STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS GROVE REHABILITATION CENTER	4255 MEDWELL DR NEWBURGH, IN 47630

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F000000	This visit was for a Recertification and State Licensure survey. Survey dates: August 18, 19, 20, 21, 25, 26, 27, 2014. Facility number: 000173 Provider number: 155273 AIM number: 100290920 Survey team: Barbara Fowler RN TC Diane Hancock RN Anna Villain RN 8/19, 8/20, 8/21, 8/25, 8/26, 8/27/14 Denise Schwandner RN 8/19, 8/20, 8/21/14 Diana Perry RN 8/19, 8/20, 8/21/14 Census bed type: SNF/NF: 71 Total: 71 Census payor type: Medicare: 8 Medicaid: 42 Other: 21 Total: 71 These deficiencies reflect state findings	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2. Quality review completd on September 2, 2014, by Jodi Meyer, RN			
F000170 SS=A	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. Based on interview and record review, the facility failed to ensure mail was delivered promptly on weekends, for 1 of 1 resident council person interviewed and 1 of 1 weekend reviewed, in that, mail did not get delivered. (Resident #15) Finding includes: On 8/25/14 at 9:00 a.m., Resident #15 was interviewed regarding the mail delivery in the facility. The resident indicated mail was only delivered Monday through Friday at the facility. On 8/25/14 at 11:10 a.m., the Administrator indicated the weekend managers were responsible for passing mail on Saturdays. The Business Office Manager was identified as the weekend	F000170	Effective 9/13/14, the Saturday weekend manager will deliver the mail if it has arrived prior to the end of his/her shift. The Saturday manager will also document in the Weekend manager binder whether or not the mail was delivered. The Sunday manager will check the mailbox and deliver any mail that was not delivered on Saturday and document in the weekend manager binder. The administrator will verify weekend mail delivery weekly on an ongoing basis to ensure continued compliance. Administrator will report findings to center Quality Assurance and Performance Improvement committee for review and recommendatins.	09/24/2014

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	manager on Saturday, 8/23/14. She was interviewed at that time and indicated the mail had not been delivered to the facility when she left on Saturday, 8/23/14 at 1:30 p.m. She indicated it depended on the mail carrier whether or not it got there in time for the weekend manager to pass on Saturday, but if not, the Sunday manager passed the mail. The Willows Unit Manger was interviewed at 11:17 a.m. on 8/25/14 and indicated she was the Sunday manager on 8/24/14. She indicated she thought the Saturday manager took care of the mail. The Director of Nurses provided a copy of the policy and procedure for "Mail - Resident Receiving and Sending," dated January, 2009, on 8/26/14 at 4:15 p.m. The policy and procedure included, but was not limited to, the following: "...Mail will be delivered to the resident within 24 hours of delivery by the postal service." 3.1-3(s)(1)			
F000242 SS=D	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			

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	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 interview and record review, the facility failed to ensure 2 of 35 stage 1 residents were given a choice about frequency of showers, in that they did not receive showers as often as they desired. (Residents #12, #85) Findings include: 1. Resident #12 indicated she was lucky to get one shower a month, when interviewed on 8/18/14 at 11:22 a.m. On 8/25/14 at 8:54 a.m., Resident #12 indicated she got one shower the previous week. She indicated she was scheduled for Monday and Thursday. On 8/25/14 at 10:48 a.m., the Assistant Director of Nurses provided documentation of showers for Resident #12 for the past 30 days. Documentation indicated the resident received showers on 7/31/14 at 8:42 p.m. and 8/18/14 at 8:26 p.m. The only refusals documented were 8/7/14 and 8/21/14. 2. On 8/19/14 at 9:11 a.m., Resident #85 was interviewed. Resident #85 indicated she did not receive showers like she was supposed to. Resident #85 further	F000242	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. F242 Resident #12 and #85 have received showers per their preference and facility policy. Other residents bathing records have been reviewed and showers or baths have been given per resident request. Resident preferences for type and frequency of bathing have been updated. The center's nursing staff have been retrained on the center policy and procedure offering showers and baths to residents and honoring resident choice for bathing. The Director of Nursing or designee will review all resident bathing records five days per week times four weeks then three times weekly for four weeks, then weekly thereafter on an ongoing basis to ensure continued compliance with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in	09/24/2014

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	indicated she received a shower about once every two weeks. On 8/25/14 at 9:27 a.m., Resident #85 was interviewed. Resident #85 indicated she did not receive any showers last week. On 8/21/14 at 10:18 a.m., Resident #85's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) Assessment, dated 6/23/14, indicated Resident #85 was cognitively intact. The MDS further indicated the resident required a one person physical assist for bathing. The Life Enrichment Assessment, dated 3/4/13, indicated it was very important for Resident #85 to choose between a shower, tub, or bed bath. On 8/25/14 at 9:17 a.m., the shower schedule was reviewed. The schedule indicated Resident #85 was to receive a shower on Mondays and Thursdays during the evening shift. On 8/25/14 at 11:27 a.m., the ADoN (Assistant Director of Nursing) provided the Bath Type Detail Report for Resident #85. The report indicated from 7/26/14 through 8/24/14, Resident #85 received 3		disciplinary action per policy up to and including termination. Identified trends will be reported by the Director of Nursing monthly to the center Quality Assurance and Performance Improvement Committee for review and further recommendations as deemed appropriate. The systemic changes will be completed by 9/24/14.	

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	showers. The report further indicated Resident #85 refused a shower one time. 3.1-3(u)(3)			
F000248 SS=E	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. Based on observation, interview, and record review, the facility failed to provide an ongoing activity program to meet the needs of the residents on the Living Moments Alzheimer's Unit, in that, activities were not provided to meet the needs of the residents. One (1) of 1 resident reviewed for activities, in the sample of 1 who met the criteria, was not provided ongoing activities. One randomly observed resident was not provided activities of interest when requested. This had the potential to affect 13 residents residing on the Living Moments Alzheimer's Unit. (Resident #52, #21) Findings include: 1. On 8/20/14 from 11:03 a.m. to 11:54	F000248	F248 Resident #52 has had his activity preferences updated and 1:1 activities have been scheduled for him as appropriate. Residents on Living Moments have had their activity preferences updated. A revised calendar of activities for the Living Moments unit has been created to reflect programming occurring from approximately 7 am until approximately 9 pm. per the center policy with the goal of engaging as many residents as possible with each activity. Living Moments staff members have been retrained on the center policy for activities on the unit and on providing 1:1 activities as needed for specific residents and appropriate documentation of the activities attended. Activities on Living Moments will be assessed daily times two weeks, then three times weekly for two weeks then weekly thereafter on an ongoing	09/24/2014

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	a.m., no activities were observed to be occurring on the Living Moments unit. On 8/20/14 at 1:33 p.m., no activities were observed to be occurring on the Living Moments unit. On 8/20/14 at 2:28 p.m., no activities were observed to be occurring on the Living Moments unit. On 8/20/14 at 2:30 p.m., Resident #21 was observed to request to go outside in the garden. The Program Manager (PM) and LPN #1 indicated they did not have time. 2. On 8/21/14 at 8:50 a.m., no activities were observed to be occurring on the Living Moments unit. On 8/21/14 at 9:45 a.m., Resident #52 was observed sleeping in his chair. On 8/21/14 at 2:07 p.m., no activities were observed to be occurring on the Living Moments unit. On 8/21/14 at 2:07 p.m., Resident #52 was observed sleeping in bed. 3. On 8/25/14 at 8:54 a.m., no activities were observed to be occurring on the Living Moments unit.		basis to ensure the activity took place, changes are made to the calendar if an activity is not engaging and that all participation is documented per center policy with results presented to Quality Assurance and Performance Improvement monthlyfor review and recommendations. Activities will be assessed by the Administrator or designee 2 times per day on weekdays between 9 and 4:30. The evening manager will assess the activity after 6 pm. The weekend manager will check to ensure activities are occurring on Saturday and Sunday. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. Identified trends will be reported monthly by the Administrator to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	On 8/25/14 at 8:55 a.m., Resident #52 was observed in his room sitting in his chair. On 8/25/14 at 9:07 a.m., no activities were observed to be occurring on the Living Moments unit. On 8/25/14 at 11:29 a.m., Resident #52 was observed sleeping in his chair. On 8/25/14 at 2:30 p.m., Resident #52 was observed sleeping in bed. 4. On 8/26/14 at 9:34 a.m., Resident #52 was observed sleeping in his room. 5. On 8/18/14 at 12:13 p.m., an anonymous interview indicated there needed to be more activities on the Living Moments unit. The interviewee further indicated residents were bored and slept in their chairs a lot. On 8/25/14 at 2:30 p.m., LPN #1 indicated Resident #52 sometimes participated in newspaper readings but did not really do any other activities. On 8/26/14 at 8:29 a.m., the PM was interviewed. The PM indicated Resident #52 did not participate in activities. The PM further indicated she did do one to			

