informing them "The effective date coverage of your current skilled nursing services will end was on 12/10/2010." There was no specific information regarding why the services were about to end.

The OMB Approval No. 0938-0953 form for Resident #67 indicated "The effective date coverage of your current skilled nursing services will end: 1/22/2011." The form was signed by the co-guardian on 1/21/2011. There was no specific information regarding why the services were about to end.

On 2/10/11 at 9:10 A.M., the B.O.M. provided the policy regarding the notification of termination of medicare services and the Detailed Notice Instructions regarding how to complete the form for Non-Coverage.

The policy, "Notice of Medicare Non-Coverage for Expedited Reviews" indicated "The Generic Notice will be given to the beneficiary at least two days prior to ending all Medicare covered services, and the beneficiary or his designated

for 2 months, then quarterly thereafter for a minimum of 6 months. The results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

4B. The Business Office Manager or designee will be responsible for completing the Liability Notices and Beneficiary Appeal Rights Review form on scheduled work days as follows: daily for 2 weeks then weekly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

The above corrective actions will be completed on or before March 12, 2011

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representative will be informed of his right to an expedited review of the service termination." The procedure included, "The provider may use the 'Additional Information' section on the Generic Notice to include detailed facts as to why Medicare coverage is ending."

3.1-4(a)
3.1-4(j)(3)
3.1-4(l)(1)
3.1-4(l)(2)

F 156

F 159 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS
SS=B

F 159

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

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The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure availability of funds to residents during weekends, which had the potential to affect 49 residents who had their personal funds managed by the facility, and failed to ensure resident's personal funds were in a secure area for 3 of 49 residents who had their personal funds managed by the facility. (Resident #15, #36, #39).

Findings include:

During interview with the Business Office Manager/Bookkeeper on 2/9/11 at 3:00 p.m., she indicated residents are able to access their money Monday through Friday from 8:00 a.m. to 4:30 p.m. She further indicated the residents do

FACILITY MANAGEMENT OF PERSONAL FUNDS

1. All residents who have their personal funds managed by the facility currently have access to their funds on the weekends.

Resident #15, #36, and #39 have their personal funds currently being kept in a secured area.

2. All residents who have their personal funds managed by the facility have the potential to be affected. The residents will have their funds kept in a secured area and will have access to personal funds on Saturday from 9am-12pm and on Sunday from 12pm to 3pm. The posting for banking hours has been revised and reflects the current changes.

3. The facility's policy for personal funds has been reviewed and no changes are indicated at this time. The Business Office Manager has been re-educated on access and storage of personal funds. The facility has implemented a weekend manager assignment to allow any

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not have access to their personal funds on the week ends.

During observation on 2/9/11 at 4:00 p.m., there was a sign posted outside the business office which read "Business hours: open Monday through Friday 8 am to 4:30 p.m.

During record review of personal funds documentation received from the Business Office Manager on 2/9/11 at 3:30 p.m., a document titled Resident Funds/Trust indicated the following: "Business Hours Monday through Friday-Please see posted hours. Business Office is closed weekends and all major holidays...Withdraws...Please give advanced notice if needing over \$25, so that we may gather the extra money for you within 2 business days or write you a check..."

During observation on 2/11/11 at 3 p.m., the medication room on the 100/300 unit two envelopes were observed tacked on the bulletin board with resident money. One marked with Resident #15's name and a 2nd marked with Resident #39's name. The envelope for Resident #39 shows total of \$80.00 was dated 2/3/11, and the envelope for Resident #15 had a total of \$8.00 on it and was dated 1/10/11.

During an interview with the Business Office Manager on 2/11/11 at 3:30 p.m., she indicated she was aware of 1 of the 2 residents who had their money in envelopes in the nursing medication rooms, (Resident #15) and indicated she knew there was one other resident (Resident #36) who had their funds in an envelope at the nurses station. She indicated allowing residents to keep their money at the nurses station was for

F 159 resident requesting funds on weekends to have access to their personal funds during the posted banking hours.
A Personal Funds Review form has been implemented (See Attachment C)

4. The Business Office Manager or designee will be responsible for completing the personal funds request form on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective actions will be completed on or before March 12, 2011

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F 159 Continued From page 9
the convenience of the residents.

F 159

3.1-6(b)
3.1-6(f)(1)

F 172 483.10(j)(1)&(2) RIGHT TO/FACILITY
SS=C PROVISION OF VISITOR ACCESS

F 172

The resident has the right and the facility must provide immediate access to any resident by the following:

- Any representative of the Secretary;
- Any representative of the State;
- The resident's individual physician;
- The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);
- The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);
- The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);
- Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and
- Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of

**F 172
RIGHT TO/FACILITY
PROVISION OF VISITOR
ACCESS**

1 & 2. All residents have been updated with information regarding the Ombudsman and how to contact them if needed.

3. The Ombudsman will be attending a Resident Council meeting on March 4, 2011. The Resident Council form used to take minutes from the meeting has been revised to include information regarding the Ombudsman.
(See Attachment D)

The Activity Director and Social Service Director have been re-educated on the Ombudsman and revised Resident Council form. A Resident Council President/Representative Interview Form has been implemented to ensure continued compliance.
(See Attachment E)

4. The Social Service Director or designee will interview three alert and oriented residents and complete the Resident Council President/Representative Interview

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 172 : Continued From page 10
the resident. F 172

The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the residents were aware and had access to the long-term care Ombudsman. This had the potential to affect all 55 residents residing in the facility.

Findings include:

On 2/9/11 at 3:00 p.m., the Resident Council President was interviewed. She indicated she had never heard of the Ombudsman, and the Ombudsman had never attended any of the Resident Council meetings. She indicated she wouldn't know how to contact him/her.

The Resident Council Minutes for the past 12 months were reviewed on 2/8/11 at 10:32 A.M. There was no indication the Ombudsman had been invited or attended a meeting during this time and documentation was lacking in the minutes that the Ombudsman's role and/or information on how to contact the Ombudsman had been discussed at any of the meetings over the past year.

On 2/10/11 at 7:00 a.m., the Social Service Director was interviewed. She indicated the Ombudsman had not been discussed at any of

Form on scheduled work days as follows: Daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's QA meetings and the plan adjusted accordingly.

5. The above corrective action will be completed on or before March 12, 2011

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F 172 Continued From page 11
the Resident Council meetings she had attended since she had been employed at the facility (March 2010).

F 172

F 174 3.1-8(b)(4)
483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY
SS=D

F 174

The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure a private place for telephone conversation for 1 of 1 resident observed requesting to use the phone on the secured dementia unit on two of four days of the survey. (Resident #36)

Findings include:

On 2/9/11 after breakfast, Resident #36 was observed to wheel himself to the nurses' station and asked to call his wife. The facility desk phone was handed to the resident and the nurse dialed the number. There was no answer so the resident requested to call his sister and the nurse assisted him with that. The resident had a conversation with his sister with his conversation easily heard behind the nurses' station. Other residents were sitting directly in front of the nurses station.
At 10 AM, the resident's wife called the facility and the nurse said they had just put him to bed and would let him know she had called, but made no offer to take a telephone to him.

**F 174
RIGHT TO TELEPHONE
ACCESS WITH PRIVACY**

1. Resident #36 currently uses the phone in a private area free from being overheard.
2. All residents have the potential to be affected. Three portable telephones have been purchased by the facility to allow phone calls to be made in private areas.
3. Staff were re-educated on telephone privacy and location of portable phones. A Resident Interview and Observation Form has been implemented to ensure continued compliance. (See Attachment F)
A Family Interview Form has been implemented to ensure private calls are being made. (See Attachment G)

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F 174 Continued From page 12
At 11 A.M., the resident was up and at the nurses station and wanted to call his wife. He talked to his wife and the personal conversation was heard by staff and residents in the area.

On 2/10/11, at 8:55 A.M., the resident asked the nurse if he could call his wife. The nurse placed the call and handed the phone to the resident. There was no answer and he left a message.

Interview with the charge nurse on the dementia unit on 2/10/11 at 9 A.M., indicated there was no private telephone for residents to use.

3.1-3(f)
F 223 483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION
SS=B

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 2 of 2 residents named in 2 reports of alleged abuse were free from physical abuse while being cared for by Certified Nursing Assistants (CNAs) (Resident #36, #100)

Findings include:
On 2/10/11 at 1:00 p.m., The Administrator provided two allegations of abuse for review. He

F 174
4. The Social Service Director or designee will interview three alert and oriented residents and complete the Resident Interview Form. The Social Service Director or designee will interview 3 family members and complete the Family Interview Form. The resident and family interviews will be completed on scheduled work days as follows: Daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's QA meetings and the plan adjusted accordingly.

F 223
5. Results of these reviews will be completed on or before March 12, 2011

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F 223 Continued From page 13
indicated these were the only ones investigated since the last annual survey in March, 2010.

The report indicated Resident #36 had been hit on the back of the head by CNA # 10 while she was providing care for him. CNA #11 reported the incident that she had witnessed. The investigation was completed in a thorough and efficient manner and reported to the state agency on 1/7/11. CNA #10 was terminated for abuse on 1/11/11.

The other report indicated Resident # 100 had been handled roughly by CNA #13 while providing care. The incident had been witnessed and reported by CNA #12. CNA #13 had left bruises on Resident # 100 and made the resident cry out. The facility thoroughly investigated the incident, protected the resident, and terminated CNA #13 on 8/11/10. The incident was reported to the state agency.

3.1-27(a)(1)

F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure meaningful activities were provided for 3 of 3 residents reviewed for activities in the sample of 12

F 223

**F 223
FREE FROM
ABUSE/INVOLUNTARY
SECLUSION**

1. The abuse allegations for Resident #36 and #100 were thoroughly investigated by the facility, reported to ISDH in a timely manner, and CNA's #10 and #13 were terminated due to the abuse allegations.

2. All residents have the potential to be affected. Abuse allegations are thoroughly investigated by the facility and reported to ISDH in a timely manner.

3. The facility's abuse policy has been reviewed and no changes are indicated at this time. Staff have been re-educated on the abuse policy and will continue to be in-serviced on abuse at a minimum of two times

F 248

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F 248 . Continued From page 14
residents who met the criteria for activities.
(Resident #44, #53, #58)

Findings include:

1. The clinical record of Resident #44 was reviewed on 2/9/11 at 8:24 a.m. The activity assessment, dated 1/20/11, indicated the resident shows little/no interest or response during activities. The assessment also included the following information: Family involved in daily routine: frequently; Daily visits (one to one visits not marked)

The care plan indicated the following:
Problem/Strength "Maintain current level of act. Family daily visits in rm (room) [with] wife" There was no goal listed for the care plan problem. The interventions included the following:
"Daily visits to ensure needs are met
Staff anticipates needs"

According to the assessment, information was obtained from observation and record review. The section of activity assessment, "Identified Leisure Interests and Hobbies (check all that apply)" was all marked "N/A" (not applicable) except "Hobbies Bird Watching," "Social Other Family Other wife in rm," "Television Other TV on" and "Multisensory Visual Auditory"

The Activity Quarterly review, dated 12/20/10, indicated the following:
Independent and/or group Activity participation since last assessment: T.V. in rm [with] wife, T.V. visits family volunteers. Care Plan: "Maintain current level of activities of past interest as tolerated."

F 248

annually. A Staff Interview Form has been implemented to ensure compliance with reporting abuse allegations.
(See Attachment H)
A Resident Interview and Observation Form has been implemented to ensure continued compliance.
(See Attachment F)
A Family Interview Form has been implemented to ensure continued compliance.
(See Attachment G)

4. The Social Service Director or designee will interview three alert and oriented residents and complete the Resident Interview Form. The Social Service Director will interview 3 family members and complete the Family Interview Form. The Administrator or designee will interview 3 staff members and complete the Staff Interview Form. The resident, family, and staff interviews will be completed on scheduled work days as follows: Daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these

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F 248 Continued From page 15 F 248

The Quarterly Activity Progress Note, dated 9/21/10, indicated, "Enjoys activities that contain passive skills, such as music, entertainment, groups, and movies. Enjoys multi-sensory activities such as tactile stimulation, aromatherapy, visual and/or auditory stimulation. Average time involved in activities - Some - from 1/3 to 2/3 of time. If no activities from above are being completed, then what one to one activities is the resident receiving and how many times a week? daily visits"

The activity progress note, dated 8/16/10, indicated, care plan, "Maintain current level of self-initiated and some facility sponsored of interest."

An activity progress note, dated 5/16/10, indicated, "Activities resident has attended since last assessment: poker run, special events. Resident [with] independent activity participation: music, visits wife. The care plan indicated, Maintain current level of self-initiated [with] facility sponsored act of interest & choice.

On 2/9/11 at 7:35 a.m., the resident was observed at an assist table, waiting for breakfast. The resident was observed with his eyes closed and CNA #1 indicated he sleeps all the time. The resident did open his eyes when spoken to, but then immediately closed his eyes again.

During observation of a music activity on 2/9/11 at 10:08 a.m., Resident #44 was not in attendance.

On 2/9/11 at 11:10 a.m., the resident was observed up in his w/c (wheelchair) in the dining room, around a horseshoe table with three other residents; sitting with eyes closed. No staff were

reviews will be discussed during the facility's QA meetings and the plan adjusted accordingly.

5. Results of these reviews will be completed on or before March 12, 2011

**F 248
ACTIVITES MEET
INTERESTS/NEEDS OF EACH
RESIDENT**

1. Residents #44, #53, and #58 or families of each resident were interviewed if indicated to determine individual interests. The activity plan of care for each resident has been reviewed and revised if indicated to reflect a more individualized activity program which is designed to meet the interests and the physical, mental, psychosocial well-being of each resident.

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F 248

On 2/10/11, the resident was not observed to attend any activities and either was observed dozing in his wheelchair or recliner or sleeping in bed at various times throughout the dayshift (9:20 a.m. transferred to the recliner in his room, where he was observed dozing again at 10:15 a.m. and 10:30 a.m. and was in bed sleeping at 1:10 p.m.).

