

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/19/2016
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NAME OF PROVIDER OR SUPPLIER  WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 14, 15, 16, 17, 18, and 19, 2016</p> <p>Facility number: 000681 Provider number:155549 AIM number:100286100</p> <p>Census bed type: SNF/NF: 45 SNF:0 NF:0 Total:45</p> <p>Census payor type: Medicare:2 Medicaid:40 Other:3 Total:45</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on August 24, 2016.</p>	F 0000		
F 0241	483.15(a)			

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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SS=E Bldg. 00	<p><b>DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>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.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure care and services were provided in order to promote and protect resident dignity regarding toileting assistance, feeding assistance and assistance to dine (Activities of Daily Living / ADLs) for 4 of 4 residents reviewed for the provision of ADL services to promote dignity (Residents #14, #24, # 55, and #9; CNA#5, LPN #8, Activity Director, ).</p> <p>B. Based on observation, interview and record review, the facility failed to ensure the staff did not store personal items in a resident room for 2 of 2 residents reviewed for dignity regarding personal resident room space. (Resident #48 and #23; CNA #16)</p> <p>Findings include:</p> <p>A.1. During a 8/14/16, 7:31 p.m. to 7:42 p.m. (11 minutes) observation of the Dementia Unit, no staff were visible anywhere on the unit. At 7:42 p.m., the Dietary Manager entered the Dementia Unit. The Dietary Manager did not offer</p>	F 0241	<p>F 241</p> <p>1 A. Resident #'s 14,24, 55, and 9 are receiving care and services to promote and protect theirdignity at all times. CNA #5, LPN #8,and the Activity Director have been re-educated on providing dignity to allresidents at all times including during toileting assistance, feedingassistance, and dining assistance.</p> <p>1 B. Resident #'s 48and 23 are receiving care and services to promote and protect their dignityrelated to personal resident room space. Staff are not storing their personal items in resident rooms. CNA #16 has been re-educated on dignityrelated to residents' personal room space with a special focus on not storingstaff's personal items in resident rooms.</p> <p>2 A/B. All residentshave the potential to be affected. Allresidents are currently receiving care and services to promote and protecttheir dignity including during toileting assistance, feeding assistance, diningassistance, and personal room space.</p>	09/18/2016			

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	<p>redirection or assistance to any resident. She completed her task at hand and then left the unit. At 7:44 p.m., the Maintenance Supervisor entered the unit and asked if there were any concerns. He did not provide redirection and assistance to any resident. At 7:46 p.m., RN Consultant #2 entered the Dementia Unit and was informed no direct care staff had been visible, nor had assistance to residents been offered to residents in common areas since 7:31 p.m., (a period of 15 minutes). During the 15 minutes with no staff visible, 5 residents were visible in the hallways and common areas on the dementia unit. During the 15 minutes, Resident #14 roamed the hallway attempting to open the closed doors to resident rooms, entering resident's rooms and spoke of needing a bathroom. Resident #14's roommate attempted multiple times to direct her to her room without success.</p> <p>During an observation of the Dementia Unit on 8/16/16 at 9:54 a.m., no staff were visible on the unit. At 9:59 a.m., Resident #14 indicated she needed to "poop" and began to wander the hallway. She entered other residents' rooms, opened doors and walked about. At 10:09 a.m., CNA #5 entered the lounge and changed the TV station to a more appropriate station. She then left the area</p>		<p>3 A/B. The facility's staff have been re-educated on resident rights and dignity with a special focuson providing dignity with toileting assistance, feeding assistance, diningassistance, and personal room space. A naudit tool has been implemented.</p> <p>4 A/B. The Administrator or Designee will be responsible for completing the audit tool to ensure dignity is being provided at all times. The audits will be completed on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>	

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	<p>to provide patient care. Resident #14 continued to wander the hallway. At 10:15 a.m., Resident #14 and the hallway smelled of bowel movement. At 10:24 a.m., CNA #5 was again visible in the common area. CNA #5 interacted with another resident. At 10:24 a.m., the Administrator entered the unit and conversed with residents. The Administrator did not provide direct care during her visit. The Administrator did not interact with Resident #14 during this brief visit to the unit. At 10:33 a.m., (34 minutes after Resident #14 indicated she needed to have a bowel movement) CNA #5 escorted Resident #14 to her room for care.</p> <p>During an 8/16/16, 10:47 a.m., interview, CNA #5 indicated Resident #14 had been incontinent of stool in the hall way by the exit door at some time that morning.</p> <p>On 8/19/16 at 7:23 a.m., Resident #14 was served her meal and cued to eat her breakfast. Resident #14 had just answered yes to being hungry right before her meal was served. Resident #14 looked at her food without taking a bite from 7:23 a.m. to 7:44 a.m. (21 minutes). During the 21 minutes without eating, Resident #14 was not cued or assisted to eat.</p>			

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	<p>Resident #14 was offered coffee at 7:44 a.m. and answered yes. Resident #14 began to drink her coffee.</p> <p>During an, 8/19/2016, 7:48 a.m., observation, LPN #8 gave Resident #14 a bite of her muffin. Resident #14 ate the bite that was offered. This was the first time the resident had been offered assistance to eat her food since it was placed in front of her at 7:23 a.m. (25 minutes). At 7:49 a.m., after being offered a bite of food, Resident #14 began to take some independent bites of food.</p> <p>During an, 8/19/2016, 7:48 a.m., observation, LPN #8 stood to give Resident #14 a bite of her muffin.</p> <p>During an, 8/19/2016, 8:09 a.m., observation, CNA #5 stood and offered Resident #14 a couple drinks of milk.</p> <p>Resident #14's clinical record was reviewed on 8/17/2016 at 1:59 p.m. Resident #14's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, and depression. Resident #14 had a current, 8/8/16, physician's order for a mechanical soft diet.</p> <p>Resident #14 had a, 6/29/16, quarterly, Minimum Date Set (MDS) assessment</p>			

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	<p>which indicated the resident was severely cognitively impaired and rarely or never made decisions, required limited assistance from the staff to eat, received a mechanically altered diet, required extensive assistance from the staff to toilet, and was occasionally incontinent of both bowel and bladder.</p> <p>Resident #14 had a 6/1/16, "Speech Therapy Plan of Care" which indicated the resident was referred to therapy due to swallowing difficulty during meals.</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding nutritional risk due to anxiety, depression, and Alzheimer's disease. Approaches to this problem included, but were not limited to, "encourage the resident to eat."</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding tooth pain due to infection.</p> <p>Resident #14 had two current, 7/14/16, care plan problems/needs regarding wandering into other's rooms. Both care plan problems/needs originated 9/9/14. The goals for this problem was "The resident will be redirected when inappropriate behavior is exhibited and the resident would not intrude on the privacy of others." Approaches to this</p>			

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	<p>problem included, but were not limited to, "attempt diversion, Ensure all basic needs are met (toileting, nutrition thirst), and redirect restless and pacing behaviors."</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding anxiety and pacing halls. Approaches to this problem included, but were not limited to, "Ensure all basic needs have been met."</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding the need for assistance with Activities of Daily Living (ADLs).</p> <p>A.2. During an, 8/17/2016,11:25 a.m., observation, the Activity Director offered Resident #55 bites of food as she stood beside the resident. During an, 8/17/2016, 11:28 a.m., observation, the Activity Director once again stood beside Resident #55 and offered him bites of food.</p> <p>A.3. During an 8/19/2016, 7:36 a.m., observation, Resident #24 was escorted to the dining room and served her meal. She was cued to eat breakfast when her meal was served. From 7:35 a.m. to 7:57 a.m.,(22 minutes) Resident #24, drug the fork over her food, picked up her food and tried to stab it with a fork and picked</p>			

