| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 11/17/2014 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESTPARK REHABILITATION CENTER | 25 S BOEHNE CAMP RD<br>EVANSVILLE, IN 47712 |

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| F000000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: November 5, 6,10,12,13,17, 2014<br><br>Facility number: 00221<br>Provider number: 155328<br>AIM number: 100267620<br><br>Survey Team:<br>Diana Perry, RN-TC November 5, 6, 12, 13, 17, 2014<br>Denise Schwandner, RN<br>Barbara Fowler, RN<br>Anna Villain, RN<br>Diane Hancock, RN November 5, 6, 10, 12, 13, 17, 2014<br><br>Census Bed Type:<br>SNF/NF: 78<br>Total: 78<br><br>Census Payor Type:<br>Medicare: 11<br>Medicaid: 59<br>Other: 8<br>Total: 78<br><br>These deficiencies also reflect State findings cited in accordance with 410 | F000000 | West Park Rehabilitation<br>25 Boehne Camp Road<br>Evansville, In 47712<br><br>Plan of Correction/Credible Allegation of Compliance/Disclaimer<br><br>This plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission or agreement, with the deficiencies or conclusions contained in the Department's inspection report.<br><br>Date 12/16/2014 | |

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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| | IAC 16.2-3.1.<br><br>Quality review completed on November 20, 2014 by Jodi Meyer, RN | | | |
| F000225<br>SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law | | | |

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| | (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on interview and record review, the facility failed to ensure prompt reporting of allegations of abuse to the administrator and the State Survey Agency for 1 of 8 allegations of abuse investigations reviewed. (Resident #151)<br><br>Findings include:<br><br>On 11/6/14 at 11:02 a.m., Resident #151 indicated there had been an occasion in which she had felt verbally abused.<br><br>On 11/12/14 at 10:00 a.m., the incidents reported to the State Survey Agency were reviewed. An incident report dated 5/2/14 indicated CNA #7 overheard inappropriate remarks from CNA #8 to Resident #151 on 4/29/14. The incident report indicated CNA #7 contacted the company compliance hotline on 4/30/14. The incident report further indicated on 5/2/14 CNA #8 was suspended and an investigation was started.<br><br>On 11/13/14 at 12:17 p.m., the Administrator and the DON were interviewed. The Administrator indicated there had been conflict between the two employees. The Administrator | F000225 | It is the policy of this facility that all allegations that meet the definition of abuse and substantiated violations will be reported to the appropriate State agencies "immediately" – meaning as soon as possible after discovery of an incident.<br><br>Facility residents have the potential to be affected by the timeliness of reportable incidents.<br><br>In order to enhance currently compliant operations, staff have been re- educated on Abuse Policy and Procedure.<br><br>Administrator/Designee will review reports of allegations of abuse daily (Monday thru Friday) x 2 weeks, 3 times a week x2weeks, then weekly for 4 months, and then monthly x6months.<br><br>Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 quarters to determine further recommendations as needed.<br><br>Date: 12/16/2014 | 12/16/2014 |

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| | indicated CNA #7 had notified the wrong people and should have contacted the Administrator or the DON, however, the CNA did not follow the policy. The Administrator indicated the CNA had contacted the hotline on 4/30/14 and the hotline sent an email to the Administrator on the evening of 5/1/14, but the Administrator had already left for the day. The Administrator indicated the issue was addressed the morning of 5/2/14.<br><br>On 11/13/14 at 2:13 p.m., the DON provided the "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" policy. The policy included, but was not limited to, "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies...requires centers to report these alleged violations to the Administrator and DON/designee immediately."<br><br>3.1-28(c) | | | |
| F000226<br>SS=D | 483.13(c)<br>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of | | | |

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| | residents and misappropriation of resident property.<br>Based on interview and record review, the facility failed to ensure the abuse policy was followed, in that, the Administrator and the State Survey Agency was not immediately notified following an allegation of abuse. (Resident #151)<br><br>Findings include:<br><br>On 11/12/14 at 10:00 a.m., the incidents reported to the State Survey Agency were reviewed. An incident report dated 5/2/14 indicated CNA #7 overheard inappropriate remarks from CNA #8 to Resident #151 on 4/29/14. The incident report indicated CNA #7 contacted the company compliance hotline on 4/30/14. The incident report further indicated on 5/2/14 CNA #8 was suspended and an investigation was started.<br><br>On 11/13/14 at 12:07 p.m., the Administrator indicated CNA #7 had not followed the abuse policy by notifying the compliance hotline instead of the Administrator immediately following an allegation of abuse.<br><br>On 11/13/14 at 2:13 p.m., the DON provided the "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, | F000226 | It is the policy of this facility that all allegations that meet the definition of abuse and substantiated violations will be reported to the appropriate State agencies "immediately" – meaning as soon as possible after discovery of an incident.<br><br>Facility residents have the potential to be affected by the timeliness of reportable incidents.<br><br>In order to enhance currently compliant operations, staff have been re- educated on Abuse Policy and Procedure.<br><br>Administrator/Designee will review reports of allegations of abuse daily (Monday thru Friday) x 2 weeks, 3 times a week x2weeks, then weekly for 4 months, and then monthly x6months.<br><br>Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 quarters to determine further recommendations as needed.<br><br>Date: 12/16/2014 | 12/16/2014 |

