

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2012
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NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey Dates: September 24, 25, 26, 27, 28, and October 1, 2012</p> <p>Facility Number: 008505 Provider Number: 155580 Aim Number: 20064830</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Kathleen Vargas, R.N.</p> <p>Census Bed Type: 129 SNF/NF 129 Total</p> <p>Census Payor Type: 13 Medicare 114 Medicaid 2 Other 129 Total</p> <p>These deficiencies reflect stated findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/9/12 Cathy Emswiller RN</p>	F0000	<p>Allegation of Credible Compliance this plan of correction is prepared and executed because it is required by the provision of State and Federal law and not because Timberview Health Care Center agrees with the allegations and citations listed on pages 1-35 of this statement of deficiency. Timberview Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance, please accept October 26, 2012, as the date of compliance. Timberview Health Care Center is requesting paper compliance for the citations listed on pages 1-35</p>	

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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F0242 SS=E	<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 had the right to choose whether they received a shower or tub bath for 3 of 3 residents reviewed for choices of the 4 residents who met the criteria for choices. (Residents #22, #60, and #70)</p> <p>Findings include:</p> <p>1. During an interview with Resident #60 on 9/25/12 at 11:18 a.m., he indicated he would rather take a tub bath than a shower. He further indicated he was never given the choice of a tub bath.</p> <p>On 9/27/12 at 8:46 a.m., the resident was observed in bed eating breakfast. The resident indicated at that time on Wednesday he was given a bed bath. He further indicated he did not want to take a shower and no staff had even offered him a tub bath.</p>	F0242	<p><b>F242 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility requests paper compliance for this citation. <b>1) Immediate actions taken for those residents identified:</b> Residents identified in the sample, #22, #60, and #70, were informed that the vendor of the Tub was notified and scheduled to repair the tub on the South Unit for showers. The resident's expressed satisfaction that the tub was being repaired. <b>2) How the facility identified other residents:</b> All interviewable residents are to be interviewed by Activity Department personnel regarding personal choice related to bathing. The ADL care plans will be updated and reflected on the Certified Nursing Assistant Kardex to inform direct care staff</p>	10/26/2012			

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	<p>The record for Resident #60 was reviewed on 9/6/12 at 10:44 a.m. The resident was admitted to the facility on 8/6/12. The resident's diagnoses included, but were not limited to, possible ankle fracture, cognitive communication deficit, dysphagia, and muscle weakness.</p> <p>Review of the shower schedule indicated the resident's weekly showers were scheduled on Mondays and Wednesdays in the evening.</p> <p>Review of the Minimum Data Set (MDS) initial assessment dated 8/13/12 indicated the resident was alert and oriented with a baseline interview for mental status (BIMS) score of 15. The resident had no behaviors, delirium, or mood problems. Review of the section for life routines and preferences indicated it was somewhat important to choose whether he wanted a tub bath, shower, bed bath, or sponge bath.</p> <p>Review of the CNA communication sheet indicated there was no documentation what the resident's preferences were for bathing.</p> <p>Interview with CNA #1 9/26/12 at 2:13</p>		<p>of individual choice related to bathing. <b>3) Measures put into place/ System changes:</b> MDS Section F will be completed upon Admission, Annually, and with any Significant Change of Condition. The Activity Director or Designee will be responsible for informing nursing, who will update the ADL care plan and Kardex. Nursing staff will be re-educated regarding resident bathing preferences and offering choices for bathing. <b>4) How the corrective actions will be monitored:</b> Activity Director or Designee will be responsible for selecting five (5) residents per week per the MDS schedule to review the last comprehensive assessment and interview the five (5) residents selected to verify they are receiving bathing per their choice as indicated on the MDS. Results will be reviewed in the Quality Assurance Meetings monthly for 3 months and quarterly x1 for total of six months. <b>5) Date of compliance: October 26, 2012</b></p>				

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	<p>p.m., indicated she was unaware the resident preferred a tub bath.</p> <p>Interview with the North Unit Manager on 9/26/12 at 2:15 p.m., indicated she was unaware the resident preferred a tub bath rather than a shower.</p> <p>2. During an interview with Resident #70 on 9/24/2012 at 11:17 a.m., indicated the resident would really like to take a bath rather than a shower. She further indicated that she could get cleaner in the tub. The resident indicated she did not know if the facility had a bath tub on this unit (North), but she did know there was a tub on the South unit. The resident indicated she would prefer a tub bath over a shower and has always taken a tub bath at home. She indicated she has told staff about her preferences and they know she would rather take a tub bath, "but that does not always happen".</p> <p>Interview with the resident on 9/26/12 at 11:04 a.m., indicated CNA #1 came into her room today and asked her if she wanted to take a shower, she refused and indicated she did not want to go to cold shower room. She indicated she was in her upper 70's and it was hard for her to sit on that cold chair, hold the shower head and</p>				

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	<p>wash herself. The resident indicated she did not ask the CNA for a tub bath, but she said there was a tub bath two units down and someone has to go with her there to help her and she did not think they would do that.</p> <p>The record for Resident #70 was reviewed on 9/26/12 at 11:22 a.m. The resident's diagnoses included, but were not limited to, dyspnea, chronic airway obstruction, chronic respiratory failure, post inflammatory pulmonary fibrosis, congested heart failure, depressive disorder, and anxiety state.</p> <p>Review of the shower schedule indicated the resident was to received a shower on Wednesday and Saturday mornings</p> <p>Review of the annual MDS assessment dated 11/17/11 indicated the resident's BIMS score was 15 which meant she was alert and oriented. The resident displayed no behavior or mood problems. Review of the resident's life routines and preference section indicated it was very important to choose between a tub bath, shower and bed bath.</p> <p>On 9/26/12 at 11:22 p.m., the bath</p>				

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	<p>tub on the North unit was observed to be out of order. There was a sign on the wall that indicated the tub did not work.</p> <p>Interview with CNA #1 on 9/26/12 at 1:50 p.m., indicated she had asked the resident earlier if she wanted to take a shower and she refused due to not feeling well. She further indicated she did know that the resident would prefer a bath over a shower.</p> <p>Interview with the North Unit Manager on 9/26/12 at 2:01 p.m., indicated she was unaware the resident wanted to take bath over a shower. She then pulled out the CNA communication form and there was no indication what the resident's preferences were.</p> <p>Interview with LPN #2 on 9/26/12 at 2:05 p.m., indicated she was very much aware the resident prefers tub/whirlpool baths over showers and indicated she gets them occasionally on Sundays if there was someone available to take her down there.</p> <p>Interview with the Administrator on 9/26/12 at 2:13 p.m., indicated the tub/whirlpool bath on the South Unit was broken and did not work. She further indicated there was no working bath tub for the residents at the</p>						

