

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 03/18/2016
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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 Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 8, 2016.</p> <p>This visit resulted in a Partially Extended Survey-Immediate Jeopardy.</p> <p>Survey dates: March 16 and 17, 2016 Partially Extended Survey date: March 18, 2016</p> <p>Facility number: 000025 Provider number: 155064 AIM number: 100274850</p> <p>Census bed type: SNF: 10 SNF/NF: 58 Total: 68</p> <p>Census payor type Medicare: 7 Medicaid: 47 Other: 14 Total: 68</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<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>	
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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 0241 SS=D Bldg. 00	<p>Quality review completed 3/26/16 by 29479.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure the resident was free from the possibility of being viewed partially undressed for 1 of 1 resident reviewed for dignity concerns. (Resident # 1)</p> <p>Finding includes:</p> <p>On 03/18/2016 at 4:28 p.m., a review of Resident #1's medical record was completed. Diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, muscle weakness, major depressive disorder, aphasia, convulsions and seizures.</p> <p>On 03/17/2016 at 10:00 a.m., Resident #1 was observed sitting in her room with the door open and curtain pulled back in full view of the hallway. She was yelling out in non-formed words. She lacked any type of clothing from the waist up. At</p>	F 0241	<p>F241</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 #1's sister (POA) was</p>	04/17/2016

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	<p>that time, LPN #2 was looking in the medication cart and speaking to the Executive Director (ED) in the hallway in front of room #121. A few minutes passed during the observation of the resident and the ED walked to the room of Resident #1 and pulled the curtain part way closed. He instructed LPN #2 to put a gown on the resident. During an interview at that time, the ED indicated Resident #1 often removed her clothing. He indicated she must have a gown placed backwards over her clothing to prevent her from exposing herself.</p> <p>During an interview on 03/17/2016 at 11:43 a.m., the Director of Nursing (DON) indicated she was aware the resident disrobed from time to time. She indicated the SSD (Social Service Director) should have contacted the resident's sister to inquire about alternative clothing for the resident to discourage her from removing her clothes in view of others.</p> <p>During an interview on 3/18/16 at 11:33 a.m., the SSD indicated she was aware that Resident #1 had a history of disrobement. She indicated she had not contacted the resident's sister about the resident disrobing.</p> <p>3.1-3(t)</p>		<p>contacted to discuss residents disrobing activity. Resident's sister is obtaining alternative clothing to discourage residents from removing her clothing in front of others. Care plan has been updated to reflect these interventions.</p> <p>2) How the facility identified other residents:</p> <p>Facility audit completed to identify any other resident that disrobes. No other resident was identified</p> <p>3) Measures put into place/ System changes:</p> <p>Guardian Angel rounds will be used to identify dignity issues and discussed at morning meeting for corrective actions and staff interventions or education.</p> <p>Staff were in-serviced on dignity and resident rights, and their responsibility for correcting any issues they identify.</p> <p>4) How the corrective actions will be monitored:</p> <p>Monitoring of this corrective action will be during daily facility rounds</p>		

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F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF 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 ensure activities were encouraged or a resident was invited to activities to meet his individualized plan of care for 1 of 3 residents reviewed for activities. (Resident #3)</p> <p>Finding includes:</p> <p>Resident #3's record was reviewed on 3/16/16 at 2:50 p.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic pain syndrome, and major depressive disorder.</p> <p>The resident had a Care Plan, dated</p>	F 0248	<p>by the Director of Nursing and Social Services. Dignity issues identified will be immediately corrected. 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>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>	04/17/2016

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	<p>4/2/14, which addressed the problem of depression related to a disease process (Curvature of the spine). Interventions/Tasks included "...5/15/14- -Assist the resident in developing /Provide the resident with a program of activities that is meaningful and of interest (music, Bingo, groups)...."</p> <p>An Annual MDS (Minimum Data Set) assessment dated 4/11/15, indicated the following: It was very important for the resident to listen to music, be around animals, keep up with the news, perform his favorite activities and go outside and get fresh air when the weather permitted him to do so.</p> <p>It was somewhat important for the resident to do activities with groups of people.</p> <p>The resident had a Care Plan, dated 7/20/15, which indicated the resident was interdependent for meeting his emotional, intellectual, physical and social needs because of his back issues. Physical limitations. Interventions/Tasks included, "7/20/15--Ensure that the activities the resident is attending are Compatible with physical and mental capabilities. Compatible with known interests and preferences; and Adapted as needed, such as large print calendars.</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>Resident #3 was assessed for activity Preferences. Care Plan was reviewed and updated. Resident will be encouraged to attend activities and refusals documented.</p> <p>2) How the facility identified other residents:</p> <p>Audit was conducted to identify those residents that do not attend activities. Any resident residing at this facility had the potential to be affected. Identified residents were assessed for Preferences, care plans reviewed and revised.</p> <p>Resident preferences will be reviewed at least quarterly at the resident care plan meeting for any changes.</p> <p>3) Measures put into place/ System changes:</p> <p>Activity Director and activity staff will be in serviced by the Director of Nursing regarding the requirements set forth in F248 regarding the provision of activities.</p> <p>Audits will be completed 3x weekly</p>		

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	<p>This is compatible with individual needs and abilities; and age appropriate. Invite the resident to scheduled activities...."</p> <p>On 3/16/16 at 1:11 p.m., the resident was sitting on the edge of his bed. He did not have a TV or music playing to listen to the news or music. He indicated he had a lot of back and leg pain that was not always controlled, but he did not tell the nurses because there was nothing else they could do for him because he had discussed this with his Physician and nothing else could be done. He indicated he could not do a lot of things do to the pain. He was not interacting with his roommate during any of this time. A staff member came into the room to provide personal care for his roommate, but did not ask Resident #3 if he needed anything while she was in the room.</p> <p>On 3/17/16 at 10:06 a.m., Resident #3 was observed sitting on the edge of his bed. There was no interaction with his roommate at that time. He did not have a TV or radio on at that time to provide news or music to the resident. The only interaction he had with staff was when LPN #2 came in to watch him take his medication she had left at his bedside at 8:00 a.m., that morning on his 5-tier shelf. The resident indicated he enjoyed playing the piano for an activity, but he</p>		<p>to identify those residents that do not attend activities/or refuse to attend activities.</p> <p>Documentation will reflect resident refusals.</p> <p>4) How the corrective actions will be monitored:</p> <p>To ensure continued compliance the Director of Nursing/designee will randomly audit the provision of activities to ensure residents were encouraged or invited to activities weekly and documentation was reflective.</p> <p>Any identified areas of concern will be addressed immediately.</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>				

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	<p>did not go to activities because his back down both his legs hurt too bad to go. He indicated he did not have one on one visits from the activities staff members nor did they invite him to the activities. The resident laid back down on his bed after he took his medications.</p> <p>A current "Documentation Survey Report" for the resident's activity participation dated for March 2016, was provided by the Activity Director on 3/17/16 at 1:15 p.m., which indicated the resident had been to activities on the following dates: Bingo--3/15/16--Active Family/Friend Visits--3/2/16--Active/Independent, 3/15/16--Active/Independent Independent Activity--3/11/16--Active/Independent Music--3/2/16--Active/Group, 3/15/16--Active/Independent Reading--3/9/16--Active/Independent Snacks--3/9/16--Active/Independent Socialization--3/9/16--Active, 3/15/16--Active Worship--3/2/16--Active, 3/9/15--Active</p> <p>There were no refusals of activities documented on the "Documentation Survey Report" activity participation form or anywhere in the resident's record.</p>			

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	<p>An activity calendar, dated March 2016, indicated the following activities were some of the activities the resident had an interest in and could have been invited to:</p> <p>3/2/16--9:30 a.m.--News 3/4/16--9:30 a.m.--News 3/7/16--9:30 a.m.--News 3/9/16--9:30 a.m.--News 3/11/16--9:30 a.m.--News 3/15/16--9:30 a.m.--News 3/17/16--9:30 a.m.--News</p> <p>During an interview on 3/17/16 at 2:04 p.m., the Activity Director indicated the resident played the organ three to four times a month, but she had no documentation to show he did that as an activity. She indicated she did not have documentation to show she had invited Resident #3 to activities because he was alert and she went around and asked the alert residents to come to the activities. She indicated there was a page with the codes on it to define and understand what the abbreviations for the activities documented meant.</p> <p>During an interview on 3/17/16 at 3:31 p.m., the Activity Director indicated she did not have any documentation when this resident refused to participate in an activity or when she asked him to participate in an activity. She indicated she did not do one on one activities with</p>			