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| | Including Injuries of Unknown Source, and Misappropriation of Resident Property" policy. The policy included, but was not limited to, "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies...requires centers to report these alleged violations to the Administrator and DON/designee immediately."<br><br>3.1-28(a) | | | |
| F000248<br>SS=D | 483.15(f)(1)<br>ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br>Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities for the cognitively impaired for 1 of 3 residents reviewed, in a sample of 7 that met the criteria. (Resident #25)<br><br>Findings include:<br><br>On 11/10/14 at 11:08 a.m., Resident #25 was observed lying in bed.<br><br>On 11/10/14 at 3:12 p.m., Resident #25 was observed lying in bed. | F000248 | F 248 D<br>Activities Meet Interests/Needs of Each Resident<br><br>Resident #25 is receiving 1:1 activities per State and Federal regulation. Activity visits are documented in the 1:1 log.<br><br>Other residents identified as needing 1:1 activities are having activities provided by the Administrator/Designee with consulting assistance from Lacy Beyl and Company. 1:1 activities are documented in the 1:1 log per visit. | 12/16/2014 |

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| | On 11/12/14 at 9:14 a.m., Resident #25 was observed lying in bed.<br><br>On 11/13/14 at 9:15 a.m., Resident #25 was observed sleeping in bed.<br><br>On 11/10/14 at 3:14 p.m., Resident #25's clinical record was reviewed. Resident #25 was admitted on 6/21/12. Resident #25's diagnoses included, but were not limited to, bipolar disorder, Parkinson's disease, affective disorder, cerebral vascular accident with right sided hemiplegia, and shared psychotic disorder.<br><br>The "Activity Progress Note", dated 10/12/14, indicated Resident #25 had attended zero group activities on a monthly basis. The form further indicated the resident had been added to 1:1 (one to one) room visits.<br><br>On 11/13/14 at 3:57 p.m., the ADON (Assistant Director of Nursing) indicated Resident #25 did not get out of bed.<br><br>On 11/13/14 at 4:10 p.m., the SSD (Social Service Director) provided the "1:1 Participation Record". The record indicated Resident #25 had 3 different visits on 10/16/14, 10/20/14, and 10/23/14. The SSD indicated those were | | The Administrator will review the 1:1 logs to ensure appropriate time and identified activities are being offered. The Administrator will review the logs weekly times 4 months, then quarterly for 2 quarters.<br><br>Identified trends will be reviewed in the monthly QA meetings for 6 months, then quarterly for 2 quarters to determine further recommendations as needed.<br><br>Date: 12/16/2014 | |

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| | 155328 | A. BUILDING 00<br>B. WING | 11/17/2014 |

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| | the only visits Resident #25 had from October to that date (11/13/14).<br><br>3.1-33(a) | | | |
| F000272<br>SS=D | 483.20(b)(1)<br>COMPREHENSIVE ASSESSMENTS<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | | | |

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| | Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set assessments reflected the residents' functional capacities, for 2 of 27 Stage 2 residents reviewed for assessments, in that a resident with limited range of motion was not assessed as having limitations, and a resident who was independently ambulatory had an assessment indicating she needed extensive assistance. (Residents #56, #121)<br><br>Findings include:<br><br>1. Resident #56's clinical record was reviewed on 11/13/2014 at 9:20 a.m. The resident's annual Minimum Data Set (MDS) assessment, dated 6/6/14, indicated he required extensive assistance of two persons for transfer and was unable to ambulate. The MDS indicated he had no impairment in range of motion. The quarterly MDS assessment, dated 9/1/14, indicated the same limitations in transfers and ambulation, and no impairments in range of motion. A quarterly MDS assessment, dated 10/8/14, indicated total assistance was needed for transfers and the resident was unable to ambulate. The assessment indicated no impairment in range of motion. | F000272 | The corrective action to be accomplished for those residents found to have be affected by the practice are that res 56 and 121 will have comprehensive assessments completed.<br><br>Since residents have the potential to be affected by the deficient practice residents will be evaluated to ensure the ROM status in the MDS is correct.<br><br>The ADL acuity report will be reviewed weekly by nursing management for variance in the reports to identify changes in ADL status.<br><br>Nursing staff have been re-educated on identification and appropriate documentation of ADLs and ROM.<br>Identified trends will be reviewed in the monthly QA for 6 months, then quarterly for 2 quarters to determine further recommendations as needed.<br><br>Date 12/16/2014 | 12/16/2014 |

