

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
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NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 1, 2, 3, 4, 5 and 8, 2016</p> <p>Facility number: 000025 Provider number: 155064 AIM number: 100274850</p> <p>Census bed type: SNF: 8 SNF/NF: 58 Total: 66</p> <p>Census payor type: Medicare: 8 Medicaid: 45 Other: 13 Total: 66</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on February 16, 2016.</p>	F 0000	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p>	
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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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F 0156 SS=D Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>			

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	<p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral</p>			

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	<p>and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents were notified timely of discontinuation of Medicare/Medicaid coverage for services for 2 of 3 residents reviewed for discontinued benefits (Residents #27 and #7).</p> <p>Findings include:</p> <p>1. Resident #27's record was reviewed on 2/5/16 at 10:50 a.m. A Speech Therapy discharge summary, dated 11/10/15, indicated "End of Goal Status." A notice indicating Medicare benefits were ending was not located in the record.</p> <p>During an interview on 02/04/2016 at 3:15 p.m. the Business Office Manager (BOM) indicated Resident #27's record did not include a Notice of Medicare Non-Coverage notice.</p> <p>2. Resident # 7's record was reviewed on 2/4/16 at 10:14 a.m.. A Notice of Medicare Non-Coverage indicated coverage of services would end on 01/05/2016. The notice was not signed by the resident until 01/04/2016.</p>	F 0156	<p>F156</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident's #7 and #27 no longer reside at facility.</p> <p>2) How the facility identified other residents:</p>	02/26/2016

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	<p>During an interview on 02/04/2016 at 3:15 p.m., the BOM indicated the resident was not provided notice of Medicare non-coverage of services until the day before coverage ended.</p> <p>3.1(a)(3)</p>		<p>Audit was conducted by the Business Office Manager to determine if any other residents required a cut letter related to discontinuation of Medicare/Medicaid benefits.</p> <p>No other residents were identified.</p> <p>3) Measures put into place/ System changes:</p> <p>Business office Manager and Social Services are aware of the requirement regarding timely notification of discontinuation of Medicare/Medicaid benefits.</p> <p>Business office Manager will notify Social Services through email notification of discontinuation of benefits 72 hours prior. Social Services will then proceed with cut letters 48 hours prior to discontinuation.</p> <p>Additionally, during morning meetings, a review will be completed per BOM regarding any residents that are coming up for discontinuation of coverage benefits.</p> <p>4) How the corrective actions will be monitored:</p> <p>Executive Director or designee is the responsible party for monitoring this process. Audit will be conducted</p>	

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F 0224 SS=D Bldg. 00	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident remained free from misappropriation of property for 1 of 5 residents reviewed during medication administration (Resident #20).</p> <p>Findings include:</p> <p>The record review for Resident #88 was completed on 2/4/16 at 4:25 p.m.</p> <p>Diagnoses included, but were not limited to, pseudobulbar effect.</p>	F 0224	<p>weekly during stand up meeting to determine timeliness of discontinuation of Medicare/Medicaid coverage for services for discontinued benefits.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute</i></p>	02/26/2016	

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	<p>A Physician's Order, dated 1/1/16, indicated Nudexta capsule 20-10 milligrams(mg) - give one capsule by mouth two times a day.</p> <p>On 2/4/16 at 3:40 p.m., RN #3 began to prepare Resident #88's medications for administration. RN #3 indicated Resident #88 was out of Nudexta. RN #3 pulled a medication bubble pack belonging to Resident #20 out of the medication cart. The label on the bubble pack indicated Nudexta 20-10 mg. RN #3 administered the medication belonging to Resident #20 to Resident #88.</p> <p>During an interview on 2/4/16 at 3:50 p.m., RN #3 indicated she was not aware if there was a facility policy regarding borrowing medications between residents, but that she often did this so that the resident would not miss a dose of their medication. She indicated she then replaced the borrowed dose when the medication arrived from the pharmacy.</p> <p>During an interview on 2/8/16 at 1:42 p.m., LPN #4 indicated borrowing another resident's medication to give to a resident who had ran out of medication was not permitted.</p>		<p><i>admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #20 was assessed. No adverse reactions noted.</p> <p>Resident #88 was assessed, No adverse reactions noted</p> <p>Notification of Pharmacy occurred, Resident #20 received credit for 1 medication that was administered to Resident #88</p> <p>Notification of resident's physicians, families and State Board of Health.</p> <p>Identified RN that administered the medication was removed from the schedule pending investigation</p> <p>It was determined that there was no ill intent on the part of the RN. She was allowed to return to work with additional education and the expectation that she will be compliant with medication passes. Failure to comply with competency requirements will</p>		

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	<p>A current policy titled "Medication Administration General Guidelines," dated 5/1/15, provided by the Director of Nursing on 2/5/16 at 1:15 p.m. indicated "...Administration...I. Medications supplied for one resident are never administered to another resident...."</p> <p>A current policy titled "Incident Reporting Policy," dated 7/15/15, provided by the Administrator on 2/5/16 at 10:50 a.m., indicated "...5. Misappropriation of resident funds or property -- deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's property or money without the resident's consent...Note: Includes any medication dispensed in the name of a resident. Does not include medications from an EDK [Emergency Drug Kit] that have not been charged to a resident...."</p> <p>3.1-28(a)</p>		<p>result in termination</p> <p>2) How the facility identified other residents: Audit was conducted by facility management staff to determine the availability of resident medications. Any medications identified to be unavailable was immediately sent to Pharmacy for refill.</p> <p>Pharmacy came to facility and completed a MAR to Cart audit to determine correct med availability. No medications were identified to be unavailable</p> <p>3) Measures put into place/ System changes: Licensed Nursing staff were educated on medication administration, medication ordering and re-ordering and the Program for Abuse Prevention as well as the Incident reporting policy with specific focus on Misappropriation of resident property.</p> <p>Medication Administration Competencies are completed for facility licensed nursing staff and QMA's. Successful completion of this competency must result in a score of at least 90%. Repeated observation will continue with</p>	

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F 0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF		<p>each licensed staff until 90% is achieved.</p> <p>Pharmacy will come to facility monthly for a MAR to Cart audit for at least 3 months when at that time the facility will determine if continued visits are required.</p> <p>4) How the corrective actions will be monitored:</p> <p>Monitoring of this Plan of Correction will be the responsibility of the Director of Nursing and or designee who will audit medication pass competencies' on a weekly basis. Identification of issues will be immediately addressed.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p>		

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Bldg. 00	<p>EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide activities for one of one cognitively impaired residents reviewed for activities.(Resident #36)</p> <p>Findings include:</p> <p>The Clinical record for resident #36 was reviewed on 2/5/2016 at 11:34 a.m. Diagnoses included, but were not limited to, dementia, muscle wasting and atrophy, failure to thrive, hypertension and anxiety.</p> <p>On 2/4/2016 at 8:42 a.m., resident observed sitting in activity room for two minutes, then removed and taken to room and placed in bed.</p> <p>On 2/4/2016 at 4:30 p.m., observed resident in bed.</p> <p>On 2/5/2016 at 9:42 a.m., observed resident in bed.</p> <p>On 2/04/2016 at 10:33 a.m., during an interview, the Activities Director</p>	F 0248	<p>F248</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #36 was re-assessed by activities, care plans were reviewed and revised.</p> <p>2) How the facility identified other residents:</p>	02/26/2016

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	<p>indicated the resident was a "one on one" activities resident. She indicated she had not documented the resident's participation or length of time of the one on one activities.</p> <p>On 2/3/2016 at 10:33 a.m., Activities attendance records were reviewed: 2/3/16: "[Name of resident] attended Bible Study this morning. [Name of resident] did Lets stretch in activity(sic) room. [Name of resident] also play the Jenga game today." 1/1/16: "Sensory, Dancercise" 1/8/16: "Music, Comedy" 1/15/16: "Reading, Bingo" 1/22/16: "Nails, Make Over" 1/29/16: "Snack, Craft, Music" 12/3/16: "Bingo, News Exercise" 12/10/15: "Reading, Jenga" 12/17/15: " Resident Council, Movie" 12/24/15: "Christmas Party, Movie, Music" 12/31/15: "New Years Eve Trivia, Reading" No additional information was documented on the one on one activity sheets.</p> <p>A current careplan dated 9/2/2015 indicated: "Focus: The resident has impaired cognitive function/dementia or impaired thought processes, Short term memory loss, Impaired decision making,</p>		<p>Audit was conducted to identify those residents that currently require one on one activities. Residents were assessed and care plans reviewed and revised. Any resident who participated in one-on-one activities had the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Activity Director and activity staff will be in serviced by the Assistant Director of Nursing regarding the requirements set forth in F248 regarding the provision of one on one activities to cognitively impaired residents.</p> <p>4) How the corrective actions will be monitored:</p> <p>To ensure continued compliance the Executive Director/Director of Nursing will randomly audit the provision of one on one activities weekly. Any identified areas of concern will be addressed immediately. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p>	

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	<p>Long term memory loss, Dementia, Difficulty making decisions. Goal: The resident will be able to communicate basic needs on a daily basis through the review date. The resident will recognize objects or animals with eye contact in activities. Interventions/Tasks: The resident will attend group activities once or twice a week... Ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed. Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. The resident will have activity by watching videos that are helpful to the resident's impaired thought....."</p> <p>An undated document titled, "ONE-TO-ONE PROGRAMMING...Purpose: Provision of programming to resident who will not, or cannot, effectively plan their own activity pursuits, or resident needing specialized or extended programs to enhance their overall daily routine and activity pursuits. The length and duration, and content of specific one-to-one activities is determined by the specific needs of the individual resident,</p>		<p>5) Date of compliance: 2-26-2016</p>	

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F 0278 SS=D Bldg. 00	<p>such as short intervention is someone has extremely low tolerance, or if there are behavioral issues. Types of Activities Utilized Sensory stimulation or cognitive therapy. Social engagement Spiritual support Creative task oriented activities Support of self directed activities For those resident with language barriers: translation tools: translators; or publications and video materials in the resident's language. Terminally ill: life review; quality time with chosen relatives, friends."</p> <p>3.1-33(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected dental status and hospice for 2 of 29 residents reviewed for accurate MDS assessment (Residents #40 and #17).</p> <p>Findings include:</p> <p>1. During an observation of Resident #40 on 02/02/2016 at 9:47 a.m., she did not have any teeth or dentures present.</p> <p>Resident #40 had an annual Minimum Data Set (MDS) dated 5/13/15, which indicated the resident was not edentulous (having no teeth).</p> <p>During an interview with the MDS coordinator on 02/05/2016 at 1:37 p.m., she indicated oral status was determined by Admission/Readmit observation</p>	F 0278	<p>F278</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #40 was assessed and an</p>	02/26/2016