On 2/10/11 at 11:30 a.m., the Activity Director provided the participation logs for Resident #44 for the months of December 2010, and January and February 2011. The logs indicated the resident was a passive participant in "Morning Socializing" each day except 1/31/11, due to being "unavailable" on that day and on 2/3/11, documentation indicated the resident refused a manicure.

On 2/9/11 at 11:20 a.m., the Activity Director indicated that morning socializing was done by the Activity Assistant and she "goes to every room and visits."

On 2/10/11 at 1:45 p.m., the Activity Assistant was interviewed and indicated, morning socializing included going to every room, knocking on the door and telling the residents good morning; chatting about the weather, asking if there is anything they need, and telling them what's on the menu and what activities are going on.

The activity calendars for December 2010, January 2011, and February 2011 were reviewed on 2/10/11 at 11:30 a.m. "Morning Socializing" was included on each day of the months, except one, and included a time frame of 20 to 50

2. All residents have the potential to be affected. The residents and/or families were interviewed if indicated to determine individual interests. The activity plan of care for each resident has been reviewed and revised if indicated to reflect a more individualized activity program which is designed to meet the interests and the physical, mental, psychosocial well-being of each resident.

3. The facility's activities policies and procedures were reviewed and no changes were indicated at this time. The Activity Director has been re-educated on the activity policies. A Resident Interview and Observation Form has been implemented to ensure continued compliance.
(See Attachment F)

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F 248

minutes for the activity assistant to visit and socialize with each of the 41 residents residing on the 100-300 units.

2. During observation on the Dementia unit on 2/9/11, the activity staff had doughnuts, coffee and conversation and a movie from 9 A.M. - 10 A.M., and Resident #58 was in bed. There was a hymn sing in main lounge late morning and the resident was not taken to the activity.

The clinical record of Resident #58 was reviewed on 2/9/11 at 10:13 A.M. The Minimum Data Set [MDS], dated 12/29/10, identified Resident #58 as having trouble concentrating on things, such as reading the newspaper or watching television daily.

The Activity Notes on 1/26/11 indicated the resident's activity preference as reading books, newspapers and listening to music. The notes listed:

"Independent and/or group Activity participation since last assessment as, "singing, music, donut day."

"If no activities from above are being completed, describe one to one activities provided and frequency thereof:

x 2 wkly [twice weekly] music, reading to her, sensory stimulation"

"Maintain current level of individualized sessions per residents response of session."

The care plan regarding activities listed the Problem: 8/10/10 through 12/18/10 and current: The resident has decreased vision, does not appear to follow objects, unable to assess and is at risk for complications.

"Provide activities appropriate for the resident Assist and encourage to attend activities of

4. The Social Service Director or designee will interview three alert and oriented residents and complete the Resident Interview Form and will interview 3 family members and complete the Family Interview Form on scheduled work days as follows: Daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months.

Results of these reviews will be discussed during the facility's QA meetings and the plan adjusted accordingly.

5. Results of these reviews will be completed on or before March 12, 2011

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choice."
"Problem, 7/28/10 and 11/10/10, and current, resident requires placement of the secured unit d/t [due to] alzheimer's dementia with psychosis and wandering.,
Intervention: Provide a consistent schedule of activities as well as a consistent daily routine."

Observation on 2/9/11 at 1:46 P.M., Resident #58 sat in the television [TV] lounge. The TV was on, but the resident was not paying attention to it.

The only two activities listed on the Dementia unit calendar for Wednesday, February 9, 2011, were: Donut Day at 9:30 A.M., socializing and Manicures at 2 PM.

At 2 P.M., three residents were taken to movie, but Resident #58 remained in the TV lounge.

At 2:27 P.M., 2/9/11, Activity Director [AD] #1 was in the TV lounge doing a manicure for one resident and Resident #58 remained in the room. Her eyes were open, she made verbalizations, and the AD called out to her. A CNA came into the room and the resident reached out to her.

Interview with AD #1 on 2/9/11 at 4 P.M., indicated she completed one on one activities with the resident twice a week, providing sensory stimulation and singing. She reported twice weekly was the plan for all residents who required one on one activities, there was no specific days she visited the resident, nor were there specific plans for what they were going to do during the one on one sessions. When asked what the resident did when she was not in activity, AD #1 indicated the resident was usually in the recliner in the TV room, but did not believe the resident

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F 248	Continued From page 19 watched the TV.	F 248		
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On 2/10/11 at 8:55 A.M., Resident #58 was observed in the T.V. room sitting along the side of the television. The resident could not see the screen but could hear the program playing. She was resting calmly.

Observation of Resident at 10:10 A.M. on 2/10/11, the resident remained in the same chair in the TV room. The program on the TV had people fighting and yelling at each other. Interview with R.N. #1, at the time, indicated she did not think having that program on was very calming for the resident and changed the station. 3. Interview with Resident # 53, conducted on 2/7/11 at 3:15 p.m., indicated the resident did not receive assistance from the activity staff to keep him busy with activities. He indicated he was "bored to death." He also indicated an interest in the Wii game module. He indicated the facility had the module and he was allowed to play it "once in a while."

The clinical record was reviewed for Resident # 53 on 2/7/11 at 1:30 p.m. The most recent comprehensive Minimum Data Set assessment (MDS), dated 7/27/10, indicated the resident was dependent on staff for all activities of daily living except eating. The assessment also indicated the resident was not ambulatory. The activity assessment of the MDS indicated the resident was awake morning, afternoon, and evenings with interests which included cards, crafts, exercise, music, reading, religious activities, walking, watching TV, gardening, and talking.

The resident had diagnoses which included, but were not limited to: diabetes, lymphedema of the

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F 248 Continued From page 20
legs (uncontrolled swelling), morbid obesity requiring a Hoyer lift for transfers, and septicemia from cellulitis of the right leg which required an amputation.

F 248

The care plan, dated as reviewed most recently on 1/4/11, indicated the following interventions for activities since the resident self initiated: "provide monthly calendar; remind resident of special activities; provide visits to ensure that resident has necessary equipment and materials to continue activities of interest: TV, family visits, cards, reading, music; encourage resident to attend resident council meetings; provide assistance if needed to facility sponsored activities."

The Activity Director was interviewed on 2/10/11 at 9:30 a.m. She indicated Resident # 53 had a cell phone. She indicated she was trying to raise money for a computer. She had never requested to get the resident up earlier to be able to attend morning activities. She knew he liked to play the Wii, but indicated the resident wanted competition and she knew of no one to play against him. She had not thought about allowing him to play against the computer. She explained he got bored easily and spent much of his time in his room. She had not thought of setting up the game for him to play in his room. She indicated she knew the resident was young and harder to please. She also indicated she had no budget for activity supplies. She indicated she had been at the facility for eight years and never had a budget for supplies.

3.1-33(a)
F 253 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES

F 253

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F 253 Continued From page 21

F 253

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure resident rooms and common areas for residents were maintained in a clean and sanitary manner. This affected 15 of 40 resident rooms and 19 of 55 residents in the facility and 3 of 3 unit common areas in the facility. (Room #102, 104, 105, 106, 108, 109, 112, 113, 203, 204, 209, 211, 212, 307, and 305 and the 100 Unit, 200 Unit, 300 Unit and the Main Dining Room)

Findings include:

1. Room 105 was observed on 2/7/11 at 12:25 p.m. The bathroom floor was stained around the stool. The commode lid was soiled with a brown substance. The bathroom had a urine odor. One resident resided in the room.
2. Room 104 was observed on 2/7/11 at 3:13 p.m. The bathroom faucet would not shut off; there was a constant stream of water running. Resident #18 indicated to shut it off, you had to push it "real hard." There was uneven and unfinished plaster all around the sink in the bathroom. The caulking around the toilet base was badly stained and the doors to the bathroom were marred. The built-in dresser in the room had mismatched doors. The air conditioned unit was missing part of the wood trim around the unit. There was no bedside chair in the room available

**F 253
HOUSEKEEPING &
MAINTENANCE SERVICES**

1. Rm 102-The room's door has been re-adjusted and now shuts without using force. A bedside chair has been placed in the room for the resident and/or visitor use.
- Rm 104-The bathroom faucet has been replaced and now shuts off easily. The plaster around the sink has been evened out and refinished. The caulking around the toilet base was replaced. The trim around the air conditioner has been replaced. A bedside chair has been placed in the room
- Rm 105-The bathroom has been thoroughly cleaned. The tile on the floor has been replaced, the commode lid has been cleaned, and the bathroom is free from urine odors.
- Rm 106-A bedside chair has been placed in the room for resident and/or visitor use. The bathroom door handle has been replaced and is no longer discolored. The caulking around the commode has been replaced and is free from discoloration. The cove base in the

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F 253 Continued From page 22
for resident/visitor use. One resident resided in the room.

3. Room 211 was observed on 2/8/11 at 9:20 a.m. The walls in the bathroom were marred. The bathroom commode caulk was discolored and the cove base was soiled. The bathroom contained a urine odor and the commode lid did not fit the stool. The closet doors were off track and the air conditioner unit was marred, missing paint, and was also dented. The caulking was rough/uneven around the built-in dresser and the drawers were soiled. One resident resided in the room.

4. Room 112 was observed on 2/8/11 at 10:25 a.m. The bathroom wall behind the sink was discolored. There was a yellow stain on the beige tile. Two residents resided in the room.

5. Room 113 was observed on 2/7/11 at 12:45 p.m. The floor in front of the toilet was stained a light yellow. The wall behind the toilet had an area not painted the same yellow as the rest of the wall. The wall appeared as it was patched and not repainted. One resident resided in the room.

6. Room 204 was observed on 2/7/11 at 11:25 a.m. The closet doors were off the tracks. Two residents resided in the room.

7. Room 212 was observed on 2/8/11 at 9:12 a.m. There was no toilet paper dispenser in the bathroom. The caulking around the bathroom sink was uneven and rough. The caulking around the commode was discolored and the lid on the commode didn't fit well. The bed was marred/missing finish in areas (Bed 1). One resident resided in the room.

F 253
bathroom has been re-attached and/or replaced and is no longer pulling away from the wall. The bathroom has been re-painted. The areas around the air conditioning unit have been fixed and no longer allows light coming in from the outside. Rm 108-A bedside chair has been placed in the room for resident and/or visitor use. The caulking around the commode has been replaced and is free from discoloration. The cove base has been replaced and/or reattached to the wall in the bathroom. Rm 109-Doors have been placed on the closet and the curtains removed. The room has been repainted and cove base has been reattached and/or replaced. The bedside table has been re-finished and is free from mars. The toilet paper dispenser has been reattached and is hanging evenly. The commode has been fixed and is now sitting straight close to the wall. The caulking around the bathroom sink has been replaced and is now smooth and even. Rm 112-The bathroom has had a thorough cleaning. The wall behind the sink is free from discoloration

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F 253 Continued From page 23

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- 8. Room 307 was observed on 2/7/11 at 4:04 p.m. The wall behind the bed had splotches of plaster patch, unfinished, over the wall. One resident resided in the room.
- 9. Room 209 was observed on 2/8/11 at 8:38 a.m. The bathroom door frames were scuffed up and had chipped paint. Two residents resided in the room.
- 10. Room 305 was observed on 2/8/11 at 11:35 a.m. The bathroom door was noted with multiple scrapes into the finish of the door. One resident resided in the room.
- 11. Room 102 was observed on 2/7/11 at 3:41 p.m. The door to the room would not shut without slamming the door with force. There was no bedside chair in the room for the residents and/or visitors. Two residents resided in the room.
- 12. Room 108 was observed on 2/7/11 at 3:30 p.m. There was no bedside chair available in the room. The bathroom door was marred. The caulking around the commode was discolored. The cove base was pulling away from the wall in the bathroom. One resident resided in the room.
- 13. Room 106 was observed on 2/7/11 at 12:42 p.m. There was no bedside chair available in the room. The closet door was marred. The bathroom door was marred. The bathroom door handle was discolored. The caulking around the commode was discolored. The cove base was pulling away from the wall in the bathroom. The bathroom was missing areas of painted finish. The room cabinets appeared to have streaks/spills on them with worn finish. The air

and the stain on the tile has been removed.
Rm 113-The bathroom has been thoroughly cleaned. The stain on the floor in front of the toilet has been removed. The wall behind the toilet has been repainted and is all one color and free from patching.
Rm 203-The bathroom door frames have been re-finished and are free from scuffs. The room has been refinished and is free from missing wall paper. The wall light cover has been replaced for bed 1.
Rm 204-The closet doors have been placed back on the tracks.
Rm 209-The bathroom door frame has been re-finished and is free from scuffs and chipped paint.
Rm 211-The bathroom has been thoroughly cleaned and is free from urine odors. The cove base has been cleaned and/or replaced. The walls in the bathroom have been fixed and are currently free from mars. The caulking around the commode has been replaced. The commode lid has been replaced and fits appropriately. The closet doors have been placed back on the tracks. The air conditioner has replaced. The caulking around the built-in dresser

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F 253 Continued From page 24

F 253

conditioned unit had areas around the unit which allowed light in from the outside. One resident resided in the room.

14. Room 109 was observed on 2/7/11 at 4:20 p.m. The closet in the room had no doors and had two curtains hanging in front of the closet. The curtains were red, white, and blue plaid while the curtains in the room were pale green in color. A portion of the wall where the dresser was located had a section of wallpaper border with the remaining border missing and the wall with the missing border contained solid colored paper/paste remaining on the wall. The wall next to the closet was marred and missing a piece of the cove base, approximately 6 inches. The bedside table was marred. The toilet dispenser in the bathroom was hanging unevenly. The commode was sitting in a crooked manner and was away from the wall. The caulking around the bathroom sink was rough/uneven. One resident resided in the room.

15. Room 203 was observed on 2/7/11 at 11:47 a.m. The door frames in the bathroom were scuffed and the wall had part of the wallpaper off. Bed 1 in the room was missing the wall light cover. One resident resided in the room.

