

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2016
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NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00192225.</p> <p>Complaint IN00192225 - Substantiated - Federal/State deficiencies related to the allegation are cited at F-241, F-242, F-280, F-282, F-353, F-425 and F-441.</p> <p>Survey dates: March 3, 4, 7, 8, and 9, 2016</p> <p>Facility number: 000305 Provider number: 155625 AIM number: 100287200</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 14 Medicaid: 39 Other: 11 Total: 69</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0241 SS=D Bldg. 00	<p>Quality review completed by 30576 on March 16, 2016.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review the facility failed to maintain residents' dignity related to incontinence care. This had the potential to effect 2 of 3 residents reviewed for scheduled incontinence checks. (Residents #B and #E)</p> <p>Findings include:</p> <p>1. During an interview on 03/04/2016 at 11:31 A.M., a family member indicated Resident #B, who could not speak for themselves or use the call light, had not been provided incontinence care on March 1, 2016 for a four hour time span from 7:00 A.M. to 11:00 A.M. The family member indicated the resident was soaked in urine including their nightgown. The family member further indicted the resident was to be checked every two hours for incontinence and was not changed enough.</p> <p>During a confidential interview on 03/08/2016, Staff #41 indicated the</p>	F 0241	<p>F241 Dignity and Respect of Individuality</p> <p>A facility must promote care for residents in amanner and in an environment that maintains or enhances each residents dignityand respect in full recognition of his or her individuality.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</p> <ul style="list-style-type: none"> ·ResidentsE and B are receiving incontinent care per plan of care. ·In-servicenursing staff on time management and resident care/resident concerns perDNS/Designee. <p>Howother residents having the potential to be affected by same deficient practicewill be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> ·Allincontinent residents have the potential to be affected. ·CustomerCare Representative/Designee 	04/08/2016

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	<p>100/200 hall is often very busy and they did not have enough help to cover it at night. The staff member indicated residents do have to wait a long time for assistance because there was usually just one aide and one nurse at night with a float aide being present only some nights. Staff #41 indicated they always felt like they were running behind and the quality of care for the residents was not where it should have been because there was not enough staff.</p> <p>During a confidential interview on 03/07/2016, Staff #52 indicated they did not have enough help to get things done. The staff member further indicated there were a lot of residents that needed 2 aides to assist them, but there was only one aide on each hall at night and there wasn't always an aide that floated to all the halls. Staff #52 indicated they felt behind constantly and could not get things done in a timely manner.</p> <p>Resident #B's quarterly MDS (Minimum Data Set) assessment dated 12/21/2015 indicated the resident needed extensive assistance of two staff members for toileting.</p> <p>The current Care Plan for Resident #B was provided by the DON (Director of Nursing) on 03/09/2016 at 1:25 P.M. and</p>		<p>interviewed all residents using QIS dignity questions;ensuring residents were receiving necessary incontinent care. Any identifiedconcerns were addressed immediately with resident care plan and residentprofile up dated.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·In-servicenursing staff on time management and resident care/resident concerns perDNS/Designee by 4/8/2016. ·Residentswill be interviewed by Customer Care Representative daily using QIS questionsregarding dignity/incontinent care, if concerns are identified, a correctiveplan will be implemented. ·DNS/Designeewill conduct rounds each shift daily to ensure incontinent care is beingprovided per resident plan of care/resident profile. <p>Howthe corrective action will be monitored to ensure the deficient practice willnot recur.</p> <ul style="list-style-type: none"> ·CQItool for Customer Care Rounds will be completed by DNS/Designee weekly x 4weeks, monthly x 3 months, and quarterly thereafter until compliance is achieved. ·Theresults will be reviewed at monthly Continuous Quality 	

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	<p>reviewed at that time. The Care Plan indicated the resident was incontinent due to Alzheimer's disease, unable to identify need to void or have a bowel movement and was to be checked every 2 hours for incontinence.</p> <p>2. During an interview on 03/04/2016 at 2:08 P.M., Resident #E indicated her coccyx wound could not heal because she kept sitting in urine. The resident further indicated the girls do not answer her call lights for long periods. Resident #E indicated she has had to wait up to three and a half hours to have her brief changed</p> <p>During an interview on 03/09/2016 at 3:40 P.M., Resident #E, who was alert and oriented, indicated it made her feel, "pretty d*** bad," when she was left to sit in their own stool or urine. The resident further indicated she was on a diuretic which made her urinate more frequently. Resident #E indicated on 03/08/2016 when staff assisted her to bed and provided care they found feces on her urinary catheter tubing, in the crease of her legs and in her labia from an earlier bowel movement. Resident #E indicated she has had to wait an hour for assistance with incontinence after the CNAs (Certified Nurses Aides) said they would be back, "in a minute." The resident</p>		<p>Improvement Meeting, which is overseen by ED.</p> <ul style="list-style-type: none"> If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance. 	

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	<p>indicated she did not like having a urinary catheter but it gave the sore on her backside a chance to heal and not be wet all the time. The resident had requested the catheter.</p> <p>During a confidential interview on 03/07/2016, Staff #36 indicated recently there had been more nights when there was not an aide to float to all the halls at night and those were the nights they did not have enough help to get to all the residents in a timely manner.</p> <p>During a confidential interview on 03/07/2016, Staff #65 indicated the facility does not have enough staff to meet the needs of the residents based on the residents' acuity.</p> <p>Resident #E's admission MDS (Minimum Data Set) assessment dated 12/30/2015 indicated the resident was alert and oriented with a BIMS (Brief Interview for Mental Status) score of 14 and needed extensive assistance of two staff members for toileting.</p> <p>The current Care Plan for Resident #E was provided by the DON on 03/09/2016 at 10:14 A.M. and reviewed at that time. The Care Plan indicated the resident needed assistance with incontinence care due to right sided weakness from a</p>				