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	<p>which the admitting nurse filled out and she based the Admission MDS on that assessment.</p> <p>An undated document titled "ADMISSION/READMIT OBSERVATION," provided by the MDS coordinator on 02/05/2016 at 2:12 p.m., indicated Resident #40 had her own teeth and did not have dentures.</p> <p>During an interview with Resident #40 on 2/5/16 at 1:42 p.m., she indicated she had not had her own natural teeth for about 7 years and she brought her own dentures when she moved into the facility.</p> <p>2. During an interview on 02/01/2016 at 3:33 p.m., the Hospice Medical Director indicated he was Resident #17's physician and indicated Resident #17 received hospice services.</p> <p>During an interview on 02/05/2016 11:15 a.m., RN # 20 indicated Resident #17 was referred to Hospice services on 10/12/15 and indicated the resident currently received hospice services.</p> <p>During an interview on 2/8/16 at 11:25 a.m., with the Director of Nursing (DON), Assistant Director of Nursing, and the MDS Coordinator present, the Director of Nursing (DON) asked the</p>		<p>MDS modification was completed.</p> <p>Resident #17 had a MDS modification completed to show Hospice Services</p> <p>2) How the facility identified other residents:</p> <p>Any resident who had an MDS completed had the potential to be affected, however no others were identified.</p> <p>A review of all assessments completed over the last quarter was completed to determine Dental issues and Hospice Services were properly coded. Any identified areas were corrected.</p> <p>3) Measures put into place/ System changes:</p> <p>An in-service was given to the interdisciplinary team on coding the RAI's correctly which included Dental and Hospice.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing/designee will review/audit two resident records each week to ensure</p>	

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F 0279 SS=D Bldg. 00	<p>MDS Coordinator for a Hospice care plan. The MDS coordinator reviewed care plans and indicated a care plan for "Do not Resituate" was the care plan for Hospice.</p> <p>Resident #17's record was reviewed on 2/8/16 at 10:52 a.m. Diagnoses included, but were not limited to, acute kidney failure, dementia, and atherosclerotic heart disease.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 10/09/2015 indicated the resident received Hospice. A MDS assessment dated 12/30/15, did not indicate Resident #17 received Hospice services.</p> <p>3.1-31(d)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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</p>		<p>compliance with dental, and Hospice submissions.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p>		

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	<p>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 interview and record review, the facility failed to ensure a care plan was developed and updated for 2 of 36 residents reviewed for careplans. (Resident #36 and Resident #17).</p> <p>Findings include:</p> <p>1.) The record for resident #36 was reviewed on 2/5/16 at 11:34 a.m. Diagnoses included, but were not limited to, dementia, muscle wasting and atrophy, failure to thrive, hypertension and anxiety.</p> <p>A facility assessment tool titled, "DEHYDRATION RISK SCORING TOOL" dated 1/30/2016, indicated the resident was a high risk of dehydration and indicated a score of 10.0. The previous assessment dated 10/30/2016, indicated the resident was a low risk of dehydration and indicated a score of 4.0.</p>	F 0279	<p>F279</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #36 was reassessed and a care plan was developed for hydration.</p>	02/26/2016

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	<p>The quarterly MDS assessment (Minimum Data Set), dated 1/31/16, indicated the resident was a low risk for dehydration.</p> <p>On 2/3/16 at 2:13 p.m., during an interview, CNA # 15 indicated she was unaware of a specific place to document times the resident was offered fluids by the staff.</p> <p>On 2/3/16 at 3:22 p.m., during an interview with CNA #16, she demonstrated the use of the Kardex system and documentation of the care provided to the resident, including how often fluids were offered.</p> <p>On 2/5/16 at 1:56 p.m., during an interview with the MDS coordinator, she indicated she should have caught the change in condition for the resident previously being a low dehydration risk in October of 2015 to a high risk in January 2016 when she completed the MDS on 1/31/16. She indicated she should have initiated a careplan and updated the resident's Kardex (a facility method of communicating resident information to the staff).</p> <p>On 2/5/16 at 1:00 p.m., during an interview with the Director of Nursing (DON), she indicated she would expect</p>		<p>Resident # 17 had a care plan developed for Hospice Care.</p> <p>2) How the facility identified other residents:</p> <p>Audit was conducted to identify those residents that were assessed to be a dehydration risk. Care Plans were reviewed and revised to reflect current plan of care.</p> <p>3) Measures put into place/ System changes:</p> <p>The MDS Coordinator conducted an in-service for the interdisciplinary team to review procedures for development of a comprehensive care plan.</p> <p>The MDS coordinator will review copies of the physician's orders at the morning clinical meeting to ensure all order changes are depicted on the plan of care.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or designee will randomly review five residents' records weekly ensure that care plans have been developed that accurately reflect any hydration issues.</p>	

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	<p>the staff member who performed the Dehydration risk assessment tool, to notify her of any change in the resident condition. She indicated the MDS coordinator should have caught the change in condition and a care plan should have been initiated.</p> <p>On 2/08/2016 at 8:45 a.m., QMA #6 indicated the resident was a one to two person assist for all ADL's (Activities of Daily Living) she indicated the resident must be fed.</p> <p>On 2/08/2016 at 8:55 a.m., during an interview, CNA #17 indicated the resident was a one to two person assist for all ADL's. She indicated the resident must be fed all meals.</p> <p>2. During an interview on 2/1/16 at 3:33 p.m., the Hospice Medical Director indicated he was Resident #17's physician and indicated Resident #17 received hospice services.</p> <p>During an interview on 2/5/16 at 11:15 a.m., RN # 20 indicated Resident #17 was referred to hospice services on 10/12/15 and indicated the resident currently received hospice services. The RN indicated she called the Hospice provider when there were concerns. RN #20 indicated she asked the Director of Nursing (DON) where she would find</p>		<p>Additionally, audits will be completed on residents that are admitted into Hospice Services and reviewed within 24-48 hours to determine care plan was developed timely.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-16</p>		

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	<p>information regarding Hospice care and indicated she was informed of a binder with Hospice notes. RN #20 indicated she was unaware of who was responsible for providing individualized care to Resident #17. The RN indicated the Hospice provider verbally communicated to staff the care they provided to the resident. She indicated there was not a written plan of care to communicate who was responsible for showers or other care to the resident.</p> <p>During an interview on 2/8/16 at 11:25 a.m., with the Director of Nursing, (DON), Assistant Director of Nursing, and the MDS Coordinator present, the Director of Nursing (DON) asked the MDS Coordinator for a Hospice care plan. The MDS coordinator reviewed care plans and indicated a care plan for "Do not Resuscitate" was the care plan for Hospice.</p> <p>Resident #17's record was reviewed on 2/8/16 at 10:52 a.m.. Diagnoses included, but were not limited to, acute kidney failure, dementia, and atherosclerotic heart disease. A Hospice binder was reviewed and the binder did not include a Hospice care plan.</p> <p>A care plan for "Do not Resuscitate," initiated 5/12/15, did not indicate what</p>			

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F 0280 SS=D Bldg. 00	<p>services would be provided by Hospice.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to revise the careplan regarding urinary incontinence for 1 of 2 residents reviewed for careplan revision (Resident #36).</p> <p>Findings include: The record for resident #36 was reviewed</p>	F 0280	<p>F280</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute</i></p>	02/26/2016

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	<p>on 2/5/2016 at 11:34 a.m. Diagnoses included, but were not limited to, dementia, muscle wasting and atrophy, failure to thrive, hypertension and anxiety.</p> <p>On 2/04/2016 at 8:52 a.m., during an observation, CNA #7 removed the resident's brief and provided incontinence care using wipes. At that time, she indicated the resident was always incontinent and incontinence care was performed every two hours. She indicated she had never taken the resident to the toilet.</p> <p>On 2/04/2016 at 10:39 a.m., observed incontinence care provided by CNA #7 and QMA #6.</p> <p>On 2/8/2016 at 8:45 a.m., during an interview, QMA #6 indicated resident was a one to two person assist for all ADL's (activities of daily living).</p> <p>On 2/8/2016 at 8:55 a.m., during an interview, CNA #17 indicated the resident was a one to two person assist for all ADL's.</p> <p>A document titled "Restorative Incontinence Screening" tool dated 9/19/2014, indicated the resident was always incontinent and was a poor</p>		<p><i>admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #36 was assessed and care plan for urinary incontinence revised.</p> <p>2) How the facility identified other residents:</p> <p>Audit was conducted of those residents that have been identified as incontinent of bowel and bladder. Care plans were reviewed and revised as necessary</p> <p>3) Measures put into place/ System changes:</p> <p>The MDS Coordinator conducted an in-service for the interdisciplinary team to review procedures for development of a comprehensive care plan.</p> <p>The MDS coordinator will review copies of the physician's orders at</p>		

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	<p>candidate for retraining/scheduled toileting.</p> <p>A quarterly bowel and bladder assessment dated 1/29/2016 indicated the resident was incontinent of bowel and bladder.</p> <p>A quarterly Minimum Data Set assessment performed 1/31/2016 indicated the resident was always incontinent of bowel and bladder.</p> <p>A current careplan initiated 8/24/14, Indicated "Focus: The resident has bowel and bladder incontinence r/t (related to) DX (diagnosis) Dementia. Goal: The resident will have less than two episodes of incontinence per day...Interventions/Tasks: Check resident every two hours and assist with toileting as needed. Ms. [name of Resident](sic) requires ext (extensive) assist for one-two staff for toileting...Provide bedpan/bedside commode...."</p> <p>A documentation Survey report for January 2016 and February 2016 indicated the resident requires extensive physical assistance of two plus persons for toilet use.</p> <p>3.1-35(d)(2)(B)</p>		<p>the morning clinical meeting to ensure all order changes are depicted on the plan of care.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or designee will randomly review five residents' records weekly to ensure that care plans have been revised to reflect incontinence.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-16</p>	

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F 0309 SS=D Bldg. 00	<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 interview and record review, the facility failed to assess and monitor pain for a resident with dementia, as well as, assess and monitor a resident after a surgical procedure and failed to have coordination of care for a resident receiving hospice services. (Resident #73, Resident #3 and Resident #17.)</p> <p>Findings include:</p> <p>1. On 2/3/16 at 12:34 p.m., the record review for Resident #73 was completed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, cerebrovascular disease, insomnia, and type 2 diabetes.</p> <p>The Admission assessment dated 8/11/15 indicated the resident had no pain, the</p>	F 0309	<p>F309</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p>	02/26/2016