16. The main dining room was observed on 2/9/11 at 7:35 a.m. There was 1 piece of cove base missing near the air conditioner unit. The outside exit doors were marred/missing areas of paint. There was a gap at the top of the doors, allowing air and light to enter. The doors were rusted at the bottom and one of the doors was missing the latching mechanism. The kick plates were soiled with streaks. One section of the right door had a bubbled-up/rough finish.

has been smoothed and evened out and the drawers were cleaned.
Rm 212-A toilet paper dispenser has been placed in the bathroom. The caulking around the bathroom sink has been replaced and is smooth. The caulking around the commode was cleaned and/or replaced. The lid on the commode was replaced and currently fits appropriately. The bed has been repaired and is free from mars/missing finish.
Rm 305-See below
Rm 307-The wall behind the bed has been repainted.
100 unit-The wall paper in the main hall has been removed. The hole in the shower room floor has been covered. The caulking around the base of the shower and sink has been replaced and is free from rough/discolored areas. The shower room walls have been repainted. The tiles have been cleaned and are free from soil/spills and stuck dried paper. Cove base has been replaced and there no longer is missing pieces or holes uncovered.
200 unit-Caulking has been replaced on the window at the end of the hallway and the window frame has been refinished. The windows in the

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F 253 Continued From page 25

F 253

17. On 2/9/11 at 2:30 p.m., the following was observed on the secured (200) unit:

The window at the end of the hallway was missing caulk and/or had rough caulking at the base of the window and the paint in the base of the window was worn off. The windows in the secured unit dining room had missing/worn paint. The cove base in the dining area was pulling away from the wall in numerous areas and was soiled with dust/dirt. The horseshoe tables (2) were noted with marred legs. Three other tables had streaks of paint/soiling on the edges of the tables.

The shower room had soiled tile grout in the shower area. Upon entry, the tile to the left of the door contained broken/chipped tiles. The finish of the door to the room was worn/off/marred. The wall around the soap dispenser was missing paint in areas.

Four chairs, used by residents, at the nurses station were marred, with worn finishes. The table in this same area was soiled with spills on top.

18. On 2/9/11 at 2:50 p.m., the main hallway of the 100 unit had wallpaper loose in numerous areas.

19. On 2/9/11 at 2:55 p.m., the windows in the lounge area on the 100/300 units were soiled with dirt/dust and had chipped paint and/or worn paint, with exposed wood noted. The outside exit door in this area was marred, and the threshold was soiled.

dining room have been refinished and no longer has missing/worn paint. The cove base has been reattached and/or replaced and is currently free from dust/dirt. The legs on the horseshoe tables have been refinished and are now free from mars. The other tables have been refinished and are free from streaks of paint/soiling. The shower room has been thoroughly cleaned and the tile grout is free from soilage. The broken/chipped tiles have been replaced. The shower room walls have been repainted. The table has been cleaned and remains free from spills. 300 unit-The trash liner in the shower room was immediately removed and discarded. The water standing in the shower room has been dried up and no longer occurs. The shower head in the right shower stall has been fixed and/or replaced and no longer leaks constantly. The holes in the wall by the commode have been fixed and the walls refinished. The caulking around the toilet and sink has been replaced and no longer is rough/cracked. The plate covers have been replaced and are free from discoloration.

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F 253 Continued From page 26

20. On 2/9/11 at 2:58 p.m., the exit door at the end of the 300 unit was rusted at the base and the doors did not meet in all areas, allowing air to enter from the outside.

21. On 2/9/11 at 3:09 p.m., the 300 unit shower room was observed. There was an open trash can in the room, containing incontinent briefs and visible soiling of bowel movement on the interior surface of the trash bag. There was water standing on the floor in the center of the room, outside the shower stalls. There was a constant leak/dripping of the shower head on the shower staff on the right side of the room. There were holes in the wall by the commode in the room. The caulking around the toilet was rough/cracked. The caulking around the back of the sink was cracked. The brass colored plate covers were discolored and the entrance door to the room were marred.

22. On 2/9/11 at 3:15 p.m., the 100 unit shower room was observed. The door to the room was marred. There was a hole in the floor of the shower room, approximately 2 inches in diameter, which was uncovered and open. The caulk around the base of the shower was rough/discolored in areas. The wall around the soap dispenser was not painted. The tiles on the ledge in the room were soiled with spills and dried paper stuck to the surface. The calking around the sink was discolored. There was a section of the flooring/edging missing with a section of vinyl cove base in front of the hole but the cove base did not cover the entire section, leaving a small hole in to the area behind the wall exposed.

23. The Administrator was interviewed on 2/10/11 at 1:00 p.m. to discuss the Quality

F 253

100/300 units—The lounge area shared by these units has been thoroughly cleaned and is free from dirt/dust. The windows have been refinished and are now free from chipped/worn paint and exposed wood. The door's threshold has been cleaned.

Main dining room-The cove base has been re-attached and/or replaced.

All bathroom doors will be replaced with new doors. The facility is requesting a 60 day extension to purchase, remove, and replace the doors. All bathroom door frames will be repainted.

All room doors will be removed, sanded, refinished, repainted and rehung. The facility is requesting a 6 month extension to allow this to be completed with a goal of 3 doors completed each week. All room door frames will be repainted.

All outside doors have been reviewed and those with concerns will be replaced. The facility is requesting a 30 day extension to receive quotes, 60 days to order and custom make the doors, and an

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F 253 Continued From page 27
Assurance program.

F 253

The Administrator indicated the environmental concerns had been addressed in the January 31, 2011 meeting. He indicated the plan was not to be completed for 3 months.

additional 30 days to remove the old doors and install the new doors for a total of 120 days extension.

F 272 3.1-19(f)
483.20, 483.20(b) COMPREHENSIVE
SS=D ASSESSMENTS

F 272

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

All handrails will be removed, repainted, and refinished. The facility is requesting a 30 day extension for purchasing materials and 60 days for repainting, refinishing, and replacing all handrails in facility.

- A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:
- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnosis and health conditions;
- Dental and nutritional status;
- Skin conditions;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge potential;
- Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and

Resident chairs at the nurses' station on the unit have been disposed of and new ones have been ordered.

New chairs have been ordered for all resident rooms.

The wallpaper on the 100 hall has been removed. The facility is requesting a 30 day extension to receive quotes and a 60 day extension to have the walls refinished.

All built in dressers were reviewed and if concerns noted, they will be replaced with new dressers. The facility is requesting a 30 day extension to purchase materials and

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F 272 Continued From page 28
Documentation of participation in assessment.

F 272 an additional 60 days to remove old and install the new dressers.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to assess 2 of 31 residents reviewed in the Stage 2 sample in order to meet their needs. Resident #53 was not assessed after his leg was amputated for other possible activities of interest. Resident #51 was not assessed for teeth caries and periodontal disease on admission.

Findings include:

1. Interview with Resident #53, conducted on 2/7/11 at 3:15 p.m., indicated the resident did not receive assistance from the activity staff to keep him busy with activities. He indicated he was "bored to death." He also indicated an interest in the Wii game module. He indicated the facility had the module and he was allowed to play it "once in a while."

The clinical record was reviewed for Resident #53 on 2/7/11 at 1:30 p.m. The most recent comprehensive Minimum Data Set assessment (MDS), dated 7/27/10, indicated the resident was dependent on staff for all activities of daily living except eating. The assessment also indicated the resident was not ambulatory. The activity assessment of the MDS indicated the resident was awake mornings, afternoons, and evenings with interests which included cards, crafts, exercise, music, reading, religious activities, walking, watching TV, gardening, and talking.

The most recent Quarterly MDS assessment had been completed on 1/31/11. The resident had

2. All areas of the facility have the potential to be affected. Rounds were completed and if concerns were noted have been repaired.

3. The maintenance director has been re-educated on building maintenance and creating a home-like environment for the residents. An Environmental Observation Form has been implemented to ensure continued compliance. (See Attachment A)

4. The Maintenance Director or designee will be responsible for doing facility rounds and completing the Environmental Observation Form on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter for a minimum of 6 months. The results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective actions will be completed on or before March 12, 2011

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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 272 Continued From page 29

recently been hospitalized and was on strict bedrest upon return to the facility on 1/1/11 until 2/7/11.

The resident had diagnoses which included, but were not limited to: diabetes, lymphedema of the legs (uncontrolled swelling), morbid obesity requiring a Hoyer lift for transfers, and septicemia from cellulitis of the right leg which required an amputation.

The Activity Director was interviewed on 2/10/11 at 9:30 a.m. She indicated she had not reassessed the resident after the resident returned from the hospital and was on strict bed rest as to how to meet his activity interests needs while the resident was on strict bed.

2. Resident #51 ' s family indicated, during interview on 2/8/11 at 11:40 a.m., that the resident has had problems with her teeth and currently had a tooth with a cavity that needs to be monitored.

Resident #51 ' s clinical record was reviewed on 2/8/11 at 3:40 p.m. The resident was admitted to the facility on 9/18/09 with diagnoses that included, but were not limited to, Alzheimer ' s Disease, Osteoporosis, Pain, and Coronary Artery Disease.

Documentation of an oral status assessment was lacking at the time of admission to the facility. Nursing assessments from the time of admission through 4/6/10 indicated the resident had no problems related to oral status, including bleeding gums, problems with teeth, or refusal of assistance with oral care.

A quarterly Minimum Data Set (MDS)

F 272

**F 272
COMPREHENSIVE
ASSESSMENTS**

1. Resident # 53 has been reassessed by activities for other possible activities of interest and the activities plan adjusted accordingly.

Resident # 51 has had a dental assessment completed.

2. All residents have the potential to be affected. Their activity assessments have been reviewed and revised if indicated to include other possible activities based on their interest. Also, dental assessments have been completed on all residents.

3. The facility's policies and procedures for the activity programs have been reviewed and no changes are indicated at this time. The Activity Director has been re-educated on providing activities of interest.

A Resident Interview and Observation Form has been implemented to ensure activities of interest is being provided.
(See Attachment F)

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F 272 Continued From page 30
assessment, with assessment reference date of 4/1/10, indicated the resident was totally dependent on staff for personal hygiene, which included brushing of teeth.

Physician's progress notes, dated 7/12/10, indicated the following: "Dental caries teeth 2, 3, 14, 16, 17, 32, and possibly other teeth. Acute gingivitis and periodontitis. Medical history complex. Plan: Oral exam under anesthesia at hospital. Extract bad teeth."

Documentation indicated the resident had dental extractions completed on 9/22/10.

When the resident returned from the hospital, following the dental extractions, on 9/22/10, documentation was lacking of an assessment of the oral status of the resident.

On 2/10/11 at 7:30 a.m., CNA #3 indicated, "... when the resident was first admitted she would not allow her teeth to be brushed and teeth would bleed with blood noted on toothbrush." The CNA also indicated, "the resident had very bad breath." CNA #3 indicated she did report the resident's condition to the charge nurse 1-2 times, but "probably not every time," then the resident had to have teeth pulled.

During interview on 2/10/11 at 9:20 a.m., the Director of Nursing indicated she was unaware of any current dental caries.

F 272 A Family Interview Form has also been implemented.
(See Attachment G)

Dental Assessments will be completed upon admission, quarterly, with significant changes and as indicated per the MDS. Nursing staff have been educated on dental assessments. A Critical Elements for Dental Status and Services Form has been implemented to ensure compliance with dental assessments.
(See Attachment I)

4. The Social Service Director or designee will be responsible for interviewing 3 residents and completing the Resident Interview and Observation Form. The Social Service Director or designee will be responsible for interviewing 3 family members and completing the Family Interview Form.

The DON or designee will be responsible for completing the Dental Status Form on 3 residents.

3.1-31(b)(3)
3-1-31(c)(9)
F 279 483.20(d), 483.20(k)(1) DEVELOP
SS=D COMPREHENSIVE CARE PLANS

F 279

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F 279 Continued From page 31

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure care plans were formulated, utilizing information specific to each resident, related to activities, fall prevention interventions, and dental services. This affected 2 of 3 residents reviewed for activities in the sample of 12 who met the criteria for activities and 1 of 3 residents reviewed for dental services in the sample of 3 who met the criteria for dental services. In addition, this affected 1 of 3 residents reviewed for falls in the sample of 8 who met the criteria for falls. (Resident #44, #58, #51, #58)

Findings include:

F 279

The forms will be completed on scheduled work days as follows:
Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective actions will be completed on or before March 12, 2011

**F 279
DEVELOP COMPREHENSIVE
CARE PLANS**

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1. The clinical record of Resident #44 was reviewed on 2/9/11 at 8:24 a.m. The activity assessment, dated 1/20/11, indicated the resident shows little/no interest or response during activities. The assessment also included the following information: Family involved in daily routine: frequently; Daily visits (one to one visits not marked)

The care plan indicated the following:
Problem/Strength "Maintain current level of act. Family daily visits in rm (room) [with] wife" There was no goal listed for the care plan problem. The interventions included the following:
"Daily visits to ensure needs are met
Staff anticipates needs"

According to the assessment, information was obtained from observation and record review. The section of activity assessment, "Identified Leisure Interests and Hobbies (check all that apply)" was all marked "N/A" (not applicable) except "Hobbies Bird Watching," "Social Other Family Other wife in rm," "Television Other TV on" and "Multisensory Visual Auditory"

The activity quarterly review, dated 12/20/10, indicated the following:
Independent and/or group Activity participation since last assessment: T.V. in rm [with] wife, T.V. visits family volunteers. Care Plan: "Maintain current level of activities of past interest as tolerated."

The quarterly activity progress note, dated 9/21/10, indicated, "Enjoys activities that contain passive skills, such as music, entertainment, groups, and movies. Enjoys multi-sensory activities such as tactile stimulation,

1. The activity plans of care for Resident # 44 and # 58 have been reviewed and revised to reflect an individualized activity program to meet the residents' needs.

The dental plan of care for Resident # 51 has been implemented to reflect an individualized approach for dental care.

The fall and Merry-walker plans of care for Resident # 58 has been reviewed and revised to reflect an individualized program for fall management.

2. All residents have the potential to be affected. The plans of care for all residents have been reviewed and revised if needed. The care plans have been individualized to meet the residents' needs.