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F 0242 SS=E Bldg. 00	<p>stroke. The Care Plan also documented the resident's request for a Foley catheter dated 03/01/2016.</p> <p>"Resident Progress Notes" were provided by the DON (Director of Nursing) on 03/09/2016 at 10:45 A.M. and reviewed at that time. A progress note dated 03/08/2016 at 7:46 A.M. indicated the resident had a new physician's order for a Foley catheter until wound on coccyx was healed and the Foley catheter was placed.</p> <p>This Federal tag related to complaint IN00192225.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to honor resident choices for activities, bed times and bathing. This had the potential to effect 4 of 5 residents reviewed for choices. (Residents #B, #C, #D and #12)</p>	F 0242	<p>F242 Self-Determination-Right to Make Choices The resident has the right to choose activities,schedules, and health care consistent with his or hers interests, assessments,and plan of care; interact with members of the community both</p>	04/08/2016

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	<p>Findings include:</p> <p>1. During an interview on 03/04/2016 at 11:31 A.M., a family member, who was also the POA (Power of Attorney), indicated Resident #B, who could not speak for themselves or use the call light, was left alone in her room most of the time even after the family had requested the resident to not be. The family further indicated they had attended a Care Plan meeting on 01/19/2016 and the resident's care plan was supposed to have been updated with their request.</p> <p>The current Care Plan for Resident #B was provided by the DON (Director of Nursing) on 03/09/2016 at 1:25 P.M. and reviewed at that time. The Care Plan, dated 01/08/2016, indicated POA stated preference for resident not to be left alone in her room when in wheelchair due to fall risk.</p> <p>On 03/08/2016 at 11:25 A.M., Resident #B was observed sitting in her wheelchair in the hallway by the nurse's station dressed appropriately and well groomed. This was the only time the resident was observed outside of her room.</p> <p>2. During an interview on 03/04/2016 at 11:30 A.M., Resident #D indicated some</p>		<p>inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Preferences for Daily Customary Routines Form completed for resident B, D, #12, C indicating resident preferences. · Resident B is not being left in room alone while in wheel chair per preference. · Resident D is being assisted to get up in the AM per her time preference. · Resident #12 is being assisted to get up in the AM and assisted to bed per his time preference. · Resident C is receiving showers as indicated per resident preference. <p>How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> · All residents that reside in the facility have the potential to be affected by the alleged deficient practice. · Preference for Daily Customary Routines Form reviewed for all residents to ensure preferences were indicated by the Activity Staff. <p>What measures will be put into place or what systemic changes will be made to</p>	

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	<p>of the staff made her get up at 5:00 A.M., even if she did not want to. She further indicated there was nothing to do and did not know why staff got her up so early.</p> <p>Record review of the "Preferences for Daily Customary Routines" form dated 01/09/2016, for Resident #D stated the resident liked to, "sleep in a little", no specific time was noted.</p> <p>3. During an interview on 03/04/2016 at 10:04 A.M., Resident #12 indicated the staff make him get up at 4:00 A.M. every morning and go to bed between 6:30 and 7:00 P.M. every night. He further indicated he wanted to stay up later but was unable to get up on his own.</p> <p>Record review of the "Preferences for Daily Customary Routines" form, provided by the Memory Care Facilitator on 03/09/2016 at 2:25 P.M., for Resident #12 stated the resident liked to get up, "before breakfast", go to bed, "after dinner," and it was somewhat important for him to choose his own bedtimes.</p> <p>Record review of the Main Dining Room mealtimes, where Resident #12 dines, indicated breakfast was served at 7:30 A.M. and dinner at 5:30 P.M.</p> <p>4. During a confidential interview on</p>		<p>ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · Activities staff to be in-serviced by DNS/designee on completing Preference for Daily Customary Routines Form and providing information to IDT for resident profile update by 4/8/2016. · Activities and Memory Care Facilitator to review resident profile binder indicating Preferences for Daily Customary Routine weekly to ensure resident preferences are communicated and updated. <p>How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <ul style="list-style-type: none"> · CQI tool for Accommodation of Needs will be completed weekly x 4 weeks, monthly x 3 months, and then quarterly thereafter until compliance is achieved. · CQI tool will be reviewed in Continuous Quality Improvement Meeting monthly, which is overseen by ED. · If a threshold of 100% is not achieved and action plan will be developed to ensure compliance. 	

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	<p>03/07/2016, Staff #65 indicated the facility does not have enough staff to meet the needs of the residents based on the residents' acuity.</p> <p>During a confidential interview on 03/07/2016, Staff #52 indicated they did not have enough help to get things done.</p> <p>During a confidential interview on 03/09/2016, Staff #38 indicated it was a struggle to get residents turned every two hours. The staff member further indicated residents do not get turned when they should.</p> <p>During an interview on 03/09/2016 at 1:36 P.M., Resident #C's family member indicated Resident #C was not receiving the requested three showers a week. The family member further indicated the Resident was lucky to receive one shower a week and "her hair smelled dirty."</p> <p>During an observation on 03/09/2016 at 1:34 P.M., Resident #C's hair appeared uncombed and the back area was flat against her head.</p> <p>Clinical record review on 03/09/2016 at 2:20 P.M., indicated Resident #C's scheduled shower days were on Monday, Wednesday, and Friday.</p>			

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F 0282 SS=E Bldg. 00	<p>Review of the "Point of Care History" for Resident #C, dated 01/08/2016 through 03/08/2016, indicated the resident did not receive 19 out of 26 scheduled showers. No showers were documented on the following Resident #C's scheduled shower dates only partial bed baths, January 11, 18, 20, 22, 25, 27, 29, 2016, February 1, 3, 8, 15, 17, 19, 24, 26, 29, 2016, and March 2, 4, 7, 2016.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 12/16/2015, indicated Resident #C had a BIMS (brief interview of mental status) of 03 which indicated severe cognitive impairment. The MDS indicated it was very important to Resident #C to choose the bathing schedule. The resident required extensive assistance of one staff member for personal hygiene.</p> <p>Resident #C's diagnoses included but were not limited to, anemia, heart failure, dementia, and gastroesophageal reflux disease.</p> <p>This Federal tag related to complaint IN00192225.</p> <p>3.1-3(U)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>			

