

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2014
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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 6, 7, 8, 9, & 10, 2014</p> <p>Facility number: 004945 Provider number: 155756 AIM number: 200814400</p> <p>Survey team: Sue Brooker RD TC Julie Call RN Martha Saull RN Virginia Terveer RN</p> <p>Census bed type: SNF: 30 SNF/NF: 104 Total: 134</p> <p>Census payor type: Medicare: 29 Medicaid: 66 Other: 39 Total: 134</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after November 9, 2014.</p>	

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

TITLE

(X6) DATE

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

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F000241 SS=E	<p>Quality Review completed on October 17, 2014, by Brenda Meredith, R.N.</p> <p>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 the dignity of the residents in the Memory Care unit dining room was promoted during mealtime as staff were cleaning while the residents were still eating their meals. This deficient practice had the potential to affect the 32 residents who ate their meals in the Memory Care Unit dining room.</p> <p>Finding includes: An observation in the Memory Care unit, on 10-8-2014 at 9:30 a.m., indicated</p>	F000241	<p>F 241 Dignity and Respect of Individuality It is the practice of this facility to ensure that all residents have dignity and respect of individuality.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-All housekeeping staff who work</p>	11/09/2014	

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	<p>Housekeeper #1 rolled the housekeeping cart into the dining room and parked the cart next to 2 residents who were still eating their breakfast. The broom was stored on the cart with the bristles up and were at eye level of the 2 residents eating breakfast. The broom had dust balls and dirt on the ends of the bristles.</p> <p>An observation in the Memory Care unit, on 10-8-2014 at 1:31 p.m., indicated the housekeeping cart was parked inside the dining room with the dusty and dirty broom bristles at eye level of a resident who was still eating lunch.</p> <p>An observation in the Memory Care unit, on 10-8-2014 at 1:35 p.m., indicated Housekeeper #1 was spraying a table with a disinfectant cleaner while a resident was eating her lunch.</p> <p>An observation in the Memory Care unit, on 10-9-2014 at 1:44 p.m., indicated the housekeeping cart was parked in the dining room as 2 residents were eating their lunch. One resident was at a table right next to the parked housekeeping cart.</p> <p>An observation in the Memory Care unit, on 10-10-2014 at 9:31 a.m., indicated Housekeeper #2 moved the housekeeping cart in the dining room right next to a</p>		<p>on the Memory Care unit were immediately in-serviced during the annual survey to prevent any other housekeeper from cleaning a table using disinfectant while residents were still sitting at the table as well as not putting the housekeeping cart in the immediate area of residents and keeping their brooms right side up so the bristles remain down in the dust pan.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>- All residents have the potential to be affected by the alleged deficient practice.</p> <p>- All housekeeping staff in the facility as well as all of nursing and activities were in-serviced to prevent anyone from cleaning a table with disinfectant while residents were still sitting at the table as well as not putting the housekeeping cart in the immediate area of residents and keeping their brooms right side up so the bristles remain down in</p>				

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	<p>table with a resident still eating her breakfast. Housekeeper #2 obtained a bag of trash and placed the trash in the cart right in front of the resident who was still eating. Another resident was at another table finishing her breakfast as the CNA (Certified Nurse Aide) staff were clearing the dirty dishes.</p> <p>A confidential interview with a family member of the resident who was still eating her meal while the housekeeping cart was parked right near her loved one, indicated it bothered her that the housekeeping cart was sitting right by her mother. The family member indicated this situation had previously been communicated to the Memory Care Unit staff.</p> <p>Further observation of Housekeeper #2, on 10-10-2014 at 9:30 a.m., indicated the Housekeeper sprayed the table with cleaner while a resident had her water and coffee still in front of her.</p> <p>An interview with the Corporate Nurse, on 10-10-2014 at 9:31 a.m., indicated she was made aware of Housekeeper #2 spraying the tables in the dining room while residents were still eating. The Corporate Nurse was observed to ask the Housekeeper to stop using the spray cleaner while residents still had their</p>		<p>the dust pan.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>- All new housekeeping staff hired into the facility will be in-serviced upon hire as well as adding annual in-servicing for housekeeping staff to prevent anyone from cleaning a table with disinfectant while residents were still sitting at the table as well as not putting the housekeeping cart in the immediate area of residents and keeping their brooms right side up so the bristles remain down in the dust pan.</p> <p>-The Housekeeping Supervisor\Designee will in-service the housekeeping staff on or before 11/9/2014 on the proper cleaning procedures for dining room tables, and the proper location of the cart and broom.</p>				

