STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: January 20, 21, 22, 23, 26, & 27, 2015 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Survey team: Lara Richards, RN-TC Heather Tuttle, RN Caitlyn Doyle, RN Janelyn Kulik, RN (1/20/15) Chris Greeney, QIDP (1/27/15) Census bed type: SNF: 21 SNF/NF: 184 Total: 205 Census payor type: Medicare: 38 Medicaid: 117 Other: 50 Total: 205 These deficiencies reflect state findings cited in accordance with 410 IAC	F000000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests paper compliance for validation of the submitted plan of correction for Survey Event BZTS11.	

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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	16.2-3.1. Quality review completed on January 30, 2015, by Janelyn Kulik, RN.			
F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure each resident's dignity was maintained related to foley catheter drainage bags being covered with dignity bags for 4 of 4 residents reviewed for dignity of the 6 who met the criteria for dignity. The facility also failed to ensure dignity was maintained during dining for 2 of 18 residents who ate their meals in the Fifth floor odd hall dining room. (Residents #60, #102, #146, #185, #271 and #294) Findings include: 1. On 1/20/15 at 12:57 p.m., Resident #294 was observed in the Fifth floor odd hall dining room. CNA #4 was assisting the resident with her meal. At this time, the CNA was observed pushing the resident's roll into her mouth with her	F000241	I. Specific corrective actions R 294 is assisted with her meals timely and utensils are used for breads. R 185 is assisted with her meals timely. R271's foley bag was replaced. The foley bag is properly positioned and in a dignity bag. R 60's foley bag is now covered with a dignity bag. R 102's foley bag is now covered with a dignity bag. R 146's foley bag is now covered with a dignity bag. II. Identification of other residents and corrective action All facility residents with urinary catheters or requiring assistance with their meals have the potential to be affected by the alleged deficient practice. An audit of residents who have orders for urinary catheters was completed. The C.N.A. who assisted R294 with her meal was in-serviced on dignity during meal service. III. Systemic changes Licensed nurses will audit for	02/09/2015

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	bare hands and telling her to take a bite. Interview with the Unit Manager on 1/27/15 at 9:45 a.m., indicated the CNA should have cut the roll up into small pieces and used a fork to place into the resident's mouth. 2. On 1/21/15 at 8:55 a.m., Residents #185 and #294 were observed in the Fifth floor odd hall dining room. The resident's breakfast trays were in front of them and covered. The other residents in the dining room at this time were eating their breakfast in front of the residents. No staff was in the room to assist the residents with their meal. Interview with the Unit Manager on 1/27/15 at 9:45 a.m., indicated the residents should have been assisted with their meals in a more timely manner. 3. On 1/21/15 at 9:42 a.m., Resident #271 was observed in bed. At that time, the resident's foley catheter bag was hooked on the side of the bed. The foley catheter was not in a dignity bag and the urine in the bag was noted. On 1/22/15 at 8:45 a.m., the resident was observed in bed. At that time, the resident's foley catheter bag was laying on the floor and it was not covered in a dignity bag. The resident's urine in the		proper placement of urinary catheters and use of dignity bags upon walking rounds. Any deficiencies noted will be immediately corrected. Nursing staff was in-serviced on: ·Proper placement of foley bags. ·Use of foley dignity bags. ·Rational for proper placement and use of foley bags. ·Maintaining dignity during meal service with emphasis given to serving meal trays, timely assisting residents with their meals, and assisting a resident with bread. ·Dining room monitoring. IV. Monitoring Three times a week on various shifts the unit manager/designee will verify that walking rounds were completed by the licensed nurse. The unit manager/designee will audit 5 residents with foley catheters three times a week to ensure proper placement of foley bags and use of dignity bags has occurred. Three times a week the unit manager/designee will monitor the dining room at various meals to ensure resident dignity is maintained, residents are served and assisted with their meals timely and utensils are used with breads. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality	

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	bag was observed from the hallway. On 1/23/15 at 8:12 a.m., the resident was observed in bed eating breakfast. His foley catheter bag was laying on the floor as well as the urine spout where the urine comes out. The catheter bag was not in a dignity bag and his urine could be seen from the hallway. Interview with LPN #1 on 1/23/15 at 8:14 a.m., indicated the resident's foley catheter bag was not to be on the floor and it should have been in a dignity bag. Interview with the Director of Nursing on 1/23/15 at 12:30 p.m., indicated the foley catheter bag should have been placed in a dignity bag so the resident's urine would not be observed by visitors or other residents. 4. On 1/20/15 at 11:49 a.m., Resident #60 was observed lying in bed in her room. The resident's urinary catheter bag was visible from her roommate's side of the room. Urine was visible in the bag and there was no dignity cover on the urinary catheter bag. On 1/21/15 at 10:05 a.m., the resident was observed lying in bed in her room. The resident's urinary catheter bag was visible from her roommate's side of the room. Urine was visible in the bag and		Assurance committee, auditing will be completed and presented quarterly at the QA meeting. Monitoring will be on going.	

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	there was no dignity cover on the urinary catheter bag. Interview with the Director of Nursing (DON) on 1/23/15 at 10:41 a.m., indicated the catheter bag should have been in a dignity bag. 5. On 1/21/15 at 10:33 a.m., Resident #102 was observed lying in bed in her room. The resident's urinary catheter bag was visible from her roommate's side of the room. Urine was visible in the bag and there was no dignity cover on the urinary catheter bag. On 1/22/15 at 1:01 p.m., the resident was observed lying in bed in her room. The resident's urinary catheter bag was visible from her roommate's side of the room. Urine was visible in the bag and there was no dignity cover on the urinary catheter bag. On 1/23/15 at 9:13 a.m., the resident was observed lying in bed in her room. The resident's urinary catheter bag was visible from her roommate's side of the room. Urine was visible in the bag and there was no dignity cover on the urinary catheter bag. Interview with the Director of Nursing (DON) on 1/23/15 at 10:41 a.m.,			

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	indicated the catheter bag should have been in a dignity bag. 6. On 1/20/15 at 12:18 p.m., Resident #146 was observed lying in bed in her room. The resident's urinary catheter bag was visible from her roommate's side of the room. Urine was visible in the bag and there was no dignity cover on the urinary catheter bag. On 1/22/15 at 1:10 p.m., the resident was observed lying in bed in her room. The resident's urinary catheter bag was visible from the hallway. Urine was visible in the bag and there was no dignity cover on the urinary catheter bag. On 1/23/15 at 9:11 a.m., the resident was observed lying in bed in her room. The resident's urinary catheter bag was visible from the hallway. Urine was visible in the bag and there was no dignity cover on the urinary catheter bag. Interview with the Director of Nursing (DON) on 1/23/15 at 10:41 a.m., indicated the catheter bag should have been in a dignity bag. 3.1-3(t)			
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO			