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure the plan of care was followed as written related to monitoring for problems with vision, providing incontinence care, accidents, and repositioning residents for 4 of 15 residents reviewed for care plans. (Resident #17, #23, #12, and #E)</p> <p>Findings include:</p> <p>1. Resident #23 was observed forcefully rubbing at her eyes during the following times:</p> <p>03/03/2016 at 11:32 A.M. 03/04/2016 at 9:12 A.M. 03/04/2016 at 10:39 A.M. 03/07/2016 at 8:50 A.M. 03/07/2016 at 10:54 A.M. 03/07/2016 at 11:34 A.M. 03/08/2016 at 10:08 A.M.</p> <p>During an observation on 03/08/2016 at 10:03 A.M., the skin around Resident #23's eyes appeared to be swollen and red.</p> <p>During an interview on 03/08/2016 at 10:16 A.M., CNA #5 indicated Resident #23 had been rubbing her eyes last week,</p>	F 0282	<p>F282 Services by Qualified Persons/Per Care Plan</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each residents written plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident 17, 23, 12 and E were not harmed by the alleged deficient practice. ·Nursing staff in-serviced on following resident specific interventions based on resident profile. ·Resident #23 is being observed for problems with vision, including pain, drainage, and declining vision. ·Resident #12 is being turned and repositioned every 2 hours with incontinent care as needed utilizing perineal wash and moisture barrier. ·Resident E is provided incontinent care as needed. ·Resident #17 falls and care plan have been reviewed by IDT and updated. Therapy screen completed on 3/22/16. <p>How other residents having the potential to be affected by same deficient practice will be identified and what corrective</p>	04/08/2016

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	<p>which was unusual for her. The CNA further indicated she had informed the resident's nurse the day she noticed the resident rubbing. CNA #5 indicated when she noticed the resident was still rubbing at her eyes on Monday, 03/07/2016, she had informed the SSD (Social Services Director) and then the resident's nurse.</p> <p>During an interview on 03/07/2016 at 11:35 A.M., RN #2 indicated Resident #23 did not currently have any medication for irritated eyes. The RN indicated she had not noticed the resident rubbing at her eyes, but that it was normal for her to have her hands on her face. RN #2 indicated the resident would also normally have glasses on, but she was not currently wearing them.</p> <p>During an interview on 03/08/2016 at 10:05 A.M., RN #2 indicated the DON (Director of Nursing) had just called and gotten eye drops ordered for Resident #23 that day.</p> <p>Record review for Resident #23 was conducted on 03/07/2016 at 9:21 A.M. The most recent quarterly MDS (Minimum Data Set) assessment, dated 01/07/2016, indicated the resident did use corrective lenses.</p> <p>Resident #23's current care plans were</p>		<p>action will be taken.</p> <ul style="list-style-type: none"> ·Allresidents who reside in the facility have the potential to be affected by thealleged deficient practice. ·Allnursing staff to be in-serviced onfollowing resident specific interventions based on residents profile by theDirector of Nursing and/or designee. ·Residentprofile binders completed which identifies resident specific interventions perresident plan of care. <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·Allnursing staff to be in-serviced on following resident specific interventionsbased on residents profile per the Director of Nursing and/or designee by 4/8/2016. ·Residentprofile binders identifying resident specific interventions per resident planof care completed per DNS . ·ResidentRounds will be completed by DNS/designee to ensure resident specificinterventions are being followed. <p>Howthe corrective action will be monitored to ensure the deficient practice willnot recur.</p> <ul style="list-style-type: none"> ·CQltool for Accommodation of Needs will be utilized by the DNS/designee weekly x4weeks, monthly x3 months and quarterly 	

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	<p>provided by the DON on 03/02/2016 at 10:40 A.M. The resident's visual function care plan indicated the staff were to observe for problems with vision, including pain, drainage, and decline in vision abilities. Staff were to document findings and notify the doctor.</p> <p>The current facility policy, titled "IDT Care Plan Review" and dated 4/2014, was provided by the DON on 03/08/2016 at 12:00 P.M. and was reviewed at that time. The policy indicated, "...each resident will have a comprehensive care plan...The care plan will include measurable goals and resident specific interventions based on resident needs..."</p> <p>2. Resident #12's "At Risk for Skin Breakdown Care Plan", which was initiated on 10/30/2015, indicated the resident had impaired mobility. The interventions included, but were not limited to, "Turn and reposition at least every 2 hours...Incontinent care as needed using perineal wash and moisture barrier."</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, dated 02/04/2016, indicated Resident #12 had a BIMS (brief interview of mental status) of 05 which indicated the resident had</p>		<p>thereafter until compliance is achieved.</p> <ul style="list-style-type: none"> ·Audit results will be reviewed at Continuous Quality Improvement meeting held monthly, which is overseen by the ED. ·If a threshold of 100% is not achieved an action plan will be developed to ensure compliance. 	

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	<p>sever cognitive impairment. The resident required extensive assistance of two staff members for toilet use and bed mobility. Resident #12 was frequently incontinent of bowel and bladder. The skin assessment indicated Resident #12 was at risk for a pressure ulcer with no current unhealed pressure ulcers.</p> <p>During an observation on 03/03/16 at 10:32 A.M., Resident #12 was sleeping on his back with his head turned to the left.</p> <p>During an observation on 03/03/16 at 2:45 P.M., Resident #12 was sleeping on his back with his head turned to the left.</p> <p>During an observation on 03/03/2016 at 4:32 P.M., Resident #12 was sleeping on his back with his head turned to the left.</p> <p>During an observation on 03/04/2016 at 10:14 A.M., Resident #12 was observed resting in bed on his back, upon approaching the resident a strong urine odor was noted coming from the resident.</p> <p>During an observation on 03/04/2016 at 10:35 A.M., Resident #12 was sleeping on his back, upon approaching the resident's bed there still was a strong urine odor.</p>			