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| | The care plan section included a Resident Program History Report, dated 1/14/14. It indicated the resident was on an active range of motion program. The plan was for restorative nursing care for active range of motion of the bilateral upper and lower extremities in group exercises or the resident's room. The resident was to do 5 repetitions of each joint. At that date, there was also an ambulation program with a goal to ambulate 200 feet daily.<br><br>On 11/13/2014 at 9:32 a.m., CNA #4 and CNA #3 were observed to transfer Resident #56 to bed with a mechanical lift. The CNA's gave the resident a bed bath. During the bath, the resident was observed to be unable to straighten his lower legs out, difficult to open legs, and the arms at the elbows would not straighten. The CNAs indicated during interview, he had been like that for awhile. His neck also was bent forward and would not straighten out throughout the bath. CNA #3 indicated the neck stayed like that.<br><br>2. Resident #121 was observed on 11/10/14 at 11:28 a.m. She was seated in a personal recliner/rocking chair. She was alert but not oriented, and indicated it was her first day in the facility. | | | |

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| | Resident #121's clinical record was reviewed on 11/10/2014 at 11:43 a.m. The resident was admitted on 5/15/14 with diagnoses included, but were not limited to, atrial fibrillation, hypertension, dementia, and generalized debility.<br><br>The resident's quarterly Minimum Data Set (MDS) assessment, dated 9/23/14, indicated she was severely cognitively impaired, and required extensive assistance of 1 staff person for transfers and walking in the room and/or corridor.<br><br>Nurses' notes indicated the resident's activity level as follows:<br>9/11/14 5:45 p.m. "ambulates ad lib..."<br>9/20/14 9:00 p.m. "...ambulates in the halls independently..."<br>9/22/14 10:20 a.m. "...feeds self [after] tray set up. Independent for transfers, toileting, and bed mobility..."<br>10/16/14 1:15 p.m. "Resident up ad lib throughout facility..."<br><br>3.1-31(a) | | | |
| F000280<br>SS=D | 483.20(d)(3), 483.10(k)(2)<br>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or | | | |

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| | changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br>Based on observation, interview, and record review, the facility failed to revise the plan of care for 1 of 27 residents reviewed, in that, the care plan did not reflect the residents preference for bathing. (Resident #25)<br><br>Findings include:<br><br>On 11/12/14 at 10:56 a.m., CNA #5 and CNA #3 were observed to provide care to Resident #25 in bed.<br><br>On 11/10/14 at 3:24 p.m., Resident #25's clinical record was reviewed.<br><br>The care plans included, but were not limited to:<br>Potential or Actual ADL/Mobility deficit, poor oral hygiene, oral infection, the interventions included, but were not limited to, Assist/encourage/provide per | F000280 | The corrective action to be accomplished for Resident # 25 is to correct the care plan to the current preference.<br><br>Other residents have the potential to be affected by the same practice. The DON/designee will conduct an audit of care plans to ensure the most current bathing preference is reflected.<br><br>Education of the care plan team to ensure Life Enrichment preferences are reflected and are update accordingly. This will be done with each OBRA assessment.<br><br>Identified trends will be reviewed in the monthly QA meeting for 6 months, then quarterly for 2 quarters to determine further recommendations as needed.<br><br>Date: 12/16/2014 | 12/16/2014 |

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| | resident preference: shower or bed bath. Activity pursuit plan of care indicated resident preferred a shower.<br><br>The Annual MDS (Minimum Data Set) assessment, dated 7/12/14, indicated it was somewhat important for Resident #25 to choose between a shower, tub bath, or sponge bath.<br><br>On 11/13/14 at 2:35 p.m., CNA #5 indicated Resident #25 only received bed baths.<br><br>On 11/13/14 at 3:57 p.m., the ADON (Assistant Director of Nursing) indicated Resident #25 no longer got out of bed because she did not wish to.<br><br>On//17/14 at 12:39 p.m., the MDS (Minimum Data Set) Specialist indicated care plans are updated on the last day of the assessment and/or when the assessment is closed.<br><br>3.1-35(d)(2)(B) | | | |
| F000318<br>SS=D | 483.25(e)(2)<br>INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 11/17/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER WESTPARK REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712 | |

