STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER HEALTH CARE CENTER	2210 GREENTREE N CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: April 26, 27, 28, 29, May 2 and 4, 2016 Facility number: 000100 Provider number: 155191 AIM number: 100266130 Census bed type: SNF/NF: 73 Residential: 90 Total: 163 Census payor type: Medicare: 10 Medicaid: 36 Other: 27 Total: 73 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on May 11, 2016	F 0000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law. Westminster Health Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor are they of such character so as to limit its ability to render adequate care. This plan of correction shall operate as Westminster Health Care Center credible allegation of compliance. This plan of correction is not meant to establish a standard of care, contract, obligation of position and Westminster Health Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
F 0226	483.13(c)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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SS=D Bldg. 00	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their policy to protect a resident when an allegation of physical abuse by a staff member occurred in that, a thorough investigation was not completed, administrative staff were not notified immediately, Local and State agencies were not notified promptly, and the staff member was not immediately removed from the situation. This deficient practice affected 2 of 2 residents reviewed for an allegation of abuse (Residents #2 and #72) Findings include: During an interview on 4/26/16 at 10:49 a.m., Resident #2 indicated a CNA (Certified Nursing Assistant) was rough with her roommate, Resident #72, while undressing the roommate for bed. She indicated her roommate said to the CNA "Stop, it hurt" and "NO NO". Resident #2 further indicated she reported what she heard to the nurse. On 4/27/16 at 2:28 p.m., the Director of	F 0226	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Resident #2 and #72's responsible party have been advised of actions we have taken related to the allegation of abuse. The abuse has been reported and the process followed related to this incident. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents have the potential to be affected. The staff will follow the policy when there is any allegation of abuse, neglect or exploitation. All staff will be re-educated on the ANE policy and procedure. Any newly hired staff will be provided this in-service at orientation. Any staff that is found not to be in compliance with this education will be re-educated and counseled as necessary with the progressive disciplinary process. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All staff will be re-in serviced on this requirement and will be educated on this	06/03/2016

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	Nursing presented a copy of the notes RN #3 wrote summarizing the incident between Resident #2, Resident #72, CNA #1, and RN #4. Review of these notes indicated the following: "4/26/16. Had a request for conversation with [Resident #2]. [Resident #2] had a concern about the night of 4/25/16. [Resident #2] verbalized that the [CNA #1] on duty was getting [Resident #72] ready for bed. [Resident #2] verbalized that the [CNA #1] was undressing [Resident #72] from the waist down. [Resident #2] stated that she heard [Resident #72] say 'no hurt'. [Resident #2] has orders that she was to be positioned with head no more than 30 degrees. This could and did block her view. [Resident #2] verbalized that she did not say anything to the [CNA #1] but then did voice her concerns to the night nurse. [RN #4] did talk with [Resident #2] and asked her if she thought the [CNA #1] was in a hurry. [Resident #2] verbalized that yes maybe she was. [RN #4] also spoke with [Resident #72]. [Resident #72] verbalized nothing was wrong and that she was fine, just tired. [RN #4] spoke to [CNA #1] to just be relax [sic] and slow down if she was feeling rushed. [CNA #1] verbalized she was fine and sorry about what [Resident #2] stated. I, [RN #3], spoke to [Resident #2] and then also to [Resident #72]. [Resident #72] again verbalized she was		requirement at orientation and annually. The Executive Director (ED) or designee will check the education sigh-in sheet related to this requirement to ensure compliance. In addition, the ED or designee will assess the knowledge of four staff members for compliance per month. Any staff member who is found not to be in compliance will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The ED's audit findings will be reviewed by the Quality Assurance Performance Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.	

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	fine and that nothing happened. [RN #3] did a head to toe check while day shift CNA was changing her brief. No visible skin issues. [Resident #72] denied any C/O (complaint) pain. I [RN #3] reassured [Resident #72] to please inform nursing staff immediately if any time she feels uncomfortable with any staff member. I [RN #3] reassured [Resident #2] that [Resident #72] is fine and thanked her for her love and concern of her roommate. I [RN #3] spoke with the DON and informed her of the situation that came up. We did discuss the possible issue of abuse. There was no evidence and [Resident #2] also never verbalized any account to abuse. The [CNA #1] was in again today. The situation was addressed and the CNA verbalized that she was sorry that [Resident #2] felt the concern, but she did not under any circumstances ever hurt [Resident #72]. [CNA #1] verbalized that [Resident #72] was cold and did not want to take her pants off. [CNA #1] did verbalize that she did feel bad and would never hurt anyone." On 4/28/16 at 1:30 p.m., an interview with RN #3 indicated she was told Resident #2 voiced a concern about CNA #1 being rough taking off her roommate's clothes to RN #4 on 4/25/16. The nurse spoke to Resident #2 and asked her if she			

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	thought maybe it was just the CNA being in a hurry and not really rough and the resident agreed that this may have been the case. RN #4 also spoke with CNA #1 and told her not to rush and take her time. The CNA was not sent home and was allowed to continue working. She indicated she did not know if any other residents or staff were spoken to in order to determine if there was an issue with CNA #1, and confirmed the Director of Nursing was not notified of the incident until the next day, 4/26/16. RN #3 further indicated she discussed this with the Director of Nursing and since there were no signs or indications this could be abuse, it was determined not to be. She also indicated no reports to the State Department of Health, local Ombudsman or Adult Protective Services were made. On 5/2/16 at 11:20 a.m., an interview with the Social Worker indicated she really did not know the whole story of what happened with both residents, but it was her understanding it had already been settled by the time she found out the next day. The Social Worker further indicated she did not follow up with the residents or anyone else as she was told it had been settled and was not considered an abuse incident.			