3. The facility's policy for care plan development has been reviewed and no changes are indicated at this time. The care plan team has been re-educated on individualized care plan development. A General Critical

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aromatherapy, visual and/or auditory stimulation.
Average time involved in activities - Some - from 1/3 to 2/3 of time. If no activities from above are being completed, then what one to one activities is the resident receiving and how many times a week? daily visits"

The activity progress note, dated 8/16/10, indicated, care plan, "Maintain current level of self-initiated and some facility sponsored of interest."

An activity progress note, dated 5/16/10, indicated, "Activities resident has attended since last assessment: poker run, special events. Resident [with]independent activity participation: music, visits wife. The care plan indicated, Maintain current level of self-initiated [with] facility sponsored act of interest & choice.

The care plan remained without a goal and did not incorporate the resident's past interests and/or past activity attendance.

2. The clinical record of Resident #58 was reviewed on 2/9/11 at 10:13 A.M. The Minimum Data Set [MDS], dated 12/29/10, identified Resident #58 as having trouble concentrating on things, such as reading the newspaper or watching television daily.

The Activity Notes on 1/26/11 indicated the resident's activity preference as reading books, newspapers and listening to music. The notes listed:
"Independent and/or group Activity participation since last assessment as, "singing, music, donut day."
"If no activities from above are being completed, describe one to one activities provided and

Element Pathway Form has been implemented to ensure compliance. (See Attachment J)

4. The DON or designee will complete the General Critical Element Pathway Form for 3 residents on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective action will be completed on or before March 12, 2011

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NAME OF PROVIDER OR SUPPLIER

UNIVERSITY NURSING CENTER

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frequency thereof:
x 2 wkly [twice weekly] music, reading to her, sensory stimulation"
"Maintain current level of individualized sessions per residents response of session."

The care plan regarding activities listed the Problem: 8/10/10 through 12/18/10 and current, the resident has decreased vision, does not appear to follow objects, unable to assess and is at risk for complications.

"Provide activities appropriate for the resident Assist and encourage to attend activities of choice."

"Problem, 7/28/10 and 11/10/10, and current, resident requires placement of the secured unit d/t [due to] Alzheimer dementia with psychosis and wandering,

Intervention: "Provide a consistent schedule of activities as well as a consistent daily routine."

The care plan did not provide specific interventions to address the resident's interest in books, newspapers, music, or the need to provide one to one activities as addressed in the activity director's progress notes.

A 2/9/11, 4 P.M., interview with Activity Director #1 indicated one on one activities were provided to the resident twice a week, and included sensory stimulation and singing. There were no set days the activities were to occur, nor was there a plan for what was to be done during the session. AD #1 reported when the resident was not in an activity, she was in the recliner in the television room. She reported that she did not believe the resident watched the television.

3. Resident #51 's family indicated, during interview on 2/8/11 at 11:40 a.m., that the

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F 279	<p>Continued From page 35</p> <p>resident has had problems with her teeth and currently had a tooth with a cavity that needs to be monitored.</p> <p>Resident #51 ' s clinical record was reviewed on 2/8/11 at 3:40 p.m. The resident was admitted to the facility on 9/18/09 with diagnoses that included, but were not limited to, Alzheimer ' s Disease, Osteoporosis, Pain, and Coronary Artery Disease.</p> <p>Nursing assessments from the time of admission through 4/6/10 indicated the resident had no problems related to oral status, including bleeding gums, problems with teeth, or refusal of assistance with oral care.</p> <p>A quarterly Minimum Data Set (MDS) assessment, with assessment reference date of 4/1/10, indicated the resident was totally dependent on staff for personal hygiene, which included brushing of teeth.</p> <p>Physician ' s progress notes, dated 7/12/10, indicated the following: "Dental caries teeth 2, 3, 14, 16, 17, 32, and possibly other teeth. Acute gingivitis and periodontitis. Medical history complex. Plan: Oral exam under anesthesia at hospital. Extract bad teeth."</p> <p>Documentation indicated the resident had dental extractions completed on 9/22/10.</p> <p>On 2/10/11 at 7:30 a.m., CNA #3 indicated, " . . . when the resident was first admitted she would not allow her teeth to be brushed and teeth would bleed with blood noted on toothbrush. " The CNA also indicated, " the resident had very bad breath. " CNA #3 indicated she did report the</p>	F 279	

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resident ' s condition to the charge nurse 1-2 times, but " probably not every time, " then the resident had to have teeth pulled.

During interview on 2/10/11 at 9:20 a.m., the DON indicated she was unaware of any current dental caries.

Review of the resident's clinical record from 11/3/09 through 2/7/11, indicated there was no specific care plan to address the resident's oral/dental needs including, resident's refusal of oral care, bleeding gums, monitoring of any dental caries, or post-operative needs for the multiple teeth extractions on 9/22/10.

4. The clinical record of Resident #58 was reviewed on 2/9/11 at 10:30 A.M. Resident #58 had fall risk assessments on 7/28/10, 10/11/10 and 1/4/11 due to a high risk of falls. The reasons making the resident a high risk were listed as: history of falls, use of assistive devices, Merry Walker [a chair device with wheels which allows the resident a place to sit when tired from walking], confusion, unsteady gait, weakness, and the use of narcotics, antipsychotics, and hypnotics.

A Merry Walker was ordered on 10/6/10.

Nurses Notes dated 11/21/10 at 5:25 P.M., indicated the resident was found on her back on the dining room floor - looking at staff and smiling. The note indicated the resident had been seated in the dining room at the table for supper

Nurses Notes dated 1/1/11 at 6:45 A.M., indicated the resident's foot was caught under Merry Walker when she fell. There was no injury to the

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resident.

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Nurses Notes dated 1/25/11 at 2 PM, indicated the resident slid down in the Merry Walker and went to her knees.

The care plan for "the resident has multiple risk factors for falls...

- Provide adequate lighting
- ensure pathways are clutter free
- resident to utilize foot wear with non-skid soles
- monitor the resident frequently when the call lights are not available
- complete fall risk assessment
- monitor vital signs
- neurological checks as indicated
- notify responsible party and MD if a fall occurs.
- Implement intervention to reduce risk for falls Merry Walker

1/1/11 - monitor resident when up in Merry Walker to ensure foot does not get caught under wheel.

check tennis shoes to be fitting appropriately 1/1/11 therapy screen"

There was a care plan problem "use of merry walker," but there were no specific interventions for this problem.

3.1-35(a)

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

**F 280
RIGHT TO PARTICIPATE
PLANNING CARE-REVISE CP**

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

1. The plan of care for Resident # 44 has been reviewed and revised to reflect the resident's current status.

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A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

2. All residents receiving psychoactive medications, utilizing splints, and receiving ROM have the potential to be affected. The plan of care for each of the potentially affected residents has been reviewed and revised if indicated.

3. The facility's policy for care planning has been reviewed and no changes are indicated at this time. Nursing, MDS, restorative staff, and social services has been re-educated on the care planning procedure. A Critical Element Psychoactive Medication Form has been implemented to ensure continued compliance.

(See Attachment K)
A Critical Elements for ADL/ROM Status Form has been implemented to ensure continued compliance.
(See Attachment L)

4. The DON or designee will be responsible for completing the Critical Element Psychoactive Medication Form and the Critical Elements for ADL/ROM Status Form for 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure care plans were updated related to psychoactive medications and the behaviors requiring use of the medications and related to range of motion needs for residents with limitations in mobility and/or contractures. This affected 1 of 3 residents reviewed with psychoactive medications in the sample of 10 who met the criteria for psychoactive medications and 1 of 3 residents reviewed for range of motion in the sample of 3 who met the criteria for range of motion. (Resident #44)

Findings include:

1.a. The clinical record of Resident #44 was reviewed on 2/8/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Type Dementia, Depression, and Dementia with Psychosis Features.

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The significant change Minimum Data Set (MDS) assessment, with assessment reference date (ARD) of 2/23/10, indicated the resident exhibited no verbal expressions of distress, no sleep-cycle issues, no sad, apathetic, or anxious appearance, and no behavioral symptoms.

An annual MDS assessment with ARD of 1/20/11, indicated the resident had no behaviors during the assessment period.

A care plan, dated 8/15/10, and updated 10/5/10 and 1/12/11, included a problem of, The resident requires the use of Aricept to treat Alzheimer's Type Dementia and is at risk for experiencing adverse side effects. The goal was for the resident to have no signs or symptoms of an adverse reaction associated with the use of Aricept. Interventions included the following:

- Administer the medication as ordered.
- Observe for s/s of an adverse reaction: insomnia, headache, nausea, diarrhea, dizziness.
- Observe for changes in mood or behavior.
- Notify the charge nurse of noted problems, for further evaluation and possible physician notification.
- Try to use short simple sentences and ask questions that require a yes or no type answer.
- Give no more than two choices to avoid confusion and over stimulation.
- Notify the charge nurse of changes in the resident's communication ability, for further evaluation and possible physician and responsible party notification. Monitor labs as ordered.

Another care plan, dated 1/20/11, included a

for 2 months, then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective actions will be completed on or before March 12, 2011

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problem, resident has diagnosis of Alzheimer's type dementia, depression, dementia with psychosis features and has a history of physical aggression and agitation. Resident is end stage Alz (Alzheimer's). Res makes noises and resist-pull back [with] ADL (Activities of Daily Living) care. The goal was the resident would accept staff intervention thru next review. Interventions included the following:

- Ensure basic needs are met
- Provide 1:1 if applicable
- Provide redirection if applicable
- Provide activity of choice or interest
- Comfort & reassurance
- Time to calm, reapproach.

Another care plan, dated 2/3/11, indicated a problem, the resident requires the use of an anti psychotic medication: Abilify and Chlorpromazine to treat Alzheimer's type Dementia with psychosis features and is at risk for adverse side effects. The goal was for the resident to have no signs/symptoms of adverse reaction associated with the use of Abilify and Chlorpromazine thru next review.

- Interventions included the following:
- Administer medication as ordered.
 - Monitor for adverse side effects such as: drowsiness, sedation, somnolence, agitation, insomnia, headache, nervousness, hostility.
 - Observe for changes in mood or behavior.
 - Notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification.
 - Refer to psychological evaluation as indicated.
 - Attempt GDR (gradual dose reduction) per policy.
 - Complete Risk/Benefit forms per policy.

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Refer to pharmacist consultant as needed.
Monitor for EPS (side effects) per policy.

Resident #44 had a care plan, dated 2/3/11, which indicated a problem that the resident requires the use of an antianxiety medication: Ativan to treat anxiety and is at risk for adverse side effects. The goal was for the resident to have no signs or symptoms of adverse reaction associated with the use of Ativan thru next review. Intervention included the following:

- Administer medication as ordered.
- Monitor for adverse side effects such as:
Drowsiness, light-headedness, depression, dry mouth, diarrhea, constipation.
- Observe for changes in mood or behavior.
- Notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification.
- Refer for psychological evaluation as indicated.
- Attempt GDR per policy.
- Complete Risk/Benefit forms per policy.
- Refer to pharmacist consultant as needed.

Social service notes in the clinical record indicated the following:
"2/7/11 -12:00 p.m. - Resident is resisting wearing his dentures. Daughter says no need to make him wear them.

1/20/11 11:15 p.m. - Annual SS (social service) asst (assessment) done. Resident has no mood or behaviors. Res (resident) is up in w/c (wheelchair), needs staff assist [with] to/from. Res unable to propel w/c at this time.

12/22/10 11:00 a.m. - Quarterly SS assessment done. Res had hitting on 10/24/10 (no time indicated) Moods & behaviors stable.

9/22/10 8:45 a.m. Quarterly MDS done Care

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plans reviewed Res triggered for repetitive verbalizations saying "hay" "hay" on 9/18/10. Insomnia - not sleeping being awake on 9/18/10. Repetitive physical movements trying to get up unassisted.
8/17/10 3:15 p.m. Quarterly MDS and care plans updated Res needs asst with all ADL's. Res moods & behaviors are stable at this time.
5/16/10 3:30 p.m. Quarterly MDS done care plan updated. Res moods & behaviors are stable.
2/23/10 2:30 p.m. Sig (significant) change MDS completed @ (at) this time. Res doing well, moods/behaviors are stable."

During observation on 2/8/11 at 10:30 a.m., Resident #44 was up in a recliner in his room, sleeping.

On 2/9/11 at 7:35 a.m., Resident #44 was in the main dining room. The resident was observed with his eyes closed and CNA #1 stated he "sleeps all the time;" the resident did open eyes when spoken to, but then immediately closed eyes again.

A physician's progress note, dated 1/31/11 at 6:30 p.m., indicated,
"Pt (patient) appears tired, but end of day. Nursing does not report [increased] daytime sedation. . . Impression: 1) Rt (right) hand osteomyelitis - Vanco (Vancomycin-antibiotic) IV 2) Dementia 3) Anxiety 4) Hand Contractures
Plan: try [increase] Abilify (psychoactive medication) - note seems to have had [increased] grip since had to stop since had to stop Clozaril (pancytopenia). Cont. scheduled Hydrocodone Monitor for sedation."

On 2/10/11 at 7:00 a.m., the Social Service

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Director (SSD) indicated during interview that Resident #44 had no behavior sheet since 10/10/10 when there was "hitting." She indicated the hitting occurred when staff were putting him to bed and he was "fussing with them while they were giving care." The SSD indicated the only other behavior he had since 1/28/10 occurred on 9/27/10 and was "cursing" and that was during care also and 9/18/10, when the resident had insomnia with repetitive verbalizations.

On 2/10/11 7:30 a.m., Resident #44 was observed up in his w/c in the dining room for breakfast and was sitting with his eyes closed.

On 2/10/11 10:30 p.m., two nurses were observed to complete the treatment to a pressure ulcer on the resident's hand. The resident did not make any attempt to interfere with the treatment and remained with eyes closed while in his recliner throughout the treatment.