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| | Based on observation, interview, and record review, the facility failed to ensure range of motion services were provided to 1 of 2 residents reviewed for range of motion, in the sample of 2 who met the criteria. (Resident #56)<br><br>Finding includes:<br><br>On 11/6/14 at 9:40 a.m., during the Stage 1 interview, RN #1 indicated the resident had contractures of both hands.<br><br>On 11/10/2014 3:08 p.m., the resident was observed in bed on his side. Contractures were observed of the lower extremities, upper extremities, and hands.<br><br>Resident #56's clinical record was reviewed on 11/13/2014 at 9:20 a.m. The resident's annual Minimum Data Set (MDS) assessment, dated 6/6/14 indicated he required extensive assistance of two persons for transfer and was unable to ambulate. The MDS indicated he had no impairment in range of motion.<br><br>The quarterly MDS assessment, dated 9/1/14, indicated the same limitations in transfers and ambulation, and no impairments in range of motion. A quarterly MDS assessment, dated 10/8/14, indicated total assistance was | F000318 | Resident #56 is receiving passive ROM daily. The unit charge nurse will ensure by visual observation and appropriate documentation in the TAR this is being carried out.<br><br>Other residents have the potential to be affected. An audit will be performed to identify any residents with contractures. The identified residents will receive therapy or restorative if indicated.<br><br>Nursing staff have been re-inserviced on ROM. Nursing care guide sheets will indicate which residents should have ROM and if passive or active. Restorative nurse champion will monitor compliance with ROM 2 X weekly via the Care tracker Program. Identified non-compliance will result in 1:1 re-education up and to termination.<br><br>Identified trends will be reviewed in QA monthly times 6 months and quarterly<br>2 quarters to determine further recommendations as needed.<br><br>Date: 12/16/2014 | 12/16/2014 |

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| | needed for transfers and the resident was unable to ambulate. The assessment indicated no impairment in range of motion.<br><br>The care plan section included a Resident Program History Report, dated 1/14/14. It indicated the resident was on an active range of motion program. The plan was for restorative nursing care for active range of motion of the bilateral upper and lower extremities in group exercises or the resident's room. The resident was to do 5 repetitions of each joint. At that date, there was also an ambulation program with a goal to ambulate 200 feet daily.<br><br>On 11/13/2014 at 9:32 a.m., CNA #4 and #3 were observed to transfer Resident #56 to bed via a mechanical lift. The CNAs gave the resident a bed bath. During the bath, the resident was observed to be unable to straighten his lower legs out, difficult to open legs, and arms at elbows would not straighten. The CNAs indicated during interview, he had been like that for awhile. His neck also was bent forward and would not straighten out throughout the bath. The CNA #3 indicated it stayed like that.<br><br>No range of motion exercises were provided for the resident. | | | |

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| | The Administrator was interviewed on 11/17/14 at 1:12 p.m. She indicated range of motion would be provided by the CNAs when they were giving care.<br><br>3.1-42(a)(2) | | | |
| F000327<br>SS=D | 483.25(j)<br>SUFFICIENT FLUID TO MAINTAIN HYDRATION<br>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.<br><br>Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident reviewed for hydration was provided fluids as tolerated between meals, in that the resident was observed with a full cup of thickened fluids at the bedside and no fluids offered during observations. (Resident #56)<br><br>Finding includes:<br><br>Resident #56 was observed in his room on 11/13/14 at 9:20 a.m. An 8 ounce cup of thickened liquids was observed on the bedside table. The cup was full; there was no spoon in the cup. The date on the cup was 11/12/14. The resident was observed continuously from 9:20 a.m. to 10:20 a.m. during a bed bath and transfer. Two CNAs, #3 and #4, were present | F000327 | Resident #56 is offered fluids with every resident fluids with his check and change and with every med pass. Fluid intake will be reviewed during daily clinical review to determine further needs.<br><br>Other residents who have the potential to be affected will be identified by review of the fluid consumptions in Care Tracker by the DON or designee. Fluid intake will be reviewed daily (Monday thru Friday)during daily clinical review on an on-going basis.<br><br>Nursing staff will be re-inserviced on hydration and recording fluid intake. Identified non-compliance will result in 1:1 education up to and including termination.<br><br>Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 quarters to | 12/16/2014 |

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| | during the bath. No fluids were offered during the time frame. The cup was observed again on 11/13/2014 at 11:30 a.m. and 2:45 p.m. It continued to be full with no spoon.<br><br>Resident #56's clinical record was reviewed on 11/13/14 at 11:04 a.m. The record included a physician's progress note, dated 10/2/14, that indicated, "Water deficit secondary to decreased po [oral] intake and I suspect strongly that he is aspirating, he remains a full code and has stated in past that he wouldn't want a feeding tube...cont [continue] hydration and pleasure feedings as tol. [tolerated]."<br><br>The record indicated the resident received supplemental IV fluids on 10/1/14 and 10/3/14.<br><br>The resident was hospitalized 10/31/14 to 11/5/14 for dehydration. Diet orders upon return from hospital were "pureed, honey thick liquids by teaspoon. PO [oral] as tolerated."<br><br>A notification of the physician, dated 11/10/14, indicated the following: "B/P [blood pressure] 116/77 [temperature] 96.1 - [pulse] 77 - [respirations] 16. Unable to obtain O2 sat. Fingers are cool. Lung sounds are | | determine further recommendations as needed.<br><br>Date:12/16/2014 | |

