

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 16, 17, 18, 19, 20, 23, 24, 2014.</p> <p>Facility number: 000306 Provider number: 155694 AIM number: 100273860</p> <p>Survey team: Tim Long, RN, TC Carol Miller, RN Rick Blain, RN (6/16, 6/17, 6/18, 6/19, 6/20, 2014) Diane Nilson, RN (6/23, 6/24, 2014)</p> <p>Census bed type: SNF/NF: 102 Total: 102</p> <p>Census Payor type: Medicare: 18 Medicaid: 50 Other: 34 Total: 102</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey revisit on or after July 9,2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000157 SS=D	<p>Quality review completed on June 26, 2014 by Randy Fry RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>			

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	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the Physician was notified in regard to the clarification of a Physicians Order for 1 of 1 dialysis resident who was on fluid restrictions (Resident #153).</p> <p>Findings include:</p> <p>Resident # 153's chart was reviewed on 6/19/14 at 10:30 a.m. Resident #153's diagnosis included, but were not limited to, hypertension, active renal disease, end stage, and active bacteremia. The resident was receiving renal dialysis 3 times a week.</p> <p>Hospital discharge Physician's Orders dated 5/22/14 indicated a fluid restriction of 1000 milliliter (ml) a day.</p> <p>Resident #153 received an IV (intravenous) nafcillin (antibiotic) 12 grams reconstituted in 1000 ml of normal saline to infuse at a continuous rate over a 24 hour period. The resident continued to receive the IV antibiotic reconstituted in 1000 ml through 5/27/14. The resident was receiving 1000 ml of oral fluids and 1000 ml of IV fluid a day.</p> <p>The Medication Administration Record</p>	F000157	<p>F157 Notify of changes (physician notification)</p> <p>-Residents affected by the alleged deficient practice; -One resident (#153) was found to have been affected by alleged deficiency. -All residents who have orders for fluid restrictions have the potential to be affected by the alleged deficient practice. -What corrective actions will be taken for the resident found to have been affected by the deficient practice? -Fluid restriction order clarification per Infectious Disease physician, attending physician, Dialysis clinic, and facility RD. (Decreased IV med from 1000ml to 500ml)</p> <p>-How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? -All residents who have fluid restriction orders have the potential to be affected by the alleged deficient practice. -DNS/designee will conduct an audit of all charts of residents with fluid restrictions to ensure that physician orders are followed and clarifications are received if necessary. -DNS/designee will in-service and educate all nursing staff on the importance of documentation of/and physician notification on or before 7/8/2014. What measures will</p>	07/08/2014

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	<p>dated 5/22/14 through 5/27/14 indicated the resident had received nafcillin antibiotic in 1000 ml of normal saline that infused continuously at 41.7 ml an hour for 5 days.</p> <p>The Progress Notes from 5/22/14 through 5/27/14 had no documentation indicating the Physician was notified to clarify the fluid restriction of 1000 ml a day.</p> <p>An interview with the Director of Nursing Services (DNS), Nurse Consultant RN, and RN #1 on 6/23/14 at 11:00 a.m., indicated Resident #153 was admitted to the facility on 5/22/14 on 1000 ml of IV oral fluids. RN #1 indicated the dialysis center called him regarding the resident receiving a total of 2000 ml of fluids a day. RN #1 indicated since the resident was new to the dialysis center they would not clarify or give a new order in regard to the resident receiving 2000 ml a day. RN #1 had called the Infectious Disease Physician from the hospital who had ordered the IV antibiotic in 1000 ml of normal saline and RN #1 did not receive a call back in regarding clarification of IV fluids. RN#1 then contacted the Medical Director who indicated he would not clarify or give a new order for the antibiotic since he was not the resident's Physician. RN #1 indicated he notified</p>		<p>be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not occur? -DNS/designee will in service and educate all nursing staff on the importance of documentation of/and physician notification on or before 7/8/2014. -Physicians orders for fluid restrictions will be reviewed in morning clinical meeting and checked for accurate transcription per DNS/designee. If clarification needed, physician will be contacted immediately by DNS/designee.-RD will be notified of all fluid restrictions. How the corrective action will be monitored to ensure the deficient practice will not recur, ie, what QA program will be put into place? -A CQI Fluid Restrictions tool will be implemented weekly per DNS/designee per one month, then monthly x6 months. -A CQI Change of condition tool will be implemented weekly per DNS/designee per one month, then monthly x 6 months. -Data will be collected per DNS/designee and submitted to the CQI committee, if threshold of 95% is not met, an action plan will be developed. Date of compliance 7/8/2014</p>				

