STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER BLAIR RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 269 MEADOWVIEW DR PERU, IN 46970	

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 22, 23, 24, 25, 26 and 29, 2014. Facility number: 012565 Provider number: 155791 AIM number: 201021970 Survey Team: Lora Swanson, RN-TC Deb Kammeyer, RN Tim Long, RN (September 24 and 25, 2014) Julie Wagoner, RN Census bed type: SNF: 32 SNF/NF: 19 Residential: 19 Total: 70 Census payor type: Medicare: 21 Medicaid: 13 Other: 17 Total: 51 Residential Sample: 7 These deficiencies reflect State findings	F000000	**F000** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on September 29, 2014. Please accept this Plan of Correction as the provider's credible allegation of compliance. **The provider respectfully <u>requests a desk review</u> with paper compliance to be considered in establishing that the provider is in substantial compliance.**	

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 16.2-3.1. Quality Review completed on October 7, 2014, by Brenda Meredith,R.N.			
F000247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to properly notify a resident of a roommate change. This affected 1 of 3 residents reviewed for admission, discharge and transfer information. (Resident #122) Finding includes: On 9/25/14 at 2:00 P.M., Resident #122's clinical record was reviewed. The diagnoses included, but were not limited to, "...Stage IV cancer, colon and brain cancer, muscular dystrophy, anxiety and depression...." The admission MDS (Minimum Data Set) assessment, completed on 9/16/14, indicated the resident had a BIMS (Brief	F000247	**F 247 (D) What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident #122 is no longer residing at Blair Ridge. Resident #122 was verbally informed by the Executive Director with the Assistant Director of Health Services at the time of her roommates arrival. This was not documented in advance as the facility was not informed of her pending transfer until she was coming through the door into the campus and they were calling report to the receiving nurse. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Residents residing in companion	10/29/2014

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	Interview for Mental Status) score of 15/15 which indicated the resident has normal cognition. During an interview on 9/23/14 at 9:10 A.M., Resident #122 indicated she remembered having a new roommate since her admission and did not recall being told before the roommate came. The resident further indicated she just remembered personal items being brought into the room and placed in the bed opposite of her. During an interview on 9/25/14 at 1:55 P.M., the SSD (Social Service Director) indicated as soon as she knew a resident would be getting a roommate she lets the resident or family member know and then writes a note in the chart under social services. The SSD further indicated when Resident #122 was admitted there was already a resident in the room. On 9/19/14, the SSD indicated Resident #122 did receive a new roommate and indicated she was sure that she had documented the notification in her notes on the chart. The SSD obtained the residents chart and indicated she could not find any documentation that she had told the resident of the new roommate. During an interview on 9/25/14 at 3:15 P.M., the Administrator indicated he		rooms are potentially affected by the alleged deficient practice. The SS Director audited all existing notices to residents in companion rooms and will ensure that all residents in companion rooms are properly notifed verbally or in writing of roommate changes. A new Notice form has been developed to help with documention of this notice to residents and will be inserviced with the management team and nursing leadership. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** The Medical Records Supervisor (or designee) will audit weekly x 4 weeks, then monthly x 5 months all roommate changes to ensure proper notification is done and documented. This report will be made to the QAA committee monthly. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Results of the audits will be reported to the facility QAA committee monthly by the Medical Records Supervisor. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	

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	remembered this situation and the facility was unsure that they would receive the new resident until the last minute due to the new residents failing health. The Administrator indicated as soon as he saw the new resident in the hallway he entered Resident #122's room and told her of the new roommate. The Administrator further indicated he did not document the notification anywhere. On 9/25/14 at 3:20 P.M., review of the current policy titled, "You have the right to be notified of a change in your room assignment or roommate," received from the Administrator, indicated "...1. The facility will provide you and your representative (sponsor) with an advance notice of a change in your room assignment or when there will be a change in your roommate. 2. The notice may be oral or in writing, or both, and will include the reason(s) for the room or roommate change...." 3.1-3(v)(2)			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or			

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	changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview, and record review, the facility failed to ensure 1 of 7 sampled residents reviewed for accidents had an updated careplan following a fall. (Resident #1) Finding includes: On 9-25-14 at 11:00 A.M., a review of the clinical record for Resident #1 was conducted. The record indicated the resident was admitted on 8-9-14. The resident's diagnoses included, but were no limited to: altered mental status, weakness, dementia, anxiety, depressive disorder, anemia, and hypertension. Resident #1's careplan, dated 8-9-14, indicated the resident was at risk for falls related to medications and a history of falls. The interventions included but were not limited to: bed at appropriate level for	F000280	**F 280 (D)** **What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** The care plan for Resident #1 has been updated to reflect all current fall interventions that are in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents at risk for falls are potetially affected by the	10/29/2014