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F 0250 SS=D Bldg. 00	<p>this resident because he was able to come out of his room and attend activities.</p> <p>This deficiency was cited on 2/8/2016. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-33(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to address a behavior or implement interventions for a resident who inappropriately disrobed for 1 of 1 resident reviewed for social services. (Resident #1)</p> <p>Finding includes:</p> <p>On 03/18/2016 at 4:28 p.m., a review of Resident #1's medical record was</p>	F 0250	<p>F250</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>	04/17/2016

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	<p>completed. Diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, muscle weakness, major depressive disorder, aphasia, convulsions and seizures.</p> <p>On 03/17/2016 at 10:00 a.m., Resident #1 was observed sitting in her room with the door open and curtain pulled back in full view of the hallway. She was yelling out in non-formed words. She lacked any type of clothing from the waist up. At that time, LPN #2 was looking in the medication cart and speaking to the Executive Director (ED) in the hallway in front of room #121. A few minutes passed during the observation of the resident and the ED walked to the room of Resident #1 and pulled the curtain part way closed. He instructed LPN #2 to put a gown on the resident. During an interview at that time, the ED indicated Resident #1 often removed her clothing. He indicated she must have a gown placed backwards over her clothing to prevent her from exposing herself.</p> <p>During an interview on 3/17/16 at 11:43 a.m., the Director of Nursing (DON) indicated she was aware the resident disrobed from time to time. She indicated the Social Service Director (SSD) should have contacted the resident's sister to</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.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #1's sister (POA) was contacted to discuss residents disrobing activity. Resident's sister is obtaining alternative clothing to discourage residents from removing her clothing in front of others. Care plan has been updated to reflect these interventions. Behavior monitoring initiated.</p> <p>2) How the facility identified other residents:</p> <p>The facility has determined that any resident presenting with behaviors have the potential to be affected.</p> <p>Residents will be identified upon admission, quarterly, annually and with any significant changes.</p> <p>3) Measures put into place/ System changes:</p> <p>Director of Nursing educated social services on facility behavior</p>		

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	<p>inquire about alternative clothing for the resident to discourage her from removing her clothes in view of others.</p> <p>During an interview on 3/18/16 at 11:33 a.m., the SSD indicated she was aware that Resident #1 had a history of disrobement. She indicated she had not developed a Care Plan for this behavior nor initiated behavior monitoring for disrobing. She indicated she had not contacted the resident's sister about the resident disrobing.</p> <p>3.1-34(a)(2)</p>		<p>management protocol, with emphasis placed on identification of behaviors, implementation of interventions to manage behaviors, initiating care plans and behavior monitoring.</p> <p>Facility employees have been educated regarding interventions commonly utilized to reduce resident behaviors.</p> <p>Interdisciplinary behavior management meetings will be held no less than monthly. They will include the facility Psychologist, Consultant Pharmacist, Social Service Director, Director of Nursing, Activities Director, and Assistant Director of Nursing.</p> <p>Audits will be conducted weekly on 3 residents by Social Services Director to determine that behaviors have been identified, interventions have been implemented, and care plans are reflective.</p> <p>4) How the corrective actions will be monitored:</p> <p>The responsible party for this plan of correction will be the Director of Nursing/Social Services Director/designee, who will monitor the audits conducted weekly on 3 residents to determine behaviors have been identified, interventions implemented and care plans are reflective. Any identified issues will</p>	

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F 0279 SS=D Bldg. 00	<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 identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to develop a Care Plan for a known behavior of inappropriate disrobement for 1 of 1 resident reviewed for Care Plans. (Resident #1)</p>	F 0279	<p>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>F279</p> <p><i>This Plan of Correction is the</i></p>	04/17/2016	

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	<p>Finding includes:</p> <p>On 03/18/2016 at 4:28 p.m., a review of Resident #1's medical record was completed. Diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, muscle weakness, major depressive disorder, aphasia, convulsions and seizures.</p> <p>On 03/17/2016 at 10:00 a.m., Resident #1 was observed sitting in her room with the door open and curtain pulled back in full view of the hallway. She was yelling out in non-formed words. She lacked any type of clothing from the waist up. At that time, LPN #2 was looking in the medication cart and speaking to the Executive Director (ED) in the hallway in front of room #121. A few minutes passed during the observation of the resident and the ED walked to the room of Resident #1 and pulled the curtain part way closed. He instructed LPN #2 to put a gown on the resident. The ED indicated at that time, Resident #1 often removed her clothing. He indicated she must have a gown placed backwards over her clothing to prevent her from exposing herself.</p> <p>During an interview on 03/17/2016 at</p>		<p><i>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 #1's had a care plan developed for inappropriate disrobing.</p> <p>2) How the facility identified other residents:</p> <p>The facility has determined that any resident presenting with disrobing behaviors have the potential to be affected.</p> <p>Residents will be identified upon admission, quarterly, annually and with any significant changes.</p> <p>Audit was conducted to identify those residents with behaviors of inappropriate disrobement. Care Plans were reviewed and revised to</p>				

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	<p>10:06 a.m., LPN #2 indicated Resident #1, lacked a Care Plan to address the resident's behavior of disrobement and lacked an intervention to place a hospital gown over the resident's clothing to prevent disrobement.</p> <p>During an interview on 03/17/2016 at 11:43 a.m., the Director of Nursing (DON) indicated she was aware the resident disrobed from time to time, but was unaware there was no Care Plan or behavior monitoring in place for this resident regarding disrobement. She indicated the Social Service Director (SSD) should have contacted the resident's sister to inquire about alternative clothing for the resident to discourage her from removing her clothes in view of others.</p> <p>During an interview on 3/18/16 at 11:33 a.m., the SSD indicated she was aware that Resident #1 had a history of disrobement. She indicated she had not developed a Care Plan for the behavior nor initiated behavior monitoring for the behavior. She indicated she had not contacted the resident's sister about the resident disrobing.</p> <p>This deficiency was cited on 2/8/2016. The facility failed to implement a systemic plan of correction to prevent</p>		<p>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 order listing report and 24 hour summary report at the morning clinical meeting to ensure all order changes and behaviors are addressed and car plan initiated.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or designee will randomly review three residents' records weekly ensure that care plans have been developed that accurately reflect disrobing/behavioral issues.</p> <p>MDS coordinator will review during scheduled care plan meetings that care plans are current. Any 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>		

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F 0323 SS=K Bldg. 00	<p>recurrence.</p> <p>3.1-35(a) 3.1-35(b)(1)</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.</p> <p>A. Based on observation, record review and interview, the facility failed to ensure the potential for elopement did not occur by failing to have windows secure with stop gaps to prevent complete opening on the locked Harmony Unit for the safety of 2 of 2 residents reviewed with elopement risk. Resident #130 had previously exited a window on the Harmony Unit. Resident #128 had exited the facility and was transferred to the Harmony Unit for safety. This deficient practice had the potential to affect 16 of 19 ambulatory residents on the locked Harmony Unit. (Resident #130 and #128). This deficiency resulted in Immediate Jeopardy.</p> <p>B. In addition to the residents in the</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 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>	04/17/2016

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	<p>Immediate Jeopardy, the facility failed to ensure the safety of a resident when medication was left unattended by staff at a resident's bedside for 1 of 5 residents reviewed for safe medication administration (Resident #3).</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy began on 3/9/16, when the facility failed to ensure windows on the Harmony locked unit had stop gaps to prevent elopement with a known history of a resident eloping through a Harmony Unit window. The Executive Director and Director of Nursing (DON) were notified of the Immediate Jeopardy at 5:55 p.m., on 3/16/16. The Immediate Jeopardy was removed on 3/18/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy</p> <p>Findings include:</p> <p>A1. During an environmental tour with the Executive Director (ED) on 3/16/16 at 1:20 p.m., a window in the Dogwood Room on the locked Harmony Hall, was open 6-8 inches in width. There was no screen present. At that time, the ED pushed the window back to full opening,</p>		<p>those residents identified:</p> <p>ITEM A.</p> <p>Resident #130 no longer resides in the facility. Resident #128 has been re-assessed, care plans and behavior monitoring have been reviewed and revised. Families and Physicians were notified.</p> <p>The facility has assured that each resident window and those windows within common areas on the secured behavior unit have been secured with a screw/ stop gap to prevent windows from opening any further than 6 inches. Should an elopement risk be determined, interventions will be immediately initiated to protect the resident in a reasonable manner and as approved by the physician.</p> <p>ITEM B</p> <p>Resident #3 was reassessed, no adverse effects related to medication administration on 3-16/2016 at 10:00am</p> <p>Medication variance report was completed for resident #3</p> <p>2) How the facility identified other residents.</p> <p>ITEM A</p> <p>Any resident rooms and common</p>				