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	<p>During an observation on 03/04/2016 at 1:45 at P.M., Resident #12 was lying on his back with his head turned to the left.</p> <p>During a continuous observation on 03/08/2016 from 4:20 A.M. to 6:47 A.M. Resident #12 was not turned or checked for incontinence. The resident was observed on his back and with his head turned to the left side.</p> <p>During an observation on 03/08/2016 at 6:29 A.M., CNA #14 walked two feet into Resident #12's room then turned around and walked back out without speaking to the resident. The resident was not turned or checked for incontinence.</p> <p>During an observation on 03/08/2016 at 6:47 A.M., CNA #14 walked into Resident #12's room and advised him they were going to get him up. CNA #14 and CNA #20 rolled Resident #12 to change his brief and discovered the resident was soiled with a 1/4 inch bright red circle on the upper coccyx area.</p> <p>During an interview on 03/04/2016 at 10:06 A.M., Resident #12 indicated he could turn his head but that he could not reposition his body without assistance from the staff.</p>			

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	<p>During an interview on 03/08/2016 at 4:21 A.M., CNA #5 indicated Resident #12 was last bed checked and turned around 3:20 A.M. The resident was due to be checked and turned at 5:30 A.M.</p> <p>During an interview on 03/08/2016 at 6:38 A.M., CNA #14 and CNA #20 indicated the red area on Resident #12's coccyx was new and they were going to inform the nurse.</p> <p>During an interview on 03/08/2016 at 7:32 A.M., LPN #19 indicated the CNA's on duty spoke to her/him concerning the new red area on Resident #12's coccyx.</p> <p>During a confidential interview on 03/09/2016, Staff #38 indicated it was a struggle to get residents turned every two hours. The staff member further indicated residents do not get turned when they should and she noticed the area on Resident #12's coccyx was still red.</p> <p>During an interview on 03/09/2016 at 10:30 A.M., the DON (Director of Nursing) indicated the area of redness on Resident #12's coccyx was blanchable and just a skin irritation.</p> <p>During an interview on 03/09/2016 at 12:39 P.M., the DON indicated Resident</p>			

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	<p>#12 had been incontinent of bladder and bowel daily for the last two weeks. The DON further indicated Resident #12 was due for an update on his care plans.</p> <p>3. During an interview on 03/04/2016 at 2:08 P.M., Resident #E indicated her coccyx wound could not heal because she kept sitting in urine. The resident further indicated the girls do not answer her call lights for long periods. Resident #E indicated she has had to wait up to three and a half hours to have her brief changed.</p> <p>During an interview on 03/09/2016 at 3:44 P.M., the DON indicated on 03/01/2016, Resident #E had asked for a catheter to be placed.</p> <p>During a confidential interview on 03/09/2016, Staff #37 indicated Resident #E has had to sit in urine for a little while. The staff member further indicated it was impossible to get all the resident taken care of in a timely manner.</p> <p>"Resident Progress Notes" were provided by the DON (Director of Nursing) on 03/09/2016 at 10:45 A.M. and reviewed at that time. A progress note dated 03/08/2016 at 7:46 A.M. indicated the resident had a new physician's order for a Foley catheter until wound on coccyx</p>			

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	<p>was healed and the Foley catheter was placed.</p> <p>Resident #E's "Self Care Deficit Care Plan", which was initiated on 02/09/2016, indicated the resident had a self care deficit related to right hemiplegia and cerebrovascular accident. The interventions included, but were not limited to, "Incontinent care as needed."</p> <p>The admission MDS assessment, dated 12/30/2015, indicated Resident #E had a BIMS of 14 which indicated the resident was alert and oriented. The resident required extensive assistance of two staff members for toilet use and bed mobility. Resident #E was occasionally incontinent of bladder and always continent of bowel.</p> <p>4. Review of Resident #17's clinical "Event Report" on 03/09/2016 at 10:52 A.M., indicated Resident #17 fell on the following dates, 02/07/2016, 02/18/2016, and 02/25/2016. The IDT (Interdisciplinary Team) note dated 02/08/2016 at 1:43 P.M., indicated Resident #17's "Fall Care Plan" and resident profile was reviewed and updated.</p> <p>Resident #17's "At Risk for Falls Care Plan", which was initiated on 01/06/2016, indicated the resident had</p>			

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	<p>cognitive impairment, weakness, and difficulty walking-standing-transfers. The interventions included, but were not limited to, "Therapy screen as needed" 01/06/2016 dated.</p> <p>During an interview on 03/08/2016 at 11:22 A.M., OT (Occupational Therapist) #21 indicated Resident #17 was discharged from PT (Physical Therapy) on 02/02/2016.</p> <p>During an interview on 03/09/2016 at 10:25 A.M., the Medical Records Coordinator indicated all residents whom fall were assessed by therapy after the fall. She further indicated Resident #17 had falls on the following dates, 02/07/2016, 02/18/2016, and 02/25/2016.</p> <p>During an interview on 03/09/2016 at 11:49 A.M., the TM indicated Resident #17 was not assessed by OT or PT after the falls on 02/07/2016, 02/18/2016, and 02/25/2016.</p> <p>The most recent annual MDS (Minimum Data Set) assessment, dated 01/09/2016, indicated Resident #17 had a BIMS (brief interview of mental status) of 05 which indicated sever cognitive impairment. The resident required extensive assistance of two staff members for toilet use and mobility.</p>			

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F 0353 SS=E Bldg. 00	<p>Resident #17's diagnoses included but were not limited to, atria fibrillation, heart failure, arthritis, and Alzheimer's disease.</p> <p>The current "Fall Management Program" policy was provided on 03/08/2016 at 12:01 P.M. by the DON (Director of Nursing). The policy indicated"...The fall event will be reviewed by the team...the care plan will be reviewed and updated, as necessary..."</p> <p>This Federal tag related to Complaint IN00192225.</p> <p>3.1-35(g)(2)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p>			