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	<p>at her food with her fingers. During this time Resident #24 only got 3 bites of food successfully to her mouth.</p> <p>At 7:57 a.m., CNA #5 offered Resident #24 two bites of her food, which she ate. Resident #24 was cued to eat. Resident #24 once again began to manipulate her food without taking successful bites.</p> <p>During an, 8/19/2016, 7:57 a.m., observation, CNA #5 offered Resident #24 two bites of food while standing beside the resident.</p> <p>During an, 8/19/2016, 8:04 a.m., observation, CNA #5 offered Resident #24 bites of food while standing beside the resident.</p> <p>During an, 8/19/2016, 8:16 a.m., observation, CNA #5 offered Resident #24 bites of food while standing beside the resident.</p> <p>During an, 8/19/2016, 8:23 a.m., observation, CNA #5 offered Resident #24 bites of food while standing beside the resident.</p> <p>Resident #24's clinical record was reviewed on 08/19/2016 at 1:59 p.m. Resident #24's diagnoses included, but were not limited to, Alzheimer's disease</p>			

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	<p>and depression.</p> <p>Resident #24 had a 5/22/16, quarterly, Minimum Data Set (MDS) assessment which indicated she was rarely or never understood, she was severely cognitively impaired and rarely or never made decisions, and required limited assistance from the staff to eat.</p> <p>Resident #24 had a current, 6/9/16, care plan problem/need regarding sticking her fingers in her food. Approaches to this problem included, but were not limited to, "attempt reorientation."</p> <p>Resident #24 had a current, 3/9/16, care plan problem/need regarding nutritional risk due to depression and Alzheimer's disease. Approaches to this problem included, but were not limited to, "encourage the resident to eat 50% of most meals."</p> <p>Resident #24 had a current, 6/9/16, care plan problem/need regarding the need of assistance from one staff member for Activities of Daily Living (ADLs). The goal for this problem was the resident would be clean, dry and odor free. Approaches to this problem included, but were not limited to, "provide assistance with ADLs as required."</p>			

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	<p>A.4. During an, 8/19/2016, 8:03 a.m., observation, CNA #5 offered Resident #9 three bites of food while standing beside her. In the hand CNA #5 was not using to feed the resident she held soiled dishes she had picked up from another resident's dining area.</p> <p>During an, 8/19/2016, 8:05 a.m., observation, CNA #5 offered Resident #9 bites of food while standing beside her. In the hand CNA #5 was not using to feed the resident she held soiled dishes she had picked up from another resident's dining area.</p> <p>During an, 8/19/2016, 8:15 a.m., observation, CNA #5 offered Resident #9 bites of food while standing beside her.</p> <p>During an 8/19/16, 8:24 a.m., interview, CNA #5 indicated she had a number of residents who required cueing or assistance to eat. She indicated she moved quickly from resident to resident offering each assistance and moving on because it was quicker. She additionally indicated she was aware she needed to sit to feed a resident.</p> <p>Resident #9's clinical record was reviewed on 8/19/2016 at 2:15 p.m. Resident #9's diagnoses included, but were not limited to, chronic pain,</p>			

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	<p>dementia with delusions and behaviors, anxiety, and macular degeneration.</p> <p>Resident #9 had a 4/29/16, quarterly, Minimum Date Set (MDS) assessment which indicated the resident was severely cognitively impaired and rarely or never made decisions, and the resident required extensive assistance from the staff to eat.</p> <p>Resident #9 had a current, 8/17/16, care plan problem/need regarding nutritional risk due to anxiety and dementia. Approaches to this problem included, but were not limited to, "encourage the resident to eat most meals."</p> <p>Resident #9 had a current care plan problem/need regarding the need for assistance with ADLs.</p> <p>Review of the current facility policy, dated 10/2014, titled "FEEDING RESIDENTS", provided by the Administrator on 8/19/16 at 10:06 a.m., included, but was not limited to,</p> <p>"...6. Sit on unaffected side, eye level with resident, facing them...."</p> <p>B.1. On 8/16/16 at 10:54 a.m., CNA #16 knocked and came into resident room #108. CNA #16 walked to Resident #48's closet, retrieved her purse and stated she was going on her break. After</p>			

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	<p>CNA #16 left the room, Resident #48 indicated she stored her purse in her closet every time she worked. Resident #48 indicated she (CNA #16) told me she did not want her money to be stolen. Resident #23, (Resident #48's roommate) indicated CNA #16 stored her purse in Resident #48's closet when she worked.</p> <p>On 8/16/16 at 2:19 p.m., CNA #16 was observed with her purse on her shoulder in the hallway.</p> <p>On 8/16/16 at 2:22 p.m., with Resident #48's permission, a black purse was observed in Resident #48's closet. Resident #48 indicated the purse did not belong to her. Resident #48 indicated the purse belonged to CNA #16. Resident #48's daughter was present and indicated the purse in the closet was not her mother's purse and she did not know the owner of the purse.</p> <p>During an interview on 8/17/16 at 8:14 a.m., Resident #23 indicated CNA #16 told her the purse had cost one hundred and twenty dollars and there was no where to lock the purse up in the employee break room.</p> <p>During an interview on 8/19/16 at 9:32 a.m., CNA #17 indicated the staff were to store personal items in the employee</p>			

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	<p>break room/lounge or secure the items in their cars. CNA #17 indicated the employee break room/lounge had lockers and the staff were allowed to put locks on the lockers.</p> <p>During an interview on 8/19/16 at 5:37 p.m., RN Consultant #1 indicated the staff were not to store personal items in a resident's room. She further indicated they did not have a policy related to the storage of staff personal property while at work.</p> <p>Review of an undated document, titled "RESIDENT RIGHTS", provided by RN Consultant #1 on 8/19/16 at 2:47 p.m., included, but was not limited to,</p> <p>"...QUALITY OF LIFE (a) Dignity. A facility must care for its 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.... ...(h) Environment. The facility must provide-... ...(4) Private closet space in each resident room with clothes racks and shelves accessible to the resident..."</p> <p>3.1-3(t)</p>				

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F 0279 SS=E Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to develop care plans with measurable goals/objectives, and behavior interventions for 4 of 5 residents receiving psychoactive medications requiring monitoring for specific targeted behaviors reviewed for care plans. (Residents #9, #16, #29, and #46)</p> <p>Findings include:</p> <p>1. On 8/18/16 at 1:20 p.m., Resident #9</p>	F 0279	<p>F 279</p> <p>1. The care plans for Resident #'s 9, 16, 29, and 46 have been reviewed and revised to include measurable goals/objectives and behavior interventions.</p> <p>2. All residents have the potential to be affected. The care plans have been reviewed and revised to include measurable goals/objectives and behavior interventions if indicated.</p> <p>3. The facility's policy for Care Plan Development has been reviewed and</p>	09/18/2016

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	<p>was observed sitting in wheel chair in hall beside nurses station smiling and talking to staff.</p> <p>The record of Resident #9 was reviewed on 8/18/16 at 12:35 p.m. Resident #9 had current diagnoses which included, but were not limited to, dementia with agitation, anxiety, chronic pain, type 2 diabetes mellitus, and chronic kidney disease.</p> <p>Resident #9 had a current, 8/1/16 physician's orders which included, but were not limited to, Remeron 7.5 mg (an anti-depressant medication), Seroquel 25 mg (an anti-psychotic medication), Ativan 0.5 mg (an anti-anxiety medication), Lasix 40 mg (a diuretic medication), Zoloft 50 mg (an anti-depressant medication).</p> <p>Resident #9 had a current, 8/17/16, care plan problem/need regarding "Resident exhibits socially inappropriate behaviors as follows: resident will become agitated with attempting to exit seek and is unable to leave secure unit. Resident believes she needs to leave and look for nephew. Resident will begin to yell: let me out. I need to leave, and will bang on exit doors." The goal for this problem/need was "Resident will be redirected when inappropriate behavior is exhibited thru</p>		<p>no changes have been indicated at this time. The care plan team has been re-educated on care plan development with a special focus on creating measurable goals/objectives and behavior interventions. An audit tool has been implemented.</p> <p>4. The Administrator or Designee will be responsible to complete these audits to ensure the care plans have measurable goals/objectives and behavior interventions if indicated. Five residents care plans will be reviewed on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>	