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	<p>the DNS on 5/23/14 regarding the resident receiving 2000 ml total fluid intake daily.</p> <p>On 5/28/14 the Pharmacy was contacted by RN #1 and the Pharmacy indicated they could reconstitute the IV antibiotic in 500 ml of fluids instead of 1000 ml the resident had been receiving.</p> <p>A document received from the DNS on 6/23/14 at 2:30 p.m., indicated LPN #2 had received a call from the Dialysis Center on 5/24/14 after Resident #153 had returned from dialysis. "The Dialysis Center was requesting a different ATB (antibiotic) that would not require 1 L (liter) bag. (LPN #2) informed dialysis center that (the resident's name) was receiving 1000 ml (antibiotic) in hosp (hospital) and they were dialyzing him according to having (antibiotic). Nurse at dialysis center ask [sic] if it could be changed. (LPN #2) told her it was an ID (Infectious Disease) MD (physician) call and would be addressed on Tuesday b/c (because) of holiday (and) on call MD wasn't comfortable dosing patient that wasn't theirs. The nurse said ok."</p> <p>A second document was received from the DNS on 6/23/14 at 2:30 p.m., in regard to Resident #153 and RN #1 indicated "The resident was admitted on</p>						

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	<p>5/22 on 1000 ml fluid restriction and 1000 ml IV bag. Writer (RN #1) notified on call attending physician to clarify fluid restriction and attending deferred to Infectious Disease MD.</p> <p>On 5/23, Writer called ID (Infectious Disease) at 11 am on 5/23 and left a message with the phone nurse. No return calls. Writer called on call ID MD and received a call back at 7 PM on 5/23. MD was not familiar with resident and said writer needed to call back next week during business hours as she was on call all weekend and throught [sic] he [sic] Holiday.</p> <p>Tuesday 5/27 AM writer called ID MD and again left a message. Dialysis contacted r/t (related to) fluid restriction. No return call in the AM from infectious disease. Called infectious disease again at 3pm and phone nurse answered and stated she would put a note in front of MD. Dialysis returned phone call and writer explained to dialysis nurse steps taken to change fluid restriction. No return call from infectious MD.</p> <p>On 5/28 writer contacted IV pharmacist to discuss fluid restriction and pharmacist stated he can reconstitute in a 500mL bag, house MD [sic] called and order clarified.</p> <p>On 5/29 in the AM infectious disease nurse returned writers call and writer explained steps taken and ID nurse</p>			

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	<p>agreed."</p> <p>An interview on 6/24/14 at 10:30 a.m. with RN #1 indicated the pharmacy was notified on 5/28/14 and were able to reconstitute the 1000 ml IV antibiotic into a 500 ml antibiotic solution and RN #1 called the house Physician who gave the order for for the IV antibiotic to be reconstituted in 500 ml of normal saline. RN #1 indicated he should have documented in the progress notes all of the information in regard to Resident #153's fluid restrictions.</p> <p>On 6/24/14 at 8:00 a.m. an interview with the Administrator indicated she was aware of Resident #153 in regard to the IV and oral fluids and indicated she was also aware the nursing staff had called the Medical Director who would not change the order, and the on call Physician did not change the order because this resident was not his patient. The Infectious Disease Physician was called and the facility did not received a return call back.</p> <p>The Policy Titled: "Resident Care and Safety: Resident Change of Condition" revised 3/2010 was received on 6/24/14 at 10:15 a.m., from the Nurse Consultant RN and included: "...3. Routine Medical Change</p>						