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	<p>resident was confused, the resident was able to communicate. The resident had only one diagnosis associated with pain, and that there was no no pain observed. The facility gave the resident a score of 2 which indicated no further assessment needed.</p> <p>A pain assessment dated 8/15/15 indicated the resident was assessed after a fall. The assessment indicated: the resident had no pain, the resident was confused, the resident was somewhat able to communicate. The resident was on routine pain medications ordered and were effective. The resident had one diagnosis associated with pain and there was no pain observed. The facility gave the resident a score of 1 which indicated no further assessment needed.</p> <p>A pain assessment dated 9/20/15 indicated the resident had no new pain, the resident was confused and was somewhat able to communicate. The resident had no routine pain medication orders. The resident had two or more conditions or diagnoses related to pain, and there were no observations of pain in the resident. The facility gave the resident a score of 4 which indicated no further assessment needed.</p> <p>A pain assessment dated 10/11/15</p>		<p>Residents # 3 and #17 have had new pain assessments completed. The resident's physicians was notified of the results of the assessment and new orders were received as appropriate.</p> <p>Routine and PRN medications have been reviewed.</p> <p>Care plans reviewed and updated.</p> <p>Hospice Company contacted and care coordination implemented.</p> <p>2) How the facility identified other residents:</p> <p>Pain assessments as well as routine and prn pain medications have been reviewed for current residents. Care plans have been reviewed and updated as needed. Audit conducted to identify those residents that have had recent surgeries to determine assessment and monitoring have occurred. Any issues identified were immediately addressed.</p> <p>Audit conducted for those residents that currently utilize Hospice services. Hospice companies contacted and care coordination reviewed.</p> <p>3) Measures put into place/ System changes:</p>		

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	<p>indicated after a fall or incident there was no new pain. The resident was confused and somewhat able to communicate. The resident had routine pain medication orders and the medication was effective. The resident had two or more conditions or diagnoses related to pain, and there were no observations of pain. The facility gave the resident a score of 4 which indicated no further assessment needed.</p> <p>A pain assessment dated 10/16/15 indicated that there was no new pain. The resident was confused and somewhat able to communicate. The resident had routine pain medication orders and the medication was effective. The resident had two or more conditions or diagnoses related to pain, and there were no observations of pain. The facility gave the resident a score of 7 which indicated further assessment was needed.</p> <p>The Medication Administration Record for August through November 2015 was reviewed and indicated: Pain assessment every shift per protocol had a numerical system in place for the resident to give a number to his pain and was documented each shift. The pain rating scale ranged from "0" no pain to "10" worst pain ever.</p>		<p>Pain assessments are completed on admission and no less than quarterly in conjunction with the MDS process.</p> <p>The facility licensed nursing staff were educated on the components of F309 and pain management with specific focus on those residents with dementia.</p> <p>Licensed nursing staff were additionally educated on assessment, monitoring and documentation of those residents that receive additional services such as surgical procedures. Monitor daily during clinical review those residents that have had recent surgical procedures for identification of assessments. Hospice services were contacted to provide in servicing on communication and coordination of services. Hospice will be invited to residents scheduled care plan meetings.</p> <p>4) How the corrective actions will be monitored:</p> <p>The facility Director of Nursing will monitor pain flow records and 24 hour documentation 3 times weekly to assure pain management is being utilized. Additional education will be provided with any identified issues.</p> <p>Audits will be conducted weekly on</p>	

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	<p>August 2015 indicated: "0" on the following dates: August 19, 27, 28, and 29. "1" to "4" on various shifts on August 12 through August 30 .</p> <p>September 2015 indicated: "0" on the following dates: September 10, 11, 12, 13, 14, 17, 23, 24, 25, 26, 28 and 29th. "1" to "3" on various shifts on September 1, 2 ,3, 4, 5, 6, 7, 8, 9, 15, 16, 18, 19, 20, 21, 22, 27, and 30th.</p> <p>October 2015 indicated: "0" on the following dates: October 2, 6, 7 ,8, 9,10,11,13,14, 16, 17, 18, 19, 20, 23, 25, 26, 27, 28, 30 and 31st. "1" to "8" on various shifts on October 1, 3, 4, 5, 12, 15, 21, 22, and 24.</p> <p>The physician's orders indicated: 8/12/15 Tylenol Extra Strength tablets 500 milligrams 1 tablet two times daily for pain relief. 8/16/15 pain assessment every shift per protocol.</p> <p>The progress notes indicated: 8/12/15 -The resident arrived on the unit accompanied by his son and daughter in law. The resident was alert and oriented to name, but confused. The family</p>		<p>residents that utilize Hospice services to determine coordination of care.</p> <p>Audits daily during clinical review on any resident that recently had a surgical procedure to determine completed assessments.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p>				

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	<p>indicated he had wounds on his right shin and left heel.</p> <p>8/22/215 at 2:54 p.m., the resident had an episode today of being combative for a brief period. The resident was given Ativan (an antianxiety medication) and was effective and the resident became calm.</p> <p>8/22/15 at 7:26 p.m., the resident was yelling out, swearing, scooting out of his wheelchair on purpose. The resident was given reminders not to do this. The resident was taken to the bathroom, give a snack of root beer with an activity of watching a movie on television.</p> <p>8/22/15 8:03 p.m., the resident was in bed and appeared comfortable, monitoring left shin and left heel done. The residents eyes were closed and he was snoring. The resident had root beer with other residents earlier and had been given Ativan for resident for the resident's agitation and anxiousness. The resident had been swearing at staff, reminders were given to him that others were here living and would like it if you did not talk that way, please don't yell out as others watching television.</p> <p>8/23/15 at 7:36 p.m., the resident was agitated, yelling out, repeating words,</p>			

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	<p>and all interventions that were used and were not helpful.</p> <p>8/26/15 at 2:01 p.m., the resident was restless with frequently getting in and out of chair with poor safety awareness. Resident also noted swinging and reaching for staff. Re-positioned with diversional activity provided and frequent redirection with no effect.</p> <p>8/26/15 at 9:47 p.m., the resident was yelling out a family members name. The resident was reminded of the time of day and that it was sleeping time. The resident was unable to be redirected and indicated, " I want her up," not wanting to listen to writer, so left the room and the resident was allowed him to continue to yell out.</p> <p>8/27/15 at 11:12 a.m., the resident was making repetitive statements, yelling, and swearing and attempting to swat at the staff. The resident was redirected, toileted, and was taken for a walk around the building. The resident was provided an activity and snack with no effect. After the interventions were completed patient behaviors continued. The resident was given an antianxiety.</p> <p>8/29/15 at 1:58 p.m., the resident continued to try to hit the CNA when</p>			

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	<p>offering care. The Staff had directed the resident several times about this action. No improvement noted.</p> <p>8/31/15 at 9:13 a.m., the resident became aggressive and hit staff while trying to pull him up in bed, patient informed by staff they were trying help, the patient continued to have loose stools temperature 98.2 at this time no complaints of stomach pain.</p> <p>9/3/15 at 8:17 p.m., the resident had a temperature of 99. The resident was resting quietly. No signs of distress noted. Dressing to right shin and left heel. Denied pain.</p> <p>9/5/15 at 10:22 p.m., no behaviors noted at that time. The resident had yelled some and swore a bit but was sleeping and appeared comfortable, no complaints of pain or discomfort. Ativan was given around 8:00 p.m., for anxiety.</p> <p>9/23/15 at 2:52 p.m., writer observed the resident in the activities room repeating, "let's go, let's go" and cursing. The resident was yelling at another resident. There was no trigger identified, however resident calmed down after staff assisted him to bed.</p> <p>9/27/15 at 9:22 a.m., resident had been</p>						

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	<p>very aggressive towards staff this morning. The resident spit out his morning medications at staff. The staff asked him why he did this and he began to cuss. Staff redirected him with no success. The staff tried to calm him with the use of activities, talk to him about what he did for a living. There was no improvement in his mood. Staff attempted to administer Ativan for his behavior and the resident then struck staff in the chest with a closed fist and again started cursing. The staff made sure the resident was safe and clean and dry then left him to calm on his own.</p> <p>9/27/15 at 10:09 a.m., the resident was calm and resting with eyes closed at this time. There were no signs of pain or discomfort noted.</p> <p>10/30/15-the resident was yelling that his leg was painful.</p> <p>On 2/8/16 at 10 a.m., a request was made to the Assistant Director of Nursing (ADON) for the pain policy and any documentation to indicate how they assessed Resident # 73's pain.</p> <p>On 2/8/16 at 10:30 a.m., the ADON provided a document dated 3/2012 titled "Pain Evaluation" The document indicated, "1. To establish guidelines to</p>			

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	<p>measure a resident's level of pain. 2. To provide optimal comfort through a pain control plan, which is established with the members of the health care team...2. A resident with cognitive impairment that is able to verbalize pain will have the PAINAD completed. 3. The resident will be asked to use a pain scale to rate their level of pain. a) Numeric pain scale-"0 to 10" "0" being no pain and "10" being the worst pain she/he has had. b) The PAINAD [a pain scale for residents with dementia] c) Descriptive words- ... 4. Nursing will document any complaints or signs/symptoms of pain in the progress notes. 5. The pain scale will be used to determine the effectiveness of the pain interventions."</p> <p>On 2/8/16 at 10:32 a.m., the ADON indicated at that time she was not aware of any other documentation of the resident assessment of pain and did not know what the PAINAD was. A request was made for any other information on how the staff were assessing this resident's pain since he was cognitively impaired.</p> <p>On 2/8/16 at 5:15 p.m., as of the exit conference, no further documentation was provided.2. During an interview with Resident #3 on 2/2/16 at 9:59 a.m., he indicated he had ongoing pain in his</p>			

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	<p>legs and bottom, nothing relieved it and he was unable to participate in activities.</p> <p>During an interview with Resident #3 on 2/3/16 at 12:39 p.m., he indicated his ribs were pushed down into his stomach and leaning back on his elbows relieved some of the pressure on his ribs. He also indicated that he could not lay down on his back nor could he straighten his back all the way without experiencing severe pain.</p> <p>During the interview, Resident #3 was observed to be sitting on the edge of the bed, leaning back on his elbows.</p> <p>The record review for Resident #3 was completed on 2/3/16 at 3:08 p.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic pain syndrome, and major depressive disorder. Resident #3 had a current, 1/10/16, quarterly Minimum Data Set assessment (MDS), which indicated the resident did not receive a scheduled pain medication regimen and did not receive non-medication interventions for pain. The MDS indicated the resident did receive PRN (as needed) pain medications. Resident #3's current medications included, but were not limited to, morphine sulfate (pain medication) 15</p>			

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	<p>mg (milligrams) by mouth every 4 hours PRN for severe pain, morphine sulfate ER (extended release) 60 mg by mouth every 8 hours PRN for chronic pain, Lyrica (pain medication) 150 mg by mouth two times a day, and ibuprofen (pain medication) 400 mg by mouth every 4 hours PRN for pain.</p> <p>A document titled "Physician History and Physical/Progress Notes," dated 8/19/15, and provided by the MDS coordinator on 2/3/2015 at 4:45 p.m., included: "... The patient describes the pattern of back pain as constant with intermittent flare ups. Describes the quality of pain as dull, throbbing, sharp at times, and aching. Patient says, at its worse his pain is 10/10, at its least it is 4/10, on an average about 6-7/10... Bilateral Lumber medial branch nerve blocks at L3-L4, L4-L5 and L5-S1 are being requested as a diagnostic trial to determine the origin of the patient?s [sic] pain... The patient will undergo a lumbar medial branch nerve block then be seen for follow-up reevaluation...."</p> <p>A document titled "[Name of Facility] Progress Notes," dated 02/03/2016, and provided by Medical Records on 02/04/2016 at 1:46 p.m., included: "res went to pain clinic apt [appointment] writer went with writer attended [sic]... Res is also scheduled for LMBB[Lumber Medial Branch Block] #1 injection on</p>			