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	<p>18-24 inches in width. He indicated the window should have a stop gap to prevent the window from complete opening.</p> <p>During an observation on the Harmony Unit with the Maintenance Director on 3/16/16 at 3:15 p.m., the following was observed:</p> <p>Dogwood room: one window did not have a stop gap to prevent complete opening and the window did not have a screen. This window opened into an enclosed courtyard with a gazebo, grill and patio furniture.</p> <p>The Dining area across from the Dogwood Room had one window without a stop gap to prevent complete opening and a window was missing a screen. This window opened to the east side of the building into an area of brush leading to the rear parking lot of a (name of restaurant) that is located off a busy state road.</p> <p>Room 208 had one window without a stop gap to prevent complete opening. This window opened into the enclosed courtyard.</p> <p>During an interview on 3/16/2016 at 3:23 p.m., CNA #1 indicated Resident #130</p>		<p>areas on the secured behavior with windows were checked by Maintenance, Nursing, and Administration to ensure a window opening of no greater than 6 inches existed. Screws / stop gaps were replaced to eliminate the likelihood or ease of removal. Exit doors were additionally checked for proper functioning. Additionally, other facility units such as long term care unit and skilled units were checked for the appropriate screw/stop gap window placement. Those window found to require screws/stop gaps have been corrected.</p> <p>Any resident residing on the behavior unit had the potential to be affected.</p> <p>Residents will be identified through the admission process, significant changes, quarterly and annual assessments.</p> <p>ITEM B</p> <p>Any resident that received medications on 3-16-2016 by LPN#3 had the potential to be affected, however none were identified.</p> <p>3) Measures put into place/ System changes:</p> <p>ITEM A</p> <p>Bi-weekly checks will be implemented to validate the security</p>		

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	<p>had tried to exit the Harmony unit about 1-2 weeks ago. He tried to exit out the back door and the Dogwood Room window. She indicated he actually got out a window into the courtyard. She indicated he had also attempted to exit the back door. She indicated the times he attempted to exit were not on her shift, so she did not know how long he was outside before someone noticed.</p> <p>During an interview with the DON on 3/16/16 at 3:51 p.m., she indicated Resident #130 who was a new admission had climbed out a window. She indicated he did not just climb out the window he jumped out the window and broke the screen in room 206 and was in the courtyard. He was observed doing this because management staff was in the conference room with the blinds open because it was a sunny day. He was walking around the courtyard and easily directed into the building. She indicated he was exit seeking on 3/10 and 3/11, but he did not get out. She indicated she did not know if this information regarding his elopement out 206's window was documented anywhere, but she could check. She indicated she did not fill out an incident report on him leaving out the window because management staff saw him in the courtyard walking around during their meeting and brought him</p>		<p>of the windows and the ongoing placement of the screw/stop gap enabling 6 inch window openings.</p> <p>Identification of areas of concern will be immediately addressed and corrected.</p> <p>Elopement education will be added to the general orientation agenda as well as annually and as needed, Elopement drills will occur no less than 3 time monthly to include all three shifts.</p> <p>Facility staff were re-educated on the Elopement Policy and procedures.</p> <p>Any resident with identified exit seeking behaviors will be discussed daily during scheduled morning meetings to determine specific interventions are unique to the risk factors assessed.</p> <p>ITEM B</p> <p>Consultant pharmacy was contacted and provided a quality assurance med pass evaluation with on the spot education as needed.</p> <p>Licensed Nurses received education on Medication Administration with specific focus regarding not leaving medications at the bedside and timely completion of medication pass.</p> <p>Director of Nursing/Assistant Director of Nursing will complete medication pass observations with</p>		

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	<p>back in so she did not consider this as an elopement.</p> <p>During interview on 3/16/15 at 4:52 p.m., the DON indicated Resident #130 had climbed out room 206's window on 3/9/16. She indicated the incident was documented on the 72 Hour Occurrence Follow/Up Charting and in the facility Quality Assurance information. She indicated a management staff member saw him climb out the window into the courtyard where he was around. The record for Resident #130 was reviewed 3/16/16 at 3 p.m. Diagnoses included, but were not limited to, Post Traumatic Stress Disorder, Alcohol abuse with Alcohol-induced psychotic disorder, and dementia with paranoia psychosis.</p> <p>An Admission Assessment, dated 3/8/16, indicated the resident was oriented to person, was ambulatory with supervision, had trouble staying asleep, woke up at night, and wandering was not assessed.</p> <p>A Social Service Survival Skills assessment, dated 3/8/16, indicated the resident was not able to navigate on community streets such as; crossing safely, maintain a safe distance from cars, and navigate sidewalks. He would not know how to locate facility or contact facility in case of emergency. He would</p>		<p>licensed nursing staff.</p> <p>Random unannounced observational audits will be conducted throughout the facility 2x weekly to determine if any medications are left at the bedside, identified issues will be immediately addressed with disciplinary action up to and including termination should a pattern be identified.</p> <p>Meeting will be held with Resident Council to educate them on the inability of Licensed Nursing Staff to leave medications at the bedside, and requirement of nursing to observe consumption of medications.</p> <p>4) How the corrective actions will be monitor</p> <p>ITEM A</p> <p>Monitoring of the facility safety and security will be the joint effort of the Executive Director/Maintenance Director/ designated Management Staff who during bi-weekly visual checks for correct placement of screw/stop gaps in all facility windows, will determine areas that need to be immediately 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</p>	

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	<p>not be able to refrain from self-harmful behavior while in the community. He would not have knowledge of potentially dangerous situations, such as walking alone after dark, straying into alley or accepting rides from strangers. He did not have the ability to adhere to policies such as; getting permission to leave, signing out, or respecting time parameters. He would not be capable of unsupervised outside pass privileges at that time.</p> <p>A 3/8/16, Social Service Elopement/Unauthorized Leave Risk Review assessment indicated the resident was at "...risk to elope and should be place on the Elopement Risk Protocol. A care plan for Elopement is indicated..."</p> <p>The progress notes did not indicate the details of the event. Additional information regarding the event was requested from the DON on 3/17/16 at 10:20 a.m., and she provided an incident form dated 3/9/16 at 9 a.m., which indicated the resident had climbed out the window in Room 206 on the Harmony Unit into the courtyard. He indicated he wanted to take a walk and was easily directed back to his room.</p> <p>A 72 hour occurrence Follow-up charting dated 3/9/16 at 5 p.m., indicated the</p>		<p>for 3 consecutive months</p> <p>ITEM B</p> <p>The Director of Nursing and Assistant Director of Nursing will monitor through observation, Medication Administration 2x weekly (to include both 12hour shifts). Any identified issues will be immediately addressed through 1-1 education, disciplinary action, and or termination.</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>	

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	<p>triggering event was elopement on 3/9/16 and to go to incident. The form indicated the resident had "...climbed out of windo [sic] into courtyard..." The assessment indicated the physician and family were not notified.</p> <p>A Behavior Management Team Review, dated 3/9/16, indicated the resident had behaviors of intrusive wandering and exit seeking, 3 episodes of wandering and exit seeking, that he was a new admission and the team recommendations were "...no changes at this time. Will monitor and review next behavior meeting."</p> <p>A plan of care, dated 3/9/16, indicated the resident was at risk for elopement and wandering and the goal was to maintain his safety. Approaches included 15 minute checks and a wanderguard.</p> <p>During an interview with the DON on 3/17/16 at 8:30 a.m., she indicated after Resident #130 had exited through the room 206 window, a directive had been given to assess the windows for safety.</p> <p>A2. During an interview on 3/16/2016 at 3:47 p.m., LPN # 2, indicated she had heard Resident #128 had eloped through the front doors a few weeks ago on a weekend, but she was not here on that day and she had heard he was past the</p>			

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	<p>parking lot right by that stop light. She indicated after that he was placed on the Harmony locked unit.</p> <p>During an interview on 3/16/2016 at 3:51 p.m., the DON indicated Resident #128 had eloped out the front door by following some friends out the door. He made it out the front door into the parking lot and CNA #3 had gone out the side door and seen the resident in the parking lot and she tried to get him to come back in, but he would not come back in, so she walked to the stoplight with him, which was probably about 12:15 p.m. She indicated at that same time the nurses inside the building were searching for the resident because it was time for his medication. The police was called and they came and encouraged him to come back in. She indicated he was probably outside by himself for 2-3 minutes before the CNA caught up with him. A wanderguard was placed back on him.</p> <p>The record for Resident #128 was reviewed on 3/17/16 at 10:43 a.m. Diagnoses included, but were not limited to, nontraumatic subarachnoid hemorrhage, abnormalities of gait and mobility, mood disorder and cognitive decline.</p>			