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F000282 SS=D	<p>a. Any symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior...</p> <p>b. The nurse in charge is responsible for notification of physician ...prior to end of assigned shift when a significant change in the resident's condition is noted.</p> <p>c. If unable to reach the physician ...all calls to physicians or exchanges ...will be documented in the medical record.</p> <p>d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow up.</p> <p>e. If unable to contact attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition.</p> <p>f. Document resident change of condition and response in the medical record. Documentation will include time and...physician response..."</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the</p>						

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	<p>facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure physician's orders and a health care plan were followed for 1 of 3 Residents (#48) reviewed for falls. In addition, the facility failed to follow physician's orders for fluid restriction for 1 of 1 Residents (#153) reviewed for dialysis.</p> <p>Findings include:</p> <p>1. Resident #48's clinical record was reviewed on 6/18/14 at 1:30 P.M.. The record indicated the resident had physician's orders dated 2/26/14 for "Positioning /Devices: Sensor alarm to bathroom door- Check placement and function every shift".</p> <p>Review of a health care plan started 6/30/2011, indicated, Resident #48 was at risk for falls due to: "unsteady gait, right eye enucleation, medication regimen, and other predisposing conditions. She is non-compliant with her alarms and using the call light to ask for assistance." Approaches included, but were not limited to, sensor alarm to bathroom door which was started on 2/28/14.</p> <p>An interview with CNA #3 and CNA #4</p>	F000282	<p>F282 Services by Qualified Persons/per Care Plan</p> <p>-Residents affected by the alleged deficient practice; -Two residents (#48 and #153) were found to have been affected by alleged deficiency. -All residents who are at risk for falls or on fluid restrictions have the potential to be affected by the alleged deficient practice. -What corrective actions will be taken for those residents found to have been affected by the deficient practice ? -Resident#48 care plan was reviewed per IDT and recommendations were to discontinue the bathroom sensor alarm and implement room move closer to nurses station. Resident#153 care plan reviewed per IDT ,updated and clarified physician orders regarding fluid restrictions(Decreased IV fluids from 1000ml to 500ml) -How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken ? -All residents have the potential to be affected by the alleged deficient practice. -DNS/designee will conduct an audit of all charts to ensure that residents who are at risk for falls or have fluid restrictions are properly care planned and care plans are being followed per</p>	07/08/2014	

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	<p>on 6/18/14, at 1:55 P.M. indicated Resident #48 refused to use her call light or a provided cow bell, and will attempt to get up and try to use the toilet on her own and has had falls in the past. CNA's #3 and #4 also indicated the resident is on a toileting schedule before and after meals.</p> <p>An observation on 6/18/14 at 2:00 P.M. indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/18/14 at 2:45 P.M. indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/18/14 at 3:15 P.M. indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/19/14 at 8:45 A.M.. indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/19/14 at 9:10 A.M.</p>		<p>qualified staff. -DNS/designee will in service and educate all nursing staff on the importance and proper procedure of following residents plan of care on or before 7/8/2014. -What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not occur? -DNS/designee will in service and educate all nursing staff on the importance and proper procedure for following residents plan of care on or before 7/8/2014. -DNS/designee will conduct rounds each shift to insure care plans are implemented as written. -Physicians orders for fall interventions and fluid restrictions will be reviewed in morning clinical meeting and checked for accurate transcription per DNS/designee. -How the corrective action will be monitored to ensure the deficient practice will not recur, ie, what QA program will be put into place? -A CQI Care Plan Review tool will be implemented during the Care Plan review meeting per DNS/designee, weekly per one month, then monthly x 6 months. -A CQI Care Plan Updating tool will be implemented during the Care Plan review meeting per DNS/ designee, weekly per one month, then monthly x 6 months. -Data will be collected by DNS/designee and submitted to the CQI committee, if threshold of 95% is not met, an action plan will</p>		