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	Resident #2's Admission Minimum Data Set (MDS) assessment, dated 2/16/16, indicated the resident scored a 15 out of 15 on her Brief Interview Mental Status (BIMS) which indicated she had no cognitive impairment. Resident #72's Quarterly MDS assessment, dated 3/19/16, indicated the resident scored a 5 out of 15 on her BIMS which indicated she could recall 3 words with clues/prompts, but had poor temporal orientation to place and time; had no mood issues; but did have occasional yelling out with rejection of care 1-3 times during the assessment period. At 2:19 p.m. on 5/2/16, the Staff Development Coordinator presented a copy of the inservices with signature pages held on 11/24/15 and 12/30/15 on "Abuse". Both CNA #1 and RN #4 attended these inservices. The Staff Development Coordinator also presented copies of the Certificates completed online for "Abuse, Neglect and Exploitation in Senior Care Settings". CNA #1 completed her training on 9/24/15 and RN #4 completed her training on 3/11/16. On 4/27/16 at 2:28 p.m., the DON			

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	presented a copy of the facility's current policy titled "General Abuse Policy". Review of this policy at this time included, but was not limited to: "Purpose: To prevent , identify, investigate, and report allegations of abuse while protecting the safety of our residents and respecting our residents' right...Policy: It is RHF policy to promote our residents' right to be free from verbal, sexual, physical, and mental abuse...neglect...or any other forms of abuse. Any such actions by employees and others directed towards our residents is prohibited and appropriate action shall be taken immediately...V. INVESTIGATION. All reports of alleged abuse shall be investigated and documented. VI. PROTECTION. A. Pending/During Investigation: Immediate steps shall be taken to protect a resident who has been subjected to alleged abuse from potential retaliation or further harm while the investigation is in process. Such steps will include, but are not limited to the following: 1. Alleged Abuse by an Employee: In accordance with RHF's Human Resource policies and procedures, employees who have been accused of any type of resident abuse shall be immediately placed on administrative leave until the investigation is completed...VII REPORTING. All abuse concerns,			

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	questions, allegations, and incidents shall be reported immediately according to RHF policies, state and federal law and regulations..." 3.1-28(c) 3.1-29(d)			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to provide medically-related Social Services in that 2 of 2 residents had no follow up for emotional well-being after an allegation of rough handling by a CNA. (Residents #2 and #72) Findings included: During an interview on 4/26/16 at 10:49 a.m., Resident #2 indicated CNA #1 (Certified Nursing Assistant) was rough with her roommate ,Resident #72, while the CNA was undressing the roommate for bed. She indicated her roommate said to the CNA "Stop, it hurt" and "NO NO". Resident #2 further indicated she reported what she heard to the nurse.	F 0250	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Resident #2 and #72 have been provided medically-related social service related to the alleged abuse. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents will be affected. All residents are assessed by social services per the MDS schedule and upon any concern of ANE for the need for follow up on emotional well-being. The Social Services Director will follow up with the provision of the service provision. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All residents are assessed by social services per the MDS schedule	06/03/2016

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	On 5/2/16 at 11:20 a.m., an interview with the Social Worker indicated that she really did not know the whole story of what happened with both residents, but it was her understanding it had already been settled by the time she found out about it the next day. She indicated she did not follow up with the residents or anyone one else as she was told it had been settled and was not considered an abuse incident. Review of the Social Service progress notes, for Resident #2 and Resident #72, indicated no documentation was located concerning Social Services having followed up with either resident after the incident to ensure the residents' emotional well-being. Resident #72's Quarterly Minimum Data Set assessment (MDS), dated 3/19/16, indicated the resident scored a 5 out of 15 on her Brief Interview Mental Status (BIMS) which indicated she could recall 3 words with clues/prompts, but had poor temporal orientation to place and time; had no mood issues; but did have occasional yelling out with rejection of care 1-3 times during the assessment period. Resident #2's Admission MDS, dated 2/16/16, indicated the resident scored a		and in any concern of ANE for the need for follow up on emotional well-being. The Social Services Director will follow up with the provision of the service provision. The ED or his designee will review four social services assessments per month and check for follow up related to emotional well-being needs. The Social Services Director has been provided re-training related to this process. If this team member is found not to be in compliance, s/he will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The ED or his designee will review four social services assessments per month and check for follow up related to emotional well-being needs. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.	

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	15 out of 15 on her BIMS, which indicated she had no cognitive impairment. On 5/2/16 at 10:58 a.m., Human Resources provided a copy of the Social Service's Job Description signed on 1/17/16. Review of this Job Description at this time included, but was not limited to: "Purpose:...The Social Services Director will assure that the medically related emotional and social needs of the resident are attained/maintained on an individual basis...Responsibilities:...9. The Social Service Director will act as the Abuse Prevention Coordinator as in accordance RHF's policies and procedures...11. Will assist in the development, administering, and coordinating of the departments' policies and procedures for the identification of medically related social and emotional needs of the resident..." 3.1-34(a)			
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI)			

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	specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on record review and interview, the facility failed to ensure nutritional assessments were completed when ordered by the wound care physician. This deficient practice affected 2 of 2 residents reviewed with pressure ulcers. (Resident #2 and #45) Findings include: 1. Clinical record review for Resident #2, on 4/29/16 at 9:50 a.m., indicated the resident had diagnoses which included,	F 0272	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. A nutritional assessment was completed for Residents #2 and #45 by the Registered Dietitian (RD). (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents could be affected. A chart audit will be completed to assure that all residents have a nutritional assessment, if ordered. If a	06/03/2016