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	<p>meals and drinks in front of them.</p> <p>An interview with Housekeeper #2, on 10-10-2014 at 11:58 a.m., indicated she was supposed to wait until the CNAs had finished removing the dishes from the tables before entering the dining room in Memory Care unit. Housekeeper #2 indicated she was to wait before using the spray cleaner on the tables until the residents were finished with their meals and drinks</p> <p>An interview with the Housekeeping Manager, on 10-10-2014 at 12:02 p.m., indicated housekeeping staff was to wait until all residents had finished their meals and left the dining room before entering to clean. The Housekeeping Manager indicated the Memory Care unit was difficult but the staff was expected to wait until all residents were away from the tables before entering with the housekeeping cart to clean the tables and floors. Further interview with the Housekeeping Manager indicated there was not a policy for when to clean the dining rooms after meals, but it was a common courtesy to wait for residents to finish their meals and leave the dining room before the housekeeping staff would begin to clean.</p> <p>An observation in the Memory Care unit,</p>		<p>-The Memory Care Facilitator\Designee will conduct rounds during meal time to ensure housekeeping carts are not placed in the immediate area of residents who are eating and housekeeping staff are not spraying disinfectant on tables while residents are eating.</p> <p>The Clinical Education Coordinator\Designee will in-service the nursing and activity staff on or before 11/9/2014 on the proper cleaning procedures for dining room tables, and the proper location of the cart and broom.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-A CQI monitoring tool, Dignity, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT. See Exhibit B.</p>		

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F000250 SS=E	<p>on 10-10-2014 at 1:46 p.m., indicated the housekeeping cart with mop water in the bucket and trash in receptacle was parked right next to a resident who was still eating her lunch.</p> <p>3.1-3(t)</p> <p>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, interview and record review, the facility failed to ensure wandering residents (Resident #53, #63, #161) were monitored to prevent unwanted intrusive behavior into other resident rooms (Resident #15, #10, #117) for 3 of 3 residents observed to wander.</p> <p>Findings include:</p> <p>During the initial tour of the facility, on</p>	F000250	<p>-Data will be collected by Executive Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>Completion date: November 9, 2014</p> <p>F 250 Provision of Medically Related Social Service It is the practice of this facility to ensure that all residents have medically related social services. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: -Residents #53, #63, #161 were reviewed by social service to ensure their care plans are up to date with respects to the wandering behavior into other</p>	11/09/2014	

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	<p>10/6/14 at 9:30 a.m., the 500 hall was observed. Across the door frames of at least two residents rooms, the following was observed: the door frame to Resident #10's room had a piece of mesh type material, which was red and white in color that extended across the entire length of the open door space. This doorway had the mesh material place at a height of 44 inches. The mesh material was held into place by Velcro strips placed on the hall side of the door frame. Resident #117 and # 15, who shared a room, had a mesh type material that was observed to be at a height of 36 inches.</p> <p>On 10/7/14 at 9:45 a.m., Resident #10 was interviewed. She indicated the reason for the mesh material placed across the doorway to her room was "to keep people out of our room. For some reason we have people that come in here at various times of day." She indicated when a resident comes in her room, she puts her call light on and the staff will come and get the resident out of the room. She indicated the facility was aware who these wandering residents were. She indicated the last time a resident came into her room uninvited was yesterday. She indicated that "everyone knows who this resident is" that wanders. She indicated she may try and ask the facility to take down the red</p>		<p>resident rooms. -Resident #10, Resident #15, and Resident #117, were all re-interviewed by social services to prevent interventions to prevent wandering behavior of other residents into their room and conduct psycho social harm follow up. The care plan's of Residents #10, #15, and #17 were updated to reflect any changes. -The stop signs used for residents #10, #15, and #17 were all adjusted to a lower height so residents who wander in wheelchairs can see the sign more easily and help prevent them from wandering into these rooms. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: - All residents have the potential to be affected by the alleged deficient practice. -Social Services will review and interview all residents in the building with a care plan for preventing wandering residents for entering their room and ensure the care plan is up to date and accurate per resident request. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur -A new behavior sheet will be utilized for all staff to use. The behavior sheet will be used for reporting behaviors to social</p>		