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	MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure resident individual preferences were followed, related to not giving the resident a choice of the amount of bathing she would prefer for 1 of 3 residents reviewed for choices of the 7 who met the criteria for choices. (Resident #146) Finding includes: During an interview on 1/20/15 at 12:07 p.m., Resident #146 indicated she had not been given a choice for the amount of showers she would like to receive. She indicated the facility had a shower schedule and she was scheduled for twice a week. The resident indicated she would prefer to receive a shower three or four times a week but understands she has to go by what the aides can do. Resident #146's record was reviewed on 1/23/15 at 9:50 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, neurogenic bladder, and anemia.	F000242	I. Specific corrective action Shower preference for resident 146 were updated on January 28, 2015 and the care card updated to reflect her choices. II. Identification of other residents and corrective action All residents have the potential to be affected by the alleged deficient practice. The Activity Director has reviewed the resident right of choice, including the number of showers preferred and how to request care changes, with the members of Resident Council. The Activity Director and Social Service assistant assigned to each unit have reviewed the process for requesting changes in care services provided with the residents on their respective unit. III. Systemic changes The resident preferences for care, including shower preferences will be reviewed with the resident by activity staff each quarter as a component of the MDS assessment. The “Who I Am” review conducted quarterly with the resident will be updated to include frequency of showers. Any change in care choices will be updated on the resident care	02/09/2015

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	The Admission MDS (Minimum Data Set) assessment, dated 9/6/14, indicated the resident was cognitively intact and it was very important to her to choose her type of bathing. Review of the "Shower List 2nd Floor", received from the Director of Nursing (DON) and identified as current, indicated the resident was scheduled for a shower on Monday and Thursday during the day shift. During an interview on 1/27/15 at 9:20 a.m., CNA #3 indicated there was a shower list the aides follow and a shower was offered to the residents twice a week. During an interview on 1/27/15 at 9:26 a.m., SSD #1 (Social Service Designee) indicated she used to ask resident's about bathing preferences on admission but that task was turned over to activities. During an interview on 1/27/15 at 10:41 a.m., the 2nd floor Unit Manager indicated residents were offered two showers a week when they come in and were asked if that was ok with them. He indicated if a resident asks for something else he would accommodate it. He further indicated activities completes a "Who Am I Plan" with the residents		card. IV. Monitoring The facility Health Information Manager/designee will review 5 resident care cards per unit per week to ensure they match the current resident's care choices as listed on the most recent "Who I Am" card, including shower frequency. The activity director will review this process at the resident council meeting quarterly and present any on-going concerns to the QA committee quarterly for review.	

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	quarterly and bathing preference is discussed. Review of Resident #146's "Who Am I Plan", indicated the resident preferred a shower and shower/bathing time was not important to the resident. The record lacked information to indicate the resident had been asked how frequently she would prefer to bathe. During an interview on 1/27/15 at 11:40 a.m., the Activity Director indicated they complete the "Who Am I" care plans with residents quarterly. She further indicated they discuss what time of day the resident would prefer a shower and if they would prefer a shower or bed bath. She indicated they do not specifically ask the residents how often they would like a shower. During an interview on 1/27/15 at 12:00 p.m., the DON indicated residents were informed the facility offers two showers a week and were asked if they were ok with that. She indicated if the residents voice they would like a shower more often, the facility would accommodate them. She further indicated residents were not specifically asked how often they would like a shower. 3.1-3(v)(1)			

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F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to provide medically-related social services to attain the highest practicable physical, mental, and psychosocial well being of residents, related to, not follow up for an oral surgeon appointment for 1 of 2 residents reviewed for dental status of the 2 residents who met the criteria for dental status. (Resident #60) Finding includes: During a family interview on 1/20/15 at 11:46 a.m., Resident #60's husband indicated Resident #60 had a tooth on the bottom that was bulging out. He indicated the resident had seen the dentist and they said she needed to go to a hospital to have it taken out. He indicated he was waiting to hear back from Social Services and the dentist about it. He further indicated he didn't believe the tooth was causing the resident any pain right now but it probably would soon. Resident #60's record was reviewed on	F000250	I. Specific Corrective Action Resident #60 has an appointment with an oral surgeon for the tooth extraction on February 16, 2015. II. Identification of other residents and corrective action All dependent residents who need oral surgery have the potential to be affected by the alleged deficient practice.Social services has reviewed the oral needs of dependent residents as coded on the MDS and the recommendations of the contracted dental provider to ensure all recommendations have been addressed. No other unaddressed dental needs were identified. III. Systemic change The social service assistant assigned to each unit will review the section of the MDS related to oral care to ensure Social Services offers the appropriate services to any dependent resident who is identified as needed dental care. The Social Service Director/assistant will audit all dental recommendations as they are provided by the contracted dental provider and document follow-up in the clinical record. IV. Monitoring The Social Service Director will	02/09/2015

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	1/22/15 at 8:50 a.m. The resident's diagnoses included, but were not limited to, dental disorder, anemia, and vascular dementia. A Social Service Progress Note, dated 9/18/14, indicated the resident's husband requested social services make an appointment at Urgent Dent to have the tooth removed. The note further indicated an appointment was made by SSD #1 (Social Services Designee) for 10/9/14. A Social Service Progress Note, dated 10/9/14, indicated the resident had gone to her appointment at Urgent Dent and was informed they were unable to perform the procedure there. The note further indicated the resident's family requested a consult appointment at Northwestern Oral Surgeons. Urgent Dent was contacted by SSD #1 for a referral for the oral surgeon. The record lacked documentation to indicate SSD #1 had followed up with the referral to the oral surgeon. During an interview on 1/27/15 at 9:26 a.m., SSD #1 indicated she thought the resident's husband was making arrangements with the oral surgeon and she had not followed up with him. She		audit five medical records per week for three months to ensure dental recommendations have been addressed. The SSD will summarize audit findings to the QA committee quarterly for four quarters on the status of dental recommendations. The QA committee will provide additional guidance as necessary, based on the audit findings.	

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	further indicated she would usually try to follow up with the family member but depending on the day she might not have had a chance. She further indicated she would speak to the resident's husband about the issue. 3.1-34(a)			
F000278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a			

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	material and false statement. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set assessment was accurately coded related to range of motion for 1 of 3 residents reviewed for range of motion of the 4 who met the criteria for range of motion and urinary continence for 1 of 3 residents reviewed for urinary incontinence of the 5 who met the criteria for urinary incontinence. (Residents #98 and #294) Findings include: 1. On 1/22/15 at 8:54 a.m., Resident #294 was observed to have a contracture to her right hand. The record for Resident #294 was reviewed on 1/23/15 at 10:34 a.m. The resident's diagnoses included, but was not limited to, joint contracture. A Physician's order dated 6/19/14, indicated the resident was to have a core splint to the right hand. The resident should wear core splint to right hand at all times and remove during periods of hygiene and signs of discomfort for contracture management. The Joint mobility assessments dated 6/17, 9/17, and 12/16/14, indicated the	F000278	1.Specific Corrective Action 1.The MDS for R294 was modified to reflect ROM limitation to the right hand. 2.The MDS for R98 was modified to reflect bladder incontinence. II. Identification of other residents and corrective action All residents receiving restorative care have the potential to be affected by the alleged deficient practice. The MDS coordinators reviewed the most recent MDSs of residents receiving restorative services to verify the coding for urinary incontinence and range of motion matched the documentation in the clinical record. No other discrepancies were noted. III. Systemic change The sections of the MDS that include restorative components, including incontinence and range of motion have been re-assigned to the MDS coordinators to complete. The MDS coordinator responsible for reviewing and verifying completeness of the MDS will compare the restorative components' answers with the documented care provided to ensure accuracy and consistency of the answers. If discrepancies are noted, the responsible MDS coordinator will be re-educated on validating the answers to the MDS section in question and the MDS will be re-completed to accurately reflect the resident's current condition. IV. Monitoring	02/09/2015