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	<p>9/15/15 at 2:30 p.m...."</p> <p>A document titled "Physician History and Physical/Progress Notes," dated 09/15/2015, and provided by Medical Records 2/4/16 at 1:10 p.m., indicated: "...Lumbar Medial Branch Block... Procedure Time Out: 3:15pm... A 25 gauge needle was advanced percutaneously to the junction of the superior aspect of the right L3 transverse process and the lateral aspect of the L3 superior articulating facets... 1 ml of a mixture of 5 mg of Depo-Medrol and Lidocaine injected through the spinal needle to block of medial branch nerve... The needle was removed and a similar procedure was performed on the right L3, L4, and L5 medial branch nerves... The procedure and risks were discussed with the patient, including but not limited to infection, bleeding, neurological complications... The patient was given written information about the procedure...."</p> <p>During an interview with the DON on 2/4/16 at 10:48 a.m., she indicated Resident #3 did have a lumbar medial branch block on 9/15/15. She also indicated there was no monitoring documented after the procedure and she would have expected to see assessment and monitoring after the procedure.</p> <p>3. During an interview on 2/5/16 11:15 a.m., RN # 20 indicated</p>			

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	<p>Resident #17 was referred to hospice services on 10/12/15 and the resident currently received hospice services. The RN indicated she called the Hospice provider when there were concerns. RN #20 indicated she asked the Director of Nursing (DON) where she would find information regarding Hospice care and indicated she was informed of a binder with Hospice notes. RN #20 indicated she was unaware of who was responsible for providing individualized care to Resident #17. The RN indicated the Hospice provider verbally communicated to staff the care they provided to the resident. She indicated there was not a written plan of care to communicate who was responsible for showers or other care to the resident.</p> <p>During an interview on 2/8/16 at 11:25 a.m., with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Minimum Data Set (MDS) Coordinator present, the DON presented a care plan for "Do Not Resuscitate" and indicated that was the only care plan she had in regard to Hospice services.</p> <p>Resident #17's record was reviewed on 2/8/16 at 10:52 a.m.. Diagnoses included, but were not limited to, acute kidney failure, dementia, and</p>			

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F 0323 SS=E Bldg. 00	<p>atherosclerotic heart disease. A Hospice binder was reviewed and the binder did not include a Hospice care plan.</p> <p>A care plan for "Do Not Resuscitate," initiated 5/12/15, did not indicate what services would be provided by Hospice.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure 2 of 4 medication carts were kept locked. The facility also failed to maintain a safe environment for 5 of 32 resident rooms reviewed for room safety (Room #106, #108, #109, #119, and #123).</p> <p>Findings include:</p> <p>1. On 2/4/16 at 9:13 a.m., Qualified Medication Aide (QMA) #6 entered a</p>	F 0323	<p>F323</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the</i></p>	02/26/2016

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	<p>resident's room on the Walnut Hall to take the resident's blood pressure before medication administration. The medication cart was left unattended and unlocked outside of the resident's room.</p> <p>2. On 02/4/16 at 3:45 p.m., RN #3 left the medication cart unlocked and unattended on the Harmony unit (a locked behavioral unit) while she went to look for a medication in the Emergency Drug Kit. The medication cart keys were left in the lock of the medication cart. RN #3 returned to the cart and removed the keys from the lock. She continued to prepare the medications needed for a resident's medication administration. At 3:55 p.m., RN #3 entered a separate room to administer the resident's medication and left the medication cart unlocked and unattended.</p> <p>During an interview on 2/4/16 at 4:05 p.m., RN #3 indicated the medication cart should have been locked when she stepped away from the cart.</p> <p>A current policy titled "Medication Administration General Guidelines," dated 5/1/15, provided by the Director of Nursing on 2/5/16 at 1:15 p.m., indicated "...2. Administration...m. During administration of medications, the medication cart is kept closed and locked</p>		<p><i>provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents were affected by this practice</p> <p>Room issues identified on the 2567, (106, 108, 109, 119, and 123) have been addressed, and if necessary were placed on a schedule for repair.</p> <p>Maintenance placed selected areas on his preventative maintenance program</p> <p>Action Plans developed for individual repair/maintenance areas</p> <p>2) How the facility identified other residents:</p> <p>Any resident living in the facility had the potential to be affected, however none were identified</p> <p>Medication carts will remain locked if not attended.</p> <p>A facility wide review was</p>		

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	<p>when out of sight of the medication nurse or aide...."</p> <p>3. During observations on the following dates and times:</p> <p>a.) Room 109: 2/2/2016 at 3:31 p.m., loose, long, cords hung from the ceiling to the floor by the entry door.</p> <p>b.) Room 106: 2/2/2016 at 1:51 p.m., the emergency call light had a very short cord. The carpeting was loose from the resident's room into the bathroom.</p> <p>c.) Room 108: 2/2/2016 at 10:43 a.m., the hot water faucet was loose and the base was rusted, jagged and broken where a resident could handle.</p> <p>d.) Room 119: 2/2/2016 at 9:21 a.m., overhead light cord was too short for resident to reach safely. The bathroom emergency pull cord was too short for the resident to use.</p> <p>e.) Room 123: 2/2/2016 at 11:09 a.m., the toilet bowl base was cracked and chipped and the resident could possibly cut their foot on jagged edges.</p> <p>During the environmental tour on 2/4/2016 at 1:30 p.m., with the Maintenance Supervisor, he indicated he was unaware of the number of resident</p>		<p>completed to identify other areas of repair that need to be addressed</p> <p>All resident rooms and common areas were inspected by the Executive Director/Maintenance Director and identified repairs were scheduled.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed staff educated on Medication Administration and maintaining a safe environment by keeping medication carts locked when not attended.</p> <p>Staff was re-educated on the maintenance repair book kept at their nurse's station which is checked by the Maintenance Director/designee and prioritized with the Executive Director. Repairs are made based on this prioritization.</p> <p>Identification of repairs that should be addressed timely was also reviewed</p> <p>The Maintenance Director will record/ log when repairs are completed.</p>	

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F 0328 SS=D Bldg. 00	<p>rooms that needed repair.</p> <p>During an interview with the Administrator on 2/4/2016 at 4:30 p.m., he indicated he was aware of minor issues that needed addressed with resident rooms, however, he indicated he had been addressing "bigger" issues.</p> <p>A current document titled, "ACTION PLAN" dated 11/21/2015, Indicated the "...Administrator and Maintenance supervisor performed Facility rounding weekly to identify areas of concern that need painting or repair...3 days per month will be set aside for painting...Every room in facility will be reviewed monthly for painting needs."</p> <p>3.1-45(a)(1)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care;</p>		<p>4) How the corrective actions will be monitored:</p> <p>Medication Carts will be monitored/audited on a random basis 3 times weekly by the Director of Nursing or the Assistant Director of Nursing.</p> <p>Monitoring of the facility repairs will be a joint effort between the Executive Director and Maintenance Director who during routine facility rounds will visually check/audit for areas that need to be addressed and repaired.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p>		

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	<p>Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to provide necessary respiratory equipment for 1 of 1 residents reviewed for respiratory equipment in a sample of 36 residents. (Resident # 97)</p> <p>Findings include:</p> <p>On 2/8/16 at 8:27 a.m., the record review for Resident #97 was completed. Diagnoses included, but were not limited to, acute respiratory failure and schizoaffective disorder bipolar type.</p> <p>The hospital discharge notes dated 11/3/15 indicated, " Bipap [respiratory equipment for people who stop breathing during sleep] 15/6 during sleep and at night. Oxygen (O2) on 3-4 liters at night and 1-2 liters during the day and activity.</p> <p>Nurses notes indicated : 11/4/15-Respirations within normal limits (WNL). Lung Assessment: Wheezing noted to lungs. Receives oxygen. 1-4 liters per nasal cannula (tubing that delivers oxygen through nose). Uses BiPAP/CPAP.</p> <p>11/5/15-Respirations WNL. Lung Assessment: Receives oxygen on 2 liters</p>	F 0328	<p>F328</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified</p> <p>Resident # 97 no longer resides within the facility.</p> <p>2) How the facility identified other</p>	02/26/2016	

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	<p>via nasal cannula.</p> <p>11/6/15 at 7:57 a.m., Bi-Pap on at night, off in morning: 15/6 setting as patient allows. The resident was to have every day and night shift for sleep apnea. The BI-pap not here.</p> <p>11/7/15 at 8:02 am., oxygen on at 2 liters via nasal cannula every day and evening shift. The resident oxygen saturation level with oxygen at 4 LPM (liters per minute) was 92%. Bipap machine to be on 15/6 setting as resident allows every day and night shift for sleep apnea, however the Bi-pap not available currently.</p> <p>11/9/15 at 5:53 a.m., awaiting delivery of Bipap.</p> <p>11/11/15 2:02 a.m., Bi-Pap to be on on at night, and off in the morning: Bipap machine to be on 15/6 setting as resident allowed every day and night shift for sleep apnea, however the resident Bi-pap not available currently.</p> <p>On 2/8/16 at 9:45 a.m., the Assistant Director of Nursing was requested to provide information as to whether to the resident's bipap had been delivered.</p> <p>On 2/8/16 at 2:39 p.m., the Administrator</p>		<p>residents:</p> <p>Audit was conducted to identify any current resident that has orders for BiPaP</p> <p>and treatments were performed as prescribed. No other resident was identified to have been affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Treatments for BiPaP are placed on the Treatment Administration Record and signed off when provided.</p> <p>Education was provided to licensed staff regarding the provision of care and documentation requirements.</p> <p>Residents will be assessed upon admission and through the 24hour admission process.</p> <p>4) How the corrective actions will be monitored:</p> <p>The responsible person for monitoring this process will be the Director of Nursing or designee to audit 2 times weekly those residents with orders for BiPaP to determine provision of care and correct documentation. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6</p>	

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F 0329 SS=D Bldg. 00	<p>indicated he had no documentation to provide that the facility had provided a Bipap machine for the resident.</p> <p>3.1-47(a)(6)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents were free from receiving a medication without an appropriate</p>	F 0329	<p>months or until 100% compliance is achieved x3 consecutive months</p> <p>5) Date of compliance: 2-26-2016</p>	02/26/2016	

