

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2015
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NAME OF PROVIDER OR SUPPLIER ALEXANDRIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 S PARK AVE ALEXANDRIA, IN 46001
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 30 and December 1, 2, 3, 4, and 7, 2015</p> <p>Facility number: 000518 Provider number: 155521 AIM number: 100266670</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 1 Medicaid: 51 Other: 5 Total: 57</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on December 9, 2015.</p>	F 0000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
F 0157	483.10(b)(11)			

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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SS=D Bldg. 00	<p>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure physician notification was completed for 1 of 3 residents whose clinical records were reviewed for hospitalization. (Resident #11)</p>	F 0157	1. Resident #11 did not receive any negative outcome related to the alleged deficient practice. The physician has been updated on the resident's current status. 2 All residents have the potential to be affected. The clinical record for	01/06/2016
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	<p>Findings include:</p> <p>The clinical record for Resident #11 was reviewed on 12/7/15 at 12:08 p.m. Diagnoses included, but were not limited to, fall with left greater trochanter fracture, seizures, hypertension and Parkinson's disease.</p> <p>A nurse's note, dated 7/11/15 at 9:15 p.m., indicated the following: "...POA [Power of Attorney] requesting pt. [patient] be sent to...ER [emergency room]. ...ambulance arrived to p/u [pick up the pt. at 9 p.m. Report called to ...ER [emergency room]. POA to meet [the] pt. there."</p> <p>During an interview with the ADON on 12/7/15 at 4:50 p.m., the ADON indicated she was unable to locate a physician notification or a physician order related to Resident #11 being sent to the emergency room for evaluation and treatment on 7/11/15.</p> <p>No further information was provided upon exit on 12/7/15 at 5:10 p.m.</p> <p>3.1-5(a)(3)</p>		<p>each resident has been reviewed for the past 30 days. If a concern is found, the primary physician has been updated on the resident's current status in an effort to confirm physician notification. 3. The facility's policy for physician notification has been reviewed and no changes are indicated at this time. The nurses have been reeducated on timely physician notification of resident changes in condition with a special focus on transfers for emergency evaluation and the documentation verifying physician notification. A monitoring tool to confirm physician notification/obtaining of a physician order has been implemented. 4. The DON or designee will be responsible for completing the monitoring tool on scheduled work days as follows: daily for two weeks and then weekly thereafter to ensure MD was notified and documentation is present to verify said notification. Should a concern be noted, immediate corrective action will occur. Results of monitoring and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made if indicated on the basis of compliance.</p>		

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure a complete and thorough investigation related to other possible staff and/or residents aware of the incidents of abuse for 2 of 3 allegations reviewed. (Resident #'s 57,38, and 77)</p> <p>Findings include:</p> <p>On 12/3/15 at 2:30 p.m., the Administrator provided 3 allegations of abuse for review. The incidents reviewed included verbal abuse with Resident # 77 in Incident #5 and Residents # 57 and # 38 in Incident # 6.</p> <p>1. Incident #5, dated 11/3/15, indicated Resident #77 was verbally abused by her roommate's daughter concerning her television being too loud and the opening of the blinds. The Social Service Director, in the report, indicated she had found Resident #77 in her dark room crying and shaking related to this incident. The investigation of this incident did not include any information</p>	F 0226	<p>1. Regarding incident #5: A complete and thorough investigation of the incident involving Resident#77 has been completed. Regarding incident #6: A complete and thorough investigation of the incident involving Resident#57 & #38 has been completed. Staff and residents, including Resident #28, #45. And #77, have been interviewed. The SSD and Administrator have been re-educated as to initiating a thorough investigation following an allegation of abuse and thorough documentation of the same. 2. All residents have the potential to be affected. Any allegation of abuse received during the last 30 days has been reviewed to ensure the allegation was completely and thoroughly investigated, including interview of applicable staff and residents and documentation of the same. 3. The facility's abuse policy has been reviewed and no changes are indicated at this time. The staff,including the Administrator and SSD, has been re-educated on the policy with a special focus on conducting a complete and thorough</p>	01/06/2016	

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	<p>related to staff's presence during or after the incident.</p> <p>On 12/4/15 at 9:48 a.m., during an interview, the Administrator indicated no staff were present on the hall during Resident #77's conflict with her roommate's daughter. She indicated the information was not included in the report because no staff had witnessed it. She indicated no staff had been interviewed to determine if there was a problem with the television sound level or light level prior to the incident. She also indicated no other residents had been interviewed concerning the incident.</p> <p>On 12/14/15 at 11:10 a.m., the Administrator provided the "RESIDENT (crossed out with Visitor written in) -TO-RESIDENT ABUSE" form. She indicated this form was her "inner" investigation. This form with the dated incident as 11/3/15 and indicated "Staff member(s) who witnessed the abuse: none."</p> <p>2. Incident #6, dated 11/17/15, indicated Resident #57 was walking out of the activity room after the morning activity with the Activity Director and was exchanging words with Resident #38. Resident #57 returned to the room and began to swing at Resident #38 with a</p>		<p>investigation including interview of applicable staff and residents.</p> <p>4. The Administrator will be responsible to review all allegations of abuse upon notification and ensure facility policy followed, including initiating investigation. Should a concern be noted with the following of the policy, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made if indicated on the basis of compliance.</p>		

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	<p>physical confrontation resulting. Resident #57 had scratches under his right and left eye, and Resident #38 had bruising to his lip and nose and left eye. The investigation did not include any information related to staff or other residents present in the activity room.</p> <p>On 12/4/15 at 9:48 a.m., during an interview, the Administrator indicated no other residents were present during Incident #6.</p> <p>On 12/04/15 at 10:19 a.m. during an interview, the Activities Director indicated other residents were present during Incident #6. The cognitively intact residents included, but were not limited to, Resident #28, #45, and #77.</p> <p>On 12/4/15 at 11:40 a.m., the Administrator provided a hand written note, dated 12/5/15 (sic), indicating a follow up on the impact on other residents who may have witnessed Resident #57 and #38's conflict on 11/14/15.</p> <p>The "ABUSE PROHIBITION, REPORTING AND INVESTIGATING," dated 10/2014, was provided by the Administrator on 12/3/15 at 8:45 a.m. This current policy indicated the following:</p>						

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	<p>"POLICY:</p> <p>It is the policy of this facility allegations of abuse will be communicated to, and thoroughly investigated by, the correct authority.</p> <p>1. This facility will not permit residents to be subjected to abuse by anyone...</p> <p>...Verbal Abuse-Episodes of oral, written and/or gestured language that includes disparaging and derogatory remarks to residents...</p> <p>...Mental Abuse-A single traumatic episode of behavior toward a resident which includes, but is not limited to , humiliation, harassment and threats of punishment... other (visitor or relative) to resident...</p> <p>...If resident abuse, suspicion of abuse is reported:</p> <p>...4. ...A thorough investigation will be initiated</p> <p>...10. Residents will be questioned about the nature of the incident and their statements placed in writing.</p> <p>11. Investigation will be conducted to assure other residents have not been affected by the incident or inappropriate behavior and the results documented.</p> <p>12. Statements will be taken including,</p>			

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F 0241 SS=D Bldg. 00	<p>but not limited to, *facts and observations by involved employees ...*facts and observations by any others with pertinent information... ...15. The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation, and to file a follow-up report to the State Department of Health...."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to maintain the dignity during dining for a resident requiring assistance (Resident #13) and of a resident waiting as her tablemates were eating (Resident #81) in a timely manner for 2 of 2 dining observations. Findings include: 1. On 11/30/15 at 12:30 p.m., during the</p>	F 0241	<p>1. Staff intervened on behalf of residents #13 and #81 in regard to needed assistance and failure to serve meals concurrently to residents seated at the same table. 2. All residents have the potential to be affected, thus the following corrective actions have been taken. 3. In an effort to ensure the observance of dignity during dining, the nursing and consultant staff have been re-educated on dignity with a special focus on providing necessary assistance to residents</p>	01/06/2016

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	<p>lunch dining observation, Resident #13 was observed to receive her meal tray, which was uncovered at this time in preparation to assist this resident with her meal. Other residents were seated at the same table. CNA # 14 was feeding Resident # 51, who received her meal after Resident # 13. At 12:52 p.m. Nurse Consultant #12 was observed to start assisting the Resident # 13 to eat. The nurse consultant did not offer to warm the food or check the food temperature prior to the assisting the resident.</p> <p>2. During a lunch dining observation in the main dining room on 12/3/15, beginning at 12:01 p.m., Resident # 81 was seated at a table with 3 other residents. At 12:05 p.m., Resident #81's table mates had been served their meals. At 12:14 p.m., Resident #81 asked CNA # 16 where her meal tray was. CNA #16 indicated they were working on it. At 12:17 p.m., Resident #81 indicated she was leaving the dining room, stating "I'm out of here" and propelling her wheelchair toward the doorway of the dining room. LPN #8 approached Resident #81 and assisted her out the dining room.</p> <p>During an interview with LPN #8 when she returned to the dining room, she indicated Resident #81 had indicated to</p>		<p>when the meal is served and serving tablemates at one table concurrently before serving another table. A monitoring tool has been implemented in an effort to monitor compliance following said re-education. 4. The DON or designee will be responsible for monitoring meal service at varied times on scheduled work days as follows: Daily for two weeks then weekly thereafter, to ensure dignity with meals for all residents. Should a concern be observed, corrective action will be taken. Results of monitoring and any corrective actions taken will be discussed at the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made if indicated on the basis of compliance.</p>	