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| | diminished. Abdomen soft, with bowel sounds present and no extremity edema noted. Is very drowsy. Arouses when spoken to but then closes his eyes. Has not eaten bkfst [breakfast] or lunch today. Lips are dry. Mucus membranes are moist and intact, resident has not voided today. Talked with family and they are requesting IV fluids until they can have a family meeting."<br><br>Physician's orders were obtained on 11/10/14 at 5:55 p.m. to start a peripheral IV and administer 5% dextrose and normal saline solution at 50 cubic centimeters per hour for 1 liter, "Dx [diagnosis] dehydration."<br><br>On 11/13/2014 at 4:09 p.m., the Director of Nurses [DON] and Assistant Director of Nurses [ADON] were interviewed. Both indicated the resident was not taking food or fluids well and fluids were being offered at meals. The facility had just notified MD that resident had no urine output on that day shift. A urinalysis and culture and sensitivity had been ordered.<br><br>The only care plan in place was to monitor for signs of dehydration and encourage fluids unless contraindicated.<br><br>On 11/13/2014 at 4:16 p.m., the DON | | | |

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| | reported the resident had taken 200 cc with breakfast and 50 cc with lunch according to the CNA documentation.<br><br>The policy and procedure for thickened liquids, dated July 2004, was provided by the Administrator on 11/17/14 at 1:12 p.m. The procedure included, but was not limited to, the following: "Ensure availability of consumable thickened liquids at all times."<br><br>3.1-46(b) | | | |
| F000329<br>SS=D | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>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.<br><br>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 | | | |

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|---|---|---|---|---|
| | these drugs.<br><br>Based on observation, interview, and record review, the facility failed to ensure that 2 of 5 residents reviewed for unnecessary medications were free of unnecessary medications, in that a mood stabilizer dosage was increased without documented behaviors and that there was no documentation for a PRN (as needed) antianxiety medication. (Resident #62, Resident #29)<br><br>Findings include:<br><br>1. Resident #62 was observed on 11/5/14 at 1:30 p.m. lying in bed awake, confused, and uninterviewable.<br><br>Resident #62 was observed on 11/6/14 at 10:20 a.m. in his wheelchair at the nurse's station.<br><br>The clinical record of Resident #62 was reviewed on 11/10/14 at 8:55 a.m. The record indicated the diagnoses included, but were not limited to, Parkinson's, dementia, coronary artery disease, osteoarthritis, anxiety, constipation, and insomnia.<br><br>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 8/23/14, indicated that Resident #62 | F000329 | The physician of Resident # 62 has been consulted regarding a medication change of the Depakote. Physician of Resident #29 has made a medication change of the Xanax.<br><br>Other residents having the potential to be affected by the same practice will be identified by the DON or designee auditing MARs daily (Monday thru Friday) x 2 weeks, 3 times a week x 2 week, then weekly for 4 months and then monthly x 6 months. Physician orders will be screened daily for changes to psychotropic medications.<br><br>To ensure the practice does not reoccur nurses will be re-educated on appropriate use of psychotropic medications | 12/16/2014 |

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|---|---|---|---|
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| | experienced severe cognitive impairment.<br><br>The Physician Orders for Resident #62 dated 8/14/14, indicated an order for Depakote (a mood stabilizer) 125 mg (milligram) po (by mouth) twice a day.<br><br>The telephone order for Resident #62 dated 9/18/14, indicated an order for Depakote 250 mg po twice a day with a diagnosis of behavior and agitation.<br><br>The behavior chart for Resident #62 dated 8/14/14 through 9/18/14, indicated the resident had 2 incidents of resisting care and no other behaviors noted.<br><br>The nurses notes and the social service notes dated 8/14/14 through 9/18/14, indicate no episodes of behaviors noted.<br><br>An interview with the DON (Director of Nursing) on 11/17/14 at 12:15 p.m. indicated that she recalled the physician increased the Depakote dosage without written justification.<br>2. On 11/10/14 at 2:05 p.m., Resident #29 was observed sleeping in bed.<br><br>On 11/12/14 at 1:53 p.m., Resident #29 was observed sleeping in bed.<br><br>On 11/10/14 at 2:07 p.m., Resident #29's clinical record was reviewed. | | and documentation. Identified non compliance will result in 1:1 re-education up to and including termination.<br><br>The process will be monitored by the QA committee monthly times six months and quarterly times two quarters to determine further recommendations as needed.<br><br>Date 12/16/2014 | |