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	<p>diagnosis for use for 1 of 5 residents reviewed for unnecessary medication use (Resident #55). The facility also failed to monitor for specific behaviors related to the use of psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident #55 and Resident #74)</p> <p>Findings include:</p> <p>1. The record review of Resident #74 was completed on 2/3/16 at 2:30 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances and cognitive communication deficit.</p> <p>A Psychotherapy Note, dated 8/27/15, indicated Resident #74 had been admitted to a psychiatric hospital, prior to her admission to the facility, due to verbal and physical aggression, wandering into other rooms, taking belongings, and trying to eat other's food. The resident had a history of alcohol-induced dementia and major depressive disorder with psychotic features. The resident was taking Risperdal 0.25 mg twice daily for delusional disorder during her stay at the psychiatric facility.</p> <p>A physician's order, dated 8/17/15, indicated Risperdal (an anti-psychotic) 0.5 mg - one tablet by mouth twice per</p>		<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #74 and Resident #55 physicians were consulted to discuss gradual dose reductions. Resident #55 mood stabilizer has been discontinued. Resident #74 antipsychotic continues to be gradually reduced.</p> <p>2) How the facility identified other residents:</p> <p>All residents taking psychotropic medications have the potential to be affected.</p> <p>Residents receiving psychotropic</p>	

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	<p>day for dementia with behavioral disturbances.</p> <p>A care plan, dated 09/16/15, indicated "...Resident has a behavior problem of invading the personal space of others...Administer medications as ordered. Monitor/document for side effects and effectiveness...."</p> <p>A care plan, dated 01/03/16, indicated "...The resident uses psychotropic medications r/t [related to] dementia...administer PSYCHOTROPIC medications as ordered by physician...consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly...."</p> <p>Facility behavior charting indicated Resident #74 had five behaviors since admission on 8/17/15.</p> <p>A Behavior Summary Report, dated the week ending 10/26/15, indicated Resident #74 had one episode of wandering on night shift.</p> <p>Behavior/Mood charting, dated 11/02/15, indicated Resident #74 was physically aggressive in the dining room. A separate Behavior/Mood charting for 11/02/15 indicated Resident #74 was socially inappropriate in the dining room</p>		<p>medications have had their clinical records, care plans and behavior monitoring programs reviewed. It is the practice of this facility to ensure the each resident's drug regime is free from unnecessary drugs. This includes: drugs in excessive dose, drugs with excessive duration, drugs without adequate monitoring, drugs without adequate indications for use, and drugs used in the presence of adverse consequences.</p> <p>Identified concerns are routinely discussed with resident's physician as well as pharmacy consultant monthly.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nursing staff will be re-in serviced by DNS /ADNS on the components of F329 related to unnecessary drugs, behavior monitoring, appropriate diagnosis, and accurate documentation of the above.</p> <p>Resident receiving psychoactive medications will be reviewed a minimum of monthly during behavior management meetings which occur weekly. Director of Nursing or designee will review new medication orders daily, on scheduled days of work. Any identified concerns will be promptly reviewed with responsible individuals and</p>	

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	<p>- Took another resident's food and went into the kitchen by herself to obtain ice.</p> <p>A Behavior Summary Report, dated the week ending 11/16/15 indicated Resident #74 had one episode of wandering on night shift.</p> <p>Behavior/Mood Charting, dated 12/14/15 indicated Resident #74 was verbally aggressive and socially inappropriate - talked rudely to her tablemates. The document indicated the behavior happens "...at times..." and "...happens in the hall, dining room, and in her room..." No documented behavior tracking was available for the additional verbal aggression and social inappropriateness mentioned in the document.</p> <p>A Psychologist's Progress Note, dated 9/12/15, indicated "...I see no reason why she could not make it well in the general population off of the unit [behavioral unit]...there are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process..."</p> <p>A Psychologist's Progress Note, dated 10/16/15, indicated "...There are no signs of anxiety...behavior in the session was cooperative and attentive with no gross behavioral abnormalities...there are no</p>		<p>notifications made accordingly. Behaviors are reviewed with IDT during morning stand up meeting and again reviewed at stand down meeting for resolution or plan.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Executive Director and the Director of Nursing are the responsible persons for this plan of correction. Review/audit of new psychotropic medications, compliance with behavior monitoring and current approaches to gradual dose reductions will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100%compliance is achieved x3 consecutive months</p> <p>5) Date of compliance: 2-26-2016</p>		

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	<p>apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process...."</p> <p>During an Interview on 02/08/16 at 4:07 p.m., the Assistant Director of Nursing indicated a gradual dose reduction (GDR) attempt had not been made by the facility. She indicated a GDR had planned to try a reduction at the end of December 2015, but Resident #74 went out to the hospital on December 28, 2015 (returned December 29, 2015) and they wanted to give her time to recoup before attempting a reduction.</p> <p>2. Resident #55 was observed in his room with his eyes closed on the following date and times: 2/4/216 at 10:33 a.m., 2:08 p.m. and 3:44 p.m.</p> <p>Review of Resident #55's clinical record was completed on 2/1/16 at 4:19 p.m. Diagnoses included, but were not limited to, cerebral infarction, hemiplegia, insomnia, major depressive disorder, and pain.</p> <p>Resident #55 had a current physician's order for Nuedexta (a mood stabilizer) 20-10 mg (milligrams) two times a day for mood.</p> <p>Review of Resident #55's medication history and administration record,</p>			

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	<p>provided by the Director of Nursing on 2/4/16 at 10:45 a.m., indicated the resident had been started on Nuedexta on 1/29/15 and the order was discontinued 12/15/15. The Medication Administration Record indicated the resident had received it two times a day every day in November 2015, two times a day December 1 - 4, one time on December 15, one time per day December 29-31, one time per day January 1 - 4, and two times per day January 5 - 31.</p> <p>Review of a document titled, "(Name of Facility) Progress Notes," provided by Medical Records on 2/4/16 at 1:46 p.m., indicated that Resident #55 was discharged from the facility on 12/4/15 and returned to the facility on 12/15/15.</p> <p>During an interview on 2/4/16 at 2:37 p.m., a facility pharmacist indicated that Nuedexta is used for pseudobulbar affect (PBA) and there were no other approved uses according to the Food and Drug Administration (FDA). He also indicated there are no off label uses listed on the Facts and Comparisons page of the FDA website.</p> <p>Review of the prescribing information for Nuedexta on 2/4/16 at 2:43 p.m., included: "...PBA is a medical condition that causes sudden, frequent and</p>			

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	<p>uncontrollable outbursts of crying and/or laughing in people living with certain neurologic conditions or brain injury. Nuedexta is not approved to treat emotional symptoms other than uncontrollable crying and/or laughing due to PBA...."</p> <p>During an interview on 2/4/16 at 2:58 p.m., a facility psychologist indicated Resident #55 does not exhibit the typical signs of PBA. He also indicated that he, as well as another facility physician, were unaware that Resident #55 was previously on Nuedexta prior to 1/27/16.</p> <p>The following diagnoses for Resident #55 were added to his medical record on 2/4/16: vascular dementia with behavioral disturbances and pseudobulbar affect.</p> <p>During an interview with RN #5 on 2/5/16 at 10:02 a.m., she indicated that she never witnessed, or heard reports of Resident #55 uncontrollably laughing and/or crying.</p> <p>During an interview with the Medical Records nurse on 2/5/2016 at 11:10 a.m., she indicated she had witnessed Resident #55 uncontrollably laughing and/or crying but she did not document it. She also indicated that she would continue to</p>			

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F 0332 SS=D Bldg. 00	<p>look for documentation of episodes of uncontrollable laughing and/or crying. As of 02/08/2016 at exit, no documents were provided.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 % for 1 of 5 residents observed during medication pass. 2 medication errors were observed during 27 opportunities for error in medication administration. This resulted in a medication error rate of 7.40% (Resident #88).</p> <p>Findings include: The record review for Resident #88 was completed on 02/04/16 at 4:25 p.m. Diagnoses included, but were not limited</p>	F 0332	<p>F332 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident #88 physician was notified regarding resident not receiving the Aggrenox and the</p>	02/26/2016

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	<p>to, hypertension and pseudobulbar effect.</p> <p>A Physician's Order, dated 10/24/15, indicated Aggrenox Capsule Extended Release 12 hour 25-200 mg (milligrams) - give one capsule by mouth two times a day.</p> <p>A Physician's Order, dated 01/01/16, indicated Nudexta capsule 20-10 mg - give one capsule by mouth two times a day.</p> <p>The Medication Administration Record for February 2016 indicated Aggrenox and Nudexta were scheduled daily at 8:00 a.m. and 4:00 p.m.</p> <p>On 02/04/16 at 3:40 p.m., RN #3 began to prepare Resident #88's medications for administration. RN #3 indicated Resident #88 was out of Aggrenox. She was unable to locate any of the medication in the facility's Emergency Drug Kit. RN #3 also indicated Resident #88 was out of Nudexta. RN #3 borrowed medication from another resident who was taking the same dose of Nudexta, and administered it to Resident #88.</p> <p>During an interview on 02/04/16 at 3:50 p.m., RN #3 indicated she was not aware if there was a facility policy regarding</p>		<p>administration of Nudexta from another residents supply as well as Notified reporting requirements regarding this event. Family was notified. Per inspection of medication cart the Aggrenox was identified in bottom drawer overflow. Audit of Resident #88 medication orders was completed and medications were found to be available. The Nudexta had been ordered and arrived during scheduled pharmacy delivery. Medication Variance report was completed. No adverse outcome occurred</p> <p>2) How the facility identified other residents: No resident was identified to have been affected by the medication administration. A facility medication audit was conducted prior to survey exit to determine medication availability. Any identified concerns were addressed immediately. Residents received ordered medications. Consultant Pharmacy completed a MAR to Cart audit and all resident medications were identified to be available.</p> <p>3) Measures put into place/ System changes: Consultant pharmacy was contacted and provided a quality assurance med pass evaluation with on the spot education as needed. Consultant Pharmacy will complete MAR to Cart audit monthly for 3 months, at which time Director of Nursing and Executive Director will determine</p>				

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	<p>borrowing medications between residents, but that she often did this so that the resident would not miss a dose of their medication. She indicated she then replaced the borrowed dose when the medication arrived from the pharmacy.</p> <p>During an interview on 2/08/16 at 9:40 a.m., RN #5 indicated the Aggrenox for Resident #88 arrived from the pharmacy on 02/05/16 at 11:34 a.m. Resident #88 did not receive his 4:00 p.m. dose of Aggrenox on 02/04/16 nor his 8:00 a.m. dose on 02/05/16.</p> <p>A current policy titled "Ordering and Receiving Medications," dated as prepared on 01/17/15, provided by the Director of Nursing on 02/05/16 at 1:15 p.m. indicated "...reorder medication when a four day supply remains, in advance of need, to assure an adequate supply is on hand...."</p> <p>A current policy titled "Medication Administration General Guidelines," dated 05/01/15, provided by the Director of Nursing on 02/5/16 at 1:15 p.m. indicated "...Administration...l. Medications supplied for one resident are never administered to another resident...."</p> <p>3.1-48(c)(1)</p>		<p>continued frequency requirements. Director of Nursing or designee completed medication pass observations with licensed nursing staff with the expectation of 90% compliance. Licensed nursing staff that do not receive 90% on first observation receive immediate 1-1 education as well as additional observation requirements. Laminated medication administration requirements were placed on each medication cart for quick reference. Licensed Nursing staff were educated on Medication Administration as well as Re-Ordering Medications timely to prevent issues with availability.</p> <p>4) How the corrective actions will be monitored: The Director of Nursing, or designee, will monitor medication administration and medication availability through direct observation of licensed nursing staff. Observations will occur randomly 3 times a week and include all shifts for 1 month then decrease to random observations monthly. Any identified issues will be immediately addressed. Review of Pharmacy consultant report will occur monthly. Concerns found during pharmacy visits will be discussed during exit with Director of Nursing/Assistant Director of Nursing. The Director of Nursing and or designee will report any unresolved concerns at Quality Assurance Meetings.</p>		