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	<p>facility.</p> <p>3. Resident #22 was interviewed on 9/24/12 at 2:46 p.m. She indicated that she was not able to choose whether she took a shower, tub or bed bath. She indicated she had only taken showers in the facility, but she preferred to take a bath.</p> <p>Interview with Resident #22 on 9/27/12 at 9:30 a.m., indicated she had just received a shower. She again indicated she would have preferred a bath, but indicated there was no bath tub on her unit.</p> <p>The record of Resident #22 was reviewed on 9/26/12 at 11:10 p.m. The resident had diagnoses that included, but were not limited to, hemiplegia, diabetes and hypertension.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 6/11/12, indicated the resident had a Brief Interview Mental Status (BIMS) score of 14, which indicated she was cognitively intact. It indicated she was dependent on staff for bathing. It also indicated that the resident felt it was very important for her to choose between a tub bath, shower, bed bath, or sponge bath.</p>						

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	<p>Interview with MDS Coordinator #1 on 9/27/12 at 10:13 a.m., indicated the MDS indicated it was very important for the resident to choose whether she received a bath or a shower.</p> <p>Interview with the Assistant Director of Nursing on 9/27/12 at 10:20 a.m., indicated she was not aware that the resident had indicated it was important for her to choose if she had a bath or shower.</p> <p>On 9/27/12 at 10:15 a.m., the shower room on the Progressive Care Unit where Resident #22 resided was observed. There was no bath tub on the unit in the shower room.</p> <p>Interview with the Administrator on 9/27/12 at 11:23 a.m., indicated there was a tub bath in the facility but it has been broken for some time.</p> <p>3.1-3(u)(3)</p>			

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F0282 SS=E	<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 Physician's orders and/or the plan of care were followed as written related to restorative services for 1 of 3 residents of the 6 who met the criteria for community discharge, oral care for 1 of 1 residents of the 1 who met the criteria for hydration, monitoring weight loss for 1 of 3 residents of the 6 who met the criteria for nutrition and monitoring blood pressures and blood sugars for 1 of 10 residents reviewed for unnecessary medications. (Residents #30, #53, #110 and #154)</p> <p>Findings include:</p> <p>1. The record for Resident #154 was reviewed on 9/28/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, rehabilitation, abnormality of gait, and muscle weakness.</p> <p>The plan of care dated 9/10/12, indicated the resident had a potential for decline in walking related to</p>	F0282	<p><b>F282</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>The facility requests paper compliance for this citation. 1) Immediate actions taken for those residents identified:</b> Oral care was immediately provided to Resident #30.As stated in 2567, Resident # 110 was seen by the Dietician on 9/26/12. Supplement orders were changed on 10/1/12.Evaluated frequency of Restorative Programs received for Resident #154.Resident #53 was hospitalized at the time of survey. Orders for blood pressure checks were clarified upon re-admission to facility and placed under appropriate order code to appear on electronic MAR. <b>2) How the facility identified other residents:</b> All NPO and/or dependent residents were assessed for completion of oral care.All residents receiving Restorative Programs were reviewed to identify frequency of programs received.Reviewed orders and records of all</p>	10/26/2012	

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	<p>decreased endurance.</p> <p>The care plan goal indicated the resident would walk 250 feet using FWW (front wheeled walker) and stand by assist 5-7 times a week thru next review.</p> <p>The interventions indicated to evaluate program effectiveness periodically and observe for decline in walking skills and report to Restorative Nurse/MDS (Minimum Data Set) Coordinator.</p> <p>Review of the Restorative Sheets for "walking" for the month of September 2012, indicated there was no documentation of the resident being walked on 9/17-9/20 and 9/22-9/24/12.</p> <p>Interview with MDS Coordinator #2 on 9/28/12 at 1:54 p.m., indicated the resident was picked up by Restorative nursing on 9/15/12 and should be seen 5-7 times a week.</p> <p>Interview with Restorative CNA #1 on 10/1/12 at 1:21 p.m., indicated that she had just walked the resident. She indicated the resident was doing well and walking up to 200 feet. She also indicated the resident was to be walked everyday.</p>		<p>residents with orders for blood pressures to ensure results were being obtained and documented as ordered. Residents with weight change noted in last 30 days will be reviewed to ensure timely follow-up for Dietician notification and evaluation. <b>3) Measures put into place/ System changes:</b> Licensed Staff will be re-educated on input of orders to ensure that orders requiring assessment and documentation will appear on Medication Administration Record or Treatment Administration Record. All nursing staff will be re-educated on Oral Care procedure and frequency, including oral care as needed for residents who are NPO. All nursing staff will be re-educated on Restorative Program requirements and frequency of programs. Random observation audits will be conducted on at least 5 care-dependent and/or NPO residents per week on varied shifts to monitor for compliance of oral care provided throughout the shift. DON/designee is responsible for oversight of audits. Staff will be addressed and re-educated if concerns are noted. Audit will be completed of at least 5 resident records per week for residents with orders to monitor blood pressures and/or fingerstick glucose results results to ensure orders are followed and documentation is complete. The DON/designee is responsible for</p>		

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	Interview with MDS Coordinator #2 on 10/1/12 at 2:46 p.m., indicated the resident was to be walked 7 times a week and that he should have been walked 9/17-9/20 and 9/22-9/24/12.		oversight of these audits. Staff will be addressed and re-educated if concerns are noted. Audit of any new physician orders to obtain vital signs including blood pressures and fingerstick blood glucose checks will be completed at least twice weekly to verify that orders were entered into computerized system to ensure documentation appears on electronic Medication or Treatment Administration Records. The DON/ designee is responsible for oversight of these audits. Staff will be addressed and re-educated if concerns are noted. Restorative Nurse will randomly observe and audit documentation on at least 5 residents per week receiving Restorative Services to ensure that services are being provided and documented according to the plan of care. The Administrator is responsible for oversight of these audits. Staff will be addressed and re-educated if concerns are noted. The Dietary Services Manager will continue to keep a list of residents to be seen by Dietician during visits and will enter current weights into the electronic record. In addition, the Dietician will also generate a report of significant weight changes based on current weights entered into weights section in the electronic record, as well as list of new admissions prior to each visit to ensure that all residents with weight changes		