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	but were not limited to: Stage 3 sacral pressure ulcer, paraplegia due to MVA (Motor Vehicle Accident), pain related to trauma, and anemia. On 3/31/16, the resident was a direct-admit to the hospital from her wound care center appointment for antibiotics and debridement of her pressure ulcer due to it being infected. She returned from the hospital on 4/2/16. Review of the 4/5/16 telephone orders, written by the Wound Care Physician, indicated a new order was given for a nutritional consult to be completed. Review of the Dietary Progress notes failed to indicate an assessment had been completed. The last note documented by Dietary was on 3/7/16. Interview with the Registered Dietitian, on 4/29/16 at 2:00 p.m., indicated she was not aware an order had been written for a nutritional consult. An interview with RN #2, on 5/2/16 at 10:20 a.m., indicated that each resident on the NAR (Nutrition At Risk) program were discussed every week and any new orders or progress notes made by the wound care center were discussed during those meetings.		nutritional assessment was ordered and not completed, the nutritional assessment will be completed in a timely manner. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The clinical team who attend the At Risk Meetings and the nurses will be provided re-education related to the process associated with orders for nutritional assessments. The DON or designee will monitor the process in the At Risk Meetings and complete a monthly audit of a sample of nutritional assessment orders to make sure they have been completed in a timely manner. Any team member who is found not to be in compliance will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The DON or designee will monitor the process in the At Risk Meetings and complete a monthly audit of a sample of nutritional assessment orders to make sure they have been completed in a timely manner. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis for one year.	

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	On 5/02/2016 at 10:23 a.m., an interview with RN #3 indicated if nursing needed to communicate with other departments, there was a communication form that was put on the chart, the facility had a NAR meeting once a week and every morning the department heads met to inform each other if any issues needed to be addressed. She also indicated that if there were any new orders from the doctor or the wound care center, nursing would leave a note on the communication form for dietary. RN #3 also indicated if there was a new order from wound care, an order was placed on the chart, in the wound care book and MDS (Minimum Data Set) personnel got a copy of the orders. RN #3 further indicated if nursing forgot to put an order on the chart, the dietitian or other departments were responsible to look at the orders that pertained to them and follow those orders. Review of the NAR meeting notes indicated the Registered Dietitian did attend the NAR meetings on 4/7/16, 4/14/16, 4/21/16 and 4/28/16 but no discussion of the need for a nutritional consult was mentioned. On 5/2/16 at 8:40 a.m., the Director of Nursing presented a copy of the			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Consultant Registered Dietitian's Job Description. Review of this Job Description at this time included, but were not limited to:...Responsibilities: 1. Assessing the resident's nutrition status which includes weight, intakes, diets etc. to provide estimated kcal (calories), protein and fluid levels....7. Provide nutrition consults from physician orders as provided by the facility.			
F 0279 SS=D Bldg. 00	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. 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. 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).			
	Based on record review and interview, the facility failed to ensure a proper care plan was implemented for 1 of 2	F 0279	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Resident	06/03/2016

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	residents related to pressure ulcers (Resident # 45). Findings include: On 4/28/16 at 8:45 a.m., review of the Quarterly MDS (Minimum Data Set) assessment, dated 01/08/16, for Resident # 45 indicated a BIMS (Brief Interview Mental Status) score of 07. The resident was always incontinent of bladder and occasionally incontinent of bowel. For Functional Status, the resident required extensive assistance with one to two person physical assistance. The resident was independent with eating and required set up assistance only. A Clinical Record review for Resident #45, on 04/28/2016 at 10:45 a.m., indicated diagnoses which included, but were not limited to: acute kidney failure, ileostomy, muscle weakness, anemia, COPD (chronic obstructive pulmonary disease), heart failure, and pulmonary embolism. Resident #45's wound care order set, dated 4/26/16, indicated the resident had an unstageable sacral wound that was improving. A clinical record review for Resident #45, on 05/02/2016 at 11:18 a.m.,		#45 was reassessed by the interdisciplinary care team and the care plan was updated to ensure interventions were individualized related to pressure ulcers. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents' care plans have been updated and will have updates on a schedule and as needed. The care plan is individualized based on the resident's needs for wound care. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The Care Planning nurse or designee will update the care plan. The Unit Manager or designee will check the care plan update to ensure appropriateness of interventions. Any improvements needed will be done in a timely manner. The clinical team will be re-educated on the care planning process and new nurse orientees will be educated related to the care planning process. The Director of Nursing or designee will review a sample of two care plans per month to ensure compliance. Any team member who is found not to be in compliance will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be	

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	indicated there was no care plan for Pressure Ulcers. During a staff interview with the Staff Development Coordinator and the MDS Coordinator, on 05/02/2016 at 12:59 p.m., the Staff Development Coordinator indicated "If a resident has a pressure ulcer there should be a care plan in the care plan book under the nursing tag." After looking through the care plan book the Staff Development Coordinator indicated she did not see a care plan for the pressure ulcers related to Resident #45. The Staff Development Coordinator requested for the MDS (Minimum Data Set) Coordinator to look for a pressure ulcer care plan. The MDS Coordinator indicated she could not find a care plan on pressure ulcers for this resident. The MDS Coordinator indicated, "Nursing is suppose to make the care plans out and she would talk to [RN (Registered Nurse) #2] about [Resident #45's] pressure ulcer care plan not being made out and in the care plan book." 3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(c)(2)(B)		monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Nursing or designee will review a sample of two care plans per month to ensure compliance. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis for one year.	