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	body height, keep call light and frequently use items within reach, ensure environment was well lighted and pathways were clear of clutter. A careplan conference, dated 8-27-14, indicated the resident was experiencing fatigue and weakness. The resident was using a walker/wheelchair for ambulation with the assistance of one person. The resident was experiencing cellulitis and pain to the left lower leg. The physical device for safety was enabler bars x (times) 2 on the bed. The form titled, "Fall Circumstance, Assessment and Intervention," dated 9-6-14, indicated the resident at 19:55 (7:55 P.M.) was found on the floor beside her bed. The resident had no injuries. The new interventions included non skid socks, adequate lighting, call light, low bed, clear clutter, bed and/or chair alarm and toilet resident every 2 hours. IDT (Interdisciplinary Team) reviewed the fall incident report and requested a bed alarm. The IDT concluded the root cause of fall was "...standing up by self...." During an interview on 9-26-14 at 10:10 A.M., RN #21 indicated the resident had a bed alarm and it was implemented after her fall.		alleged deficient practice. Residents who are at risk for falls have had their care plans reviewed / revised as deemed necessary to include appropriate interventions in place. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** 1) Nursing staff will be inserviced regarding fall prevention and ensuring that interventions planned are in place; 2) Nursing leadership team will review the 24 hour report, circumstance forms, incident reports and telephone orders in the daily clinical meeting 5 days per week ongoing - to ensure the care plans have been initiated and/or updated as necessary through assessment of falls and interventions. The Daily Clinical Report will be completed to document the	

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	On 9-26-14 at 10:15 A.M., an observation was made of the resident's bed and an alarm was underneath the fitted sheet. During an interview on 9-26-14 at 11:20 A.M., the DON (Director of Nursing) indicated during a facility fall incident review with the IDT team, she would expect all new interventions to be added to the resident's careplan to prevent another fall, at time of the review. She could not explain why the bed alarm intervention wasn't added to the careplan. On 9-26-14 at 12:05 P.M., a review of policy titled, "Interdisciplinary Team Care Plans Guidelines-I Care Plans," undated, indicated "Purpose: To ensure appropriateness of services and communication that will meet the resident's needs...Update as care needs change and set date to review at least quarterly...." 3.1-35(e)		review of the above stated forms/reports. Audits and/or observations related to falls and interventions will be conducted by the DHS or designee weekly X 4 weeks, then monthly x 5 months to ensure compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Results of the audits will be reported to the facility QAA committee monthly by the Director of Health Services. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR			

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	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 interviews, the facility failed to ensure 1 of 1 residents reviewed receiving Hospice services had documentation of those services in the facility. (Resident #63) Finding includes: Record review of the clinical record for Resident #63 was completed on 09/23/14 at 9:08 A.M. Resident #63 was admitted to the facility on 04/27/12, with diagnosis, including but not limited to, congestive heart failure, dementia, hypothyroidism, hypertension, dysarrhythmias, constipation, difficulty walking, and muscle weakness. The record indicated Resident #6 was receiving Hospice services. The orders for the Hospice services and/or the terminal diagnosis were not present in the clinical record. A Social Service note, dated 06/21/13, indicated the resident was to be evaluated by Hospice for services at that time.	F000309	F 309 (D) **What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident #63 Hospice chart has been audited and updated with the available Hospice documentation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents receiving hospice services are potentially affected by the alleged deficient practice; and all have been audited to ensure proper documentation is available on the chart.	10/29/2014

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	The Hospice chart was requested, on 09/23/14 at 9:10 A.M. At that time, the hospice diagnosis was documented in the chart, as congestive heart failure. The most recent nursing notes on the Hospice chart were dated 08/05/14, and there were no Hospice aide documentation in the chart even though they were to visit twice weekly. During an interview on 09/23/14 at 9:15 A.M., LPN #7 indicated she did not know exactly what care the Hospice aides performed for Resident #63. She indicated nursing staff did not document the care for the Hospice staff anywhere. She indicated she would call the Hospice agency and inquire about the missing documentation. On 09/23/14 at 2:00 P.M., LPN #7 indicated she had spoken with the Hospice nurse who informed her Hospice aides did not leave any documentation in the facility Hospice chart ever. The nurse indicated the Hospice nurses, whom had visited Resident #63 in August and September 2014, had the notes with them and would put the notes in the chart on the next visit. On 09/25/14 at 9:53 A.M., the Hospice chart was reviewed and there were faxed copies, dated as faxed on 09/23/14 at		**What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** 1) Licensed nursing staff have been educated regarding a communication binder put in place which includes a hospice/SNF visit and collaboration log. 2) Audits will be conducted by the DHS or designee weeky x 4 weeks; then monthly x 5 months to ensure that documentation from Hospice is recieved and placed in the chart. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Results of the audits will be reported to the facility QAA committee monthly by the Director of Health Services or designee. The results will be reveiwed and trended for	

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	9:44 A.M., of the Hospice nursing assessments and copies of the Hospice Aides biweekly "Task Sheets" from 08/05/14 - 09/16/14 for Resident #63. The Hospice aide worksheets indicated the Hospice aides usually gave Resident #63 a bed bath, performed personal hygiene and grooming tasks, and if applicable assisted to feed the resident. The Hospice aide worksheets indicated they routinely visit from around 5:00 A.M. - 7:00 A.M. in the mornings. During an interview on 09/29/14 at 10:10 A.M., RN #5 indicated if the Hospice aide was still at the facility when her shift started, they did check out with her and get a signature on their documentation. She indicated she was aware the Hospice aides usually gave the resident a bed bath when they visited She indicated the resident was usually accepting of the early morning time as long as they left her in bed for the whole visit. She indicated on rare occasions the resident was ready to get up and eat her breakfast but usually desired to be left in bed. RN #5 indicated the Hospice nurse usually visited later in the morning around 9:00 A.M. She was unsure of the day of the Hospice nurse's visits. RN #5 indicated the Hospice nurse always spoke with her and they reviewed the resident's medication use and supplies.		compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	