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	<p>sign (mesh material) because she thinks the "red color on the sign may be attracting them, the wanders." She indicated the mesh cover over the door "doesn't keep the wanders" out of her room.</p> <p>On 10/7/14 at 10 a.m., the clinical record of Resident #10 was reviewed. The MDS (Minimum Data Set) assessment, dated 9/2/14, indicated the resident was of moderately impaired cognition. The plan of care, dated 1/15/14, identified the following problem: "...appreciates her privacy and has request a stop banner be placed on her door to inhibit others from wandering into her room...goal: will be able to utilize stop banner as she chooses; approach: place stop banner on door and honor privacy by monitoring room so no one wanders in."</p> <p>On 10/7/14 at 10:26 am, Resident #15 was interviewed regarding the reason the mesh material was in place across the entry door to her room. The resident stated the reason the gate was across the door was "because there are so many people coming in here, I don't know why all those people want to come in here." She indicated one resident who came into her room, came in and looked through her drawers. Resident #15 indicated she referred to this resident as "the intruder."</p>		<p>services by way of the nurse and to ensure all behavior are reported and documented. The behavior sheet will be collected daily and reviewed by IDT to determine of any medically related social services are needed. -The Social Services Director\Designee will in-service the all of the nursing staff on or before 11/9/2014 on the Behavior Tracking policy and new Behavior sheet. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: -A CQI monitoring tool, Behavior Monitoring, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT. See Exhibit C. -Data will be collected by Social Services Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>Completion date: November 9, 2014</p>	

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	<p>Resident #15 indicated the resident who comes into her room is Resident #53.</p> <p>On 10/7/14 at 11 a.m., the clinical record of Resident #15 was reviewed. The MDS assessment, dated 8/14/14, indicated the resident was of moderately impaired cognition.</p> <p>On 10/8/14 at 9:40 a.m., Resident #53 was observed in the 500 hall self propelling her wc (wheelchair). At this time, she self propelled to the end of the 500 hall by the floor length glass door. The resident sat in her wc and at 9:50 a.m. she was observed to have wheeled herself into Resident #15's room. The mesh material was observed to be hanging down from one side of the door frame and did not block entry into the room. Resident #53 was observed to remain in this room for at least 2 minutes. At the time, the Activity Staff #1 (AS) was observed to be walking down the 500 hall at the same time Resident #53 was backing out of Resident #15's room. AS #1 was observed to go into Resident # 15's room and push Resident #15 out of the her room and down the hall. As the AS #1 pushed Resident #15 by Resident # 53 in the hall, Resident #15 was heard to state to AS #1, while pointing to Resident #53, "this is the one I call the intruder."</p>			

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	<p>On 10/8/14 at 11 a.m., Resident #15 was interviewed. She indicated "that intruder came into my room." She indicated at the time, that Resident #53 came into her room uninvited. Resident #15 indicated when Resident #53 comes in her room, sometimes she just looks around and sometimes she looks through drawers and "I don't like that." Resident #15 indicated at the time, that when the "intruder" comes in her room, she does tell the staff so they can get Resident #53 out of her room. Resident #15 indicated her roommate Resident #117, will also notify staff when Resident #53 comes in their room.</p> <p>On 10/8/14 at 11:09 a.m. an alarm was heard sounding in the 500 hall and had been sounding for at least 1 minute. At the time, CNA #21(certified nursing assistant) was observed to go into Room #520. CNA #21 was heard to state "[Resident #63's name] , what are you doing? Well let's go down to your room. " At the time, Resident #63 was observed to be pushed out of Room #520 by CNA #21. CNA #21 was observed to take Resident #63 back down the hall to her room.</p> <p>On 10/8/14 at 11:19 a.m., CNA #21 was interviewed. She indicated Resident #63</p>			

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	<p>"just wanders sometimes and gets confused."</p> <p>On 10/8/14 at 1:37 p.m., CNA #22 and CNA #21 were observed to remove Resident #161 from a room in the 500 hall in which 2 male residents resided. Resident #161 was observed to be in her wheelchair at the time.</p> <p>On 10/9/14 at 9 a.m., Resident #117 was interviewed. She is the roommate of Resident #15. She indicated that she does have residents come in her room uninvited and this does bother her. She indicated there is a few people that come in her room in wheelchairs and she doesn't understand why they come into her room. She indicated there was a mesh "stop sign" gate across the door but she doesn't use it as it is hard to put on when she's in the room. She indicated when the mesh stop sign gate was up across her doorway, resident's "just bend over and go underneath it because it is too high."</p> <p>On 10/9/14 at 9:15 .m., the clinical record of Resident #117 was reviewed. The MDS assessment, dated 8/5/14, indicated the resident was of moderately impaired cognition. The care plan, dated 1/17/14, identified the following problem: "...appreciates her privacy and</p>			

