

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155344	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/09/2013
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HWY 20 E MICHIGAN CITY, IN 46360
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey Dates: August 5, 6, 7, 8, &amp; 9, 2013</p> <p>Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700</p> <p>Survey Team: Heather Tuttle, RN. TC. Lara Richards, RN. Cynthia Stramel, RN. Yolanda Love, RN. Janelyn Kulik, RN.</p> <p>Census Bed Type: SNF/NF: 77 Total: 77</p> <p>Census Payor Type: Medicare: 18 Medicaid: 51 Other: 8 Total: 77</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 14, 2013, by Janelyn Kulik, RN.</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and it also not to not to be construed as of an admission of interest against the facility, the Administrator or any employee or agents, or any other individuals who draft or may be discussed in the Plan of Correction. In addition preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirement under State and federal law that mandates submission of the Plan of Correction a condition to participate in the Title 18 and Title 19 programs. The submission of this plan of correction within this timeframe should in no way be of non-compliance or admission by the facility. This provider is respectfully requesting paper compliance. If accepted, all</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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			documentation will be faxed or mailed as requested.	

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each residents' dignity was maintained during dining related to being called "honey" and "baby girl" for 2 residents in the West dining room for 1 of 1 meals observed. (Residents #4 and #13)</p> <p>Findings include:</p> <p>On 8/5/13 at 12:04 p.m., in the West dining room, LPN #1 was observed to call Resident #4 "baby girl" while repositioning her in her broda chair. The LPN then proceeded to call Resident #13 "honey" while cuing her to eat.</p> <p>Interview with the Staff Development Coordinator on 8/8/13 at 12:00 p.m., indicated that staff should not call the residents "sweetheart or honey" and that it was a dignity issue.</p> <p>3.1-3(t)</p>	F000241	<p>1) Resident #4 and #13 were not adversely affected by staff calling them "honey and baby girl".2) A resident choice assessment was completed on all other residents for preferences on terms of endearment on 8/14/13 and 8/15/13 by the Director of Nursing (DON)/designee. Those who are unable to answer, a family member will be contacted for resident preferences.3) Staff were in-serviced on 8/8/13 and 8/12/13 by the Staff Development Coordinator (SDC) on calling residents by their name or the resident's preference. The Administrator/designee will randomly audit the dining rooms 3 times weekly, to include all three meals, to ensure residents are spoken to in a respectful manner.4) Resident Dignity will be discussed at Quality Assurance meeting on 8/21/13 and the dignity audits will be presented to QA monthly x 3 months or until 90% compliance has been achieved for 3 consecutive months. 5) Date certain is Sept 8, 2013.</p>	09/08/2013			

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident's choice was honored related to the time they liked to get up in the morning for 1 of 1 residents reviewed for choices of the 1 resident who met the criteria for choices. (Resident #115)</p> <p>Findings include:</p> <p>On 8/8/13 at 5:35 a.m., Resident #115 was observed dressed and seated in her wheelchair in the West dining room.</p> <p>The record for Resident #115 was reviewed on 8/7/13 at 8:35 a.m. The resident's diagnosis included, but was not limited to, cerebral vascular accident (CVA/stroke).</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated 7/30/13, indicated the resident was unable to complete the BIMS (Brief</p>	F000242	<p>1) Resident # 115 was not adversely affected by getting out of bed early. The resident does not usually get up early.2) A resident Choice assessment was completed 8/14/13 by the DON/designee on all other residents for preference on getting out of bed. Those who were unable to answer, the next of kin will be contacted and asked for the resident preferences. Resident Care Guides were updated to include resident preferences. Resident choice assessment was added to the admission assessments.3) Staff were in-serviced on 8/12/13 by the SDC on the updated Resident Care Guides and resident preferences. Resident choice assessments will be updated quarterly with the resident's MDS. Five (5) choice assessments will be audited for completion weekly with the MDS.4) Resident choice assessment audits will be discussed at the Quality Assurance meeting on 8/21/13 and monthly for 3 months or until 90% compliance has been</p>	09/08/2013	