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	<p>next review." There was no indication for how the goal would be measured.</p> <p>Resident #9 had a current, 8/10/16, care plan problem/need regarding "The resident has the progressive cognitive and communicative deficits associated with Dementia with Delusions. She is sometimes able to make self understood and sometimes able to understand others. Speech is mumbled at times. BIMS [Brief Interview for Mental Status] dated 5/4/16, which indicated resident is severely impaired, never/rarely made decisions." The goal for this problem/need was "The resident will have all basic needs met by staff daily thru next review."</p> <p>Resident #9 had a current, 8/17/16, care plan problem/need regarding "The resident suffers from delusions due to: dementia with delusions and behaviors as evidenced by: history of hearing baby crying wanting to go home." The goal for this problem/need was "The resident will not harm self or others thru next review." There was no indication of how the delusions would harm others or how the goal would be measured.</p> <p>Resident #9 had a current, 8/17/16, care plan problem/need regarding "Resident has a diagnosis of anxiety/agitation."</p>			

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	<p>The goal for this problem/need was "Resident will respond to staff interventions thru next review." There was no indication of what behaviors the resident exhibited as anxiety or agitation. There was no way to measure the goal.</p> <p>2. On 8/15/16 at 10:20 a.m., Resident #29 was observed walking down hall pushing wheel chair.</p> <p>The clinical record of Resident #29 was reviewed on 8/19/16 at 9:29 a.m. Resident #29 had current diagnoses which included, but were not limited to, dementia, unsteady gait, poor vision, type 2 diabetes mellitus, depression, and history of headaches.</p> <p>Resident #29 had a current, 8/1/16 physician's orders which included, but were not limited to, Trazodone 100 mg (an anti-depressant medication), Depakote sprinkles 125 mg (an anti-seizure medications used as a mood stabilizer), Aricept 10 mg (an Alzheimer's medication), cilostazol 100 mg (an medication to increase blood flow used for Alzheimer's disease), Namenda 10 mg (an Alzheimer's medication).</p> <p>Resident #29 had a current, 8/17/16, care plan problem/need regarding "Resident exhibits socially inappropriate behaviors</p>			

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	<p>as follows: undressing in inappropriate areas, repetitive verbalizations, yelling out, running wheel chair into other people." The goal for this problem/need was "Resident will be redirected when inappropriate behavior is exhibited thru next review." There was no indication of what specific redirection would be used or for which behavior the goal was intended.</p> <p>Resident #29 had a current, 6/30/16, care plan problem/need regarding "Resident has a diagnosis of anxiety: restless and pacing." The goal for this problem/need was "Resident will respond to staff interventions thru next review." There was no indication as to how to measure the response of the resident.</p> <p>Resident #29 had a current, 6/30/16, care plan problem/need regarding "Resident exhibits verbal behavior symptoms directed toward others such as: cursing at others, agitation." The goal for this problem was "The behavior will not have a significant impact on resident or others daily thru next review." There was no indication as to how to prevent the occurrence or how to measure occurrences of the resident's behaviors.</p> <p>Resident #29 had a current, 6/30/16, care plan problem/need regarding "Resident</p>			

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	<p>exhibits wandering behavior. The wandering significantly intrudes on the privacy or activities of others, wandering in and out of other residents rooms."</p> <p>The goal for this problem/need was "Resident will not wander from the facility nor intrude on the privacy or activities of others thru next review."</p> <p>There was no indication as to how the wandering behavior would be deemed acceptable.</p> <p>During an interview on 8/19/16 at 3:34 p.m., the Social Services Designee indicated the health care plans did not have specific targeted behaviors or measurable goals.</p> <p>3. On 8/16/16 at 10:21 a.m., Resident #46 was observed in the resident's room sitting on the side of the bed looking at roommate.</p> <p>On 8/17/16 at 11:00 a.m., Resident #46 was observed sitting in the resident's room, awake, and watching men mowing outside window.</p> <p>The record of Resident #46 was reviewed on 8/19/16 at 3:27 p.m. Resident #46 had current diagnoses which included, but were not limited to, vascular dementia with behavior disturbances, cognitive communication deficit,</p>			

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	<p>psychosis, insomnia, history of colon cancer, history of skin cancer, and history of breast cancer.</p> <p>Resident #46 had a current, 8/1/16 physician's orders which included, but were not limited to, Trazodone 50 mg (an anti-depressant medication), oxcarbazepine 150 mg (an anti-seizure medications used as a mood stabilizer), Aricept 10 mg (an Alzheimer's medication), Remeron 7.5 mg (an anti-depressant medication used for appetite stimulant), Seroquel 75 mg (an anti-psychotic medication).</p> <p>Resident #46 had a current, 6/2/16, care plan problem/need regarding "Resident exhibits socially inappropriate behaviors as follows: entering other resident rooms when doors, [sic] chairs." The goal for this problem/need was "Resident will be redirected when inappropriate behavior is exhibited thru next review." There was no way to measure how the resident was redirected or what inappropriate behaviors meant.</p> <p>Resident #46 had a current, 6/2/16, care plan problem/need regarding "The resident has multiple health conditions: history of colon cancer, history of skin cancer, history of breast cancer, history of</p>			

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	<p>transurethral resection of the prostate, and chronic obstruction pulmonary disease, and is at risk for complications associated with these conditions." No complications were listed. The goal for this problem/need was "The resident will be free from complications associated with listed conditions thru next review." There was no way to measure the goal.</p> <p>Resident #46 had a current, 6/2/16, care plan problem/need regarding "Potential for fear and anxiety due to incident that occurred on 1/29/16." The goal for this problem/need was "Resident will not exhibit any signs or symptoms of increased anxiety thru next review." There was no indication as to what anxiety meant for resident behaviors.</p> <p>During an interview on 8/19/16 at 3:34 p.m., the Social Services Designee indicated the health care plans did not have specific targeted behaviors or measurable goals.</p> <p>4. On 8/17/16 at 11:19 a.m., Resident #16 was observed in bed yelling "hey" repeatedly.</p> <p>On 8/17/16 at 1:37 p.m., Resident #16 was observed in bed yelling "hey" or "help me" every time a person passed her room. Staff would go in the resident's room and as soon as staff left the room</p>			

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	<p>the resident would begin yelling again.</p> <p>On 8/18/16 at 7:44 a.m., Resident #16 was assisted to the dining room. As soon as the resident entered the dining room she began asking loudly "where's the food?" Once the food was delivered the resident began to request loudly "take be back to bed."</p> <p>On 8/18/16 at 9:02 a.m., Resident #16 was observed in bed yelling "hey" and "help me" repeatedly.</p> <p>On 8/18/16 at 9:19 a.m., Resident #16 was observed in bed talking loudly, no one present in the room.</p> <p>On 8/18/16 at 9:21 a.m., Resident #16 was observed in bed, she asked a visitor walking by "can you help me?"</p> <p>On 8/18/16 at 2:50 p.m., Resident #16 was heard in her room yelling "help" repeatedly.</p> <p>On 8/18/16 at 3:36 p.m., Resident #16 was heard in her room yelling "help" and "hey" repeatedly.</p> <p>On 8/18/16 at 3:51 p.m., Resident #16 was heard in her room yelling "help me" repeatedly.</p>			

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	<p>On 8/19/16 at 8:20 a.m., Resident #16 was in her wheelchair in the hallway yelling "I want to go back to bed" or "put me back to bed".</p> <p>On 8/19/16 at 10:55 a.m., Resident #16 was heard in her room yelling "help me" repeatedly.</p> <p>The clinical record for Resident #16 was reviewed on 8/17/16 at 1:48 p.m. Diagnoses for Resident #16 included, but were not limited to, dementia with behaviors, delusional disorder, and depression.</p> <p>Resident #16 had the following current physician's orders:</p> <ul style="list-style-type: none"> <li>a. Risperdal (an anti-psychotic medication) 0.25 mg, 1 tablet by mouth at bed time. The original date of this order was 5/11/16.</li> <li>b. Trazodone (an anti-depressant medication also used as a sleep aid) 50 mg, 1 tablet by mouth at bed time. The original date of this order was 5/11/16.</li> <li>c. Zoloft (an anti-depressant medication) 50 mg, 1 tablet by mouth daily. The original date of this order was 5/20/16.</li> <li>d. Ativan (an anti-anxiety medication) 0.5 mg, 1 tablet by mouth 2 times a day. The original date of this order was 5/17/16.</li> </ul>			