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	<p>has request a stop banner be placed on her door to inhibit others from wandering into her room; goal:...privacy and preference will be honored; approach: place stop sign banner on door and honor [resident's name] privacy."</p> <p>On 10/9/14 at 9:47 a.m., CNA #20 was interviewed. She indicated she works in the 500 hall. She indicated there were resident's who wander in and out of other resident's rooms. She indicated when she observed this happen, she would remove the wandering resident out of the room and then tell the supervisor. At this time, CNA #20 identified Resident #161 as a wanderer. CNA #20 indicated the resident's usually put the stop sign across their door when they are out of the room to keep wanders out of their room when they are gone.</p> <p>On 10/9/14 at 11:10 a.m., LPN #20 was interviewed. She indicated when a staff member alerts her to a resident having had a behavior and/or she observed a resident behavior, she addressed the behavior with the resident and then would enter the behavior into the computer as well as notify Social Service and also the Nurse Practitioner (NP).</p> <p>On 10/9/14 at 2:18 p.m., the Social Service Director (SSD) and Social</p>			

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	<p>Service Consultant (SSC) were interviewed. She indicated when a resident has an observed event/ behavior; staff would fill out a "behavior event" in the computer if it is new or worsening behavior. She then indicated each morning the behavior event forms were printed from the computer and then presented to the IDT (Interdisciplinary) team every day. She indicated the team reviewed the behavior itself, what is going on around it and try to determine what the behavior is trying to tell them as well as the interventions to deal with the problem after identifying the root cause. She indicated if the behavior needed care planned, the team developed a care plan, by working with nursing, CNAs (certified nursing assistants) and all to develop a global impression. She indicated if it was a behavior which needed to be monitored, they would create a flow sheet that included interventions and the identified behaviors were monitored every shift. She indicated this information was also presented to the Nurse Practitioner. She indicated, at the end of each month and monthly summary was completed. If the resident had no behaviors for 3 months, the resident was taken out of the program. She indicated if a staff observes a behavior, they are to report to the nurses and then the nurses fill out an "event summary form," which</p>			

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	<p>is on the computer. She indicated this information was also conveyed to the next shift during end of shift of report. The Social Service Staff indicated the Social Service staffs also attend the end of shift report.</p> <p>On 10/9/14 at 2:25 p.m., the Social Service Staff (SSS) and the Social Service Consultant (SSC) were interviewed. They indicated the following regarding what behaviors were being monitored of residents in the 500 hall. They indicated the following:</p> <p>Resident #161 wanders, at times has been intrusive but not so much anymore. They indicated the facility monitored her surrounding and this was care planned. They indicated, "the behavior care plan reads the same as the behavior flow sheet."</p> <p>At this time, the Social Service Consultant (SSC) provided behavior logs as well as the care plans for Resident #161. She indicated at the time, they were not monitoring any other behaviors for this resident other than her "making repetitive statements/asks repetitive questions." The SSC indicated this was the only behavior they were monitoring with the behavior tracking. She indicated wandering was care planned. She</p>			

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	<p>indicated they know the resident wanders and the interventions were effective but if the behavior changed, the nurse would do the new or worsening event form. The resident used to go in others rooms at times but not with regularity but "she doesn't do that anymore." The SSD indicated she "wouldn't consider Resident #161 to wander anymore."</p> <p>At this time, the SSD indicated, regarding Resident #63, there was no care plan specifically for wandering but does have a care plan for elopement as "she is at risk for elopement." The SSD indicated at the time, Resident #63 "doesn't wander" as "she has purpose" when she is propelling around the facility in her wheelchair. The SSD indicated the facility puts any behaviors on flow sheets for which they were looking at for trends. The SSD indicated there were no new or worsening behaviors for Resident #63 and her care plan interventions for risk of elopement were effective.</p> <p>On 10/9/14 at 2:43 p.m., the SSD was interviewed regarding Resident #53. She indicated at the time, the only behavior the facility was monitoring was "anxiety." At the time, the SSD indicated the resident "has purpose to her strolling about so no" regarding the resident wandering.</p>						

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	<p>At the time, the SSD indicated for Resident #63, Resident #161 and Resident #53, none of these resident would be considered as "wanders," and/or intrusive to other residents. She indicated for a resident to be considered a wander, the resident "would have to not have purpose to their movement and go in and out of others rooms."</p> <p>She indicated if a resident went into someone else's room and/or broke their pattern of what they normally do the facility would trigger a new worsening behavior. If a resident had a change in behavior, new or worsening, staff would report it to the nurse and the IDT would discuss the situation and decide if the behavior needed to be tracked or not.</p> <p>Regarding the mesh stop signs, which were observed to be placed over several resident doors, the SSD indicated in the 500 hall, said the resident's "want their privacy from prohibiting others from coming into the room and/or wanders." She indicated Resident #10, had a resident that used to come into her room but (Resident #10 name) likes to keep it up" as it "gives her a feeling of security." The SSD indicated the resident who used to come into Resident #10's room was no longer a resident at the facility.</p>			