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	<p>made along with LPN #5 indicated the sensor alarm to the bathroom door for Resident #48 was in the off position. LPN #5 indicated the sensor alarm is to be turned on according to physician's orders for Resident #48.</p> <p>Review of a treatment administration history record, provided by the Director of Nursing Services (DNS) indicated an order for :Sensor alarm to the bathroom door-check placement and function every shift. On 6/18/14 from 2:00 P.M.-10 P.M.. and 6/19/14 from 6:00 A.M.-2:00 P.M., the dates and times were signed by the nurses on duty.</p> <p>On 6/23/14 at 10:A.M., the DNS provided the facility policy titled: Fall Management Program, original date, 7/2001 and revised most recently on 9/2013. The policy indicated under fall risk, #4: "Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift".</p> <p>2. Resident # 153's chart was reviewed on 6/19/14 at 10:30 a.m. Resident #153's diagnosis included, but were not limited to, hypertension, active renal disease, end stage, and active bacteremia. The resident was receiving renal dialysis 3 times a week.</p>		be developed. Date of compliance 7/8/2014				

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	<p>Hospital discharge Physician's Orders dated 5/22/14 indicated a fluid restriction of 1000 milliliter (ml) a day.</p> <p>Resident #153 received an IV (intravenous) nafcillin (antibiotic) 12 grams reconstituted in 1000 ml of normal saline to infuse at a continuous rate over a 24 hour period. The resident continued to receive the IV antibiotic reconstituted in 1000 ml through 5/27/14. The resident was receiving 1000 ml of oral fluids and 1000 ml of IV fluid a day.</p> <p>The Medication Administration Record dated 5/22/14 through 5/27/14 indicated the resident had received nafcillin antibiotic in 1000 ml of normal saline that infused continuously at 41.7 ml an hour for 5 days.</p> <p>The Progress Notes from 5/22/14 through 5/27/14 had no documentation indicating the Physician was notified to clarify the fluid restriction of 1000 ml a day.</p> <p>An interview with the Director of Nursing Services (DNS), Nurse Consultant RN, and RN #1 on 6/23/14 at 11:00 a.m., indicated Resident #153 was admitted to the facility on 5/22/14 on 1000 ml of IV oral fluids. RN #1 indicated the dialysis center called him regarding the resident receiving a total of 2000 ml of fluids a day. RN #1 indicated</p>			

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	<p>since the resident was new to the dialysis center they would not clarify or give a new order in regard to the resident receiving 2000 ml a day. RN #1 had called the Infectious Disease Physician from the hospital who had ordered the IV antibiotic in 1000 ml of normal saline and RN #1 did not receive a call back in regarding clarification of IV fluids. RN#1 then contacted the Medical Director who indicated he would not clarify or give a new order for the antibiotic since he was not the resident's Physician. RN #1 indicated he notified the DNS on 5/23/14 regarding the resident receiving 2000 ml total fluid intake daily.</p> <p>On 5/28/14 the Pharmacy was contacted by RN #1 and the Pharmacy indicated they could reconstitute the IV antibiotic in 500 ml of fluids instead of 1000 ml the resident had been receiving.</p> <p>A document received from the DNS on 6/23/14 at 2:30 p.m., indicated LPN #2 had received a call from the Dialysis Center on 5/24/14 after Resident #153 had returned from dialysis. "The Dialysis Center was requesting a different ATB (antibiotic) that would not require 1 L (liter) bag. (LPN #2) informed dialysis center that (the resident's name) was receiving 1000 ml (antibiotic) in hosp (hospital) and they were dialyzing him</p>			