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	<p>Interview for Mental Status) interview. The MDS, also indicated the resident was extensive assist for transfers out of bed.</p> <p>Review of the 5/28/13 "Choice" assessment form, indicated the resident "can't answer", there was a question on the form related to what time the resident preferred to get up in the morning. The resident's family had not been interviewed.</p> <p>Interview with the resident's family member on 8/5/13 at 2:46 p.m., indicated she had been told the resident was gotten up every morning between 5:00 and 5:30 a.m. The resident's family member indicated the resident did not get up that early at home. She also indicated that she visited daily.</p> <p>Interview with CNA #2 on 8/8/13 at 6:15 a.m., indicated there was no set "get up" list for the midnight shift. She indicated the residents are asked if they want to get up. She indicated the resident was gotten up everyday between 5:00 and 5:30 a.m. as well as her roommate.</p> <p>Interview with the Director of Nursing on 8/9/13 at 8:20 a.m., indicated the resident's "Choice Assessment" had</p>		<p>achieved for 3 consecutive months.5) Date certain is 9/8/2013.</p>				

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	<p>not been completed. She indicated the resident's sister would need to be contacted due to the resident would not be able to answer the questions.</p> <p>3.1-3(u)(3)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written related to obtaining a dental consultation for 1 of 1 residents reviewed for dental status and services of the 1 resident who met the criteria for oral status observation. (Resident #66)</p> <p>Findings include:</p> <p>On 8/6/13 at 10:00 a.m., Resident #66 was observed to have broken upper teeth. What was remaining of the teeth in front, were black in color. Interview with the resident at this time, indicated that her upper teeth were broken off and it seemed like some of the teeth were "growing back."</p> <p>The record for Resident #66 was reviewed on 8/6/13 at 1:55 p.m.</p> <p>The bi-monthly summaries dated 5/29, 6/13, 6/27, and 7/11/13, indicated the resident needed assistance with oral hygiene and had</p>	F000282	<p>1) Resident #66 was seen by the Dentist on 8/13/13.2) An audit was conducted on 8/6/13 by Social Service Director of all residents in the facility at least 12 months, to ensure an annual dental exam was conducted. Those identified as not having an exam, a letter will be sent, by the social service director, to the responsible party to schedule an exam.3) Staff were in-serviced on 8/12/13 by the SDC on providing yearly dental exams. Should the licensed nurse determine that a resident is in need of a dental exam, he or she will notify the Social Service Director and an appointment will be scheduled.4) Resident dental audits will be discussed monthly at the Quality Assurance meeting x 3 months or until 90% compliance has been achieved for 3 consecutive months.5) Date certain is 9/8/2013.</p>	09/08/2013

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	<p>her own teeth.</p> <p>The Oral assessment form dated 7/29/13, indicated the resident had some missing upper and lower teeth.</p> <p>The resident's Significant change Minimum Data Set (MDS) assessment dated 10/29/12, indicated the resident had obvious or likely cavity or broken natural teeth.</p> <p>The plan of care dated 2/8/13, indicated the resident exhibited dental/mouth problems as evidenced by cavities/decay. The interventions included, but were not limited to, consider consults as indicated (dental) and discuss oral health concerns with the resident or responsible party.</p> <p>Review of the "Consult" section in the resident's record, indicated there were no dental progress notes for review.</p> <p>Interview with the Social Service Director (SSD) on 8/7/13 at 12:30 p.m., indicated the resident was on the list in January 2013 to be seen by the dentist. She indicated she would call for the notes. Continued interview indicated that Primesource indicated the resident had denied consent. The</p>						