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	<p>An elopement risk review, dated 2/19/16, indicated the resident had a history of wandering/elopement and had a strong desire to leave. He had prior documented elopement attempts, and had signs of compromised decision making skills.</p> <p>A care plan, dated 2/29/16, indicated the resident was at risk for elopement and wandering and his safety would be maintained. Approaches included, but were not limited to, transfer to locked unit, wanderguard and 15 minute checks.</p> <p>A physician progress note, dated 2/29/16, indicated the resident wanted to leave the facility Against Medical Advice and encouraged not to do that.</p> <p>A progress note dated on these dates indicated the following:</p> <p>2/20/16 at 10:32 p.m., indicated the resident was exit seeking and intrusively wandering into residents rooms.</p> <p>2/21/16 at 1:34 a.m., the resident was ambulating in hallways, exit seeking, and intrusively wandering into others rooms. Refused redirection.</p> <p>2/29/16 at 10 a.m., the resident was exit seeking and a wanderguard was applied to ankle with order to check placement</p>			

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	<p>and functioning every shift.</p> <p>A 3/2/16, Behavior management team review indicated the resident continued to exit seek, was irritable and had anger toward self and others. The form indicated no changes to care at this time.</p> <p>A 3/7/16, Interdisciplinary Team note indicated the resident had eloped and was currently on the Harmony unit, on 15 minute checks.</p> <p>A 3/9/16, Behavior management team review indicated the resident was verbally aggressive, exit seeking irritability, and anger toward self and others. The form indicated he was wanting to go home and was non compliant with redirection. The resident was moved to the Harmony Unit on 3/6/16.</p> <p>The record did not indicate why the wanderguard did not function or if it was on when the resident eloped on 3/6/16.</p> <p>A policy titled "Elopement Risk Assessment" was provided by the DON on 3/17/16 at 10 a.m., and deemed as current. The policy indicated "Procedure:...Risk factors will be assessed...c. Purposeful exit seeking d. Restless aimless pacing...3. Should an</p>			

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F 0328 SS=D Bldg. 00	<p>elopement risk be determined, interventions will be immediately initiated to protect the resident in a reasonable manner...6. The Social Service Department will notify the Facility Staff and initiate interventions necessary to protect the resident...."</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; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation and record review, the facility failed to ensure respiratory equipment was changed weekly according to physician order and facility policy for 2 of 2 residents reviewed for respiratory equipment. (#47 and #122)</p> <p>Findings included:</p> <p>1. On 03/17/2016 at 11:24 a.m., the record review was completed for Resident #47. Medical diagnoses included, but were not limited to, acute respiratory failure, unspecified and chronic obstructive pulmonary disease.</p>	F 0328	<p>F 328</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</i></p>	04/17/2016

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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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	<p>A Physician signed Recapitulation, dated March 2016, included, but were not limited to the following orders: DuoNeb solution (a medication to open bronchial airways) 0.5-2.5(3) mg (milligrams) /3 ml (milliliters) four times daily. Oxygen 2 L (liters) by nasal cannula continuously. Change O2 (oxygen) and Neb (nebulizer) tubing every Sunday.</p> <p>On 3/16/2016 at 12:50 p.m., Resident #47 was observed sitting in the dining room with O2 on at 2.5 lpm (liters per minute) via concentrator by nasal cannula. At that time, the O2 concentrator in the resident's room was running without tubing attached at 3 lpm. The nebulizer administration equipment was observed sitting on the resident's bedside table and was bagged and labeled 3/7/16.</p> <p>On 03/17/2016 at 10:08 a.m., the nebulizer administration equipment was observed sitting on the resident's bedside table bagged and labeled 3/7/16.</p> <p>2. On 03/17/16 at 11:14 a.m., the record review was completed for Resident #122. Medical diagnoses included, but were not limited to, acute respiratory failure,</p>		<p><i>by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident # 47 had his nebulizer and O2 tubing changed and dated.</p> <p>Resident # 122 had his C-PAP and O2 tubing changed and dated.</p> <p>Both residents were assessed and found to be in no respiratory distress.</p> <p>Orders were reviewed for both identified residents. Care Plans reviewed and revised as needed.</p> <p>2) How the facility identified other residents:</p> <p>Facility wide audit was conducted to identify those residents that currently utilize respiratory equipment.</p> <p>Residents identified had their tubing changed and dated.</p> <p>Orders were reviewed to clarify flow rates on those residents receiving oxygen.</p> <p>Any resident that utilizes respiratory equipment had the potential to be affected however none were identified.</p>	

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	<p>unspecified, sleep apnea, and aphonia.</p> <p>A Physician signed Recapitulation orders, dated March 2016, included, but were not limited to the following orders: C-Pap (a machine to assist in respiratory function) on at h.s. (hour of sleep) with a setting of 9 with 2 L of humidified oxygen, and off in a.m. (morning). Incentive spirometer (respiratory exercise equipment) q.i.d. (four times a day). Ipratropium-Albuterol Solution (medication to open bronchial airways) 0.5-2.5 (3) mg/3 ml every four hours prn (as needed).</p> <p>On 03/16/2016 at 1:20 p.m., the oxygen tubing was observed sitting on the bedside table and was bagged and labeled 3/5/16.</p> <p>On 3/17/2016 at 10:21 a.m., the C-Pap mask and tubing lacked a bag for storage and was positioned on the resident's bed. The resident's oxygen tubing was observed sitting on the bedside table bagged and labeled 3/5/16.</p> <p>A current, undated policy titled, "OXYGEN THERAPY-MASK AND NASAL CANNULA" provided by Medical Records on 03/17/2016 at 1:15 p.m., indicated "...8. When masks and cannulas are not in use, store in special</p>		<p>3) Measures put into place/ System changes:</p> <p>Nursing staff were educated on policies: Oxygen Therapy-Mask and Nasal Cannula as well as Respiratory Treatment /Nebulizer Hand Held and the requirement to change and date equipment weekly.</p> <p>Additionally educated on oxygen administration orders and the requirement to ensure accurate flow rates.</p> <p>Respiratory equipment will be changed and dated weekly by nurse management.</p> <p>Documentation will be reflected on the Treatment Administration Record.</p> <p>4) How the corrective actions will be monitored:</p> <p>The monitoring of this will plan of correction will be the Director of Nursing/Designee. Observational audits will occur on 3 residents weekly to determine that tubing has been changed and dated weekly and that the correct oxygen flow is used per physician order. Any issues will be immediately addressed.</p>	

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F 0332 SS=D Bldg. 00	<p>plastic bag...labeled with resident's name and date...12. Nasal cannula and tubing should be routinely changed weekly."</p> <p>A current, undated policy titled, "RESPIRATORY TREATMENT NEBULIZER (HAND HELD)" provided by Medical Records on 03/17/2016 at 1:15 p.m., indicated, "...14. Nasal Cannula or Mask and Tubing are to be changed weekly."</p> <p>3.1-47(a)(6)</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 and record review, the facility failed to ensure 2 of 25 medications were administered timely, resulting in a medication error rate greater than 5% for 1 of 5 residents reviewed for medication administration (Resident #101).</p> <p>Finding includes: During the medication pass observation</p>	F 0332	<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>F332</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</i></p>	04/17/2016

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	<p>on 3/17/16 at 9:20 a.m., LPN #2 prepared the medications for Resident #101. She indicated at that time, she was running behind that morning. She prepared all of his medications. LPN #1 prepared Metoprolol Tartrate (a blood pressure medication) 25 milligrams (mg)one-half tablet by mouth twice daily and Levetericatem (a seizure medication) one tablet by mouth two times daily.</p> <p>On 3/17/16 at 1:20 p.m., the record review for Resident #101 was completed. Diagnoses included, but were not limited to, pulmonary embolus (blood clot in the lung), seizures, and depression.</p> <p>A Physician's Order, dated 01/01/16, indicated Levetericatem 500 mg give one tablet by mouth two times a day.</p> <p>A Physician's Order, dated 2/23/16, indicated Metoprolol Tartrate 25 mg, give one-half tablet by mouth twice daily.</p> <p>The Medication Administration Record for March 2016, indicated Metoprolol Tartrate and Levetericatem were scheduled daily at 8:00 a.m. and 8:00 p.m.</p> <p>The facility policy for Medication Administration General Guidelines dated 5/1/15, indicated, provided by the</p>		<p><i>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 #101 physician and family was notified regarding resident not receiving medications timely on 3/17/2016. LPN # 2 received individualized 1-1 education and disciplinary action.</p> <p>Medication Variance report was completed. No adverse outcome occurred</p> <p>2) How the facility identified other residents:</p> <p>Any resident that received medications from LPN #2 had the potential to be affected, however no one was identified.</p> <p>Interviews conducted with residents of a BIMS score of 13 or above to determine timely medication administration.</p> <p>3) Measures put into place/ System</p>		