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F 0242 SS=E Bldg. 00	<p>her that if she wasn't going to be given a tray, then she wanted to go to her room. LPN #8 indicated she would have Resident #81's meal served to her in her room.</p> <p>During an interview with Resident #81 on 12/3/15 at 12:32 p.m., Resident #81 indicated she had left the dining room because she was upset that everyone around her had received their noon meal and she had not. She further indicated it happens occasionally.</p> <p>During an observation on 12/3/15 at 12:38 p.m., Resident #81 was assisted by LPN #8 from her room to the dining room to eat, when Resident #81 stated to LPN #8 " ...I was p----- off but have now cooled down...."</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES 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. Based on interview and record review,</p>	F 0242	1. Residents #15, 77 and 29	01/06/2016
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	<p>the facility failed to provide residents with choices regarding frequency of bathing for 3 of 3 residents reviewed for choices (Residents # 15, 77, and 29).</p> <p>Findings include:</p> <p>1. During an interview, on 11/30/15 at 2:58 p.m., Resident #29 indicated she preferred to shower daily, but only showered twice a week, as this was what the facility offered.</p> <p>Review of Resident #29's clinical record began on 12/1/15 at 8:32 a.m. Resident #29 had a current, 10/09/2015, quarterly Minimum Data Set assessment, which indicated the resident was cognitively intact and required assistance with bathing and hygiene.</p> <p>Review of a document titled "Daily Preferences", dated 10/28/15 and initiated 7/3/15, indicated Resident #29 was asked whether she preferred a tub bath, shower, or sponge bath, but did not indicate the number of showers she preferred to take a week.</p> <p>Review of the facility shower schedule indicated Resident #29's room number was assigned showers on Mondays and Thursdays on evening shift.</p>		<p>have been interviewed in an effort to confirm their desire/choice regarding frequency of bathing. Responses will communicated to the nursing department and schedules/plans of care updated to reflect care consistent with resident choice. 2. As all residents have the potential to be affected, the following actions shall be taken: 3. The interviews regarding frequency in bathing/showering for all residents will be reviewed with the applicable resident or legal representative (for non-interviewable residents). Should resident preference differ from the current bathing/showering frequency scheduled, the resident's plan of care will be updated and frequency revised to ensure adherence with resident preference. Nursing staff shall be addressed in regard to adherence with resident preference in regard to bathing/showering and of the need to update/revise the schedule should a resident voice a desire to change said frequency. The Daily Preferences document shall be revised to include not only method of bathing, but also frequency of bathing. Newly admitted residents shall be interviewed as to preference in manner and frequency and the same communicated to administrative nursing to ensure the resident's plan of care reflects the desire of</p>		

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	<p>During an interview, on 12/3/15 at 1:25 p.m., the Social Services Consultant indicated the document titled "Daily Preferences" was used at facility admission to determine resident preferences.</p> <p>During an interview, on 12/3/15 at 1:32 p.m., the Social Services Director indicated she had discussed care preferences with Resident #29 when she was admitted to the facility, but only asked about the questions on the preferences document. She further indicated showering more than twice weekly didn't usually come up in the admission discussions, as common facility practice was showering twice weekly.</p> <p>2. On 12/1/15 at 8:38 a.m., during an interview, Resident #15 indicated she would like more showers than what she was receiving which she indicated was one shower a week. On 12/3/15 at 3:19 p.m., during an interview, Resident #15 indicated she would like to have a shower at least 3 times a week.</p> <p>Resident #15's clinical record was reviewed on 12/3/15 at 3:37 p.m. The resident's diagnoses included, but were no limited to, Congestive Heart Failure, cardiomegaly, hypertension, diabetes, rheumatoid arthritis. The quarterly</p>		<p>the newly admitted resident. 4. As a means of quality assurance, the DON/designee shall monitor compliance with bathing as per resident preference on scheduled days of work. Daily for two weeks then weekly thereafter, to ensure adherence with resident preference. Should a concern be observed, corrective action will be taken. Results of monitoring and any corrective actions taken will be discussed at the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made if indicated on the basis of compliance.</p>	

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	<p>Minimum Data Set assessment, dated 10/3/15, indicated the resident was cognitively intact and required extensive assistance of one person for activity of daily living. The shower record for November and December of 2015 indicated the resident was receiving 2 showers weekly.</p> <p>3. On 11/30/15 at 3:12 p.m., during an interview Resident #77 indicated she would like to have more showers. On 12/3/15 at 3:13 p.m., during an interview, Resident #15 indicated she would like to have a shower at least 3 times a week.</p> <p>Resident #77's clinical record was reviewed on 12/3/15 at 3:37 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia, Coronary artery disease, benign hypertension. The Admission Minimum Data Set assessment, dated 10/3/15, indicated the resident was cognitively intact and required supervision for bathing.</p> <p>On 12/04/2015 at 2:38 p.m., during an interview CNA #3 indicated Resident #77 had showers 2 times a a week and would not refuse them.</p> <p>3.1-3(u)(3)</p>				

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F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide activities for cognitively impaired and dependent residents for 3 of 3 residents reviewed for activities (Resident's #44, #48, and #78).</p> <p>Findings include:</p> <p>1. During an observation on 12/01/2015 at 9:23 a.m., Resident #44 was observed to be sitting in the activity room. There was music playing on the television, but the resident's eyes were opened and closed as if nodding off to sleep.</p> <p>During an activity observation on 12/01/2015 at 9:38 a.m., Resident #44 was observed to be sitting on the couch in the activity room lounge on the locked unit during the stretch activity with her eyes closed not participating and not being encouraged to participate.</p> <p>During a random observation on</p>	F 0248	<p>1 Activity interests for residents #44 and #78 shall be reviewed and plans of care updated to include appropriate interests relative to cognitive impairment and dependency. Resident #48 is no longer at facility 2. As all residents could be affected, the following actions shall be taken:</p> <p>3. The facility shall review and identify those residents with cognitive deficits and/or dependence warranting specialized activities. The activities schedule shall be reviewed to ensure activities are provided to meet the various needs of the resident population. Following revision, activities shall be monitored by administration to confirm provision of appropriate activities to meet the needs of the residents. 4. In an effort to confirm compliance with provision of appropriate activities, random observations will be conducted by the Administrator/designee on scheduled days of work in an effort to evaluate participation, appropriateness, and attentiveness to the residents'</p>	01/06/2016

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	<p>12/01/2015 at 11:25 a.m., Resident #44 was observed to be laying in bed with her eyes closed.</p> <p>During an observation 12/01/2015 at 1:39 p.m., Resident #44 was observed sitting in the activity room with her eyes closed. At this same time, the Activity Director was observed painting the fingernails of residents in the dining room.</p> <p>During an activity observation on 12/02/2015 at 3:19 p.m., Resident #44 was observed sitting in the dining room at a table by herself. At this same time, three residents from the locked unit and the Activity Director were observed to be separating and cutting up Christmas cards at a table in the dining room.</p> <p>A review of the Activity calendar for December indicated that exercise was to begin on 12/3/2015 at 9 a.m. During an observation on 12/3/2015 at 9:05 a.m., Resident #44 was observed sitting on the couch in the activity room with her eyes closed and head propped up on her hand with her mouth open.</p> <p>During an activity observation on 12/03/2015 at 9:29 a.m., the balloon activity was started. On 12/03/2015 at 9:30 a.m., the Activity Director walked out of room while holding the balloon</p>		<p>needs. Daily for two weeks then weekly thereafter, to ensure adherence with appropriate activities. Should a concern be observed, corrective action will be taken. Results of monitoring and any corrective actions taken will be discussed at the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made if indicated on the basis of compliance.</p>	

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	<p>and entered the activity closet. She stopped the activity and left the residents.</p> <p>On 12/03/2015 at 9:32 a.m., the Activity Director walked out of the closet and started a conversation with the Activity Assistant #1 about what Christmas movie they were planning for the residents to watch on Friday.</p> <p>On 12/03/2015 9:33 a.m., the Activity Director carried the balloon back into the activity room and restarted the balloon activity. During an activity observation on 12/03/2015 at 9:44 a.m., the Activity Director was observed holding the balloon and ending the balloon activity.</p> <p>During an activity observation on 12/07/2015 at 9:11 a.m., a guest musical artist was observed to be singing to the residents on the locked unit. At the same time, Resident #44 was observed to be laying in bed with her eyes closed.</p> <p>During an observation on 12/07/2015 at 9:34 a.m., the Activity Director was observed offering juice in to the residents in the activity room on the locked unit. During this time, Resident #44 was observed laying in bed with her eyes closed.</p> <p>During an activity observation on</p>			

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	<p>12/07/2015 at 9:50 a.m., the Activity Director began the balloon activity in the activity room of the locked unit. At this time, Resident #44 was laying in bed with her eyes closed.</p> <p>During an interview with the Activity Director on 12/03/2015 at 12:50 p.m., she indicated that for the cognitively impaired residents she played music and did manicures. She indicated Resident #44 actively participated in all activities and did not receive 1:1 services. The Activity Director indicated that the activity calendar posted was the same for the entire building.</p> <p>During an interview with the Activity Director or 12/07/2015 11:20 a.m., she indicated Resident #44 activity interests included special music and drinking hot chocolate.</p> <p>A review of the medical record for Resident #44 began on 12/3/2015 at 3:15 p.m. and indicated her diagnoses included but were not limited to: Transient Ischemic Attack, Depression, Alzheimer's Disease and Dementia.</p> <p>A review of the Activity care plan, provided by the Nurse Consultant on 12/07/2015 at 12:40 p.m., last revised on 10/13/2015, indicated that the resident's</p>			

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	<p>cognitive status was confused. The resident had a short attention span and was in and out of activities. The goal indicated the resident would stay in an activity of interest for 10-15 minutes. It also indicated that Resident #44 liked ball toss, coloring papers and walking with her walker.</p> <p>A review of the Activity Assessment, provided by the Administrator on 12/07/2015 at 12:37 p.m., indicated that it was done on 09/21/2015. The assessment indicated Resident #44 needed verbal cueing and reminding. It also indicated the resident preferred small groups and that her interests included gospel music, walking, floral arrangements and people watching. The activity assessment indicated that all information gathered for this form was gathered from the medical record.</p> <p>2. During an observation on 12/01/2015 at 9:19 a.m., Resident #78 was sitting on the couch in the activity room lounge of the locked unit with her hands together in her lap. Resident #78 was faced away from the TV. The TV was on and there was music playing.</p> <p>During an activity observation on 12/01/2015 at 9:33 a.m., Resident #78 was sitting on the couch with her hands</p>			