No changes had been made in the resident's care plans related to psychoactive medications although the resident was not exhibiting behaviors as indicated when the care plans were first formulated.

b. The clinical record of Resident #44 was reviewed on 2/8/11 at 8:45 a.m. A care plan, dated 11/24/10 and updated 1/12/11, indicated a problem of, "The resident has contractures Bilateral hands and is at risk for pain and further contractures. (Refuses to wear palm rolls - wriggles until rolls are out of his hands. Refuses rolled up washcloths also - Attempted to try finger separater (sic) hand rolls et res refuses to wear those also. Refuses to wear palm protector -

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added in writing without date of addition)." Goal
"The resident will have pain < ___ on a scale from
0-5 due to contractures. The resident will be free
from further contractures. Thru next review"

F 280

Interventions included the following:

"Monitor vital signs routinely. Assess pain level and treat as ordered. Complete pain assessment at least quarterly and with any significant change. Refer to therapy as indicated. Ensure splints are in place as ordered: Palm protector Lt (left) hand on 7 a - 7 p off 7 p - 7a (has been yellowed out). Perform exercises as ordered to prevent further contractures. Observe for pain medication efficacy. Notify charge nurse of any observed problems and possible MD and responsible party notification. OT (Occupational Therapy) @ (at) this time 11/11/10 D/C 12/8/10"

Restorative Nursing Tracking Log - 8/10 - 15 minutes 23 of 31 days - 15 minutes ambulating 100-200 feet and Passive ROM (doesn't indicate to what) 15 minutes.

MD Order 11/23/10 - Palm protectors to bilat (bilateral) hands for contracture management on 7A-7P off 7P-7A

A Significant Change MDS assessment, with ARD of 2/23/10, indicated the following:

- Bed Mobility - requires extensive assist of 1 person
- Transfer - requires extensive assist of 1 person
- Walk in Room - requires extensive assist of 1 person
- Walk in Corridor - requires extensive assist of 1 person

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Functional Limitation in Range of Motion - No limitations in any area - neck, arm, hand, leg, foot

An annual MDS assessment with ARD of 1/20/11, indicated the following:

- Bed Mobility - totally dependent on 1-2 persons
- Transfer - totally dependent on 1-2 persons
- Walk - did not occur

Functional Limitation in Range of Motion
Upper extremity (shoulder, elbow, wrist, hand) - Impairment on both sides;
Lower extremity (hip, knee, ankle, foot) - Impairment on both sides.

The 2/3/11, assessment summary indicated, "Contractures" Resident hands are contracted and requires a total assist for all mobility per MDS staff interview on 1/20/11.

On 2/10/11 at 9:20 a.m. CNA #1 and CNA #2 transferred the resident from the w/c to the recliner. The resident did not extend his legs during transfer. The resident made no verbalization and was cooperative with the transfer process.

On 2/10/11 at 1:30 p.m., Restorative CNA #1 indicated the splints, documented daily on the restorative nursing log are bilateral leg splints and she put them on the resident around 9:30-10:00 today (2/10).

On 2/10/11 at 3:00 p.m., the Assistant Director of Nurses (ADON) provided the resident's restorative nursing tracking logs for review. She indicated the resident was on the physical/occupational therapy caseload the entire month of November 2010. The logs indicated the resident was doing active range of motion prior to

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July 2010. According to the documentation on the log, on 8/26/10, the resident started receiving passive (staff perform the exercises) range of motion (ROM - exercises of all major joints). The logs indicated passive ROM was done 5 - 6 days weekly for a total of 10-15 minutes each of the days. The restorative care plan, dated 2/3/11, indicated the resident was to receive 20 repetitions of passive ROM to bilateral upper and lower extremities one time daily. There had been no change in the resident's plan although the resident's mobility had declined and he had an increase in limitation of range of motion. The care plan, contained in the clinical record, had not been updated to reflect the use of the leg splints.

F 280

F 282 3.1-35(d)(2) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review, interview and observation, the facility failed to ensure the care plan was followed regarding the provision of supervision and proper footwear to prevent falls for 2 of 3 residents reviewed for falls in the sample of 8 who met the criteria for falls/accidents. (Residents #24 and #58)

Findings include:

1. The clinical record of Resident #24 was

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**F 282
SERVICES BY QUALIFIED
PERSONS/PER CARE PLAN**

1. The plan of care for Resident # 24 has been reviewed, revised, and supervision is being provided as per the plan of care.

The plan of care for Resident # 58 has been reviewed, revised and supervision is being provided as per the plan of care.

New tennis shoes are in place and fit appropriately. The crocs have been removed and sent home with the family.

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reviewed on 2/8/11 at 3:30 P.M. Resident #24 had fall risk assessments completed on 9/10/10 and 12/21/10 due to his high risk of falls. Reasons listed as increasing the resident's risk were his history of falls, use of a wheel chair, confusion, and use of antipsychotics and diuretics.

The care plan, dated 8/10/10 through 12/20/10 and current, listed the Problem:
"The resident requires the use of a safety alarm mat"

Interventions were:

- Personal alarm d/c [discontinue] 9/10/10
- Mat alarm 9/10/10 due to high fall risk r/t decreased safety awareness:
- Provide adequate lighting, ensure clutter free and well lit pathways, res [resident] to wear footwear with non skid soles, monitor res frequently when the call light is not available (dining room, activities)
- place the alarm appropriately per manufacturer's instructions
- observe for signs of a low battery and replace as needed
- "Remind the resident to request assist before attempting to rise."
- Notify the charge nurse of attempts to remove the device, for further evaluation and possible physician notification
- "Respond to alarm when sounding as quickly as possible."
- "Check each shift to be sure properly working/placement
- notify the physician and responsible party as indicated."

The care plan 6/10/10 through present:
The resident has multiple risk factors for falls,

F 282

2. All residents who are at risk for falls have the potential to be affected. The plan of care for the potentially affected residents have been reviewed, revised if indicated, and interventions are being followed.

3. The facility's policy for care planning has been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on following the plan of care.

The General Critical Element Pathway Form has been implemented to ensure continued compliance.
(See Attachment J)

4. The DON or designee will be responsible for completing the General Critical Element Pathway Form on 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

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5. The above corrective actions will be completed on or before March 12, 2011

such as:
diagnoses of dementia, atypical psychosis, DM, hypertension, coronary artery disease, depression, antipsychotic, antidepressant, diuretics, wheel chair use, hx (history) of falls and inability to transfer independently.

Provide adequate lighting
ensure pathways clutter free
resident to use nonskid shoes
These interventions were added:

- 2/22/10 1/2 side rails
- 4/19/10 encourage resident to lay down when tired
- 4/19/10 encourage resident to sit in area c (with supervision increased when up for meals.
- 9/1/10 mat alarm to be used in all seated surfaces to prevent unassisted transfer
- 2/4/11 dycem under cushion and on top of cushion

Review of the 11/23/10 nurses notes, indicated at 7 P.M. the resident was found on the floor on the right side. He stated he slipped out of the chair, trying to get his call light. The resident hit the right side of his head during this fall.

Nurses notes, dated 2/4/11 5:35 P.M., indicated the resident was up in his wheel chair in the hallway and slid out of wheel chair to the floor. He hit his head and had a raised area on the crown of head.

The fall investigation for the 2/4/11 fall 5:35 P.M., indicated the resident was propelling self c (with his feet in the wheel chair back to his room and he slid from his chair. The investigation indicated all fall interventions were in place per care plan and effective. The fall investigation failed to identify if the resident had proper supervision at

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the time of the fall. F 282

Interview with LPN #1 on 2/8/11 at 3:30 p.m., indicated she worked the last time the resident fell. She indicated the resident said he slid out of his wheel chair and he probably did.

On 2/9/11, 8:10 A.M. informed R.N. #1 that Resident #24's light had been on since 7:55 A.M. and asked how she knew when a light was on. She indicated since the call lights did not sound, and they just keep an eye on the halls. Breakfast was going on in dining room and she was passing medications. The CNAs were feeding residents at the horseshoe table and could not see the hallway to know when lights were on.

2. The clinical record of Resident #58 was reviewed on 2/9/11 at 10:30 A.M. Resident #58 had fall risk assessments on 7/28/10, 10/11/10 and 1/4/11 due to a high risk of falls. The reasons making the resident a high risk were listed as: history of falls, use of assistive devices, Merry Walker [a chair device with wheels which allows the resident a place to sit when tired from walking], confusion, unsteady gait, weakness, and the use of narcotics, antipsychotics, and hypnotics.

A Merry Walker was ordered on 10/6/10.

Nurses Notes dated 11/21/10 at 5:25 P.M., indicated the resident was found on her back on the dining room floor - looking at staff and smiling. The note indicated the resident had been seated in the dining room at the table for supper

Nurses Notes dated 1/1/11 at 6:45 A.M., indicated the resident's foot was caught under Merry

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Walker when she fell. There was no injury to the resident.

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Nurses Notes dated 1/25/11 at 2 P.M., indicated the resident slid down in the Merry Walker and went to her knees.

The care plan for "the resident has multiple risk factors for falls...
Provide adequate lighting
ensure pathways are clutter free
resident to utilize foot wear with non-skid soles
monitor the resident frequently when the call lights are not available
complete fall risk assessment
monitor vital signs
neurological checks as indicated
notify responsible party and MD if a fall occurs.
Implement intervention to reduce risk for falls Merry Walker
1/1/11 - monitor resident when up in merry walker to ensure foot does not get caught under wheel.
check tennis shoes to be fitting appropriately
1/1/11 therapy screen"

There was a care plan problem "use of merry walker," but there were no specific interventions for this resident.

On 2/10/11 at 10:54 A.M., review of 11/21/10 fall investigation indicated staff were not present and intervention added to the plan indicated, Resident Supervision modifications: "staff supervision when in D.R. "

Observation of lunch set up, on 2/9/11 at 11:42 A.M., the resident sat at the horseshoe table with two other residents. No staff were the in dining room and the table could not be observed by

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F 282 Continued From page 51
staff. Resident was wearing Crocs on her feet. They were not tight to the feet as the straps at the back were loose and hanging down. F 282

Observation on 2/10/11 at 10 A.M., indicated the resident wore Crocs. RN #1 indicated she did not know how it was decided to place Crocs on the resident, or if the resident was to wear them or tennis shoes because the resident wore both. She came to the facility with both.

CNA #1 was interviewed on 2/10/11 at 10:20 A.M. regarding the resident's shoes and indicated the resident's tennis shoes needed replaced because the shoe was falling off the soles. They were waiting for the family to come in to let them know the tennis shoes needed replaced. Observation with the CNA of the resident's room indicated there were no tennis shoes.

3.1-45(a)(2)
F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS=D DEPENDENT RESIDENTS F 312

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure a dependent for care resident received appropriate care and services related to oral care and incontinence care for 1 of 3 residents reviewed for oral/dental care in the sample of 3 who met the criteria for

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F 312 Continued From page 52
dental care. (Resident #51).

F 312

Findings include:

The clinical record of Resident #51 was reviewed on 2/8/11 at 3:40 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, Coronary Artery Disease, Osteoporosis, and Dementia.

The quarterly Minimum Data Set (MDS) assessment, dated 4/1/10, indicated the resident was totally dependent for personal hygiene. The quarterly MDS assessment, dated 7/2/10, indicated the resident was totally dependent for personal hygiene.

During an observation on 2/8/11 at 3:30 p.m., the resident was sitting in a lounge chair in the main lounge area of the facility. While attempting to interview the resident, the resident did not respond to verbalization. When getting closer to the resident's ears to talk to her, foul smelling breath was noted.

During observation on 2/10/11 at 7:00 a.m., two CNAs were providing morning care for the resident. CNA #3 first washed the resident's face with a washcloth, using rough motions. CNA #3 then reached under the resident's gown and washed under the resident's breasts and armpits. The resident was moaning during the entire process. CNA #3 then applied deodorant, while reaching under the resident's gown. The resident cried out, "that hurts." At most times, the resident's communication was garbled and difficult to understand. CNA #3 removed the disposable gloves and applied new ones, then applied lotion to both of the resident's legs. CNA

**F 312
ADL CARE PROVIDED FOR
DEPENDENT RESIDENTS**

1. Resident # 51 has been observed and is receiving appropriate oral care and peri care from staff as per the facility's policy and procedures.

CNAs' # 2 & 3 have been re-educated on oral care and pericare procedures.

2. All dependent care residents have the potential to be affected. The dependent residents have been observed and staff is providing appropriate oral care and pericare as per the facility's policy and procedures.

3. The facility's policies for oral care and pericare have been reviewed and no changes are indicated at this time. Nursing staff

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F 312 Continued From page 53

#3 did not wash the resident's feet. Both CNA #3 and CNA #2 rolled the resident on to her left side to do perineal care. The resident was incontinent of stool, noted on two separate washcloths. CNA #3 wiped from front to back, only wiping in between the buttocks area two separate times, without washing the front perineal area. CNA #2 held both of the resident's legs up, separating them, during this process. Both CNAs rolled the resident onto her back to apply an incontinence brief. After transferring the resident to her wheelchair, CNA #3 combed Resident #51's with a pick, using rough movements.

During interview with the DON on 2/10/11 at 9:20 a.m., she indicated the CNA who provided morning care was extremely nervous to be watched. She indicated it was not the way the staff were taught regarding how to wash residents and provide perineal care. The DON indicated her expectation would not be the way the CNA provided perineal care or the way the CNA washed the resident's face and kept her gown on while washing her upper body.

On 2/10/11 at 11:00 a.m., the Director of Nursing provided a current policy and procedure entitled, "Perineal Care" which indicated the following:

Purpose:
to cleanse perineum for prevention of infection, irritation and to contribute to the resident's positive self image...Procedure. . .provide privacy. Drape if needed. Position resident - female resident may be cleansed in supine position or in side lying position if unable to adequately access the labia from supine position due to positioning problems, contractures of legs or resident's resistance to care. . .for females: separate labia,

F 312

have been re-educated on providing appropriate oral care and pericare to dependent residents. Nursing staff have also completed skills check offs for oral care and pericare. A Critical Elements for Dental Status and Services Form has been implemented to ensure continued compliance. (See Attachment I)

A Critical Elements for Urinary Incontinence, Urinary Catheter, Urinary Tract Infection Form has also been implemented to ensure continued compliance. (See Attachment M)

4. The DON or designee will Complete the Critical Elements for Dental Status and Services Form and the Critical Elements for Urinary Incontinence, Urinary Catheter, Urinary Tract Infection Form on 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these observations will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly.