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	one activities for residents who did not participate in group activities but they were not documented. The PM indicated Resident #52 and his wife did current events and read the newspaper together. The PM indicated she did reminiscing with the resident because he was the oldest living veteran. The PM further indicated Resident #52 watched television. The PM indicated Resident #52 socialized during dinner time in the dining room. On 8/26/14 at 9:20 a.m., RN #3 indicated there were not any activities provided for the residents on the Living Moments unit. RN#3 further indicated residents on the Living Moments unit only slept. On 8/20/14 at 11:03 a.m., Resident #52's clinical record was reviewed. The Activity Pursuit Plan of Care, dated 5/29/14, indicated Resident #52 preferred sports magazines, newspapers, easy listening music, fresh air outside, religious services. Interventions included, but were not limited to, assist resident to activities of interest. 6. On 8/21/14 at 2:17 p.m., RN #2 provided the August Activity Calendar. The Calendar indicated activities occurred at 9:30 a.m., 10:00 a.m., 11:00 a.m., 11:30 a.m., 1:00 p.m., 4:00 p.m.,			

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	and 4:30 p.m. everyday. On some days there was a 6:00 p.m. activity scheduled. On 8/26/14 at 8:40 a.m., the PM provided the August Daily Activity Attendance/Participation Record. There were no activities identified as attendance/participation for Resident #52 from 8/20/14 through 8/26/14. On 8/26/14 at 4:15 p.m., the DoN (Director of Nursing) provided the, "Daily Living Routine and Programming" policy. The policy indicated, "The Living Moments activity program is designed to increase the quality of life for the residents who reside on the unit." The policy further indicated, "...activities are structured throughout the day and are focused on engaging the resident..." On 8/26/14 at 4:15 p.m., the DoN provided the "Extendicare Life Enrichment Program" policy. The policy indicated, "The focus is to enrich the residents' lives by providing meaning and purpose to engage them in the best quality of life at the center." 3.1-33(a)			
F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and			

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	periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, interview, and record review, the facility failed to ensure residents were comprehensively assessed for colostomy, dental status and contractures, for 3 of 36 stage 2 sampled residents, in that, the Minimum Data Set	F000272	F272 The MDS assessments for residents #6, #56 and #52 were modified on 8/27/14 to reflect the colostomy, dental status and contracture. The most recent MDS	09/24/2014

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	Assessments did not indicate these items. (Residents #6, #56, #52) Findings include: 1. During an observation on 8/18/14 at 2:55 p.m., Resident #6 was observed to be sitting in a chair in his room. Resident #6 was observed to have a pouch on his abdomen under his clothes. During an observation on 8/21/14 at 8:40 a.m., Resident #6 was observed to be in his room. Resident #6 indicated he had a colostomy and showed the colostomy stoma and appliance. During an interview on 8/19/14 at 10:05 a.m., RN #1 indicated Resident #6 had a colostomy. RN #1 indicated Resident #6 performed his own colostomy care. During an interview on 8/21/14 at 8:44 a.m., Resident #6 indicated he had been instructed on the care of his colostomy and took care of the colostomy himself. The clinical record for Resident #6 was reviewed on 8/20/14 at 2:42 p.m. Resident #6 had diagnoses including, but not limited to, chronic back pain, BPH (benign prostatic hypertrophy), gastrointestinal bleed, dementia, depression, and muscle spasms. A		assessments for residents have been reviewed to ensure that the MDS accurately reflects the residents' current status. The center MDS coordinator has been retrained on the proper coding of the MDS assessment as it relates to colostomy, dental status and contractures. The Director of Nursing or designee will review MDS assessments completed times 30 days to ensure accuracy of ostomy, dental status and contractures. The Director of Nursing or designee will then review 25% of completed assessments times 6 months to ensure continued accuracy with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. Identified trends will be reported monthly by the Director of Nursing to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	quarterly MDS, dated 7/26/14, indicated Resident #6 had a BIMS (Brief Interview for Mental Status) assessment score of 11, indicating slight cognitive impairment. The MDS indicated Resident #6 had occasional bowel incontinence. The MDS indicated Resident #6 had occasional bowel incontinence but did not indicate the resident had a colostomy under the "Bowel Continence" section. During an interview on 8/26/14 at 2:36 p.m., the DoN (Director of Nursing) indicated Resident #6 had a colostomy and did not have any bowel incontinence. The DoN further indicated the MDS was incorrectly marked. 2. On 8/21/14 at 9:43 a.m., Resident #56 was observed in bed. Resident #56 was not observed to be wearing a splint on the left hand. On 8/19/14 at 11:56 a.m., LPN #2 was interviewed. LPN #2 indicated Resident #56 had a contracture to the left hand. LPN #2 further indicated Resident #56 refused therapy and did not wear a splint. On 8/20/14 at 3:32 p.m., QMA (Qualified Medication Aide) #1 indicated Resident #56 had a contracture on the left hand but did not use any splints or receive any range of motion services.			

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	On 8/20/14 at 1:36 p.m., Resident #56's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 7/9/14, indicated Resident #56 had no impairment on her functional range of motion. The Quarterly Nursing Data Collection and Assessment, dated 7/9/14, indicated Resident #56 had a contracture. The Multidisciplinary Therapy Screening Tool, dated 4/17/14, indicated, nursing staff requested an evaluation related to Resident #56's decreased range of motion. The Multidisciplinary Therapy Screening Tool, dated 6/27/14, indicated Resident #56 had a contracture. 3. On 8/25/14 at 8:55 a.m., Resident #52 was observed with some missing teeth. On 8/20/14 at 1:23 p.m., LPN #1 indicated Resident #52 had a lower partial plate and some natural teeth. On 8/20/14 at 11:03 a.m., Resident #52's clinical record was reviewed. The Significant Change MDS			

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	Assessment, dated 5/29/14, indicated Resident #52 was edentulous. The Potential for Actual ADL (Activities of Daily Living)/Mobility deficit care plan indicated Resident #52 had a lower partial plate. 3.1-31(d)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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). Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was developed	F000279	F279 Resident # 12's safety device care plan was updated on 8/28/14 to reflect the use of the seatbelt on her electric wheelchair.	09/24/2014