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	resident had moderate limitation in range of motion to the right wrist, hand and fingers. The Admission Minimum Data Set (MDS) assessment dated 6/24/14, indicated the resident had no impairment to the upper extremities related to range of motion. The 9/10 and 12/7/14 Quarterly MDS assessments, indicated the resident had no impairments to the upper extremities related to range of motion. Interview with the MDS Coordinator on 1/27/15 at 2:20 p.m., indicated the Admission and Quarterly MDS assessments were coded inaccurately related to range of motion status. 2. The record for Resident #98 was reviewed on 1/22/15 at 10:02 a.m. The resident's diagnoses included, but were not limited to, dementia, debility, and muscle weakness. Review of the Admission Minimum Data Set (MDS) assessment dated 8/13/14, indicated the resident was not alert and oriented and was always continent of bladder. Review of the Quarterly MDS assessment dated 11/9/14, indicated the resident was		For the next three months the facility MDS coordinators will check 5 random charts per week completed by a peer MDS coordinator of residents on the restorative program who are in the MDS reference period for congruence of documentation and MDS answers. The coordinator will report any documentation errors or inconsistencies to the administrator for further follow-up.	

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	now frequently incontinent of bladder. Review of the bladder observation assessment dated 8/7/14, indicated the resident was dependent on staff for transfers and had impaired mobility. The resident was currently not continent of bladder. Review of the 30 day bladder observation assessment dated 9/2/14, indicated the resident was not continent of bladder and had functional incontinence. The resident had severe cognitive impairment and impaired mobility. Nursing Progress Notes dated 8/11/14 at 1:15 a.m., 8/12/14 at 1:45 a.m. and 10:59 a.m., and 8/13/14 at 1:59 a.m., indicated the resident was incontinent of bowel and bladder. Interview with CNA #1 on 1/26/15 at 9:02 a.m., indicated the resident had been incontinent of bladder for a very long time. Interview with the 3rd Floor Unit Manager on 1/26/15 at 9:10 a.m., indicated the resident had been incontinent of bladder since admission. Interview with the MDS Coordinator on 1/27/15 at 8:15 a.m., indicated the			

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	Admission MDS was inaccurately coded for bladder incontinence. 3.1-31(h)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to follow Physician Orders and/or the resident's plan of care related to oral care for 1 of 1 residents reviewed for Activities of Daily Living (ADLs) of the 1 resident who met the criteria for ADLs and for obtaining a weight post dialysis for 1 of 1 residents reviewed for dialysis. (Residents #60 and #246) Findings include: 1. The record for Resident #246 was reviewed on 1/22/15 at 2:37 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, congestive heart failure and renal dialysis. The Admission Minimum Data Set (MDS) assessment dated 12/23/14, indicated the resident was alert and	F000282	I. Specific corrective actions R60 care plan was reviewed and updated. R246 physician was notified and new orders were received. II. Identification of other residents and corrective action All facility residents who require assistance with oral care or have orders for dialysis have the potential to be affected by the alleged deficient practice. An audit of residents who require assistance with oral care and orders for dialysis was completed. III. Systemic changes Licensed Nursing staff were in-serviced on: ·Following physician's orders related to post-dialysis follow up. · Policy titled Post- Dialysis Monitoring and Observation with Implanted A-V Shunt. Nursing staff was in-serviced on: ·Following the plan of care with emphasis given to oral care. V. Monitoring Weekly, the unit manager/designee will audit 5	02/09/2015

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	oriented with a Brief Interview for Mental Status (BIMS) score of 13. The resident received dialysis services. Physician Orders dated 12/17/14, indicated dialysis three times a week on Mondays, Wednesdays, and Fridays. Physician Orders dated 12/16/14, indicated complete vitals, blood pressure and weight upon return from dialysis. Review of the vital signs and weight section in the clinical record from 12/17/14-1/26/15 on Mondays, Wednesdays, and Fridays, indicated there was no weight obtained after the resident returned from dialysis. The Medication Administration Record (MAR) for the months of 12/2014 and 1/2015, indicated the resident's vital signs were recorded upon return from dialysis but there was no weight available for review. Interview with LPN #2 on 1/26/15 at 10:01 a.m., indicated obtaining the resident's weight upon return from dialysis would be something the 3-11 shift was responsible for. Interview with the First Floor Unit Manager on 1/26/15 at 10:16 a.m.,		residents with orders for dialysis to ensure dialysis physician's orders are followed. Weekly, the unit manager/designee will audit 10 residents who require assistance with oral care to ensure oral care was completed. The DON /designee will present a summary of the audit findings to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing will be completed and presented quarterly at the QA meeting. Monitoring will be on-going.	

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	indicated she was aware they were to get the vital signs which were recorded on the MARs however, she was unaware the Nurses were to get a weight as well. Interview with the Director of Nursing on 1/26/15 at 11:33 a.m., indicated she was only able to provide wet and dry weights from the dialysis center. 2. During a family interview on 1/20/15 at 11:29 a.m., with Resident #60's husband, indicated the resident did not always receive the assistance she needed with oral hygiene. He indicated most times he had to do oral care for the resident when he would come to visit. On 1/23/15 at 12:05 p.m., Resident #60 was observed lying in bed in her room. A dried brown crusty substance was observed on her bottom lip and the top of her tongue. On 1/23/15 at 2:35 p.m., the resident was observed lying in bed in her room. A dried brown crusty substance was observed on her bottom lip and the top of her tongue. On 1/27/15 at 8:55 a.m., the resident was observed lying in bed in her room. A dried brown crusty substance was observed to her bottom lip. Dry flaky skin was also observed on the residents			

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	bottom lip. Resident #60's record was reviewed on 1/22/15 at 8:50 a.m. The resident's diagnoses included, but were not limited to, contractures to BUE (bilateral upper extremities) and LE (lower extremities), gastrostomy, and dysphagia. A Quarterly MDS (Minimum Data Set) assessment, dated 12/24/14, indicated the resident had impairment to both upper and lower extremities on both sides and the resident required an extensive assist of two with personal hygiene. A care plan, dated 10/10/14, indicated the resident was at risk for adverse complications related to gastric tube and enteral feedings. The Nursing interventions included, provide frequent oral care. During an interview on 1/27/15 at 9:15 a.m., CNA #2 indicated she provided oral care to resident #60 sometimes two or three times per shift. CNA #2 indicated she had noticed the dried brown crusty substance on the resident's lips earlier but had not cleaned it yet because she was helping with breakfast. She further indicated, "It should have been done the previous shift, if you want to know the truth." She indicated she would go assist			

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	the resident with oral care. 3.1-35(g)(2)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to monitor and assess bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non pressure related skin conditions. The facility also failed to complete the pre dialysis sheets prior to sending a resident to the hemodialysis unit for 1 of 1 residents reviewed for dialysis. (Residents #221 and #246) Findings include: 1. The record for Resident #246 was reviewed on 1/22/15 at 2:37 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, congestive heart failure and renal dialysis. The Admission Minimum Data Set	F000309	I. Specific corrective actions R246 pre-dialysis communication sheet is currently being completed, before sending the resident to dialysis. R221 bruises were reassessed by nurse and the physician. R22 was diagnosed with purpura. II. Identification of other residents and corrective action All facility residents who have orders for dialysis have the potential to be affected by the alleged deficient practice. An audit of residents who have orders for dialysis was completed. All facility residents who have bruises have the potential to be affected by the alleged deficient practice. All current residents with bruising have been identified and assessed. III. Systemic changes Nursing staff was in-serviced on: ·Completion of dialysis Pre- and Post- communication form. ·Upon return of resident	02/09/2015