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F 0281 SS=D Bldg. 00	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.			
	Based on observation, interview, and record review, the facility failed to ensure standards were followed during the administration of nebulizer medication for 2 of 2 residents observed for treatments. (Residents #99 and #142) Findings include: 1. On 04/28/16 at 8:30 a.m., LPN (Licensed Practical Nurse) #1, administered duoneb per MN (mini-nebulizer) 2.5 mg (milligrams)/0.5 mg/3 ml (milliliters) nebulizer treatment to Resident #99. The LPN did not auscultate lung sounds or obtain the respiratory rate. The LPN then left the resident's room, leaving the resident alone with the breathing treatment, to administer medication to another resident. On 04/28/16 at 8:51 a.m., LPN # 1, entered Resident #99's room to turn off the nebulizer machine, after the resident had completed the breathing treatment alone. No auscultation of lungs, respiratory or pulse rates were obtained after the machine was turned off.	F 0281	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. The auscultation of lungs, respiratory or pulse rates were obtained for residents #99 and #142. The nebulizer treatment orders were obtained from the physician and the order was modified in the medication administration record to include the requirement associated with auscultation of lungs and respiratory or pulse rates. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents who have a nebulizer treatment order could be affected. All nurses will be re-educated on the need for this step for nebulizer treatments. (c) What measures will be put into place or what systematic changes you will make to ensure that deficient practices do not recur. All nurses will be re-educated on the need for this step for nebulizer treatments. The DON or designee will complete a check of four different nurses providing nebulizer treatments during the month. IF there are concerns, they will be taken care of in a	06/03/2016

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	A copy of the Physician's Orders was provided by the Business Office Manager on 04/29/16 at 9:25 a.m., which indicated the order for duoneb per MN 2.5 mg/0.5 mg/3 ml for COPD (chronic obstructive pulmonary disease) . No order could be obtained to indicate Resident #99 could self administer the medication. No assessment for self administration could be found in the clinical records. 2. On 04/29/16 at 8:14 a.m., RN (Registered Nurse) #1, administered budesonide 0.5 mg/2 ml inhaled two times daily to Resident #142. The RN checked the resident's O2 SATs (oxygen saturation) at 93%, and turned on the nebulizer. The RN left the resident's room to initial the administration of the resident's medications in the MAR (medication administration record). She then prepared medication to administer for the next resident. The RN returned 15 minutes later to the resident's room to turn off the nebulizer machine, after the resident had completed the breathing treatment alone. A copy of the Physician's Order was provided by the Business Office Manager on 04/29/16 at 8:54 a.m., which indicated the order for budesonide 0.5 mg 2 ml Give one vial per nebulizer two times		timely manner. The nurse will be re-educated on the procedure and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The DON or designee will complete a check of four different nurses providing nebulizer treatments during the month. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis for one year.	

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	daily for COPD. No order could be obtained to indicate Resident #142 could self administer the medication. No assessment for self administration could be found in the clinical records. On 04/29/16 at 9:51 a.m., LPN/Charge Nurse #2 indicated the policy for nebulizer treatment was for staff to check the order, do a respiratory assessment, check lung sounds, O2 SATs , and make sure the equipment was working correctly and stay with the resident during the administration of the nebulizer treatment. After the completion of the treatment, the nurse would check the respirations, lung sounds and O2 SATs and then rinse the equipment and have the resident rinse their mouth. During an interview on 04/29/16 at 10:01 a.m., the DON (Director of Nursing), indicated the expectation for the administration of a nebulizer treatment would be to obtain the pulse, respirations and lung sounds prior to treatment. They would also check the pulse throughout the treatment and stay with the resident while administering the treatment. Afterwards, the nurse would recheck the pulse, respirations and lung sounds. During an interview, on 05/02/16 at 10:21 a.m., LPN #1 indicated before the			

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	administration of a nebulizer treatment, she would listen to the lungs and obtain a pulse. The LPN further indicated she would stay with the resident during the treatment, then turn off nebulizer and recheck the lungs and pulse. During an interview, on 05/02/16 at 10:25 a.m., RN #1 indicated for the administration of the nebulizer treatment, she would explain the procedure to the resident, check the lung sounds and O2 SATs. She indicated to check the pulse before and after the breathing treatment and stay with the resident during the treatment, in a perfect world. The RN #1 indicated she had not stayed with Resident #142 when she administered the breathing treatment on 04/29/16 at 8:14 a.m. On 04/28/16 at 11:00 a.m., the Staff Development Coordinator provided a copy of the facility policy for "Medication Administration Nebulizer (Updraft)." The Procedures indicated, but were not limited to, the following: "5. Obtain baseline pulse, respiratory rate and lung sounds... 13. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer. 14. Monitor for medication side effects,			

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	including rapid pulse restlessness and nervousness. 15. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits. 16. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup. 17. Encourage the resident to cough and expectorate as needed... 19. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. 20. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings on the MAR or in the resident's medical record following facility policy." On 05/02/16 at 9:00 a.m. the DON provided a copy of the Self-Administration of Medication, which indicated, but was not limited to the following: "...1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician." 3.1-35(g)(1)			

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician orders were followed for increased protein on a resident with pressure ulcers (Resident #2). Findings include: Clinical record review for Resident #2, on 4/29/16 at 9:50 a.m., indicated the resident had diagnoses which included, but were not limited to: Stage 3 sacral pressure ulcer, paraplegia due to MVA (Motor Vehicle Accident), pain related to trauma, gastroesophageal reflux disease, peptic ulcer, and anemia. Review of the Wound Care Physician notes between March and May of 2016 indicated the physician ordered increased protein to be given multiple times. There was no documentation in Resident #2's clinical record indicating the orders were completed as written. Albumin levels were: 4/4 = 2.8 (normal range was 3.5 - 5.5) 4/1 = 2.2	F 0282	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Resident #2's orders for increased protein were followed. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents who have orders for improved would healing could be affected. All nurses will be re-educated on the need to follow physician orders. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All nurses will be re-educated on the need for following physician orders. The DON or designee will complete a check of four residents per month to assure orders are being followed. IF there are concerns, they will be taken care of in a timely manner. If there are concerns, the nurse will be re-educated on the procedure and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what	06/03/2016