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	<p>Medical Records staff member on 3/17/16 at 1:15 p.m., "...2. Administration...j. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule or the facility...."</p> <p>This deficiency was cited on 2/8/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25(b)(9)</p>		<p>changes:</p> <p>Licensed nurses were educated on: Medication Administration, time frames, and the need to alert their direct supervisor for assistance if there could be a delay in providing medications in the appropriate time-frames.</p> <p>Consultant pharmacy was contacted and provided a quality assurance med pass evaluation with on the spot education and focus on timeliness of medication administration.</p> <p>Director of Nursing or Assistant Director of Nursing completed medication pass observations with licensed nursing staff with the expectation of 100% compliance expected with medication time frames.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing and Assistant Director of Nursing will monitor through observation, Medication Administration 2x weekly (to include both 12hour shifts). Any identified issues will be immediately addressed through 1-1 education, and or disciplinary action. Specific focus placed on administration of meds within appropriate time frames.</p>		

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F 0333 SS=D Bldg. 00	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to administer two medications within a safe time frame to ensure the resident was free from two significant medication errors for 1 of 2 residents reviewed regarding medication error (Resident #3).</p> <p>Finding includes:</p> <p>Resident #3's record was reviewed on 3/16/16 at 2:50 p.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic pain syndrome, dementia with behavioral disturbance, major depressive disorder, hypertension, and cerebrovascular disease.</p> <p>An EMAR (Electronic Medication Administration Record), dated March</p>	F 0333	<p>Interviews will be conducted with 3 alert and oriented residents weekly to determine timely medication administration.</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>F333</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>	04/17/2016

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	<p>2016, indicated the resident was to receive the following medications at 7:00 a.m. and 12:00 p.m., which included, but were not limited to:</p> <p>1/28/15--Sinemet (medication to treat Parkinson's Disease) 25-100 mg (milligrams) give two tablets four times a day scheduled at 7:00 a.m., 12:00 p.m., 4:00 p.m. and 10:00 p.m., for treatment of Paralysis Agitans (Parkinson's disease).</p> <p>1/29/15--Propranolol HCL (Hydrochloride) (a heart medication) 10 mg give one tablet by mouth three times a day scheduled for 7:00 a.m., 12:00 p.m. and 10:00 p.m., for tremors.</p> <p>The resident's record did not have a self administration of medication assessment found in his chart nor an order that he could administer his own medications.</p> <p>On 3/17/16 at 10:06 a.m., Resident #3 was observed self-administering medications from a clear plastic cup. He indicated at that time, a nurse left the cup of pills on top of his five-tier stand. LPN #2 indicated the cupful of medications were left in the room at 8:00 a.m. and indicated the cup contained the resident's 7:00 a.m. scheduled medications.</p> <p>During an interview on 3/17/16 at 2:38 p.m., LPN #2 indicated Qualified</p>		<p>Resident # 3 was assessed, medications and care plans reviewed and updated as required.</p> <p>Notification was made to family and physician</p> <p>Disciplinary action was provided to LPN #2 and QMA #4 as well as 1-1 directed education regarding medication administration, time frames for administration and not leaving medications at the bedside.</p> <p>Medication variance was completed related to Resident 3#.</p> <p>2) How the facility identified other residents</p> <p>Interviews conducted with residents of a BIMS score of 13 or above to determine timely medication administration.</p> <p>Any resident that received medications from LPN#2 on 3-16-2016 had the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses were educated on: Medication Administration, time frames, and the need to alert their</p>		

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	<p>Medication Aide (QMA) #4 prepared Resident #3's 7:00 a.m. medications and stored them in the medication cart. LPN #2 indicated she took the medications to the resident's room and left them on the five-tier stand in his room. She indicated she waited until 1:00 p.m. to administer Propanolol and Sinemet since the 7:00 a.m., doses were not taken until 10:00 a.m.</p> <p>During an interview on 3/17/16 at 4:20 p.m., LPN #2 indicated she had looked at the policy and procedure for Medication Administration and she was not supposed to pass medications to residents, which she had not set up herself.</p> <p>During an interview on 3/18/16 at 5:38 a.m., QMA #4 indicated the morning of 3/17/16, she had prepared Resident #3's 7:00 a.m., medications, which included Amiodarone HCL (a heart medication), Amlodipine Besylate (a blood pressure medication), Aspirin (helps prevent heart attacks), Colace (a stool softener medication), Lasix (a water pill), Multivitamin (a vitamin supplement), Omperazole (a stomach medication), Sinemet (a medication to treat Parkinson's disease) (two tablets), Potassium Chloride, (an electrolyte supplement) Pristiq (a medication to treat depression) (two tablets), Tamsulosin</p>		<p>direct supervisor for assistance if there could be a delay in providing medications in the appropriate time-frames.</p> <p>Consultant pharmacy was contacted and provided a quality assurance med pass evaluation with on the spot education as needed.</p> <p>Meeting will be held with Resident Council to educate them on the inability of Licensed Nursing Staff to leave medications at the bedside, and requirement of nursing to observe consumption of medications.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing and Assistant Director of Nursing will monitor through observation, Medication Administration 2x weekly (to include both 12hour shifts). Any identified issues will be immediately addressed through 1-1 education, and or disciplinary action. Specific focus placed on administration of meds within appropriate time frames. Interviews will be conducted with 3 alert and oriented residents weekly to determine timely medication administration.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or</p>	

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	<p>HCL (Hydrochloride) (a medication for urine retention), Lyrica (a pain medication to treat nerve pain) and Propranolol HCL (a heart medication). She indicated she took the medications into Resident #3's room to administer the medications to him and he asked her to give him a few minutes to wake up. She indicated she placed the medications in the top drawer of the medication cart, then LPN #2 came in, so she asked her to administer Resident #3's medications to him and she agreed.</p> <p>During an interview on 3/18/16 at 9:00 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were in attendance and were informed of the concern of two significant medication errors regarding Propanolol and Sinemet being given three hours apart on 3/17/16 a.m. The ADON indicated at that time, the Propanolol and the Sinemet should have been given at least four hours apart and they were not.</p> <p>Nursing Drug Handbook 34th Edition, dated 2014, indicated Propranolol Hydrochloride's onset when given by mouth was 30 minutes, the peak of the dose (the highest concentration of the medication in the resident's bloodstream) was 60-90 minutes when given by mouth and the duration of the drug (the length of</p>		until 100% compliance is achieved x3 consecutive months.	

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	<p>time a medication was effective) was 12 hours when given by mouth. The half-life of the drug (how long it takes the body to get rid of half of the dose of the medication) was about four hours. The Indications and Dosages was for Essential Tremors for adults was 40 mg by mouth twice daily. Usual maintenance dose is 120 to 320 mg daily in three divided doses.</p> <p>Nursing Drug Handbook 34th Edition, dated 2014, indicated Sinemet's onset when given by mouth was unknown. The peak of the medication was 40-150 minutes when given by mouth. The duration of the medication was unknown. The half-life of the medication when given by mouth was one-two hours. The Indications and Dosages was for Idiopathic Parkinson disease, postencephalitic parkinsonism and symptomatic parkinsonism resulting from carbon monoxide or manganese intoxication. One tablet of 100 mg Levodopa with 25 mg Carbidopa by mouth three times a day, then increased by one tablet daily or every other day, as needed, to maximum daily dose of eight tablets. Give in divided doses at intervals of four to eight hours.</p> <p>A current policy and procedure titled "Medication Administration General</p>			

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	<p>Guidelines" dated 5/1/15, provided by the Medical Records staff member on 3/17/16 at 1:15 p.m., indicated "Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication... Procedure: 1. Preparation: a. Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare medications... c. Prior to administration the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label... 2. Administration: a. Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications. b. Medications are administered in accordance with written orders of the attending physician... d. Medications are administered at the time they are prepared. Medications are not pre-poured. e. Medications are administered without unnecessary interruptions. f. The person who prepares the dose for administration is the person who administers the dose... j.</p>			

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	<p>Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.</p> <p>k. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications...o. The resident is always observed after administration to ensure that the dose was completely ingested...</p> <p>3. Documentation: a. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given... d. The resident's MAR is initialed by the person administering the medication in the space provided under the date, and on the line for that specific medication dose administration... f. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is</p>			

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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 0465 SS=F Bldg. 00	<p>entered on the reverse side of the record provided for PRN [as needed] documentation...."</p> <p>3.1-25(b)(9)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a clean, sanitary and home-like environment for entry doors, bathroom doors, walls, floors and closets, laundry room, hallways and resident rooms (Room's #101, 102, 106, 108, 109, 111, 115, 117, 119, 123, 127, 129, 202, 208 and 209). This deficient practice had the potential to impact 68 residents out of 68 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During resident room observations on 3/16/16 at 1:20 p.m. with the Executive Director in attendance, the following was observed:</p> <p>a.) Room #101: The entry and bathroom</p>	F 0465	<p>F465 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.</p> <p>1.)Immediate actions taken for those residents identified: No resident was identified to have been affected. Issue # 1) a.)room 101 Painting was accomplished b.) room 102 Painting was accomplished Baseboard was replaced c.) room 106 Painting was accomplished, threshold was placed to secure carpeting between bathroom and residents</p>	04/17/2016	