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F 312 Continued From page 54
wash urethral area first. . . was between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of cloth for each stroke. . . change water in basin; use clean washcloth; use new wipe and rinse area thoroughly in the same direction as when washing. . .

F 312
5. The above corrective actions will be completed on or before March 12, 2011

F 315 3.1-38(a)(3)(C)
483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

F 315
F 315
NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

1. Resident # 24 has been observed and is currently receiving appropriate catheter care/maintenance as per the facility's policy and procedure.

RN #1 and CNA #1 have been re-educated on appropriate catheter care, maintenance, and hand-washing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident with a catheter, in the Stage 2 sample of 31, received care to the catheter equipment and ensured staff washed their hands during care of the equipment to prevent infections. (Resident #24)

2. All residents utilizing catheters have the potential to be affected. Those residents have been observed and are currently receiving appropriate catheter care/maintenance.

Findings include:
On 2/9/11 at 8:23 A.M., during observation of RN #1 and CNA #1 transferring Resident #24 from bed to chair, the resident's suprapubic catheter

Skills check offs have been completed on the nursing staff for hand-washing and catheter care/maintenance.

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F 315 Continued From page 55

bag was placed on the resident's bed as they prepared to put the gait belt on the resident to transfer him. The catheter bag was then hooked on the CNA's pants pocket, and she touched the bag and tubing with bare hands as she transferred the resident to the chair. The CNA left the room without washing her hands. She entered the code to get out of the unit and then used sanitizing gel on her hands. The RN also touched the bag and tubing as she put it the cover bag on the bottom of the wheel chair. She wheeled the resident out of the room, pulled the over the bed tray up to resident in the hallway and had not washed her hands as she walked into the nurses station.

During observation on 2/9/11 at 11:48 A.M., the resident sat in the hall waiting for lunch. The catheter tubing was laying on the floor under the wheel chair.

During observation on 2/9 at 2:37 P.M., the resident was sitting in a chair at his bedside. The catheter tubing laid on the floor.

The clinical record of Resident #24 was reviewed on 2/10/11 at 10 A.M. The resident was treated for a urinary tract infection on 1/25/11 and continued to receive Trimethoprim 100 mg [milligram] q hs [every night] since 1/25/11 for "recent uti [urinary tract infection]."

The care plan, dated 8/26/10, indicated "The resident has a urinary tract infection as evidenced by: labs and pubic cath." Review of the interventions indicated there was nothing about keeping infection control practices with the catheter.

F 315

3. The facility's policies for catheter care/maintenance and hand-washing have been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on appropriate hand-washing and catheter care/maintenance. A Critical Elements for Urinary Incontinence, Urinary Catheter, Urinary Tract Infection Form been implemented to ensure continued compliance.
(See Attachment M)

4. The DON or designee will complete the Critical Elements for Urinary Incontinence, Urinary Catheter, Urinary Tract Infection Form on 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these observations will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective actions will be completed on or before March 12, 2011

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F 315 Continued From page 56
Interview with the DON (Director of Nursing) on 2/10/11 at 3 P.M., indicated the facility currently made 90 staff handwashing observations a month. This was part of their healthcare associated infection initiative.

F 315

F 317 3.1-41(a)(2)
SS=D 483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE

F 317

**F 317
NO REDUCTION IN ROM
UNLESS UNAVOIDABLE**

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

1. Resident # 44 has Osteoarthritis which resulted in decreased joint mobility and is currently receiving restorative nursing services.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure residents who had no limitation in range of motion did not develop limitations in range of motion of major joints. This affected 1 of 3 residents reviewed for range of motion in the sample of 3 residents who met the criteria for range of motion limitations. (Resident #44)

2. All the residents have the potential to be affected. Observations of the residents have been completed and their clinical records have been reviewed. The residents are currently receiving restorative nursing services to prevent a decline in ROM unless the decline is unavoidable.

Findings include:

1. Resident #44's clinical record was reviewed on 2/9/11 at 8:24 a.m. The resident's significant change MDS (Minimum Data Set) assessment, with assessment reference date (ARD) of 2/23/10, indicated the resident had no functional limitation in range of motion (ROM) in the neck, hands, arms, legs, or feet.

3. The facility's policy for ROM has been reviewed and no changes are indicated at this time. The restorative and nursing staff has been re-educated on ROM and preventing a decline in joint range. The Critical Elements for ADL/ROM Form has been implemented to ensure continued compliance. (See Attachment L)

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F 317 Continued From page 57

F 317

An annual MDS assessment, with ARD of 1/20/11, indicated the resident had functional limitation in range of motion in both shoulders, elbows, wrists, hands, hips, knees, ankles, and feet. The resident assessment summary, dated 2/3/11, indicated "Contractures" "Resident hands are contracted and requires a total assist for all mobility per MDS staff interview on 1/20/11."

Documentation of a change in condition was lacking in the clinical record to indicate the decline in the resident's functional range of motion between 2/23/10 and 1/20/11.

A "Restorative Program" sheet, dated as started on 7/24/10, indicated the resident required passive range of motion exercises to his bilateral upper and lower extremities 6 days per week.

A "Restorative Program" sheet, dated as started on 12/9/10, indicated the resident was being enrolled in the splinting program. The "Problem" indicated, "Resident's upper and lower extremities are contracted at this time related to decreased mobility and Osteoarthritis." The specific instructions indicated the resident was to have bilateral upper and lower extremity splints for 4 hours each day. The goal was for the resident to have no increase in contractures as evidenced by not having any negative changes on quarterly joint mobility through next review.

Documentation on Restorative Nursing Tracking Logs indicated the resident received ambulation and active ROM 5-6 days per week at 10-15 minutes for each from December 2010 until July 2010. There was no change in the services until July 2010, when the resident started receiving

4. The DON or designee will complete the Critical Elements for ADL/ROM Form on 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.
5. The above corrective actions will be completed on or before March 12, 2011

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F 317 Continued From page 58

passive (staff move joints as resident not able to exercise joints fully) on 7/26/10. The resident continued to receive the passive ROM and ambulation 5-6 days per week through August 2010. During the month of September 2010, the resident received ambulation assistance on 12 of 28 days, at which time, the resident was discontinued from restorative nursing and physical therapy started seeing the resident. The log indicates the resident received ambulation assistance for 15 minutes on September 1, 2, & 3 and walked 150-200 feet, then received no ambulation assistance September 4-8. The resident then received 15 minutes ambulation assistance on September 8, 9, and 10, and ambulated 100-200 feet and then no assistance September 12-20. On September 21, documentation indicated the resident ambulated 25 feet with assistance and continued to receive ambulation assistance through September 24, ambulating 10-90 feet. The resident did not receive assistance on September 25 and 26 and received assist to ambulate 90 feet on September 27 and 28. The resident was discontinued from restorative nursing for ambulation at this time to attempt to increase ambulation ability. During this time, the resident continued to receive passive ROM 1 time per day for 15 minutes each day.

F 317

During the month of September 2010, the resident received passive ROM for 15 minutes on 20 of 31 days. During the month of October 2010, the resident received passive ROM for 15 minutes on 3 days and documentation indicated the resident was discontinued to therapy on 10/5/10. There was no restorative tracking log for the month of November and the December log indicated the resident was restarted on passive ROM and splinting on 12/9/10. The logs

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F 317 Continued From page 59
indicated the resident continued to receive ROM one time per day for 5-6 days per week, without any change/increase in the frequency of the exercises to ensure the resident's limitation in mobility did not worsen.

F 317

Resident #44 was observed on 2/10/11 at 9:20 a.m. CNA #1 and CNA #2 transferred the resident from his wheelchair to the recliner. The resident kept his legs in a flexed position during the transfer. The resident was observed with bilateral hands in a contracted position. The resident was observed during a treatment on 2/10/11 at 10:30 a.m. Both hands were contracted, with the right hand/fingers contracted in a manner that resulted in a pressure ulcer on one digit.

The ADON indicated on 2/10/11 at 3:00 p.m. that Resident #44 was on therapy during the entire month of November 2010.

F 318 3.1-42(a)(1)
483.25(e)(2) INCREASE/PREVENT DECREASE
SS=D IN RANGE OF MOTION

F 318

F 318
INCREASE/PREVENT
DECREASE IN RANGE IN
MOTION

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

1. The clinical record has been reviewed and Resident # 44 has been observed and currently wears splints to the lower extremities as per the restorative program.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure residents

The clinical record has been reviewed and Resident # 38 has been

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F 318 Continued From page 60
who had a limitation in range of motion received services to prevent further decline in range of motion in that range of motion exercises were not completed in a manner to promote full range of joints and splints were not applied as scheduled. This affected 2 of 3 residents reviewed for range of motion in the sample of 3 who met the criteria for range of motion. (Resident #44, #38,)

Findings include:

1. Resident #44's clinical record was reviewed on 2/9/11 at 8:24 a.m. The resident's significant change MDS (Minimum Data Set) assessment, with assessment reference date (ARD) of 2/23/10, indicated the resident had no functional limitation in range of motion (ROM) in the neck, hands, arms, legs, or feet.

An annual MDS assessment, with ARD of 1/20/11, indicated the resident had functional limitation in range of motion in both shoulders, elbows, wrists, hands, hips, knees, ankles, and feet. The resident assessment summary, dated 2/3/11, indicated "Contractures" "Resident hands are contracted and requires a total assist for all mobility per MDS staff interview on 1/20/11."

A care plan, dated 8/15/10 and updated 10/5/10 and 1/12/11, indicated, "Impaired physical mobility related to diagnosis of Osteoarthritis. The goal was for the resident to maintain joint function at current level as evidenced by no contractures or joint deformities through next review. Interventions included, but were not limited to, promote maximum joint function per rehabilitation as outlines in FMP (functional maintenance program) as established by occupation and physical therapy.

F 318
observed and currently receives appropriate ROM to all extremities as per the restorative program.

2. All residents receiving ROM and or splinting have the potential to be affected. The clinical records have been reviewed and observations of those residents have been completed and services are being provided for their individual needs per their restorative programs.
3. The facility's policies for ROM and splinting have been reviewed and no changes are indicated at this time. The restorative and nursing staff have been re-educated on the policies. The Critical Elements for ADL/ROM Form (See Attachment L)
4. The DON or designee will complete the Critical Elements for ADL/ROM Form on 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the

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F 318

Another care plan in the clinical record, dated 11/24/10 and updated 1/12/11, indicated a problem of contractures of the bilateral hands.

facility's quarterly QA meetings and the plan adjusted accordingly.

A "Restorative Program" sheet, dated as started on 12/9/10, indicated the resident was being enrolled in the splinting program. The "Problem" indicated, "Resident's upper and lower extremities are contracted at this time related to decreased mobility and Osteoarthritis." The specific instructions indicated the resident was to have bilateral upper and lower extremity splints for 4 hours each day. The goal was for the resident to have no increase in contractures as evidenced by not having any negative changes on quarterly joint mobility through next review.

5. The above corrective actions will be completed on or before March 12, 2011

The restorative care plan, dated 2/3/11, indicated the resident was at risk for contractures related to decreased mobility and a diagnosis of Osteoarthritis. The goal was for the resident to tolerate 20 repetitions of passive ROM through next review. A second restorative care plan, dated 2/3/11, indicated the resident has contracture of the bilateral upper and lower extremities. The goal was for the resident to show no increase in contractures by application of bilateral upper and lower extremity splints for 4 hours daily.

Documentation in nurses notes indicated the resident refused to wear the hand splints and they were discontinued from the care plan in the clinical record (no date indicated).

Resident #44 was observed on 2/10/11 at 9:20 a.m. CNA #1 and CNA #2 transferred the resident from his wheelchair to the recliner.

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F 318 : Continued From page 62 F 318

There were no leg splints in place on the resident. The resident was observed during a treatment on 2/10/11 at 10:30 a.m. There were no splints on the resident's legs during the observation.

On 2/10/11 at 1:30 p.m., Restorative CNA #1 indicated the splints were applied between 9:30 and 10:00 a.m. At this time, Restorative CNA #1 and the Assistant Director of Nursing (ADON) went to Resident #44's room and the splints were located in his wheelchair. The restorative CNA indicated it might have been later than 10:00 a.m., when she put the splints on and they were removed after lunch (12:30 - 1:00 p.m.) At this time, the ADON provided the restorative plan for review which indicated the splints were to be applied for 4 hours before removing.

2. The clinical record of Resident #38 was reviewed on 2/9/11 at 3:35 p.m. The resident's most recent MDS assessment, with assessment reference date of 1/10/11, indicated the resident had a functional limitation in range of motion on both sides of upper extremities and lower extremities.

A restorative care plan, dated 9/11/09 and updated through 1/10/11, indicated the resident had decreased mobility and was unable to actively range joints related to a diagnosis of Alzheimer's Disease. The goal was for the resident to tolerate 20 repetitions of passive range of motion to bilateral upper and lower extremities 6 days per week.

During observation of ROM on 2/10/11 at 8:37 a.m., Restorative CNA #1 performed the exercises to the resident while she was in a reclining position in the Broda chair. She

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F 318 Continued From page 63 F 318

completed 20 repetitions to each joint on the left side. When doing the exercises of abduction/adduction to the hip, the resident's joints were tight and her right leg was held tightly against the left leg and upon trying to exercise the hip, the resident moved from side to side in the chair, not allowing for full movement of the hip joint.

After 24 minutes of exercises to the left side, the CNA attempted to start range of motion exercises to the right side. The resident refused, stating she had had enough.

When the documentation for restorative services was reviewed, documentation indicated the resident received passive ROM to upper and lower extremities each day, 5-6 days per week, and the services were provided in 15 minutes each session.

The policy and procedure for Range of Motion was provided for review by the ADON on 2/10/11 at 10:50 a.m. The policy indicated the resident should be in a supine position and if the resident was in a chair, the resident should be instructed to slide back into the chair so that his or her back is against the chair. The ADON was informed of the manner in which the ROM was done for Resident #38. No additional information was provided for review prior to the exit conference.