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	<p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to ensure adequate staffing was maintained in relation to incontinence care, repositioning not being provided in a timely manner and call lights not being answered in a timely manner for 10 of 11 staff interviews, 5 of 35 resident interviews, and 1 of 3 family interviews. (Resident #B, #D, #E, #12, #54, and #90)</p> <p>Findings include:</p> <p>1. During an interview on 03/04/2016 at 10:06 A.M., Resident #12 indicated he could turn his head but that he could not reposition his body without assistance from the staff.</p> <p>During an interview on 03/08/2016 at 4:21 A.M., CNA #5 indicated Resident #12 was last bed checked and turned around 3:20 A.M. The resident was due to be checked and turned at 5:30 A.M.</p> <p>During a continuous observation on 03/08/2016 from 4:20 A.M. to 6:47 A.M., Resident #12 was not turned or checked for incontinence.</p>	F 0353	<p>F 353 Sufficient 24-HR Nursing Staff Per CarePlans The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #12 is being turned and checked for incontinent care every 2 hours. · Resident E is receiving incontinent care as indicated and checked every 2 hours. · Resident #54, D, E, #90 is being assisted with toileting needs in a timely manner. · Residents affected were followed by Social Services/Memory Care Facilitator for any distress related to concerns on decreased staffing. <p>How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> · All resident that reside at the facility have the potential to be affected by the alleged deficient 	04/08/2016

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	<p>During an observation on 03/08/2016 at 6:29 A.M., CNA #14 walked two feet into Resident #12's room then turned around and walked back out without speaking to the resident. The resident was not turned or checked for incontinence.</p> <p>During an observation on 03/08/2016 at 6:47 A.M., CNA #14 and CNA #20 rolled Resident #12 to change his brief and discovered the resident was soiled and had a 1/4 inch bright red circle on the upper coccyx area.</p> <p>2. During an interview on 03/04/2016 at 2:08 P.M., Resident #E indicated her coccyx wound could not heal because she kept sitting in urine. The resident further indicated the girls do not answer her call lights for long periods. Resident #E indicated she has had to wait up to three and a half hours to have her brief changed.</p> <p>During an interview on 03/09/2016, Staff #37 indicated Resident #E has had to sit in urine for a little while. The staff member further indicated it was impossible to get all the residents taken care of in a timely manner.</p> <p>3. During an interview on 03/04/2016 at 9:12 A.M., Resident #90 indicated she has had to wait long periods for</p>		<p>practice.</p> <ul style="list-style-type: none"> ·In-servicenursing staff on time management and resident care / resident concerns perDNS/designee. ·ED/DNS/Schedulerto review facility staffing needs per shift and adjust accordingly. <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·In-serviceto be completed per DNS/designee by 4/8/2016 on time management, resident care,resident concerns related to staffing. ·2weekend option CNAs have been hired ·1CNA has been added to night shift ·EDis interviewing for 1 CNA shower aid. ·Facilityutilizes Face Book, Bill Boards and the local news paper to advertisingstaffing positions open and available. ·EDto oversee schedule to ensure appropriate staffing is maintained. <p>Howthe corrective action will be monitored to ensure the deficient practice will notrecur.</p> <ul style="list-style-type: none"> ·CQltool for Accommodation of Needs will be utilized for 3 residents weekly x 4weeks, 3 residents monthly x 3 months, and quarterly thereafter untilcompliance is achieved. ·Auditresults will be reviewed at the Continuous Quality 	

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	<p>assistance getting on and off the bed pan.</p> <p>4. During an interview on 03/04/2016 at 9:22 A.M., Resident #54 indicated she sometimes gets left in the restroom for 10 to 15 minutes after she calls for assistance. The resident indicated this was a long time for her because she had claustrophobia (a fear of small spaces).</p> <p>5. During an interview on 03/04/2016 at 10:12 A.M., Resident #12 indicated he was unable to get up on his own and had layed wet after an incontinent episode for up to three hours. The resident further indicated once or twice a day he had to wait long periods to be changed after incontinent episodes.</p> <p>6. During an interview on 03/04/2016 at 11:35 A.M., Resident #D indicated she has had to wait up to two hours for assistance.</p> <p>7. During an interview on 03/04/2016 at 2:04 P.M., Resident #E indicated she often had to wait long periods for help to the restroom.</p> <p>8. During an interview on 03/04/2016 at 11:56 A.M., a family member of Resident #B indicated Resident #B did not get checked for incontinence every two hours as they were supposed to and</p>		<p>Improvement meeting held monthly, which is overseen by ED. If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p>		

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	<p>that Resident #B did not get changed enough because of this.</p> <p>During a confidential interview on 03/07/2016, Staff #52 indicated they did not have enough help to get things done. The staff member further indicated there were a lot of residents that needed 2 aides to assist them, but there was only one aide on each hall at night and there wasn't always an aide that floated to all the halls. Staff #52 indicated they felt behind constantly and could not get things done in a timely manner.</p> <p>During a confidential interview on 03/07/2016, Staff #55 indicated there was not enough staff and it sometimes took an hour and a half to check blood sugar levels on the hall.</p> <p>During a confidential interview on 03/07/2016, Staff #36 indicated recently there had been more nights when there was not an aide to float to all the halls at night and those were the nights they did not have enough help to get to all the residents in a timely manner.</p> <p>During a confidential interview on 03/07/2016, Staff #65 indicated the facility does not have enough staff to meet the needs of the residents based on the residents' acuity.</p>			