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	(MDS) assessment dated 12/23/14, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 13. The resident received dialysis services. Physician Orders dated 12/17/14, indicated dialysis three times a week on Mondays, Wednesdays, and Fridays. The dialysis facility report sheets were reviewed. Nursing staff were to obtain vital signs and any other pertinent assessments of the resident and document it on the report sheets prior to the resident leaving the facility for dialysis. The report sheets were unavailable for review on 12/18, 12/23, 12/29, 12/31/14, 1/5/15, 1/14, 1/21 and 1/23/15. Interview with the Director of Nursing on 1/26/15 at 11:44 a.m., indicated there were no other dialysis sheets available for review. She further indicated the dialysis center was sending them back with the resident and he had kept them, however, Nursing staff should have asked for them back to file in his clinical record. 2. On 1/21/15 at 8:49 a.m., Resident #221 was observed with red and purple discolored areas to her left forearm. On 1/22/15 at 9:00 a.m., and 1:15 p.m.,		from dialysis, check for completion of dialysis portion of report, and forward to unit manager. ·Rational for completion of dialysis communication form ·Monitoring and assessment of bruises, with emphasis on specific location and color. ·Rational for monitoring and assessment of bruises. ·Update physician of non-healing bruises. IV. Monitoring The unit manager/designee will audit 5 residents with orders for dialysis weekly to ensure proper completion of dialysis pre- and post- communication form. The unit manager/designee will audit 5 residents a week for proper monitoring and assessment of bruises. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing will be completed and presented quarterly at the QA meeting. Monitoring will be on-going.	

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	the resident was observed with a purple/red bruise on the top of her left arm near her elbow. There were also red and purple discolored areas noted to her right arm. On 1/23/15 at 8:25 a.m., the resident was observed with a purple/red bruise on the top of her left arm near her elbow. There were also red and purple discolored areas noted to her right arm. At that time, the Second Floor Unit Manager was asked to perform a skin assessment. The Unit Manager indicated he was not sure what the policy for bruises was regarding monitoring and measuring them. He further indicated when a new bruise was observed by staff they were to put an "Event" in the computer. At that time the areas of discoloration were measured. The Unit Manager indicated the only event in the computer for the bruises that were measured was dated 9/23/14 (Four months ago). The record for Resident #221 was reviewed on 1/22/15 at 10:43 a.m. The resident was admitted to facility on 8/6/14 and then readmitted back to the facility on 9/17/14. The resident's diagnoses included, but were not limited to, hypothyroidism, Alzheimer's disease,			

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	anemia, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment dated 1/4/15, indicated the resident needed extensive assist with two person physical assist for bed mobility and transfers. Physician Orders on the current 1/2015 recap, indicated St. Joe Aspirin 81 milligrams (mg) daily. The resident was also receiving Prednisone (a steroid) 5 mg daily. An Event dated 9/23/14 indicated bruises to the left forearm measuring: 1. 2.5 centimeters (cm) by 1.5 cm 2. 0.75 cm by 0.75 cm 3. 2 cm by 1.5 cm 4. 0.5 cm by 0.5 cm All red/purple in color. Skin checks dated 12/5, 12/9, 12/12, and 12/19/14 all indicated "BUE (Bilateral Upper Extremities) bruises" There were no measurements or color documented on the sheets. A full clinical body observation dated 1/14/15, indicated bilateral upper extremities bruises. There were no measurements or color documented. A skin check dated 1/10/15 and 1/20/15,			

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	indicated bilateral upper extremities bruises. There were no measurements or color documented. The current care plan dated 8/22/14 and updated 1/2015, indicated the resident was at risk for gastrointestinal upset, bruising and/or bleeding related to aspirin usage. The Nursing approaches were to observe for and encourage resident to report any bruising and bleeding. Nursing Progress Notes for the months of 10/2014, 11/2014, 12/2014 and 1/2015, indicated there was no documentation regarding any non healing discoloration areas to the resident's left and right forearms. Physician Progress Notes dated 10/22/14, 11/26/14, and 12/28/14, indicated there was no documentation regarding bruises to the left and right forearms. There was no diagnoses documented to support the non healing red/purple discolored areas to her arms. A clinical body observation dated 1/23/15 was reviewed. The following was documented and assessed to the resident's left and right forearms: 1. right forearm lateral proximal 1.1 cm by 1 cm purple 2. right forearm lateral middle 2.2 cm by			

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	1.5 cm red/purple 3. right forearm lateral distal 2 cm by 1.5 cm red/purple 4. left forearm proximal 3.4 cm by 3.5 cm by 0.1 cm dark purple/red 5. left forearm distal faded 3 cm by 3.5 cm red/purple 6. left inferior to wrist 2 cm by 2.5 cm 7. discoloration to left thumb base 3.5 cm by 2.5 cm green/purple fading Interview with the Director of Nursing on 1/23/15 at 9:40 a.m., indicated bruises and or discolorations did not have to be measured weekly per facility policy. She further indicated she was aware the resident had a bruise to her left forearm which was not healing. She indicated back in December 2014, she was made aware the area was not getting better. She further indicated there were no Physician Progress Notes to indicate the resident had non healing discolorations to her left and right forearms. She indicated there was no documentation in Nursing Progress Notes regarding the areas of discoloration to the left and right forearms. She further indicated the areas on the resident's left and right forearms were the same areas documented on the original Event assessment, however, there was no documentation regarding those areas as being non healing.			

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	3.1-37(a)			
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure the necessary care and services were provided related to oral care for 1 of 1 residents reviewed for activities of daily living of the 1 resident who met the criteria for activities of daily living. (Resident #60) Findings include: During a family interview on 1/20/15 at 11:29 a.m. with Resident #60's husband, he indicated the resident did not always receive the assistance she needed with oral hygiene. He indicated most times he had to do oral care for the resident when he would come to visit. On 1/23/15 at 12:05 p.m., Resident #60 was observed lying in bed in her room. A dried brown crusty substance was observed on her bottom lip and the top of	F000312	I. Specific corrective actions R 60 - oral care is routinely provided to R 60. II. Identification of other residents and corrective action All facility residents who require assistance with oral care have the potential to be affected by the same deficient practice. An audit of residents who require assistance with oral care was completed. III. Systemic changes Nursing staff was in-serviced on following the plan of care with emphasis given to oral care. IV. Monitoring Weekly, the unit manager/designee will audit 10 residents who require assistance with oral care to ensure oral care was completed. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing will be completed and presented quarterly at the QA	02/09/2015

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	her tongue. On 1/23/15 at 2:35 p.m., the resident was observed lying in bed in her room. A dried brown crusty substance was observed on her bottom lip and the top of her tongue. On 1/27/15 at 8:55 a.m., the resident was observed lying in bed in her room. A dried brown crusty substance was observed to her bottom lip. Dry flaky skin was also observed on the resident's bottom lip. Resident #60's record was reviewed on 1/22/15 at 8:50 a.m. The resident's diagnoses included, but were not limited to, contractures to BUE (bilateral upper extremities) and LE (lower extremities), gastrostomy, and dysphagia. A Quarterly MDS (Minimum Data Set) assessment, dated 12/24/14, indicated the resident had impairment to both upper and lower extremities on both sides and the resident required an extensive assist of two with personal hygiene. A care plan, dated 10/10/14, indicated the resident was at risk for adverse complications related to gastric tube and enteral feedings. The Nursing interventions included, provide frequent		meeting. Monitoring will be on-going.	