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	3/31 = 2.8 3/8 = 2.9 The resident received a new order for Beneprotein following readmission on 4/2/16. During an interview with the Registered Dietitian on 4/29/16 at 2:00 p.m., indicated she was not aware orders had been written for increased protein because no one told her about it. The Dietitian did attend the NAR (Nutrition At Risk) meetings on 4/7/16, 4/14/16, 4/21/16 and 4/28/16, but no discussion of the the orders from the physician for increased protein to be given were mentioned. She also indicated she was not aware of the resident's lab results, especially the albumin levels. During an interview with RN #2 on 5/2/16 at 10:10 a.m., she indicated the notes sent back from the wound care center were the orders and recommendations the physician wanted the resident to have. A second interview with RN #2 on 5/2/16 at 10:20 a.m. indicated that each resident on the NAR program were discussed every week and any new orders or progress notes made by the wound care center were discussed during these		quality assurance program will be put in place. The DON or designee will complete a check of four residents per month to assure orders are being followed. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis for one year.	

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	meetings. On 5/02/2016 at 10:23 a.m., an interview with RN #3 indicated if nursing needed to communicate with other departments, there was a communication form that was put on the chart, they had a NAR meeting once a week and every morning the department heads met to inform each other if any issues needed to be addressed. She also indicated that if there were any new orders from the doctor or the wound care center, nursing would leave a note on the communication form for dietary, and there also was a wound care book for the departments to look at. RN #3 also indicated if there was a new order for wound care, an order was placed on the chart, one in the wound care book that was at the desk and MDS (Minimum Data Set) personnel got a copy of the orders also. She indicated if nursing forgot to put an order on the chart, the dietitian or other departments were responsible to look at the orders that pertained to them and follow those orders. 3.1-35(g)(2)			

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F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to ensure a resident maintained acceptable parameters for nutrition, including a therapeutic diet with increased protein for wound healing. This deficient practice affected 1 of 3 residents reviewed for nutrition. (Resident #2) Findings include: Clinical record review for Resident #2, on 4/29/16 at 9:50 a.m., indicated the resident had diagnoses which included, but were not limited to: Stage 3 sacral pressure ulcer, paraplegia due to MVA (Motor Vehicle Accident), pain related to trauma, gastroesophageal reflux disease, peptic ulcer, and anemia. The admission and current diet orders for Resident #2	F 0325	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. A nutritional consult was provided for resident #2 and this resident was provided the therapeutic diet as ordered. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents who have orders for therapeutic diets or a nutritional consult could be affected. All nurses will be re-educated on the need to follow physician orders for therapeutic diets. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All nurses will be re-educated on the need for following physician orders for therapeutic diets and nutritional	06/03/2016

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	was documented as a regular diet. Interview with RN #3, on 4/29/16 at 10:20 a.m., indicated the resident was now on the supplements Beneprotein and Vitamin C for wound healing. Review of the Wound Care Physician's notes between March and May of 2016 indicated the physician ordered increased protein to be given multiple times. There was no documentation in Resident #2's clinical record indicating the order was completed as written. Albumin levels were: 4/4 = 2.8 (normal range was 3.5 - 5.5) 4/1 = 2.2 3/31 = 2.8 3/8 = 2.9 On 4/2/16 the resident received a new order for Beneprotein. On 4/5/16, the Wound Care Physician wrote an order for a nutritional consult to be completed. Review of the Dietary Progress notes failed to indicate an assessment had been completed. During an Interview, on 4/29/16 at 2:00 p.m., The Registered Dietitian indicated she was not aware the order had been written because no one told her about it.		consults. If there are concerns, they will be taken care of in a timely manner. The DON or designee will complete a check of four residents per month to assure orders are being followed for therapeutic diets and/or nutritional consults. If there are concerns, the nurse will be re-educated on the procedure and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The DON or designee will complete a check of four residents per month to assure orders are being followed for therapeutic diets and/or nutritional consults. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis for one year.	

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	The Dietitian did attend the NAR (Nutrition At Risk) meetings on 4/7/16, 4/14/16, 4/21/16 and 4/28/16, but no discussion of the need for a nutritional consult or the orders from the physician for increased protein to be given were mentioned. She also indicated she was not aware of the resident's lab results, especially the albumin levels. Interview with RN #2, on 5/2/16 at 10:10 a.m., indicated the notes sent back from the wound care center were the orders and recommendations the physician wanted the resident to have. A second interview with RN #2, on 5/2/16 at 10:20 a.m., indicated that each resident on the NAR program were discussed every week and any new orders or progress notes made by the wound care center were discussed during these meetings. Review of the NAR meeting notes and the Dietitian notes with the Registered Dietitian, indicated the Registered Dietitian confirmed no documentation could be located where the resident's slow weight loss and wounds were addressed. Review of the physician orders and the Dietary section of the clinical record with			

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	the Assistant Dietary Manager and the Dietitian failed to locate a slip which indicated the resident was receiving a supplement. When questioned about adding increased protein to the resident's diet, RD indicated that she found most residents did not like the Beneprotein so she was limited as to what to use. She also indicated she was unsure what type of nutritional snacks/food items to offer the resident to help with nutrition, especially protein. Review of the Medication Administration Record (MAR) for April 2016 indicated the resident accepted her Beneprotien supplement every day as ordered. A 2/15/16 Care plan with review dates of 2/24/16 and 3/7/16 was developed for: - Problem - "At nutritional risk r/t (related to) paraplegia secondary to MVA". - Goal - "Will receive appropriate textured diet. Will consume adequate percent of meals and snacks to maintain stable weights." - Approaches - "Provide regular diet as ordered. Honor food preferences. Provide appropriate textured snacks, fluids, and			