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	for 2 of 36 stage 2 sampled residents, in that, the use of a safety belt and rejection of care were not included on the care plans for the residents. (Resident #12, Resident #56) Findings include: 1. Resident #12 was observed to be up in an electric wheelchair (w/c) on 8/20/14 at 11:22 a.m. and 1:34 p.m. The resident had a self-release seat belt in place across her lap. The resident was up in the electric wheelchair again on 8/21/14 at 10:05 a.m. The self-release seat belt was in place at that time. Again on 8/26/14 at 10:00 a.m., the resident was up in the wheelchair in her room with the seat belt in place. Resident #12's clinical record was reviewed on 8/25/14 at 9:22 a.m. The resident was admitted to the facility on 4/25/08 with diagnoses including, but not limited to, hyperlipidemia, anxiety, osteoporosis, hypertension, arthritis, depressive disorder, cognitive disorder, and narcolepsy. The resident's daily clinical review notes, dated 7/23/14, indicated the resident "had fall from w/c with upper torso and head hitting floor and lower extremities in chair...Res. uses electric w/c for mobility as is not wt. [weight] bearing..."		Resident #56's behavioral care plan was updated on 8/28/14 to reflect her refusal of care. Other residents with safety devices and behaviors have had care plans reviewed and revised to reflect the resident's current status. The Interdisciplinary team has been retrained on the center policy for care plan development and implementation for safety devices and refusal of care. The Director of Nursing or designee will review care plans on all residents who receive a new safety device or begin to refuse care times 6 months to ensure proper care plans are developed and implemented based on the individual need of the resident. Reviews will be conducted monthly thereafter with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. Identified trends will be reported by the Director of Nursing monthly to the center Quality Assurance and Performance Improvement Committee for	

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	The resident had a care plan for Activities of Daily Living and Mobility, dated 8/7/14. The care plan indicated the resident was to be transferred with two assist and a mechanical lift and used an electric wheelchair. The Fall/Injury Assessment: Prevention and Management Plan of Care, dated 8/7/14, indicated the resident required two assist and a mechanical lift for transfers, staff were to lock the bed wheels, use 1/2 siderails X 2, and obtain a therapy consult 7/23/14. A care plan for Safety Devices, dated 8/7/14, addressed 1/2 siderails X 2 in bed. The care plans failed to address the use of the self-release seat belt. A policy and procedure for Safety Device Application, dated January 2009, was provided by the Director of Nurses on 8/26/14 at 4:15 p.m. The procedure included, but was not limited to, "Safety device is documented on the Safety Device Plan of Care." 2. On 8/21/14 at 2:08 p.m., Resident #56 was observed sleeping in bed. On 8/25/14 at 8:57 a.m., Resident #56 was observed sleeping in bed.		review and recommendations. The systemic changes will be completed by 9/24/14.	

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	On 8/26/14 at 9:35 a.m., Resident #56 was observed sleeping in bed. On 8/20/14 at 3:32 p.m., QMA #1 indicated Resident #56 refused therapy and splints. On 8/20/14 at 1:36 p.m., Resident #56's clinical record was reviewed. Resident #56's diagnoses included, but was not limited to, dementing illness with associated behavior symptoms. The Quarterly MDS Assessment, dated 7/9/14, indicated Resident #56 rejected care daily. The Plan of Care for the presence of behavioral symptoms that may be harmful to self or others, or interfering with the function or care, updated 7/8/14, lacked documentation indicating Resident #56 rejected care. On 8/26/14 at 4:15 p.m., the DoN (Director of Nursing) provided the "Care Plan" policy. The policy indicated, "....develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI (Resident Assessment Instrument) process, with necessary monitoring and follow-up."			

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	3.1-35(a)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to provide treatment and services for skin conditions for 3 of 4 residents reviewed for skin conditions, in a sample of 9 residents who met the criteria, in that, 2 residents who had received a treatment did not have the wounds reassessed upon completion of the treatment and obtain new orders, and 1 resident who received a skin tear was not assessed or orders obtained. (Resident #89, Resident #33, Resident #52) Findings include: 1. During an observation on 8/18/14 at 2:23 p.m., Resident #89 was observed to have a bandage on the 2nd (second) toe of the right foot. Resident #89 indicated he had a wound on the toe. Resident #89 indicated the dressing was to be changed	F000309	F309 Resident # 89 had 2nd toe on right foot reassessed on 8/25/14. Physician's orders for treatment were obtained and are being followed. Resident #33's skin tear was no longer visible on 8/25/14 and requires no additional treatment. Resident #52's skin tear has healed. Other center residents with skin impairments have been reassessed per center policy and physician's orders for treatment are being followed. Licensed nurses were retrained on the center policy for completing weekly skin assessments, identifying skin tears, notifying physician for treatment orders, documentation on the Treatment Administration Record for daily monitoring and reassessment as needed. Upon a resident's initial interdisciplinary team review for skin impairment, the date for necessary follow up will be noted on the calendar to ensure completion. The ADON and Unit Manager will monitor skin tears	09/24/2014

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	daily. During an observation on 8/25/14 at 9:50 a.m., Resident #89 was observed to be sitting in a wheelchair in his room. Resident #89 was observed to have a wound on the end of his 2nd toe on the right foot. The wound had a dried liquid on it and appeared to be black. The clinical record for Resident #89 was reviewed on 8/20/14 at 1:50 p.m. Resident #89 had diagnoses including, but not limited to, diabetes, anemia, atrial fibrillation, right kidney transplant, prostate cancer, left arm fistula, right rotator cuff syndrome, and leukocytosis. The quarterly MDS (Minimum Data Set) assessment, dated 6/23/14, indicated Resident #89 had a BIMS (Brief Interview for Mental Status) assessment score of 14, indicating slight cognitive impairment. Resident #89 had a physician's order, dated 8/8/14, for the right 2nd toe to be treated with Bactroban (antibiotic treatment) and dry dressing after cleansing with normal saline bid (twice a day) for 14 days. The order further indicated the toe was to be reassessed after 14 days. No documentation of the wound		five times weekly for four weeks then three times weekly four weeks, then weekly thereafter on an ongoing basis for treatment and documentation with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. Identified trends will be reported monthly to the center Quality Assurance and Performance Improvement Committee by the Director of Nursing for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	reassessment after the 14 days was located in the clinical record. During an interview on 8/19/14 at 9:15 a.m., RN #1 indicated Resident #89 did not have a wound. During an interview on 8/25/14 at 11:35 a.m., RN #3 indicated no reassessment had been done for Resident #89's wound. RN #3 indicated she would be reassessing the wound that date and would notify the resident's physician. 2. On 8/19/14 at 3:27 p.m., Resident #33 was observed with a healing skin tear to the left hand. On 8/20/14 at 10:02 a.m., Resident #33 was observed with a healing skin tear to the left hand. On 8/25/14 at 3:56 p.m., the DoN (Director of Nursing) and WUM (Willows Unit Manager) indicated they were unaware of any skin tear on Resident #33's hand. On 8/25/14 at 4:45 p.m., the DoN indicated the area on Resident #33's hand could have been an old skin tear. On 8/26/14 at 9:08 a.m., the WUM was interviewed. The WUM indicated if any skin area was observed, staff members			

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	should contact the resident's physician and family members. The WUM further indicated the area should be placed on the TAR (Treatment Administration Record) for monitoring. On 8/20/14 at 2:46 p.m., Resident #33's clinical record was reviewed. The Fall/Injury Risk plan of care, indicated resident required the assistance of 2 persons and a sit to stand lift for transfers. The most recent signed physician's recapitulation orders, signed 7/30/14, lacked a treatment order for a skin tear. The orders indicated a skin assessment was to be completed every Friday. The August TAR indicated a skin assessment was to be completed on 8/1, 8/8, 8/15, and 8/22. The TAR indicated the assessments were completed on 8/8 and 8/15. On 8/26/14 at 4:15 p.m., the DoN provided the "Skin Tear Treatment Protocol" policy. The policy included, but was not limited to, "Notify physician and obtain orders...notify the responsible party describe the circumstances and document...evaluate the skin tear daily...document daily..."			