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	<p>door and door frames and air conditioning/heating unit were peeling, marred and scratched.</p> <p>b.) Room #102: The entry and bathroom door and door frames marred and scratched. The bathroom wall by the mirror and the floor by the baseboard had areas of chipped and marred paint.</p> <p>c.) Room #106: The entry and bathroom doors and door frames were chipped, marred and scratched. The carpeting was loose from the resident's room into the bathroom. The bathroom had a very strong urine smell. The wall paper was peeling from the wall at the bathroom entry.</p> <p>d.) Room #108: The bathroom and entry doors and frames were chipped, marred and scratched. The hot water faucet was loose.</p> <p>e.) Room #109: The wall around the bathroom sink was missing drywall and the sink was pulling away from the wall. The entry doors, bathroom doors and walls and frames were marred and scuffed.</p> <p>f.) Room #111: The entry and bathroom door and frames were marred and chipped. There was no closet door, and</p>		<p>room. Bathroom was cleaned per housekeeping and placed Wallpaper was repaired.</p> <p>d.)room108 Painting was accomplished. Hot water faucet was repaired e.) room 109 The bathroom sink was replaced and drywall repaired. Painting was accomplished. f.) room 111 Painting was accomplished Closet door replaced Wall paper was repaired Privacy curtains were hung correctly. g.) room 115 Painting accomplished h.) room 117 Painting accomplished Bathroom was cleaned per housekeeping Light was replaced over the sink Hand towel rack was replaced Toilet paper holder was replaced Emergency call light replaced Privacy curtains were laundered and hung correctly Bed light was identified during repairs and will be replaced j.) room 119 Painting was accomplished Toilet paper bracket was replaced Bathroom fan cover was secured to the ceiling Towel rack was repaired Broken handle on bottom drawer of nightstand was repaired j.) room 123 Painting was accomplished Telephone wires were secured Toilet was replaced Baseboard was replaced Floor tiles at the closet and drawer corrected Privacy curtain was repaired or replaced k.) room 127 Painting was accomplished Privacy curtain laundered or replaced Toilet paper holder replaced</p>	

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	<p>the wall paper was peeling at the closet entry on the right. The privacy curtain was off the hooks.</p> <p>g.) Room #115: The entry and bathroom doors were marred and peeling.</p> <p>h.) Room #117: There was chipped paint on the bathroom door and entry way door. In the bathroom there was a strong smell of urine and three tiles pulling away from the wall above the sink. There was not a light over the sink. The hand towel rack was broken. There was no round holder for the toilet paper and the emergency call cord was dragging on the floor and was soiled with a dark substance. The privacy curtain was soiled and loose from the hangers.</p> <p>i.) Room #119: The entry way door and frame was marred and chipped. The overhead light cord was too short. The toilet paper bracket did not have a round toilet paper holder or toilet paper present. The bathroom fan cover was not secured to the ceiling and the towel rack was broken. The nightstand by Bed B had a broken handle on the bottom drawer.</p> <p>j.) Room #123: The entry way door and frame was marred and chipped. The telephone cord wires were exposed and</p>		<p>Emergency call cord was replaced Baseboard replacement identified during repairs will be replaced l.) room 129 Painting was accomplished Grout was cleaned in the bathroom Particle board chipped around the sink will be repaired Wall paper by bed b was repaired m.) 202 Painting was accomplished Flooring in bathroom was repaired by 4-30-2017 Toilet paper holder replaced Hole above toilet was repaired Bathroom was cleaned. n.) room 208 Painting was accomplished Walls were repaired Laminate flooring in bathroom repaired and a threshold placed by 4-30-2016 Baseboard was replaced Light above the bed was repaired or replaced o.)room 209 Painting was accomplished Laminate flooring to be replaced by 4-30-2016 Cabinet chipped and peeling was repaired Housekeeping will clean couch, if unable to remove debris couch will be discarded p.) Laundry room Drywall around door frames entering laundry will be repaired or doorframe replaced by 4-30-2016 Missing tiles were replaced Blankets were removed surrounding the air conditioner q.) Harmony Unit Painting was accomplished New exit door has been purchased to be installed by 4-30-2016 r.) Harmony and Dogwood lounge Chair railing repaired Sofa will</p>				

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	<p>not secure within the jack box. The toilet bowl base was cracked and chipped. There was a missing baseboard at the closet and drawers, missing floor tiles at the closet and drawer area. No closet door was present. Clothes drawers were broken and the particle board was crumbling. The privacy curtain was not hemmed properly and in disrepair.</p> <p>k.) Room #127: The entry way door and frame was marred and chipped. The privacy curtain at the A bed was non-functional and soiled. There was no toilet paper round holder. The emergency call light cord was too short and there was dried brown soilage on the wall in the bathroom.</p> <p>l.) Room #129: The entry way door and frame was marred and chipped. There was dark debris at the base of the toilet and bathroom grout. The particle board around the sink was broken and chipped and the wall paper was peeling from the wall by bed B.</p> <p>m.) Room #202: The entry way door and frame was marred and chipped. The walls were marred. The bathroom flooring was loose. The toilet paper holder was not present. A hole with a metal fragment was protruding from the wall above the toilet. Urine smell in</p>		<p>be cleaned by s.) Hallway outside Occupational Therapy Handrail repaired t.) Build up on Fire doors Fire doors were cleaned by housekeeping u.) Window on 100 hall Window was closed and repaired Above items identified will be corrected by 4-17-2016, with the exception of those areas that require total flooring replacement and facility must order products. Exit door was previously ordered and awaiting arrival for installation. Maintenance will place identified areas on his preventative maintenance program Housekeeping will place specific cleaning projects on schedule. Action Plans developed for individual repair/maintenance areas 2) How the facility identified other residents: A facility wide review was completed by management staff to identify areas other than those identified on the 2567. Any resident that resides within the facility had the potential to be affected, however none were identified. 3) Measures put into place/ System changes: Updated Angel Round reports to include specific items for identification. The Administrator/Maintenance Director and Guardian Angels will make daily rounds of facility rooms and common areas. Daily review of Angel Round reports will be accomplished and reported during stand up meeting to</p>		

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	<p>bathroom.</p> <p>n.) Room #208: The entry way door and frame was marred and chipped. The walls and closet doors were marred. The bathroom door and frame were gouged and marred. Laminate flooring in the bathroom was loose. The baseboard in the bathroom was loose and coming off the bathroom wall. The reading light above the bed was non-functional.</p> <p>o.) Room #209: The entry way door and frame was marred and chipped. The walls were marred and gouged. Laminate flooring was ripped in multiple places in the room. The particle board cabinet was peeling and chipped. The couch in the room was stained with a brown substance.</p> <p>p.) Laundry room: There was crumbling drywall around door frames entering the laundry room. There was missing floor tiles. There were blankets tucked into gaps surrounding air conditioning units in the window.</p> <p>q.) Harmony unit: The south exit door had a patched area of dry wall without paint. The exit door did not have a handle.</p> <p>r.) Harmony unit Dogwood lounge had</p>		<p>ensure management as well as maintenance is aware of ongoing repairs. Maintenance request forms will be filled out at the identification of any needed repairs. Staff was educated on the maintenance repair slips kept at the nurse's station which is checked by the Maintenance Director/designee and prioritized with the Executive Director. Repairs are made based on priority. The Maintenance Director will record/ log when repairs are completed. Inability to complete identified repairs timely will be brought to the Executive Directors attention. Housekeeping staff, will have individual assignments and responsibilities related to identified housekeeping issues</p> <p>4) How the corrective actions will be monitored: The monitoring of this will be a joint effort between the facility Executive Director/ Maintenance Director/ and designated management team members who will Grand Round at least 2 x weekly to identify areas needing repair or cleaned Executive Director will keep a specific log of these Grand Rounds and compare with daily Angel rounds to determine accurate identification of areas throughout the facility that need attention. Maintenance Director will review 2x weekly with Executive Director and or Director of Nursing the log book of completed repairs The</p>		