3.1-42(a)(2)
F 323 483.25(h) FREE OF ACCIDENT F 323
SS=E HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards

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F 323 Continued From page 64
as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 323

**F 323
FREE OF ACCIDENT
HAZARDS / SUPERVISION /
DEVICES**

1 All handrails will be removed, repainted, and refinished. The facility is requesting a 30 day extension for purchasing materials and 60 days for repainting, refinishing, and replacing all handrails in facility.

The fall plan of care for Resident # 24 has been reviewed, revised, and interventions are being provided as per the plan of care.

The fall plan of care for Resident # 58 has been reviewed, revised and interventions are being provided as per the plan of care. New tennis

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure the residents' environment remained free of potential hazards related to rough edged/splintered hand rails on 1 of 3 units (200 unit) which had the potential to affect 14 residents residing on the 200 unit, and the facility failed to ensure 2 of 3 residents reviewed for falls/accidents in the sample of 8 who met the criteria for accidents received services to prevent further falls. (Resident #58, #24)

Findings include:

1. On 2/9/11 at 2:45 p.m., handrails throughout the hall on the locked unit (200 unit) had the finish worn off, exposing bare wood and rough edges/splintered areas on portions of the rails. One section of the rail, on the right side of the hall upon entry to the unit, approximately one-half down the hallway, was pulled away slightly from the wall, causing a rough area of the wall/handrail. This sections also contained a staple sticking out of rail.
2. The clinical record of Resident #24 was reviewed on 2/8/11 at 3:30 P.M. Resident #24 had fall risk assessments completed on 9/10/10 and 12/21/10 due to his high risk of falls. Reasons listed as increasing the resident's risk were his history of falls, use of a wheel chair,

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F 323 Continued From page 65
confusion, and use of antipsychotics and diuretics.

The Minimum Data Set [MDS], dated 1/19/11, noted moderately impaired vision, poor memory recall, and short and long term memory problems. The resident was identified as having moderately impaired cognitive status (decisions poor; cues/supervision required). The resident required total assistance of two staff for bed mobility and transfers. The required extensive assistance of one staff for locomotion in his wheel chair on the unit, and did not walk. His balance from seated to standing was not steady, but was able to stabilize without human assistance.

The care plan, dated 8/10/10 through 12/20/10 and current, listed the Problem:
"The resident requires the use of a safety alarm mat"

Interventions were:
Personal alarm d/c [discontinue] 9/10/10
Mat alarm 9/10/10 due to high fall risk r/t decreased safety awareness:
Provide adequate lighting, ensure clutter free and well lit pathways, res to wear footwear with non skid soles, monitor res frequently when the call light is not available (dining room, activities) place the alarm appropriately per manufacturer's instructions
observe for signs of a low battery and replace as needed
"Remind the resident to request assist before attempting to rise."
Notify the charge nurse of attempts to remove the device, for further evaluation and possible physician notification
"Respond to alarm when sounding as quickly as

F 323
shoes are in place and fit appropriately. The cros have been removed and sent home with the family.

2. All handrails will be removed, repainted, and refinished. The facility is requesting a 30 day extension for purchasing materials and 60 days for repainting, refinishing, and replacing all handrails in facility.

All residents who are at risk for falls have the potential to be affected. The fall plan of care for the potentially affected residents have been reviewed, revised if indicated, and interventions are being followed.

3. The facility's preventative maintenance for handrails has been reviewed and no changes are needed at this time. The maintenance staff have been re-educated on maintaining the handrails. An Environmental Observation Form has been implemented to ensure continued compliance.
(See Attachment A)

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F 323 Continued From page 66

possible."
"Check each shift to be sure properly working/placement notify the physician and responsible party as indicated."

The care plan 6/10/10 through present:
The resident has multiple risk factors for falls, such as:
diagnoses of dementia, atypical psychosis, DM, hypertension, coronary artery disease, depression, antipsychotic, antidepressant, diuretics, wheel chair use, hx of falls and inability to transfer independently.
Provide adequate lighting
ensure pathways clutter free
resident to use nonskid shoes
These interventions were added:
2/22/10 1/2 side rails
4/19/10 encourage resident to lay down when tired
4/19/10 encourage resident to sit in area c (with supervision increased when up for meals.
9/1/10 mat alarm to be used in all seated surfaces to prevent unassisted transfer
2/4/11 Dycem under cushion and on top of cushion

Review of the 11/23/10 nurses notes, indicated at 7 P.M. the resident was found on the floor on the right side. He stated he slipped out of the chair, trying to get his call light. The resident hit the right side of his head during this fall. The most previous nurses note was ten days earlier on 11/13/10.

The fall investigation for the fall 11/23/10 at 7:10 P.M., indicated assistive device modifications: call light in reach - Dycem in w/c under cushion

F 323

The facility's policy for care planning has been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on following the plan of care. The General Critical Elements Pathway Form has been implemented to ensure continued compliance.
(See Attachment J)

4. The Maintenance Director or designee will be responsible for completing the Environmental Observation Form on scheduled work days.
The DON or designee will be responsible for completing the General Critical Elements Pathway on 3 residents.
The forms will be completed on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, then monthly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

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F 323	<p>Continued From page 67</p> <p>mental health referral reaching for call light that fell from his hand was in w/c</p> <p>The conclusion was that the call light was not within reach due to dropping it, all other interventions in place and effective.</p> <p>The fall investigation failed to identify if the resident had proper supervision at the time of the fall.</p> <p>Nurses notes, dated 2/4/11 5:35 P.M., indicated the resident was up in his wheel chair in the hallway and slid out of wheel chair to the floor. He hit his head and had a raised area on the crown of head.</p> <p>The fall investigation for the 2/4/11 fall 5:35 P.M., indicated the resident was propelling self c (with) his feet in the wheel chair back to his room and he slid from his chair.</p> <p>The investigation indicated all fall interventions were in place per care plan and effective.</p> <p>The fall investigation failed to identify if the resident had proper supervision at the time of the fall.</p> <p>Observation on 2/8/11 at 3:30 P.M., the resident was in bed, two half rails raised. The call light was accessible, but he called out loudly at times. One time, he just wanted his curtains pulled. Interview with LPN #1 at this time, indicated she worked the last time the resident fell. She indicated the resident said he slid out of his wheel chair and he probably did.</p> <p>On 2/9/11, 8:10 A.M., RN #1 was informed that Resident #24's light had been on since 7:55 A.M., and asked how she knew when a light was on. She indicated since the call lights did not sound,</p>	F 323	<p>5. The above corrective actions will be completed on or before March 12, 2011</p>

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F 323 Continued From page 68
they just keep an eye on the halls. Breakfast was going on in dining room and she was passing medications. The CNAs were feeding residents at the horseshoe table and could not see the hallway to know when lights were on.

F 323

3. The clinical record of Resident #58 was reviewed on 2/9/11 at 10:30 A.M. Resident #58 had fall risk assessments on 7/28/10, 10/11/10 and 1/4/11 due to a high risk of falls. The reasons making the resident a high risk were listed as: history of falls, use of assistive devices, Merry Walker [a chair device with wheels which allows the resident a place to sit when tired from walking], confusion, unsteady gait, weakness, and the use of narcotics, antipsychotics, and hypnotics.

A Merry Walker was ordered on 10/6/10.

Nurses Notes dated 11/21/10 at 5:25 P.M., indicated the resident was found on her back on the dining room floor - looking at staff and smiling. The note indicated the resident had been seated in the dining room at the table for supper

Nurses Notes, dated 1/1/11 at 6:45 A.M., indicated the resident's foot was caught under Merry Walker when she fell. There was no injury to the resident.

Nurses Notes, dated 1/25/11 at 2 P.M., indicated the resident slid down in the Merry Walker and went to her knees.

The care plan for "the resident has multiple risk factors for falls...
Provide adequate lighting
ensure pathways are clutter free

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resident to utilize foot wear with non-skid soles
monitor the resident frequently when the call lights are not available
complete fall risk assessment
monitor vital signs
neurological checks as indicated
notify responsible party and MD if a fall occurs.
Implement intervention to reduce risk for falls
Merry Walker
1/1/11 - monitor resident when up in merry walker to ensure foot does not get caught under wheel.
check tennis shoes to be fitting appropriately
1/1/11 therapy screen"

There was a care plan problem "use of merry walker," but there were no specific interventions for this resident.

On 2/10/11 at 10:54 A.M., the fall investigation of the 11/21/10 fall was reviewed. It indicated staff were not present at the time of the fall and interventions added included, "staff supervision when in D.R. "

The Post Fall Investigation Worksheet provided by the DON (Director of Nursing) on 2/9/11 at 3 P.M., indicated on 1/1/11 at 7 P.M. the resident was walking up and down the hall, the resident was incontinent at time, in Merry Walker, and no staff were present. According to the interventions list on the form, Therapy was to screen for Merry Walker use and tennis shoes "are appropriate fit."

The 1/25/11 at 2 PM fall investigation indicated the resident was in the Merry Walker, not incontinent, staff were present, and all interventions were in place and effective. The resident became startled and her knees gave way. A therapy referral was sent to screen for

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F 323 Continued From page 70
Merry Walker use. F 323

Observation of lunch set up, 2/9/11 at 11:42 A.M., indicated the resident sat at the horseshoe table with two other residents. No staff were in the dining room and the table could not be observed by staff. The resident was wearing Crocs [plastic shoes] on her feet. They were not tight to the feet, as the straps at the back were loose and hanging down.

Observation of the resident on 2/10/11 at 10 A.M., indicated the resident wore Crocs. RN #indicated she did not know how it was decided to place Crocs on the resident, or if the resident was to wear them or tennis shoes because the resident wore both. She indicated the resident came to the facility with both.

CNA. #1 was interviewed on 2/10/11 at 10:20 A. M. regarding the resident's shoes and indicated the resident's tennis shoes needed replaced because the shoe was falling off the soles. They were waiting for the family to come in to let them know the tennis shoes needed replaced. Observation with the CNA of the resident's room indicated there were no tennis shoes.

3.1-45(a)(1)
3.1-45(a)(2)

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS F 329

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of

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adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure residents were free of unnecessary psychoactive medications, including duplicate medications, in that residents were receiving medications to treat behaviors when there were no behaviors documented and/or behaviors were not being monitored. This affected 1 of 3 residents reviewed for psychoactive medications in the sample of 10 who met the criteria for psychoactive medications. (Resident #44)

Findings include:

1. The clinical record of Resident #44 was reviewed on 2/8/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to,

F 329

**F 329
DRUG REGIMEN IS FREE
FROM UNNECESSARY DRUGS**

1. The clinical record for Resident # 44 has been reviewed and revised to reflect the resident's current status. The physician has been contacted related to the psychoactive medications and any behavior issues and the orders are currently being followed.
2. All residents receiving psychoactive medications have the potential to be affected. The clinical records have been reviewed for psychoactive medications and any behavior issues, the physician contacted, and orders are currently being followed.
3. The facility's policies for psychoactive medication reductions have been reviewed and no changes

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F 329 Continued From page 72
Alzheimer's Type Dementia, Depression, and Dementia with Psychosis Features.

The significant change Minimum Data Set (MDS) assessment, with assessment reference date (ARD) of 2/23/10, indicated the resident exhibited no verbal expressions of distress, no sleep-cycle issues, no sad, apathetic, or anxious appearance, and no behavioral symptoms.

An annual MDS assessment with ARD of 1/20/11, indicated the resident had no behaviors during the assessment period.

The clinical record indicated the following physician's orders:
 1/31/11 - Change Abilify (antipsychotic medication) to 15 mg (milligrams) every day at bedtime; Monitor for daytime sedation and call if note change. The medication had been ordered for 5 mg prior to this.
 9/25/10 - Chlorpromazine (antipsychotic medication) 25 mg 1 three times daily.
 9/25/10 - Chlorpromazine 10 mg 1 every day at bedtime.
 9/3/08 - Citalopram Hbr (medication for depression) 20 mg 1 every day.
 1/16/10 - Aricept (medication for Alzheimer's Disease) 10 mg 1 every day.
 12/30/10 - Lorazepam (Ativan) (medication for anxiety) 0.5 mg 1/2 tablet (.25 mg) twice daily.
 1/19/10 - Namenda (medication for Alzheimer's Disease) 10 mg 1 daily.

The resident also had a current physician's order for Lorazepam 0.25 mg to be given as needed for anxiety.

A physician's progress note, dated 1/31/11 at 6:30 p.m. indicated, "Pt (patient) appears tired,

F 329

are indicated at this time. The facility's staff have been re-educated on the above policies. A Critical Elements for Unnecessary Medication Review Form has been implemented to ensure continued compliance.
(See Attachment N)

4. The DON or designee will complete the The Critical Elements for Unnecessary Medication Review Form on 3 residents on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plans adjusted accordingly.

5. The above corrective actions will be completed on or before March 12, 2011

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F 329 Continued From page 73

but end of day. Nursing does not report [increased] daytime sedation. . . Impression: 1) Rt hand osteomyelitis - Vanco IV 2) Dementia 3) Anxiety 4) Hand Contractures Plan: try [increase] Abilify - note seems to have had [increased] grip since had to stop since had to stop Clozaril (pancytopenia). Cont. scheduled Hydrocodone Monitor for sedation."

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The Medication Administration Record for January 2011 indicated on 1/18/11 at 3:00 p.m. Ativan 0.25 i po without documentation of rationale for administration and documentation of "E" for effective. The nurses notes for 1/18/11 included entries at 12:10 a.m., 6:30 p.m. and 11:00 p.m. but there was nothing documented at time of the Ativan administration to indicate what was occurring to warrant the medication and why non-pharmacological interventions were attempted prior to administration of the medication.