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	<p>Resident #16 had a 3/12/16, quarterly Minimum Data Set (MDS) assessment, and a 5/20/16, significant change assessment and both assessments indicated the resident had severe cognitive impairment.</p> <p>An interdisciplinary care plan conference meeting for Resident #16 was held on 6/2/16 with nursing, dietary, social services, activities, and MDS representatives in attendance.</p> <p>Resident #16 had a current, updated on 6/2/16, health care plan with the problem of socially inappropriate behaviors as follows: "yelling 'help me', yelling inappropriate comments". The goal for this problem was "The resident will be redirected when inappropriate behavior is exhibited. Thru next review". The health care plan lacked resident specific targeted behaviors and measurable goals.</p> <p>Resident #16 had a current, updated on 6/2/16, health care plan with the problem of "Resident has a diagnosis of anxiety". The goal for this problem was "Resident will respond to staff interventions thru next review". The health care plan lacked resident specific targeted behaviors and measurable goals.</p>			

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	<p>Resident #16 had a current, updated on 6/2/16, health care plan with the problem of repetitive complaints and concerns as evidenced by "yelling 'help me' then when asked what was wrong Res [Resident] need [sic] anything". The goal for this problem was "RESIDENT WILL VOICE ALL COMPLAINTS &amp; CONCERNS TO APPROPRIATE STAFF THRU NEXT REVIEW." The health care plan lacked resident specific targeted behaviors and measurable goals.</p> <p>Resident #16 had a current, updated on 6/2/16, health care plan with the problem of "The resident requires the use of an anti depressant [sic] medication: Trazodone to treat: Behaviors and is at risk for adverse side effects." The health care plan lacked resident specific targeted behaviors and measurable goals.</p> <p>Resident #16 had a current, initiated on 6/2/16, health care plan with the problem of "The resident requires the use of an anti depressant [sic] medication: Trazodone to treat: sleep disorder, depression and is at risk for adverse side effects." The health care plan lacked resident specific targeted behaviors and measurable goals.</p> <p>Resident #16 had a current, initiated on 6/2/16, health care plan with the problem</p>			

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	<p>of "The resident requires the use of an anti- psychotic [sic] medication: Risperdal to treat: Behavior and is at risk for adverse side effects." The clinical record lacked a health care plan with specific targeted behaviors for the use of Risperdal. The health care plan lacked resident specific targeted behaviors and measurable goals.</p> <p>During an interview on 8/19/16 at 3:34 p.m., the Social Services Designee indicated the health care plans for Resident #16 did not have specific targeted behaviors or measurable goals. She indicated the health care plans did not describe the specific targeted behaviors for the each different medication.</p> <p>Review of the current facility policy, revised 10/2014, titled "CARE PLAN DEVELOPMENT AND REVIEW", provided by RN Consultant #2 on 8/19/16 at 4:36 p.m., included, but was not limited to,</p> <p>"PURPOSE: To ensure an interdisciplinary approach to plan for and meet resident's needs.</p> <p>Policy: Facility personnel will ensure development of a comprehensive care plan for each resident that includes</p>			

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	<p>measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs.</p> <p>PROCEDURE:...</p> <p>...4. The comprehensive care plan is designed to: address the needs, strengths and preferences identified in the comprehensive resident assessment... ...reflect standards of current professional practice... ...reflect treatment goals and objectives in measurable outcomes....</p> <p>...6. Care plans shall be revised with changes in the resident's condition. Changes in the resident's care as a result of condition change should be promptly addressed on the care plan (i.e., physician orders, diet changes, therapy changes, behavior changes, ADL [Activities of Daily Living] changes, skin conditions, etc.)...."</p> <p>Review of the current facility policy, revised 11/2013, titled "MOOD AND BEHAVIOR PROGRAM", provided by RN Consultant #1 on 8/19/16 at 12:23 p.m., included, but was not limited to,</p> <p>"Documentation of Mood/Behavior...</p> <p>...7. A written plan of care will be developed by social services and interdisciplinary team to address the</p>			

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F 0309 SS=D Bldg. 00	<p>mood(s) and/or behavior(s), including interventions to address any noted intrinsic and/or extrinsic factors precipitating the mood(s) and/or behaviors(s), as identified in the aforementioned assessment. The resident careplan, including any entries relative to mood/behavior/management will be accessible to all caregivers...."</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a physician's response to a resident's abnormal urine laboratory result had been addressed to provide appropriate treatment and care for 1 of 6 residents reviewed for laboratory testing. (Resident #12)</p> <p>Findings include:</p> <p>The clinical record for Resident #12 was reviewed on 8/18/16 at 12:35 p.m. Diagnoses for Resident #12 included, but</p>	F 0309	<p>F 309</p> <p>1. Resident #12 received treatment beginning on 5/20/16 and lasting 30 days for the abnormal urine lab result. Resident #12's other lab results, physician progress notes, and nurses' notes for the past 30 days have been reviewed and have been addressed in a timely manner. Physician's progress notes were obtained and placed on the resident's clinical record for the physician's visit on 5/20/16.</p> <p>2. All residents have the potential to</p>	09/18/2016

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	<p>were not limited to, diabetes, hypertension, and dementia.</p> <p>A telephone order for Resident #12, dated 5/3/16, indicated an urinalysis and an urine culture and sensitivity (both urine laboratory tests), for dysuria (painful urination) had been ordered. A nurses note, dated 5/3/16, indicated the urine for the laboratory tests had been collected.</p> <p>A copy of the the final urinalysis and culture laboratory report for Resident #12, dated 5/6/16, was filed in Resident #12's clinical record. The physician had written on the final urine laboratory results "on meds [medications]? allergies?" with his signature. No other documentation was noted on the final urine laboratory results.</p> <p>The clinical record for Resident #12 lacked any documentation of a response to the physician's questions on the final urine laboratory results. A nurses note, dated 5/20/16, indicated Resident #12 had been to see the physician. Resident #12 returned to the facility with a new order for Septra (an antibiotic commonly prescribed for urinary tract infections) for thirty days. The clinical record for Resident #12 had physician visit progress notes from 4/27/16 and 6/29/16, but not a</p>		<p>be affected. Lab results, physician progress notes, and nurses' notes have been reviewed for the past 30 days to ensure physician response was addressed in a timely manner. The MD was contacted for further orders if indicated.</p> <p>3. The facility's policies for change in resident condition and charting guidelines have been reviewed and no changes are indicated at this time. The nurses have been re-educated on addressing physician's responses in a timely manner to provide appropriate treatment and care for the resident. An audit tool has been implemented.</p> <p>4. The DON or designee will be responsible for completing this audit tool to ensure physician response was addressed in a timely manner. Five resident's clinical records will be reviewed on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>	

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	<p>physician progress note for the 5/20/16 visit.</p> <p>During an interview on 8/19/16 at 2:53 p.m., the RN Consultant #1 indicated she had no additional information to provide regarding the lack of response to the physician's questions or verification of treatment for Resident #12 related to her urine laboratory results on 5/6/16.</p> <p>During an interview on 8/19/16 at 3:26 p.m., LPN #4 was shown a copy of the final urine laboratory results dated 5/6/16. She indicated she would have checked to determine if Resident #12 had been on antibiotics or any treatment for an urinary tract infection. She indicated she would have let the physician know the name of the medication or would have let the physician know the resident had not been on a medication and supplied any medication allergy information. She further indicated a response to the physician's questions was needed to ensure the resident was being treated appropriately.</p> <p>Review of the current facility policy, revised 10/2015, titled "CHANGE IN RESDIENT CONDITION/EMERGENCY TRANSFER TO ACUTE CARE HOSPITAL", provided by RN Consultant</p>			