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	3.1-37(a)			
F000323 SS=E	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, record review and interviews, the facility failed to ensure hazardous hygiene items were not accessible for 15 of 15 residents on the memory care unit of 51 residents in the facility. Findings include: 1. During observation of resident rooms, conducted on 09/22/14 and 09/23/14, during the day, the following was noted: Room #507, observed on 09/23/14 at 2:31 P.M., had a tube of toothpaste and a can of shaving cream in a pink plastic bin on an open shelf in the bathroom Room 505, observed on 09/22/14 at 2:30 P.M., had a can of shaving cream, a tube of toothpaste, and a razor stored in a plastic bin on an open shelf in the bathroom Room 506, observed on 09/23/14 at 2:11 P.M., had a can of shaving cream stored	F000323	**F 323 (E)** **What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** All items were promptly removed and placed in safekeeping by nursing staff for all the residents identified in the observation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents residing on the dementia unit are potentially	10/29/2014

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	on an open shelf in the bathroom Room 510, observed on 09/22/14 at 2:28 P.M., had a tube of toothpaste, two containers of medicated fungal powder, and a full container of nail polish remover stored on a nightstand in the bathroom between the toilet and the sink Room 512, observed on 09/23/14 at 2:14 P.M., had a box of denture cleanser tablets, and a can of hairspray stored in a medicine wall cabinet next to the bathroom sink. The door to the cabinet was ajar and the denture cleanser tablets were visible and the hairspray was stored on top of the cabinet Room 509, observed on 09/23/14 at 10:50 A.M., had a tube of toothpaste and a can of hairspray and a can of hair mousse stored on an open shelf. 2. During an interview on 09/23/14 at 3:45 P.M., CNA #6 indicated she noticed when she came on the second shift a few of those type of items out in the bathrooms and she indicated she had removed the items she had found. She indicated those items were not to be left in resident bathrooms but "always seemed to end up there." She indicated one resident's family would leave razors out. She indicated there were 3 residents who ambulated independently and were confused on the unit.		affected by the alleged deficient practice. All rooms on Legacy Lane have a lockable drawer for safekeeping of personal care items that are potentially hazardous and have been secured there by the nursing staff. Drawer locks were all standardized for greater efficiency of nursing staff on 10/09/14. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** 1) Nursing staff have been re-inserviced on keeping hazardous items secured in a locked drawer. 2) Room audits will be conducted by the DHS or designee weekly x 4 weeks; then monthly x 5 months to ensure hazardous hygiene items are properly secured. Random visual audits will also be done to ensure all interventions are being	

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	3. During an environmental tour of the facility, conducted on 09/29/14 between 10:30 A.M. - 11:09 A.M., with the Housekeeping Supervisor, the Maintenance supervisor, and the Administrator, the following was noted on the secured dementia unit: Room 505 - hygiene tubs, stored on chest height open shelf had razors, shaving cream, and toothpaste Room 507 - hygiene tub open with shaving cream Room 508 - toothpaste in tub and an ant trap by the toilet. The housekeeping supervisor indicated the ant traps were to be "hidden" and not visible. Room 510 - medicated foot powder, shaving cream, and fingernail polish remover on a night stand in the bathroom Room 512- hairspray on top of a wall cabinet in the bathroom 4. The facility policy and procedure, provided by the Administrator, on 0929/14 at 11:50 P.M., titled "Items of Caution for Resident Living in Memory Care Neighborhoods," dated 11/11, included the following: "Please make sure team members are rounding daily to monitor the safe storage of these items. All items listed below must be stored in a safe manner in order to minimize the possibility that they might bring harm to our residents... "Potentially toxic toiletry		followed related to storage of hazardous personal care items. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Results of the audits will be reported to the facility QAA committee monthly by the Director of Health Services or designee. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	

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	items... Sharp objects - should be locked in a cabinet or drawer with a "sink" or cylinder lock verses padlock. Razors with blades....." The Administrator indicated the toiletry items noted should not have been left out on the memory care unit. 3.1-45(a)(1)			
F000327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observations, interviews and record review, the facility failed to ensure adequate hydration needs were met for 1 of 1 resident's reviewed for hydration. (Resident #43) Finding includes: On 9-23-14 at 9:52 A.M., Resident #43's lips were observed to be dry and cracked. Resident was observed breathing with her mouth open. No water pitcher was observed in the resident's room. On 9-24-14 at 2:06 P.M., Resident #43 was observed lying in bed, she was breathing thru her mouth and her lips appeared dry. When the resident was	F000327	**F 327 (D)** **What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident #43 no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the	10/29/2014

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	asked if her lips felt dry she licked her lips and replied "yes". No water pitcher was observed in the resident's room. The clinical record of Resident #43 was reviewed on 9-24-14 at 2:09 P.M. The resident's diagnoses included, but were not limited to: dysphagia, history of hip fracture, anorexia, weight loss, anemia and hypertension. A Physician's order, dated 8-26-14, indicated "...D/C [discontinue] current diet. Begin pureed diet w [with] honey thick liquids...." Medications included, but were not limited to: digoxin, carvedilol, enalapril maleate, lexapro, ferrex, remeron, oxybutynin (for urinary control), potassium and senokot (for constipation). Resident #43's careplans, no initiated date, indicated resident was on nectar thick liquids and needed encouragement/cueing to begin feeding herself and increase intakes. The resident's weights had been fluctuating and the careplan indicated staff was to observe intakes, provide substitutes,and offer extra fluids. Another careplan indicated the resident was at risk for constipation and skin alteration. The		alleged deficient practice. All nursing staff have been inserviced on offering extra fluids between meals and documenting fluid intake in the KIOSK. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** The nursing leadership team will review fluid intakes during the daily clinical care meeting (CCM) daily at least 5 x per week to ensure proper documentation is being recorded. This will be audited by the DHS or designee weekly X 4 weeks; then monthly x 5 months to ensure proper documentation of fluid intake is being recorded. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Results of the audits will be	