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	<p>SSD looked in the resident's record and indicated that she did sign consent upon admission. She indicated since Primesource did not have consent, more than likely she had not been seen. Interview with the SSD at 12:37 p.m., indicated Primesource indicated they were under the impression the resident refused everything except podiatry. The SSD indicated she was refaxing the consent sheet to Primesource and the dentist was scheduled to be at the facility on Tuesday 8/13/13 and the resident would be seen.</p> <p>Interview with the SSD on 8/7/13 at 12:59 p.m., indicated the resident's admission papers were pulled from the business office and the total care consent form indicated podiatry services was the only one approved. When asked if the resident had her own dentist out in the community, the SSD was not aware. She indicated the resident's daughter was her Power of Attorney (POA) and took care of everything. She indicated that she would contact the resident's daughter and see if she had a dentist out in the community. She indicated that she did not understand why nursing did not notify her of the resident's carious teeth.</p>						

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	<p>Interview with the SSD on 8/8/13 at 9:15 a.m., indicated that she had contacted the resident's daughter and that she was going to come in to sign the consent form for the resident to be seen by the Dentist. The SSD indicated the resident was going to be added to the Primesource list and be seen by the dentist on Tuesday.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the necessary care and services were provided related to positioning of a dependant resident in a wheelchair for 1 of 2 residents reviewed for positioning of the 2 who met the criteria for positioning . (Resident #34).</p> <p>Findings include:</p> <p>On 8/5/13 at 11:15 a.m., Resident #34 was observed in her Broda chair (a specialty wheelchair) in the activity area. Both legs were pulled up toward her chest, she was leaning to the right side, and sliding down with her head resting on the arm rest of the chair.</p> <p>On 8/7/13 at 10:00 a.m., the resident was observed in her Broda chair in her room. She was leaning to the right, her right arm and head were hanging over the arm rest. At 12:12 p.m., the resident was observed at</p>	F000309	<p>1) Resident #34 was evaluated again on 8/12/13 for seating and positioning. Staff were educated on resident's seating and positioning on 8/8/13. The resident's Care Plan reflects the residents positioning habits.2) An audit of other residents was conducted on 8/12/13 for seating and positioning by the Rehab Service Manager (RSM) and DON. Any identified residents will be evaluated by the therapy department.3) Staff were in-serviced 8/12/13 by the SDC for repositioning resident and referring residents to therapy when deemed necessary.4) An audit for residents seating and positioning will be completed monthly by the RSM. Audits will be discussed monthly at the QA meeting for 3 months or until 90% compliance has been achieved for 3 consecutive months.5) Date certain is 9/8/2013.</p>	09/08/2013			

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	<p>the dining room table in her Broda chair. She was leaning to the right, with her head hanging over the arm rest of the chair. At 1:55 p.m., the resident was observed in bed. The Broda chair was in her room, the Dycem mat (a thin mat used to prevent sliding) was underneath a blanket on the seat. It was folded in half, crumpled and pushed to the right side of the seat, not covering the seat.</p> <p>On 8/8/13 at approximately 1:15 p.m., the resident was observed being put into bed by CNA #1. The Broda chair had a chair alarm pad on the seat, underneath the pad was the Dycem mat. The Dycem mat was crumpled and pushed to the right side of the seat. Interview with the CNA at that time, indicated the Dycem mat should not be crumpled and pushed to the side of the seat, it should be spread out flat on the seat cushion and on top of the chair alarm pad. The CNA further indicated if the resident's head was hanging over the side of the wheelchair armrest, that meant the resident needed to be repositioned.</p> <p>On 8/9/13 at 9:30 a.m., the resident was observed in her Broda chair in the activity area. She was leaning to the right, her head was on the arm</p>			