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	supplements as ordered. Monitor and record intakes. Monitor and record weights each month. Encourage fluids and intakes. Labs as ordered." On 4/29/16 at 1:19 p.m., the Director of Nursing presented a copy of the facility's current policy titled : "Nutritionally at Risk Residents". Review of this policy at this time included, but was not limited to: "Policy: Nutritionally at Risk (NAR) residents are identified in a timely manner and monitored frequently. Procedures: 1. "Nutritionally at Risk" (NAR) residents are identified through the admission process as well as planned NAR screening process (monthly screening or weights, intakes and skin records). 2. Nutritionally at risk (NAR) residents include:...residents exhibiting significant weight loss of 5% or more in one month (and who are not on a weight reduction diet)...residents with pressure sores of Stage 2 or higher...9. Each resident considered Nutritionally at Risk is documented in the Medical Record, by the Registered Dietitian, a minimum of once a month, as time allows..." On 5/2/16 at 8:40 a.m., the Director of Nursing presented a copy of the Consultant Registered Dietitian's Job Description. Review of this Job Description at this time included, but was			

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	not limited to:..7. Provide nutrition consults from physician orders as provided by the facility... 3.1-46(a)(1) 3.1-46(a)(2)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash			

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	their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to perform handwashing per facility policy during 3 of 3 observations for medication administration (Residents #92, #99, and #81). Findings include: 1. On 04/28/16 at 11:38 a.m., LPN (Licensed Practical Nurse)/Charge Nurse #2, performed a blood sugar check on Resident #92. After removing her gloves, she rubbed her hands together for 15 seconds, with a total handwashing time of 30 seconds. The LPN obtained the insulin and returned to the room. During handwashing, she rubbed her hands together for 19 seconds, with a total handwashing time of 33 seconds, and applied gloves. After administering the insulin, she removed the gloves and washed her hands, rubbing her hands together for 17 seconds, with a total handwashing time of 38 seconds.	F 0441	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Nurses (LPN/Charge Nurse #2, LPN #1) providing medication administration for residents #92, #99 and #81 were re-educated on the hand washing protocols and completed competency review successfully. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents could be affected. All nurses were provided a hand washing competency review and an in-service associated with infection control. Any newly hired nurses will be provided a hand washing competency review and an in-service associated with infection control. (c) What measures will put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All nurses will be provided a hand washing competency test and will be educated on infection control at orientation and annually. The Director of Nursing or designee will visualize four nurses'	06/03/2016

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	2. On 04/28/16 at 8:30 a.m., LPN #1 entered Resident #99's room to administer a breathing treatment. She performed handwashing, rubbing her hands together for 10 seconds, with a total handwashing time of 25 seconds. 3. On 04/28/16 at 8:49 a.m., LPN #1 entered the room of Resident #81 and administered medication to the resident. Afterwards, she performed handwashing, rubbing her hands together for 14 seconds, with a total handwashing time of 29 seconds. 4. On 04/28/16 at 8:51 a.m., LPN #1 entered the room of Resident #99 to turn off the breathing treatment. She then performed handwashing, rubbing her hands together for 10 seconds, with a total handwashing time of 22 seconds. During an interview with LPN #1, on 05/02/16 at 10:21 a.m., she indicated for handwashing, she would keep her hands pointed downward, turn on the faucet, get soap, and lather up, washing her nails, fingers, and around the thumbs for 30 seconds or for one minute if contaminated. She would then rinse, holding her hands downward, dry her hands with a paper towel, and turn off faucet with another dry towel.		medication administration hand washings per month to ensure compliance. Any nurse who is found not to be in compliance with hand washing procedures will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s0 will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Nursing or designee will visualize four nurses' medication hand washing per month to ensure compliance. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.	

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	During an interview on 05/02/16 at 10:25 a.m., RN (Registered Nurse) #1 indicated for handwashing, she would get the water warm, get a paper towel and wash her hands, doing the birthday song twice, scrubbing. She would then rinse off her hands and get a paper towel and dry. She would then get another paper towel to turn off the water. During an interview on 05/02/16 at 1:51 p.m., the DON (Director of Nursing) indicated the staff should wash their hands before coming out of rooms. The facility follows the CDC (Centers for Disease Control and Prevention) guidelines for hand washing and the staff are trained upon hire and annually by Staff Development. During an interview, on 05/02/16 at 2:20 p.m., the Staff Development Coordinator indicated handwashing in-services were provided to staff upon hire and annually. She then indicated handwashing in-services were performed two times per year. The Staff Development Coordinator further indicated she teaches staff to rub their hands together for 20 seconds for normal care and for contaminated care they should rub hands together for one minute, or sing happy birthday twice.			