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	interventions included but were not limited to: staff to encourage resident to consume 75% of her foods and fluids and offer fluids between meals. A careplan for risk for dehydration was not included in the resident's careplans. A monthly nursing assessment, dated 9-21-14, indicated Resident #43 had difficulty swallowing and was on a pureed diet with honey thick liquids. The assessment further indicated a risk factor for dehydration had been identified. A form titled "Nutrition Assessment and Data Collection," dated 7-11-14, indicated the resident's estimated fluid needs were 1295 milliters/day. A form titled, "Meals and Fluids Detailed Report," indicated Resident #43 had the following total fluid intake during breakfast, lunch and supper on the following dates: 9-1-14 total fluid intake was 1140 9-2-14 total fluid intake was 960 9-3-14 total fluid intake was 880 9-4-14 total fluid intake was 1320 9-5-14 total fluid intake was 700 9-6-14 total fluid intake was 560 The form did not indicate the resident was receiving additional fluids between her meals.		reported to the facility QAA committee monthly by the Director of Health Services or designee. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	

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	A Speech Therapy Note, dated 9-2-14, indicated on 8-23-14, Resident #43 had onset of dysphagia. Goal: Resident to safely swallow sips of honey thick liquid using no compensatory strategies. Skilled Service provided since start of care included diet analysis and assessment of swallow function or tolerance of least restrictive and safest diet. Liquid consistencies allowing for the resident to achieve decreased signs and symptoms of aspiration. On 9-25-14 at 8:18 A.M., Resident #43 was observed eating her breakfast in the main dining area. The resident consumed a cup of coffee and glass (8 oz) of orange juice. Both were thickened. The resident was observed tipping the empty cup of coffee and juice glass several times to get more fluid, however no staff member offered to get her more to drink. During an interview, on 9-26-14 at 11:38 A.M., CNA #22 indicated Resident #43 did not have a pitcher in her room because the resident required thickened liquids. She further indicated the nurse provided extra fluids between meals for the resident with her medication passes. During an interview on, on 9-26-14 at 11:40 A.M., RN #21 indicated she did not record extra fluids on the Medication			

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	Record Administration for Resident #43. RN #21 further indicated the CNA's would provide extra fluids during their routine fill of water pitchers. 3.1-46(b)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interviews, the facility failed to ensure 2 of 5 residents reviewed for unnecessary medications (Residents #96 and 72) and 1 of 1 residents reviewed for behavior	F000329	**F 329 (D)** **What corrective actions will be accomplished for residents found to have been affected**	10/29/2014

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	and emotional declines (Resident # 24) had adequate indication to support the use of antipsychotic medication and/or adequate indications to support the increase in psychotropic medications. Findings include: 1. The clinical record for Resident #96 was reviewed on 09/25/14 at 2:37 P.M. Resident #96 was admitted to the facility on 04/14/14, with diagnosis, including but not limited to, dementia, Alzheimer dementia, hypertension, GERD, depression, overactive bladder, insomnia, osteoporosis, and history of cerebral vascular accidents. The admitting physician's orders, dated 04/14/14 indicated Resident #96 was admitted with orders for the antipsychotic, Risperdone .5 mg twice a day. The physician's orders for medications, dated as reviewed on 08/28/14, included the following medications: Risperdone 1 mg (milligram) twice a day for dementia with psychotic behaviors. A nursing note, dated 08/29/14 at 7:30 A.M.,indicated the resident had been up at night, yelling, anxious, restless, and wandering. The note indicated the		**by the deficient practice:** Residents #96, #72, #24 were reviewed by the nursing clinical leadership team for dosage reductions and documentation of appropriate follow-up and supporting diagnoses. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents records were reveiwed to ascertain those receiving psychactive medications; and those receiving such medications were reviewed to ensure adequate indications to support the continued use of the medication(s); and that adequate monitoring of medical symptoms are in place. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice**	

