

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the investigation of complaint #IN00150070.</p> <p>Survey dates: May 27, 28, 29, 30, 2014 and June 2, 3, 4, 5, 2014.</p> <p>Facility number: 000222 Provider number: 155329 AIM number: 100274950</p> <p>Survey Team: Tom Stauss, RN-TC Beth Walsh, RN Karina Gates, Generalist Courtney Mujic, RN (May 28, 2014 and June 4, 5, 2014)</p> <p>Census bed type: SNF: 11 SNF/NF: 133 Total: 144</p> <p>Census payor type: Medicare: 38 Medicaid: 75 Other: 31 Total: 144</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after June 30th, 2014</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000156 SS=C	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 13, 2014 by Cheryl Fielden, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which</p>			

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	<p>the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a</p>			

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	<p>complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to ensure required Notice of Medicare Non-Coverage (NOMNC) letters were signed by 3 residents who required such notification. The practice had the potential to affect 3 out of 3 residents reviewed for liability notices. (Resident #'s 93, 196, 228)</p> <p>Findings include:</p> <p>On 6/4/14 at 2:26 p.m., the Business Office Manager (BOM) indicated Resident #'s 93, 196, and 228 should have had "cut letters", or NOMNC (Notice of Medicare Non-Coverage) letters signed by each of the residents or their legal representatives and the contents of the</p>	F000156	<p>F156 Notice of Rights, Rules, Services, and Charges</p> <p>It is the practice of this provider to ensure that all alleged violations involving the notice to residents of rights, rules, services, and charges are in accordance with State and Federal law.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Resident # 93, 196 and 228 no longer resident in the facility do to discharge. .</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	06/30/2014

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	<p>letters explained to each of the residents or their legal representatives prior to the discharge of those residents. She indicated Resident #'s 93, 196, and 228 "had Medicare days remaining" upon their discharge from the facility. She indicated the letters should have been explained to and signed by the residents and/or their legal representatives, but was not done. She indicated a facility Social Worker who is no longer employed at the facility usually handled having the NOMNC letters signed. The BOM indicated not having the NOMNC letters signed and given to residents prior to their discharge from the facility was not a practice consistent with facility policy.</p> <p>A facility policy titled "Checklist/Instructions for issuing a Notice of Medicare Non-Coverage (NOMNC)/Determination On Continued Stay" indicated the following: "...When should notices be given?..." and "...Part A-End of Part A covered level of care with benefit days remaining..." The policy also indicated "...NOMNC form must be issued no later than two days (48 hours) before the proposed end of services..."</p> <p>3.1-4(f)(3)</p>		<p>All residents receiving medicare coverage have the potential to be affected by this alleged deficient practice.</p> <p>The Social Service Director or designee will in-service the Social Service department and business office manager on the NOMNC procedure.</p> <p>Resident who were discharged in the last 14 days were audited by SS or designee to ensure proper notification regarding medicare cuts. If these residents were not notified appropriate action was taken per policy.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The Social Service Director or designee will in-service the Social Service department and business office manager on the NOMNC procedure on or before 6/30/14</p> <p>The IDT team will meet weekly to review all residents who are receiving medicare coverage. During this weekly meeting the team will discuss all residents who are pending discharge of services and in need of NOMNC letters. These letters will then be created and presented to the residents and or</p>	

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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.		family members for notification and signatures. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Medicare Cut letter CQI will be completed once weekly x4 then monthly times 6 months, then quarterly thereafter. A Medicare Cut letter CQI tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/30/14		