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	<p>#2 on 8/19/16 at 4:50 p.m., included, but was not limited to,</p> <p>"PURPOSE: Resident condition changes are reported to the physician, in a timely manner, in order to ensure provision of necessary care...."</p> <p>Review of the current facility policy, revised 10/2014, titled "CHARTING AND DOCUMENTATION", provided by RN Consultant #2 on 8/19/16 at 4:50 p.m., included, but was not limited to,</p> <p>"PURPOSE: The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized....</p> <p>PROCEDURE:...</p> <p>...3. The Nursing narrative notes are to reflect:...</p> <p>...Care provided and response to care...</p> <p>...Attempts to notify physicians, whether successful or not, and the results of the notification...</p> <p>...Physician or consulting physician visits...."</p> <p>3.1-37(a)</p>			

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F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to offer supervision when dining to cognitively impaired residents placing them at possible risk for aspiration for 6 of 6 residents reviewed for supervision when dining (Residents #50, #29, #43, #55, #14 and #9).</p> <p>Findings include:</p> <p>1. During an 8/14/16, 7:31 p.m., observation of the Dementia Unit, the unit had 2 resident dining areas. One dining room was on the left side of the unit as one entered the unit and one dining room was on the right. When standing in either dining room you could see across to the other dining area, but could not see the entire dining room. Approximately half of each dining room could not be observed when in the other dining room.</p> <p>During an 8/15/16, 11:10 a.m. to 11:40</p>	F 0323	<p>F 323</p> <p>1. Supervision during dining is currently being provided to Resident #'s 50, 29, 43, 55, 14, and 9. CNA # 5 and LPN # 8 have been re-educated regarding dining service with a special focus on providing supervision during dining.</p> <p>2. All cognitively impaired residents have the potential to be affected. Supervision during dining is currently being provided while residents are in the dining room for meals.</p> <p>3. Staff has been re-educated on dining service with a special focus on providing supervision during dining. An audit tool has been implemented.</p> <p>4. The DON or Designee will be responsible for completing the audit tool to ensure supervision is being provided in the dining rooms. The audit will be completed on alternate meal services on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then</p>	09/18/2016

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	<p>a.m., dining observation on both the right and left side Dementia Unit Dining Rooms the following occurred:</p> <p>At 11:18 a.m., all staff left the left side assisted dining room in the Dementia Unit. There were 7 residents left unsupervised in the dining room. Residents #55, #14, #24, #9 and #43 were included in the group of 7. Staff members did not return to the left dementia assisted dining room until 11:19 a.m. (9 minutes).</p> <p>At 11:19 a.m., staff left the right side dining room in the dementia unit leaving the room unsupervised. Three residents were eating in the right dining room at this time. Residents #29 and #50 were included in the group of 3. A staff member did not return to the right side dining room until 11:25 a.m. (6 minutes). At 11:24 a.m., Resident #50 took a bite and began to cough aggressively. Resident #50's face turned a bright red and purple color. The resident's cough was deep, moist and rattling and her eyes watered. After each long aggressive cough the resident would gasp in air making a strong sucking sound. The nurse was summoned for assistance. LPN #8 responded when summoned. The LPN stayed with Resident #50 offering encouragement as the resident</p>		<p>quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>	

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	<p>coughed multiple times until the resident was able to clear her throat. At this time LPN #8 was the only staff member present on the Dementia Unit.</p> <p>At 11:27 a.m., after Resident #50 had cleared her throat, LPN #8 left the right dining room once again leaving the residents unsupervised. The LPN went to the nursing station. At this time there were no staff members present in either the right or left Dementia Unit dining rooms.</p> <p>At 11:26 a.m., Resident #55 was coughing a moist cough in the left Dementia Unit dining room.</p> <p>At 11:29 a.m., LPN #8 looked into one dining room then the other. She then left the area to obtain a soft drink for a resident.</p> <p>At 11:30 a.m., CNA #5 returned to the unit.</p> <p>At 11:33 a.m., CNA #5 began to clean away the soiled dishes from the tables. While bussing the tables she went back and forth between the right and left dining rooms. While doing the table clearing, she left each dining room unsupervised for approximately one minute at a time.</p>			

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	<p>3. During an 8/17/16, 11:15 a.m. to 11:52 a.m., lunch observation of the Dementia Unit right dining room the following occurred:</p> <p>At 11:25 a.m., no staff member was present to supervise the meal. Four residents were in the room without staff present. The residents were eating their meals. Residents #29 and #50 were included in the group of 4.</p> <p>At 11:26 a.m., a staff member entered the room and stay in the room for 15 seconds.</p> <p>At 11:30 a.m.,(4 minutes without supervision) a staff member entered the room and stayed for 10 seconds.</p> <p>At 11:32 a.m., a resident in the right dining room coughed softly.</p> <p>At 11:33 a.m., (3 minutes without supervision) a staff member entered the room and stayed 7 seconds.</p> <p>On 8/17/16 at 11:33 a.m., CNA #5 indicated she had spilled a shake and would need to go to the kitchen and replace it. CNA #5 left the unit at 11:34 a.m. LPN #8 remained on the unit alone until CNA #5 returned at 11:38 a.m. (4</p>			

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	<p>minutes). During the four minutes with only 1 staff member on the Dementia Unit, the LPN was unable to supervise both dining rooms. During this time LPN #8 stayed in the left dining room and did not supervise the right dining room.</p> <p>At 11:38 a.m., (5 minutes without supervision) a staff member entered the room and stayed 30 seconds.</p> <p>At 11:43 a.m., (5 minutes without supervision) a staff member entered the room and stayed 8 seconds.</p> <p>At 11:44 a.m., a resident coughed a soft cough.</p> <p>At 11:47 a.m., (4 minutes without supervision) a staff member entered the dining room and stayed less than 1 minute.</p> <p>At 11:52 a.m., (5 minutes without supervision) a staff member entered the room and left in 1 second due to a loud noise in the hallway.</p> <p>4. During an 8/19/16, 7:18 a.m. to 8:15 a.m., breakfast meal observation of the Dementia Unit dining service the following was observed:</p> <p>During an, 8/19/2016, 7:33 a.m.,</p>			

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	<p>observation of the right Dementia Unit dining room, no staff were in the room supervising residents. Three residents were in the dining room. Residents #29 and #50 were included in the group of 3. At 7:40 a.m., a resident in the right dining room coughed a moist wet cough. At 7:42 a.m. (9 minutes without supervision) a staff member entered the room and stayed for 45 seconds.</p> <p>On 8/19/2016 at 7:43 a.m., no staff members were present in either the right or left Dementia Unit dining rooms.</p> <p>On 08/19/2016 at 7:46 a.m. (3 minutes without supervision) a staff member entered the right dining room and stayed less than 1 minute.</p> <p>On 8/19/2016 at 7:48 a.m. (5 minutes without supervision) a staff member entered the left dining room. Residents #55, #24, #14, #43 and #9 were present in the room while no supervision was provided. Each resident had food in front of them on the dining table.</p> <p>5. During an 8/19/16, 8:24 a.m., interview, CNA #5 indicated she had a number of residents who required cueing or assistance to eat. She indicated she moved quickly from resident to resident offering each assistance and moving on</p>			

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	<p>because it was quicker. She additionally indicated she was aware she needed to sit to feed a resident.</p> <p>During an 8/19/16, 8:28 a.m., interview, LPN #8 indicated she felt the residents in the right Dementia dining room did not require as much supervision because they fed themselves and ate quickly. She additionally indicated she could not hear Resident #50 the day she had coughed when eating and would not have known about the resident's difficulty if she had not been summoned by the surveyor.</p> <p>6. Resident #50's clinical record was reviewed on 8/17/2016 at 1:34 p.m. Resident #50's diagnoses included, but were not limited to, severe Alzheimer's disease with behavioral disturbances, anxiety and depression.</p> <p>Resident #50 had an 8/19/16, "Speech/ Language Therapy" which indicated the resident had swallowing difficulty and had 2 episodes of "coughing" with a "croupy" sound.</p> <p>Resident #50 had a, 5/20/16, quarterly, Minimum Data Set (MDS) assessment which indicated was severely cognitively impaired and rarely or never made independent decisions.</p>			