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	<p>On 10/9/14 at 3 p.m. the clinical record of Resident #53 was reviewed. Diagnosis included, but was not limited to, the following: Vascular Dementia. The MDS (Minimum Data Set) assessment dated 8/8/14 included but was not limited to, the following: severe cognitive impairment; presence of delusions and no wandering. At the time, the SSC provided the "Behavior...History" for this resident dated 10/1/14 - 10/9/14. This included the only behavior they were monitoring for this resident was "Res (resident) experiences symptoms of anxiety, AEB (as evidenced by) she gets anxious and begins to have breathing difficulties." Care plans provided by the SSC at the time lacked documentation of a care plan for the behavior of wandering. Documentation was also lacking on a Behavior History form for wandering as well.</p> <p>On 10/9/14 at 3:10 p.m., the clinical record of Resident # 63 was reviewed. Diagnoses included but were not limited to, the following: Senile Dementia, anxiety and depressive disorder. The MDS assessment, dated 4/21/14, included but was not limited to, the following: severe cognitive impairment and no behaviors and or wandering.</p>			

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	<p>Documentation was lacking of a behavior record to monitor wandering and/or a care plan for wandering.</p> <p>On 10/9/14 at 3:30 p.m., the clinical record of Resident #161 was reviewed. Diagnoses included, but were not limited to, the following: Alzheimer's Disease, Pseudobulbar affect and presenile dementia. The MDS assessment, dated 9/11/14, included but was not limited to the following: severe cognitive impairment; has difficulty focusing attention (easily distracted, out of touch, difficulty following what was said); behaviors continually present, does not fluctuate; behavior of wandering occurred daily.</p> <p>On 10/9/14 at 4 p.m., the SSD and the SSC were interviewed. They indicated this was the first time they heard about Resident #53 and Resident #63 wandering in and out of resident rooms. They indicated they would start a new and/or worsening behavior for these two residents and would put them on tracking for the wandering behavior. She indicated they will observe Resident #161 closely.</p> <p>On 10/9/14 at 4:12 p.m. the AS #1 was interviewed. She indicated she was the staff that was observed yesterday to</p>			

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	<p>overhear Resident # 15 refer to Resident # 53 as "the intruder." Regarding resident behaviors, she indicated it would depend what the behavior was as to what she did. She indicated if it was a new or worsening behavior she observed, she would tell someone. She indicated at the time, she told her supervisor regarding the observed incident between Resident #53 and Resident #15. She indicated Resident #53 "was known for doing that [going into others rooms]."</p> <p>On 10/10/14 at 9 a.m., the AS #1 was interviewed. She indicated she was not aware she was to report "all" situations observed regarding residents and their behaviors/wandering, etc.</p> <p>On 10/10/14 at 12 p.m., the SSD provided a current copy of the facility policy and procedure for "Behavior Management policy." This policy was dated 7/14, and included but was not limited to, the following: "...care plans should be initiated for any behavioral issue that affects, or has the potential to affect, the resident or other residents...When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior on the monitoring form, and included what interventions were attempted during the episode and whether</p>			

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F000353 SS=E	<p>or not they were effective...."</p> <p>3.1-34(a)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other</p>			

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	<p>nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to ensure nurse staffing was sufficient to meet the needs of the residents in the Memory Care unit in the facility. This deficient practice had the potential to affect the 32 residents who resided in the Memory Care unit.</p> <p>Findings include:</p> <p>An observation in the Memory Care unit on 10-8-2014 at 9:19 a.m., indicated 1 CNA (Certified Nursing Assistant) was taking lunch orders from residents in the dining room; the Memory Care Director was with an angry resident, another CNA was washing her hands in dining room and the LPN (Licensed Practical Nurse) was with another nurse in the dining room. There were no staff observed at the nurse's station or in the hall when a call light was activated by a resident.</p> <p>An observation in the Memory Care unit on 10-9-2014 at 9:30 a.m., indicated 2 CNAs were clearing tables of dirty breakfast dishes in the dining room, the Memory Care Director was obtaining</p>	F000353	<p>F 353 Sufficient 24-Hr Nursing Staff It is the practice of this facility to ensure that all residents have sufficient 24 hour nursing staff. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: -The facility will schedule the locked dementia unit with at least 3 C.N.A.'s and a licensed nurse on day shift and evening shift. If less than 3 C.N.A.'s arrive for the shift, the on call nurse manager or manager on duty will be notified and make calls to replace staff or assist the staff on the Memory Care unit. -The facility will ensure the Activity staff, will be certified as nursing assistants, and will be assigned a group of residents during meals to feed and assist during their normally scheduled shift to ensure residents ADL needs are met. -The facility will schedule a nurse manager and an ancillary manager to be in the building each weekend and two nurse managers on evenings during the week for the purpose of helping on the floor if less than 3 C.N.A.'s arrive to work. How will you identify other residents having the potential to be affected by</p>	11/09/2014			