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	3. On 8/20/14 at 1:30 p.m., Resident #52's right arm skin tear was observed with LPN #1. LPN #1 removed the tubigrip stocking from the resident's arm and then removed the non-adherent telfa dressing. A zigzag like healing skin tear was revealed with a few areas observed to still have scab like areas. LPN #1 placed the soiled telfa dressing back over the skin tear and placed the tubigrip over the telfa dressing. On 8/20/14 at 1:23 p.m., LPN #1 was interviewed. LPN #1 indicated Resident #52's skin tear was almost healed, however, there were still a few scabs present and a scant amount of blood on the dressing. LPN #1 further indicated the dressing was changed every other day. On 8/26/14 at 9:08 a.m., the WUM indicated staff members should contact the physician and obtain a new treatment order when a treatment order expired, unless the area had healed. On 8/20/14 at 11:03 a.m., Resident #52's clinical record was reviewed. A Telephone Order, dated 7/23/14, indicated a treatment order to, "steri-strip to skin tear right forearm cover with non			

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	adherent dressing and wrap with kerlix gauze then cover protective skin sleeve for 14 days then reassess." The August TAR indicated the treatment was completed 8/1 through 8/21. The Progress Note dated 8/20/14 at 10:20 a.m., indicated the dressing to the skin tear was changed. The clinical record lacked a reassessment and any new orders for the treatment of the skin tear to Resident #52's right forearm. On 8/26/14 at 4:15 p.m., the DoN provided the "Skin Tear Treatment Protocol" policy. The policy included, but was not limited to, "implement physician's order for treatment". 3.1-37(a)			
F000315 SS=D	483.25(d) 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			

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	restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure appropriate care to a resident's urinary catheter, in that, catheter care was not performed following an incontinence episode for 1 of 4 residents reviewed for urinary catheter use. (Resident #33) Findings include: On 8/25/14 at 10:51 a.m., CNA #1 and CNA #2 were observed to assist Resident #33 to the bathroom. The resident was assisted into the shower room and CNA #1 and CNA #2 were observed to perform hand hygiene and apply gloves. The catheter bag was observed to be above the level of the bladder while the resident was being transferred from the wheelchair to the commode. The catheter bag remained above the level of the bladder while the resident was sitting on the commode. CNA #1 was observed to cleanse and dry Resident #33's bottom. CNA #1 and CNA #2 were observed to apply a new brief and pull Resident #33's pants up. No catheter care or cleansing of the front peri-area was observed. On 8/25/14 at 3:58 p.m., the DoN (Director of Nursing) indicated catheter	F000315	F315 Resident # 33 exhibits no signs or symptoms of a UTI as a result of the alleged deficient practice. Residents with indwelling catheters have been assessed for signs and symptoms of UTI. CNA's were retrained on catheter care and assuring the catheter and drainage bag are kept below the level of the bladder. The Assistant Director of Nursing and the Unit Manager will monitor catheter care on one resident five times weekly for 4 weeks then three times weekly times four weeks, then weekly thereafter on an ongoing basis to ensure continued compliance with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination Identified trends will be reported by the Assistant Director of Nursing monthly to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	09/24/2014

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	care should be completed after every incontinence episode. On 8/20/14 at 2:46 p.m., Resident #33's clinical record was reviewed. Resident #33's diagnoses included, but were not limited to, UTI (Urinary Tract Infection) and Benign Prostate Hyperplasia. The Catheter Care Plan, dated 8/12/14, interventions included, but were not limited to, assure catheter and drainage bag are below the level of the bladder, strive to keep free of feces. The Actual/Potential for Infection Care Plan, dated 8/12/14, interventions included, but were not limited to, cath care per protocol. 3.1-41(a)(1)			
F000318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF 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. Based on observation, interview, and	F000318	F318 Resident #56 was evaluated and is receiving occupational therapy services for	09/24/2014

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	record review, the facility failed to provide appropriate range of motion care and services, in that, a resident with a contracture did not receive range of motion services or a splint device for 1 of 1 residents reviewed for range of motion, in a sample of 1 who met the criteria. (Resident #56) Findings include: On 8/21/14 at 9:43 a.m., Resident #56 was observed lying in bed, no splint devices were observed on Resident #56's left hand contracture. On 8/19/14 at 11:56 a.m., LPN #2 was interviewed. LPN #2 indicated Resident #56 had a contracture of the left hand. LPN #2 further indicated Resident #56 did not receive therapy or have a splint device. On 8/20/14 at 3:32 p.m., QMA (Qualified Medication Aide) #1 indicated Resident #56 had a left hand contracture. QMA #1 further indicated Resident #56 did not receive any range of motion services or splint devices. On 8/20/14 at 1:36 p.m., Resident #56's clinical record was reviewed. The Quarterly MDS assessment, dated		her contracture. Other residents with contractures have been screened by therapy services to ensure the proper range of motion, restorative services and splints or positioning devices are in place. Licensed nurses have been retrained on the center policy for range of motion services and the treatment of residents with contractures. Any resident with a newly identified contracture will be reviewed by the interdisciplinary team to ensure appropriate measures are in place and a range of motion program is established. The Assistant Director of Nursing and the Unit Manager will review all residents with contractures weekly times 3 months and monthly thereafter on an ongoing basis to ensure range of motion services are being provided appropriately with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. Identified trends will be reported by the Director of Nursing monthly to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	7/9/14, indicated Resident #56 was severely cognitively impaired. The Quarterly Nursing Data Collection and Assessment, dated 7/9/14, indicated Resident #56 had a contracture. The Multidisciplinary Therapy Screening Tool, dated 6/27/14, indicated resident had a hand contracture. The tool further indicated the resident was not appropriate for skilled therapy intervention and was not receiving any restorative care. The Multidisciplinary Therapy Screening Tool, dated 4/17/14, indicated the nursing staff requested an evaluation due to decreased range of motion to the hand. The tool indicated the resident was not appropriate for skilled therapy intervention. The Nursing Assistant Assignment Worksheet, provided on 8/20/14 by LPN #1, did not indicate a splint or range of motion services for Resident #56. The record lacked documentation of restorative notes. The August TAR (Treatment Administration Record) lacked documentation for any type of splint or range of motion services.			

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	On 8/26/14 at 4:15 p.m., the DoN (Director of Nursing) provided the "Contracture Prevention and Management Program" policy. The policy indicated, "Determine if the resident would benefit from, or requires contracture prevention or management which may include, but is not limited to: passive range of motion, active range of motion, active assistive range of motion, splint/brace assistance, positioning." 3.1-42(a)(2)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure the resident's environment remained free from accident hazards, in that, side rails were not secured for 1 of 2 residents, in a sample of 2 who met the criteria. (Resident #53) Finding includes: On 8/18/14 at 3:24 p.m., Resident #53's right side rail was observed to be loose.	F000323	F323 Resident #53's side rail was repaired on 8/20/14. Resident #53 has suffered no ill effects of the loose rail. Other resident side rails were checked on 8/20/14 and are secured. Nursing and housekeeping staff have been retrained on the center policy for reporting any equipment that needs repair or adjustment and how to identify loose side rails. A preventive maintenance program will be implemented to check all side rails weekly. The center maintenance director will check	09/24/2014

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	On 8/20/14 at 9:58 a.m., Resident #53's right side rail was observed to be loose and appeared to be hanging at a 45 degree angle from the bed. On 8/20/14 at 10:42 a.m., the DoN was notified of the loose side rail. The DoN indicated the side rail should not be loose and it would be fixed immediately. 3.1-45(a)(1)		all the center side rails five times weekly for four weeks then weekly thereafter on an ongoing basis and make repairs or adjustments as needed with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination Identified trends will be reported monthly by the maintenance director to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	
F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for nutrition, in the sample of 5 who met the criteria, was	F000325	F325 Resident #12 was weighed on 8/25/14 and 9/2/14 and her weight is up to 101.6 pounds. Resident #12's food preferences were updated, an enhanced food program was offered, her care	09/24/2014