A care plan, dated 8/15/10, and updated 10/5/10 and 1/12/11, included a problem of, The resident requires the use of Aricept to treat Alzheimer's Type Dementia and is at risk for experiencing adverse side effects. The goal was for the resident to have no signs or symptoms of an adverse reaction associated with the use of Aricept. Interventions included the following:

- Administer the medication as ordered.
- Observe for s/s of an adverse reaction: insomnia, headache, nausea, diarrhea, dizziness.
- Observe for changes in mood or behavior.
- Notify the charge nurse of noted problems, for further evaluation and possible physician notification.
- Try to use short simple sentences and ask

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F 329 Continued From page 74 F 329

questions that require a yes or no type answer.
Give no more than two choices to avoid confusion and over stimulation.

Notify the charge nurse of changes in the resident's communication ability, for further evaluation and possible physician and responsible party notification. Monitor labs as ordered.

Another care plan, dated 1/20/11, included a problem, resident has diagnosis of Alzheimer's type dementia, depression, dementia with psychosis features and has a history of physical aggression and agitation. Resident is end stage Alz (Alzheimer's). Res makes noises and resist-pull back [with] ADL (Activities of Daily Living) care. The goal was the resident would accept staff intervention thru next review. Interventions included the following:

- Ensure basic needs are met
- Provide 1:1 if applicable
- Provide redirection if applicable
- Provide activity of choice or interest
- Comfort & reassurance
- Time to calm, reapproach.

Another care plan, dated 2/3/11, indicated a problem, the resident requires the use of an anti psychotic medication: Abilify and Chlorpromazine to treat Alzheimer's type Dementia with psychosis features and is at risk for adverse side effects. The goal was for the resident to have no signs/symptoms of adverse reaction associated with the use of Abilify and Chlorpromazine thru next review.

Interventions included the following:

Administer medication as ordered.

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F 329	<p>Continued From page 75</p> <p>Monitor for adverse side effects such as: drowsiness, sedation, somnolence, agitation, insomnia, headache, nervousness, hostility. Observe for changes in mood or behavior. Notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification. Refer to psychological evaluation as indicated. Attempt GDR (gradual dose reduction) per policy. Complete Risk/Benefit forms per policy. Refer to pharmacist consultant as needed. Monitor for EPS (side effects) per policy.</p> <p>Resident #44 had a care plan, dated 2/3/11, which indicated a problem that the resident requires the use of an antianxiety medication: Ativan to treat anxiety and is at risk for adverse side effects. The goal was for the resident to have no signs or symptoms of adverse reaction associated with the use of Ativan thru next review. Intervention included the following:</p> <p>Administer medication as ordered. Monitor for adverse side effects such as: Drowsiness, light-headedness, depression, dry mouth, diarrhea, constipation. Observe for changes in mood or behavior. Notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification. Refer for psychological evaluation as indicated. Attempt GDR per policy. Complete Risk/Benefit forms per policy. Refer to pharmacist consultant as needed.</p> <p>Social service notes in the clinical record indicated the following: "2/7/11 -12:00 p.m. - Resident is resisting wearing his dentures. Daughter says no need to make</p>	F 329		
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F 329 Continued From page 76

F 329

him wear them.

1/20/11 11:15 p.m. - Annual SS (social service) asst (assessment) done. Resident has no mood or behaviors. Res (resident) is up in w/c (wheelchair), needs staff assist [with] to/from. Res unable to propel w/c at this time.

12/22/10 11:00 a.m. - Quarterly SS assessment done. Res had hitting on 10/24/10 (no time indicated) Moods & behaviors stable.

9/22/10 8:45 a.m. Quarterly MDS done Care plans reviewed Res triggered for repetitive verbalizations saying "hay" "hay" on 9/18/10. Insomnia - not sleeping being awake on 9/18/10. Repetitive physical movements trying to get up unassisted.

8/17/10 3:15 p.m. Quarterly MDS and care plans updated Res needs asst with all ADL's. Res moods & behaviors are stable at this time.

5/16/10 3:30 p.m. Quarterly MDS done care plan updated. Res moods & behaviors are stable.

2/23/10 2:30 p.m. Sig (significant) change MDS completed @ (at) this time. Res doing well, moods/behaviors are stable."

During observation on 2/8/11 at 10:30 a.m., Resident #44 was up in a recliner in his room, sleeping.

On 2/9/11 at 7:35 a.m., Resident #44 was in the main dining room. The resident was observed with his eyes closed and CNA #1 stated he "sleeps all the time;" the resident did open eyes when spoken to, but then immediately closed eyes again.

On 2/10/11 at 7:00 a.m., the Social Service Director (SSD) indicated during interview that Resident #44 had no behavior sheet since 10/10/10 when there was "hitting." She indicated

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F 329 Continued From page 77 F 329

the hitting occurred when staff were putting him to bed and he was "fussing with them while they were giving care." The SSD indicated the only other behavior he had since 1/28/10 occurred on 9/27/10 and was "cursing" and that was during care also and 9/18/10, when the resident had insomnia with repetitive verbalizations.

On 2/10/11 7:30 a.m., Resident #44 was observed up in his w/c in the dining room for breakfast and was sitting with his eyes closed.

On 2/10/11 10:30 p.m., two nurses were observed to complete the treatment to a pressure ulcer on the resident's hand. The resident did not make any attempt to interfere with the treatment and remained with eyes closed while in his recliner throughout the treatment.

No changes had been made in the resident's psychoactive medications although the resident was not exhibiting behaviors.

On 2/10/11 at 9:55 a.m, the Assistant Director of Nursing (ADON) provided a "Psychotropic Monitoring Log" for Resident #44. The log indicated the medications that were added and the behaviors exhibited at the time to justify the medication use. According to the documentation, the resident was receiving the Abilify for hitting, slapping, and yelling. The Celexa had been ordered since 9/3/08 and was for "yelling." On 2/10/11 at 1:20 p.m., the ADON indicated she had no additional information regarding the resident's behaviors or medications.

3.1-48(a)(1)
3.1-48(a)(3)

F 371 483.35(i) FOOD PROCURE,

F 371

F 371

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F 371 Continued From page 78
SS=F STORE/PREPARE/SERVE - SANITARY

F 371

**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

1 & 2. The dishwasher has been fixed and is currently running at appropriate temperature levels for sanitizing dishes and utensils.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure the dishwasher was at the appropriate temperature level for sanitizing dishes and utensils. This practice had the potential to affect 54 of 55 residents who received meals from the kitchen.

The facility's policy for low temperatures on the dish machine has been reviewed and no changes are indicated at this time. The dietary staff have been re-educated on the policy. Dietary staff will continue to do temperature checks and log them on the temperature log form. In addition, a Temperature Spot Check Form has been implemented to ensure compliance with temperatures.
(See Attachment O)

Findings include:

During observation on 2/9/11 at 10:00 a.m., dietary staff were running dishes through the dishwasher for lunch use. Upon checking the dishwasher temperature they were found to be 90 degrees Fahrenheit (F) for wash and 95 degrees (F) for the rinse cycle. Upon recheck with the next load, it was 98 degrees (F) for both wash and rinse cycles.

The NSF (National Sanitation Foundation) label on the outside of the dishwasher indicated temperature must be 120-140 degree (F) for wash and rinse cycles.

During an interview with the Dietary Manager at

The Dietary Manager or designee will be responsible for doing spot checks of the actual temperature of the dish machine on a rotating meal basis as follows: Daily for 2 weeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter for a minimum of 6 months. Results of these reviews will be reviewed

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F 371 Continued From page 79

F 371

the time of the observation, she indicated the dishwasher was a chemical dishwasher and showed me the dishwasher log where they recorded the temperatures at breakfast lunch and dinner. For 2/9/11, the log indicated the temperature for wash and rinse were 140 degrees (F) for both breakfast and lunch. The Dietary Manager indicated someone must have already filled in the temperature level for lunch that day.

during the facility's quarterly QA checks and the plan adjusted accordingly.

The above corrective action will be completed on or before March 12, 2011

During observation in the kitchen at 10:15 a.m., on 2/9/11, the Maintenance Supervisor was checking the temperatures of the dishwasher. The Maintenance Supervisor indicated he was in the process of trying to get the temperature levels at a high enough level by turning up the temperature on the water heater. The Maintenance Supervisor worked on the dishwasher for over an hour before it got up to 120 degrees (F) for both wash and rinse cycles. The Dietary Manager and staff were preparing food to be served on paper plates and plastic utensils for the lunch meal.

On 2/10/11 at 3 p.m., the Dietary Manager provided a policy and procedure titled 11/12/2008 "Dish Machine Operation-Low Temperature...Check manufacturer's guidelines for exact temperature requirements...."

3.1-21(i)(2)
3.1-21(i)(3)

F 441 483.65 INFECTION CONTROL, PREVENT
SS=D SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and

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F 441 Continued From page 80
to help prevent the development and transmission of disease and infection.

F 441

**F 441
INFECTION CONTROL,
PREVENT SPREAD, LINENS**

- (a) Infection Control Program
The facility must establish an Infection Control Program under which it -
 - (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing Spread of Infection
 - (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
 - (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
 - (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
- (c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

1. Resident # 24 has been observed and is currently receiving appropriate catheter care/maintenance as per the facility's policy and procedure.

RN #1 and CNA #1 have been re-educated on appropriate catheter care, maintenance, and hand-washing.

2. All residents utilizing catheters have the potential to be affected. Those residents have been observed and are currently receiving appropriate catheter care/maintenance.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure staff followed infection control practices for suprapubic catheter

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care for 1 of 1 resident with a catheter in the Stage 2 sample of 31 and failed to ensure 1 of 2 staff washed their hands after providing care to this resident. The facility also failed to ensure 1 of 1 resident with a suprapubic catheter in the Stage 2 sample of 31 had care to decrease the likelihood of infections. (Resident #24)

Findings include:

On 2/9/11 at 8:23 A.M., during observation of RN #1 and CNA #1 transferring Resident #24 from bed to chair, the resident's suprapubic catheter bag was placed on the resident's bed as they prepared to put the gait belt on the resident to transfer him. The catheter bag was then hooked on the CNA's pants pocket, and she touched the bag and tubing with bare hands as she transferred the resident to the chair. The CNA left the room without washing her hands. She then entered the code to get out of the unit and then used sanitizing gel on her hands. The RN also touched the bag and tubing as she put the cover bag on the bottom of the wheel chair. She wheeled the resident out of the room, pulled the over the bed tray up to resident in the hallway, and had not washed her hands as she walked into the nurses' station.

Observation on 2/9/11 at 11:48 A.M., the resident sat in the hall waiting for lunch. The catheter tubing was laying on the floor under the wheel chair.

Observation on 2/9 at 2:37 P.M., the resident was sitting in a chair at his bedside. The catheter tubing laid on the floor.

The clinical record of Resident #24 was reviewed

F 441

Skills check offs have been completed on the nursing staff for hand-washing and catheter care/maintenance.

3. The facility's policies for catheter care/maintenance and hand-washing have been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on appropriate hand-washing and catheter care/maintenance. A Critical Elements for Urinary Incontinence, Urinary Catheters, Urinary Tract Infections has been implemented to ensure continued compliance.
(See Attachment M)

4. The DON or designee will complete the Urinary Incontinence, Urinary Catheters, Urinary Tract Infections Form on 3 residents on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these observations will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly.

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F 441	Continued From page 82 on 2/10/11 at 10 A.M. The resident was treated for a urinary tract infection on 1/25/11 and continued to receive Trimethoprim 100 mg [milligram] q hs [every night] since 1/25/11 for "recent uti [urinary tract infection]." The care plan, dated 8/26/10, indicated "The resident has a urinary tract infection as evidenced by: labs and pubic cath." Review of the interventions indicated there was nothing about keeping infection control practices with the catheter. Interview with the DON (Director of Nursing) on 2/10/11 at 3 P.M., indicated the facility currently made 90 staff handwashing observations a month. This was part of their healthcare associated infection initiative.	F 441	5. The above corrective actions will be completed on or before March 12, 2011
F 520 SS=E	3.1-18(b) 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. A State or the Secretary may not require	F 520	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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F 520 Continued From page 83

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.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to assure the quality assurance committee functioned effectively to identify and address the concerns identified by the survey conducted from 2/7/11 through 2/10/11. This had the potential to affect all 55 residents residing in the facility.

Findings include:

The Administrator was interviewed on 2/10/11 at 1:00 p.m. to discuss the quality assurance program.

The problem area of activities meeting the residents' needs for 2 of 3 residents reviewed was discussed. The quality assurance program had not addressed individual needs for activities.

Range Of Motion exercises were discussed and the staff not following the plan of care for them. The Administrator indicated this area of concern had not been addressed in quality assurance.

The Administrator indicated the environmental concerns had been addressed in the January 31, 2011 meeting. He indicated the plan was not to be completed for 3 months.

F 520

QAA COMMITTEE – MEMBERS / MEET / QUARTERLY / PLANS

1. Appropriate quarterly assurance plans have been developed and implemented for activities meeting the needs of the residents, following plans of care for range of motion, environmental concerns, hand-washing, catheter care/maintenance, psychoactive medication monitoring, and personal funds.
2. Each department in the facility has been reviewed and any concerns noted have had plans developed and implemented and included in the facility's quarterly assurance meetings.
3. The facility's QA program procedure has been reviewed and no

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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	
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F 520 Continued From page 84

F 520

Infection Control was discussed as a concern, particularly with handwashing and catheter care. The Director of Nursing presented handwashing logs done through the state initiative for infection control for review. She indicated their monitoring had not identified any concerns.

The Administrator indicated there was no plan in the quality assurance committee to address the inadequate monitoring of psychoactive medications or the unnecessary use of medications as identified by the survey.

The Administrator indicated he was unaware of three residents personal funds being kept in the medication rooms. This concern had not been discussed in quality assurance.

The Administrator was given the opportunity to present any other information about the quality assurance program and its effectiveness prior to the exit at 5:30 p.m. on 2/10/11. No other information was presented.

3.1-52(b)(2)

changes are indicated at this time. The department heads have been re-educated on the QA program. The QA and A Review Form has been implemented to ensure continued compliance.
(See Attachment P)

4. The Administrator or designee will review the QA program and complete the QAA Form on scheduled work days as follows: daily for 2 weeks, weekly for 2 weeks, monthly for 2 months then quarterly thereafter for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.

5. The above corrective actions will be completed on or before March 12, 2011