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	<p>rest and both feet were hanging off the foot rests of the Broda chair.</p> <p>The resident's record was reviewed on 8/6/13 at 1:52 p.m. The resident's diagnoses included, but were not limited to, Parkinsons, CVA (stroke), late effect hemiplegia, and dementia.</p> <p>A Minimum Data Set (MDS) assessment dated 5/14/13, indicated the resident was totally dependant for bed mobility and transferring.</p> <p>A care plan updated 3/4/13, indicated a problem of self care deficit related to advanced dementia, weakness and cognitive impairment. Approaches included for nursing staff to provide ADL (activities of daily living) care to ensure daily needs were met.</p> <p>A care plan updated 3/4/13, indicated a problem of falls related to disease process, Parkinsons, and advanced dementia. Approaches included to provide and observe use of adaptive devices such as the Broda chair and Dycem mat.</p> <p>The August 2013 Treatment Flowsheet, indicated the use of a Dycem mat to provide upright positioning when in Broda chair was initiated on 3/24/13.</p>			

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	<p>An inservice was provided to nursing staff by Occupational Therapy on 11/28/12 regarding repositioning and straightening her legs out when in the Broda chair. An Updated Plan of Treatment by Physical Therapy dated 11/27/12, indicated caregiver education was provided related to positioning when in the Broda chair.</p> <p>Interview with the Occupational Therapist on 8/7/13 at 3:02 p.m., indicated the resident had been previously evaluated for positioning issues. A Broda chair was used to provide lateral support. She indicated when the resident was observed leaning in one direction or her head was touching the arm rest, that should be a cue to nursing staff to recline the Broda chair or reposition the resident. She further indicated the correct use of the Dycem mat was to be flat and placed underneath the cushion on the wheelchair to prevent sliding down.</p> <p>3.1-37(a)</p>				

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F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review, and interview, the facility failed to ensure Restorative Therapy was initiated in a timely manner after the discontinuation of the Skilled Services of Physical and Occupational Therapy which consisted of weekly assessments and a plan of care for 1 of 2 residents reviewed for positioning of the 2 residents who met the criteria for positioning. (Resident #45)</p> <p>Findings include:</p> <p>On 8/05/13, at 11:21 a.m., Resident #45 was observed in her wheelchair. The resident was leaning to the right side in her chair with her right arm dangling on the side by the wheel spokes of the wheelchair.</p> <p>The record for Resident #45 was reviewed on 8/6/13 at 1:27 p.m. The resident was admitted to the facility on 5/12/13 from the hospital. The resident's diagnoses included, but were not limited to, high blood pressure, stroke, anxiety, and shortness of breath.</p>	F000311	<p>1) Resident # 45 was not adversely affected by the delay in receiving restorative services. Resident was placed on restorative on 7/7/13.</p> <p>2) All other residents that were discharged from therapy from August 1, 2013 were audited for timely restorative services on 8/13/13 by the RSM and DON. Any residents identified were initiated in restorative services. The form Restorative Nursing Program was revised to include dates. A new policy was written to indicate that restorative programs should be initiated (within 72 hours) after therapy discharge.</p> <p>3) Staff were in-serviced on 8/12/13 by the SDC on completing a Restorative Nursing Program form with dates and on initiating a restorative program timely. An audit of the Restorative Nursing Program form will be conducted weekly by the Restorative Nurse to ensure timely admission to the restorative program.</p> <p>4) The restorative audits will be discussed at the QA meeting monthly x 3 months or until 90% compliance has been achieved for 3 consecutive months.</p>	09/08/2013	

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	<p>Review of Physician Orders dated 6/24/13, indicated the resident was to be discontinued from Physical and Occupational Therapy services secondary to having reached her highest potential.</p> <p>Review of the Restorative Nursing Program Assessment Plan (undated) indicated the resident's current functional status was ambulation with rolling walker 60 feet with contact guard assist and arm bike for upper extremities. The resident's problem was with poor endurance. The rest of the form was not completed including recommended approaches and devices to be used, frequency, duration, restorative program summary goals, precautions, and the signature and date of the Restorative Nurse.</p> <p>Interview with the Director of Rehab on 8/6/13 at 3:09 p.m., indicated the resident's last day of Physical Therapy was 6/21/13 and the last day for Occupational Therapy was 6/22/13. She further indicated the actual referral date for the resident to have received Restorative Therapy would have been the discharge date of the skilled therapies. .</p>		5) Date certain is 9/8/2013.				