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F 0371 SS=F Bldg. 00	<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 a sanitary kitchen environment. This deficient practice had the potential to affect 66 of 66 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>Initial tour of the kitchen was performed on 2/1/2016 at 10:05 a.m., with the Dietary Manager (DM). The following was observed:</p> <p>1.) The dry storage area was observed to have open, uncovered and not dated items: large non-labeled, dry storage container with oats, saltine cracker box not dated, open oatmeal cream pies not dated, open cheese cracker packages not</p>	F 0371	<p>The results of audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 2-26-2016</p> <p>F371 Kitchen Sanitation</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>#1-Dry storage items were covered and dated appropriately</p> <p>#2 Items found in freezer to have been open, uncovered, and not dated no longer remain in the freezer.</p> <p>#3 Items found in walk in cooler to have been open,</p>	02/26/2016	

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	<p>dated, open maple syrup not dated, open boxes of graham crackers not dated, one white, unlabeled and undated bag, two open boxes of fig-filled cookies not dated, two open jelly boxes not dated, one open box of diced red peppers in cans not dated.</p> <p>2.) The freezer area was observed to have open, uncovered and not dated items: two packages of lima beans was not dated, two packages of peas was not dated, four packages of frozen, long rolls was not dated, one box of sausage patties was open and not dated, one box of cauliflower was open and not dated, one box of vegetable meadow blend was open and not dated, one box of cheese manicotti was open and not dated, one box of chicken patties was open and not dated, one box of bologna was open and not dated, one box of hot dogs was open and not dated. Five, ten pound packages of ground beef was not dated, one large pork roast was not dated, one box of frozen potatoes was not dated, one box of ice cream cups was not dated. One box of frozen cookie dough with open inner bag was unsecured and not dated.</p> <p>3.) The walk-in cooler was observed to have open, uncovered, unlabeled and not dated items: One, five liter clear container with lid contained orange liquid</p>		<p>uncovered, unlabeled and not dated no longer remain in the walk in cooler.</p> <p>#4 Dietary aide #9 was immediately educated on the requirement of hairnet or hair restraint covering all hair that will be worn at all times while in kitchen area.</p> <p>#5 Identified mop head was disposed of. Clean dish holding cart was cleaned of the gray debris. Ceiling area identified to have been splattered with brown debris was cleaned. The dining room/kitchen entry door was repaired prior to survey exit.</p> <p>#6 The dietary manager and kitchen staff were immediately educated on ensuring the blender container and blades were dry before utilizing to puree food.</p> <p>#7 Dietary Aide #8 was immediately educated on the requirement of hairnet or hair restraint covering kitchen floor all hair that will be worn at all times while in the kitchen.</p>		

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	<p>without labeling or date. Lettuce leaves in a plastic baggie was without a label or date. Four, ten pound packages of ground beef was thawing on shallow metal tray, without date. One box of platter bacon was open and had no date. One box of platter bacon without date received indicated. On 2/1/2016 at 10:49 a.m., during an interview, the DM indicated the platter bacon was delivered in a box without a bag. She indicated they kept the open bacon in the box and indicated they do not secure the bacon in a bag after opening.</p> <p>On 2/1/2016 at 4:32 p.m., during an interview with the DM, she indicated the labeling of food items should be done when items are received, before storage. She indicated some of the dietary staff put items away without being labeled. She indicated all boxes and containers should be labeled whether they had been opened or not.</p> <p>A current policy titled "Leftover Food" dated 2009 indicated, "...1. Leftover food will be properly wrapped/covered, labeled, and dated. The product will be refrigerated immediately...."</p> <p>4.) On 2/1/2016 at 10:52 a.m., observed Dietary Aide #9 with uncovered beard.</p>		<p>#8 The gray fluid with debris noted in the middle of the kitchen floor around the drain was cleaned and sanitized and drain/grease trap was pumped clear. Routine draining/pumping has been scheduled for every other month.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident who receives food from the kitchen has the potential to be affected; however, none was found to be affected.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>The Dietary Manager and food service staff were educated by the Executive Director on the federal requirement of F371 and the importance of keeping all foods covered, labeled and dated correctly,</p>	

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	<p>5.) On 2/1/2016 at 10:22 a.m., observed one mop head hanging on the dining room/kitchen entry door, gray debris on top of the clean dish holding cart, brown debris was splattered on the ceiling beside the ovens and the serving line.</p> <p>On 2/1/2016 at 12:22 p.m., in an interview with the DM, she indicated the dining room/kitchen entry door had been broken since yesterday. She indicated the mop head was used to keep the door open. She indicated maintenance was aware.</p> <p>6.) On 2/1/2016 at 12:05 p.m., the Assistant Dietary Manager was observed to retrieve blender blade and container from the dish drying rack. The blender container and the blade was visibly wet. She placed a broccoli, cauliflower, carrot blend into the blender and pureed the vegetables for the noon meal.</p> <p>7.) On 2/1/2016 at 1:00 p.m., observed Dietary Aide #8 enter the kitchen without a hairnet.</p> <p>8.) On 2/1/2016 at 1:06 p.m., during noon meal service, observed large amounts of gray fluid with dark debris flow onto the kitchen floor from a drain located in the middle of the kitchen. The fluid had a strong odor of wet mud and</p>		<p>wearing appropriate hair and beard coverings; and keeping the dietary/kitchen department in a clean and sanitary condition. Executive Director/designee will check for optimum sanitation, correct storage of the dry storage area, freezer storage, and walk-in storage areas two times weekly.</p> <p>The Maintenance Director will check the Kitchen drain for evidence of further drain concerns during his routine monthly preventative maintenance rounds.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Dietary Manager will perform an audit of all food storage areas to determine accurate dating and covering of all food products 3x per week, and will immediately correct any issues found.</p> <p>Executive Director/designee will check for optimum sanitation, correct storage of the dry storage area, freezer storage, and walk-in storage areas 3x times weekly.</p> <p>The RD will check the Kitchen Sanitation and Storage procedures 2x/month during her facility visits. Any sanitation issues will be brought</p>	

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	<p>feces.</p> <p>On 2/1/2016 at 1:08 p.m., during an interview, the DM indicated fluid backs up into the kitchen "every once in a while; at busy peaks." She told the Maintenance Supervisor the fluid overflow was from the hand wash sink in the dining room. At that time, Maintenance staff member #10 told the DM the fluid overflow was from grease.</p> <p>On 2/1/2016 at 1:14 p.m., during an interview, dietary aide #9 indicated water comes "up through the drain every once in a while when they use the sink too much". He indicated the sink that was used too much was the hand wash sink in the dining room.</p> <p>A current policy titled "Storage of Food and Supplies" dated 2009 indicated "...Food and supply storage areas shall be maintained in a clean, safe, and sanitary manner...1. Food services will maintain clean food storage areas...2...The storage rooms will be well ventilated, illuminated, and not subject to sewage or wastewater backflow or contamination...4. Prepared foods stored in the refrigerator until service will be covered, labeled, and dated with an expiration date...6. All foods will be covered, labeled, and dated...."</p>		<p>to the attention of the Dietary Manager, Executive Director, and any other applicable staff.</p> <p>Results of Dietary/Kitchen inspections/audits will be taken to the next facility monthly The results of these audits will be reviewed in Quality Assurance Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>Date of compliance 2-26-2016</p>	

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	<p>A document dated 11/10/15 from [unnamed plumbing company] indicated, "...Tank level appeared high in tank. May need jetted to city...."</p> <p>On 2/02/2016 at 1:57 p.m., during an interview with the ADM, he indicated the holding tank outside the facility was pumped quarterly to alleviate overflow into the facility. He indicated the facility was built many years ago and could not accommodate the volume produced by the kitchen's food residues, fluids and grease. He indicated he would expect his supervisory staff to immediately notify him of an overflow into the kitchen. The ADM indicated he provided the dietary staff verbal educational information regarding water overflow into the kitchen. He indicated he had no written information regarding the education.</p> <p>On 2/3/2016 at 12:36 p.m., during an interview with the Maintenance Supervisor, he indicated the holding tank was a gravity fed line from the kitchen and laundry and did not pump excess water to the city sewer system. He indicated the system is gravity fed, and when the tank is too full, the tank contents would back up into the kitchen.</p> <p>3.1-21(i)(3)</p>			

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F 0372 SS=F Bldg. 00	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to provide sanitary handling and containment of garbage for two of two observations of garbage handling. This deficient practice had the potential to affect 66 of 66 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>On 2/1/16 at 12:52 p.m., observed dietary aide #8 remove full garbage bags from large, gray trash cans in the kitchen. Dietary aide #8 stacked several bags on top of one another for transport to the dumpster. The bottom inner rim of the garbage can was engulfed in beige fluid containing food debris and a very foul odor. Dietary aide #8 placed clean trash bags into the garbage cans over the fluid.</p> <p>On 2/4/16 at 2:45 p.m., during the environmental tour with the Maintenance</p>	F 0372	<p>F372</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for</p>	02/26/2016

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	<p>Supervisor, one of two dumpsters behind the facility was observed with no lid.</p> <p>On 2/4/16 at 1:30 p.m., during an interview, the Maintenance Supervisor indicated the dumpster lid should remain closed at all times.</p> <p>On 2/1/16 at 1:15 p.m., the Dietary Manager indicated the trash cans should be cleaned when soiled.</p> <p>3.1-21(i)(5)</p>		<p>those residents identified:</p> <p>The dumpster lid was closed and gray garbage cans were cleaned</p> <p>2) How the facility identified other residents:</p> <p>The nature of the deficiency prohibits the identification of affected residents.</p> <p>3) Measures put into place/ System changes:</p> <p>The Executive Director or designee will check the dumpster lid for closure and cleanliness of the dietary gray garbage cans 3 times weekly</p> <p>Any identified areas of concern will be immediately addressed and corrected. In-service facility staff on the importance of keeping the dumpster lid closed and regular cleaning of the dietary gray garbage cans</p> <p>4) How the corrective actions will be monitored:</p> <p>The Executive Director is responsible for overall compliance.</p> <p>The Executive Director or designee,</p>	

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F 0431 SS=D Bldg. 00	<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</p>		<p>will monitor/audit through direct observation the closure of the dumpster lid and cleanliness of the gray garbage cans at least 3 times weekly.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p>	