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| | The most recent signed physician's recapitulation orders, signed 10/30/14, indicated an order for Xanax (a medication used for the treatment of anxiety), 0.5 mg (milligrams), give 1 tablet, orally, 3 times a day as needed for anxiety.<br><br>The MAR (Medication Administration Record), dated 9/1/14 through 9/30/14, indicated the medication was administered daily 9/1/14 through 9/9/14, 9/11/14 through 9/17/14, 9/19/14 through 9/23/14, and 9/26/14 through 9/28/14. The MAR lacked documentation regarding the interventions attempted to treat the resident's anxiety prior to the as needed medication administration. The MAR lacked documentation regarding the effectiveness of the medication.<br><br>On 11/17/14 at 12:35 p.m., LPN #3 indicated if an anti-anxiety medication is ordered PRN (as needed) the staff documented the interventions prior to administering the medication and the medication's effectiveness on the back of the MAR.<br><br>3.1-48(a)(3)<br>3.1-48(a)(4) | | | |
| F000371 | 483.35(i) | | | |

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|---|---|---|---|---|
| SS=E | FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>Based on observation, interview, and record review, the facility failed to ensure food was distributed to 3 of 3 residents in a total of 17 residents who received their meals on the "A" and "B" units, in that, a CNA (certified nursing assistant) failed to sanitize her hands when delivering trays to residents rooms, and a CNA handled resident glasses by the rim for 3 of 3 residents observed during the meal meal pass on the skilled unit. (Resident #9, Resident #132, Resident #64, Resident #55, Resident #110, Resident #21)<br><br>Findings include:<br><br>1. During an observation on 11/6/14 at 12:05 p.m., CNA #1 was observed to obtain a lunch tray from the hall dining cart and deliver it to Resident #9. Upon entering the resident's room, CNA #1 placed the tray onto the resident's overbed table. CNA #1 applied Resident #9's bilateral hand splints. CNA #1 placed Resident #9's call light within the | F000371 | Residents were not Affected by the deficient practice.<br><br>Residents who eat in their rooms have the potential to be affected by the deficient practice.<br><br>CNAs will be re-inserviced on infection control, the proper serving of glasses and utensils, use of handwashing and alcohol gel during tray pass on the hall. Audits will be done daily, (Monday thru Friday) for 2 weeks, three times per week x 4 weeks, then once per week x 4 weeks, then monthly times 4 months, then quarterly x 2 to ensure trays being | 12/16/2014 |

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|---|---|---|---|
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| | resident's reach. CNA #1 proceeded to reposition Resident #9 in bed. CNA #1 placed the overbed table with the tray across Resident #9 and placed a spoon into Resident #9's hand. CNA #1 cut up the meat and place sweetener into his tea. CNA #1 obtained the spoon from Resident #9's hand and stirred the tea. After stirring the tea, CNA #1 placed the spoon back into Resident #9's hand. CNA #1 obtained the resident's straw from his chest of drawers and placed it into the milk container. CNA #1 opened the salt and pepper packets and sprinkled them over the resident's carrots. No hand hygiene was observed prior to or after delivering of the food tray.<br><br>2. During an observation on 11/6/14 at 12:08 p.m., CNA #1 was observed to push the hall food cart down the "A" hall. CNA #1 obtained a tray for Resident #132. CNA #1 delivered the tray to Resident #132 's room and placed it on the overbed table. CNA #1 exited the room and walked to the nurse's station, proceeded to speak with another employee, and lifted a desk calendar off of the nurse's desk and looked through the pages of the calendar. CNA #1 returned it to the nurse's desk. No hand hygiene was performed.<br><br>3. During an observation on 11/6/14 at | | passed appropriately. Management staff will conduct audits. Identified non-compliance will result in 1:1 re-education up to and including termination.<br><br>Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 quarters to determine further recommendation as needed.<br><br>Date: 12/16/2014 | |