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	<p><b>Review of the Nursing Rehabilitation/Restorative Daily flow sheets indicated the resident's first day of restorative therapy was on 7/7/13 (15 days after she had been discharged from Physical and Occupational Therapy). The resident received Restorative therapy on 7/7, 7/8, 7/9, 7/10, 7/15-7/20, 7/21, 7/23-7/27, and 8/4-8/6/13.</b></p> <p>Further review of the Restorative Flow Sheets indicated there were no comments on any of the sheets to indicate how the resident was progressing. There were no further assessments of the resident's progress towards her goals.</p> <p>Interview with the Restorative Nurse on 8/6/13 at 2:43 p.m., indicated she had one full time CNA and one part time CNA for Restorative care. She indicated the resident was to receive Restorative Therapy six times a week for 90 days. The Restorative Nurse indicated the resident's first day of therapy was not until 7/7/13 and she had no explanation as to why it had not been started immediately after Physical and Occupational Therapy were discontinued. She further indicated there were no Restorative Progress Notes or assessments of the resident's weekly progress nor</p>			

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	<p>was there a plan of care for Restorative Therapy.</p> <p>Review of the current and undated Restorative Services Policy provided by the Restorative Nurse on 8/6/13 at 3:15 p.m., indicated residents were reviewed weekly in a Restorative Team Meeting. The Restorative assessment identified the level of functioning and includes the following steps: provide a detailed description of the resident's current abilities (identifying not only deficiencies, but more importantly the resident's strengths). Establish resident specific restorative-oriented goals and outcomes, consistently review and revise as needed and document whether the goals/outcomes have been met. Develop a comprehensive care plan identifying the level of nursing care maintenance, restorative, or skilled therapies.</p> <p>3.1-38(a)(2)(B)</p>				

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure there was an indication for the use of a hypnotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #143)</p> <p>Findings include:</p> <p>The record for Resident #143 was reviewed on 8/6/13 at 1:25 p.m. The resident's diagnoses included, but were not limited to, anxiety,</p>	F000329	<p>1) Resident #143 has a diagnosis for the use of Ambien (insomnia) dated for 8/8/13.2) All other residents with hypnotics and sedatives will be audited for appropriate diagnoses on 8/20/13 by the Consultant Pharmacist. Any medications without a proper diagnosis identified will have a proper diagnosis written. The 72 hour documentation audit form was updated to include a diagnosis for hypnotics and sedatives. 3) Staff were in-serviced on 8/12/13 by the SDC on the importance</p>	09/08/2013			

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	<p>depression, and bi-polar disorder. The resident did not have a diagnosis of insomnia.</p> <p>A Physician's order dated 8/2/13, indicated the resident was to receive Ambien (a sleeping pill) 10 milligrams (mg) by mouth every evening as needed.</p> <p>Review of the 8/2013 Medication Administration Record (MAR) indicated the resident had been requesting the Ambien on a routine basis.</p> <p>Interview with the Assistant Director of Nursing on 8/9/13 at 8:20 a.m., indicated the resident did not have a diagnosis to support the use of the Ambien.</p> <p>3.1-48(a)(4)</p>		<p>of sedatives and hypnotics to have an appropriate diagnosis. The SDC was educated on the changes in the 72 hour documentation form on 8/15/13 by the DON. Sedatives and hypnotics will be audited monthly for appropriate diagnosis by the Consultant Pharmacist.4) The hypnotic and sedatives audits will be discussed at the QA meeting monthly x 6 months or until 90% compliance has been achieved for 3 consecutive months.5) Date certain is 9/8/2013.</p>		

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F000356 SS=C	<p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Nurse Staffing hours were posted everyday at the beginning of the first shift for 1 of 1 Nurse Staffing signs reviewed. This had the</p>	F000356	1) The nurse staffing board was updated on 8/5/13. 2) The nurse staffing board will be updated daily. The secretary will write the numbers on the nurse staffing board Monday- Friday. On weekends, the manager on duty	09/08/2013