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	resident was given an antianxiety medication after all non-pharmalogical interventions had failed. A subsequent nursing note, dated 08/29/14 at 2:00 P.M., indicated the resident was still wandering, but was not anxious or yelling. A behavior documentation, in the Kiosk system (electronic documentation), dated 9/11/14 at 1:53 A.M., indicated the resident had demonstrated a "socially inappropriate" behavior and was redirected and given a diversional activity which was successful in altering the behavior. There were no further details on exactly what behavior the resident had been demonstrating at the time. A nurse's note, dated 09/12/14 at 11:30 A.M., indicated the physician was notified of the resident's increased trouble sleeping at night and increased behaviors during the day and a physician's order was received to increase the resident's Risperdal from .5 mg twice a day to 1 mg twice a day. During an interview on 09/29/14 at 1:30 P.M., the SSD (Social Service Director) indicated the nursing staff did not notify her before they faxed the physician to request medication changes. She shook her head "no" when asked if there was		**does not recur:** 1) The facility formed a committee to review psychotropic mediction use and to recommend possible GDR (Gradual Dose Reductions). These reviews will occurr at least quarterly. 2) All nursing staff were re-educated regarding behavior documentation and follow-up regarding interventions attempted. 3) Clinical leadership nurses will review daily (5 x week) in the Clincical Care Meeting the KIOSK widgets (behavior related) and appropriateness of interventions attempted. This will be audited weekly x 4 weeks, then monthly x 5 months; then randomly thereafter to ensure proper documentation and follow-up regarding interventions attempted. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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	anything more to support the increase in Resident #96's Risperdal. The SSD indicated the physician had been notified on 09/11/14 regarding the pharmacists recommendation to decrease the resident's Risperdone but the physician had not yet responded to the request. 2. The clinical record for Resident #72 was reviewed on 09/26/14 at 9:40 A.M. Resident #72 was admitted to the facility on 05/21/13, with diagnosis, including but not limited to, nonorganic psychosis, diabetes mellitus, encephalopathy, hypertension, atrial fibrillation, congestive heart failure, chronic airway obstruction, history of acute respiratory failure, irritable bowel syndrome, muscle weakness, history of breast malignancy, history of thrombosis/embolism, insomnia, dementia with associated behavioral symptoms and depression. A physician's order, dated 10/20/13, indicated the resident was started on Risperdone 0.25 milligrams once a day. A current physician's orders, dated on 08/28/14, included the following medication orders: Risperdal 0.25 mg one tablet q am and .5 mg one tablet in the evenings for dementia with delusions. Nursing notes, dated 10/01/13 - 10/19/13,		**assurance program will be put into place:** Results of the audits will be reported to the facility QAA committee monthly by the Director of Health Services or designee. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	

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	indicated the resident had demonstrated behaviors at a dental appointment and an order was received to give the resident an anxiety medication prior to any further dental appointments. In addition, a note, dated 10/17/13, indicated an order was received to perform a urinalysis test for Resident #72. On 10/18/13, an order was received for an antibiotic to treat a urinary tract infection. On 10/19/13, the resident was wandering into other resident's rooms and taking their items. She was also noted to go into another resident's bathroom and exit the bathroom wearing just a shirt and her incontinence brief. The resident would leave the other resident's rooms when redirected but would return to the same behavior. A 10/12/14 "new or worsening behavior notification" form, indicated on 10/12/13, the resident was wandering in and out of other resident's rooms and taking their items. This behavior was also noted on 10/17/13 and 10/19/13. An initial psychiatric evaluation and consult, conducted on 10/08/13 for Resident #72 indicated the recommendations were to check the resident for a urinary tract infection, initiate a medication to treat dementia, and increase a natural supplement to aide			

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	in sleep induction. A behavior notes form, dated 10/04/13 indicated on 09/29/13, the resident was verbally abusive to staff during care. On 10/05/13 a "new/worsening behavior notification form was completed. The form indicated the resident continued to be aggressive with staff, refused to wear her nightgown, and was cussing at staff during care. On 10/08/13, the resident pulled a wanderguard bracelet off of her arm. The form indicated on 10/20/13, the psych services was notified of the resident's behaviors and her one time delusional verbalization that she "had no heart or heart beat." An order for Risperdal .25 was received. On 10/23/13, the resident was moved to a secured dementia unit. During an interview on 09/29/14 at 1:30 P.M., the SSD indicated there was no further documentation regarding the need to initiate an antipsychotic medication for Resident #72. The SSD indicated by nodding her head that it was not a good idea to initiate an antipsychotic medication while a resident with dementia was being treated for a urinary tract infection.			

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	3. Resident #24 was observed, on 09/24/14 at 2:00 P.M. in the main lounge observing residents play a ball toss game. The resident kept complaining that the game was not "fair." An unknown staff member indicated to be careful around Resident #24 because she was "in a bad mood today." Resident #24 then continually demanded the staff member get away from the game board. The resident continued to call out derogatory statements about the game and the activity staff member. The staff member did ask the resident not to use one particular derogatory statement word. The activity staff member did try to verbally address Resident #24's concerns. The resident continued to call out "cheat cheat, cheat" to residents trying to play the game. She was instructed a few times by the Activity aide to "be nice." The resident called out "Cheat, cheat" in a loud, distressed manner through the whole activity and even after the activity was completed. At 2:36 P.M., the Administrator and another staff member tried to talk to the resident, an activity staff member tried to get her to eat some ice cream. The resident declined the ice cream and indicated she just wanted to "sit and howl" when asked what she would like to the do. The DON (Director of Nursing)			

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	tried to interest the resident in going outside and tried talking to her about flowers. Staff tried to gently push her wheelchair but the resident refused to lift her feet when asked to do so. At 2:43 P.M., the resident, after requesting the DON to leave, started yelling loudly, "Help, Help, Help" repeatedly. A staff member then approached the resident and asked if there was something she could do, asked resident if she wanted to talk to the beautician and resident said "No." After being left alone again, the resident started yelling loudly, "Help." When approached and her back was patted, the resident then punched the staff member. She was left alone in her wheelchair in the lounge. After yelling some more, another staff member approached her and talked with her. The staff member offered her several more options and then noticed Resident #24 had tears running down her face and went to get her some tissues. Before the staff member returned with the Kleenex, the resident had started yelling "Help, Help' in a loud distressed tone again. After 20 minutes, Resident #24's voice increased and she became distressed and was crying and covering her eyes. A			