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	<p>2. On 9/24/12 at 11:20 a.m., Resident #30 was observed in bed. The resident was noted with dry cracked lips.</p> <p>On 9/24/12 at 1:27 p.m., the resident was up in a geri chair. Her lips were dry and there were areas of skin peeling away from the bottom lip.</p> <p>On 9/25/12 at 8:33 a.m., and 10:33 a.m., the resident was in bed. The resident was noted with dry cracked lips with areas of skin peeling away from her bottom lip.</p> <p>On 9/27/12 at 8:20 a.m., the resident was observed in bed. Her lips were dry and cracked, with skin peeling away from her bottom lips.</p> <p>On 9/28/12 at 7:13 a.m., the resident</p>		<p>and/or new admissions are reviewed during visits. The Dietary Services Manager or designee will audit at least 3 residents per week as appropriate with significant weight changes to ensure residents were seen by Dietician timely. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. <b>5) Date of compliance: 10/26/12</b></p>		

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	<p>was observed sitting up in geri chair. Her bottom lips were cracked with skin peeling away. The resident's mouth was dry.</p> <p>Interview with CNA #1 on 9/28/12 at 7:15 a.m., indicated she was the day CNA and the midnight CNA had gotten the resident out of bed. Further interview with the CNA indicated she did not get a verbal report from the midnight CNA and did not know if oral and mouth care had been provided to the resident. The CNA indicated at the time, that oral hygiene was a part of morning care when the resident's were gotten up.</p> <p>Interview with the Director of Nursing on 9/28/12 at 7:33 a.m., indicated she was not aware the resident ever refused oral care. She further indicated the resident would be able to tell us if she had oral care this morning.</p> <p>Interview with Resident #30 at that time, indicated she had not had oral care yet this morning.</p> <p>Further interview with the Director of Nursing at the time, indicated oral care should be done with am care.</p> <p>The record for resident #30 was</p>				

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	<p>reviewed on 9/28/12 at 8:27 a.m. The resident's diagnoses included, but were not limited to, aphasia, cerebrovascular disease, senile dementia, hemiplegia on left side, chronic gingivitis, diabetes, dysphagia, and gastrostomy.</p> <p>Review of the current 9/18/12 plan of care indicated the resident had oral/dental problems related to missing or broken teeth. The nursing approaches were to report to signs and symptoms of oral/dental problems needing attention like lips cracked or bleeding and to provide mouth care as per ADL personal hygiene.</p> <p>Another current plan of care dated 9/18/12 indicated the resident had an ADL self care deficit related to decreased mobility and impaired cognition. The nursing approaches were to provide oral care per facility policy.</p> <p>3. On 9/26/12 at 8:17 a.m., Resident #110 was observed eating breakfast in bed. The resident was served one glass of orange juice, one glass of milk, two sausage links, 1 piece of toast, one hard boiled egg, and one bowl of grits.</p>			

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	<p>The record for Resident #110 was reviewed on 10/1/12 at 9:44 a.m. The resident was admitted to the facility on 7/13/12 for the hospital. The resident's diagnoses included, but were not limited to, weight loss, congestive heart failure, muscle weakness, and dysphagia.</p> <p>Review of the current plan of care plan dated 7/27/12 indicated the resident had an abnormal BMI (body mass index). The nursing approaches were to report any significant weight changes to the Registered Dietitian (RD).</p> <p>Review of the weight record indicated the resident weighted 134 pounds on 7/16/12. On 8/13/12 the resident weighed 117 pounds which was a 12.7% weight loss in one month.</p> <p>Review of Dietary Progress Notes dated 8/9/12 indicated the Dietary Food Manager had identified a significant weight loss for the resident. She indicated the resident would be referred to the RD to assess for further weight loss.</p> <p>Further review of Dietary Progress Notes indicated the next time the resident was seen by the RD was on 9/26/12 to address his weight loss.</p>				

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	<p>Interview with the Dietary Food Manager on 10/1/12 12:32 p.m., indicated she failed to place the resident on the list to be seen by the RD after the initial weight loss. She further indicated the RD visits weekly.</p> <p>4. The record for Resident #53 was reviewed on 9/27/12 at 9:11 a.m. The resident's diagnoses included, but were not limited to, high blood pressure.</p> <p>Review of Physician Orders dated 11/2/11 indicated monitor blood pressure daily.</p> <p>Review of the blood pressure log indicated the resident's blood pressure was taken on 5/3/12, 6/3/12, 7/3/12, 8/3/12, 9/3/12, 9/4/12, 9/5/12, 9/6/12, 9/7/12, and 9/12-9/15.</p> <p>Review of Nursing Progress Notes indicated there was no documentation of the resident's blood pressure on 7/1-7/12, 7/14-7/31, 8/1-8/4, 8/6-8/27, 8/29-8/31, 9/1, 9/2, 9/9, and 9/10.</p> <p>Interview with LPN #2 on 9/27/12 at 1:55 p.m., indicated she has never taken the resident's blood pressure before administering his medications. She further indicated he was not</p>			

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	<p>taking any blood pressure medication, and the order was not transcribed onto the Medication Administration Record.</p> <p>3.1-35(g)(2)</p>				

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F0311 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 record review and interview, the facility failed to ensure restorative services were provided related to ambulation for 1 of 3 residents of the 6 who met the criteria for community discharge. (Resident #154)</p> <p>Findings include:</p> <p>The record for Resident #154 was reviewed on 9/28/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, rehabilitation, abnormality of gait, and muscle weakness.</p> <p>The Physical therapy discharge summary electronically signed 9/27/12, indicated therapy ended 9/14/12. The summary indicated the resident required a front wheeled walker and stand by assist for safe ambulation for 200 feet with initiation cue. Restorative nursing was educated for both lower extremity active ROM (range of motion) and ambulation with FWW (front wheeled walker) with stand by assist with</p>	F0311	<p><b>F311 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> Restorative Programs were reviewed for Resident #154. <b>2) How the facility identified other residents:</b> Audit was completed of all residents receiving Restorative Services to evaluate frequency of programs received. <b>3) Measures put into place/ System changes:</b> Restorative Nursing staff will be re-educated on Restorative Program requirements and frequency of programs. Restorative Nurse will randomly observe and audit documentation on at least 5 residents per week receiving Restorative Services to ensure that services are being provided and documented according to the plan of care. The Administrator is responsible for oversight of these audits. Staff will be addressed and re-educated if concerns are</p>	10/26/2012