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	<p>potential to effect 77 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 8/5/13 at 7:14 a.m., the Nurse Staffing sign posted in the main lobby of the facility was dated 8/3/13. This was the date for Saturday (two days prior). The Nurse Staff hours were posted on a dry erase board on the wall in the front lobby of the facility.</p> <p>Interview with the Administrator on 8/9/13, at 10:30 a.m., indicated the Nurse Staffing sign for the current day should be posted at the beginning of each shift everyday.</p> <p>3.1-13(a)</p>		<p>will transcribe the numbers to the nurse staffing board. The list of duties for the weekend manager was updated to include a check of the nurse staffing board.3) Staff was in-serviced on 8/12/13 and 8/14/13 related to updating the nurse staffing board daily. The Administer will audit the nurse staffing board weekly for compliance.4) The nurse staffing board audits will be discussed at the monthly QA meeting x 3months or until 90% compliance has been achieved for 3 consecutive months.5) Date certain is 9/8/2013.</p>				

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F000371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was served under sanitary conditions from the steam table related to serving uncovered bowls of soup below waist level for 1 of 2 dining rooms observed. (The Main Dining Room)</p> <p>Findings include:</p> <p>1. On 8/5/13, at 12:15 p.m., the Social Service Director was observed passing soup to the residents in the Main Dining Room. At that time, there were five bowls of soup on a transportation cart. All the bowls of soup were uncovered. The uncovered bowls of soup were on a smaller transportation cart that was observed below the Social Service Director's waist level. After she had passed those five bowls, she went back to the counter and poured another six bowls of soup and passed those bowls as well to the residents. The six bowls of soup were also noted uncovered and on the cart.</p>	F000371	<p>1. No residents were adversely affected by the deficient practice.2. An audit of all three meals was conducted by the dietary manager on 8/16/13 to identify any additional food items that were in need of being covered.3. The Social Service Director was inserviced on 8/12/13 by the Dietary Manager on making sure that all food served in the dining room at waist level is covered. All staff that served food in the dining room were inserviced on 8/12/13 by the Dietary Manager on making sure that all food served in the dining room at waist level is covered. All kitchen staff that serve food were inserviced by the Executive director on 8/12/13 and 8/14/13 on making sure that all food served in the dining room at waist level is covered. 4. To insure compliance the dietary manager will keep an observation checklist for all meals for the next three months to monitor that all foods served at waist level are covered. Results of the audit will be discussed at QA meetins for six consecutive months or until 90% compliance has been</p>	09/08/2013			

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	<p>She then went back to the crock pot of soup and poured another six bowls of soup and placed them on the cart. Those bowls of soup were again uncovered and served to the residents. As the Social Service Director was passing the uncovered bowls of soup, there were residents sitting at the tables as the small transportation cart was wheeled in between the residents and the tables.</p> <p>2. On 8/7/13, at 11:57 a.m. Dietary Cook #1 was observed passing eight bowls of soup on the small transportation cart in the Main Dining Room. All eight bowls of soup were uncovered and the cart was observed below the staff's waist level.</p> <p>Continued observation at 12:00 p.m. indicated she passed six more bowls of soup on the same cart. All the bowls of soup were uncovered and on the same low cart. There were residents observed seated at their tables as the cart passed by them.</p> <p>Interview with the Dietary Food Manager (DFM) on 8/7/13 at 12:14 p.m., indicated she was unsure if the facility had a policy regarding serving the soup uncovered and would have to look for one. She further indicated she was unaware that was a problem.</p>		achieved for 3 months.Date certain 9/8/2013	

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	<p>Interview with the DFM on 8/8/13, at 8:23 a.m., indicated there was no policy regarding the food transportation in the dining rooms, however, she understood the concern of passing uncovered food below waist level in the dining rooms.</p> <p><b>3.1-21(i)(3)</b></p>			