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	oral care. During an interview on 1/27/15 at 9:15 a.m., CNA #2 indicated she provided oral care to Resident #60 sometimes two or three times per shift. CNA #2 indicated she had noticed the dried brown crusty substance on the resident's lips earlier but had not cleaned it yet because she was helping with breakfast. She further indicated, "It should have been done the previous shift, if you want to know the truth." She indicated she would go assist the resident with oral care. 3.1-38(a)(3)(C)			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with an indwelling foley catheter received the necessary treatment and	F000315	I. Specific Corrective Action R271's foley bag was replaced. The foley bag is properly positioned and in a dignity bag. II. Identification of other residents	02/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/27/2015
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	services to prevent infection related to a foley catheter bag laying on the floor for 1 of 3 residents reviewed for urinary catheter use of the 3 residents who met the criteria for urinary catheter use. (Resident #271) Findings include: On 1/22/15 at 8:45 a.m., Resident #271 was observed in bed. At that time, the resident's foley catheter bag was laying on the floor and it was not covered in an dignity bag. On 1/23/15 at 8:12 a.m., the resident was observed in bed eating breakfast. His foley catheter bag was laying on the floor as well as the urine spout where the urine comes out. The catheter bag was not in a dignity bag and his urine could be seen from the hallway. Interview with LPN #1 on 1/23/15 at 8:14 a.m., indicated the resident's foley catheter bag was not to be on the floor. The record for Resident #271 was reviewed on 1/23/15 at 10:26 a.m. The resident's diagnoses included, but were not limited to, urinary tract infection, dementia, and urinary retention. The Quarterly Minimum Data Set (MDS)		and corrective action All facility residents with urinary catheters have the potential to be affected by the alleged deficient practice. An audit of residents who have orders for urinary catheters was completed. III. Systemic changes Licensed nurses will audit for proper placement of urinary catheters and use of dignity bags upon walking rounds. Any deficiencies noted will be immediately corrected. Nursing staff was in-serviced on: ·Proper placement of foley bags. ·Use of foley dignity bags. ·Rational for proper placement and use of foley bags. IV. Monitoring Three times a week on various shifts the unit manager/designee will verify that walking rounds were completed by the licensed nurse. The unit manager/designee will audit 5 residents with foley catheters three times a week to ensure proper placement of foley bags. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, as determined by the Quality Assurance committee, auditing will be done quarterly and presented at the QA meeting. Monitoring will be on-going.	

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	assessment dated 1/7/15, indicated the resident had an indwelling foley catheter. Physician Orders on the current 1/2015 recap, indicated the resident had a 16 FR (French) indwelling foley catheter. Review of the current 9/2005 Catheter Care, Urinary policy provided by the Director of Nursing indicated "Be sure the catheter tubing and drainage bag are kept off the floor." Interview with the Director of Nursing on 1/23/15 at 12:30 p.m., indicated the foley catheter bag should have been placed in a dignity bag so the resident's urine would not be observed by visitors or other residents. 3.1-41(a)(1)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure supervision was maintained during dining for 18 of 18	F000323	I. Specific Corrective Action The staff member who had stepped out of the dining room to obtain water for the residents returned to	02/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/27/2015
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	residents who ate their meals in the Fifth floor odd hall dining room. Findings include: On 1/21/15 at 8:55 a.m., eighteen residents were observed in the Fifth floor odd hall dining room. There were fifteen residents who were eating their breakfast at this time. No staff members were in the dining room. The Activity Consultant was observed in the hall by the food cart along with other staff members. Not all of the residents were visible from the hallway. The Fifth floor was a secured Memory Care Unit. Interview with the Unit Manager on 1/27/15 at 9:45 a.m., indicated the residents in the dining room should not have been left unattended. 3.1-45(a)(2)		the dining room and remained with the residents for the remainder of breakfast. II. Identification of other residents and corrective action All residents who eat in a congregate dining setting have the potential to be affected by the alleged deficient practice. The other five dining areas of the facility were checked to assure the staff member assigned to the area for meals was in the dining room while residents were present in the room. No other instance of non-compliance was noted. III. Systemic change Nursing staff were re-educated that the dining room is not to be left unsupervised at mealtime. A staff member will be assigned to each dining room for each meal. The staff will remain in the dining room to provide supervision while residents are present for the meal. IV. Monitoring The charge nurse will check each dining room once daily to ensure the assigned staff member is present during the mealtime while residents are dining. Any staff who is not in the dining room as assigned will receive education/counseling as appropriate regarding duties and expectations. The DON/designee will review the dining room audits monthly for nine months, for continued compliance or revision, as necessary. Findings will be reported to the QA committee for	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

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			review and recommendations.	
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 record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary medications related to the indication for the use of as needed (prn) anti-anxiety medications, interventions attempted prior to giving the prn medication and behavior monitoring for 3 of 5 residents reviewed for unnecessary medications. (Residents #271, #282, and #294)	F000329	I. Specific Corrective Action R271, R282, R294 anti-anxiety medications were reviewed. No changes were made. II. Identification of other residents and corrective action All facility residents with orders for PRN anti-anxiety medications have the potential to be affected by the alleged deficient practice. The facility has identified all residents with orders for PRN anti-anxiety medications. III. Systemic changes Licensed nurses were	02/09/2015

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	Findings include: 1. The record for Resident #294 was reviewed on 1/23/15 at 10:34 a.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance and anxiety. A Physician's order dated 11/20/14, indicated the resident was to receive Ativan (an anti-anxiety medication) 1 milligram (mg) by mouth every 6 hours as needed (prn) for anxiety. The November 2014 PRN Medication Administration Record (MAR), indicated the resident received the prn Ativan on 11/4, 11/13, 11/19, and 11/29/14 due to yelling out. The November 2014 Behavior/Intervention flow sheet was blank except for 11/17 and 11/28/14. There was no documentation to indicate what interventions had been attempted prior to giving the prn Ativan. The January 2015 PRN MAR, indicated the resident received the prn Ativan on 1/1 at 3:45 p.m., 1/3 at 8:00 a.m., 1/4 at 10:00 a.m., 1/6 at 10:15 a.m., 1/12 no time, 1/14 at 1:00 p.m., and 1/17/15 at 10:00 a.m.		in-serviced on: ·Use of non-pharmacological interventions prior to administration of any PRN anti-anxiety medication. ·Every shift completion of the behavior intervention form for each resident with orders for PRN anti-anxiety medications. ·Monitoring residents that receive PRN anti-anxiety medications and recording behaviors, interventions and side effects on the“Behavior Intervention Monthly Flow Record”. IV. Monitoring Three times a week the unit manager/designee will review 10 behavior monitoring sheets to ensure documentation is complete. Issues identified as a result of the review will be reported to the Director of Nursing, with staff re-education/counseling, or physician consultation as appropriate. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, as determined by the Quality Assurance committee, auditing will be completed and presented quarterly at the QA meeting. Monitoring will be on-going.	