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	The Procedure # 3: HANDWASHING/HANDRUB in-service indicated, but was not limited to the following: "...NOTE: Direct caregivers must rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers." 3.1-18(l)			
F 0460 SS=D Bldg. 00	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. Based on observation and interview, the facility failed to ensure resident bedrooms had full visual privacy, in that curtains were too short when pulled around the resident bed, and/or were hanging off the ceiling tracks. This deficient practice affected 3 of 35	F 0460	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Privacy curtains have been replaced and hung correctly for rooms #223B, #220A and #220B. (b) How you will identify other residents having	06/03/2016

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	resident rooms observed. (Rooms #223B, #220A and 220B). Findings include: During initial room observations, on 4/26/16 at 11:03 a.m. and again at 1:48 p.m., the following was observed: 1. Room 223B - the curtain between the beds was caught at the junction and would not pull across the foot of the bed to assure full visual privacy when extended. 2. Room 220A - Bed 1 privacy curtain was 3 feet too short when fully extended. The curtain between the beds was 8 inches too short when fully extended due to empty hooks in the way. 3. Room 220B - The right curtain to the window which looked outside had the first hook off its track which left a 3 inch gap to the outside side yard. The curtain between the beds was 8 inches too short when fully extended due to empty hooks in the way. During an interview on 4/29/2016 at 10:01 a.m., the Director of Nursing (DON) indicated the curtains in the bedrooms should assure the residents have full privacy.		the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents could be affected. Resident room privacy curtains will be checked by housekeeping team members assigned on a daily basis to ensure that they are hung correctly and assure privacy. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All housekeeping staff will be re-educated on checking the privacy curtains on a daily basis. Any concerns from the daily check will be addressed in a timely manner. The Director of Housekeeping or designee will audit privacy curtain compliance on a weekly basis. Any housekeeping team member who does not report privacy curtain concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Housekeeping or designee will audit privacy curtain compliance on a weekly basis. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI	

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	3.1-19(l)(6)		for a period of one year.	
F 0465 SS=D Bldg. 00	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 provide a sanitary and comfortable environment in that bedroom floors were sticky, cove baseboards were loose and/or missing, wall plaster was chipped and cracked, and cob webs were observed on sprinkler heads and ceilings. This deficient practice affected 5 of 35 resident rooms. (Rooms #223, #220, #221, #107, and #106) Findings include: 1. During the initial room observations on 4/26/16 at 11:03 a.m. and at 1:46 p.m., the following was observed: a. Room 223 - the floor was sticky by the window side of bed (Bed B). Review of staff meeting notes, dated 3/10/16, indicated the resident's family member complained of the room not being cleaned at times. b. Room 220 - the cove base boards behind the left side of and behind the	F 0465	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Repairs and cleaning were performed for rooms #2d23, #220. #221, #107 and #106. (b) How you will identify other residents having potential to be affected by the same deficient practice and what corrective actions will be taken. All residents could be affected. Resident rooms' cleanliness will be checked by housekeeping team members assigned on a daily basis. The Maintenance Director and his team have completed an audit of all residents rooms. Repairs of cove baseboards and wall plaster will be completed as needed. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All housekeeping staff have been re-educated on assuring cleanliness of floors and sprinkler heads and ceilings. Any concerns will be addressed in a timely manner. The Director of Housekeeping or designee will audit cleanliness compliance on a	06/03/2016

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	commode was loose approximately 18 inches in length. Cob webs were observed on the bathroom sprinkler, in the corners of the bathroom near the ceiling and behind the room door near the ceiling for 2 of 2 observations. c. Room 221 - upon the entrance to the bathroom, the right bottom side of the wall had chipped and cracked plaster with missing cove base board approximately 8 inches in length. 2. During the initial room observations, on 4/26/16 from 10 a.m. to 1 p.m., the following observations were made: a. Observations in room 107's bathroom: In front of the toilet the tile was a brown sticky substance, protruding from the floor one inch in height, and one inch in diameter. b. Observations in room 106's bedroom: The baseboard was pushed in 8 inches in length. During an interview on 4/29/2016 at 10:01 a.m., the Director of Nursing (DON) was asked for an environmental/ maintenance policy and no policy was provided. During an interview on 5/4/2016 at 10:38 a.m., the Maintenance Director		weekly basis. Any housekeeping team member who does not report housekeeping concerns that cannot be completed will be re-educated and counseled as necessary with the progressive disciplinary process. All maintenance staff have been re-educated on assuring repair of cove baseboards and wall plaster as needed. Any concerns will be addressed in a timely manner. The Director of Maintenance or designee will audit maintenance repair of cove baseboards and wall plaster on a monthly basis. Any maintenance team member who does not report cove baseboard and wall plaster concerns that cannot be completed will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Housekeeping will audit resident room cleanliness compliance on a weekly basis. The Director of Maintenance or designee will audit repair of cove baseboards and plaster repair compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.	

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	acknowledged all of the above issues. 3.1-19(f)			
F 0469 SS=D Bldg. 00	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview and record review, the facility failed to provide a pest free environment for 1 of 35 bedrooms observed and 1 hallway observed. (100 hallway and Room #106) Findings include: During an observation in room 106, on 04/26/16 at 10:05 a.m., a rodent-insect glue trap, under the air unit, had numerous bugs and one dead lizard. During an observation in the 100 hallway, on 4/26/16 at 10:30 a.m., 6 out of 7 of the overhead lights had numerous bugs in the light coverings. During an interview on 4/26/2016 at 10:38 a.m., the Housekeeping Supervisor	F 0469	(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Pest elimination was completed on room #106 and hallway 100. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents could be affected. Hallway and resident rooms' pest control will be checked by housekeeping team members assigned on a daily basis. The Housekeeping Director and his/her team have completed an audit of all resident rooms and hallways. Pest control has been completed as needed. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All housekeeping staff will	06/03/2016