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F 0490 SS=F Bldg. 00	<p>chair rail pulling away from the wall and the sofa had brown stains.</p> <p>s.) Hallway outside of Occupational therapy: Hand rail had a gap with uncovered edges.</p> <p>t.) The seven sets of fire doors had a build up of dust and debris in the corners.</p> <p>u.) There was a window on the 100 hall that was gapped open two inches without a handle present to close.</p> <p>During the tour with the Executive Director, he indicated he was not aware the repairs and cleaning was not completed. He indicated privacy curtains were on order and the south door for Harmony Unit was ordered. He indicated he had not checked all the rooms, but only his Angel rooms.</p> <p>This deficiency was cited on 2/8/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(f)</p>		<p>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>		
	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING				

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	<p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the Executive Director (ED) failed to ensure follow up of concerns regarding a clean, sanitary and home-like environment for entry doors, bathroom doors, walls, floors, and closets, laundry room, hallways and resident rooms (Rooms #101, 102, 106, 108, 109, 111, 115, 117, 119, 123, 127, 129, 202, 208 and 209). This deficient practice had the potential to impact 68 residents out of 68 residents in the facility.</p> <p>Findings include:</p> <p>The facility's Plan of Correction (POC) for their annual Recertification and State Licensure survey was reviewed prior to the entrance on 3/16/16. The POC indicated "An audit of the facility was conducted to identify any areas other than those identified in the 2567 that required repair... An Action Plan developed for the individual repair/maintenance areas... All resident rooms and common areas were inspected by the Executive Director/Maintenance Director and identified repairs were scheduled... The</p>	F 0490	<p>F490</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>No resident was identified to have been affected. Maintenance placed identified areas of concern on the preventative maintenance program.</p> <p>Housekeeping will place identified cleaning projects on a specific schedule.</p>	04/17/2016			

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	<p>Administrator/Maintenance Director and/or Guardian Angels will make daily rounds of all rooms and common areas and report any needed repairs. 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...."</p> <p>During resident room observations on 3/16/16 at 1:20 p.m. with the Executive Director in attendance, the following was observed:</p> <p>a.) Room #101: The entry and bathroom door and door frames and air conditioning/heating unit were peeling, marred and scratched.</p> <p>b.) Room #102: The entry and bathroom door and door frames marred and scratched. The bathroom wall by the mirror and the floor by the baseboard had areas of chipped and marred paint.</p> <p>c.) Room #106: The entry and bathroom doors and door frames were chipped, marred and scratched. The carpeting was loose from the resident's room into the bathroom. The bathroom had a very strong urine smell. The wall paper was peeling from the wall at the bathroom</p>		<p>Action Plans developed for individual repair/maintenance/housekeeping areas.</p> <p>2) How the facility identified other residents:</p> <p>A facility wide review was completed by management staff to identify areas other than those identified on the 2567.</p> <p>Any resident that resides within the facility had the potential to be affected, however none were identified.</p> <p>3) Measures put into place/ System changes:</p> <p>Updated Angel Round reports to include specific items for identification.</p> <p>The Administrator/Maintenance Director and Guardian Angels will make daily rounds of facility rooms and common areas.</p> <p>Daily review of Angel Round reports will be accomplished and reported during stand up meeting to ensure management as well as maintenance is aware of ongoing repairs.</p>		

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	<p>entry.</p> <p>d.) Room #108: The bathroom and entry doors and frames were chipped, marred and scratched. The hot water faucet was loose.</p> <p>e.) Room #109: The wall around the bathroom sink was missing drywall and the sink was pulling away from the wall. The entry doors, bathroom doors and walls and frames were marred and scuffed.</p> <p>f.) Room #111: The entry and bathroom door and frames were marred and chipped. There was no closet door, and the wall paper was peeling at the closet entry on the right. The privacy curtain was off the hooks.</p> <p>g.) Room #115: The entry and bathroom doors were marred and peeling.</p> <p>h.) Room #117: There was chipped paint on the bathroom door and entry way door. In the bathroom there was a strong smell of urine and three tiles pulling away from the wall above the sink. There was not a light over the sink. The hand towel rack was broken. There was no round holder for the toilet paper and the emergency call cord was dragging on the floor and was soiled with a dark</p>		<p>Maintenance request forms will be filled out at the identification of any needed repairs.</p> <p>Staff was educated on the maintenance repair slips kept at the nurse's station which is checked by the Maintenance Director/designee and prioritized with the Executive Director. Repairs are made based on priority.</p> <p>The Maintenance Director will record/ log when repairs are completed.</p> <p>Inability to complete identified repairs timely will be brought to the Executive Directors attention.</p> <p>Housekeeping staff, will have individual assignments and responsibilities related to identified housekeeping issues</p> <p>4) How the corrective actions will be monitored:</p> <p>The monitoring of this will be a joint effort between the facility Executive Director/ Maintenance Director/ and designated management team members who will Grand Round at least 2 x weekly to identify areas needing repair or cleaned</p> <p>Executive Director will keep a specific log of these Grand Rounds and compare with daily Angel rounds</p>	

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	<p>substance. The privacy curtain was soiled and loose from the hangers.</p> <p>i.) Room #119: The entry way door and frame was marred and chipped. The overhead light cord was too short. The toilet paper bracket did not have a round toilet paper holder or toilet paper present. The bathroom fan cover was not secured to the ceiling and the towel rack was broken. The nightstand by Bed B had a broken handle on the bottom drawer.</p> <p>j.) Room #123: The entry way door and frame was marred and chipped. The telephone cord wires were exposed and not secure within the jack box. The toilet bowl base was cracked and chipped. There was a missing baseboard at the closet and drawers, missing floor tiles at the closet and drawer area. No closet door was present. Clothes drawers were broken and the particle board was crumbling. The privacy curtain was not hemmed properly and in disrepair.</p> <p>k.) Room #127: The entry way door and frame was marred and chipped. The privacy curtain at the A bed was non-functional and soiled. There was no toilet paper round holder. The emergency call light cord was too short and there was dried brown soilage on the wall in the bathroom.</p>		<p>to determine accurate identification of areas throughout the facility that need attention.</p> <p>Maintenance Director will review 2x weekly with Executive Director and or Director of Nursing the log book of completed repairs</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>	

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	<p>l.) Room #129: The entry way door and frame was marred and chipped. There was dark debris at the base of the toilet and bathroom grout. The particle board around the sink was broken and chipped and the wall paper was peeling from the wall by bed B.</p> <p>m.) Room #202: The entry way door and frame was marred and chipped. The walls were marred. The bathroom flooring was loose. The toilet paper holder was not present. A hole with a metal fragment was protruding from the wall above the toilet. Urine smell in bathroom.</p> <p>n.) Room #208: The entry way door and frame was marred and chipped. The walls and closet doors were marred. The bathroom door and frame were gouged and marred. Laminate flooring in the bathroom was loose. The baseboard in the bathroom was loose and coming off the bathroom wall. The reading light above the bed was non-functional.</p> <p>o.) Room #209: The entry way door and frame was marred and chipped. The walls were marred and gouged. Laminate flooring was ripped in multiple places in the room. The particle board cabinet was peeling and chipped. The couch in the</p>			

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	<p>room was stained with a brown substance.</p> <p>p.) Laundry room: There was crumbling drywall around door frames entering the laundry room. There was missing floor tiles. There were blankets tucked into gaps surrounding air conditioning units in the window.</p> <p>q.) Harmony unit: The south exit door had a patched area of dry wall without paint. The exit door did not have a handle.</p> <p>r.) Harmony unit and the Dogwood lounge had chair rails pulling away from the wall and the sofa had brown stains.</p> <p>s.) Hallway outside of Occupational therapy: Hand rail had a gap with uncovered edges.</p> <p>t.) The seven sets of fire doors had a build up of dust and debris in the corners.</p> <p>u.) There was a window on the 100 hall that was gapped open two inches without a handle present to close.</p> <p>During the tour with the Executive Director, he indicated he was not aware the repairs and cleaning was not completed. He indicated privacy curtains</p>			

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F 0520 SS=F Bldg. 00	<p>were on order and the south door for Harmony Unit was ordered. He indicated he had not checked all the rooms, but only his Angel rooms.</p> <p>During an interview on 3/16/16 at 3:15 p.m., the Maintenance Director indicated he did daily rounds on all the resident rooms, but the Executive Director did not accompany him.</p> <p>During an interview on 3/18/16 at 4:50 p.m., the Executive Director indicated he had to take responsibility as well as the Maintenance Director for the environmental concerns, which was the "housekeeping items" not being finished after the 2/26/16 POC date. He indicated he will have to QA (Quality Assurance) the environmental concerns again.</p> <p>3.1-13(q)</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</p>			