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| | 12:09 p.m., CNA #1 was observed to obtain a lunch tray from the hall cart for Resident #64. CNA #1 entered Resident #64's room and placed the tray onto the resident's overbed table. CNA #1 was observed to move the covered catheter bag off of Resident #64's wheelchair and place it on the floor. CNA #1 opened the eating utensils for Resident #64 and began cutting up the meat. Resident #64 requested soup and CNA #1 walked down to the kitchen and obtained a bowl of soup which she delivered to Resident #64. CNA #1 obtained a clean towel from CNA #5 and placed the clean towel across Resident #64's chest. CNA #1 exited the room. CNA #1 pushed the lunch cart down the "B" hall and then sanitized her hands.<br><br>During an interview on 11/17/14 at p.m., CNA #2 indicated hands should be sanitized between residents when passing trays to them.<br><br>A procedure titled, Hand Hygiene - Plain Soap and Water Handwash," revised in November, 2011, and obtained from the DON (Director of Nursing) on 11/17/14 at 2:15 p.m., indicated hand hygiene is to be performed before and after having direct contact with residents and after contact with inanimate objects.<br>4. On 11/05/14 at 12:20 p.m., CNA #6 | | | |

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| | was observed to handle Resident #55's glass by the rim. There was no hand hygiene observed.<br><br>5. On 11/5/14 at 12:22 p.m., CNA #6 was observed to handle Resident #110's glass by the rim. There was no hand hygiene observed.<br><br>6. On 11/5/14 at 12:25 p.m., CNA #6 was observed to handle Resident #21's glass by the rim. There was no hand hygiene observed.<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F000441<br>SS=D | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections. | | | |

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| | (b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>Based on observation, interview and record review, the facility failed to ensure the infection control program was implemented to prevent possible transmission of infections from one resident to another for 1 of 2 observations of the cleaning of the glucometers, in that, the glucometer was not sanitized according to the manufacturer's instructions between residents. This had the potential to affect 2 residents residing on the "D" hall. (Resident #150, Resident #101)<br><br>Findings include:<br><br>During an observation on 11/13/14 at 11:29 a.m., LPN #1 was observed to be | F000441 | No residents were affected by the cited practice. Other residents have the potential to be affected by the same deficient practice. DON/designee will monitor cleaning of glucometers three times per week x 4 weeks, weekly x 3 weeks, monthly x 4 months and then quarterly x 2. Licensed nursing staff have been re-educated regarding appropriate cleaning of glucometers. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 quarters to determine further recommendations as needed.<br>Date: 12/16/2014 | 12/16/2014 |

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| | exiting Resident #150's room. LPN #1 was carrying a glucometer and set it upon the medication cart. LPN #1 indicated she had just obtained a blood sugar on the resident. LPN #1 wrote the results of the blood sugar into the log book and completed a narcotic count. LPN #1 indicated she had another blood sugar to obtain. LPN #1 picked up the glucometer from the top of the medication cart and obtained an alcohol wipe. LPN #1 proceeded to walk into Resident #101's room with the glucometer. LPN #1 indicated she cleaned the glucometer with an alcohol wipe as she could not find the proper sanitizing wipes on her cart. LPN #1 indicated the sanitizing wipes were located at the nurse's station but she did not have room for the wipes to be placed on her medication cart. LPN #1 was queried about locating the proper sanitary wipes and she proceeded to the nurse's station and questioned LPN #2 regarding the sanitation wipes for the glucometers. LPN #2 proceeded to the medication cart with LPN #1 and located the wipes in the bottom drawer. LPN #1 indicated she was planning to use alcohol wipes on the glucometer throughout the day if the wipes had not been located on her cart. LPN #1 indicated there were no immunocompromised residents on the hall who had blood sugars checked. LPN | | | |

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| | #1 obtained a sanitizing wipe and proceeded to clean the glucometer. Upon query, LPN #1 indicated the glucometer was to be wiped with the sanitizing wipe and left to dry for 5 minutes.<br><br>During an interview on 11/13/14 at 11:40 p.m., the DoN (Director of Nursing) indicated LPN #1 had just returned to work after being off on a medical leave. The DoN indicated LPN #1 should have wiped the glucometer as per the manufacturer's recommendations and the DoN instructed the Unit Manager to inservice LPN #1 regarding the cleaning of the glucometer.<br><br>A policy titled, "Glucose Monitoring Equipment: Disinfect/Decontaminate", dated November, 2011, and obtained on 11/17/14 at 12:37 p.m., from the DON (Director of Nursing), indicated the glucometer would be sanitized with a disinfectant wipe that is "EPA registered as tuberculoidal."<br><br>3.1-18(b)(1) | | | |
| F000465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the | F000465 | Tiles/floor/wall areas needing cleaned or repaired have been | 12/16/2014 |