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	<p>in her lap in the activity room lounge of the locked unit while the stretch activity was going on. Resident #78 did not participate and was not encouraged to do so by the Activity Director. The stretch activity was 7 minutes in length.</p> <p>During an observation on 12/01/2015 at 1:37 p.m., Resident #78 was sitting in the activity room on the couch with her eyes closed. At this same time, the Activity Director was painting fingernails in dining room.</p> <p>During an observation on 12/02/2015 at 3:19 p.m., Resident #78 was observed sitting in the activity room looking at the wall. At the same time, three residents from the locked unit and the Activity Director were observed to be separating and cutting up Christmas cards.</p> <p>On 12/03/2015 at 9:29 a.m., the Activity Director began a balloon activity. On 12/03/2015 at 9:30 a.m., she walked out of the activity room lounge while holding the balloon and entered the activity closet, thus stopping the activity.</p> <p>On 12/03/2015 at 9:32 a.m., the Activity Director walked out of the closet and started a conversation with the Activity Assistant #1 about what Christmas movie they were planning for the residents to</p>			

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	<p>watch on Friday.</p> <p>At 9:33 a.m., the Activity Director carried the balloon back into the activity room and restarted the balloon activity. During this time, Resident #78 sat on the couch in the activity room with her eyes closed. No interaction between the Activity Director and Resident #78 was observed throughout the activity.</p> <p>During an activity observation on 12/03/2015 at 9:44 a.m., the Activity Director ended the balloon activity.</p> <p>During an observation on 12/07/2015 at 7:17 a.m., Resident #78 was observed sitting on the couch in the activity room. Resident #78 was not sitting in an area where the TV could be seen and was looking at the wall.</p> <p>During an observation on 12/07/2015 at 9:11 a.m., a musical guest was singing to the cognitively impaired residents of the locked unit. Resident #78 was sitting on the couch with her eyes closed. Resident #78 was not encouraged to participate in the singing and sat with her eyes closed for the duration of the activity (14 minutes).</p> <p>During an interview with the Activity</p>			

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	<p>Director on 12/02/2015 at 3:17 p.m., she indicated that the residents were ending their day by cutting up Christmas cards to prepare for the next day's activities.</p> <p>During an interview with the Activity Director on 12/07/2015 at 11:20 a.m., she indicated that Resident #78 liked ball toss, music and regularly participated in all activities.</p> <p>A review of the medical record for Resident #78 began on 12/03/2015 at 3:31 p.m. It indicated the diagnoses included but were not limited to: Alzheimer ' s disease, dementia and weakness.</p> <p>A review of the Activity Assessment for Resident #78 was provided by the Administrator on 12/07/2015 at 12:37 p.m. The assessment indicated that it was done on 9/17/2015. The Activity Assessment indicated that Resident #78 liked to participate in small group activities and required verbal assistance and reminders. It also indicated Resident #78 liked gospel music, floral arrangements, and bird watching.</p> <p>No Activity Care Plan was provided during the time of the survey for Resident #78</p>			

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	<p>A review of the Policy titled "Resident's with Special Needs dated November 2008, indicated "It is the policy of this facility to 1. Provide activity programs and modified interventions to promote the maintenance or enhancement of each resident's quality of life, and to promote physical, cognitive, and/ or emotional to the extent practicable. 2. Offer meaningful activity programs for residents who have disorientation to time, place, and/or person. 3. Provide Activity programs to reflect the resident's individual needs, to enhance and promote each resident's physical and mental status, and to promote cognitive health....." Procedures included "...modifying programs to promote each resident's meaningful participation by simplifying steps, adapting approaches, and modifying instructions."</p> <p>3. On 11/30/15 at 11:29 a.m., Resident #48 was observed sitting in his wheelchair in the hallway near the 100 Hall nurses station.</p> <p>On 11/30/15 at 12:30 p.m., Resident #48 was observed sitting in his wheelchair in the main dining room during lunch service.</p> <p>On 11/30/15 at 1:27 p.m., Resident #48 was observed sitting in his wheelchair</p>			

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	<p>being taken into his room by CNA #13.</p> <p>On 12/1/15 at 8:11 a.m., Resident #48 was observed sitting in his wheelchair being taken into his room by CNA #14.</p> <p>On 12/2/15 at 8:14 a.m., Resident #48 was observed sitting in his wheelchair in his room.</p> <p>On 12/3/15 at 8:12 a.m., Resident #48 was observed in bed with the TV on news channel.</p> <p>On 12/3/15 at 10:43 a.m., Resident #48 was observed in bed with the TV on.</p> <p>On 12/3/15 at 1:14 p.m., Resident #48 was observed in bed with the TV on.</p> <p>Review of Resident #48's activity logs for November 2015 and December 1 and 2, 2015, provided by the Activity Director on 12/3/15 at 2:10 p.m., indicated the resident had attended the following activities on 11/30/15 through 12/2/15:</p> <p>The log for 11/30/15 indicated the resident was sick all day and did not attend activities.</p> <p>The log for 12/1/15 indicated Resident #48 attended and participated in exercise at 9:00 a.m., live music presentation at</p>			

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	<p>10:30, and snacks and juice at 3:00 p.m.</p> <p>The log for 12/2/15 indicated Resident #48 attended and participated in exercise at 9:00 a.m., and coffee and news at 10:30 a.m.</p> <p>Review of Resident #48's clinical record began on 12/1/15 at 9:05 a.m. Diagnoses included, but were not limited to, debility, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>Resident #48 had a current, 9/11/15 quarterly Minimum Data Set assessment (MDS), which indicated the resident was severely cognitively impaired and dependent on staff for ADLs, bed mobility, and transfers.</p> <p>Review of an activity assessment, dated 9/11/15, indicated Resident #48 enjoyed group activities, music, and "coffee and news".</p> <p>Resident #48 had a current, 9/23/15, "Activity Care Plan Worksheet", which indicated the resident would be encouraged to attend activities of choice and interest, such as food, social times, bingo, and family visits.</p> <p>During an interview, on 12/3/15 at 1:06 p.m., Activity Assistant #5 indicated</p>			

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F 0250 SS=G Bldg. 00	<p>Resident #48 had not been attending activities since he had developed a pressure ulcer, as he was to be in bed at all times except for meals. She further indicated Resident #48 had previously participated in coffee and news, bingo, and other group activities.</p> <p>During an interview on 12/3/15 at 1:50 p.m., the DON indicated the resident was to lay down between meals due to having a pressure ulcer. She indicated the resident had previously wanted to be up in his wheelchair all of the time.</p> <p>During an interview, on 12/7/15 at 9:13 a.m., CNA #13 indicated Resident #48 was not to attend activities due to having a pressure ulcer and was to lay down between meals.</p> <p>3.1-33(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse resulting in</p>	F 0250		

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	<p>tearfulness and isolation for 1 of 15 residents interviewed for roommate concerns. (Resident #77)</p> <p>Findings include:</p> <p>On 11/30/15 at 3:28 p.m., during an interview, Resident #77 indicated Resident #25's daughter had yelled at her and had pointed her finger at her about having her television too loud.</p> <p>Resident # 25 was interviewed and indicated she did not like the television volume loud. She also indicated she did not particularly like watching television. She also indicated she did not have any issues with other residents. She indicated she had a sensitivity to light and developed migraines as a result.</p> <p>Resident #77's clinical record was reviewed on 12/03/15 at 3:42 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, coronary artery disease, and hypertension. The admission Minimum Data Set assessment, dated 9/9/15, indicated the resident was cognitively intact. No information about the incident was indicated in the nurse's notes.</p> <p>The "POSSIBLE OR POTENTIAL MENTAL ANGUISH</p>			

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	<p>ASSESSMENT,"dated 11/3/15, indicated the purpose of the interview as "Verbal Abuse." The resident indicated she refused breakfast and was tearful and/or crying with fearfulness described as "Voiced being in trouble" with increased agitation. The observations by the staff indicated the resident ate in her room with encouragement and stayed in her new room throughout the day. She was observed tearful and crying in the morning with increased agitation.</p> <p>The "EVALUATION OF NEW OR WORSENING MOOD OR BEHAVIOR," dated 11/3/15, indicated the resident was verbally abused by her roommate's family member. The resident was "sobbing" and stated "I will leave this building if treated like that again." The additional comments indicated Resident #77 was emotionally distraught this a.m. due to the roommate's daughter's accusation of causing trouble for roommate.</p> <p>The Social Service (SS) progress notes indicated the following: On 10/30/15 Resident #77 indicated she was not allowed to turn up the television or open the blinds in the room as this bothered the roommate. On 11/3/15 (no time "Insert-Update-") the Social Service Director indicated she</p>			

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	<p>found Resident #77 in her "dark" room shaking and crying. The resident indicated the roommate's daughter "had cornered her" the evening prior and yelled and accused her of causing problems for her roommate. Resident was taken to the SS's office where she continued to cry and was visibly upset.</p> <p>A review of the Visitor to Resident Abuse form, dated 11/3/15, indicated the resident was moved to another room to keep her safe. It also indicated the daughter of Resident # 15 would be supervised during visits "due to volatile outbursts." The form also indicated the daughter had been interviewed by the SSD regarding the incident on 11/2/15 with Resident # 77. The daughter was recorded as "becoming verbally aggressive" with the SSD.</p> <p>The "INTRA-FACILITY TRANSFER," dated 11/3/15, indicated the resident requested a room change, waived the relocation plan, and was moved to a different room.</p> <p>3.1-27(a)(1)</p>			