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	<p>Resident #50 had a, 6/2/16, care plan problem/need having a communication deficit due to Alzheimer's disease. This care plan problem/need originated 4/21/16. The goal for this problem was the resident will have all basic needs met by staff. Approaches to this problem included, but were not limited to, placement on a secured unit.</p> <p>Resident #50 had a, 6/2/16, care plan problem/need regarding nutritional risk due to Alzheimer's disease.</p> <p>Resident #50 had a, 6/2/16, care plan problem/need regarding requiring assistance with Activities of Daily Living (ADLs).</p> <p>Resident #50 had a, 6/2/16, care plan problem/need regarding the potential for weight loss due to Alzheimer's disease. This care plan problem/need originated 4/21/16. Approaches to this problem included, but were not limited to, "encourage the resident to eat as much as possible and provide meal set up and assist as needed."</p> <p>7. Resident #29's clinical record was reviewed on 8/19/2016 at 12:21 p.m. Resident #29's diagnoses included, but were not limited to, dementia, depression, poor vision, and unsteady</p>			

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	<p>gait.</p> <p>Resident #29 had a 6/14/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident required assistance and cueing with decision making, had impaired vision, required extensive assistance for transferring, was not steady when going from sitting to standing and used a walker or wheelchair for mobility.</p> <p>Resident #29 had a 1/8/16, speech therapy progress note which indicated the resident had poor safety awareness.</p> <p>Resident #29 had a 6/30/16, care plan problem/need regarding difficulty making himself understood due to disorganized thinking. Approaches to this problem included, but were not limited to, "Provide assistance as needed."</p> <p>Resident #29 had a 6/30/16, care plan problem/need regarding a risk for falls. Approaches to this problem included, but were not limited to, "Keep frequently used items within reach of the resident."</p> <p>Resident #29 had a 6/30/16, care plan problem/need regarding risk for fainting and falls due to hypertension. Approaches to this problem included, but were not limited to, "Change positions</p>			

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	<p>slowly."</p> <p>8. Resident #43's clinical record was reviewed on 8/17/2016 at 3:07 p.m. Resident #43's diagnoses included, but were not limited to, Huntington's disease, expressive language disorder, depression, anxiety, dysphagia (swallowing difficulty) and dementia.</p> <p>Resident #43 had a current, 8/8/16, physician's order for a mechanical soft diet.</p> <p>Resident #43 had a, 6/14/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident required limited assistance from the staff for eating and required a mechanically altered diet.</p> <p>Resident #43 had an, 11/25/15, "Speech Therapy Plan of Care" which indicated she had mild swallowing impairment, 25-50% impairment, risk of aspiration on liquids, may need ground meat, and required cueing and intermittent supervision when eating.</p> <p>Resident #43 had a, 6/30/16, care plan problem/need regarding Huntington's disease and it's progression. The problem statement indicated "As the disease progresses the resident may have</p>			

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	<p>difficulty feeding self and swallowing." This care plan problem/need originated 3/10/16.</p> <p>Resident #43 had a, 6/30/16, care plan problem/need regarding the risk for aspiration. This care plan problem/need originated 3/10/16. Approaches to this problem included, but were not limited to, encourage to chew food thoroughly.</p> <p>9. Resident #55's clinical record was reviewed on 8/17/2016 at 3:37 p.m. Resident #55's diagnoses included, but were not limited to, Downs syndrome, Alzheimer's disease and gastroesophageal reflux disease, and depression.</p> <p>Resident #55 had a, 7/15/16, admission, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, was rarely understood by others, and required extensive assistance from the staff to eat.</p> <p>Resident #55 had a, 7/14/16, care plan problem/need regarding nutritional risk due to dementia and Downs syndrome. Approaches to this problem included, but were not limited to, "encourage resident to eat."</p> <p>Resident #55 had a, 7/13/16, care plan problem/need requiring assistance for</p>			

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	<p>ADLs. Approaches to this problem included, but were not limited to, "provide assistance with ADLs as needed."</p> <p>10. Resident #14's clinical record was reviewed on 8/17/2016 at 1:59 p.m. Resident #14's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, and depression. Resident #14 had a current, 8/8/16, physician's order for a mechanical soft diet.</p> <p>Resident #14 had a, 6/29/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired and rarely or never made decisions, required limited assistance from the staff to eat, received a mechanically altered diet, required extensive assistance from the staff to toilet, and was occasionally incontinent of both bowel and bladder.</p> <p>Resident #14 had a 6/1/16, "Speech Therapy Plan of Care" which indicated the resident was referred to therapy due to swallowing difficulty during meals.</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding nutritional risk due to anxiety, depression, and Alzheimer's disease. Approaches to this problem included, but were not limited</p>			

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	<p>to, "encourage the resident to eat."</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding tooth pain due to infection.</p> <p>Resident #14 had two current, 7/14/16, care plan problems/needs regarding wandering into other's rooms. Both care plan problems/needs originated 9/9/14. The goals for this problem was "The resident will be redirected when inappropriate behavior is exhibited" and the resident would not intrude on the privacy of others. Approaches to this problem included, but were not limited to, "attempt diversion, Ensure all basic needs are met (toileting, nutrition thirst), and redirect restless and pacing behaviors."</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding anxiety and pacing halls. Approaches to this problem included, but were not limited to, "Ensure all basic needs have been met."</p> <p>Resident #14 had a current, 7/14/16, care plan problem/need regarding the need for assistance with Activities of Daily Living (ADLs).</p> <p>11. Resident #9's clinical record was reviewed on 8/19/2016 at 2:15 p.m.</p>			

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F 0325 SS=D Bldg. 00	<p>Resident #9's diagnoses included, but were not limited to, chronic pain, dementia with delusions and behaviors, anxiety, and macular degeneration.</p> <p>Resident #9 had a 4/29/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired and rarely or never made decisions, and the resident required extensive assistance from the staff to eat.</p> <p>Resident #9 had a current, 8/17/16, care plan problem/need regarding nutritional risk due to anxiety and dementia. Approaches to this problem included, but were not limited to, "encourage the resident to eat most meals."</p> <p>Resident #9 had a current care plan problem/need regarding the need for assistance with ADLs.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical</p>			

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	<p>condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to follow dietary recommendations for a nutritionally at risk resident for 1 of 3 residents reviewed for nutrition. (Resident #24)</p> <p>Findings include:</p> <p>During an 8/19/2016, 7:36 a.m., observation, Resident #24 was escorted to the dining room and served her meal. She was cued to eat breakfast when her meal was served. From 7:35 a.m. to 7:57 a.m., (22 minutes) Resident #24, drug the fork over her food, picked up her food and tried to stab it with a fork and picked at her food with her fingers. During this time Resident #24 only got 3 bites of food successfully to her mouth. At 7:57 a.m., CNA #5 offered Resident #24 two bites of her food, which she ate. Resident #24 was cued to eat. Resident #24 once again began to manipulate her food without taking successful bites.</p> <p>The clinical record for Resident #24 was reviewed on 8/18/16 at 10:46 a.m. Diagnoses for Resident #24 included, but were not limited to, Alzheimer's disease, hypertension and depression.</p>	F 0325	<p>F 325</p> <p>1. Resident #24 is currently receiving all dietary supplements as recommended by the Registered Dietician and ordered by the physician.</p> <p>2. All residents have the potential to be affected. Dietary recommendations have been reviewed for the previous 30 days to ensure they are being followed. The physician was contacted if indicated.</p> <p>3. The facility's policy for Dietician Recommendations has been reviewed and no changes are indicated at this time. The Registered Dietician has been instructed to leave a copy of her recommendations with the DON, Administrator, and Dietary Manager. The DON and Dietary Manager have been re-educated on the policy with a special focus on following dietary recommendations in a timely manner. An audit tool has been implemented.</p> <p>4. The Administrator or Designee will complete the audit tool to ensure dietary recommendations are followed in a timely manner. These audits will be conducted on a scheduled work day every other week. Should a concern be found, immediate corrective action will</p>	09/18/2016