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| | facility failed to ensure a safe, functional, and sanitary environment, for 12 of 30 rooms, in that resident care equipment was uncovered and unlabeled in shared bathrooms, paint was chipped, dirt and debris was built up in the corners and along the edges, and caulking was stained. (Room #231, 223, 217, 210, 213, 232, 214, 224, 216, 236, 208, 227)<br><br>Findings include:<br><br>1. On 11/5/14 at 11:37 a.m., Room 231 was observed. The walls in the bathroom were observed with black marks and chipped paint. The towel rack was observed with chipped paint. The commode caulking was observed to be stained brown. The handle to the closet door was observed to be loose. On 11/13/14 at 9:21 a.m., the same was observed.<br><br>2. On 11/6/14 at 8:49 a.m., Room 223 was observed. In the bathroom, three toothbrushes were observed to be uncovered and unlabeled. On 11/12/14 at 1:16 p.m., three toothbrushes and one bed pan was observed to uncovered and unlabeled in the bathroom.<br><br>3. On 11/6/14 at 9:04 a.m., Room 217 was observed. A piece of the bedroom | | identified and corrected. Caulking was replaced around the base of commodes where the caulking was discolored. Residents in shared rooms will have containers or storage bags provided for their personal equipment. Residents requiring assistance with storage of personal care items will be provided staff support. Upon a resident receiving new personal care equipment the items will be marked with the resident's name. The Maintenance and Housekeeping Supervisors will monitor bathrooms four time per week for six weeks, then quarterly thereafter. The Administrator or designee will be notified of any problems maintaining sanitary conditions. A compliance report will be provided to the Quality Assurance and Performance Improvement Committee (QAPI) during monthly meetings for a resolution to the problem. Date: 12/16/2014 | |

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| | floor tile was observed to be missing. On 11/12/14 at 1:27 p.m., the same was observed.<br>4. On 11/6/14 at 9:19 a.m., Room 210 was observed. The cove base was observed with dirt and debris built up. On 11/12/14 at 1:06 p.m., the same was observed.<br><br>5. On 11/06/14 at 9:23 a.m., Room 213 was observed. In the bathroom, two razors, one toothbrush, 2 cans of shaving cream, one black comb, one container of toothpaste, and one denture cup were observed to be unlabeled lying on the shelf above the sink. The floor tile in the bedroom was observed to be broken. The bathroom door frame was observed with chipped paint. On 11/12/14 at 1:09 p.m., the same was observed.<br>6. On 11/6/14 at 9:58 a.m., Room 232 was observed. The cove base in the bathroom was observed with dirt and debris built up. On 11/12/14 at 1:32 p.m., the same was observed.<br><br>7. On 11/6/14 at 9:58 a.m., Room 214 was observed. In the bathroom, a bottle of personal cleanser and a toothbrush were observed to be unlabeled. On 11/12/14 at 1:30 p.m., the same was observed. | | | |

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| | 8. On 11/6/14 at 10:22 a.m., Room 224 was observed. In the bathroom, two wash basins and one bottle of personal cleanser was observed to be unlabeled. The caulking around the base of the commode was observed to be brown in color. In the bathroom, the cove base was observed with dirt and debris built up. On 11/12/14 at 1:21 p.m., the same was observed.<br>9. On 11/6/14 at 11:06 a.m., Room 216 was observed. In the bathroom, two containers of baby oil, one container of body wash, one container of roll-on deodorant, one denture cup, one tube of Petroleum Jelly, and one tube of extra protective cream were observed to be unlabeled. In the bathroom, two bedpans were observed to be unlabeled and uncovered. The bedroom tile was observed to be missing. A pink stain was observed on the bathroom floor. On 11/12/14 at 1:11 p.m., the same was observed.<br>10. On 11/6/14 at 11:50 a.m., Room 236 was observed. The heating/air conditioning unit was observed with a foil like substance to cover the area between the wall and the unit. On | | | |

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| | 11/12/14 at 1:35 p.m. the heating/ air conditioning unit was observed with a one half inch area not covered by the foil like substance. The outside was visible through the opening.<br><br>11. On 11/6/14 at 1:53 p.m., Room 208 was observed. Dirt and debris was observed to be built up in the corners and along the edges and around the commode. On 11/12/14 at 1:05 p.m., the same was observed.<br>12. On 11/06/14 at 2:57 p.m., Room 127 was observed. The caulking around the commode was observed to be stained brown. On 11/13/14 at 2:27 p.m., the same was observed.<br>13. On 11/17/14 at 12:43 p.m., CNA #6 indicated resident care equipment should be in a bag with the residents name on it.<br>14. On 11/17/14 at 12:43 p.m., the Housekeeping Supervisor indicated resident rooms are cleaned daily including: trash removal, check of supplies, dust, clean furniture, clean bathroom, and sweep and mop. The Housekeeping Supervisor further indicated the deep cleaning of rooms included: pulling out the furniture, clean bed and bed frames, change the curtains, | | | |

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| | clean the edges and in the corners of the floors, sweep, mop and buffing of the floor. The Housekeeping Supervisor indicated if the room required maintenance the staff was to fill out a request and submit it.<br>3.1-19(f) | | | |