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	<p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to develop and implement appropriate plans of action to address the environmental concerns, which were addressed on the annual recertification and state licensure survey along with new environmental concerns, individualized activity care plans being followed (Resident #3), the medication error rate being below 5%, and failed to ensure a potential for an elopement did not occur by failing to have windows secure with stop gaps secure to prevent complete opening of windows on the Harmony Unit for safety. This deficient practice had the potential to affect 68 of 68 residents residing in the facility.</p> <p>Findings include:</p>	F 0520	<p>F520</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>No Resident was identified to have been adversely affected.</p>	04/17/2016

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	<p>1. An Environmental tour was completed on 3/16/16 at 1:20 p.m., the Executive Director was in attendance and he was informed of the environmental concerns that had not been addressed from the annual recertification and state licensure survey and the new concerns observed during the environmental tour.</p> <p>2. Resident #3's activity care plan was not being followed and he had indicated he was not been invited to activities. His record was reviewed and the record did not indicated he had been invited to activities as his Care Plan indicted he would be. The Activity Director indicated she did not document when she invited residents to activities or when they refused to come to activities.</p> <p>3. The medication error rate for the Mediation Administration pass was 8%, which was not below the 5%. There were also two medication errors during the medication pass.</p> <p>4. The Harmony unit had 3 windows that did not have stop gaps on them that could be opened completely 18-24 inches, which one of the windows in the dining room opened into a parking lot of a restaurant and led to a busy state road. A resident had already previously climbed out one of the unsecured windows into an</p>		<p>a.) room 101 Painting was accomplished</p> <p>b.) room 102 Painting was accomplished Baseboard was replaced</p> <p>c.) room 106 Painting was accomplished, threshold was placed to secure carpeting between bathroom and residents room. Bathroom was cleaned per housekeeping and placed Wallpaper was repaired.</p> <p>d.) room 108 Painting was accomplished. Hot water faucet was repaired</p> <p>e.) room 109 The bathroom sink was replaced and drywall repaired. Painting was accomplished.</p> <p>f.) room 111 Painting was accomplished Closet door replaced</p>	

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	<p>enclosed courtyard.</p> <p>During a Quality Assessment and Assurance (QA & A) interview on 3/18/16 at 4:50 p.m., the Executive Director indicated he would have to QA these concerns to take back to the team, so they could make new action plans and work on these areas again. He indicated all the concerns were being audited already except the Harmony unit windows and he thought those had been taken care of when he gave a directive to the Maintenance Director to make sure the windows had stop gaps on them to secure them, so they could not be opened completely. He indicated he was going to have to take these concerns back to the QA & A committee to have action plans developed again to have these areas audited again.</p> <p>This deficiency was cited on (2/8/2016). The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-52(b)(2)</p>		<p>Wall paper was repaired</p> <p>Privacy curtains were hung correctly.</p> <p>g.) room 115</p> <p>Painting accomplished</p> <p>h.) room 117</p> <p>Painting accomplished</p> <p>Bathroom was cleaned per housekeeping</p> <p>Light was replaced over the sink</p> <p>Hand towel rack was replaced</p> <p>Toilet paper holder was replaced</p> <p>Emergency call light replaced</p> <p>Privacy curtains were laundered and hung correctly</p> <p>Bed light was identified during repairs and will be replaced</p> <p>j.) room 119</p> <p>Painting was accomplished</p> <p>Toilet paper bracket was replaced</p> <p>Bathroom fan cover was secured to the ceiling</p> <p>Towel rack was repaired</p>	

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			<p>Broken handle on bottom drawer of nightstand was repaired</p> <p>j.) room 123</p> <p>Painting was accomplished</p> <p>Telephone wires were secured</p> <p>Toilet was replaced</p> <p>Baseboard was replaced</p> <p>Floor tiles at the closet and drawer corrected</p> <p>Privacy curtain was repaired or replaced</p> <p>k.) room 127</p> <p>Painting was accomplished</p> <p>Privacy curtain laundered or replaced</p> <p>Toilet paper holder replaced</p> <p>Emergency call cord was replaced</p> <p>Baseboard replacement identified during repairs will be replaced</p> <p>l.) room 129</p> <p>Painting was accomplished</p> <p>Grout was cleaned in the bathroom</p> <p>Particle board chipped around the sink will be repaired</p>	

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			Wall paper by bed b was repaired m.) 202 Painting was accomplished Flooring in bathroom was repaired by 4-30-2017 Toilet paper holder replaced Hole above toilet was repaired Bathroom was cleaned. n.) room 208 Painting was accomplished Walls were repaired Laminate flooring in bathroom repaired and a threshold placed by 4-30-2016 Baseboard was replaced Light above the bed was repaired or replaced o.)room 209 Painting was accomplished Laminate flooring to be replaced by 4-30-2016 Cabinet chipped and peeling was repaired Housekeeping will clean couch, if	

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			<p>unable to remove debris couch will be discarded</p> <p>p.) Laundry room</p> <p>Drywall around door frames entering laundry will be repaired or doorframe replaced by 4-30-2016</p> <p>Missing tiles were replaced</p> <p>Blankets were removed surrounding the air conditioner</p> <p>q.) Harmony Unit</p> <p>Painting was accomplished</p> <p>New exit door has been purchased to be installed by 4-30-2016</p> <p>r.) Harmony and Dogwood lounge</p> <p>Chair railing repaired</p> <p>Sofa will be cleaned by</p> <p>s.) Hallway outside Occupational Therapy</p> <p>Handrail repaired</p> <p>t.) Build up on Fire doors</p> <p>Fire doors were cleaned by housekeeping</p> <p>u.) Window on 100 hall</p> <p>Window was closed and repaired</p>	

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			<p>Above items identified will be corrected by 4-17-2016, with the exception of those areas that require total flooring replacement and facility must order products. Exit door was previously ordered and awaiting arrival for installation.</p> <p>Maintenance will place identified areas on his preventative maintenance program</p> <p>Housekeeping will place specific cleaning projects on schedule.</p> <p>Action Plans developed for individual repair/maintenance areas</p> <p>Resident #3 was reassessed, no adverse effects related to medication administration on 3-16/2016 at 10:00am</p> <p>Medication variance report was completed for resident #3</p> <p>2) How the facility identified other residents:</p> <p>Any resident rooms and common areas on the secured behavior with windows were checked by Maintenance, Nursing, and Administration to ensure a window opening of no greater than 6 inches existed. Screws / stop gaps were replaced to eliminate the likelihood</p>	

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			<p>or ease of removal. Exit doors were additionally checked for proper functioning. Additionally, other facility units such as long term care unit and skilled units were checked for the appropriate screw/stop gap window placement. Those window found to require screws/stop gaps have been corrected.</p> <p>Any resident residing on the behavior unit had the potential to be affected.</p> <p>Residents will be identified through the admission process, significant changes, quarterly and annual assessments.</p> <p>Any resident that received medications on 3-16-2016 by LPN#3 had the potential to be affected, however none were identified.</p> <p>3) Measures put into place/ System changes:</p> <p>Bi-weekly checks will be implemented to validate the security of the windows and the ongoing placement of the screw/stop gap enabling 6 inch window openings.</p> <p>Identification of areas of concern will be immediately addressed and corrected.</p> <p>Elopement education will be added to the general orientation agenda as well as annually and as needed,</p>	

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			<p>Elopement drills will occur no less than 3 time monthly to include all three shifts.</p> <p>Facility staff were re-educated on the Elopement Policy and procedures.</p> <p>Any resident with identified exit seeking behaviors will be discussed daily during scheduled morning meetings to determine specific interventions are unique to the risk factors assessed.</p> <p>Consultant pharmacy was contacted and provided a quality assurance med pass evaluation with on the spot education as needed.</p> <p>Licensed Nurses received education on Medication Administration with specific focus regarding not leaving medications at the bedside and timely completion of medication pass.</p> <p>Director of Nursing/Assistant Director of Nursing will complete medication pass observations with licensed nursing staff.</p> <p>Random unannounced observational audits will be conducted throughout the facility 2x weekly to determine if any medications are left at the bedside, identified issues will be immediately addressed with disciplinary action up to and including termination should a pattern be identified.</p> <p>Meeting will be held with Resident</p>	

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			<p>Council to educate them on the inability of Licensed Nursing Staff to leave medications at the bedside, and requirement of nursing to observe consumption of medications.</p> <p>4) How the corrective actions will be monitored:</p> <p>Monitoring of the facility safety and security will be the joint effort of the Executive Director/Maintenance Director/ designated Management Staff who during bi-weekly visual checks for correct placement of screw/stop gaps in all facility windows, will determine areas that need to be immediately 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 for 3 consecutive months</p> <p>The Director of Nursing and Assistant Director of Nursing will monitor through observation, Medication Administration 2x weekly (to include both 12hour shifts). Any identified issues will be immediately addressed through 1-1 education, disciplinary action, and or termination.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or</p>	

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

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			until 100% compliance is achieved x3 consecutive months.		