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	<p>During a confidential interview on 03/08/2016, Staff #59 indicated the staffing situation was "horrible". The staff member indicated there is often only one aide on a hall when there are numerous residents who require two staff to assist them, which meant the residents had to wait for assistance with care. Staff #59 indicated there was supposed to be a floating aide, but they often left before the night was over, at 2:00 A.M., or arrived at the end of the shift, at 5:00 A.M. The staff member indicated the staffing problems affected both nurses and certified nursing aides, that nurses could not complete medication administration on time, and that the amount of work that needed to be done, including resident care and paperwork, could not be done in the amount of time they had.</p> <p>During a confidential interview on 03/08/2016, Staff #41 indicated the 100/200 hall is often very busy and they did not have enough help to cover it at night. The staff member indicated residents do have to wait a long time for assistance because there was usually just one aide and one nurse at night with a float aide being present only some nights. Staff #41 indicated they always felt like they were running behind and the quality</p>			
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	<p>of care for the residents was not where it should have been because there was not enough staff.</p> <p>During a confidential interview on 03/08/2016, Staff #63 indicated staffing was "terrible" on all the shifts and the residents were not being taken care of right. The staff member further indicated it was sometimes extremely difficult to get to every resident that they were scheduled to assist and it was hard to get everything done. The staff member indicated the 100/200 hall was very busy and was difficult to manage with only one aide. "It is aggravating not being able to do as much as you want to," for the residents.</p> <p>During a confidential interview on 03/09/2016, Staff #49 indicated the residents on the 100/200 hall needed more assistance than the number of staff working could provide.</p> <p>During an interview on 03/09/2016, Staff #38 indicated it was a struggle to get residents turned every two hours. The staff member further indicated residents do not get turned when they should.</p> <p>A list of residents who required assistance from two staff was provided by the MDS (Minimum Data Set)</p>			

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F 0371 SS=E Bldg. 00	<p>Coordinator on 03/07/2016 at 12:21 P.M., there were 23 residents in the facility that required two staff assistance.</p> <p>The Resident Council minutes were reviewed with permission on 03/09/2016 at 1:40 P.M. During two of the three most recent Resident Council meetings, December, 2015 and February, 2016, concerns were voiced about the length of time it takes for call lights to be answered.</p> <p>The February, 2016 Resident Council minutes indicated, "...Residents agreed that at times, mostly days, it can take quite a long time or several calls to get a response. (Resident's Name) comments [sic] I don't think they realize how it feels when you need to go to the bathroom or to bed and you have to rely on someone else to help you..."</p> <p>This Federal tag related to complaint IN00192225.</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or</p>				

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	<p>considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored and served in a sanitary manner for residents related to dating open food, disposing of expired food, covering food in the halls, and proper handwashing during dining. This deficient practice had the potential to affect 69 of 69 residents who were provided food by the facility kitchen.</p> <p>Findings include:</p> <p>1. During the initial kitchen tour on 03/03/2016 at 9:51 A.M., the following was observed in the dry storage area:</p> <ul style="list-style-type: none"> -One large plastic container of powder sugar, open date 01/01/2016, use by date 02/01/2016 -One bowl of cookies in unsealable plastic bags, no open or use by dates -One container taco seasoning, no open or use by dates -One bottle corn syrup, open date 12/01/2015 -One open bag of cherry gelatin in a large baggy, no open or use by dates -One open bag of chocolate mousse mix in large baggy, no open or use by dates -One box of dehydrated onions with open 	F 0371	<p>F371 Food Procure, Store/Prepare/Serve-Sanitary The facility must – Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·The items identified in the dry storage area during the initial kitchen tour were discarded. ·The items identified in the walk-in refrigerator during the initial kitchen tour were discarded. ·Dietary staff was re-in-serviced on covering all food that is distributed to resident rooms. ·RN#2 and CNA #8 were re-in-serviced on hand hygiene. <p>How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·ED/Designee will conduct daily rounds in the kitchen to check containers for accurate labeling and dating. ·In-Service completed by 	04/08/2016

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	<p>inner bag, no open or use by dates</p> <ul style="list-style-type: none"> -One large plastic container of bread crumbs, open date 12/24/2015, use by date 01/24/2016 -One open bag of crisp rice cereal, no open or use by dates -One open bag of corn flakes, no open or use by dates <p>The following was observed in the walk-in refrigerator:</p> <ul style="list-style-type: none"> -One bottle of thickened iced tea, no open or use by dates -One open box of margarine packets, no open or use by dates -One bottle of medium salsa, open date 02/01/2016, use by 03/01/2016 -One bottle Bulgarian style cultured whole buttermilk, no open or use by dates <p>During an observation on 03/08/2016 at 5:32 A.M., the following was observed in the walk-in refrigerator, walk-in freezer, and dry storage area:</p> <ul style="list-style-type: none"> -One open bottle of pineapple juice with the lid dated 12/9 -One open bag of carrots, open date 03/03/2016, use by date 03/07/2016 -Three unopened loaves of sliced bread, not dated with no printed expiration date on the package -Two large containers of taco seasoning, 		<p>DNS/Designee on hand hygiene during meal times and medication administration.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · In-Service completed by ED/Designee on General Food Preparation and Handling by 4/8/2016. · In-Service completed by DNS/Designee on hand hygiene by 4/8/2016. · ED/Designee to make daily rounds checking on covered food and proper hand hygiene. <p>How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <ul style="list-style-type: none"> · ED/Designee will be responsible for utilizing Food Procure CQI tool to check containers for accurate labeling and dating weekly x 4 weeks, monthly x 3 months and quarterly thereafter until compliance is achieved. · DNS/Designee will be responsible for monitoring hand hygiene x 4 weeks, monthly x 3 months, and quarterly thereafter until compliance is achieved. · Results will be reviewed at the Continuous Quality Improvement meeting held monthly, which is overseen by ED. · If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance. 	