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to ensure expired insulin vials were not in use for 1 of 6 insulin dependent diabetics who resided on the East wing. (Resident #85)</p> <p>Findings include:</p> <p>On 8/8/13 at 8:56 a.m., a vial of Novolog insulin for Resident #85 was observed in the East wing medication cart. The insulin vial was dated as opened on 7/3/13 with an expiration date of 8/1/13.</p>	F000425	<p>1) The insulin for resident # 85 was discarded. 2) All other insulins were inspected for expiration dates and discarded as necessary. Those that were expired were discarded. An Insulin Storage Recommendation form was placed in each Medication Administration Record as a resource for nurses.3) Staff were in-serviced on 8/12/13 by the SDC to ensure insulin is not expired and dated upon opening. Insulin will be audited for expiration weekly x 6 months and monthly thereafter. 4) Insulin audits will be discussed at the monthly QA meeting x 6 months or until 90% compliance is</p>	09/08/2013			

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	<p>The record for Resident #85 was reviewed on 8/8/13 at 9:00 a.m. Review of the August 2013 Physician's order summary (POS), indicated the resident was to receive Novolog insulin, inject 6 units subcutaneously (sq) 5 times per day at 5:00 a.m., 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>Review of the August 2013 Medication Administration Record (MAR), indicated the Novolog insulin had been signed out as scheduled 8/1-8/8/13.</p> <p>Interview with LPN #2, indicated the insulin for Resident #85 was discarded due to being expired and a new vial was obtained from the EDK (Emergency Drug Kit) kit.</p> <p>Review of the Insulin Storage Recommendations provided by the Staff Development Coordinator on 8/9/13 at 9:10 a.m., which were identified as current, indicated Novolog insulin was to be discarded 28 days after being opened.</p> <p>3.1-25(o)</p>		achieved for 3 consecutive months.5) Date certain is 9/8/2013.		

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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.</p> <p>(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.</p> <p>(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 their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F000441	1) Residents #103 and #141 were not adversely affected by	09/08/2013			

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	<p>ensure Nursing staff washed their hands after glove removal and in between residents during medication pass related to a glucometer and an insulin injection for 2 of 8 residents observed during medication pass. (Residents #103 &amp; #141)</p> <p>Findings include:</p> <p>1. On 8/7/13, at 3:46 p.m., RN #1 was observed at the medication cart. At that time, the nurse had just finished a glucometer (a device used to obtain a resident's blood sugar) check for Resident #103. The RN was wearing the same pair of gloves she had on during the glucometer check. The RN then was observed removing the vial of Insulin from the medication cart. The RN did not remove her gloves or wash her hands with soap and water or use alcohol gel before drawing up the Insulin. She then prepared the Insulin injection with the same gloves on and walked into the resident's room and administered the Insulin injection with the same pair gloves on. The RN then walked out of the room with the gloves on removed them at the medication cart and placed them into the trash can on the side of the cart. She did not wash her hands with soap and water or use alcohol gel at</p>		<p>the lack of handwashing after glove removal during the medication pass. 2) No other residents were affected. Nurses will have a competency medication observation completed annually by the consultant Pharmacist. Licensed nurses will also complete competency based training related to use of Glucometer and glove use when administering an insulin injection. 3) The staff were in-serviced on 8/12/13 on hand washing. . The SDC will randomly monitor 5 nurses, covering at least one nurse per shift, on hand-washing during medication administration weekly x 6 months. 4) The hand washing audits and competency testing results will be discussed at the QA meeting for 6 months or until 90% compliance is achieved for 3 consecutive months. 5) Date certain is 9/8/2013.</p>				