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	<p>according to having (antibiotic). Nurse at dialysis center ask [sic] if it could be changed. (LPN #2) told her it was an ID (Infectious Disease) MD (physician) call and would be addressed on Tuesday b/c (because) of holiday (and) on call MD wasn't comfortable dosing patient that wasn't theirs. The nurse said ok."</p> <p>A second document was received from the DNS on 6/23/14 at 2:30 p.m., in regard to Resident #153 and RN #1 indicated "The resident was admitted on 5/22 on 1000 ml fluid restriction and 1000 ml IV bag. Writer (RN #1) notified on call attending physician to clarify fluid restriction and attending deferred to Infectious Disease MD.</p> <p>On 5/23, Writer called ID (Infectious Disease) at 11 am on 5/23 and left a message with the phone nurse. No return calls. Writer called on call ID MD and received a call back at 7 PM on 5/23. MD was not familiar with resident and said writer needed to call back next week during business hours as she was on call all weekend and throught [sic] he [sic] Holiday.</p> <p>Tuesday 5/27 AM writer called ID MD and again left a message. Dialysis contacted r/t (related to) fluid restriction. No return call in the AM from infectious disease. Called infectious disease again</p>			

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	<p>at 3pm and phone nurse answered and stated she would put a note in front of MD. Dialysis returned phone call and writer explained to dialysis nurse steps taken to change fluid restriction. No return call from infectious MD.</p> <p>On 5/28 writer contacted IV pharmacist to discuss fluid restriction and pharmacist stated he can reconstitute in a 500mL bag, house MD [sic] called and order clarified.</p> <p>On 5/29 in the AM infectious disease nurse returned writers call and writer explained steps taken and ID nurse agreed."</p> <p>An interview on 6/24/14 at 10:30 a.m. with RN #1 indicated the pharmacy was notified on 5/28/14 and were able to reconstitute the 1000 ml IV antibiotic into a 500 ml antibiotic solution and RN #1 called the house Physician who gave the order for for the IV antibiotic to be reconstituted in 500 ml of normal saline. RN #1 indicated he should have documented in the progress notes all of the information in regard to Resident #153's fluid restrictions.</p> <p>On 6/24/14 at 8:00 a.m. an interview with the Administrator indicated she was aware of Resident #153 in regard to the IV and oral fluids and indicated she was also aware the nursing staff had called the</p>				

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	<p>Medical Director who would not change the order, and the on call Physician did not change the order because this resident was not his patient. The Infectious Disease Physician was called and the facility did not received a return call back.</p> <p>The Policy Titled: "Resident Care and Safety: Resident Change of Condition" revised 3/2010 was received on 6/24/14 at 10:15 a.m., from the Nurse Consultant RN and included:</p> <p>"...3. Routine Medical Change</p> <p>a. Any symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior...</p> <p>b. The nurse in charge is responsible for notification of physician ...prior to end of assigned shift when a significant change in the resident's condition is noted.</p> <p>c. If unable to reach the physician ...all calls to physicians or exchanges ...will be documented in the medical record.</p> <p>d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow up.</p> <p>e. If unable to contact attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition.</p>			
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F000323 SS=D	<p>f. Document resident change of condition and response in the medical record. Documentation will include time and...physician response..."</p> <p>3.1-35(g)(2)</p> <p>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, interview and record review, the facility failed to ensure physician's orders and a health care plan were followed for 1 of 3 Residents (#48) reviewed for falls.</p> <p>Findings include:</p> <p>1. Resident #48's clinical record was reviewed on 6/18/14 at 1:30 P.M.. The record indicated the resident had physician's orders dated 2/26/14 for "Positioning /Devices: Sensor alarm to bathroom door- Check placement and function every shift".</p>	F000323	<p>F323 Free of Accident Hazards/Supervision/Devices -Residents affected by the alleged deficient practice; -One resident (#48) was found to be affected by alleged deficiency. -All residents who are at risk for falls have the potential to be affected by the alleged deficient practice. -What corrective actions will be taken for those residents found to have been affected by the deficient practice? -Resident#48 fall interventions and care plan were reviewed per IDT and recommendations were to discontinue the bathroom sensor alarm and implement room(move closer to nurses station). -How will you identify</p>	07/08/2014