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	<p>no open or use by dates</p> <p>During an interview on 03/03/2016 at 10:05 A.M., the DM (Dietary Manager) indicated all opened foods should have had open dates.</p> <p>During an interview on 03/08/2016 at 5:40 A.M., Dietary Aide #3 indicated after food is opened, it is wrapped up or sealed and then labeled with an open and use by date. She further indicated when food is put in the freezer it should be dated.</p> <p>The current facility policy, titled "Food Storage" and dated 07/15, was provided by the DON (Director of Nursing) on 03/08/2016 at 12:00 P.M. and reviewed at that time. The policy indicated, "...All containers must be accurately labeled and dated...Refrigerated, ready-to-eat, potentially hazardous food purchased from approved vendors, shall be clearly marked with the date the original container is opened and the day by which the food shall be consumed or discarded...All foods should be covered or wrapped tightly, labeled and dated..."</p> <p>2. During an observation on 03/03/2016 at 11:53 A.M., a meal cart was delivered to the 400 hall. The meal cart contained 14 trays. Four of the meal trays, which</p>			

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	<p>were taken from the covered cart and walked through the hall to the residents' rooms, contained uncovered salads. One of the trays had an uncovered side dish.</p> <p>During an interview on 03/03/2016 at 2:43 P.M., Resident #20 indicated he ate in his room and he often received uncovered food on his meal tray. The Resident further indicated for lunch they had brought him a large bowl of dressing that was not covered.</p> <p>During an interview on 03/08/2016 at 5:40 A.M., Dietary Aide #3 indicated all food should be covered on the hall carts.</p> <p>The current facility policy, titled "General Food Preparation and Handling" and dated 07/15, was provided by the Administrator on 03/09/2016 at 9:30 A.M. and was reviewed at that time. The policy indicated, "...Prepared food will be transported to other areas either covered or in covered containers/enclosed carts..."</p> <p>3. During the initial dining observation on 03/03/2016 at 11:58 A.M., RN #2 administered insulin to Resident #150. After administering the medication, the RN then picked up a meal tray and served food to Resident #61, touched Resident #61's back, scratched her own face, picked up a new meal, served food to</p>			

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	<p>Resident #27, touched Resident #27's shoulder, served food to Resident #68, opened Resident #69's silverware for her, picked up the resident's silverware and handed it to her. The RN then rubbed Resident #67's back as she assisted the resident to the restroom. RN #2 did not wash or use hand sanitizer after administering the insulin, before serving resident trays, or before assisting the resident to the restroom.</p> <p>During an observation on 03/03/2016 at 11:53 A.M., a meal cart was delivered to the 400 hall. The meal cart contained 14 trays. Dietary Aide #4 delivered five trays to residents eating in their rooms. The Dietary Aide did not wash her hands before she began serving and did not wash or sanitize her hands between serving trays or prior to returning to the kitchen with an unneeded tray.</p> <p>During an observation on 03/09/2016 at 12:07 P.M., CNA #8 brought Resident #14 into the dining room, walked over to Resident #34 and touched the resident's shoulder, then moved Resident #17's cup closer to the resident. The CNA did not wash or used hand sanitizer between touching residents.</p> <p>The current facility policy, titled "Hand Hygiene" and dated 12/2015, was</p>			

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F 0425 SS=E Bldg. 00	<p>provided by the DON on 03/09/2016 at 2:23 P.M. and was reviewed at that time. The policy indicated, "...Five moments for Hand Hygiene..." included "...Before touching a patient...After touching a patient...After touching patient surroundings..."</p> <p>3.1-21(i)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to provide routine medications related to</p>	F 0425	F425 Pharmaceutical SVC-Accurate Procedures, RHP The facility must provide routine and emergencydrugs and	04/08/2016

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	<p>Percocet, vitamin B complex, and Levemir for 2 of 4 residents reviewed for pharmaceutical services. (Resident #20 and #24)</p> <p>Findings include:</p> <p>1. During an observation on 03/07/2016 at 8:11 A.M., LPN (License Practical Nurse) #11 prepared Resident #20's medications. The resident was out of Vitamin B complex.</p> <p>During an interview, on 03/07/2016 at 8:14 A.M., LPN #11 indicated Resident #20 was out of Vitamin B complex and he/she would not be able to administer the medication until the pharmacy delivered the prescription.</p> <p>During an interview on 03/07/2016 at 2:33 P.M., Resident #20 indicated he had not received his Vitamin B complex for the last two days and on several occurrences the facility had run out of his pain medication. Resident #20 further indicated on one occurrence he had to wait three hours to receive pain medication. The resident indicated he was advised from the nurse that the delay in pain medication was due to the facility waiting on the physician's approval to acquire the pain medication out of the EDK (emergency drug kit).</p>		<p>biological to its residents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Audit completed of resident #20 medications and all medications are available and being administered as ordered. · Audit completed of resident #11 medications and all medications are available and being administered as ordered. <p>How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> · All residents that receive medications have the potential to be affected by the alleged deficient practice. · In-service licensed staff on ordering process and obtaining medications from the EDK completed by DNS/designee. · Contact with pharmacy per DNS on resident medication auto-refill to ensure medications are being refilled as indicated per order. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · In-service licensed staff completed by DNS/designee by 4/8/2016 on medication ordering process and obtaining 	

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	<p>The clinical record for Resident #20 was reviewed on 03/07/2016 at 11:36 A.M. The diagnoses included, but were not limited to, complex regional pain syndrome, osteopathic, and type 2 diabetes mellitus.</p> <p>Resident #20 was prescribed Vitamin B Complex one capsule daily to promote wound healing with a start date of 02/02/2016. The Vitamin B complex was not administered on 03/06/2016 & 03/07/2016 due to the medication being unavailable.</p> <p>Resident #20 was prescribed two Percocet 10/325 milligrams every four hours as needed for pain with a start date of 01/25/2016. On the following five occurrences the pain medication was acquired from the EDK, February 2 at 1:30 A.M. & 8:00 P.M., February 15 at 8:00 A.M. & 1:00 P.M., and one additional occurrence documented with no date or time.</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 01/31/2016, indicated Resident #20 was alert and oriented with a (BIMS) Brief Interview for Mental status score of 15.</p> <p>2. During an observation on 03/07/2016</p>		<p>medications from EDK.</p> <ul style="list-style-type: none"> · If medications are not available DNS will be notified by hall nurse with documentation of physician and family notification and pharmacy has been contacted. · DNS/designee to make daily rounds checking with hall nurses to ensure medications are available / ordered if indicated. <p>How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <ul style="list-style-type: none"> · CQI for pharmacy service tool for Medication Availability will be completed weekly x 4 weeks, monthly x 3 months, and quarterly thereafter until compliance is achieved. · Results will be reviewed at Continuous Quality Improvement Meeting monthly, which is overseen by ED. · If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 	