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	provided services to maintain body weight, in that, recommendations were made for supplement and frequent weight monitoring and they were not followed. (Resident #12) Finding includes: Resident #12's clinical record was initially reviewed on 8/19/14 at 10:45 a.m. The resident's weights were as follows: 8/8/14, 103 pounds, 7/7/14, 116 pounds, 5/9/14, 116 pounds, and 3/26/14, 116 pounds. Further review of the clinical record, on 8/25/14 at 9:29 a.m., indicated the resident's diagnoses included, but were not limited to, history of stasis ulcers, hyperlipidemia, anxiety disorder, osteoporosis, hypertension, arthritis, depressive disorder, cognitive disorder, gastroesophogeal reflux disease, coronary artery disease, and peripheral vascular disease. Diet orders were for a regular diet with fortified foods. The resident had an order for a house supplement 60 milliliters twice daily with medications. A daily clinical review note, dated 8/14/14, indicated they were reviewing the resident for "Wt. [weight] loss of 12.5 lbs [pounds] in 30 days 10% [percent] in 30 days. Resident best consumption is @ [at] breakfast and on average consumes <		plan was updated and the nutritional supplement is served on her breakfast tray each morning. Resident #12 is also receiving an additional milkshake daily. Residents have been reviewed and appropriate interventions are in place. Other residents on weekly weights have been weighed appropriately. Nursing staff have been retrained on the center policy for weight loss interventions, documenting supplements and obtaining weekly weights. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. The Interdisciplinary team will review residents with weight loss weekly until the weight is stable and monthly thereafter on an ongoing basis to ensure all interventions are being carried out and weekly weights are obtained with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified trends will be reported by the Director of Nursing monthly to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	[less than] 50% of supper. Resident did have multiple UTIs [urinary tract infections] and infection of grt [great] toe over last 2 months...Has been reviewed by RD [Registered Dietitian] and will receive supplement with breakfast and continue fortified foods. Will weigh wkly [weekly] to monitor." A note from the Registered Dietitian, dated 8/12/14, indicated the following: "Current wt 103.5 down 10.77% over the last 30 days. Res had fall et when sent to ER [emergency room] was dx [diagnosed] with UTI. Recent orders for omeprazole [to reduce stomach acid] r/t [related to] GERD [gastroesophogeal reflux disease]. Receives regular diet with fortified foods et offered 60 ml [milliliter] BID [twice daily] with meds [supplement]. Intake at meals avg 66%. Send supplement with breakfast. Wkly weights." The resident's care plan for nutrition, dated 4/4/14, reviewed 8/14/14, indicated the resident consumed less than 75% of meals, was on a regular diet, received vitamins as ordered, fortified foods, weights to be monitored weekly (8/14/14), and labs monitored." Receipt of the med pass supplement twice daily was documented in the			

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	Medication Administration Record (MAR). There was no documentation on the MAR of the resident receiving a supplement at breakfast. On 8/25/14 at 11:00 a.m., the Willows Unit Manager was asked about the weekly weights for the resident, since the last documented weight was 8/7/14. At 11:43 a.m. on 8/25/14, the Willow Unit Manager indicated the weekly weights had not been done and they had just then weighed the resident and her weight was currently 96 pounds. On 8/25/14 3:36 p.m., the Dietary Service Manager (DSM) provided resident's tray cards for all three meals. Instructions on the tray cards indicated enhanced food for breakfast, enhanced pudding for lunch and supper. Nothing indicated the resident received a supplement with breakfast. The DSM indicated, at that time, the supplement would come from nursing, so they could document it on their forms. During the stage 1 interview of Resident #12, on 8/18/14 at 11:20 a.m., she indicated she did not like the food. On 8/26/14 at 8:45 a.m., the resident was observed in bed with her breakfast tray. The resident indicated the food was "so-so" for breakfast. No supplement			

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	was observed served with the breakfast. The policy and procedure for "Weight Loss - Interventions," dated July, 2004, revised July, 2010, was provided by the Director of Nurses on 8/26/14 at 4:15 p.m. The policy and procedure included, but was not limited to, the following: "Food Preferences." "Review food preferences with resident to obtain new food preferences..." "Update care plan." "Enhanced Food Program." "Utilize enhanced food program/fortified foods program." "Provide fortified foods including: super cereal, super spuds, super pudding." "Update care plan." "Nutritional Supplements." "Utilize Nutritional Supplements if food interventions are unsuccessful." "Update care plan." 3.1-46(a)(1)			
F000363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F000363	F 363 None of the residents identified in the alleged deficient	09/24/2014

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	Based on observation, interview, and record review, the facility failed to ensure menus were followed for puree and ground meat diets, in that, serving sizes for pureed meat and ground meat were incorrect according to the recipes. This affected 3 residents who received pureed food and 12 residents who received ground meat. (Resident #2, Resident #18, Resident #59, Resident #1, Resident #54, Resident #52, Resident #56, Resident #17, Resident #97, Resident #79, Resident #111, Resident #24, Resident #28, Resident #36, Resident #44) Findings include: 1. During an observation on 8/25/14 at 12:00 p.m., Cook #1 was observed to puree meatballs for the lunch meal. Cook #1 indicated the facility had 3 residents (#2,18, 59) who required pureed meat but she prepared enough pureed meat for 10 servings. 2. During an observation on 8/25/14 at 12:45 p.m., Cook #1 was observed to be serving pureed meat and ground meat for lunch using a blue handled scoop. Cook #1 was observed to place 1 scoop of meat for each resident receiving either pureed meat or ground meat. Residents receiving ground meat		practice were negatively impacted. Residents on ground/pureed meat were identified in the alleged deficiency. The cooks have been retrained on following the menus and the appropriate scoop and portion sizes for pureed and ground meat. The dietary manager or assistant dietary manager will observe three meals per day (breakfast, lunch and supper) times 14 days then once daily five days per week times three months then weekly thereafter on an ongoing basis to ensure continued compliance with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. . Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination Identified trends will be reported by the Dietary Services Manager monthly to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	Resident # 1, 54, 52,56, 17, 97, 79, 111, 24, 28, 36, 44. 3. During an interview on 8/25/14 at 1:08 p.m., the DM (Dietary Manager) indicated the scoops either served 2 or 3 ounces. 4. During an interview on 8/26/14 at 11:30 a.m., the DM indicated the blue handle scoop was a #16. The blue handled scoop served 2 ounces. 5. During an interview on 8/27/14 at 8:40 a.m., the DM indicated 4 (four) ounces of meat should have given to the residents instead of 2 ounces. 6. During a review of the recipe for Swedish Meatballs, the recipe indicated the resident was to receive 4 ounces of ground meat. The pureed recipe for Swedish Meatballs indicated the resident was to receive 4 ounces of pureed meat. 3.1-20(i)(4)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			

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	Based on observation, interview, and record review, the facility failed to ensure the kitchen and kitchen equipment were clean, food was prepared and served under sanitary conditions, in that the kitchen floor was soiled and sticky, the storage room floor was soiled and sticky, the walk-in freezer had ice build-up around the door and in the freezer, foods were open with no dates on them, and handwashing was not done adequately by kitchen staff. This had the potential to affect 71 of 71 residents who resided in the facility. Findings include: During the initial tour of the kitchen on 8/18/14 at 9:00 a.m., the following were observed: 1. Hot dog buns were open on the shelf with no date on them. 2. A box of plastic spoons and a box of plastic knives were opened in the dry storage room. 3. The shelving unit in the dry storage unit had rust on it. 4. A bag of dried macaroni was opened with no date on it.	F000371	F371 The hot dog buns have been removed. Plastic spoons and knives are stored appropriately in the pantry. The shelving unit has been cleaned. The macaroni was disposed of. The floor in the dry storage room has been cleaned and repaired. The kitchen floor has been pressure washed. The frozen pork chops have been disposed of. The bag of chicken pieces has been disposed of. The walk in freezer has been defrosted and repaired. The scoops for the flour and the thickener have been stored properly. The ice maker has been cleaned and repaired. The fronts of the utensil drawers have been cleaned. The food processor has been cleaned. The hall serving cart has been cleaned. A full nutrition services sanitation audit was completed by the center dietitian to ensure all areas were inspected. Dietary staff have been retrained on the center policy on sanitation and cleaning. The maintenance supervisor has been retrained on the center policy for entering the kitchen. Signs have been placed noting the policy that no one can enter the kitchen without proper hair coverings to both the head and facial hair. Staff have been retrained on proper hand washing. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to	09/24/2014