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure careplans were updated and revised for activities for 1 of 3 residents reviewed for activities for cognitively impaired residents (Resident #48).</p> <p>Findings include:</p> <p>On 11/30/15 at 11:29 a.m., Resident #48 was observed sitting in his wheelchair in the hallway near the 100 Hall nurses station.</p> <p>On 11/30/15 at 12:30 p.m., Resident #48 was observed sitting in his wheelchair in</p>	F 0280	<p>1. Resident #48 is no longer at the facility 2. The facility shall identify all residents with conditions which would restrict ability to participate in group activities. Plans of Care shall be reviewed to ensure activities of interest are incorporated, as possible, for those residents unable to participate in group settings due to their medical conditions/needs/restrictions. 3. The Activity Director has been re-educated on the facility's policy regarding updating care plans. Following revision, activities shall be monitored by administration/designee to confirm provision of appropriate activities to meet the needs of the</p>	01/06/2016
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	<p>the main dining room during lunch service.</p> <p>On 11/30/15 at 1:27 p.m., Resident #48 was observed sitting in his wheelchair being taken into his room by CNA #13.</p> <p>On 12/1/15 at 8:11 a.m., Resident #48 was observed sitting in his wheelchair being taken into his room by CNA #14.</p> <p>On 12/2/15 at 8:14 a.m., Resident #48 was observed sitting in his wheelchair in his room.</p> <p>On 12/3/15 at 8:12 a.m., Resident #48 was observed in bed with the TV on news channel.</p> <p>On 12/3/15 at 10:43 a.m., Resident #48 was observed in bed with the TV on.</p> <p>On 12/3/15 at 1:14 p.m., Resident #48 was observed in bed with the TV on.</p> <p>Review of Resident #48's activity logs for November 2015 and December 1 and 2, 2015, provided by the Activity Director on 12/3/15 at 2:10 p.m. indicated the resident had attended the following activities on 11/30/15 through 12/2/15:</p> <p>The log for 11/30/15 indicated the resident was sick all day and did not</p>		<p>residents with restrictions. 4. In an effort to confirm compliance with provision of appropriate activities, random observations will be conducted by the Administrator/designee on scheduled days of work in an effort to evaluate participation, appropriateness, and attentiveness to the residents' needs based off the resident specific care plan.. Daily for two weeks then weekly thereafter, to ensure adherence with appropriate activities. Should a concern be observed, corrective action will be taken. Results of monitoring and any corrective actions taken will be discussed at the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made if indicated on the basis of compliance.</p>				

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	<p>attend activities.</p> <p>The log for 12/1/15 indicated Resident #48 attended and participated in exercise at 9:00 a.m., live music presentation at 10:30, and snacks and juice at 3:00 p.m.</p> <p>The log for 12/2/15 indicated Resident #48 attended and participated in exercise at 9:00 a.m., and coffee and news at 10:30 a.m.</p> <p>Review of Resident #48's clinical record began on 12/1/15 at 9:05 a.m. Diagnoses included, but were not limited to, debility, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>Resident #48 had a current, 9/11/15 quarterly Minimum Data Set assessment (MDS), which indicated the resident was severely cognitively impaired and dependent on staff for ADLs, bed mobility, and transfers.</p> <p>Review of an activity assessment, dated 9/11/15, indicated Resident #48 enjoyed group activities, music, and "coffee and news".</p> <p>Resident #48 had a current, 9/23/15, "Activity Care Plan Worksheet", which indicated the resident would be encouraged to attend activities of choice</p>			

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F 0282 SS=D	<p>and interest, such as food, social times, bingo, and family visits.</p> <p>During an interview, on 12/3/15 at 1:06 p.m., Activity Assistant #5 indicated Resident #48 had not been attending activities since he had developed a pressure ulcer, as he was to be in bed at all times except for meals. She further indicated Resident #48 had previously participated in coffee and news, bingo, and other group activities.</p> <p>During an interview on 12/3/15 at 1:50 p.m., the DON indicated the resident was to lay down between meals due to having a pressure ulcer. She indicated the resident had previously wanted to be up in his wheelchair all of the time.</p> <p>During an interview, on 12/7/15 at 9:13 a.m., CNA #13 indicated Resident #48 was not to attend activities due to having a pressure ulcer and was to lay down between meals.</p> <p>3.1-33(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER</p>			

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Bldg. 00	<p>CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to follow physician orders related to administration of prescribed medication to a resident for 3 days (Resident #82) and related to dressing change for 1 of 3 residents reviewed for pressure ulcer (Resident #24).</p> <p>Findings include:</p> <p>1. During an observation of medication administration with LPN #4 on 12/03/2015 at 7:27 a.m., she indicated that Lidocaine 5% Topical Film was ordered for Resident #82 and was not in the medication cart. She then looked in the medication administration record and indicated that the medication had not been given for 3 days.</p> <p>During an interview with LPN #4 on 12/03/2015 at 2:00 p.m., she indicated that when a medication was not available she circled that box on the medication administration record, wrote the medication, time and date on the back of the medication administration record, called the doctor and called the family. She indicated that she had been the first person to notify the pharmacy and doctor</p>	F 0282	<p>1. Resident #82 is receiving medications as ordered by the physician. Resident #24 is receiving treatments as ordered by the physician. 2. All other residents have the potential to be affected. The clinical records, including current orders, have been reviewed and residents are receiving medications and/or treatments as ordered by the physician. 3. The facility's policy for physician's orders/medication administration has been reviewed and no changes are indicated at this time. The nurses and QMAs have been re-educated on following physician's orders and obtaining medications timely, with emphasis placed on notifying administrative nursing staff should a medication be unavailable, as well as following orders, as written. 4. The DON or designee will be responsible for completing monitoring to ensure medications are present and treatments are done per orders. These audits will occur on scheduled work days as follows: daily for two weeks then weekly thereafter. Should a concern be identified, immediate corrective action will occur. Results of these reviews and any corrective action will be discussed during the facility's monthly QA meetings on</p>	01/06/2016
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	<p>about the unavailability of the medication for Resident #82. LPN #4 indicated the reason the facility did not have the medication was because the facility needed a prior authorization. LPN #4 indicated she did not know the medication had not been given until she saw it circled in the book that morning.</p> <p>During an interview with the Director of Nursing (DON) on 12/07/2015 at 10:38 a.m., she indicated that when a medication was not available the nurse was to call the pharmacy and ask for the medication to be sent to the back-up pharmacy. She further indicated that the reason Resident #82 did not receive her Lidocaine Patch was because the facility needed a prior authorization for the medication and did not have it. The DON indicated she did not know until 12/3/2015 that the facility needed and did not have that authorization for the Lidocaine Patch. She also indicated that she did not know the medication had not been given to Resident #82.</p> <p>The nurse's notes, provided by the Business Office Manager on 12/7/2015 at 11:02 a.m., indicated that Resident #82 arrived to the facility on 11/30/2015 at 2:45 p.m. The pharmacy and the medical doctor had been notified of the arrival.</p>		<p>an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.</p>				

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	<p>There were no nurse's notes in reference to the unavailability of the Lidocaine Patch from 11/30/2015 until the note was made on 12/3/2015 at 1 p.m. On 12/1/2015 at 6 p.m. the nurse's note indicated the resident was complaining of pain in her hip and leg at an 8/10. On 12/2/2015 at 2 p.m., a note indicated Resident #82 was complaining of pain in her hip. On 12/03/2015 at 7 p.m., a nurse's note indicated the resident had complained of pain at a 7/10.</p> <p>A review of the medical record for Resident #82 began on 12/7/2015 at 11:02 a.m. It indicated that Resident #82's diagnoses included but were not limited to chronic dementia, renal failure with hemodialysis, left hip fracture and pain.</p> <p>A review of the medication administration record for Resident #82 indicated the medication had not been given on the dates of 12/01/2015-12/03/2015.</p> <p>A review of the physician orders, dated 12/1/2015 through 12/31/2015, indicated an order for Lidocaine 5% topical film, apply to left anterior thigh daily for diagnosis of pain. The order indicated to apply the patch at 8 a.m.</p>			

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	<p>On 12/07/2015 at 10:38 a.m., the Director of Nursing (DON) was asked for a policy regarding medication administration. There was no policy offered as of the time of exit.</p> <p>2. LPN #10, on 12/02/2015 at 3:21 p.m., was observed during a dressing change for a pressure ulcer for Resident #24. LPN #10 removed the soiled dressing, cleansed and measured the wound and began to apply the new dressing. LPN #10 applied Santyl cream to the wound, applied saline to two pieces of gauze and indicated she was packing the gauze into the wound. She then covered the moistened gauze with medipore tape. The LPN indicated the wound was a stage 3 and now measured 2cm in length by 3 cm wide and was 0.5 cm in depth. She further indicated the wound bed had some granulation tissue and slough.</p> <p>During an interview with LPN #10 on 12/02/2015 at 4:07 p.m., she reviewed the physician order indicated she was to cover the wound with Santyl, cover with moist fluff gauze and then cover the moist gauze with dry gauze. She then indicated that she only lightly packed the gauze into the wound so she would not damage the wound further.</p> <p>A review of the physician orders for Resident #24 began on 12/02/2015 at</p>						

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F 0314 SS=D Bldg. 00	<p>4:05 p.m. An order, dated 11/12/2015, read: "change order for wound care. Cover wound with Santyl, cover with moist fluff gauze, and then cover with dry gauze BID (two times per day)."</p> <p>A review of the medical record for Resident #24 began on 12/3/2015 at 1:06 p.m. It indicated her diagnoses included but were not limited to: Alzheimer's disease, history of left hip arthroplasty, altered mental status, weakness, degenerative arthritis, diabetes and dementia with agitated features and physical aggression.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from</p>			