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	<p>verbal cues for increased base of support and for safety.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/7/12, indicated the resident needed extensive assistance with walking in his room and in the corridor.</p> <p>The plan of care dated 9/10/12, indicated the resident had a potential for decline in walking related to decreased endurance.</p> <p>The care plan goal indicated the resident would walk 250 feet using FWW (front wheeled walker) and stand by assist 5-7 times a week thru next review.</p> <p>The interventions indicated to evaluate program effectiveness periodically and observe for decline in walking skills and report to Restorative Nurse/MDS (Minimum Data Set) Coordinator.</p> <p>Review of the Restorative Sheets for "walking" for the month of September 2012, indicated there was no documentation of the resident being walked on 9/17-9/20 and 9/22-9/24/12.</p> <p>Interview with MDS Coordinator #2 on</p>		<p>noted. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. <b>5) Date of compliance: 10/26/12</b></p>				

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	<p>9/28/12 at 1:54 p.m., indicated the resident was picked up by Restorative nursing on 9/15/12 and should be seen 5-7 times a week.</p> <p>Interview with Restorative CNA #1 on 10/1/12 at 1:21 p.m., indicated that she had just walked the resident. She indicated the resident was doing well and walking up to 200 feet. She also indicated the resident was to be walked everyday.</p> <p>Interview with MDS Coordinator #2 on 10/1/12 at 2:46 p.m., indicated the resident was to be walked 7 times a week and that he should have been walked 9/17-9/20 and 9/22-9/24/12.</p> <p>3.1-38(a)(2)(B)</p>						

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure a resident who was dependent on personal hygiene related to oral care received the necessary services to maintain good oral hygiene for 1 of 1 residents reviewed for dehydration of the 1 resident who the met the criteria for dehydration. (Resident #30)</p> <p>Findings include:</p> <p>On 9/24/12 at 11:20 a.m., Resident #30 was observed in bed. The resident was noted with dry cracked lips.</p> <p>On 9/24/12 at 1:27 p.m., the resident was up in a geri chair. Her lips were dry and there were areas of skin peeling away from the bottom lip.</p> <p>On 9/25/12 at 8:33 a.m., and 10:33 a.m., the resident was in bed. The resident was noted with dry cracked lips with areas of skin peeling away from her bottom lip.</p>	F0312	<p><b>F312 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> Oral care was immediately provided to Resident #30. <b>2) How the facility identified other residents:</b> All NPO and/or dependent residents were assessed for completion of oral care. <b>3) Measures put into place/ System changes:</b> All nursing staff will be re-educated on Oral Care procedure and frequency, including oral care as needed for residents who are NPO. Resident orders, care plans and Kardex will be updated to reflect frequency of oral care to be provided. Random observation audits will be conducted on at least 5 care-dependent and/or NPO residents per week on varied shifts to monitor for compliance of oral care provided throughout the shift.</p>	10/26/2012			

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	<p>On 9/27/12 at 8:20 a.m., the resident was observed in bed. Her lips were dry and cracked, with skin peeling away from her bottom lips.</p> <p>On 9/28/12 at 7:13 a.m., the resident was observed sitting up in geri chair. Her bottom lips were cracked with skin peeling away. The resident's mouth was dry.</p> <p>Interview with CNA #1 on 9/28/12 at 7:15 a.m., indicated she was the day CNA and the midnight CNA had gotten the resident out of bed. Further interview with the CNA indicated she did not get a verbal report from the midnight CNA and did not know if oral and mouth care had been provided to the resident. The CNA indicated at the time, that oral hygiene was a part of morning care when the resident's were gotten up.</p> <p>Interview with the Director of Nursing on 9/28/12 at 7:33 a.m., indicated she was not aware the resident ever refused oral care. She further indicated the resident would be able to tell us if she had oral care this morning.</p> <p>Interview with Resident #30 at that time, indicated she had not had oral</p>		<p>DON/designee is responsible for oversight of audits. Staff will be addressed and re-educated if concerns are noted. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. <b>5) Date of compliance: 10/26/12</b></p>	

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	<p>care yet this morning.</p> <p>Further interview with the Director of Nursing at the time, indicated oral care should be done with am care.</p> <p>The record for resident #30 was reviewed on 9/28/12 at 8:27 a.m. The resident's diagnoses included, but were not limited to, aphasia, cerebrovascular disease, senile dementia, hemiplegia on left side, chronic gingivitis, diabetes, dysphagia, and gastrostomy.</p> <p>Review of Physician Orders dated 11/1/11 and on the current 9/12 recap indicated the resident could have nothing by mouth. The resident was receiving an enteral feeding of glucerna 1.2 at 70 cubic centimeters (cc) times 18 hours on at 6:00 p.m., and off at 12:00 p.m.</p> <p>Another Physician Order was for chlorhexidine gluconae (a medication used for the resident's chronic gingivitis) for mouth and throat .12% reordered 9/18/12- swab mouth with 5 milliliters four times a day at 6 a.m., 12 p.m., 4 p.m., and 8 p.m.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 9/17/12, indicated the resident's BIMS</p>				

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	<p>(Brief Interview for Mental Status) score was a 9. The resident had intermittent confusion and rejection of care was not exhibited. The resident was totally dependent on staff for personal hygiene with one person physical assist. The resident also received 51% or more of her nutrition from a tube feeding.</p> <p>Review of the current 9/18/12 plan of care indicated the resident had oral/dental problems related to missing or broken teeth. The nursing approaches were to report to signs and symptoms of oral/dental problems needing attention like lips cracked or bleeding and to provide mouth care as per ADL personal hygiene.</p> <p>Another current plan of care dated 9/18/12 indicated the resident had an ADL self care deficit related to decreased mobility and impaired cognition. The nursing approaches were to provide oral care per facility policy.</p> <p>3.1-38(a)(3)(C)</p>				