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	<p>Monthly weights in 2016 for Resident #24 were January: 131.5 pounds, February: 129.5 pounds, March: 131.5 pounds, April: 130 pounds, May: 128.5 pounds, June: 126 pounds, July: 126 pounds, and August: 117 pounds.</p> <p>A telephone order for Resident #24, dated 8/12/16, indicated a Mighty shake (a high protein and high calorie supplemental drink) at 10 a.m., and to change the ice cream given at dinner to Thrive (a high protein and high calorie supplement) ice cream.</p> <p>A nutritional progress note, dated 8/5/16, indicated the Registered Dietician (RD) recommended for Resident #24 to add a shake supplement drink at 10:00 a.m., and changing the ice cream served at dinner to Thrive ice cream.</p> <p>A nurses note, dated 8/12/16, indicated the new orders of a Mighty shake at 10:00 a.m., and change the ice cream given at dinner to Thrive ice cream were received for Resident #24. This order was received seven days after the RD's recommendations were made for the resident.</p> <p>During an interview on 8/19/16 at 10:19 a.m., the Dietary Manager indicated a</p>		<p>occur. Results of these reviews and any correctiveactions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>	

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	<p>copy of the recommendations from the Registered Dietician were given to the nursing staff and the dietary staff. The Dietary Manager indicated the recommendations were in place for the resident within 48 hours if not sooner.</p> <p>During an interview on 8/19/16 at 12:25 p.m., RN Consultant #1 indicated the RD recommendations for Resident #24 did not get addressed until the S.W.A.T. (Skin and Weight Assessment Team) meeting on 8/12/16. RN Consultant #1 indicated the RD recommendations had not been given to the nursing staff, the Administrator or the Dietary Manager as they should have been.</p> <p>Review of the current facility policy, revised 10/2014, titled "DIETITIAN [sic]RECOMMEDATION", provided by RN Consultant #1 on 8/19/16 at 4:35 p.m., included, but was not limited to,</p> <p>"PURPOSE: To ensure the nutritional status of each resident is reviewed, as warranted and necessary nutritional recommendations made and followed as deemed appropriate....</p> <p>...4. The RD [Registered Dietician] will make recommendations and place them on the RD recommendation form.</p> <p>5. A copy of the RD recommendation</p>			

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F 0371 SS=E Bldg. 00	<p>sheet(s) will be distributed to the Administrator, Dietary Manager and Director of Nursing.</p> <p>6. Administrative nursing staff shall be responsible to ensure said recommendations are communicated to the resident's physician as soon as possible. but not later than three (3) days from receiving said recommendation. Physician response shall be documented and implemented accordingly.</p> <p>7. A completed copy of the RD recommendation (with resolution action and date) shall be kept in a binder located in a designated area."</p> <p>3.1-46(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was handled in a manner to prevent cross contamination and ensure sanitary</p>	F 0371	F 371  1. Resident #'s 55 and 43 are currently receiving food that is handled in a manner to prevent cross	09/18/2016

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	<p>food service for 2 of 3 meals observed on the Dementia Unit. This deficient practice directly impacted Residents #55, #43, #24 and #14.</p> <p>Findings include:</p> <p>During an observation on 8/15/16 at 11:31 a.m., CNA #5 took a dessert and slice of bread that wasn't eaten by Resident #46. Resident #46 had multiple food items on his plate and in bowls which he had not eaten. However, Resident #46 had eaten a little off his plate and moved items around. CNA #5 then gave the food items from Resident #46's plate to Resident #55 to eat.</p> <p>During an observation on 8/15/16 at 11:32 a.m., CNA #5 placed a slice of bread on her bare hand and spread butter on the bread. She then handed the bread on butter to Resident #55 to eat. Resident #55 ate the bread.</p> <p>During an 8/15/16, 11:40 a.m., observation, CNA #5 placed a second piece of bread on her bare hand buttered it and handed it to Resident #55. This was the slice of bread the CNA had removed from another resident's dining area. Resident #55 ate the slice of bread.</p> <p>During an 8/19/2016, 7:41 a.m., dining</p>		<p>contamination and ensure sanitary foodservice. CNA #5 and LPN #8 have beenre-educated on food service with a special focus on not touching food with barehands, not taking food off of resident trays and giving to another resident,and hand hygiene during meal service.</p> <p>2. All residents have the potential to be affected. The residents are currently receiving foodthat is handled in a manner to prevent cross contamination and ensure sanitaryfood service.</p> <p>3. The facility's policies for Glove Use and Meal Serviceand Hand Hygiene have been reviewed and no changes are indicated at thistime. The nursing staff have beenre-educated on food service with a special focus on not touching food with barehands, not taking food off of resident trays and giving to another resident,and hand hygiene during meal service. Anaudit tool has been implemented.</p> <p>4. The DON or designee will be responsible for completingthe audit tool to ensure food is served in a manner to prevent crosscontamination and ensure sanitary food service. The audit will be completed on alternate meal services on scheduled workdays as follows: Daily for two weeks,weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found,</p>	

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	<p>observation CNA #5 removed the muffin wrapper from Resident #43's muffin and touched the muffin with her bare hand.</p> <p>During an 8/19/2016, 7:42 a.m., dining observation CNA #5 removed the muffin wrapper from Resident #24's muffin and touched the muffin with her bare hand.</p> <p>During an 8/19/2016, 7:45 a.m., dining observation, LPN #8 removed the paper wrapper from Resident #14 with her bare hands. LPN #8 did not wash her hands prior to removing the muffin wrapper. As the LPN removed the wrapper, her bare hands touched the muffin. LPN #8 then told Resident #14 she needed to eat a little bit because she had not eaten anything. The nurse then showed Resident #14 where her silverware was located and walked away. LPN #8 did not offer Resident #14 a bite of her food.</p> <p>During an 8/19/2016, 8:09 a.m., dining observation, CNA #5 handed Resident #55 a cookie with her bare hand.</p> <p>Review of the current facility policy, dated 11/2014, titled "Glove Use &amp; Meal Service", provided by the Administrator on 8/19/16 at 9:40 a.m., included, but was not limited to,</p> <p>"...6. Employees should use utensils such as spatulas, scoops, forks and tongs to</p>		<p>immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>				

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F 0465 SS=F Bldg. 00	<p>serve food...."</p> <p>Review of the current facility policy, dated 10/2014, titled "HANDWASHING/HAND HYGIENE", provided by the Administrator on 8/19/16 at 10:06 a.m., included, but was not limited to,</p> <p>"...HAND HYGIENE:.... ...Before and after eating or handling food (handwashing with soap with water)...."</p> <p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure clean and well maintained floors, walls, doors, and common areas were in good repair for 5 of 30 resident rooms. This deficient practice had the potential to affect 45 residents that resided in the 60 licensed beds. (Room #108, #109, #112, #117, #118 and #123)</p> <p>Findings include:</p>	F 0465	<p>F 465</p> <p>1. Room 108: The tilefloor in the bathroom is no longer discolored in front of the sink and toilet. Room 109: The tilefloor in the bathroom is no longer discolored around the toilet and beside the wall under the sink. Room 112: The tilefloor beside the baseboard heater has been replaced. The tile floor in the bathroom is no longer discolored around the toilet. Room 117: The entrydoor to the</p>	09/18/2016