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	<p>developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure accurate assessment of pressure ulcers for 1 of 3 residents reviewed (Resident #48) and failed to ensure physician's orders were followed for treatment of pressure ulcers for 1 of 3 residents (Resident #24).</p> <p>Findings include:</p> <p>1. Review of Resident #48's clinical record began on 12/1/15 at 9:05 a.m. Diagnoses included, but were not limited to, debility, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>Resident #48 had current 11/13/15 physician's orders for Santyl ointment to be applied three times daily to the slough in the center of the wound and Medihoney to the outer edge of the wound.</p> <p>Resident #48 had a current, 9/11/15, quarterly Minimum Data Set assessment (MDS). It indicated the resident was severely cognitively impaired and was totally dependent for bed mobility and transfers.</p> <p>Review of an "Initial Pressure Ulcer Assessment", dated 11/9/2015, indicated Resident #48 had a Stage 3 pressure ulcer</p>	F 0314	<p>1. Resident #48 is no longer a resident at the facility. Resident #24 is currently receiving a treatment as ordered by the physician. 2. All residents with pressure areas have the potential to be affected. The clinical record reflects an accurate assessment of any pressure area. The residents are also receiving treatments as ordered by the physician. 3. The facility's policies for skin management and physician's orders have been reviewed and no changes are indicated at this time. The nurses, including the DON and LPN #10, have been re-educated on the policies with a special focus on accurately assessing pressure areas and completing treatments as ordered by the physician. 4. The DON or designee will be responsible for completing an audit on scheduled work days as follows: daily for two weeks then weekly thereafter to ensure assessments of pressure areas are correct and treatments are completed per physician's orders. Should a concern be found, immediate corrective action will occur. These audits and any corrective actions taken will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.</p>	01/06/2016

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	<p>to his left buttock/coccyx area. The wound measured 3 cm long x 2.5 cm wide x less than 0.1 cm depth with a pink wound bed. A picture of a human body indicated the wound was on the resident's coccyx.</p> <p>Review of an "Ongoing Assessment of Pressure Ulcer" document, signed on each date by the DON, indicated the following:</p> <p>On 11/13/15, the wound measured 2.5 cm long x 2.4 cm wide with a depth of 0.6 cm, with the entire area measuring 5 cm long x 5 cm wide and 6.0 cm, and covered by black eschar.</p> <p>On 11/20/15, the wound measured 1.5 cm long x 1.5 cm wide with a depth of 1.4 cm, with the entire area measuring 5 cm long x 5.4 cm wide with a depth of 1.4 cm with a pink wound bed.</p> <p>On 11/27/15, the wound measured 1.5 cm long x 1.5 wide with a depth of 1.4 cm, with the entire area measuring 5 cm long x 5 cm wide with a depth of 1.4 cm with a pink wound bed.</p> <p>On 12/4/15, the wound measured 5 cm long x 5 cm wide with a depth of 1.4 cm with a pink wound bed.</p>			

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	<p>A progress note, dated 11/5/15 and signed by the Nurse Practitioner, indicated Resident #48 had a left hip wound measuring "...4.5 x 6.0 [with] darkened area in the center measuring 2.5 x 2 [with] moderate drainage..." A drawing on the progress note indicated black eschar was present to the center of the wound.</p> <p>During an observation of Resident #48's pressure ulcer on 12/2/15 at 2:53 p.m., the wound was observed to be on the left lower buttock, near the gluteal fold. The wound was round in shape, measuring 5 cm long x 3.5 cm wide with a depth of 3 cm, and a smaller area of yellow slough, measuring 2 cm x 2 cm in the center of the wound. The wound bed was not visible.</p> <p>During an interview on 12/7/15 at 3:11 p.m., with the DON and Nurse Consultant #2, the DON indicated Resident #48's pressure ulcer was on the left buttock, not the coccyx area. The DON indicated the measurement of 5 cm long x 5 cm wide, documented for the 12/4/15 assessment, was taken from the wound observation on 12/2/15 and was not a complete assessment of the wound. She further indicated she was not sure when the wound measurements actually took place, as the hospice nurse measured</p>			
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	<p>the wound, but she documented the measurements on Fridays for her corporate report. Nurse Consultant #2 indicated the measurements should be taken on the same day of the week and documented on the day the measurement was taken.</p> <p>2. During an observation of a dressing change for a pressure ulcer for Resident #24 with LPN #10 on 12/02/2015 at 3:21 p.m., LPN #10 removed the soiled dressing, cleansed and measured the wound and began to apply the new dressing. LPN #10 applied Santyl cream to the wound, applied saline to two pieces of gauze and indicated she was packing the gauze into the wound. She then covered the moistened gauze with medipore tape. The LPN indicated the wound was a stage 3 and now measured 2cm in length by 3 cm wide and was 0.5 cm in depth. She further indicated the wound bed had some granulation tissue and slough.</p> <p>During an interview with LPN #10 on 12/02/2015 at 4:07 p.m., she reviewed the physician order. She indicated it said to cover the wound with Santyl, cover with moist fluff gauze and then cover the moist gauze with dry gauze. She then indicated that she only lightly packed the gauze into the wound so she would not</p>			

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F 0315 SS=D Bldg. 00	<p>damage the wound further.</p> <p>A review of the physician orders for Resident #24 began on 12/02/2015 at 4:05 p.m. It indicated an order, dated 11/12/2015, that read: "change order for wound care. Cover wound with Santyl, cover with moist fluff gauze, and then cover with dry gauze BID (two times per day)."</p> <p>A review of the medical record for Resident #24 began on 12/3/2015 at 1:06 p.m. It indicated her diagnoses included but were not limited to Alzheimer's disease, history of left hip arthroplasty, altered mental status, weakness, degenerative arthritis, diabetes and dementia with agitated features and physical aggression.</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder</p>			

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	<p>receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure sanitary maintenance of a urinary catheter for 1 of 1 residents with a urinary catheter (Resident #48).</p> <p>Findings include:</p> <p>On 11/30/15 at 11:29 a.m., Resident #48 was observed in the hallway near the 100 Hall nurses station, sitting in his wheelchair. A urinary catheter dignity bag was secured under his wheelchair, with the catheter tubing touching the floor.</p> <p>On 11/30/15 at 12:30 p.m., Resident #48 was sitting in his wheelchair in the main dining room with the urinary catheter tubing touching the floor.</p> <p>On 11/30/15 at 1:27 p.m., Resident #48 was observed being taken to his room in his wheelchair by CNA #13, with the urinary catheter tubing touching the floor.</p> <p>On 12/1/15 at 8:11 a.m., Resident #48 was observed being taken to his room in his wheelchair by CNA #14, with the urinary catheter tubing touching the floor.</p>	F 0315	<p>1. Resident #48 no longer resides at the facility 2. No other resident has a urinary catheter at this time. 3. All nursing staff have been re-educated on correct care and maintenance of a urinary catheter with a special focus on placement of catheter tubing so it does not touch the floor. A monitoring tool has been implemented. 4. The DON or designee will be responsible for completing monitoring on scheduled workdays as follows: Daily for two weeks then weekly thereafter to ensure appropriate maintenance of urinary catheters. Should a concern be observed, immediate corrective action will occur. Results of monitoring and any corrective actions taken will be discussed at the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revision made as indicated on the basis of compliance.</p>	01/06/2016	

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	<p>On 12/2/15 at 8:14 a.m., Resident #48 was observed sitting in his wheelchair in his room, with the urinary catheter tubing touching the floor.</p> <p>Review of Resident #48's clinical record began on 12/1/15 at 9:05 a.m. Diagnoses included, but were not limited to, debility, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>Resident #48 had a current, 9/11/15, quarterly Minimum Data Set assessment (MDS), which indicated the resident was severely cognitively impaired and dependent on staff for ADLs.</p> <p>Resident #48 had a current, 11/9/15, physician's order for a urinary catheter for wound healing and urinary retention.</p> <p>Review of Resident #48's physician orders indicated the resident had received an order for Doxycycline 100 mg (an antibiotic) twice daily for 7 days for "prophylactic UTI [urinary tract infection]" on 11/13/15. An additional physician's order was received on 11/20/15 for Bactrim DS (an antibiotic) twice daily for 10 days for UTI. There was no urinalysis in the clinical record. A hospice note, dated 11/20/15, indicated the resident's urine was foul smelling.</p>			

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F 0323 SS=D Bldg. 00	<p>During an interview on 12/7/15 at 9:12 a.m., CNA #13 indicated urinary catheter tubing should be kept off of the floor.</p> <p>During an interview on 12/7/15 at 11:37 a.m., the DON indicated Resident #48 received antibiotics due to having cloudy urine and a urinalysis was not completed prior to the start of either medication.</p> <p>During an interview on 12/7/15 at 10:54 a.m., RN #15 indicated urinary catheter tubing should be kept off the floor.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide staff supervision measures to prevent a resident to resident altercation for 2 of 2 residents reviewed during an altercation. (Resident #57 and #38).</p> <p>Findings include:</p> <p>On 12/3/15 at 2:30 p.m. the Administrator provided Incident #6,</p>	F 0323	The facility respectfully requests to IDR this deficiency. While it is true Resident #57 and #38 were attending an activity on Saturday morning at approximately 10:30am after which Resident #57 initiated an altercation, the activity was supervised. Further, Resident #57 and #38 had attended multiple activities together throughout the months of October and early November with no altercations. 1. Resident	01/06/2016