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	<p>at 8:29 A.M., LPN #11 prepared Resident #24's medications. LPN #11 indicated the resident was out of Levemir and he/she would not be able to administer the medication to the resident until the physician was contacted for an alternative medication or the pharmacy delivered the Levemir refill to the facility.</p> <p>The clinical record for Resident #24 was reviewed on 03/07/2016 at 11:36 A.M. The diagnoses included, but were not limited to, type 2 diabetes mellitus with proliferative diabetic retinopathy.</p> <p>Resident #24 was prescribed Levemir, 60 units, subcutaneous twice daily with a start date of 12/31/2015. .</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 01/20/2016, indicated Resident #24 was alert and oriented with a BIMS score of 14.</p> <p>During an interview on 03/07/2016 at 11:15 A.M., the DON (Director of Nursing) indicated she was not aware of any problems with refills from the pharmacy. The DON further indicated most medications were on automatic refill and residents should not run out of medications. The DON further indicated she did not know why Resident #24 had run out of Levemir.</p>			

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	<p>During an interview on 03/08/2016 at 11:05 A.M., LPN #19 indicated there were times when a resident ran out of medications prior to receiving the refill on some occurrences the medication was in over stock and was missed. The automatic refill system does not seem to reorder soon enough.</p> <p>During an interview on 03/08/2016 at 10:33 A.M., the Pharmacy Manager indicated most prescriptions were filled the same day if the request was received by 1:00 P.M. Medication refill request received after 1:00 P.M. were filled the next day. The automatic refills do not apply to injectable's, pain medications, controlled substances or as needed medications. When a prescription was marked "as soon as possible" the pharmacy uses a local pharmacy to deliver the requested medication.</p> <p>The current "Pharmacy Products and Services", dated 02/2014, was provided by the DON on 03/08/2016 at 10:00 A.M. The policy indicated, "orders excluded from the Auto-Refill program must be refilled by facility request and include:...All controlled substances and insulin..."</p> <p>This Federal tag related to Complaint</p>			

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F 0441 SS=E Bldg. 00	<p>IN00192225.</p> <p>3.1-25(a) 3.1-25(1)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>			

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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure proper infection control measures were followed by staff for 2 of 3 direct care observations (Resident #116 and #20) in that handwashing was not done at the proper times or for the required length of time and linens were not handled properly. (CNA #9, RN#10, Laundry Staff #13)</p> <p>Findings include:</p> <p>1. During an observation on 03/07/2016 at 11:11 A.M., Housekeeper #28 pulled linens from the 200 cart dropped a sheet on the floor picked the sheet up and put it back on the bottom shelf of the cart. The housekeeper carried the stack of linens under her arm and against her shirt to Resident #50's room and used the linens to make his bed.</p> <p>During an observation on 03/08/2016 at 8:04 A.M., CNA #20 changed Resident #17's clothing. CNA #20 placed the resident's top and pants on the resident's bathroom floor then assisted the resident to the dining room. CNA #20 then returned to the resident's room and</p>	F 0441	<p>F441 Infection Control, Prevent Spread, Linens The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident #17 and #24 were not harmed by the alleged deficient practice. ·Resident #17 and #24 were reviewed by DNS/designee for any signs and symptoms of infection with none identified. How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken. ·All residents that reside at the facility have the potential affected by the alleged. ·All staff in-serviced to be completed by DNS/designee on hand washing and linen storage/handling. ·Linen carts are fully covered. What measures will be put into place or what systemic</p>	04/08/2016

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	<p>gathered the clothing laying on the floor and placed the soiled clothing in a plastic bag and carried the bag to the soiled linen closet.</p> <p>During an interview on 03/09/2016 at 12:18 P.M., the CEC (Clinical Education Coordinator) indicated linens should not be placed on the floor. She further indicated all soiled linens should be placed in plastic bag and taken to the soiled linen closet. The CEC indicated all clean linens should be carried away from the staff members body and not against the uniform. Any linens landing on the floor are considered soiled linens.</p> <p>The current "Laundry / Linen" policy was provided on 03/08/2016 at 12:01 P.M. by the DON (Director of Nursing). The policy indicated "...Clean linen must be protected from soiling or contamination...Clean linen should be carried away from body to prevent contamination..Place soiled linen in plastic bag..."</p> <p>2. During an observation on 03/07/2016 at 8:40 A.M., LPN #11 was observed to administer Resident #24's medication. The resident was handed the medication cup. After the resident dropped two oral medications out of his mouth and the medication landed in the resident's</p>		<p>changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·Handwashing skills validations completed by DNS/designee for all nursing staff. ·All staff in-service to be completed by DNS/designee by--- on hand washing and proper handling/storage of linens. <p>How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <ul style="list-style-type: none"> ·CQI tool for Infection Control to be completed weekly x 4 weeks, monthly x 3 months, and quarterly thereafter until compliance is achieved. ·Results will be reviewed at Continuous Quality Improvement Meeting monthly, which is overseen by ED. ·If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 		

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	<p>pocket, LPN #11 reached in to the resident's pocket two separate times with her bare hand pulling out one tablet each time and placed the tablets back in to the resident's medication cup. Resident #24 continued to take the dropped medication. LPN #11 wiped her hands on her uniform top then documented the administered medication in the resident's chart on the computer. LPN #11 then used hand gel to clean her hands.</p> <p>During an interview on 03/09/2016 at 12:20 P.M., the CEC indicated proper handwashing was for 40 to 60 seconds when hands were visibly soiled. Staff should use gloves to touch a residents medication and staff should never touch medication with their bare hands.</p> <p>The current "Medication Pass Procedure" policy was provided on 03/08/2016 at 12:01 P.M. by the DON (Director of Nursing). The policy indicated "...dropped medication destroyed properly...Medications are opened without contaminating...Hands washed following administered (gel x 5 then water) unless resident contact then washes hands after..."</p> <p>This Federal tag related to Complaint IN00192225.</p>			
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	3.1-18(l) 3.1-19(g)				