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	<p>Review of a health care plan started 6/30/2011, indicated Resident #48 was at risk for falls due to: "unsteady gait, right eye enucleation, medication regimen, and other predisposing conditions. She is non-compliant with her alarms and using the call light to ask for assistance." Approaches included, but were not limited to, sensor alarm to bathroom door which was started on 2/28/14.</p> <p>An interview with CNA #3 and CNA #4 on 6/18/14, at 1:55 P.M. indicated Resident #48 refused to use her call light or a provided cow bell, and will attempt to get up and try to use the toilet on her own and has had falls in the past. CNA's #3 and #4 also indicated the resident is on a toileting schedule before and after meals.</p> <p>An observation on 6/18/14 at 2:00 P.M. indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/18/14 at 2:45 P.M. indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/18/14 at 3:15 P.M.</p>		<p>other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? -All residents have the potential to be affected by the alleged deficient practice. -DNS/designee will conduct an audit of all charts to ensure that alarms are on the care plan, implemented and activated as evidenced per resident care rounds. -DNS/designee will in service and educate all nursing staff and IDT the importance and proper procedure for implementing and activating alarms on or before 7/8/2014. -What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not occur? -DNS/designee will in service and educate all nursing staff and IDT the importance and proper procedure for implementing and activating alarms on or before 7/8/2014. -DNS/designee will conduct rounds each shift to insure care plans are implemented as written. -How the corrective action will be monitored to ensure the deficient practice will not recur, ie, what QA program will be put into place ? -A CQI Resident Care Rounds tool will be implemented per DNS/designee weekly per one month, then monthly x 6 months. -Data will be collected per DNS/designee and submitted to the CQI committee, if</p>		

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	<p>indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/19/14 at 8:45 A.M.. indicated Resident #48 was in a recliner beside her bed. No facility staff were present. The sensor alarm to the bathroom door was in the off position.</p> <p>An observation on 6/19/14 at 9:10 A.M. made along with LPN #5 indicated the sensor alarm to the bathroom door for Resident #48 was in the off position. LPN #5 indicated the sensor alarm is to be turned on according to physician's orders for Resident #48.</p> <p>Review of a treatment administration history record, provided by the Director of Nursing Services (DNS) indicated an order for :Sensor alarm to the bathroom door-check placement and function every shift. On 6/18/14 from 2:00 P.M-10 P.M.. and 6/19/14 from 6:00 A.M.-2:00 P.M., the dates and times were signed by the nurses on duty.</p> <p>On 6/23/14 at 10:A.M., the DNS provided the facility policy titled: Fall Management Program, original date, 7/2001 and revised most recently on 9/2013. The policy indicated under fall</p>		<p>threshold of 95% is not met, an action plan will be developed. Date of compliance 7/8/2014</p>		

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F000371 SS=E	<p>risk, #4: "Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift".</p> <p>3.1-45(a)(1)</p> <p>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 observations, interviews, and record review, the facility failed to ensure left over food that was stored in the refrigerator was covered, labeled, and dated. The facility further failed to ensure a Dietary Aide kept her hand clean during a meal service observation. This had the potential to affect 102 of 102 residents who received their meals in the facility.</p> <p>Finding include:</p>	F000371	F371 Food Procure/Store/Prepare/Serve-Sanitary -Residents affected by the alleged deficient practice; -No residents were found to have been affected by alleged deficiency.(Food was immediately discarded and staff inserviced) -All residents have the potential to be affected by the alleged deficient practice. -What corrective actions will be taken for those residents found to have been affected by the deficient practice ? -No residents were	07/08/2014