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	nursing staff member tried to ask her what was wrong and she struck the CNA lightly in the face a few times. The Activity aide instructed Resident #24 not to hit. At 2:30 P.M., another activity staff member tried to ask Resident #24 if she wanted to go for a walk. The resident declined and exclaimed "I have to stay here and watch her cheat." The resident was reapproached with various options to paint, go for a walk, go to her room and she refused all options and said "I need to watch her cheat." When offered an opportunity to play the game the resident declined because she "would have to cheat to do it." After the DON stayed talking with the resident for several minutes, at 2:57 P.M., the resident did stop yelling out, however, 3 minutes later the resident started yelling "Help" again. This time when staff approached her she just leaned forward and yelled "help" in their face and did not respond to their offerings of various things. Resident #24 was observed on 09/25/14 at 9:00 A.M. in her wheelchair in the lounge area. She was calm and pleasant, had a rolled up magazine in her hand. She indicated she wanted to "get out of this place" and requested some			

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	assistance. The nurse, RN #8 was notified and pushed her from the lounge to the cafe area and got her some ice cream and directed her to a picture of an owl. The resident repeated a few times that she desired to go to her room but was accepting of the ice cream and was noted to feed herself ice cream. The clinical record for Resident #24 was reviewed on 09/24/14 at 2:06 P.M. Resident #24 was admitted to the facility on 05/27/14 with diagnosis, including but not limited to, arthritis, hypertension, hyperlipidemia, hypothyroidism, depression, osteoarthritis, osteoporosis, anxiety, and chest pain. The admission MDS (minimum data set) assessment, completed on 06/08/14, indicated the resident scored a 1 out of 15 on the BIMS (Brief Interview for Mental Status) assessment, which indicated she was severely cognitively impaired. and only exhibited wandering type behaviors, which were easily altered. The quarterly MDS assessment, dated 9/8/14, indicated the resident scored a 2 out of 15 on the BIMS assessed and displayed verbally and physically disruptive behavior 1 - 3 days of the observation period.			

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	Upon admission, on 05/28/14, the resident was receiving the antidepressant, Sertraline HCL 50 milligrams once a day. The resident also had an order to receive Hydroxyzine HCL 25 mg one tablet q 6 hours as needed for anxiety. On 05/29/14 a Psychiatric evaluation was completed and Ativan 1 mg IM (Intramuscular) q (every) 3 hours prn (as needed) for increased agitation/combativeness was ordered. In addition, another order, on the same day, discontinued the Ativan and Buspar 5 mg TID was ordered and Haldol 5 mg IM PRN one time only was ordered for increased agitation/combativeness. On 05/30/14 the antibiotic, Cipro 500 mg BID x 7 days was ordered for a urinary tract infection. On 06/08/14 the antipsychotic, Abilify 2.5 mg once a day in the mornings was ordered for mood disorders. On 07/22/14 the nutritional supplement, Melatonin 6 mg was added at bedtime for insomnia and the antidepressant Zoloft was increased. On 07/25/14 the antianxiety medication, Ativan .5 mg every 6 hours as needed was reordered for anxiety.			

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	On 07/28/14 the Ativan was discontinued and Buspar 5 mg at night as needed was added for anxiety. On 08/01/14, the Buspar 5 mg PRN at bedtime was discontinued and Depakote 125 mg once a day was added for a mood disorder. Nursing notes, from 08/01/14 - 08/27/14 indicated there was no documentation in the nursing notes regarding an increase in behaviors. However, review of Social service notes and "Clinically at Risk individual monitoring sheets" for Resident #24 from 08/01/14 - 08/21/14, indicated the resident had behaviors on 08/18/14 where she was verbally and physically aggressive with staff during care at night. The note indicated the interventions attempted were not successful in altering the resident's behaviors. There was no documentation other than the Clinically at Risk form to know what interventions were attempted or any other details regarding the incident. The behavior documentation in the KIOSK electronic system for Resident #24, from 08/01/14 - 08/27/14, indicated there was a physically abusive behavior documented on 08/16/14 at 1:37 A.M.			

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	which indicated the resident was physically abusive to staff while being transferred with a mechanical lift and during incontinence care. The note indicated a 1:1 intervention was successful in altering the behavior. There were no other behaviors documented in the KIOSK system. A nurse's note, dated 08/27/14 indicated the resident was observed by the nurse digging her nails into a staff member during care and an order was received to double the Depakote dose from 125 mg once a day to 125 mg twice a day. Physician's order on 09/15/14, discontinued the Abilify medication and added another antipsychotic medication, Seroquel 50 mg in the mornings for dementia with behaviors. Nurses's notes and KIOSK behavior documentation indicated on 09/16/14 at 11:28 A.M., the resident was hitting staff during care but the 1:1 intervention was successful to alter the behavior. On 09/20/14 at 12:54 A.M., the resident was yelling out for help and she calmed down with 1:1 interventions. On 09/20/14 at 11:23 A.M., the resident was physically abusive to staff, hitting, pinching, at spitting at staff when incontinence care was attempted.			