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Registered Dietitian was notified in a timely manner of a significant weight loss for 1 of 3 residents reviewed for nutrition of the 6 residents who met the criteria for nutrition. (Resident #110)</p> <p>Findings include:</p> <p>1. On 9/26/12 at 8:17 a.m., Resident #110 was observed eating breakfast in bed. The resident was served one glass of orange juice, one glass of milk, two sausage links, 1 piece of toast, one hard boiled egg, and one bowl of grits.</p> <p>The record for Resident #110 was reviewed on 10/1/12 at 9:44 a.m. The resident was admitted to the facility on 7/13/12 for the hospital. The resident's diagnoses included, but</p>	F0325	<p><b>F325 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> As stated in 2567, Resident # 110 was seen by the Dietician on 9/26/12. Supplement orders were changed on 10/1/12. <b>2) How the facility identified other residents:</b> Residents with weight change noted in the last 30 days will be reviewed to ensure follow-up for Dietician notification and evaluation. <b>3) Measures put into place/ System changes:</b> The Dietary Services Manager will continue to keep a list of residents to be seen by Dietician during visits and will enter current weights into the electronic record. In addition, the Dietician</p>	10/26/2012	

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	<p>were not limited to, weight loss, congestive heart failure, muscle weakness, and dysphagia.</p> <p>Review of the initial Minimum Data Set (MDS) assessment dated 7/20/12 indicated the resident was alert and oriented and required extensive assistance with two person assist, for most of his Activities of Daily living. The resident had no swallowing problems, and his current weight was 134 pounds.</p> <p>Review of the current plan of care plan dated 7/27/12 indicated the resident had an abnormal BMI (body mass index). The nursing approaches were to report any significant weight changes to the Registered Dietitian (RD).</p> <p>Review of the weight record indicated the resident weighted 134 pounds on 7/16/12. On 8/13/12 the resident weighed 117 pounds which was a 12.7% weight loss in one month.</p> <p>Review of Dietary Progress Notes dated 7/18/12 by the RD indicated the resident had a BMI of 17.6 and was considered underweight with an admission weight of 133.5 pounds. The RD indicated the resident had two plus pitting edema to his bilateral</p>		<p>will also generate a report of significant weight changes based on current weights entered into weights section in the electronic record, as well as list of new admissions prior to each visit to ensure that all residents with weight changes and/or new admissions are reviewed during visits. The Dietary Services Manager or designee will audit at least 3 residents per week as appropriate with significant weight changes to ensure residents were seen by Dietician. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. <b>5) Date of compliance: 10/26/12</b></p>				

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	<p>lower extremities and also edema to his left elbow which could mask true weight loss. The RD addressed the resident's caloric intake, labs and the fact that he had a 20 pound weight loss over last year. Her recommendations were to provide a 4 ounce health shake for lunch and dinner and for the resident to be followed in weekly Nutrition at Risk assessments.</p> <p>Review of Physician Orders dated 7/20/12 indicated the 4 ounce healthshake was ordered for lunch and supper.</p> <p>Review of the Dietary Food Manager Progress Note dated 8/9/12 indicated the resident had a weight loss of 10.2 pounds in a week. She further indicated the resident consumes greater than 75% of his meals. The recommendation was to refer to the RD for further weight loss assessment.</p> <p>Review of the 8/15/12 Dietary Progress Note by the Dietary Food Manager indicated a weight loss of 12.7% in 30 days had triggered for the resident.</p> <p>Review of the 8/20/12 Dietary Progress Note by the Dietary Food</p>				

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	<p>Manager indicated "weight warning" the resident's weight was 123 pounds with 8.1% weight change in the last 30 days. RD to assess for weight change.</p> <p>Review of the NAR weekly notes indicated the resident was seen in the NAR meetings with his weight monitored and intake on a weekly basis.</p> <p>The next documented RD assessment of the resident was not until 9/26/12 which indicated the resident had a 9% weight loss in the last month and his current weight was 119 pounds. The RD indicated the resident was receiving healthshakes and was monitored with weekly weights. She indicated the resident's weight loss had arrested at this time. The RD recommended larger portions at breakfast in effort to increase calories.</p> <p>Interview with the Dietary Food Manager on 10/1/12 12:32 p.m., indicated she failed to place the resident on the list to be seen by the RD after the initial weight loss. She further indicated the RD visits weekly.</p> <p><b>3.1-46(a)(1)</b></p>				

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F0329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></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 each resident's drug regimen was free from unnecessary drugs related to the lack of an indication for the use of a medication used to treat gastroesophageal reflux disease (GERD) and monitoring blood sugars for 2 of 10 residents reviewed for unnecessary medications. (Residents #42 and #53)</p> <p>Findings include:</p>	F0329	<p><b>F329 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> Resident #42- Diagnosis of GERD was updated to clinical record for the use of Reglan. Resident #53- Resident</p>	10/26/2012			

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	<p>1. <b>The record for Resident #42 was reviewed on 9/27/12 at 1:40 p.m. A Physician's order dated 8/12/12, indicated the resident was to receive Reglan (a medication used to treat GERD) 5 milligrams (mg) by the way of his percutaneous endoscopic gastrostomy tube three times a day.</b></p> <p>Review of the resident's diagnoses, indicated the resident did not have a diagnosis to support the use of the Reglan.</p> <p>Interview with the Director of Nursing on 10/1/12 at 1:10 p.m., indicated the resident returned from the hospital with the order for the Reglan on 8/12/12. She indicated that she called the resident's physician today and got the diagnosis of GERD to support the use of the Reglan. She further indicated the Physician wanted the resident to receive the medication due to the tube feeding and the fact the resident was receiving the medication while in the hospital.</p>		<p>was in the hospital at time of survey. Orders for blood glucose monitoring were clarified upon return from hospital and placed under related order code to appear on electronic MAR. <b>2) How the facility identified other residents:</b> Pharmacist will conduct review of all medication orders to ensure that an appropriate diagnosis for use is listed in orders and/or in clinical record. Reviewed orders and records of all residents with receiving hypoglycemic medications to ensure finger-stick blood sugars were being obtained and documented as ordered.<b>3) Measures put into place/ System changes:</b> Licensed staff will be re-educated on obtaining appropriate diagnosis for medication use and medications that require lab or vital sign monitoring, including fingerstick glucose testing. Licensed staff will be re-educated on input of orders to ensure that orders requiring assessment and documentation such as fingerstick glucose results will appear on Medication Administration Record or Treatment Administration Record. New medication orders will be audited at least twice weekly to ensure that an appropriate diagnosis and/or vital sign/lab monitoring are present for use of medications as recommended. DON/designee is responsible for oversight of audits. Physicians will</p>		