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	<p>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, record review, and interview, the facility failed to ensure a system of accurate reconciliation of controlled medications for 1 of 3 medication carts reviewed for medication storage. This deficient practice affected 2 of 15 residents whose medications were stored in the medication cart (Residents #70 and #88).</p> <p>Findings include:</p> <p>1. During an observation on 2/5/16 at 2:26 p.m., Resident #70's medication punch card contained 52 Klonopin (medication to treat anxiety) tablets. A medication count sheet indicated the resident should have 51 tablets available for administration.</p> <p>During an interview on 2/5/16 at 2:26 p.m., RN #21 indicated she signed out the pill and had not given it and indicated she signed it out in advance of</p>	F 0431	<p>F431</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	02/26/2016

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	<p>administering it because she worked a 12 hour shift.</p> <p>2. During an observation on 2/5/16 at 2:26 p.m., Resident #88's medication punch card had 1 Norco (narcotic pain medication) tablet remaining in the punch card. A medication count sheet indicated the resident should have 2 tablets available for administration.</p> <p>During an interview on 2/5/16 at 2:26 p.m., RN #21 indicated she administered Norco to Resident #88 40 minutes prior to the observation and indicated she forgot to "click the save" tab on her computerized Medication Administration Record (MAR). She indicated a medication should be signed out when it was taken from the cart.</p> <p>During an interview on 2/8/16 at 3:51 p.m., LPN #22 indicated the process of narcotic administration was to check the MAR and verify the dose, remove the medication from the locked narcotic box, and then sign it out in the book. She indicated after a second verification of the medication, the medication was signed out in the computer and taken to the resident.</p> <p>A policy, titled, "Controlled Medication Storage," dated 5/1/15, and identified as current was provided by LPN #23. The policy indicated, "...4. At each shift change, a physical inventory of all</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>Resident #70 and Resident #80 medications were reconciled, narcotic count correct.</p> <p>Nurse #21 was educated on correct documentation and signing out of routine medications narcotics.</p> <p>2) How the facility identified other residents:</p> <p>Any resident administered medications from nurse #21 had the potential to be affected, however no one was identified.</p> <p>Audit was conducted to determine that narcotic counts were correct and reconciled prior to survey exit</p> <p>Consultant Pharmacy completed a Quality Assurance Cart audit related to labeling and storage of drugs and biologicals.</p> <p>Any concerns were immediately corrected. Immediate education was provided on the spot as needed during the QA audit.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nursing staff were educated</p>		

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	<p>controlled medications...is conducted by two licensed nurses and is documented on the controlled medication accountability record per facility procedure. 5. Any discrepancy in controlled substance medication counts is reported to the director or nursing (sic) immediately. The director or designee investigated and makes very reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator...."</p> <p>3.1-25(e)(3)</p>		<p>on medication administration and included components of F 431 labeling and storage of drugs and biologicals.</p> <p>Director of Nursing or designee completed medication pass observations with licensed nursing staff with the expectation of 90%compliance. Licensed nursing staff that do not receive 90% on first observation receive immediate 1-1 education as well as additional observation requirements. Laminated medication administration requirements were placed on each medication cart for quick reference.</p> <p>Consultant Pharmacy will complete MAR to Cart audit monthly for 3 months, at which time Director of Nursing and Executive Director will determine continued frequency requirements.</p> <p>Random audits weekly per Nursing Administration to identify Narcotic counts are correct and reconciled correctly. Any concerns identified will result in immediate 1-1 education.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing, or designee, will monitor correct narcotic reconciliation, labeling and storage through direct observation of</p>	

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F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -		licensed nursing staff. Observations will occur randomly weekly and include all shifts for 1 month then decrease to random observations monthly. Any identified issues will be immediately addressed. Concerns found during scheduled pharmacy visits will be discussed during exit with Director of Nursing/Assistant Director of Nursing. The Director of Nursing and or designee will report any unresolved concerns at Quality Assurance Meetings. The results of audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 2-26-2016		

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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review the facility failed to ensure that linen was handled in a manner to prevent the possibility of cross-contamination for 4 of 4 observations of linen handling (Residents #5, 47, 55, and 40) and 15 of 15 residents residing in the Harmony unit. The facility also failed to ensure that infection control procedures were followed during medication pass for 1 of 5 residents for medication pass (Resident #88). The</p>	F 0441	<p>F441 <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1.)Immediate actions taken for those residents identified:</p>	02/26/2016

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	<p>facility also failed to ensure that handwashing was performed when indicated for 1 of 2 observations of peri-care (Resident #36)</p> <p>Findings include:</p> <p>1. On 02/03/2016 at 3:04 p.m., housekeeping staff was observed transporting personal clothing hanging uncovered and walking into the Harmony locked unit.</p> <p>On 02/04/2016 at 8:55 p.m., CNA #1 was observed carrying towels and washcloths against the front of her body while pushing Resident #5 in a wheelchair down the hallway.</p> <p>On 02/05/2016 at 9:41 p.m., CNA #1 was observed carrying sheets and pillowcases against the front of her body down the hallway and walking into room 117(Resident #47 and Resident #55).</p> <p>When CNA #1 was interviewed at the time of the observation, she indicated she just carried clean linens into rooms and would bag if she were taking clean or dirty linens out of a room.</p> <p>On 02/04/2016 at 10:32 p.m., CNA #2 left soiled linen on the floor outside of the bathroom door of Resident #40's</p>		<p>Issue #1) Housekeeping personnel educated on covering resident personal laundry while delivering throughout the facility. Licensed nursing staff and C.N.A's were educated on appropriate linen handling, and containment of soiled linens to reduce contamination. No adverse effects identified with resident #47, #57and #40. Issue #2) Resident #88 has shown no ill effects related to the medication administration by RN#3 on 2/4/2016. RN #3 was educated on infection control related to medication administration. Issue #3) Resident #37 has shown no negative affect related to the peri care care provided by C.N.A#7 on 2/4/2016. C.N.A's were educated on hand washing and hand hygiene, glove use and removal to prevent contamination. 2) How the facility identified other residents: Issue #1) Any resident cared for by C.N.A#1 or#2 had the potential to be affected however no one was identified. Any resident that had laundry delivered on 2/3/2016 had the potential to be affected however no one was identified. Issue #2) No other resident was identified to have had negative effects related to medications administered by RN#3 Issue #3) Any resident had the potential to be affected if cared for by C.N.A #7 on 2/4/2016, however no resident has been identified 3) Measures put into place/</p>		

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	<p>room.</p> <p>Review of a policy titled, "Linen Handling - Nursing," dated 1/1/2015 and received from the DON on 2/5/2016 at 10:45 a.m., indicated the following: "6. ...Soiled linens shall not be placed on the floor... 14. Nursing personnel shall handle clean or soiled linen in a manner to prevent contamination of the linen or the employee...."</p> <p>2. On 02/04/16 at 3:40 p.m., RN #3 began to prepare Resident #88's medications for administration. Once all of the medications were ready, RN #3 pulled out a plastic sleeve in which to place the medications in order to crush them. RN # 3 attempted to open the plastic sleeves with her fingers, but was unable to do so. She placed the sleeve up towards her mouth and blew twice into the plastic in order to open it. RN #3 then placed the resident's medications inside of the sleeve and crushed them. The crushed medications were then mixed with vanilla pudding and administered to the resident.</p> <p>During an interview on 02/04/16 at 4:05 p.m., RN #3 indicated she should not have blown into the bag due to infection control concerns.</p> <p>3. On 02/04/2016 at 8:52 a.m., CNA #7 was observed to wash her hands for 20</p>		<p>System changes: In-service was provided for facility licensed nursing staff, CNAs, and housekeeping staff regarding the facility standard for infection control i.e. Hand washing/hand hygiene, glove use, removal and disposal; linen handling and transporting as well as the containment of soiled linens to reduce contamination. In-service provided on Medication administration to licensed nursing staff which included infection control component. The Director of Nursing Services/designee will conduct observational audits of hand hygiene\glove usage and linen handling techniques 3 times a week to assure adherence. Observational audits per Director of Nursing or designee are conducted on medication administration which includes infection control. Observational audits by Director of Nursing/or designee of handwashing / glove use during resident care 3 times weekly by C.N.A's. Areas of concern will be immediately corrected with 1-1 education.</p> <p>4) How the corrective actions will be monitored: The Director of Nursing Services/designee will conduct observational audits of hand hygiene\glove usage, linen handling, med administration, and resident personal care techniques 3 times a week to assure adherence to the facilities infection control standard. Any variations will be immediately</p>				

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	<p>seconds and don clean gloves. She assisted resident #36 to bed. The CNA removed the resident's soiled brief and provided incontinence care using wipes. She removed her gloves, immediately put on clean gloves without hand washing and placed a clean brief on resident #36.</p> <p>4. On 02/04/2016 at 10:39 a.m., an observation of peri care for resident #36 provided by QMA #6 and CNA #7. Both staff members washed their hands and donned clean gloves. CNA #7 removed the resident's soiled brief and cleansed the peri/rectal area using wipes. A clean brief was applied by CNA #7. QMA #6 removed her gloves and washed her hands. Without removing her gloves, CNA #7 lowered the bed height and elevated the head of bed and foot of bed using the hand held bed control. She pulled the blankets over the resident and adjusted the pillow and placed the hand held bed control on the pillow. CNA #7 gathered trash, removed her gloves and left the resident's room. She walked to soiled utility, opened the soiled utility door and threw the trash away. She left the room and did not wash her hands.</p> <p>An undated policy titled "Procedure for Incontinent/Perineal Care" Indicated "...Incontinent care will be completed as follows:..Wash hands or use</p>		<p>corrected with 1-1 education. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p>		

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F 0465 SS=F Bldg. 00	<p>alcohol-based hand rub. Apply gloves...Remove gloves and wash hands...Dispose of all soiled equipment and supplies per facility policy. Wash hands...."</p> <p>3.1-18(l) 3.1-19(g)(1) 3.1-19(g)(2) 3.1-19(g)(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, interview and record review, the facility failed to ensure a clean, sanitary and home-like environment for entry doors, bathroom doors walls, floors and closets in laundry room, hallways and resident rooms (Room's # 101, 102, 106, 108, 109, 111, 115, 117, 119, 123, 127, 129, 202, 208, 209), and 2 of 15 rooms without a call light pull cord attachment (Room's #108, 119). This deficient practice had the potential to impact 66 residents out of 66 residents utilizing rooms in the facility.</p>	F 0465	<p>F456</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in</i></p>	02/26/2016