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	5. The dry storage room floor was soiled and sticky and had cracked tiles. 6. The kitchen floor was soiled and sticky. 7. A bag of frozen pork chops was opened with no date on them in the walk-in freezer. 8. A bag of frozen chicken pieces was opened with no date on them in the walk-in freezer. 9. The walk-in freezer had ice build-up around the door and ice build-up in the freezer. 10. A scoop was observed lying in the flour bin. 11. A scoop was observed lying in the thickener bin. During an observation on 8/25/14 at 10:15 a.m., the following were observed: 12. The kitchen and storage room floors were soiled and sticky. 13. Ice build-up was observed inside the walk-in freezer by the handle.		and including termination. The administrator or designee will complete a sanitation audit five times weekly for one month then weekly on an ongoing basis to ensure continued compliance with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified trends will be reported monthly by the Administrator or Dietary Services Manager to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	14. The side of the ice maker had brown spots on it and the seal inside of the ice maker was loose. 15. The front of the utensil drawers had brown spots on them. 16. During an observation on 8/25/14 at 11:15 a.m., Cook #1 was observed to be pureeing foods. Cook #1 was observed to wash her hands for 10 (ten)seconds between preparing the pureed peas and pureed buttered noodles. Cook #1 was observed to wash the food processor prior to washing her hands. 17. During an observation on 8/25/14 at 11:26 a.m., the Maintenance Manager was observed to enter the kitchen area along with a Contracted Worker to check the smoke detectors. The Maintenance Manager and the Contracted Worker were observed to have facial hair but did not have their facial hair covered. The Maintenance Manager and the Contracted Worker walked next to the food preparation table. Upon query to the DM regarding facial hair covering, the DM indicated facial hair is to be covered when anyone is in the kitchen. The DM then obtained the workers a cover for their facial hair which they applied. The Contracted Worker obtained a small step ladder and placed it in front of an open			

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	hall serving cart which was used to deliver trays on the hall. A cart containing eating utensils and cloth napkins was sitting aside of the hall serving cart. The Contracted Worked stepped onto the step ladder, placed a box on top of the opened hall serving cart, and removed a smoke detector from the ceiling which was directly over the serving cart. The DM moved the utensil cart away from the area after the Contracted Worker started to work on the old smoke detector. The Contracted Worker removed the smoke detector, handed it to the Maintenance Manager, and stated, "See how dirty this one is." The Contracted Worker then opened the box, removed a new smoke detector, and replaced the smoke detector above the hall serving cart. After stepping off of the ladder, the Maintenance Manager moved the step ladder to the side of the opened hall serving cart, obtained a cloth from the sanitizing bucket, and wiped the top of the hall serving cart. No hand hygiene was performed by either the Maintenance Manager or the Contracted Worker.. 18. During an observation on 8/25/14 at 12:20 p.m., the DM (Dietary Manager) was observed to wash her hands for 10 seconds prior to assisting with serving trays.			

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	19. During an observation on 8/25/14 at 12:43 p.m., Cook #1 was observed to carry pans of pureed foods from the steamer to the steam table with insulated gloves on. Cook #1 had her gloved thumbs inside of the pans almost touching the pureed foods. 20. During an observation on 8/25/14 at 12:50 p.m., Cook #1 was observed to be serving food onto plates and grabbing her leg. Cook #1 indicated her left leg was hurting. 21. During an interview on 8/18/14 at 9:17 a.m., the DM indicated opened food is to be sealed and dated. The DM indicated the ice build-up is probably from the seal being bad and it was replaced a couple of years ago. 22. During an interview on 8/26/14 at 11:39 a.m., the DM indicated the maintenance workers should have covered their facial hair. 23. During an interview with the DM on 8/27/14 at 8:40 a.m., the DM indicated hands should be washed while singing, "Happy Birthday" through twice. The DM indicated the floor was mopped twice a day and it had been totally cleaned by the housekeeping department			

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	recently. 24. During an interview on 8/27/14 at 10:00 a.m., the DM indicated she did not have any documentation which indicated the kitchen was being cleaned. 25. A policy titled, "Cleaning and Sanitizing," dated October, 2013, and obtained from the DoN (Director of Nursing) on 8/26/14, indicated the walls, floors, ceilings, equipment, and utensils are clean, sanitized, and in good working order. The policy further indicated the staff is to complete the "Nutrition Services Cleaning Schedule." The policy indicated the cleaning schedule is to be accessible to all employees. The "Nutrition Services Cleaning Schedule" indicated the dietary floor and the dish room floors were to be cleaned twice a day, the ice machine monthly, the shelving and drawers every 2 (two) weeks. The policy indicated only nutrition services employees were allowed into the kitchen unless wearing appropriate hair restraint. 3.1-21(i)(2) 3.1-21(i)(3)			
F000387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at			

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	least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on record review and interview, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days and at least every 60 days after that, for 4 of 35 stage 1 sample residents, in that visits were less frequent than required. (Residents #1, #105, #53, #89) Findings include: 1. Resident #1's clinical record was reviewed on 8/19/14 at 11:10 a.m. The resident was a long term resident of the facility. The recapitulations of physician's orders for May through August, 2014 were not signed by the resident's physician. The last documented progress note, indicating the last visit from the physician, was dated 1/2/14. The Willows Unit Manager indicated, at that time, the resident's doctor would not come in to see patients like he was supposed to. 2. Resident #105's clinical record was reviewed on 8/19/14 at 2:02 p.m. The	F000387	F387 Residents #1, 105, 53, 89 have been seen by a physician. Resident charts have been reviewed and residents have been seen by physicians per Federal guidelines. The medical director contacted the two physicians that were late and obtained commitments verbally and notified them also by letter of their obligation to see their patients. The medical records clerk has established a tracking system to notify physicians of impending visits and to notify the medical director to cover if they fail to visit. The Administrator will review the schedule of visits weekly times 6 months to ensure continued compliance with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Identified trends will be reported monthly by the Administrator to the center Quality Assurance and Performance Improvement	09/24/2014

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	record lacked any progress notes from the resident's physician. The resident was admitted to the facility 4/19/14 and there was no indication he had been seen by his attending physician since admission. 3. Resident #53's clinical record was reviewed on 8/19/14 at 2:38 p.m. She was admitted to the facility on 1/15/14. The resident had recapitulations of physician's orders for May through August, 2014 that were not signed by the physician. There were no progress notes in the current record to indicate the resident had been seen by her physician. The Willows Unit Manager indicated, on 8/19/14 at 11:10 a.m., they had a couple doctors who did not visit like they were supposed to. 4. The clinical record for Resident #89 was reviewed on 8/20/14 at 1:50 p.m. The clinical record indicated Resident #89 was admitted on 11/1/13. Resident #89 had diagnoses including, but not limited to, diabetes, anemia, atrial fibrillation, anxiety, right kidney transplant, left arm fistula, COPD (chronic obstructive pulmonary disease), hypertension, prostate cancer, CAD (coronary artery disease), right rotator cuff syndrome, dementia, and leukocytosis.		Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	No documentation was located in the clinical record which indicated Resident #89 had been visited by the physician. During an interview on 8/26/14 at 11:55 a.m., the DoN (Director of Nursing) indicated the facility knew they had a problem with Resident #89's physician seeing his clients in the facility. The DoN indicated the physician had been notified regarding the issue. 5. The Director of Nurses provided the policy and procedure for physician visits, dated July, 1999, revised January, 2007, on 8/26/14 at 4:15 p.m. The policy indicated the physician would visit the resident once every 30 days for the first 90 days after admission and once every 60 days thereafter. 3.1-22(d)(1)			
F000441 SS=E	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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents			