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	<p>2. The record for Resident #53 was reviewed on 9/27/12 at 9:11 a.m. The resident's diagnoses included, but were not limited to, diabetes.</p> <p>Review of Physician Orders on the current 9/10 recap indicated accucheck one time a day call if blood sugar less than 60 or greater than 400. This order was originally ordered on 10/31/11.</p> <p>Further review of Physician Orders dated 10/31/11, indicated the resident was receiving the oral hypoglycemic medication of Metformin 1000 milligrams one tablet two times a day.</p> <p>Review of the Medication Administration Record (MAR) for the months of 11/1, 12/11, 1/12, 2/12, 3/12, 4/12, 5/12, 6/12, 7/12, 8/12, and 9/12 indicated the accuchecks were unavailable for review.</p> <p>Review of the current plan of care</p>		<p>be contacted and staff will be addressed and re-educated if concerns are noted. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. <b>5) Date of compliance: 10/26/12</b></p>				

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	<p>dated 7/30/12 indicated the resident has diabetes. The nursing approaches were to obtain fasting blood sugars as ordered by the doctor.</p> <p>Interview with LPN #2 on 9/27/12 at 1:33 p.m., indicated she has not ever taken the resident's accucheck.</p> <p>Interview with the Director of Nursing on 9/27/12 at 10:20 a.m., indicated the wrong code was put in the computer regarding the accuchecks, therefore it did not carry over to the MAR.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F0356 SS=C	<p><b>483.30(e)</b> <b>POSTED NURSE STAFFING INFORMATION</b> 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 and interview, the facility failed to post accurately the Nursing Staffing information which included the total number and the actual hours worked by Registered Nurses and Licensed Practical</p>	F0356	<b>F356 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as	10/26/2012			

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	<p>Nurses directly responsible for resident care. This had the potential to affect 129 residents residing in the facility and their visitors.</p> <p>Findings include:</p> <p>Observation during the Initial Tour on 9/24/12 at 9:30 a.m., indicated the facility had 3 nursing units. The North Unit had 3 Licensed Practical Nurses (LPNs) working on the Unit that were responsible for resident care.</p> <p>The Progressive Care Unit had 2 LPNs working on the unit that were responsible for resident care.</p> <p>The South Unit had 3 LPNs working and responsible for direct resident care.</p> <p>Observation on 9/24/12 at 10:05 a.m., indicated the Nursing Staffing information was posted on the wall near the receptionist desk. It indicated 1 Registered Nurse (RN) and 14 LPNs were working the day shift. Interview with the receptionist at that time, indicated there were a total of 14 LPNs and 1 RN in the facility doing various jobs.</p> <p>On 9/25/12 at 10:21 a.m., the Nursing Staffing information posting indicated</p>		<p>evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> There were no residents affected by this finding. The posting was corrected on the date of this finding.</p> <p><b>2) How the facility identified other residents:</b> The facility cannot identify other residents affected by this finding. The posting was corrected on the date of this finding.</p> <p><b>3) Measures put into place/ System changes:</b> The receptionist/staffing coordinator, responsible for completing the nursing staffing information was inserviced on the date of this finding as to the requirement for posting of nursing staffing in the facility. The Human Resources Director or designee and the Receptionist/Staffing Coordinator or designee will verify the posting weekly by comparing the staffing with the posting. Results will be documented on a "Posted Staff Nursing" audit form. The Administrator or DON will review the audit form weekly.</p> <p><b>4) How the corrective actions will be monitored:</b> The results of the audits will be reviewed in Quality Assurance Meeting monthly for three months and quarterly for a total of six months.</p> <p><b>5) Date of compliance: October 26, 2012</b></p>		

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	<p>there were 14 LPNs and 2 RNs for the day shift.</p> <p>Interview with the South Unit Manager on 9/25/12 at 10:23 a.m., indicated there were 3 LPNs providing direct resident care on the South Unit.</p> <p>Interview with LPN #2 on 9/25/12 at 10:38 a.m., indicated there were 3 LPNs on the North Unit responsible for direct resident care.</p> <p>Interview with LPN #3 on 9/25/12 at 10:42 a.m., indicated there were 2 LPNs, a LPN Nurse Manager and a LPN Nurse Manager in-training on the unit.</p> <p>Interview with the DON on 10/1/12 at 2:40 p.m., indicated the posting listed all nurses in the building even if the nurse was not providing a full shift of direct resident care.</p> <p>Interview with the Administrator on 10/1/12 at 3:44 p.m., indicated the receptionist responsible for completing the Nursing Staffing information, was including all nurses in the staffing hours even those nurses not providing direct resident care. She indicated the staffing posting was inaccurate and did not reflect the correct number of nurses</p>				

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	that provided direct care to the residents.  3.1-13(a)				

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F0371 SS=F	<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 stored and prepared in a sanitary manner related to labeling of food and an accumulation of burnt food spillage inside the oven for 1 of 2 pantry refrigerators and 1 of 1 kitchens. This had the potential to affect 37 residents who resided on the North Unit and 117 of the 129 residents who resided in the facility. (The North Unit pantry and the Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Environmental Tour on 10/1/12 at 2:08 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>a. Inside the North Unit pantry refrigerator, a sandwich was observed on a plate covered in plastic wrap, there was no date visible. There was also food wrapped in tin foil that was</p>	F0371	<p><b>F371 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>1) Immediate actions taken for those residents identified:</b> There were not any residents directly identified in this finding. The plate covered in plastic wrap, food wrapped in tin foil and plastic bowl inside of the North Unit pantry refrigerator were removed immediately. The areas identified during the Kitchen Sanitation Tour indicating burnt food debris on the bottoms of ovens were cleaned immediately. <b>2) How the facility identified other residents:</b> An audit of all kitchen and nursing unit areas/pantries was completed and any identified concerns were addressed immediately. <b>3) Measures put into place/ System changes:</b> Update current cleaning monitoring tools for kitchen and nourishment pantry areas. <b>4)</b></p>	10/26/2012			