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	<p>that time. She then indicated, another resident needed a glucometer check also. At 3:52 p.m., she donned a pair of clean gloves while standing at the medication cart to both of her hands before she entered the resident's room. She still had not washed her hands with soap and water or used alcohol gel from the last glucometer check for Resident #103.</p> <p>She then walked into Resident #141's room wearing a pair gloves, wiped the resident's finger with an alcohol pad, and pricked her finger. The nurse was unable to obtain a good sample of blood so she left the room (wearing the same pair of gloves and without removing them), walked to the medication cart to get a new lancet and alcohol pad. The RN then came back into the room and did the glucometer again with the same pair of gloves on. The RN then left the room wearing the gloves and walked to the medication cart. She then removed the gloves and threw them into the trash can on the side of the medication cart.</p> <p>Review of the current 7/18/11 Standard Precautions policy provided by the Staff Development Nurse, indicated "Personal Protective</p>				

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	<p>Equipment is located in an accessible area as defined by the facility and presented to associates during training.... All associates using Personal Protective Equipment must observe the following precautions: Follow hand hygiene recommendations immediately or as soon as feasible after removal of gloves or other Personal Protective Equipment."</p> <p>Interview with RN #1 on 8/7/13, at 4:07 p.m., indicated she should have removed her gloves before leaving Resident #103's room and washed her hands with soap and water or used alcohol gel. She further indicated she did not wash her hands with soap and water or use alcohol gel in between the medication pass, glucometer and insulin injection for Residents #103 and #141.</p> <p>3.1-18(b)(1)</p>				

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance of the facility's Restorative Therapy Program related to the lack of weekly assessments and progress towards goals through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with the Administrator on 8/9/13 at 10:15 a.m., indicated the</p>	F000520	<p>1) No residents were adversely affected by the delay in restorative services.2) All other residents that were discharged from therapy from August 1, 2013 were audited for timely restorative services on 8/14/13 by the RSM. Any residents identified were initiated in restorative services. The form Restorative Nursing Program was revised to include dates. A new policy was written to indicate that restorative programs should be initiated (within 72 hours) after therapy discharge.3)</p>	09/08/2013	

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	<p>facility's Quality Assurance Committee meets every month and consists of herself, the Director of Nursing, Social Service, Dietary, Activities, and Nursing as well as the Medical Director. The Administrator indicated at the time, the Restorative Therapy process had not been discussed, addressed or identified as being a problem in Quality Assurance. She further indicated there had been no action plan or system put into place to identify the problem of not starting Restorative Therapy timely, the lack of assessments and progress towards goals in the Restorative Therapy Program.</p> <p>Interview with the Director of Rehab on 8/6/13 at 3:09 p.m., indicated Restorative Therapy referrals were made immediately when a resident was discharged from Skilled Therapy such as Physical and/or Occupational Therapy. She further indicated Restorative Therapy was to begin when Skilled Therapy was discontinued.</p> <p>Interview with the Restorative Nurse on 8/6/13 at 2:43 p.m., indicated she had one full time CNA and one part time CNA for Restorative care. She received referrals from the Therapy</p>		<p>Staff were in-serviced on 8/12 by the SDC on completing a Restorative Nursing Program form with dates and on initiating restorative program timely. Staff were in-serviced on 8/12/13 that systematic concerns must be reported to the QA committee. An audit of the Restorative Nursing Program form will be conducted weekly by the Restorative Nurse to ensure timely admission to the restorative program.4) The restorative audits will be discussed at the monthly QA meeting x 6 months or until 90% compliance is achieved for 3 consecutive months.5) Date certain is 9/8/2013.</p>		

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	<p>department when Skilled services had been discontinued. She further indicated Restorative Therapy was to begin shortly after the discontinuation of Skilled Therapy. The Restorative Nurse indicated she was responsible for assessing every resident and initiating a plan of care for Restorative Therapy.</p> <p>Interview with the Director of Nursing on 8/9/13 at 10:45 a.m., indicated she would be the person who was supposed to audit and/or check the Restorative Nurse's assessments and documentation for the residents who were receiving Restorative Therapy. She further indicated the Restorative Nurse was responsible for weekly Restorative assessments and documentation of the resident's progress towards their goals.</p> <p>3.1-52(b)(2)</p>			