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	<p>1. On 6/16/14 at 9:40 a.m. during the tour of the kitchen with Dietary Cook #7 the following observations were made: In the refrigerator there were unlabeled, undated, and uncovered, 10 individual servings of fruit cups, 7 individual servings of salads, 6 individual servings of "cherry fluff", and 8 individual servings of cream pie. Dietary Cook #7 indicated the "cherry fluff" was left over from 6/13/14, the salads were left over from 6/15/14, and the dietary staff should have covered, labeled, and dated each item, prior to placing the pieces of pie, the salads, the fruit cups, and the "cherry fluff" in the refrigerator.</p> <p>The policy for Food Storage revised on 7/2013, received from the Registered Dietician (RD) Consultant on 6/17/14 at 10:00 a.m., indicated "All foods should be covered, labeled and dated".</p> <p>On 6/18/14 at 11:00 a.m. the Certified Dietary Manager (CDM) was interviewed and indicated the pie and salads were from the Sunday meal and the "cherry fluff" was from the Friday night meal. The CDM also indicated all the food including the salads, the "cherry fluff, the pie, and the mixed fruit cups should have been labeled, dated, and covered prior to</p>		<p>found to have been affected by alleged deficiency, all residents had the potential to be affected by the alleged deficient practice. -Food that was found not covered, labeled or dated, was immediately disposed of. CDM/designee will monitor daily for compliance. -Dietary aide immediately washed hands, was provided education per CDM regarding hand washing policy. -How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken ? -All residents have the potential to be affected by the alleged deficient practice. -CDM/designee will conduct an audit after each meal of all food items to ensure all are covered, labeled, dated, and stored correctly per policy. -CDM/designee will conduct an audit of meal service observation to ensure that dietary staff will obtain good personal hygiene to prevent food contamination. -CEC/CDM/designee will conduct in service and educate all staff on proper hand washing procedure on or before 7/8/2014. -What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not occur ? -CEC/CDM/designee will conduct in service and educate all staff on proper hand washing procedure via skills validation no later 7/8/2014. -CDM/designee</p>				

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	<p>placing the left overs in the refrigerator.</p> <p>On 6/17/14 at 9:30 a.m. the RD Consultant was interviewed and indicated the uncovered food items should have been labeled, covered, and dated prior to being placed in the refrigerator.</p> <p>2. On 6/16/14 at 11:50 a.m. in the kitchen during the meal service, Dietary Aide #6 was observed 4 times to lick the second finger on her right hand and touch the resident's menu card as she picked up the menu card and placed it on the resident's tray. Dietary Aide #6 then touched the napkin and placed this on the resident's tray. Then she touched the handle of the knife, the spoon, the fork, and placed the silver wear on the napkin.</p> <p>On 6/16/14 at 12:00 p.m. interview with the CDM indicated the Dietary Aide #6 should not touch any part of her body during the tray line.</p> <p>Interview with the RD Consultant on 6/17/14 at 9:30 a.m. indicated Dietary Aide #6 should not have licked her finger prior to touching the resident's menu cards.</p> <p>The Policy Dietary Personal Hygiene dated 2/2007 received from the RD Consultant on 6/17/14 at 10:00 a.m.,</p>		<p>will conduct inservice and educate all dietary staff on proper policy and procedure for food storage on or before 7/8/2014.</p> <p>-CDM/designee will conduct a dietary walk thru daily to insure food is covered, labeled, and dated. CDM/designee will also insure proper hand washing technique is being followed. -How the corrective action will be monitored to ensure the deficient practice will not recur,ie, what QA program will be put into place ?</p> <p>-A CQI Meal Service Observation tool will be implemented during meal tray preparation per CDM/designee weekly per one month, then monthly x 6 months.</p> <p>-An audit tool, Dietary AM Daily Walk-thru Checklist, will be implemented daily per CDM/designee. -Data will be collected by CDM/designee and submitted to the CQI committee, if threshold of 95% is not met, an action plan will be developed. Date of compliance 7/8/2014</p>		

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	<p>indicated "Employees will maintain good personal hygiene to prevent food contamination." Procedure 1. " Dietary employees must wash their hands before they start work and after: ...c. Touching the hair, face, or body." 3.1-21(i)(3)</p>						