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	<p>not dated and a plastic bowl with food in it that was inside a plastic bag that was not dated. In the back of the refrigerator was a styrofoam bowl that contained food and was loosely covered with foil, again there was no date.</p> <p>Interview with the North Unit Manager at the time, indicated the food should not have been left in the refrigerator.</p> <p>2. Observation during the Kitchen Sanitation Tour on 9/26/12 at 2:25 p.m., indicated the areas on the inside of the doors and on the bottoms of 3 of 3 ovens were soiled with burnt food debris.</p> <p>Interview with the Dietary Manager at the time of the tour, indicated all 3 ovens were soiled and in need of cleaning.</p> <p>3.1-21(i)(3)</p>		<p><b>How the corrective actions will be monitored:</b> The Dietary Manager and Housekeeping Supervisor will be responsible for ongoing monitoring of the respective areas on a weekly basis. The Housekeeping Supervisor and Dietary Supervisor will monitor areas weekly and every two weeks thereafter to ensure compliance with this requirement. Results of the audits will be reviewed with the Administrator. Results will be reviewed in the Quality Assurance Meetings monthly for 3 months and quarterly x1 for total of six months. <b>5) Date of compliance: October 26, 2012</b></p>		

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F0425 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 and record review, the facility failed to ensure insulin vials were not being used after their expiration date for 2 of 21 diabetics who resided on the Progressive Care Unit (PCU). (Residents #62 and #91)</p> <p>Findings include:</p> <p>1. Observation of the PCU medication room on 10/1/12 at 2:26 p.m., indicated a vial of Novolin 70/30 insulin for Resident #62 was dated as being opened on 8/1/12.</p>	F0425	<p><b>F425 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> Expired insulin vials for Residents #62 and #91 were removed and destroyed. <b>2) How the facility identified other residents:</b> Audit was completed of all medication carts and medication rooms to check for</p>	10/26/2012	

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	<p>Interview with LPN #5 at the time, indicated the pharmacy recommendations recently changed and she was not sure if the insulin was good for 30 or 90 days.</p> <p>The record for Resident #62 was reviewed on 10/1/12 at 3:20 p.m. A Physician's order dated 8/24/12 indicated the resident was to receive Novolin 70/30 insulin, 25 units before supper. A Physician's order dated 9/11/12 indicated the resident was to receive 15 units of Novolin 70/30 insulin every morning at breakfast.</p> <p>Review of the September 2012 Medication Administration Record (MAR), indicated the resident had received the insulin as ordered.</p> <p>Interview with the Assistant Director of Nursing on 10/1/12 at 3:20 p.m., indicated Novolin 70/30 insulin expired 42 days after being opened. Further interview indicated this information was posted in the medication room.</p> <p>2. Observation of the PCU medication room on 10/1/12 at 2:26 p.m., indicated a vial of Novolin Regular insulin for Resident #91 was dated as being opened 8/3/12.</p>		<p>expired medications, and no further issues were identified. <b>3) Measures put into place/ System changes:</b> Licensed staff will be re-educated regarding expiration dates of medications. Audits will be completed of medication carts, medication rooms and medication refrigerators at least twice weekly to monitor for expired medications. The DON/ designee is responsible for oversight of these audits. Staff will be addressed and re-educated if concerns are noted. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. <b>5) Date of compliance: 10/26/12</b></p>		

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	<p>Interview with LPN #5 at the time, indicated the pharmacy recommendations recently changed and she was not sure if the insulin was good for 30 or 90 days.</p> <p>The record for Resident #91 was reviewed on 10/1/12 at 3:25 p.m. Review of the October 2012 Physician's Order Summary (POS), indicated the resident was to received the Novolin Regular based on a sliding scale.</p> <p>Review of the September 2012 MAR, indicated the resident received the Novolin Regular insulin on the following dates: 9/16 at 6 p.m., 9/18 at 6 p.m., 9/20 at 6 p.m., 9/21 at 6 p.m., 9/28 at 6 p.m., and 9/29/12 at 6 p.m.</p> <p>Interview with the Assistant Director of Nursing on 10/1/12 at 3:20 p.m., indicated Novolin 70/30 insulin expired 42 days after being opened. Further interview indicated this information was posted in the medication room.</p> <p>3.1-25(o)</p>				

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, that facility failed to ensure the pharmacist's drug review recommendation related to providing the clinical rationale for not reducing a medication was acted upon for 1 of 10 resident's reviewed for unnecessary medications. (Resident #91)</p> <p>Findings include:</p> <p>The record of Resident #91 was reviewed on 9/28/12 at 1:35 p.m. The resident had diagnoses that included, but were not limited to, leukemia, depression and diabetes.</p> <p>There was a Consultant Report completed by the Pharmacist and dated 5/22/12 that indicated:</p> <p>"Comment: Please respond promptly to assure facility compliance with Federal regulations. (Resident #91's name) has taken cymbalta (an</p>	F0428	<p><b>F428 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> Resident #91- Obtained appropriate documentation from physician of clinical rationale for decline of Gradual Dosage Reduction (GDR) for medication Cymbalta. <b>2) How the facility identified other residents:</b> Facility completed audit of pharmacist recommendations for GDR's completed in the last 30 days to ensure documentation of clinical rationale is present when recommendations for GDR's are declined. <b>3) Measures put into place/ System changes:</b> Nursing Managers, Medical Record Nurse and Social Services will be re-educated regarding required documentation of clinical rationale</p>	10/26/2012	

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	<p>antidepressant medication) 60 mg (milligrams) daily for management of depressive symptoms since 6/27/09. Recommendation: If therapy is to continue at the current does, please provide rationale describing a dose reduction as clinically contraindicated.</p> <p>Rationale for Recommendation: For individuals taking antidepressant therapy for management of depressive symptoms, gradual discontinuation may be considered in the absence of recurrence or relapse following 6 months of continuous treatment. Federal nursing facility regulations require that consideration be given to gradual dosage reduction (GDR) for antidepressant therapies in two separate quarters within the first year in which an individual is admitted or after the facility has initiated such a medication, and then annually, UNLESS CLINICALLY CONTRAINDICATED."</p> <p>The Physician responded to the recommendation, date not indicated, with a check for the section: "I decline the recommendation above because GDR is Clinically contraindicated for this individual as indicated below."</p> <p>The form indicated the Physician was to: "Please provide CMS (Centers for</p>		<p>for decline of GDR's. The DON/designee will complete a review of pharmacist recommendations for GDR requests monthly to ensure that documentation of clinical rationale for decline of GDR's are present upon receipt from physician. 4) <b>How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. 5) <b>Date of compliance: 10/26/12</b></p>		

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	<p>Medicare and Medicaid Services) required patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual."</p> <p>There was no documentation provided by the Physician to support the patient-specific rationale to not reduce the medication as recommended by the Pharmacist.</p> <p>Interview with the ADON on 10/1/12 at 9:25 a.m., indicated the Physician did not provide the patient-specific rationale that was required for declining to reduce the cymbalta.</p> <p>Review of the current Physician orders indicated there was an order for the resident to receive cymbalta 60 mg daily. The medication had not been reduced.</p> <p>3.1-25(h)</p>				