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	<p>dated 11/17/15. This incident indicated Resident #57 was walking out of the activity room after the morning activity with the Activity Director and was exchanging words with Resident #38. The Activity Director indicated Resident #57 returned to the room and began yelling he "was going to beat his a--" directing these words to Resident #38 resulting in a physical confrontation.</p> <p>Resident #57 had scratches measuring 0.3 cm (centimeter) x 0.3 cm scratch under his right eye and 0.3 cm x 0.3 cm under his left eye. Resident #38 received a 1.8 cm x 2.0 cm bruise to left lower lip and a 0.5 cm to medial, purple hematoma to left outer eye measured at 1.0 cm x 1.3 cm and bruising to left nostril measuring 1.4 cm x 2.0 cm.</p> <p>The Social Service notes, dated 11/14/15, indicated Resident #57 had indicated Resident #38 would not leave him alone and grabbed at his necklace. Resident #57 he would do it again if he saw him. The Social Services interview with Resident #38 indicated the residents exchanged looks and words and could not not remember details because it happened so quickly.</p> <p>The Activity Director statement indicated, on the way out of the activity</p>		<p>#57 & #38 are receiving staff supervision in an effort to prevent a resident to resident altercation, as possible. There was no known antecedent behavior to the action of Resident #57, and staff responded quickly to the behavior. 2. All other residents have the potential to be affected, thus, the facility is providing staff supervision measures in an effort to prevent a resident to resident altercation. Residents with a history of concern or who are known to provoke other residents have been identified in an effort to monitor proximity to other residents during activities, meals, etc. and prevent inappropriate interaction, as possible. Plan of care have been reviewed and updated accordingly. 3. The staff, including the AD and SSD, have been addressed as to the need to identify and provide supervision to those residents with known behaviors which could provoke an altercation with another resident. 4. The Administrator or designee will be responsible for completing monitoring of the identified residents during activities, meals, etc. on scheduled work days as follows: daily for two weeks then weekly thereafter to ensure staff supervision is in place in an effort to prevent resident to resident altercations. Should a concern be observed, immediate corrective action will occur. The monitoring</p>		

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	<p>room, Resident #57 suddenly started swinging at Resident #38 who was just sitting in the room. Although Resident #57 was told to stop, he continued hitting Resident #38 by reaching around her. She then indicated she called for help and LPN #7 assisted in separating the residents and redirecting Resident #57 away from activity room.</p> <p>Resident #57's care plan, originally dated 9/11/15 with updates on 11/14/15 for the focus area, as "The resident exhibits physical behavioral symptoms directed toward others such as hitting" with a goal to have "resident's behavior to not have significant impact on self or others." Interventions included but were not limited to, "approach from the front and in a firm, but calm voice; tell the resident to stop, Separate the residents if applicable, try to identify the immediate cause for the behavior."</p> <p>On 12/04/15 at 10:19 a.m., during an interview, the Activity Director indicated, during the incident, she motioned for other residents to come toward her and, the next thing she knew, Resident #57 was swinging.</p> <p>3.1-45(a)(2)</p>		and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.	

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F 0329 SS=D Bldg. 00	<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 observation, interview and record review, the facility failed to assess and monitor a resident's behavior for inappropriate episodes of laughter resulting in the addition of a new medication for 1 of 5 residents reviewed for unnecessary medications. (Resident # 43)</p> <p>Findings include:</p> <p>On 12/02/2015 at 3:31 p.m., Resident #43 was observed, pleasant and talkative</p>	F 0329	<p>1. Resident #43 is no longer on the medication 2. All other residents have the potential to be affected. Their clinical record has been reviewed and behaviors are being monitored associated with medications being used relative to behaviors. If any unnecessary medications were noted, the physician was contacted in regard to potential reduction or discontinuance of the medication.</p> <p>3. The staff have been re-educated on the behavior management program with a special focus on correct</p>	01/06/2016	

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	<p>regarding her most recent outing to lunch and bingo.</p> <p>On 12/03/2015 at 8:31 a.m., Resident #43 was observed in the dining room. The resident was smiling and conversational about her new hairdo.</p> <p>On 12/4/15 at 8:52 a.m., Resident #43 was observed pleasant, smiling and talkative, as she ambulated with her walker down the hallway after breakfast.</p> <p>On 12/04/2015 at 2:46 p.m., during an interview, the Social Services Director indicated she would receive the "MOOD AND COMMUNICATION MEMO" filled out by the staff for behaviors. She indicated she collected this information and would log the information into the "MOOD AND BEHAVIOR MONTHLY FLOW RECORD" to identify any mood and behavior exhibited, which were reviewed at the morning meetings. She indicated she was unaware of any outbursts of laughter or crying/weepiness over the past few months with Resident #43 besides what was identified in her past mood communication logs. She also indicated she was unaware of the reason for the addition of the newly prescribed medication, Nuedexa, for any new behaviors.</p> <p>On 12/04/2015 at 2:59 p.m. during an interview, the Assistant Director of</p>		<p>completion of behavior memos and not contacting the MD relative to potential medication as an intervention until other non-pharmaceutical interventions have been attempted and found to be ineffective. A monitoring tool has been implemented. 4. The DON or designee will be responsible for reviewing newly ordered medications daily on scheduled work days to ensure there are no unnecessary medications being requested/ordered for the residents. Should a concern be noted, immediate corrective action will occur. Results of the audits and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.</p>		

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	<p>Nursing (ADON) indicated Resident #43 had episodes of inappropriate laughter, crying and negative statements. She also indicated any behaviors being tracked should be documented on the "BEHAVIOR MONTHLY FLOW RECORD".</p> <p>On 12/03/2015 at 3:44 p.m. Resident #43's clinical record was reviewed. The resident's diagnoses included, but were not limited to, diabetes mellitus, dementia, moderate mental handicap and mental retardation and hypertension. The quarterly Minimum Data Set assessment, dated 11/9/15, indicated the resident was cognitively intact. Her mood indicated she had feelings of depression, trouble falling or staying asleep for frequency of never to 1 day and experienced feeling bad about herself for 2 to 6 days a week. No other psychosis, behaviors or delirium were indicated.</p> <p>The signed, 10/13/15, physician's rewrite orders included, but were not limited to: Abilify 2 mg (milligrams) one every day for diagnosis of Major Depressive disorder and psychosis. Melatonin 5 mg one at hour of sleep for diagnosis of sleep disturbance. Depakote 125 mg one capsule twice daily for diagnosis of bipolar-manic, depression and dementia with behavior</p>			

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	<p>disturbances.</p> <p>Lorazepam (anti-anxiety) 0.5 mg one tablet two times daily.</p> <p>On 10/14/15, the physician's order was to discontinue Wellbutrin (anti-depressant) 150 mg twice daily related to dose change for pill reduction and was changed to Wellbutrin XL 300 mg daily.</p> <p>On 11/5/15, the physician's order was Nuedexta 20/10 mg one daily for seven days, then twice daily for diagnosis of PBA (Pseudobulbar Affect - inappropriate laughing or crying)</p> <p>On 11/5/15, the Nurse Practioner progress notes indicated the chief complaint of PBA, increased laughing and tearfulness with the nurses reporting on 11/5/15 the resident had increased emotions associated with PBA.</p> <p>The "NURSES NOTE," dated from 6/13/15 to the last entry on 11/25/15, and the "SOCIAL SERVICE PROGRESS NOTE," from 5/28/15 to the last entry on 11/25/15, indicated no behavior/mood episodes.</p> <p>The "MOOD AND BEHAVIOR MONTHLY FLOW RECORD" records indicated the following:</p>			

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	<p>August, 2015 indicated no mood/behavior episodes. No inappropriate laughing episodes were indicated.</p> <p>September, 2015 indicated one episode of negative statements on 9/19/15 and 9/20/15 during the night shift with intervention #12 allow to vent, #29 Other (no information) with positive outcome both times.</p> <p>No inappropriate laughing episodes were indicated.</p> <p>October, 2015 indicated the behavior of "Crying/Tearful" on 10/5/15 with one night and one evening episode with interventions for both as #11 one to one and #21 direction with unchanged outcome. Additionally on 10/15/15, the resident had 2 episodes on the night shift with the same interventions and same outcome as 10/5/15. On 10/9/15, one episode on evening shift with interventions of #12 allow to vent, #13 conversation of interest and #14 activity with improved outcome. On 10/10/15, the resident had one episode on night shift with the interventions of #3 food and fluids, #11 one to one and #13 conversation of interest with improved outcome.</p>			

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	<p>No inappropriate laughing episodes were indicated.</p> <p>November, 2015 indicated the behavior of "Crying/Tearful" one episode on 11/11/15 on evening shift with interventions # 11 of one to one, #15 reassurance with unchanged outcome. On 11/17/15, two episodes on day shift with interventions #11 one to one and #12 allow to vent and #21 direction with unchanged outcome. On 11/29/15, one episode on night shift with interventions of #11 one to one, #12 allow to vent, #20 time to calm and reapproach and and #21 direction with improved outcome.</p> <p>No inappropriate laughing episodes were indicated during the month.</p> <p>December 1-3, 2015 indicated no episodes of targeted behaviors.</p> <p>No inappropriate laughing episodes were indicated.</p> <p>The "MOOD AND BEHAVIOR COMMUNICATION MEMO" records indicated the following:</p> <p>On 9/19/15 and 9/20/15, Resident #43 indicated a negative statement related to the pudding used during med pass with successful interventions and positive</p>			

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	<p>outcomes of allowing to vent feelings and using different pudding.</p> <p>On 10/5/15 at 10:30 a.m., resident was noted in front lobby crying because she wanted to spend her money that her aunt had given her. The successful interventions were 1 to 1 and redirection. Although staff member told her she would take her shopping and "to stop worrying", the outcome was unchanged. On 10/5/15 at 4:03 p.m.: Resident again was observed crying in front lobby because she could not spend her money. The successful intervention was one to one with a reminder staff would be taken shopping. Resident outcome was unchanged.</p> <p>On 10/9/15 from 4-4:30 p.m.: Resident was found crying/tearful with negative statements. The resident indicated she was still upset that she was not allowed to spend the money she had. The successful interventions were to allow the resident to vent, called family for assistance and provided conversation of interest with positive outcome.</p> <p>On 10/10/15 at 10:20 a.m., the resident was in the front lobby crying about her money again. The successful interventions were allowing to vent, provided a snack and conversation of</p>			