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	<p>lunch and dinner orders from residents and the LPN was in the dining room for medication pass. There was not staff available at the nurse's station or in the hall when a call light was activated by a resident. The 3rd CNA was not present and returned to the unit at 9:38 a.m.</p> <p>An observation in the Memory Care unit on 10-9-2014 at 9:55 a.m., indicated an alarm was sounding in one room and another resident was up and walking out of the bathroom with her pants not completely pulled up. There was not staff available at the nurse's station. The Memory Care Director was conducting an exercise activity in the dining room, the LPN was in the dining room for medication pass, 1 aide was in the linen closet getting a towel for a resident waiting to take a shower and another CNA was at the end of the hall assisting another resident. The 3rd CNA returned to the unit at 9:59 a.m.</p> <p>An observation in the Memory Care unit on 10-9-2014 at 10:15 a.m., indicated a resident was overheard to call out "hey, I have to go potty" and there was not staff available in the hall or at the nurse's station to hear the resident.</p> <p>An observation in the Memory Care unit on 10-10-2014 at 9:21 a.m., indicated a</p>		<p>the same deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> - All residents have the potential to be affected by the alleged deficient practice. -DNS/Designee will review all staffing for all units for each shift on an on-going basis in the building to ensure adequate staff is in place. -The DNS/Designee will review the residents on the memory care unit monthly to determine if they are still appropriately placed and will make recommendations to move residents off of the memory care unit if their needs could be met better on a different unit. -The facility will schedule the locked dementia unit with at least 3 C.N.A.'s and a licensed nurse on day shift and evening shift. If less than 3 C.N.A.'s arrive for the shift, the on call nurse manager will be notified and make calls to replace staff. -The facility will ensure the Activity staff, will be certified as nursing assistants, and will be assigned a group of residents during meals to feed and assist during their normally scheduled shift to ensure residents ADL needs are met. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>-The Director of Nursing will run</p>		

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	<p>resident alarm sounded and there was not staff available in the hall or at the nurse's station to assist the resident. The Memory Care Director was obtaining lunch and dinner orders from the residents in the dining room, the LPN was in dining room for medication pass and 2 CNAs were in the dining room. One CNA was in a room assisting another resident. A CNA and the Memory Care Director both tried to get out of the dining room but were delayed as a resident in a wheelchair and was blocking the doorway.</p> <p>An observation in the Memory Care unit on 10-10-2014 at 9:31 a.m., indicated the Memory Care Director, the LPN and the 3 CNAs were in the dining room and there was not staff available at the nurse's station or in the hall as a resident who required a walker for ambulation did not have the walker as he was walking in the hallway of the unit.</p> <p>Confidential resident interviews were conducted and indicated the following comments regarding staffing:</p> <p>On 10-7-2014 at 9:21 a.m., the confidential interview #1 indicated the facility was "short CNA's."</p> <p>On 10-7-2014 at 8:43 a.m., the</p>		<p>Activity of Daily Living (ADL) scores for each hall on a monthly basis to adjust staffing throughout the building to ensure all resident ADL needs are being met.</p> <p>-The DNS or Designee will establish an on call system whereby nurse managers or designees will come in to the building when more a call in has occurred and additional staffing is needed.</p> <p>-The Clinical Education Coordinator will in-service the licensed nursing staff on or before 11/9/2014 on the nurse manager on call system in case staffing is low for any particular unit.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-A CQI monitoring tool, Staffing, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at</p>				

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	<p>confidential interview #2 indicated the facility "could use more help."</p> <p>On 10-7-2014 at 8:27 a.m., the confidential interview #3 indicated the facility "overall did not have enough help...had to wait...varies 15 to 45 minutes...bad last night...took an hour to get the nurse to give the breathing treatment...thought they were short a nurse...evening shift short of help...thought last night was one of the worst ones...didn't get shower until after 9:00 p.m. and likes to go to bed at 8:30 p.m."</p> <p>On 10-7-2014 at 10:09 a.m., the confidential interview #4 indicated "there was not enough staff and they really push the staff that works."</p> <p>On 10-6-2014 at 3:44 p.m., the confidential interview #5 indicated "staff said they were short last night and had to wait an hour for help; usually waits 1/2 hour for assistance at night."</p> <p>On 10-7-2014 at 11:05 a.m., the confidential interview #6 indicated "staffing short on the weekends; staff call in and it bothers the other staff and it bothers us too...takes about 30 minutes to get lights answered at times."</p>		<p>least 6 months and discussed with IDT. See Exhibit A.</p> <p>-Data will be collected by DNS/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>Completion date: November 9, 2014</p>	