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	<p>Based on observation, interview, and record review, the facility failed to provide one-on-one activities three times weekly and failed to offer activities for a resident as care planned, for 2 of 3 residents reviewed of 10 who met the criteria for activities. (Resident #'s 117 & 199)</p> <p>Findings include:</p> <p>1) The clinical record for Resident #117 was reviewed on 6/2/14 at 10:30 a.m. The diagnoses for Resident #117 included, but were not limited to, heart failure.</p> <p>The 5/15/13 activities care plan, reviewed 4/25/14, for Resident #117 indicated, "Resident has low attendance to group activities and would benefit from one-on-one programming." The goal, with a target date of 7/17/14, was, "Resident will engage in combing hair, nail care, sensory stimi (sic) or listen to variety of music during activity one-on-one visits." An approach indicated on the care plan, effective 5/15/13, was, "Provide 1:1 visits 3 x (times) a week."</p> <p>Resident #117 was not observed to engage in one-on-one activities from 5/27/14 through 5/29/14.</p>	F000248	<p>F248 Activities Meet interests/Needs of each resident</p> <p>It is the practice of this provider to ensure that all alleged violations involving activities meet interests/needs of each resident are in accordance with State and Federal law.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>The facility reviewed and updated resident # 177 and 199's activity care plans. The facility has began providing activities to resident 177 and 199 per their care plan.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Activities staff will be educated on 1 on 1 activities, activities schedule, and activity care plans by the Activities Director or designee on or before 6/30/2014.</p> <p>Activities will complete a house wide audit to ensure that all residents have a current activity care plan and they are receiving activities based on the</p>	06/30/2014

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	<p>The Activity Director provided the May, 2014 One-to-One Participation Record for Resident #117 on 6/2/14 at 11:00 a.m. The record indicated she engaged in 9 one-to-one activities the entire month of May, 2014.</p> <p>An interview was conducted with the Activity Director on 6/2/14 at 11:04 a.m. After she reviewed Resident #117's May, 2014 One-to-One Participation Record, the Activity Director stated, "I see she did it 9 times in the month on May." She indicated if Resident #117 had received one-on-one activities 3 times weekly, there would be at least 12 entries on her May, 2014 activity record. Regarding why Resident #117 was not provided one-to-one activities 3 times weekly in the month of May, 2014 as care planned, she stated, "My new assistant only did it twice (weekly), but she should have done it 3 times weekly." Regarding why Resident #117 received one-on-one activities, she stated, "Her cognitive and physical status declined so much, she stopped coming out for activities, so I started doing one-on-ones with her."</p> <p>2) Resident #199's record was reviewed on 5/30/14 at 2:44 p.m. The resident's diagnoses included, but were not limited to, COPD, dysphagia, failure to thrive, DM type II, hypothyroidism,</p>		<p>care plan and designated schedule.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Activities staff will be educated on activity preferences and following the residents activity care plan by the Activities Director or designee on before 6/30/2013</p> <p>A daily/activity preferences form will be completed upon admission and with significant change by the activities director. The residents care plan will then be updated with the current resident activity preferences by the activities director or IDT team. The activities director will utilize an activity attendance record to ensure residents are offered/participating in their activity preference based on the residents care plan.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>An activity CQI audit tool will be completed for six months with audits being completed once weekly for one month,, and then monthly for 6 months by a nurse manager or designee</p>	

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	<p>hypertension, anxiety, dementia, depression, cerebrovascular disease, hemiplegia, neuropathy, psychosis.</p> <p>On 6/2/14 at 10:25 a.m., Res #199 was observed lying in bed.</p> <p>On 6/2/14 at 10:39 a.m., during an interview, Resident #199's nurse indicated the resident likes to lay in bed after breakfast.</p> <p>On 6/2/14 at 1:16 p.m., during an interview with the Activities Director (AD), she indicated Resident #199 enjoys the musical activities and concerts that the facility provides. The Activities Director provided copies of an activities calendar between March 1st, 2014 and 6/2/2014. It indicated the resident participated in multiple activities during April and May of 2014. The Activity calendar for Resident #199 indicated she refused various facility activities during March, April, and May of 2014. The AD indicated the resident enjoys watching television while lying in her bed, but the activities and nursing staff try and get her to participate in facility activities frequently.</p> <p>An activities care plan, dated 4/16/14, indicated Resident #199 should be invited and assisted to facility activities</p>		<p>The activity CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/30/2014.</p>	

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	<p>by facility staff. Some of the resident's preferred activities are concerts, theme parties, church, nail care, sensory group, and exercise.</p> <p>On 6/2/14 at 1:38 p.m., during an interview, the AD indicated the activities calendars for March, April, and May of 2014 included activities which are specifically identified on Resident #199's care plan, such as church, exercise, clergy visits, and nail care. The AD indicated the facility activity calendars for March 25th, April 5th (exercise), April 7th (exercise), April 8th (exercise, nail care, reverend lanier), April 12th (exercise), April 13th (church), April 15th (exercise, bible study, reverend lanier), April 20th (Easter prayer, church), April 29th (exercise, reverend lanier), April 30th (exercise), May 1st (exercise, learn the bible), May 3rd (exercise, martindale church of christ), May 4th (church), May 6th (exercise, bible study, nail care, reverend lanier), May 8th (exercise, country music), May 11th (church), May 16th (exercise), May 25th (church), and May 27th (exercise, gospel music, reverend lanier) included activities Resident #199 has care planned as activity preferences. She indicated the facility activity calendars should have the activity items highlighted when a resident is offered or encouraged to attend those</p>			