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	The January 2015 Behavior/Intervention flow sheet was blank. There was no documentation of what interventions were attempted prior to giving the prn Ativan. Interview with the Unit Manager on 1/27/15 at 9:45 a.m., indicated the Behavior/Intervention flow sheets were not being completed and there was no documentation to indicate what interventions had been attempted prior to giving the prn Ativan. 2. The record for Resident #282 was reviewed on 1/22/15 at 10:40 a.m. The resident's diagnoses included, but were not limited to, anxiety and nonorganic psychosis. A Physician's order dated 11/20/14, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.5 milligrams (mg) three times a day as needed (prn) for anxiety. The December 2014 PRN Medication Administration Record (MAR), indicated the resident received the Xanax on the following dates: 12/2 at 9:00 p.m., 12/17 at 9:00 a.m. and 2:00 p.m., 12/19 at 10:00 a.m., 12/23 at 9:00 a.m., and 12/27/14 at 12:45 p.m.			

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	The December 2014 Behavior/Intervention flow sheet, had no documented behaviors for the above dates and there were no documented interventions attempted prior to giving the prn Xanax. The January 2015 PRN MAR, indicated the resident received the Xanax on the following dates: twice on 1/7, 1/9, 1/10, 1/11, 1/14, 1/15, and 1/20/15. Again, there were no documented behaviors and/or interventions attempted prior to giving the prn Xanax on the January 2015 Behavior/Intervention flow sheet. Interview with the Unit Manager on 1/27/15 at 9:45 a.m., indicated the behavior intervention flow sheets were not being completed to show what interventions were attempted prior to giving prn medications. 3. The record for Resident #271 was reviewed on 1/23/15 at 10:26 a.m. The resident's diagnoses included, but were not limited to, anxiety and dementia. The Quarterly Minimum Data Set (MDS) assessment dated 1/7/15 indicated the resident had short term memory problems, and was moderately impaired			

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	for decision making. The resident received an anti-anxiety medication for 7 days during the assessment reference period. Physician Orders on the current 1/2015 recap indicated Xanax (an anti-anxiety medication) 0.5 milligrams (mg) every 8 hours. Another order for Xanax was 0.25 mg prn (as needed for anxiety) every 6 hours. Review of the 12/2014 Medication Administration Record indicated on 12/10/14 no time, the resident received Xanax 0.25 mg one tab. Review of the 12/2014 Behavior/Intervention monthly flow sheet indicated there was no documentation of any behaviors prior to giving the prn Xanax. The 1/2015 MAR was reviewed. On 1/1/15 at 9:00 p.m., the resident received Xanax 0.25 mg. Review of the 1/2015 Behavior/Intervention monthly flow sheet indicated there was no documentation of any behaviors prior to giving the prn Xanax. Interview with the Director of Nursing on 1/26/14 at 1:45 p.m., indicated the Behavior flow sheets were to be completed when residents had behaviors and prior to the administration of the prn			

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	medications. 3.1-48(a)(4)			
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were stored properly on 1 of 5 units throughout the facility. (The third floor) Findings include: On 1/26/15 at 4:26 p.m., LPN #3 walked away from her Medication cart and came to the Nurses' station and took Resident #289 down the hall to her room to administer eye drops. At this time, the LPN left all of her eye drop medications on top of the Medication cart. There was one bottle of "bio tears", three bottles of "artificial tears", a bottle of "natural tears" a bottle of "Cosopt" eye drops and a bottle of "brimonide 0.2%" eye drops. There were residents in the hall way at this time. No other Nursing staff members were present in the hall. Interview with the Director of Nursing on 1/27/15 at 10:38 a.m., indicated the medication should not have been left unattended on top of the medication cart. The facility policy titled "Medication Storage in the Facility" was reviewed on 1/27/15 at 11:30 a.m., and identified as current by the Director of Nursing. The policy indicated the following:	F000431	I. Specific Corrective Action The eye drop vials were placed in the locked third floor medication cart. No residents were affected. II. Identification of other residents and corrective action All residents have the potential to be affected by the alleged deficient practice. The nurse assigned to the medication cart was educated on proper storage of eye drops. III. Systemic changes Licensed Nursing staff were in-serviced on: ·Medication storage related to eye drops. ·Rational for proper storage of medication. IV. Monitoring The unit manager/designee will observe 10 carts a week on different shifts to ensure that eye drops are stored properly. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, as determined by the Quality Assurance committee, auditing will be completed and presented quarterly at the QA meeting. Monitoring will be on going.	02/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/27/2015
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	"Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." 3.1-25(j)			
F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin			

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure wash basins and urinals were stored properly to prevent the spread of infection for 5 of 5 Units. (Units 100, 200, 300, 400, and 500) Findings include: 1. On 1/21/15 at 1:22 p.m., in Room 116, there was an urinal located on the back of the toilet. It was uncovered with the lid off. There was one resident who resided in the room. 2. On 1/21/15 at 8:49 a.m., in Room 205, there was a urine collection device uncovered and sitting on the back of the toilet tank. There were two residents who resided in the room. 3. On 1/21/15 at 8:56 a.m., in Room 207, there was a urinal and graduated collection device uncovered and stored	F000441	I. Specific Corrective Action ·The urinal in room 116 located on the back of the toilet was disposed of. A new urinal was re-issued and it stored properly. ·The urine collection device in room 205 sitting on the back of the toilet tank was disposed of. The resident in 205-1 was re-issued a new one and it was stored properly. ·The urinal and graduated collection device for room 207 was disposed of from the back of the toilet tank. A new graduated collection device was re-issued and stored properly. ·In room 202 the three bedpans on the floor, the two wash basins in the bathtub, and the urinal uncovered sitting on the back of the toilet tank were disposed of. The resident in 202-1 was re-issued a bed pan, wash basin and graduated collection device and stored properly. The resident in 202-2 was re-issued a bed pan and wash basin and stored properly. ·In room 229 the graduated	02/09/2015