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	<p>Findings include;</p> <p>1. During resident room observations on 2/1/16, 2/2/16 and 2/4/16 the following was observed:</p> <p>a.) Room #101: 2/2/16 at 10:59 a.m., the door frames, doors, air conditioning/heating unit were peeling, marred and scratched.</p> <p>b.) Room #102: 2/2/16 at 10:39 a.m., the doors frames and doors were marred and scratched.</p> <p>c.) Room #106: 2/2/16 at 1:51 p.m., the doors and door frames were chipped, marred and scratched. The emergency call light had a very short cord. The carpeting was loose from the resident's room into the bathroom. The bathroom had a very strong urine smell.</p> <p>d.) Room #108: 2/2/16 at 10:43 a.m., the doors and frames were chipped, marred and scratched. The hot water faucet was loose and the base was rusted and broken.</p> <p>e.) Room #109: 2/2/16 at 3:31 p.m., the wall around the bathroom sink was missing drywall. Loose, long, cords hung from the ceiling to the floor. Doors, walls and frames were marred and</p>		<p><i>the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Hose residents</i></p> <p>1) Immediate action taken for those residents identified to have been affected</p> <p>Issue # 1)</p> <p>An audit of facility was conducted to identify any areas other than those identified in the 2567 that required repair.</p> <p>Each Item identified was immediately placed on a schedule for repair.</p> <p>Maintenance will place selected areas on his preventative maintenance program</p> <p>Action Plans developed for individual repair/maintenance areas</p> <p>2) How the facility identified other residents:</p> <p>A facility wide review was completed to identify areas that need to be addressed</p> <p>All resident rooms and common areas were inspected by the</p>	

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	<p>scuffed. Baseboards in the bathroom had thick, dark debris.</p> <p>f.) Room #111: 2/2/16 at 11:22 a.m., no closet door.</p> <p>g.) Room #115: 2/2/16 at 10:18 a.m., the doors were marred and peeling.</p> <p>h.) Room #117: 2/1/16 at 3:56 p.m., chipped paint on the bathroom door. Strong smell of urine in the bathroom.</p> <p>i.) Room #119: 2/2/16 at 9:21 a.m., the overhead light cord was too short. The toilet paper holder was broken. The bathroom emergency pull cord was too short. The bathroom fan cover was not secure to the ceiling. The bathroom cabinet was rusty and did not close securely.</p> <p>j.) Room #123: 2/2/16 at 11:09 a.m., several black cords dangled from the ceiling. The telephone cord wires were exposed and not secure within the jack box. The toilet bowl base was cracked and chipped. Dry wall was crumbling in the closet. Missing baseboard coverings at the closet and drawers. Missing floor tiles at the closet and drawer area. No closet door was present. Clothes drawers were broken and crumbling. The privacy curtain was not hemmed properly and in</p>		<p>Executive Director/Maintenance Director and identified repairs were scheduled.</p> <p>Areas needing repair will be identified through scheduled Angel Rounds and reported each morning at Stand up Meeting</p> <p>3) Measures put into place/ System changes:</p> <p>The Administrator/Maintenance Director and/or Guardian Angels will make daily rounds of all rooms and common areas and report any needed repairs.</p> <p>Staff was re-educated on the maintenance repair book kept at their nurse's station which is checked by the Maintenance Director/designee and prioritized with the Executive Director. Repairs are made based on this prioritization. Identification of repairs that should be addressed timely was also reviewed</p> <p>The Maintenance Director will record/ log when repairs are completed.</p> <p>Housekeeping staff, will have individual assignments and responsibilities</p> <p>4) How the corrective actions will</p>	

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	<p>disrepair.</p> <p>k.) Room #127: 2/2/16 at 9:48 a.m., the walls were marred and dresser drawers were non-functional.</p> <p>l.) Room #129: 2/2/16 at 2:43 p.m., strong urine smell in bathroom. Dark debris at base of toilet and bathroom grout.</p> <p>m.) Room #202: 2/2/16 at 9:59 a.m., the walls were marred. The bathroom flooring was loose. The toilet paper holder was broken and on the floor. A hole with a metal fragment was protruding from the wall above the toilet. Urine smell in bathroom.</p> <p>n.) Room #208: 2/1/16 at 3:39 p.m., the walls and closet doors were marred. Bathroom door and frame were gouged and marred. Laminate flooring in the bathroom was loose. The baseboard in bathroom was loose and coming off bathroom wall. The reading light above bed was non-functional.</p> <p>o.) Room #209: 2/2/26 at 2:49 p.m., the walls were marred and gouged. Laminate was ripped. The bathroom was missing a baseboard.</p> <p>3.) During the environmental tour on</p>		<p>be monitored:</p> <p>The monitoring of this will be a joint effort between the facility Executive Director and Maintenance Director who will during the routine facility rounds visually check/audit for areas that need to be addressed or repaired. The results of these audits will be reviewed in Quality Assurance Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of Compliance: 2-26-2016</p>				

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	<p>2/4/16 at 1:30 p.m., with the Maintenance Supervisor, the following was observed:</p> <p>a.) Laundry room: one, loose electrical outlet and face plate. Crumbling drywall around door frames. Missing floor tiles. Wet floor beside the washing machine units. Blankets tucked into gaps surrounding air conditioning units in the window.</p> <p>b.) Harmony unit: Plum-sized hole in drywall at back door covering window. Six metal brackets with sharp edges were partially attached to the door frame in the center of the hallway.</p> <p>c.) Kitchen: Door to the dining room was marred, scuffed and gouged.</p> <p>d.) Hallway outside of Occupational therapy: Hand rail was broken and had sharp, uncovered edges.</p> <p>On 2/4/16 at 1:30 p.m., during an interview with the Maintenance Supervisor, he indicated he was unaware of the number of resident rooms that needed repair. He indicated he addressed painting three days a month.</p> <p>During an interview with the Administrator on 2/4/16 at 4:30 p.m., he indicated he was aware of the minor</p>			

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F 0520 SS=F Bldg. 00	<p>issues that needed addressed with resident rooms, however, he indicated he had been addressing "bigger" issues.</p> <p>A current document titled, "ACTION PLAN" dated 11/21/15 indicated the "...Administrator and Maintenance supervisor performed Facility rounding weekly to identify areas of concern that need painting or repair...3 days per month will be set aside for painting...Every room in facility will be reviewed monthly for painting needs."</p> <p>3.1-19(f)(5)</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/08/2016	
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	<p>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, the facility failed to have systems in place to correct infection control concerns, kitchen sanitation concerns, and environmental concerns. This deficient practice had the potential to affect 66 of 66 residents residing in the facility.</p> <p>Findings include:</p> <p>On 2/8/16 at 2:45 p.m., the Administrator indicated they had been working on infection control, specific to handwashing, handling of linens, the storage of resident items and catheter care.</p> <p>The Administrator indicated the only environmental plan he had in place was to do touch up painting around the facility. The environment observation indicated 15 resident rooms were not in good repair and clean. (Room's # 101, 102, 106, 108, 109, 111, 115, 117, 119, 123, 127, 129, 202, 208, 209) Also,</p>	F 0520	<p>F520 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Dry storage items were covered and dated appropriately. Items found in freezer to have been open, uncovered, and not dated no longer remain in the freezer. Items found in walk in cooler to have been open, uncovered, unlabeled and not dated no longer remain in the walk in cooler. Clean dish holding cart was cleaned of the gray debris. Ceiling area identified to have been splattered with brown debris was cleaned. The dietary manager and kitchen staff were immediately educated on</p>	02/26/2016			

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	<p>common hallways and entry doors were not in good repair.</p> <p>The kitchen was found with many concerns including the following: Food items were opened and undated in the dry storage area. The freezer was observed with numerous open, uncovered items, not dated. The walk-in cooler was observed to have open, uncovered, unlabeled and not dated items.</p> <p>A current policy titled "Leftover Food" dated 2009 indicated, "...1. Leftover food will be properly wrapped/covered, labeled, and dated. The product will be refrigerated immediately...."</p> <p>The kitchen was also found to have a dirty ceiling beside the oven and serving line, debris on the clean dish cart, wet nesting of the blender blade, and employees not wearing hairnets.</p> <p>The kitchen was also observed to have a back flow of dark debris and fluid from a drain located in the middle of the kitchen. The fluid had a foul odor.</p> <p>On 2/1/2016 at 1:08 p.m., during an interview, the DM indicated fluid backs up into the kitchen "every once in a while; at busy peaks." She told the Maintenance Supervisor the fluid</p>		<p>"nesting" ensuring the blender container and blades were dry before utilizing to puree food. The gray fluid with debris noted in the middle of the kitchen floor around the drain was cleaned and sanitized and drain/grease trap was pumped clear. Routine draining/pumping has been scheduled for every other month. An audit of facility was conducted to identify any areas other than those identified in the 2567 that required repair. Each item identified was immediately placed on a schedule for repair. Maintenance will place selected areas on his preventative maintenance program Action Plans developed for individual repair/maintenance areas 2)</p> <p>How the facility identified other residents: Any resident who receives food from the kitchen has the potential to be affected; however, none was found to be affected. A facility wide review was completed to identify areas that need to be addressed. All resident rooms and common areas were inspected by the Executive Director/Maintenance Director and identified repairs were scheduled. Areas needing repair will be identified through scheduled Angel Rounds and reported each morning at Stand up Meeting. No residents were found to have been affected 3)</p> <p>Measures put into place/ System changes: The Dietary Manager and food service staff</p>		

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	<p>overflow was from the hand wash sink in the dining room. At that time, Maintenance staff member #10 told the DM the fluid overflow was from grease.</p> <p>On 2/1/2016 at 1:14 p.m., during an interview, dietary aide #9 indicated water comes "up through the drain every once in a while when they use the sink too much". He indicated the sink that was used too much was the hand wash sink in the dining room.</p> <p>There were also concerns noted with linen handling, handwashing, and infection control measure.</p> <p>On 2/8/16 at 3:00 p.m., the Administrator was asked to provide any documentation specific to any plans to address kitchen sanitation, environmental concerns with the exception of painting, and any other infection control quality assurance plans in place.</p> <p>On 2/8/16 at 3:15 p.m., the Administrator indicated he had no other documentation to provide.</p> <p>3.1-52(b)(2)</p>		<p>were educated by the Executive Director on the federal requirement of F371 and the importance of keeping all foods covered, labeled and dated correctly, wearing appropriate hair and beard coverings; and keeping the dietary/kitchen department in a clean and sanitary condition. Executive Director/designee will check for optimum sanitation, correct storage of the dry storage area, freezer storage, and walk-in storage areas two times weekly. The Maintenance Director will check the Kitchen drain for evidence of further drain concerns during his routine monthly preventative maintenance rounds. The Administrator/Maintenance Director and/or Guardian Angels will make daily rounds of all rooms and common areas and report any needed repairs. Staff was re-educated on the maintenance repair book kept at their nurse's station which is checked by the Maintenance Director/designee and prioritized with the Executive Director. Repairs are made based on this prioritization. Identification of repairs that should be addressed timely was also reviewed. The Maintenance Director will record/log when repairs are completed. Housekeeping staff, will have individual assignments and responsibilities 4) How the corrective actions will be monitored: The Dietary</p>		

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			<p>Manager will perform an audit of all food storage areas to determine accurate dating and covering of all food products 3x per week, and will immediately correct any issues found. The RD will check the Kitchen Sanitation and Storage procedures 2x/month during her facility visits. Any sanitation issues will be brought to the attention of the Dietary Manager, Executive Director, and any other applicable staff. Maintenance Director who will during the routine facility rounds visually check/audit for areas that need to be addressed or repaired. Results of Dietary/Kitchen inspections/audits will be taken to the next facility monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 2-26-2016</p>	