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	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. Based on observation, interview and record review, the facility failed to ensure infection control procedures were followed in 4 of 5 residents observed receiving care, in that, hand hygiene measures and glove changes were not followed. (Resident #19, Resident #52, Resident #33, Resident #114) Findings include: 1. During an observation on 8/18/14 at	F000441	F441 Residents # 19, 52, 33, 114 were not negatively impacted by the alleged deficiency. Residents have the potential to be impacted by the alleged deficient practice. Center staff have been retrained on the center policy for hand washing to include when to wash and how to wash effectively. Center staff have been retrained on appropriate use of gloves. The ADON and Unit Manager or designee will observe 2 staff per shift on all shifts daily five times per week times two weeks then 1 staff per shift on all shifts daily	09/24/2014

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	11:55 a.m., RN #1 was observed to perform a blood glucose on Resident #19. RN #1 was observed to apply gloves prior to obtaining the blood sample. After completing the test, RN #1 was observed to remove her gloves and clean the glucometer. RN #1 proceeded to move the medication cart and administer a medication to another resident. No hand hygiene was performed prior to or after the procedure. During an interview on 8/27/14 at 8:45 a.m., RN #3 indicated hands should be washed prior to and after performing a treatment. 2. On 8/20/14 at 1:30 p.m., Resident #52's right arm skin tear was observed with LPN #1. LPN #1 entered the room and applied gloves. No hand hygiene was observed to be performed. LPN #1 removed the tubigrip stocking from the resident's arm and then removed the non-adherent telfa dressing. A zigzag-like healing skin tear was revealed with a few areas observed to still have scab like areas. LPN #1 placed the soiled telfa dressing back over the skin tear and placed the tubigrip over the telfa dressing. LPN #1 was observed to remove gloves and perform hand hygiene.		times 6 months to ensure proper hand washing is occurring with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. . Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. Identified trends will be reported by the Assistant Director of Nursing monthly to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	3. On 8/25/14 at 10:51 a.m., CNA #1 and CNA #2 were observed to assist Resident #33 to the commode. CNA #1 and CNA #2 performed hand hygiene at the sink in the shower room. A wet washcloth was observed to be lying in the sink. CNA #1 was observed to apply gloves and clean the toilet. CNA #1 was observed to remove gloves and apply new gloves. No hand hygiene was observed between glove changes. CNA #2 was observed to apply gloves. Resident #33 was observed to be assisted to transfer by the sit to stand lift to the commode. CNA #2 was observed to remove a soiled brief and placed it in a plastic bag. CNA #2 was observed to change gloves and assisted Resident #33 the remaining way to sit on the commode. No hand hygiene was observed between glove changes. CNA #1 was observed to place the plastic bag in the trash, removed her gloves, and performed hand hygiene. CNA #2 was observed to remove gloves and perform hand hygiene. CNA #1 was observed to leave the shower room to obtain a clean brief. CNA #1 returned to the shower room and performed hand hygiene for 9 seconds. CNA #1 was observed to exit the shower room for supplies and returned to the shower room. CNA #1 was observed to perform hand hygiene for 6 seconds. CNA #1 and CNA #2			

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	were observed to apply gloves. CNA #1 was observed to assist Resident #33 to stand. CNA #2 was observed to cleanse and dry Resident #33's bottom area. No hand hygiene or glove change was observed to occur. CNA #1 and CNA #2 were observed to apply a clean brief and assist the resident to pull up the resident's pants. No catheter care was observed to be completed. CNA #1 and CNA #2 assisted the resident via the sit to stand lift back to the wheelchair. CNA #1 emptied Resident #33's catheter bag. CNA #2 was observed to provide toilet paper for CNA #1 to catch the remaining urine from the catheter bag spout. CNA #2 was then observed to remove gloves and perform hand hygiene. CNA #1 was observed to clean the toilet and then remove gloves and perform hand hygiene.			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe, functional, sanitary, and comfortable environment was provided for the residents, staff and the public, for 18 of 30 resident rooms observed during stage 1 of the survey, in	F000465	F465 Room 120's bathroom has been stripped and waxed. The plastic strip has been repaired. The non skid strips have been removed. The ceiling has been repaired. Room 126's bathroom has been stripped and waxed. The plastic strip has been cleaned near the	09/24/2014

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	that, floors were soiled, walls were marred or had peeling paint/wallpaper, ceilings were peeling, and bathrooms were soiled. (Rooms 120, 126, 133, 137, 140, 153, 174, 179, 186, 188, 190, 192, 193, 196, 198, 206, 209, 212) Findings include: 1. Room 120 was observed on 8/19/14 at 10:24 a.m. The bathroom floor was soiled with a build-up of soil, especially in the corners and edges and around the toilet. A plastic white strip along the floor by the shower was loose with accumulated dirt around it. Non-skid strips on the floor by the bed had large sections missing. The room was observed again on 8/26/14 at 8:30 a.m. The observations remained the same. Also noted was the ceiling was peeling/loose in one of the corners. 2. Room 126 was observed on 8/18/14 at 11:42 a.m. The bathroom floor was soiled in the corners, edges, and the threshold, with a build-up of gray soil/stain. The room floor at the threshold of the door was soiled with a build-up of gray. The room was again observed on 8/26/14 at 8:37 a.m. A plastic strip along the floor in front of the shower was soiled with accumulated dirt along the edge. The bathroom floor		shower. The faucet has been delimed and cleaned. The heat vent has been cleaned and painted. The bathroom in 133 has been replaced. The toilet has been cleaned. The floor in bathroom 137 has been stripped and waxed. The bathroom in 140 has been cleaned and the floor stripped and waxed. The shower has been cleaned. The room floor and the bathroom floor have been stripped and waxed. Room 174's floor has been stripped and waxed. The ceiling has been repaired and the caulking has been replaced around the toilet. The bedside cabinet has been replaced. The toilet seat extender has been removed. Room 179 has been stripped and waxed. Room 186 bathroom floor has been stripped and waxed. The bedpan and urine collector have been replaced and properly labeled. The bathroom in 188 has been stripped and waxed. The edging has been cleaned. The toilet lid has been cleaned. The bedpans have been replaced and properly labeled. Room 190 floor has been cleaned. The caulking around the air conditioner and the toilet has been replaced. The urinal has been replaced and properly labeled. The portable oxygen device has been uprighted and cleaned. The corner/wall has been repaired to the right of the sink. The bathroom floor in rom 193 has been stripped and	

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	continued to be soiled/stained in the corners and edges. The faucet had a greenish lime build-up. The heat vent in the bathroom was soiled/rusty. 3. Room 133 was observed on 8/18/14 at 11:12 a.m. The bathroom floor was stained and soiled with dirt and debris. The toilet was grossly soiled with brown fecal matter. The threshold to the bathroom door had torn vinyl with some vinyl missing and accumulated soil around the missing vinyl. The room was again observed on 8/26/14 at 8:43 a.m. and was the same. 4. Room 137 was observed on 8/18/14 at 2:53 p.m. The bathroom floor was soiled in the edges, corners and threshold with a build-up of dirt/soil. When observed on 8/26/14 at 8:48 a.m., it was the same. 5. Room 140 was observed on 8/18/14 at 3:08 p.m. There was a strong urine odor in the room and bathroom. The shower was soiled with removable soap/shampoo residue and stained. The bathroom floor was soiled in the corners and edges. There was a blue stain in front of the toilet. A soiled towel was on the floor around the base of the toilet. The room was observed again on 8/26/14 at 8:51 a.m. and appeared the same.		waxed. The cove base has been cleaned. The wall around the soap dispenser has been repaired. The cove base behind the door has been secured. The wallpaper in 193 has been secured. The caulking in the bathroom has been replaced. The grab bars around the toilet have been secured. The cove in room 196 has been secured. The stain around the toilet has been cleaned. The washbasin has been replaced. Room 198 has been stripped and waxed as well as the bathroom floor. The caulk around the sink and toilet has been replaced. The bedpan has been replaced and properly stored and identified. The toilet in 206 has been repaired. The floor tile has been repaired and cleaned. The bathroom floor has been stripped and waxed. Room 209 bathroom floor has been stripped and waxed. The heat vent has been repaired. The toilet has been cleaned. The caulking has been replaced. Room 212 floor and the bathroom floor have been stripped and waxed. The ceiling has been repaired. The maintenance director and the administrator made rounds throughout the center to ensure any similar issues were identified and corrected. Facility maintenance staff has been retrained on the facility policy for maintaining caulking,	