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	on the back of the toilet tank. There was one resident who resided in the room. 4. On 1/20/15 at 11:12 a.m., in Room 202, there were three bedpans stored on the floor behind the toilet in the bathroom. There were also two wash basins stored in the bathtub, and a urinal uncovered sitting on the back of the toilet tank. There were two residents who resided in the room. 5. On 1/21/15 at 10:33 a.m., in Room 229, there was a graduated urine collection device uncovered on the back of the toilet tank. There were two residents who resided in the room. 6. On 01/21/15 at 10:47 a.m., in Room 221, there was a bath basin uncovered and stored on the back of the toilet tank. There were two toothbrushes uncovered and sitting on the mirror ledge in bathroom. There were two residents who resided in the room. 7. On 1/21/15 at 9:40 a.m., in Room 322, there was a wash basin on the floor by the resident's bed. The basin was not covered in plastic. There were two residents who resided in the room. 8. On 1/21/15 at 9:01 a.m., in Room 425, there was a wash basin on the floor in the		urine collection device uncovered on the back of the toilet tank was disposed of. The resident was re-issued a new one and it was stored properly. ·In room 221 the wash basin uncovered on the back of the toilet tank, and the two toothbrushes uncovered and sitting on the mirror ledge in bathroom were disposed of. The resident in 221-1 was re-issued a washbasin and toothbrush. Items were stored properly. The resident in 221-2 was re-issued a toothbrush and it was stored properly. ·In room 322-1 the wash basin on the floor by the resident's bed was disposed of. A new one was re-issued and stored properly. ·In room 425 the wash basin on the floor in the bathroom was disposed of. A wash basin was re-issued and stored properly. ·In Room 412 the urinal located on the night stand was disposed of. A urinal was re-issued and stored properly. ·In room 501 the can of shaving cream was removed. ·In room 511 wash basin on the floor underneath the sink in the bathroom was disposed of. The resident in room 511-1 was re-issued a wash basin and it was stored properly. III. Identification of other residents and corrective action All facility residents who use wash basins, urinals, tooth brushes, shaving cream and graduated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/27/2015
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	bathroom. The wash basin was not covered in plastic. There was one resident who resided in the room. 9. On 1/21/15 at 9:20 a.m., in Room 412, there was a urinal located on the night stand where the resident's belongings were located. The lid was observed to be off. There were two residents who resided in the room. 10. On 1/21/15 at 9:11 a.m., in Room 501, there was a can of shaving cream on the back of the toilet. There were two residents who resided in the room. 11. On 1/21/15 at 9:23 a.m., in Room 511, there was a pink wash basin on the floor underneath the sink in the bathroom. The basin was not covered in plastic. There were two residents who resided in the room. The current 4/2007 Bedpan/Urinal Offering/Removing policy provided by the Director of Nursing indicated "If the resident keeps his urinal at his bedside, check it frequently. Empty and clean it as necessary. Note on the resident's care plan his request to keep the urinal at his bedside. Clean the urinal. Wipe dry with a clean paper towel. Discard paper towel in designated container. Store the bedpan or urinal per facility policy. Do not leave		cylinders have the potential to be affected by the alleged deficient practice. A room-to-room audit was completed to ensure all washbasins, urinals, bedpans, toothbrushes, graduated cylinders and shaving cream were stored properly. III. Systemic changes All Nursing staff were in-serviced on: ·Proper cleaning, disposal, labeling and storage of wash basins, toothbrushes, urinals and graduated cylinders. ·Proper storage of shaving cream. ·Policy titled "Bedpan/urinal - offering/removing". ·If the resident prefers to store his/her belongings in a different location, notification to the nurse needs to be made and it must be care planned. IV. Monitoring Weekly, the Environmental services/designee will monitor 10 resident rooms for proper storage of items. The Environmental services /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, as determined by the Quality Assurance committee, auditing and monitoring will be completed and presented quarterly at the QA meeting. Monitoring will be on-going.	

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	it in the bathroom or on the floor. Interview with the Environmental Supervisor on 1/26/15 at 1:30 p.m., indicated Nursing staff were responsible for the storage of wash basins and urinals. Interview with the Director of Nursing on 1/27/14 at 10:30 a.m., indicated urinals, wash basins, and urine collection devices were not to be stored on the floor in the bathrooms. 3.1-18(b)(1)			
F000463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the resident's call system was functioning on 1 of 5 units. (Unit 500) Findings include: On 1/21/15 at 9:19 a.m., in Room 505-2 the call light was not functioning next to resident's bed. Further observation	F000463	I. Specific corrective action The call light in room 502-2 was immediately repaired by the maintenance director. II. Identification of other residents and corrective action The facility has performed an audit of all call lights in the building to ensure all are in proper working order. III. Systemic changes Nursing staff have been in-serviced on the process for immediately notifying	02/09/2015

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	indicated when pressed the call light did not light up outside the resident's room, nor did it make any type of sound. Interview with the 5th Floor Unit Manager at that time, indicated the call light was not functioning properly. 3.1-19(u)(1)		maintenance of any improperly working call light. Maintenance has been instructed on prioritizing the repair of any noted call light malfunction. Each nursing station has been provided with manual hand bells for resident use in the event maintenance cannot immediately repair a call light. IV. Monitoring The Maintenance Director/designee will conduct a call light audit of one nursing unit and ground floor resident area each week to verify proper functioning of the call lights. Audit findings will be presented to the Administrator for monthly review at the Quality Assurance meeting for three quarters. On-going audits will be conducted by maintenance, with revision by QA recommendation as necessary.	
F000465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to keep the resident's environment clean and in good repair related to rusty toilet bowls, dusty ceiling vents, marred walls and torn wallpaper on 2 of 5 units. (The 400 and 500 units) Findings include: 1. The following was observed during the Environmental Tour on 1/26/15 at	F000465	I. Specific corrective action 1A and 2B. The toilet bowls in rooms 410 and 510 were cleaned. 1B. The bathroom vent in 425 was dusted. 2A, 2C and 2D. The marred walls were patched and painted. The wallpaper was repaired and/or re-glued. The cove base was replaced. II. Identification of other residents and corrective action All residents have potential to be	02/09/2015

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	12:50 p.m., on Unit 400: A. The toilet bowl was rusty in Room 410. There was one resident who resided in the room. B. The bathroom ceiling vent was dusty in Room 425. There was one resident who resided in the room. 2. The following was observed during the Environmental Tour on 1/26/15 at 12:55 p.m., on Unit 500: A. In Room 524, the cove base and wall were marred by the heat register. The wall was marred at the base of both beds The wallpaper behind bed two was torn and peeling. There were two residents who resided in the room. B. The toilet bowl was rusty in Room 510. There were two residents who resided in the room. C. Behind the head of the bed in Room 505-2 the walls were marred and the wallpaper was torn. There were also holes noted in the plaster. There were two residents who resided in the room. D. In Room 503-1 the walls by the television stand were marred. There were chunks of plaster missing as well on the		affected by the alleged deficient practice. Maintenance and Environmental Services have conducted rounds on each unit to ensure a safe, functional, sanitary and comfortable environment. III. Systemic changes Nursing and environmental services staff have been re-educated on the procedure of notifying maintenance of any necessary repairs. The Environmental Services Supervisor/designee will audit 5 rooms per week, per unit, for maintenance repairs, forwarding any identified concerns to Maintenance for correction. IV. Monitoring The Environmental Services Supervisor will submit the audit results monthly to the Administrator. The Administrator will submit a summary of the findings to the Quality Assurance Committee quarterly for three quarters for review and/or recommendations. Monitoring will be on-going.	