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F0463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the call system was functioning for 1 of 40 resident call lights checked for function. (Resident #147)</p> <p>Findings include:</p> <p>On 9/25/12 at 8:25 a.m., the emergency call light cord in the bathroom of Resident #147's room was pulled. The indicator lights outside of the resident's room and on the board at the Nurses' Station did not light up. There was no sound at the resident's room or at the Nurses' Station that indicated the emergency call light was activated.</p> <p>At 10:28 a.m. on 9/25/12, the bathroom emergency call light cord was again pulled. The indicator lights outside of the resident's room and on the board at the Nurses' Station did not light up. There was no sound at the resident's room or at the Nurses' Station that indicated the emergency call light was activated.</p>	F0463	<p><b>F463 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> Immediate action was taken on 9/26/12 to repair the call light and the call light was working on 9/26/12. <b>2) How the facility identified other residents:</b> An audit was conducted of all call lights and all call lights were in working order. As an extra measure, call-light vendor was contacted to look at call system for resident #147 and found the system to be in proper functioning order and made no additional repairs. The call light vendor also audited all call lights in the facility and all were in working order. <b>3) Measures put into place/ System changes:</b> Staff inservices will be conducted regarding communicating with maintenance staff or Administrator immediately if they should notice a call light is not</p>	10/26/2012

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	<p>Interview with the Assistant Director of Nursing (ADON) at that time, indicated the emergency call light in the bathroom was not functioning properly.</p> <p>On 9/26/12 at 9:48 a.m., the emergency call cord was pulled in Resident #147's bathroom. The call light was not functioning. Additional attempts to activate the call light were made and the light only functioned one time of the ten attempts.</p> <p>Interview with the ADON on 9/26/12 at 9:48 a.m., indicated the call light was not functioning properly. She indicated, "there must be a short."</p> <p>Interview with Maintenance Staff #1, on 9/26/12 at 9:52 a.m., indicated he did not repair the light on 9/25/12 because when he checked the call light it was functioning correctly.</p> <p>Interview with the Administrator, on 9/26/12 at 9:55 a.m., indicated the light bulb for the call light had been changed on 9/25/12 in an attempt to correct the problem. She indicated the call light needed to be repaired.</p> <p>3.1-19(u)(2)</p>		<p>working properly. Maintenance staff will audit twenty (20) rooms per week on a rotating schedule to ensure ongoing compliance with this requirement. <b>4) How the corrective actions will be monitored:</b> The Administrator or designee will review the call system audits weekly to ensure completion. The audits will be reviewed in Quality Assurance Meetings monthly x3 months, then quarterly x1 for a total of 6 months. <b>5) Date of compliance: October 26, 2012</b></p>		

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F0465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to torn furniture, marred walls, broken heat register covers a nonfunctional tub bath, and soiled ice machines for 3 of 3 units throughout the facility and for 1 of 1 kitchen areas. This had the potential to affect 129 residents residing in the facility. (The North, South, and Progressive Care Units and the Main Kitchen)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 9/25/2012 at 9:01 a.m., a section of missing wallpaper was observed behind the head of bed #1 in Room 209. Further, the base board in the bathroom was loose and detached from the wall. One resident resided in this room.</li> <li>On 9/25/12 at 9:04 a.m., the vinyl seat cover for the chair in Room 129 was cracked in several places. One resident resided in this room.</li> <li>On 9/25/12 at 10:47 a.m., the plastic vent cover on top of the</li> </ol>	F0465	<p><b>F465 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b> Immediate action was taken for all resident rooms cited in this deficiency and is in the process of having repairs completed. The chairs cited in this example were removed. The ice machine was also cleaned on the date of this finding. <b>2) How the facility identified other residents:</b> Other rooms will be identified using a resident room Bi-weekly preventative Maintenance Checklist. Any issues identified will be placed on a priority list and scheduled for repairs. <b>3) Measures put into place/ System changes:</b> A system will be put into place whereby maintenance personnel and/or designee will check a sample of rooms to ensure compliance with this requirement. Any concerns will be noted and placed on the priority list. <b>4) How the</b></p>	10/26/2012

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	<p>heating/air conditioning unit in Room 211 was cracked and broken in sections. Two residents resided in this room.</p> <p>4. On 9/25/12 at 9:59 a.m., the vinyl chair located next to bed #1 in Room 222 was torn along the edge of the seat cushion. Two residents resided in this room.</p> <p>5. On 9/25/12 at 10:28 a.m., there was no plastic vent cover for the heating/air conditioning unit in Room 210. One resident resided in this room.</p> <p>6. On 9/25/12 at 8:42 a.m., the bathroom walls in Room 312 were scratched and marred. The inside edge of the bathroom door was splintered along the edge and the wall behind the head of bed #1 was scratched and marred. One resident resided in this room.</p> <p>7. On 9/26/12 at 11:22 p.m., the bath tub on the North unit was observed to be out of order. There was a sign on the wall that indicated the tub did not work.</p> <p>Interview with the Administrator on 9/27/12 at 11:23 a.m., indicated there was a tub bath in the facility but it has been broken for some time.</p>		<p><b>corrective actions will be monitored:</b> The corrective action will be monitored by using an audit tool every two weeks for three months and monthly thereafter. Any issues identified will be communicated in the Quality Assurance Meetings monthly for three (3) months and quarterly thereafter. <b>5) Date of compliance: October 26, 2012.</b></p>		

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	<p>Interview with the Maintenance Supervisor on 10/1/12 at 2:00 p.m., indicated all of above areas had been repaired except for the plastic covers for the heating/air conditioning units.</p> <p>8. During the Kitchen Sanitation Tour on 9/26/12 at 2:25 p.m., the following was observed with the Dietary Manager:</p> <p>a. The wall in the dish room near the ceiling had a three foot by one foot section in need of repair. The area had water stains.</p> <p>b. There was a four foot by three inch section of the wall on the left of the dish washer that was damaged and gouged and in need of repair.</p> <p>c. The outside of the ice machine located in the Main Dining Room was soiled and in need of cleaning.</p> <p>Interview with the Dietary Manager at the time of the tour, indicated the above areas were damaged or soiled and in need of repair or cleaning.</p> <p>3.1-19(f)</p>			