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	A physician's order was received on 09/22/14 at 4:00 P.M. to increase the Seroquel from 50 mg in the AM for 50 mg twice a day. It was unclear why the physician doubled the dose of the Seroquel antipsychotic medication when non-pharmalogical interventions were successful and there were only three behaviors noted from the time of the previous medication change for Resident #24. 3.1-48(a)(6)			
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. Based on observations, record review, and interviews, the facility failed to ensure the menus were followed for 15 of 15 residents on the secured dementia unit. Finding includes: During an interview, conducted on 09/23/14, an anonymous family member	F000363	**F 363 (E) What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Dining Service and Nursing staff on the Legacy were inserviced by the DFS (Director of Food Service) to ensure that menus served are consistent with the menu's planned for the campus both on and off the dementia unit. Variations from these menu's will be documented	10/29/2014

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	of a resident who resided on the secured dementia unit indicated he/she was not satisfied with the food served to the residents on the dementia unit. She indicated the food was of a lesser quality, included lots of sandwiches and fried food, and way too much starch. She indicated a family member, who had no chewing or eating problems, did not like the type of food served. Observation of the preparation of the noon meal for 09/22/14, conducted during the sanitation tour, on 09/22/14 between 10:15 A.M. - 11:00 A.M., indicated the Cook, Employee #3 was noted to have cooked a large ham in a dark brown colored liquid and was noted to be breaking the pieces up in small chunks to later be served to residents. He indicated this was the Honey Maple Pork. The Brussels sprouts were also being prepared with pieces of bacon. Observation of the noon meal and menus, conducted on 09/22/14, indicated the menu for the meal was the following: "Honey Maple Port, Roasted Potatoes, Roast Brussels Sprouts, Assorted Desserts, and Assorted Beverages." However, the residents on the secured dementia unit were served deep fried pork tenderloin sandwiches, roasted potatoes, and green beans instead of the		with written justifications for the changes and may include special requests of residents and POA's. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** 1) All residents residing on the dementia unit are affected by the alleged deficient practice. 2) Dining Service and Nursing staff on the Legacy were inserviced by the DFS (Director of Food Service) to ensure that menu served are consistent with the menu's planned for the campus both in the dementia unit and outside the unit. Variantions from these menu's will be documented with written justifications for the changes. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** 1) Audits of meals served on the dementia unit will be conducted and documented by the DFS (or designee) 5x per week x 4 weeks, then monthly x 5 months on a random selection of meal times to verify consistency with the planned menu. If variations occurr, supporting documentation will be verified. 2) The DFS will review with the dietician and/or the nursing coordinator for the dementia unit any residents unable to eat the regular planned menu. Any residents requiring 'finger foods'	

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	Honey Maple Pork and the Roasted Brussels Sprouts. On 09/23/14 at 12:05 P.M., residents on the memory care unit were noted to be served the noon meal, which consisted of: beef and rice cabbage rolls, creamed parsley potatoes, and a cold cucumber tomato salad. There were a few residents who received various meals from the substitution list, however, most of the resident did receive the menued meal. During an interview on 9/23/14 at 12:10 P.M., the FSS (Food Service Supervisor) indicated the residents on the Legacy (name of the memory care unit) chose tenderloin sandwiches and green beans instead of the menued items. When the dementia status of the residents on the unit was mentioned, the FSS said it was their family's choosing the menu changes also. He indicated the residents ate better if they were served sandwiches and food they could pick up with their hands. He indicated the dietician signed off on the substitutions. Observation of the noon meal, on 09/25/14 at 12:05 P.M. indicated CNA #4 was noted to be serving residents on the dementia unit a plain beef pattie on a bun, potatoes, and beets. When nursing		only will be careplanned as such with supporting dietary orders. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Results of the audits will be reported to the facility QAA committee monthly by the DFS. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	

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	staff were asked why the resident in the main dining room were receiving a Swiss steak portion topped with a tomato "gravy" sauce, the nursing staff indicated the dietary staff had only brought back this food for them to serve. RN #5 then went to the kitchen and returned with a pan of plain diced tomatoes, which CNA #4 then put on top of the beef pattie. Observation of the noon meal, on 09/26/14 at 11:55 P.M., indicated the resident in the main dining room were served a grilled salmon filet, baked potato, and buttered peas. However, residents in the memory care unit were served two breaded fish planks, a baked potato, and buttered peas. During an interview on 09/26/14 at 1:45 P.M.,the Administrator indicated the residents on the dementia unit got a substitute for the salmon filet because they did not like the salmon. He indicated the fish they were served today was a breaded cod. He indicated the staff on the memory care unit had previously been requesting multiple substitutes for their residents and so the FSS had been altering the menu to try to reduce the number of individual requests and find some food items a majority of the residents would accept.			

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	During an interview on 9/29/14 at 1:54 P.M., the FSS indicated the menu for the dementia unit was the same as the menu for the main dining room, except for the day salmon was menued. When reminded residents had received a substitute for the honey maple pork and the Swiss steak, in addition to the salmon, he indicated the substitutes were a result of conversations with residents on the dementia unit, their families, and nursing staff. He again indicated he had been told residents on the dementia unit ate better with foods they could easily pick up with their hands. Review of the diet orders for the 15 residents on the dementia unit, indicated none of the residents had a finger foods diet ordered. He indicated there was no documentation of the plan and dietician's plan to adjust and change the menus for the resident on the dementia unit. Observation of the noon meals, on 09/22, 09/25, and 09/26/14, indicated of the 15 residents on the dementia unit, only two residents were noted to consistently try to eat their food with their fingers. The other residents were either assisted to eat by staff or fed themselves with silverware. 3.1-20(i)(4)			