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	wall and the edge of the wall had plaster missing. There were two residents who resided in the room. Interview with the Environmental Supervisor on 1/26/15 at 1:30 p.m., indicated all of the above were in need of cleaning and/or repair. 3.1-19(f)			
F000520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review,	F000520	I. Specific corrective action	02/09/2015

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	the facility failed to implement an ongoing action plan of monitoring behaviors and non-medication interventions prior to giving prn (as needed) psychotropic medications through the facility's quality assurance protocol. (Residents #271, #282, and #294) Findings include: Interview with the Administrator on 1/27/15 at 11:24 a.m., indicated the Quality Assessment and Assurance (QA & A) committee consisted of herself, the Director of Nursing, department heads, Medical Director, and the consulting Pharmacist. She indicated the committee met monthly. She indicated the QA & A committee had identified the need to decrease the use of psychotropic medications. The interventions currently used included gradual dose reductions, using proper diagnoses to justify medication use and Pharmacist reviews of medication regimens. She indicated an issue had been identified related to the Behavior/Intervention flow sheets not being completed and lack of documentation indicating what non-medication interventions had been attempted before giving a prn psychotropic medication.		Licensed professional staff were re-educated on the requirements for properly completing the behavior monitoring records for residents receiving PRN psychotropic medications on February 5, 2015 by the Director of Nursing/designee. The respective physicians for residents 282, 294 and 271 were consulted regarding clinical appropriateness of ordered PRN psychotropic medications. The current orders were confirmed by the physician. II. Identification of other residents and corrective action All residents receiving PRN psychotropic medications have the potential to be affected by the alleged deficient practice. A list of residents currently on PRN psychotropic medications will be compiled and any identified issues be addressed. III. Systemic Changes A special subcommittee meeting of the Quality Assurance Committee was held on February 9, 2015 to review issues associated with psychotropic PRN medication documentation and to broaden the current action plan of monitoring behaviors and non-medication interventions prior to PRN psychotropic medication administration, including: ·Unit manager/designee will review ten (10) behavior monitoring sheets 3 x weekly for completion. ·Issues identified as a result of the review will be reported to the	

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	Interview with the Director of Nursing (DON) on 1/27/15 at 2:52 p.m., indicated an issue with the completion of the Behavior/Intervention flow sheets had been identified in the previous QA & A meetings. The DON indicated only "so many" behavior sheets would be audited monthly. She indicated there was still a problem with the completion of the behavior sheets but a new system had not been implemented to correct the problem. The record for Resident #294 was reviewed on 1/23/15 at 10:34 a.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance and anxiety. A Physician's order dated 11/20/14, indicated the resident was to receive Ativan (an anti-anxiety medication) 1 milligram (mg) by mouth every 6 hours as needed (prn) for anxiety. The November 2014 PRN Medication Administration Record (MAR), indicated the resident received the prn Ativan on 11/4, 11/13, 11/19, and 11/29/14 due to yelling out. The November 2014 Behavior/Intervention flow sheet was blank except for 11/17 and 11/28/14. There was no documentation to indicate		Director of Nursing, with staff re-education/counseling, or physician consultation as appropriate. IV. Monitoring The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, as determined by the Quality Assurance committee, auditing will be completed and presented quarterly at the QA meeting. Monitoring will be on going.	

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	what interventions had been attempted prior to giving the prn Ativan. The January 2015 PRN MAR, indicated the resident received the prn Ativan on 1/1 at 3:45 p.m., 1/3 at 8:00 a.m., 1/4 at 10:00 a.m., 1/6 at 10:15 a.m., 1/12 no time, 1/14 at 1:00 p.m., and 1/17/15 at 10:00 a.m. The January 2015 Behavior/Intervention flow sheet was blank. There was no documentation of what interventions were attempted prior to giving the prn Ativan. Interview with the Unit Manager on 1/27/15 at 9:45 a.m., indicated the Behavior/Intervention flow sheets were not being completed and there was no documentation to indicate what interventions had been attempted prior to giving the prn Ativan. The record for Resident #282 was reviewed on 1/22/15 at 10:40 a.m. The resident's diagnoses included, but were not limited to, anxiety and nonorganic psychosis. A Physician's order dated 11/20/14, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.5 milligrams (mg) three times a day as			

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	needed (prn) for anxiety. The December 2014 PRN Medication Administration Record (MAR), indicated the resident received the Xanax on the following dates: 12/2 at 9:00 p.m., 12/17 at 9:00 a.m. and 2:00 p.m., 12/19 at 10:00 a.m., 12/23 at 9:00 a.m., and 12/27/14 at 12:45 p.m. The December 2014 Behavior/Intervention flow sheet, had no documented behaviors for the above dates and there were no documented interventions attempted prior to giving the prn Xanax. The January 2015 PRN MAR, indicated the resident received the Xanax on the following dates: twice on 1/7, 1/9, 1/10, 1/11, 1/14, 1/15, and 1/20/15. Again, there were no documented behaviors and/or interventions attempted prior to giving the prn Xanax on the January 2015 Behavior/Intervention flow sheet. Interview with the Unit Manager on 1/27/15 at 9:45 a.m., indicated the behavior intervention flow sheets were not being completed to show what interventions were attempted prior to giving prn medications.			

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	The record for Resident #271 was reviewed on 1/23/15 at 10:26 a.m. The resident's diagnoses included, but were not limited to, anxiety and dementia. The Quarterly Minimum Data Set (MDS) assessment dated 1/7/15 indicated the resident had short term memory problems, and was moderately impaired for decision making. The resident received an anti-anxiety medication for 7 days during the assessment reference period. Physician Orders on the current 1/2015 recap indicated Xanax (an anti-anxiety medication) 0.5 milligrams (mg) every 8 hours. Another order for Xanax was 0.25 mg prn (as needed for anxiety) every 6 hours. Review of the 12/2014 Medication Administration Record indicated on 12/10/14 no time, the resident received Xanax 0.25 mg one tab. Review of the 12/2014 Behavior/Intervention monthly flow sheet indicated there was no documentation of any behaviors prior to giving the prn Xanax. The 1/2015 MAR was reviewed. On 1/1/15 at 9:00 p.m., the resident received Xanax 0.25 mg. Review of the 1/2015			

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	Behavior/Intervention monthly flow sheet indicated there was no documentation of any behaviors prior to giving the prn Xanax. Interview with the Director of Nursing on 1/26/14 at 1:45 p.m., indicated the Behavior flow sheets were to be completed when residents had behaviors and prior to the administration of the prn medications. 3.1-52(b)(2)			
F009999	3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced	F009999	I. Specific corrective action The facility is unable to retrospectively correct the survey observations as the 2014 calendar year time period for corrections has ended. II. Identification and corrective action for other instances of non-compliance The facility is unable to retrospectively correct any identified instances of non-compliance as the 2014 calendar year time period for corrections has ended. III. Systemic changes The facility will continue to offer monthly dementia training in-services for all staff, including the “Hand in Hand” training program. Each department director will be responsible for assigning staff members in their respective departments to attend the	02/09/2015

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	by: Based on record review and interview, the facility failed to ensure three hours of dementia-specific training was completed annually for 5 of 10 employee files reviewed. (Housekeeper #1, Dietary Staff #1, CNA #2, Maintenance Staff #1, and CNA #5) Findings include: Review of the inservice log for the calendar year 2014, on 1/27/15 at 11:30 a.m., indicated the following employees did not have the annual three hours of dementia specific training: -CNA #5 20 minutes -CNA #2 30 minutes -Housekeeper #1 60 minutes -Dietary Staff #1 60 minutes -Maintenance Staff #1 60 minutes Interview with the Assistant Administrator on 1/27/15 at 3:30 p.m., indicated the above employees did not receive the annually required three hours of dementia training. 3.1-14(u)		required dementia training. The In-service Director will track each staff member's attendance at the training, via individual employee signature on the in-service attendance record. The In-service Director will notify each department director of staff who have yet to complete the annually required number of hours at the end of August each calendar year. The department heads will then assign their respective employees to attend training by the end of the calendar year. Instances of non-compliance by the end of the calendar year will result in the staff member being taken off the schedule until the requirement is fulfilled. IV. Monitoring The In-service Director will track each employee's attendance for the three hour annual training. Each department head will assign the employees in their department to attend the dementia training as a component of their scheduled hours. Non-compliance by the end of the calendar year will be referred to the Administrator and HR for follow-up.	