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	6. Room 153 was observed on 8/19/14 at 3:19 p.m. The room floor was soiled in the corners and edges with dirt and debris. The bathroom floor threshold had space between the tile with accumulated soil. The bathroom floor around the toilet was soiled with dried on brown material. The room was observed again on 8/26/14 at 8:54 a.m. and appeared the same. 7. Room 174 was observed on 8/19/14 at 10:41 a.m. The floor was soiled, especially in corners and edges. The room was observed again on 8/26/14 at 9:00 a.m. The ceiling was peeling and loose in the corner. The caulking around the toilet was loose, soiled, and stained. The bedside cabinet had rough worn edges. The toilet seat extender legs had peeling paint and rust. 8. Room 179 was observed on 8/18/14 at 4:01 p.m. The floors were soiled in the corners and edges. The room was again observed on 8/26/14 at 9:04 a.m. and was the same. 9. Room 186 was observed on 8/18/14 at 4:24 p.m. The bathroom floor was soiled. Hand and body lotion was stored on the bathroom floor. Two bedpans and a urine collection "hat" were stored in plastic bags on the back of the		ceilings and general room maintenance. The centers housekeepers have been retrained on the center policy for cleaning resident rooms and how to report maintenance issues. The nursing staff have been retrained on proper storage and labeling of urinals and bedpans. A room maintenance and housekeeping checklist will be implemented to guide staff in identifying issues. The Nursing Home Administrator and the maintenance director will perform rounds weekly times 6 months and monthly thereafter to ensure continued compliance with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. . Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination. The maintenance director will report to the center Quality Assurance and Performance Improvement committee monthly for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	commode with no names on them. The room was observed again on 8/26/14 at 9:05 a.m. The bathroom floor continued to be soiled. 10. Room 188 was observed on 8/18/14 at 11:43 a.m. The bathroom floor was soiled. The edging around the bathroom was soiled. There was a blue stain on the lid of the toilet. There were two bedpans on the back of the toilet with no identifiers in a shared bathroom. The room was observed again on 8/26/14 at 9:08 a.m. The bathroom floor continued to be soiled. 11. Room 190 was observed on 8/18/14 at 2:27 p.m. The room floor was soiled. The caulking around the air conditioner was cracked. The caulking around the toilet was stained/soiled. A urinal was stored on the back of the toilet with no name, in a shared bathroom. A portable oxygen device was overturned on the floor in the room. The wall/corner to the right of the sink was marred and soiled. When the room was observed on 8/26/14 at 9:10 a.m., the wall/corner to the right of the sink continued to be marred and soiled. 12. Room 192 was observed on 8/18/14 at 2:58 p.m. The bathroom floor was soiled. The cove base was soiled. The			

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	wall board around the soap dispenser was torn. The room floor was soiled in the corners and around the cove base. The cove base was loose behind the room door. When observed again on 8/26/14 at 9:12 a.m., these areas remained the same. 13. Room 193 was observed on 8/18/14 at 3:19 p.m. The wallpaper was peeling off the wall under the window. The bathroom had soiled/stained caulking around the bath tub and toilet. The grab bars over the toilet were loose from the wall. When observed again on 8/26/14 at 9:15, these items remained the same. 14. Room 196 was observed on 8/19/14 at 2:39 p.m. The cove base was loose under the air conditioner. There was a brownish stain around the base of the toilet. On 8/26/14 at 9:17 a.m., the room was observed again and remained the same. There was also a grossly soiled wash basin in the floor in the room, with a brownish dried substance. 15. Room 198 was observed on 8/19/14 at 2:33 p.m. The caulking was cracked around the sink. The floor was soiled under the sink, along the edges and in the corners. The bathroom floor was soiled and the caulking was soiled/stained brown around the toilet. A bedpan was observed in a plastic bag with no name			

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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
	identifying who it belonged to. When observed again on 8/26/14 at 9:21 a.m., the bathroom floor continued to be soiled/stained, especially the corners/edges and under the sink and toilet. 16. Room 206 was observed on 8/19/14 at 11:19 a.m. The toilet water was running continuously. Floor tile to the left of the air conditioner along the wall was loose/missing with accumulated soil in the area. The wallpaper behind the bedside chair was missing a large piece. The bathroom floor had a build-up of gray/brown soil along the edges and around the toilet. When checked again on 8/26/14 at 9:23 a.m., the toilet was not running, though the tile was the same, the wallpaper was the same, and the bathroom floor continued to be soiled. 17. Room 209 was observed on 8/18/14 at 11:22 a.m. The bathroom floor was soiled. An old heat vent was uncovered and rusty. The toilet was soiled. The caulking around the toilet was soiled and stained brown. On 8/26/14 at 9:28 a.m., the caulking around the toilet had been replaced. The bathroom floor continued to be soiled/stained. 18. Room 212 was observed on 8/18/14 at 11:26 a.m. The bathroom floor around			

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	the base of the toilet was soiled and stained. The room floor was soiled in the corners and edges. The room was observed again on 8/26/14 at 9:29 a.m. The edges and corners of the room and bathroom floors were soiled/stained. The bathroom floor around the base of the toilet was soiled/stained. The ceiling was peeling. 3.1-19(f)			
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review, and interview, the facility failed to ensure that documentation was complete and accurate in 1 of 9 residents observed receiving medications. in that, a medication was not documented as being administered for a resident. (Resident	F000514	F514 Resident #111 suffered no ill effect from the alleged documentation error. Medication administration records have been reviewed and no other residents were impacted. Licensed nurses have been retrained on the center policy for medication documentation. The Assistant Director of Nursing and the Unit Manager will review the	09/24/2014

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	#111) Findings include: On 8/20/14 at 11:59 a.m., RN #1 was observed to administer one tablet of Norco 5/325 mg (milligrams) (a narcotic pain medication), to Resident # 111, by mouth, for pain, as requested by Resident #111. On 8/20/14 at 1:30 p.m., the Resident #111's clinical record was reviewed. The resident's diagnoses included, but were not limited to, right breast cancer, cellulitis right side chest wall, diabetes, and asthma. The resident had physician's orders, dated 8/1/14, including, but not limited to, the following medication: Norco 5/325 mg every 6 hours for pain PRN (as needed). The Controlled Substance Record book was reviewed at that time for the Norco 5/325 mg and included, but was not limited to, the following entries of when the medication had been administered: 8/20/14 0830 (8:30 a.m.) 8/20/14 1400 (2:00 p.m.) On 8/20/14 at 1:50 p.m., RN #1 was queried about the Norco given at 11:59 a.m., but was signed out as given at 2:00 p.m. She was also queried as to why a		medication administration records and observe medication administration for five residents daily five times per week times 4 weeks then three times per week for four weeks, weekly thereafter on an ongoing basis to ensure continued compliance with results presented to Quality Assurance and Performance Improvement monthly for review and recommendations. Medication administration observation will occur on all three shifts for the monitoring period.Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination Identified trends will be reported by the Assistant Director of Nursing monthly to the center Quality Assurance and Performance Improvement Committee for review and recommendations. The systemic changes will be completed by 9/24/14.	

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	dose was given at 11:59 a.m. when a prior dose was documented as being given at 8:30 a.m. RN #1 indicated she may have given the Norco at 7:00 a.m. instead of 8:30 a.m.; she would have to check. When RN #1 was queried if there was a routine Norco order she stated, "no, just PRN." On 8/20/14 at 1:45 p.m., the PRN Analgesic Record was reviewed. No Norco 5/325 mg had been documented as given since 8/18/14 at 16:12 p.m (4:12 p.m.). The DoN asked, at that time, if RN #1 could have until the end of the shift to chart her medications. 3.1-50(a)(2)			