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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 Based on observation, record review, and interviews the facility failed to ensure 2 of 2 staff serving food in 2 of 2 dining room served food in a sanitary manner, related to glove use and proper handwashing. This potentially affected 49 of 51 residents in the facility who consumed food. Findings include: 1. On 09/22/14 at 12:08 P.M., Cook #1 was observed in the memory care unit, preparing to serve the noon meal from a steam table. The cook donned a pair of gloves, handled the thermometer, handles of the steam table pans, paper menus, and the outside of the bun bag, and then reached in touching buns directly with her contaminated gloved hands. 2. On 9/22/14 at 12:10 P.M., Cook #16 was observed serving food from the steam table in the main dining room with gloved hands. Cook #16 stopped serving food onto the plates and was observed	F000371	**F 371 (F) What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** 1) Inservice will be conducted for all employees responsible for serving food on proper procedures for food handling in regard to glove use; handwashing and contamination. 2) Employees identified will be counseled with teachable moments related to glove use, handwashing; and contamination. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** 1) All residents have the potential to be affected by the alleged deficient practice. 2) Inservice will be conducted for all employees responsible for serving food on proper procedures for food handling in regard to glove use; handwashing and contamination. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** The DFS	10/29/2014

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	adjusting his glasses and rubbing his face with his gloved hands, he then picked up a stack of paper menus and displayed them across the top of the steam table. After arranging the menus Cook #16 placed 4 plates on top of the steam table ledge. He then left the serving area and entered into the kitchen area through a door with a handle on it. Cook #16 entered back into the dining room through the kitchen door and continued to serve food without changing his gloves or washing his hands. At 12:15 P.M., Cook #16 stopped serving food and entered into the kitchen and retrieved a bowel of salad, he then placed the salad onto a serving tray and was not observed to change his gloves and continued to serve food. At 12:21 P.M., Cook #16 left the steam table, entered into the kitchen and retrieved a bowel of cottage cheese, he placed the cottage cheese onto a serving tray then readjusted his hat with his gloved hands. He was not observed to change his gloves or wash his hands but continued to serve food from the steam cart. On 9/29/14 at 11:30 A.M., the current policy titled "Guidelines for Handwashing," received from the Administrator, indicated "...1. All health care workers shall wash their hands frequently and appropriately...3. Health		(Director of Food Service) or designee will document observations of food handling techniques by line staff 5 X per week x 4 weeks, the monthly x 5 months and take corrective action as needed. Observations will be documented on a log. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** 1) Results of the food handling and sanitation audits will be reported monthly to the QAA committee by the DFS. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	

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	care workers shall wash hands at times such as:...handling hair, etc...." A form titled "Proper Glove Use Fact Sheet," received from the administrator indicated "...Wash your hands before putting them on and when changing to a fresh pair...Change them when necessary. You should change them at the following times:...Before beginning a different task...Gloves can help keep food safe by creating a barrier between hands and food. but if they are not properly used, they can contaminate food just as easily as dirty hands...." 3.1-21(i)(2)			
F000425 SS=D	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. 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.			

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	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 ensure medication administration was not delayed for a resident with medication changes. (Resident #20) Finding includes: During a medication pass observation, on 9-25-14 at 8:28 A.M., Resident #20 was not given two medications (oxybutynin and Zantac) during her AM medication pass. RN #21 indicated the resident was readmitted to the facility on 8-24-14 and the medications had not arrived from the pharmacy. RN #21 further indicated the medications were not available in the EDK (Emergency Drug Kit). On 9-26-14 at 9:38 A.M., a physician's order, dated 8/24/14, indicated Resident #20 was to received oxybutynin (oxytrol, for over active bladder) 5 mg. (milligrams) orally once a day and Zantac (for stomach illness) 150 mg orally BID (twice a day). During an interview, on 9-26-14 at 9:41 A.M., RN #21 indicated the missing medications for Resident #20 arrived and the resident was given the ordered	F000425	**F 425 (D)** **What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** The medications for resident #20 were delivered to the facility in the next shipment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All new residents are potentially affected by the alleged deficient practice. All new residents medications will be audited by the night shift nurse to ensure all ordered medications are recieved. The dispensing pharmacy and the DHS or ADHS will be contacted if any medications are not recieved to facilitate timely	10/29/2014

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	medications this morning. The RN further indicated the resident did not receive the two medications yesterday (9-25-14) because the medications were not received until today's pharmacy delivery. During an interview on 9-26-14 at 9:50 A.M. the DON (Director of Nursing) indicated the medications should have arrived yesterday (9-25-14), since her readmission was on the 24th. On 9-26-14 at 10:13 A.M., a Nursing Note, dated 9-24-14, indicated the resident arrived at the facility at 5:00 P.M. On 9-26-14 at 11:30 A.M., a review of a policy titled "Medication Ordering and Receiving from Pharmacy" dated 2-1-10 indicated on line 3 "... New medications, EXCEPT for emergency or "stat" medications, are ordered as follows: a. If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and indicate time next dose due. b. Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy		procurement. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** 1) All licensed nursing staff were re-inserviced on ordering medications to ensure medications are recieved from pharmacy in a timely manner. This will include a call to the pharmacy when the medications are ordered outside of normal business hours. 2) An audit will be conducted by the DHS or designee weekly x 4 weeks; then monthly x 5 months; then randomly thereafter to ensure medications are available for administration. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:**	

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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
	delivery...." 3.1-25(a)		Results of the audits will be reported to the facility QAA committee monthly by the Director of Health Services or designee. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. **Completion Date: 10/29/14**	
R000000	Blair Ridge Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R000000	**F000** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on September 29, 2014. Please accept this Plan of Correction as the provider's credible	

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			allegation of compliance. **The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	