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	<p>interest with improved outcome.</p> <p>On 10/15/15 from 7:30 a.m. to 8:00 a.m., the resident was crying and tearful in the front lobby because she indicated she was reprimanded when her sister did not sign her out for their shopping trip. The successful interventions of allowing to vent, redirection and one to one. Resident outcome was unchanged.</p> <p>On 11/29/15 at 6:30 a.m., The resident was crying/tearful with negative statements because she had no clothes to wear and she said she was not going to leave her room. The successful interventions were one to one, allow to vent, time to calm and reapproach and helped resident find clothes to wear with improved resident outcome. There was no communication memo for the 11/11/15 crying episode.</p> <p>No inappropriate laughing episodes were indicated.</p> <p>The "MOOD AND BEHAVIOR PROGRAM" policy, revised 11/2013, was received by the Social Services Director on 12/04/2015 at 3:23 p.m. This current policy indicated the following:</p> <p>"Documentation of Mood/Behavior"</p>			

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F 0371 SS=F Bldg. 00	<p>...2. The Mood and Behavior Communication Memo will be completed by any staff member upon witnessing a resident mood/behavior.</p> <p>3. Once completed, the Mood and Behavior Communication Memo will be placed in a location designated by the facility...</p> <p>5. Should a mood/behavior be identified as "new" or "worsening" for the resident, an Evaluation of New or Worsening Mood or Behavior assessment will be initiated by social services or nursing and completed by the interdisciplinary team, in an attempt to identify any intrinsic or extrinsic factors which may be causing or precipitating the new or worsening mood(s) or behavior(s)...."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <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, record review and</p>	F 0371	1 & 2. A. The top of the black	01/06/2016
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	<p>interview, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions. Of the facility's 57 residents, this deficient practice had the potential to impact 56 who were served food from the facility's kitchen.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Kitchen sanitation tour accompanied by the Dietary Manager on 11/30/15 at 9:12 a.m. indicated the following: <ol style="list-style-type: none"> a. An accumulation of dust and debris was on top of the black microwave and white standup freezer. b. An accumulation of gray dust was on the large brown vent located in the ceiling, between the food prep and serving area. An accumulation of gray/black dust was on the florescent light covers and on the white ceiling surrounding the light fixtures located over the food prep area and next to the stainless steel table where the coffee maker was located. The Dietary Manager indicated the lights and vents were to be cleaned by maintenance. c. An accumulation of debris and gray dust was located on the floor behind the stainless steel refrigerators and freezers. 		<p>microwave and the white standup freezer have been cleaned. B. The brown air vent, the areas around and including the florescent light covers have been cleaned. C. The floor under the stainless steel refrigerators and freezers was cleaned and free of debris. D. The manual can opener has been cleaned. E. The ceiling above the food prep area and the dishwashing area was cleaned and painted. F. The white caulking above the sink in the dishwashing room was replaced. G. The 12" Teflon pan was discarded. All pots and pans were inspected and those found with scratches were discarded. H. All items in freezer were audited for use-by dates. A subsequent walk through of the kitchen was conducted to identify any additional concerns in need of corrective action with any actions taken. 3. The facility's Policy and Procedure for kitchen sanitation was reviewed and no changes were made. The facility's Cleaning schedules were reviewed and updated as needed. A Dietary In-service has been completed regarding kitchen sanitation and use by dates. 4. The Dietary Manager or designee will be responsible for monitoring kitchen sanitation and use-by dates on the appropriate monitoring sheet daily (Monday through Friday) for 4 weeks then twice weekly for 4 weeks then</p>	

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	<p>The following was also located behind the stainless steel refrigerators: a broken green plastic lid, a pink sugar packet and a plastic wrapper.</p> <p>d. The manual can opener with base and insert had an accumulation of a black sticky substance and gray/brown food debris located on the blue insert. The metal pointed blade of the can opener had a brown, dried substance and torn paper located on it. The Dietary Manager indicated the manual can opener with base and insert needed to be cleaned and should be cleaned once a week.</p> <p>e. Scattered brown splatter spots were located on the white ceiling above the food prep area and in front of the stainless steel refrigerators. The white ceiling in the dishwashing area had scattered brown, pink spattered food debris on the ceiling.</p> <p>f. Black spots were observed on the white caulking located above the sink in the dishwashing room. The Dietary Manager indicated she would contact Maintenance to replace the caulking.</p> <p>g. A 12 inch Teflon frying pan was located on a shelf in the food prep area and was ready to use. The pan had multiple scratch marks that were down to</p>		<p>weekly for two (2) months then monthly to ensure continued compliance. Should a concern be found, immediate corrective action will occur. The findings of the above audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings on an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.</p>		

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	<p>the metal where the Teflon was removed. The Dietary Manager indicated the Teflon pan should be thrown out and replaced.</p> <p>h. An observation of the stainless refrigerators indicated the following: One opened 5 pound container of low fat cottage cheese 1% milkfat and small curd. The Dietary Manager weighed the container and indicated it had 3.75 pounds left in the container and a best by date of "November 22" and was opened 11/25/15. The Dietary Manager indicated the cottage cheese came in on 10/30/15.</p> <p>A review of cleaning schedules for "DAY COOK CLEANING, PM Cook, AM AIDE, PM AIDE", provided by the Administrator on 11/30/15 at 3:04 p.m., indicated no cleaning schedule for the microwave or overhead lights in the kitchen.</p> <p>A review of the "PM Cook" cleaning schedule indicated the following were cleaned on 11/29/15 and 11/30/15:</p> <p>"...sweep/mop behind refrig [refrigerator]...sweep /mop behind freezer...."</p> <p>A review of the "DAY COOK</p>				

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	<p>CLEANING" cleaning schedule indicated the can opener was cleaned on 11/29/15 and 11/30/15.</p> <p>A review of a policy titled "Cleaning Schedule", dated 11/2014, was provided by the Administrator on 11/30/15 at 3:04 p.m., and indicated the following:</p> <p>"Policy: It is necessary to ensure that equipment is cleaned and sanitized on a timely basis.</p> <p>Procedures:</p> <ol style="list-style-type: none"> Daily cleaning schedules should be listed on the individual job procedure or master cleaning schedule... Once initialed and dated by the employee, the dietary manager inspects the item... If another department does the cleaning, dietary coordinates the cleaning. All equipment is cleaned as it is used." <p>No further information was provided at exit on 12/7/15 at 5:10 p.m.</p> <p>3.1-21(i)(3)</p>			

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F 0425 SS=D Bldg. 00	<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, interview and record review, the facility failed to provide prescribed medication to a resident for 3 days (Resident #82). Findings include: During an observation of medication administration with LPN #4 on 12/03/2015 at 7:27 a.m., she indicated that Lidocaine 5% Topical Film was ordered for Resident #82 and was not in the medication cart. She then looked in the medication administration record and indicated that the medication had not been given for 3 days.</p>	F 0425	<p>1. Resident #82 is receiving medications as ordered by the physician. 2. All other residents have the potential to be affected. The clinical records, including current orders, have been reviewed and residents are receiving medications and/or treatments as ordered by the physician. 3. The facility's policy for physician's orders/medication administration has been reviewed and no changes are indicated at this time. The nurses and QMAs have been re-educated on following physician's orders and obtaining medications timely, with emphasis placed on notifying administrative nursing</p>	01/06/2016			

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	<p>During an interview with LPN #4 on 12/03/2015 at 2:00 p.m., she indicated that when a medication was not available she circled that box on the medication administration record then she wrote the medication name, time and date on the back of the medication administration record, called the doctor and called the family. She indicated that she had been the first person to notify the pharmacy and doctor about the unavailability of the medication for Resident #82. LPN #4 indicated the reason the facility did not have the medication was because the facility needed a prior authorization. LPN #4 indicated she did not know the medication had not been given to Resident #82 until she saw it circled in the book that morning.</p> <p>During an interview with the Director of Nursing (DON) on 12/07/2015 at 10:38 a.m., she indicated that when a medication was not available the nurse was to call the pharmacy and ask for the medication to be sent to the back-up pharmacy. She further indicated that the reason Resident #82 did not receive her Lidocaine Patch was because the facility needed a prior authorization for the medication and did not have it. The DON indicated she did not know until 12/3/2015 that the facility needed and did</p>		<p>staff should a medication be unavailable, as well as following orders, as written. 4. The DON or designee will be responsible for completing monitoring to ensure medications are present and treatments are done per orders. These audits will occur on scheduled work days as follows: daily for two weeks then weekly thereafter. Should a concern be identified, immediate corrective action will occur. Results of these reviews and any corrective action will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.</p>				

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	<p>not have that authorization for the Lidocaine Patch. She also indicated that she did not know the medication had not been given to Resident #82.</p> <p>The nurse's notes, provided by the Business Office Manager on 12/7/2015 at 11:02 a.m., indicated Resident #82 arrived to the facility on 11/30/2015 at 2:45 p.m. and the pharmacy and the medical doctor had been notified of the arrival. On 12/1/2015 at 6 p.m., the nurses note indicated the resident was complaining of pain in her hip and leg at an 8/10. On 12/2/2015 at 2 p.m., a note indicated Resident #82 was complaining of pain in her hip. On 12/03/2015 at 7 p.m., a nurses note indicated the resident had complained of pain at a 7/10. There were no nurse's notes in reference to the unavailability of the Lidocaine Patch from 11/30/2015 until the note was made on 12/3/2015 at 1 p.m.</p> <p>A review of the medical record for Resident #82 began on 12/7/2015 at 11:02 a.m. It indicated Resident #82's diagnoses included but were not limited to chronic dementia, renal failure with hemodialysis, left hip fracture and pain.</p> <p>A review of the medication administration record for Resident #82 began on 12/07/2015 at 11:02 a.m. It</p>			