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	<p>1. The following observations of resident rooms were made on the following dates and times;</p> <p>Room 108 on 8/16/16 at 8:16 a.m., the tile floor in the bathroom was discolored in front of the sink and toilet.</p> <p>Room 109 on 8/15/16 at 2:07 p.m., the tile floor in the bathroom was discolored around the toilet and beside the wall under the sink.</p> <p>Room 112 on 8/15/16 at 10:47 a.m., the tile floor approximately 24 inches by 2 inches beside the baseboard heater was broken in approximately 10 pieces. The tile floor in the bathroom was discolored around the toilet.</p> <p>Room 117 on 8/17/16 at 7:45 a.m., the entry door to the room had a whitish film coating covering the bottom half of the door.</p> <p>Room 118 on 8/17/16 at 7:45 a.m., the tile floor in the bathroom was discolored around the toilet. The wall under the soap dispenser, approximately 1 foot by 1 foot, had a rough surface and was missing paint. The wallpaper above the bed located beside the window was torn approximately 8 inches in length. The tile floor located in the Southwest corner</p>		<p>room no longer has a whitish film coating covering the bottom half of the door.</p> <p>Room 118: The tilefloor in the bathroom is no longer discolored around the toilet. The wall under the soap dispenser no longerhas a rough surface and is no longer missing paint. The wallpaper above the bed located by thewindow has been fixed. The floor in theSouthwest corner behind the bed has been replaced.</p> <p>Room 123: The tilefloor in the bathroom is no longer discolored in front of the sink andtoilet. The wallpaper around the toiletis no longer discolored.</p> <p>The carpet in the main corridor, main corridor in front ofthe water fountain, at the employee time clock, outside the exam room door, outsidersroom 103, in B hall, and outside Room 124 has been cleaned and repaired.</p> <p>Room 108: The floorin the bedroom has been repaired.</p> <p>A threshold strip has been replaced on the carpet areabetween the hard wood floor and B hall.</p> <p>2. All other resident rooms and common areas have thepotential to be affected. They have beenobserved and issues were noted in all rooms. The facility will plan to repair (1) room daily 5 days a week includingtearing down all wallpaper, painting the room, replacing all discolored tilesin rooms, and repairing the bathrooms until all rooms and bathrooms arerepaired.</p>	

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	<p>and along the wall behind the bed approximately 7 feet by 2 inches was broken in multiple pieces.</p> <p>Room 123 on 8/17/16 at 7:58 a.m., the tile floor in the bathroom was discolored in front of the sink and toilet. The wallpaper located around the toilet approximately 3 feet by 3 feet was discolored.</p> <p>2. The environmental tour was conducted on 8/19//16 at 5:01 p.m., with the Maintenance Director, the Administrator, the Housekeeping Supervisor and the Corporate Consultant.</p> <p>The carpet located in the main corridor according to the Maintenance Director had a approximately 2 feet long tear.</p> <p>The carpet located in the main corridor in front of the water fountain had an approximately 6 feet by 6 feet stain according to the Maintenance Director.</p> <p>The carpet located at the employee time clock had an approximately 2 feet by 2 feet stain according to the Maintenance Director.</p> <p>The carpet located outside the exam room door had an approximately 3 feet by 1 foot stain according to the Maintenance</p>		<p>3. The facility's policies for Preventative Maintenance and Tile and Refinish have been reviewed and no changes are indicated at this time. The Maintenance Director and Housekeeping Supervisor have been re-educated on the policies with a special focus on providing an environment in good repair. An audit tool has been implemented.</p> <p>4. The Administrator or Designee will be responsible for completing the audit tool to ensure the facility remains in good repair. Five resident rooms/common areas will be observed on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>	

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NAME OF PROVIDER OR SUPPLIER  WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>Director.</p> <p>The carpet located outside room 103 had an approximately 8 inch round worn and indented area located over the clean out drain according to the Maintenance Director.</p> <p>Room 108 according to the Maintenance Director the bedroom floor had small indented circles covering approximately 6 square feet, that was caused by a chair leg.</p> <p>The carpet located in the B hall according to the Maintenance Director had an approximately 8 inch round worn and indented area located over the clean out drain.</p> <p>The carpet located outside resident room 124's door had an approximately 4 inch stain according to the Maintenance Director.</p> <p>The carpet located between the hard wood floor and the B hall had no threshold strip.</p> <p>A current, 2015 facility policy, titled "Preventative Maintenance", provided by the Administrator on 8/19/16 at 5:56 p.m., indicated: " This facility shall have in place a written program to ensure the</p>			

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	<p>continued upkeep of the facility. This program shall serve to maintain all essential mechanical, electrical, and resident care equipment in safe operating condition."</p> <p>A current, undated facility policy, titled "Tile and Refinish", provided by the Administrator on 8/19/16 at 5:56 p.m., indicated: "The idea of scrubbing is to attempt to remove a few coats of debris, finish and scrub down to a clean base. The idea is not to take the floor down to the bare tile... Fresh finish must always be used on the floor."</p> <p>A current, undated facility policy, titled "Wall Washing ", provided by the RN Consultant #1 on 8/19/16 at 5:58 p.m., indicated: "...for wallpaper/paint walls: if walls have scrub-able paper or paint, use a mild solution in the pail with a sponge or cloth."</p> <p>The 8/15/16, "Bed Inventory" form, completed by the Regional Director, indicated the following: Rooms 108, 109, 117, 118, and 123 were each licensed for 2 beds. Rooms 112 was licensed for 1 bed. Resulting in the possibility of 11 resident residing in the rooms with identified concerns.</p> <p>The "Facility Census" form completed by</p>			

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F 0520 SS=E Bldg. 00	<p>the Regional Director on 8/15/16 indicated 45 residents resided in the facility.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review,</p>	F 0520	F 520	09/18/2016	

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	<p>the facility's QAA (Quality Assessment and Assurance) Committee failed to identify and implement a plan of action to address clean and well maintained floors, walls, doors, and common areas in good repair for 5 of 30 resident rooms. This deficient practice had the potential to affect 45 residents that resided in the 60 licensed beds. (Room #108, #109, #112, #117, #118 and #123)</p> <p>Findings include</p> <p>1. During the survey process the following observations of resident rooms (108, 109, 112, 117, 118, and 123) were made:</p> <p>The tile floor in the bathrooms were discolored.</p> <p>The tile floor in 2 of the 30 resident rooms had areas of broken tile.</p> <p>An entry door to a resident's room had a whitish film coating covering the bottom half of the door.</p> <p>The wall under the soap dispenser in resident's bathrooms had a rough surface and missing paint.</p> <p>The wallpaper in residents rooms was torn.</p>		<p>1. Corrective actions as described in the Plan of Correction were taken to provide an environment that is in good repair for Room #'s 108, 109, 112, 117, 118, 123 and common areas.</p> <p>2. As all residents could be affected, the following corrective action(s) have been taken. 3. Administrative staff have reviewed the current Quality Assurance Committee procedures, including monthly meetings (exceeding the quarterly requirement) to include audits of the Environment. The Administrator shall be responsible to conduct and/or delegate audits in an effort to identify areas of concern and address with the QA committee in an effort to formulate an action plan should deficient practice be identified. 4. As a means of quality assurance, the Administrator shall report findings of the aforementioned audit and immediate corrective actions taken to the QA committee during monthly meetings on an ongoing basis for a minimum of six months. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next Quality Assurance meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified concern.</p>				

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	<p>2. The environmental tour was conducted on 8/19//16 at 5:01 p.m. with the Maintenance Director, the Administrator, the Housekeeping Supervisor and the Corporate Consultant.</p> <p>The carpet located in the main corridor and throughout the facility had large stains and multiple tears.</p> <p>The carpet located between the hard wood floor and the B hall had no threshold strip.</p> <p>During an interview on 8/19//16 at 5:01 p.m., the Administrator and Regional Director indicated they were not employed at the facility last year. The Plan of Care from the Annual Survey, dated 10/19/15, was reviewed with noted environmental concerns related to problem areas identified during the environmental tour conducted on 8/19//16 at 5:01 p.m.</p> <p>During an interview on 8/19/16 at 5:32 p.m., the Maintenance Director indicated the Housekeeping Supervisor cleaned the carpet in the main corridor and the halls throughout the facility. The Regional Consultant indicated the facility needed new carpet.</p>			

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	Environmental cleanliness and repair concerns were cited on the annual 10/19/15 survey.  3.1-52(b)(2)				