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	<p>On 10-6-2014 at 2:39 p.m., the confidential interview #7 indicated "there was not enough staff and has had to wait 30 minutes for assistance."</p> <p>Confidential family interviews indicated the following comments regarding staff in the facility:</p> <p>On 10-6-2014, a confidential family interview #1, indicated 2 aides were present for the residents in the Memory Care unit on 10-6-2014 at 7:30 a.m. on the previous Saturday. The family member indicated she "tries to help but it is overwhelming for her." The family member indicated her loved one was not shaved either day on the weekend. Further interview with the family member indicated the "CNAs were responsible to clean up the tables after the noon meal which finished around 1:00 p.m., and toilet their residents before the shift change at 2:00 p.m. The family member indicated the Memory Care Director and activity assistant were CNAs, but they did not have time to take the residents to the toilet, or showers.</p> <p>On 10-8-2014, a confidential family interview #2, indicated in the Memory Care unit the "staff do all they can- -everybody is short."</p>			

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	<p>On 10-10-2014, a confidential family interview #3, indicated she was not sure if there was enough staff on the Memory Care unit. The family member indicated she needed help now with her mother as she needed to go to the restroom. The family member indicated her mother "just sits in the wheelchair or is in bed" and indicated "I wish they would get her up and walk her."</p> <p>On 10-10-2014, a confidential family interview #4 indicated the family member visited the Memory Care unit often. The family member indicated "there was not enough staff and that was why she was here." The family member indicated she "came last night and her mom was still sitting at the table in the dining room at 7:00 p.m. and she was soaked with urine." The family member indicated she saw only 2 CNAs, 1 nurse and no activity staff last night.</p> <p>Confidential staff interviews indicated the following comments regarding staffing in the facility:</p> <p>On 10-8-2014, Staff #4 indicated "sometimes short and happens in the mornings."</p> <p>On 10-8-2014, Staff #5 indicated "there was enough staff unless there was a</p>				

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	<p>call-in."</p> <p>On 10-8-2014, Staff #6 indicated there was not enough help on the weekends when a staff member called in.</p> <p>On 10-8-2014, Staff #7 indicated there was not enough staff and indicated there were only 2 aides scheduled during the day and evening shift in the Memory Care unit. Staff #7 indicated the activity staff were CNAs (Certified Nursing Assistants) but were busy enough with the activities for the residents to assist with the toileting and ADLs (Activities of Daily Living) of the residents.</p> <p>On 10-8-2014, Staff #8 indicated there was not enough staff on the Memory Care unit; only 2 CNAs were present and a third was scheduled but did not work.</p> <p>On 10-9-2014, Staff #9 indicated with 2 CNAs on the Memory Care unit, it took the staff longer to meet the needs of the residents. Staff #9 indicated the activity personnel would alert the aides if a resident needed assistance for toileting but only occasionally were the activity staff available to toilet a resident.</p> <p>An interview with the Resident Care Coordinator on the Memory Care Unit on 10-8-2014 at 9:45 a.m., indicated there</p>				

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	<p>were 32 residents on the Memory Care unit and all the residents needed assistance with ADLs (Activities of Daily Living) from supervision, cueing to actual assistance to complete an ADL task.</p> <p>A review of the Resident Council Minutes, dated 8-21-2014, and provided by the DON (Director of Nursing), on 10-10-2014 at 2:45 p.m., indicated "a couple residents on 100 and 500 hallways would like to see the response time to call lights faster, especially on 2nd shift."</p> <p>An interview with the DON and the Corporate Nurse, on 10-10-2014 at 2:00 p.m., indicated there was not a facility policy for staffing.</p> <p>3.1-17(b)</p>			

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F000431 SS=F	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure individual unidentified medication</p>	F000431	F 431 Drug Records, Label/Store Drugs & Biologicals It is the practice of this facility to ensure that all drugs	11/09/2014