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F 0441 SS=E Bldg. 00	<p>indicated the Lidocaine patch had not had not been administered on the dates of 12/01/2015-12/03/2015.</p> <p>A review of the physician orders, dated 12/1/2015 through 12/31/2015, indicated an order for Lidocaine 5% topical film, apply to left anterior thigh daily for diagnosis of pain. The order indicated to apply the patch at 8 a.m.</p> <p>On 12/07/2015 at 10:38 a.m., the Director of Nursing (DON) was asked for a policy regarding medication administration. There was no policy offered as of the time of exit. 3.1-25(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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</p>			
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	<p>isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (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. Based on observation, interview and record review, the facility failed to ensure the infection control program included employees' health and education to ensure the correct handling of linen for 3 of 6 observations of linen handling. (CNA #14, Laundry Aide #17, and Housekeeper # 5) In addition, the facility failed to ensure proper procedure was followed while passing ice to residents (CNA # 3).</p> <p>Findings include:</p> <p>1. On 12/02/15 at 10:39 a.m. CNA #14</p>	F 0441	<p>1. Applicable staff members have been addressed and re-educated. 2. As all residents have the potential to be affected, the following corrective actions have been taken. 3. The facility's policy for Infection control and employee health have been reviewed to verify appropriate policies in place relative to linen handling and passing of ice water. Staff, including CNA #14 and Laundry Aide #17, have been re-educated on proper linen handling & CNA 14 has been re-educated on when to use gloves. Staff, including CNA #3, has been re-educated on proper</p>	01/06/2016

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	<p>was observed with ungloved hands assisting an unidentified resident with ambulation. CNA #14's bilateral wrists and hands were observed red in color, open in several areas and peeling.</p> <p>On 12/02/15 at 9:41 a.m., during an interview, CNA #14 indicated she was not sure when she should be wearing gloves during resident care. She indicated she had been to her family doctor and she had been given 2 tubes of unknown medication, and she was about out. She indicated she was going back to the physician next month.</p> <p>On 12/03/15 at 9:07 a.m., during an interview, the Administrator and DON indicated lack of monitoring of staff for infection with CNA #14's skin condition of hands/wrists. The DON indicated CNA #14 had asked for information related to the glove policy, and she had instructed CNA #14 to wear gloves at all times.</p> <p>On 12/3/15 at 10:30 a.m., the Administrator provided the facility policy, "OVERVIEW OF THE FACILITY INFECTION CONTROL PROGRAM" which indicated the following: "...EMPLOYEE HEALTH AND</p>		<p>procedures for passing ice. The DON has been re-educated regarding the monitoring of employees with possible infected skin lesions. A monitoring tool has been implemented. 4. The DON or designee will be responsible for completing monitoring on scheduled work days as follows: Daily for two weeks then weekly thereafter to ensure proper technique of passing ice & linen handling, avoiding direct contact with a resident from an employee with a potential risk such as open lesions or illness, and the monitoring of employees for potential contagious infections. Should a concern be found, immediate corrective action will occur. These audits will be discussed at the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.</p>				

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	<p>SAFETY</p> <p>The facility adheres to screening of employees in regard to infectious disease and prohibition of personnel with acute or active communicable or infectious disease or infected skin lesion(s) from participating in direct resident care responsibilities until they are no longer considered infectious or contagious...."</p> <p>2. On 11/30/15 at 9:28 a.m., Laundry Aide #17 was observed passing personal linen. A purple top and a gray top fell on the floor. Laundry Aide #17 picked them off of the floor and proceeded to place them in Resident #306's room.</p> <p>On 11/30/15 at 3:50 p.m., the linen cart on the 200 hall was observed uncovered with clean sheets, blankets, towels, and washcloths on it.</p> <p>On 12/04/15 at 11:02 a.m., during an interview, Laundry Aide #17 indicated she would need to take any laundry that was dropped on the floor back to the soiled area to be cleaned again.</p> <p>3. During an observation of a linen pass on the 200 Hall on 12/1/15, beginning at 8:21 a.m., the following was observed:</p> <p>A metal linen cart holding resident clothing was observed to be outside of room 210. A sheet was covering half of</p>			

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	<p>the cart and another sheet was covering one corner of the other half of the cart. Housekeeper #5 removed hangers holding resident clothing from the cart, and draped them over her right arm, holding them against her body. She then removed another group of hangers with her left hand and carried the clothing items to room 210. The sheet remained on the corner of the cart, leaving the clothing uncovered. Housekeeper #5 then returned to the cart, and removed and carried clothing to room 208 in the same manner.</p> <p>After leaving room 208, Housekeeper #5 returned to the linen cart and dropped the sheet to the floor after attempting to pull it over the cart. She picked the sheet up from the floor and replaced it on the corner of the clothing cart. Nurse Consultant #12 approached the cart and assisted Housekeeper #5 in covering the linen cart with the sheet.</p> <p>Housekeeper #5 removed folded clothing from the cart, held them against her body with her hands and entered room 208.</p> <p>Housekeeper #5 returned to the cart and removed and carried hanging clothing while holding them against her body with her right arm and carrying a pile of clothing in her left hand, entering room</p>			

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	<p>206. She returned to the cart, and removed and carried hanging clothing in the same manner to room 201.</p> <p>Housekeeper #5 then returned to the cart and removed a set of folded pajamas. She turned to speak to another housekeeper, who was standing next to a housekeeping cart. Housekeeper #5 walked by the housekeeping cart, causing the pajamas to brush over the top of the end of the cart holding folded wet floor signs.</p> <p>During an interview, on 12/1/15 at 8:38 a.m., Housekeeper #5 indicated she was aware the linen cart was to be kept covered while containing clean linen or clothing.</p> <p>4. During an observation of ice pass on the 200 Hall on 12/1/15, beginning at 1:13 p.m., the following was observed:</p> <p>CNA #3 filled a container with ice using a plastic scoop, placed the scoop in a plastic storage bag sitting on top of the ice cart, and carried the container to room 202. The lid to the ice compartment was left open. CNA #3 returned to the ice cart, filled a container with ice, placed the scoop on top of the plastic bag, and entered room 204. The lid to the ice compartment was left open. CNA #3</p>			

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	<p>repeated this process for rooms 206 and 201. Before entering room 211, CNA #3 closed the lid to the ice compartment with her right hand while holding the ice scoop in the same hand. CNA #3 returned to the ice cart, opened the lid, scooped ice into a container, placed the scoop on top of the plastic bag, and shook her hand over the ice compartment. She then entered room 212.</p> <p>During an interview, after leaving room 212, CNA #3 indicated she was aware the scoop was to be covered and the ice compartment was to be kept covered.</p> <p>Review of a policy titled, "Water, Fresh Ice", dated 10/2014, and provided by the Nurse Consultant on 12/1/15 at 1:44 p.m., indicated the following:</p> <p>"...PROCEDURE:...</p> <p>...4. Replace ice scoop in proper covered container, or cover it with a clean towel or plastic bag to prevent contamination...."</p> <p>3.1-18 (a) 3.1-18(b)(6) 3.1-18(g)(1) 3.1-18(g)(2) 3.1-18(g)(3)</p>			

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F 0464 SS=E Bldg. 00	<p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation, interview and record review, the facility failed to ensure sufficient space to maneuver residents in the dining room without interrupting social and meal times for 2 of 2 dining observations. (12/3/15 and 12/4/15)</p> <p>Findings include:</p> <p>On 12/03/15 at 12:06 p.m., Resident #51 was observed to be moved away from the table to allow for Resident #32 to get to his table for lunch. Resident #8 was observed to turn her walker sideways to pass through two tables of seated residents to get to her table setting.</p> <p>During an interview on 12/04/15 at 8:52 a.m., Resident #15 indicated she must move herself around so "other people can get through" while she was in the dining room.</p>	F 0464	<p>1. The dining room has been re-arranged to allow sufficient space to maneuver residents without interrupting social and meal times. Residents #51, #15, #73. & #55 no longer have to be moved around in the dining room to allow others in. Resident #8 no longer needs to turn his walker sideways to get through. Resident#70's walker no longer has to be moved to allow others to pass it in the dining room. Should continued observations indicate need for further revisions in seating, etc., the same shall be implemented to allow sufficient space. 2. All residents have the potential to be affected. The dining room has been re-arranged to allow sufficient space to maneuver residents without interrupting social and mealtimes. 3. The facility staff have been re-educated on providing sufficient space in the dining room to allow for uninterrupted social and mealtimes. A monitoring tool has</p>	01/06/2016

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	<p>The lunch meal was observed again on 12/04/15 at 11:53 a.m. During an interview, CNA #18 and CNA #13 both indicated the dining room was small and required them to move residents around in order to get other residents in for meals in the dining room. They indicated Resident #15 and Resident #73 must be moved out to allow for the residents who require feeding assistance in the back of the dining room to be moved in and out. Resident #70's walker needed moved frequently to allow for Resident #81 in and out of the dining room. Resident #55 must be moved away from the dining table to allow for other residents to get in and out of the dining room.</p> <p>On 12/4/15 at 3:30 p.m., the ADON provided the dining room seating chart with 43 residents identified as eating in the main dining room. Review of the residents utilizing the main dining room, indicated there were 22 residents using wheelchairs and 8 residents using walkers.</p> <p>3.1-19(v)(1)</p>		<p>been implemented. 4. The Administrator or designee will be responsible for completing the monitoring at varied meals on scheduled work days as follows: daily for two weeks then weekly thereafter to ensure there is sufficient space in the dining room to allow for uninterrupted social and meal times. Should a concern be noted, immediate corrective action will occur. Results of these audits and any corrective actions will be reviewed in the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months with revisions made as indicated on the basis of compliance.</p>		

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

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