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	indicated it was the responsibility of the Certified Nursing Assistants to check the rodent-insect glue traps and dispose of them. During an interview, on 4/29/2016 at 10:01 a.m., the Director of Nursing (DON) indicated it was the responsibility of the housekeeping staff was to check and dispose of the rodent-insect glue traps. The current Policy and Procedure dated June 24, 2011 and titled "Pest Control" was provided by the DON on 4/28/16 at 2:30 p.m. It included, but was not limited to, the following: "...3. Each Housekeeper will be provided with a copy of a list of rooms that have a pest glue board... 4. Housekeeping Staff shall check all Pest glue boards daily for Pest. Should a pest be inside of the box, the Housekeeper will contact Maintenance for removal of the box. Housekeeping staff may in the absence of Maintenance staff remove the glue board..." 3.1-19(f)(4)		be re-educated on assuring pest control in resident rooms and hallways. Any concerns will be addressed in a timely manner. The Director of Housekeeping or designee will audit pest control compliance on a weekly basis. Any housekeeping team member who does not report pest control concerns that cannot be completed will be re-educated and counseled as necessary with progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be in place. The Director of Housekeeping or designee will audit resident room pest control compliance on a weekly basis. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential census: 90 Sample: 7 The following residential findings were cited in accordance with 410 IAC 16.2-5. Quality review completed by 34233 on May 11, 2016	R 0000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law. Westminster Health Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor are they of such character so as to limit its ability to render adequate care. This plan of correction shall operate as Westminster Health Care Center credible allegation of compliance. This plan of correction is not meant to establish a standard of care, contract, obligation of position and Westminster Health Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to provide a clean, comfortable, and functional environment in the dining room and hallways on the second floor. This had the potential to affect 90 out of 90 residents who dined on the second floor.	R 0144	1. Sanitation and Safety Standards (a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Water stained tiles were replaced with new tiles on 2 South hallway. (b) How you will identify other residents having the potential to be affected by same deficient	06/03/2016

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129	

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	Findings include: During an observation on 6/4/16 that began at 9:00 a.m., the following was observed: 1. On the 2 South Hallway, there were three water stains on the tiles, two of the stains measured 3 inches by 3 inches, and one stain measured 6 inches by 4 inches. 2. In the entrance to the hallway for rooms 212-220 was a raised area in the carpet that measured 60 inches long by 6 inches wide by one inch tall. 3. In the entrance to the hallway for rooms 221-228 was a raised area in the carpet that measured 60 inches long by 6 inches wide by one inch tall. 4. In the entrance to the hallway for rooms 201-211 was a raised area in the carpet that measured 36 inches long by 24 inches wide by one inch tall. 5. In the second floor dining room entrance to the bathroom, was a raised area in the carpet that measured 60 inches long by 12 inches wide by one inch tall. 6. In the second floor dining room floor, was a raised area in the carpet that measured 60 inches long by 6 inches		practice and what corrective actions will be taken. All ceilings in the facility will be audited to assure all stained tiles are replaced. No residents were affected. All ceiling tiles will be audited weekly by maintenance staff assigned on a weekly basis to ensure that they are clean without stains. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All maintenance staff will be re-educated on checking the ceiling tiles on a weekly basis. Any concerns from the weekly check will be addressed in a timely manner. The Director of Maintenance or designee will audit ceiling tiles on a monthly basis. Any maintenance team member who does not report ceiling tile concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit ceiling tiles for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year. 2.	

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	wide by one inch tall. 7. In the second floor dining room bathroom on the floor was a crack that measured 36 inches long by one inch wide. 8. In the second floor dining room there were multiple stains that measured the following: red stain 12 inches by 12 inches, red stain 12 inches by 9 inches, red stain 6 inches by 3 inches, brown stain 12 inches by 12 inches, black stain 15 inches by one inch, black stain 8 inches by 8 inches, black stain 3 inches by 3 inches, black stain 6 inches by 2 inches, 36 black stains measuring one inch in diameter. During an interview on 4/29/2016 at 10:01 a.m., the Director of Nursing (DON) was asked for an environmental/maintenance policy and no policy was provided. During an interview on 5/4/2016 at 10:38 a.m., the Maintenance Director acknowledged all of the above issues. 16.2-5-1.5(a)		Sanitation and Safety Standards. (a) What corrective actions will be accomplished for the residents found to have been affected by the deficient practice. The contractor agreement has been initiated to repair raised concrete causing the carpet to be raised in the entrance to the rooms 221-220. Also to be repaired at that time is the raised areas in the entrance to the hallway for 201-211 and 212-220. The time frame of Completion of repairs is as follows: The repair of floor and carpet replacement to those areas will be completed by 6/3/2016. We are requesting an extension for the repair of those uneven areas. (b) All residents could be affected by the raised areas in the carpet in hallway and entrances to resident's rooms. Hallways and residents rooms will be checked by maintenance team members assigned on a weekly basis to ensure that there are no safety issues regarding raised floors. Any maintenance team member who does not report raised carpet concerns will be re-educated.(c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. All maintenance staff will be re-educated on checking the hallways on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of	

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			Maintenance or designee will audit the hallways on a monthly basis. Any maintenance team member who does not report carpet concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit floors for unsafe raising of floors on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year. 3 Sanitation and Safety Standards (a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice. Contractor agreement is in place for all stain carpeting in 2nd floor dining and the cracked tile in dining room restroom will be removed and replaced with laminate flooring. The construction began on May 13, 2016. (b) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents could be affected. Carpet is in the process of being removed in dining room and tile in dining room restroom. There will	

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			be no potential stains. The cracks in the dining room restroom are being leveled before placing the laminate. The time frame of competition per contractor is projected to be 6/3/2016. We request an extension for the dining room and bathroom repairs. (c) What measures will be put into place or what systematic changes will make to ensure that the deficient practices do not recur. With the carpet being removed and the floors leveled in both the dining room and the restroom, there will be no further stains on carpet or cracks in tiles in restroom. The flooring in the dining room and dining room restroom will be checked monthly to ensure that are no concerns. Any concerns will be addressed in a timely manner. The Director of Maintenance or designee will audit for compliance monthly. Any maintenance team member who does not report flooring will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit and monitor dining room and dining room restroom for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement	

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			Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.	