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	<p>tablets/capsules were secured in the medication container in 7 of 7 medication carts effecting all of the units in the facility (100 Hall, 200/300 Hall, 400 Hall, 500 Hall and the Memory Unit). Furthermore, the facility failed to provide a clean storage area in 1 of 5 treatment carts (200/300 Hall).</p> <p>Findings include:</p> <p>An observation of the two 100 Hall medication carts with Nurse #10 on 10/10/2014 at 10:30 a.m., indicated the Front Medication Cart had multi-colored powder and small pieces of pills in the bottoms of the drawers containing the Rx (prescription) blisters/medication pill cards (medication container). The Back Medication Cart contained 3 loose pills in the second drawer beneath the medication containers.</p> <p>During an interview, on 10-10-14 at 10:45 a.m., Nurse #10 indicated she tries to look at the medication carts daily to make sure they were clean and indicated the medications carts were cleaned a least weekly. She indicated she the medication carts needed to be cleaned.</p> <p>An observation of the 200/300 Hall Mediation Cart with Nurse#11 on 10/10/14 at 11:05 a.m., indicated the</p>		<p>and biologicals are stored in a safe manner.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-All medication and treatment carts in the building were cleaned thoroughly removing all debris, including any loose pills or powder, from the bottom of the drawers.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>- All residents have the potential to be affected by the alleged deficient practice.</p> <p>- All medication and treatment carts in the building were cleaned thoroughly removing all debris, including any loose pills or</p>		

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	<p>Medication Cart had multiple loose whole tablets and capsules and pieces of pills and powder in the bottom of the 2 drawers beneath the medication containers. Nurse #11 removed the loose medications and pieces of foil and paper and placed them in a disposable plastic cup for disposal.</p> <p>An observation of the 200/300 Hall Treatment Cart with Nurse#11 on 10/10/14 at 11:15 a.m., indicated the top drawer had a dry white powdery residue on the right side and bottom of the drawer. The nurse indicated something must have spilled in the drawer and indicated the cart would be cleaned.</p> <p>An observation of the 400 Hall Medication Cart with Nurse #12 on 10/10/14 at 11:25 a.m., indicated the Medication Cart had multiple loose medications, whole and half tablets, capsules and multi-colored powder was in the bottom of both drawers beneath the medication containers. Nurse #12 removed the loose pills and disposed of them in the bio-hazard sharps container on the side of the medication cart.</p> <p>An observation of the two 500 Hall Medication Carts with Nurse #13 on 10/10/14 at 11:35 a.m., indicated the Front Medication Cart had 3 loose pills in</p>		<p>powder, from the bottom of the drawers.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>-Each unit manager/designee will inspect and clean all medication carts weekly. The unit manager will fill out a medication cart audit form and turn in to the DNS for review to ensure carts were cleaned weekly.</p> <p>-The Clinical Education Coordinator/Designee will in-service all licensed nursing staff on or before 11/9/2014 on checking their carts each shift for cleanliness and removing all debris including loose pills or powder. .</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>		

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	<p>the bottom of the 2 drawers containing the medication containers. The nurse removed the pills and disposed of the medication in the bio-hazard sharps container on the medication cart. The Back Medication Cart had 1 loose pill in the bottom of drawer beneath the medication containers. The nurse removed the pill and disposed of it in the bio-hazard sharps container on the side of the medication cart.</p> <p>An observation of the Memory Unit's Medication Cart with Nurse #14 on 10/10/14 at 11:50 a.m., indicated the cart had 3 loose pills in the 2 drawers of the medication cart below the medication containers. The Nurse removed the pills and disposed of them in the bio-hazard sharps container on the side of the medication cart.</p> <p>During an interview, on 10/10/14 at 2:10 p.m., the DON (Director of Nursing) indicated the medication and treatment carts were to be clean and loose pills should not have been in the medication carts. She indicated the unit managers were responsible to make sure the carts were cleaned weekly and also indicated the medications cards and bottles were to be removed and all of the drawers when the carts were cleaned. She indicated the unit managers were to complete a weekly</p>		<p>-A CQI monitoring tool, Medication Cart Storage, will be completed weekly x 4 weeks, then monthly x 3 months and quarterly thereafter for at least 6 months and discussed with IDT. See Exhibit D.</p> <p>-Data will be collected by Social Services Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>Completion date: November 9, 2014</p>				

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	<p>med (medication) cart and med room inspection and also document on the Medication Cart Audit form when it was done. The DON also indicated the Pharmacy Tech had just gone through all of the medication carts earlier this week.</p> <p>A review of the non-dated audit form, titled, "Medication Changes Form, Weekly Med Cart and Med Room Inspection," provided by the DON on 10//10/14 at 2:35 p.m., indicated the following: "...Medication carts are free from spills, dirt and are in proper working condition...outdated, contaminated or deteriorated medications are removed from stock and disposed of according to policy...."</p> <p>During an interview, on 10/10/14 at 2:35 p.m., the DON indicated the facility did not have a policy for medication storage or for the cleaning of the medication and treatment carts. She indicated, she had developed the audit tool too make sure the medication carts and medication rooms were clean.</p> <p>3.1-25(o)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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