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F000253 SS=E	<p>activities. The above listed activities were not highlighted on the facility's activity calendars provided to the surveyor on 6/2/14 at 1:38 p.m. She indicated she doesn't know why Resident #199 was not offered to attend those activities.</p> <p>3.1-33(a) 3.1-33(b)</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure a homelike environment was maintained by having handrails throughout the facility with deep gouges and marks on them and by having a resident's room with various gouges/marks on a wall and ceiling not repaired. This affected 127 out of 144 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During random observations throughout the facility, on 5/30/14 at 12:00 p.m., the following handrails near</p>	F000253	<p>F253 Housekeeping & Maintenance Services</p> <p>It is the practice of this provider to ensure that all alleged violations involving Housekeeping & Maintenance Services are in accordance with State and Federal law.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>The handrails throughout the facility at the north nurses station, near rooms 111, 127, 128, 145, 149 182,</p>	06/30/2014			

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	<p>these locations had various sized [from two-hand length to fingernail length], deep gouges/marks on them: North Unit Nurse's Station, Room #111, #127, #128, #145, # 149, #182, Activity Office, and the Rose Cafe.</p> <p>During an interview with the Maintenance Director, on 5/30/14 at 12:05 p.m., he indicated most of the handrails in the facility do not look good and need to be repaired. The Maintenance Director indicated they usually have someone fill the gouges/marks with putty, sand down the handrails, and then repaint them. He further indicated plastic handrails would probably be best for the facility, because the handrails will probably have these deep gouges/marks again. The Maintenance Director also indicated the handrails with these deep gouges/marks do not provide a homelike environment.</p> <p>On 6/5/14, at 11:15 a.m., the Executive Director indicated he was aware of the condition of the handrails and the handrails need to be repaired.</p> <p>2. During a random observation of Resident #158 and #226's room, on 5/30/14 at 11:10 a.m., the wall next</p>		<p>activity off and the rose café have been repaired, sanded, and painted to remove gouges and marks.</p> <p>The wall in resident 158s room was repaired and repainted</p> <p>The popcorn ceiling next to resident 226's bed was repaired and painted</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents residing in the facility have the potential to be affected by this alleged deficient practice.</p> <p>The SDC or designee will educate all staff on reporting any non homelike environmental observations to the facility supervisor for repair on before 6/30/2014.</p> <p>An audit of all rooms and hallway handrails was conducted by the maintenance supervisor and repairs made to ensure no gouges or marks are present.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The SDC or designee will educate all staff on reporting any non homelike</p>	

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	<p>Resident #158's bed had several deep gouges/marks of various sizes and shapes on it. There was different colored paint on this area with the marks, than on the rest of wall in the room. The "popcorn" ceiling next to Resident #226's bed was falling off of the plaster ceiling creating an appearance of a foot sized hole in the ceiling.</p> <p>During an interview with Resident #226, on 5/30/14 at 11:39 a.m., Resident #226 indicated the ceiling had looked like that, since he moved in the room about a week ago.</p> <p>On 5/30/14, at 11:40 a.m., RN #3 indicated she felt the deep gouges/marks on the wall and ceiling did not provide a homelike environment for Residents #158 and #226.</p> <p>At 12:04 p.m., on 5/30/14, the Maintenance Director indicated they had not gotten around to fixing the wall or the ceiling in Residents #158 and #226's room and the gouges/marks and ceiling did not provide a homelike environment for the Residents in the room.</p> <p>3.1-19(f)(5)</p>		<p>environmental observations to the facility supervisor for repair on before 6/30/2014.</p> <p>The facility department heads will complete daily rounds Monday thru Friday excluding holidays and report any environmental findings in the afternoon CQI meeting. The weekend house supervisor will make rounds on Saturday and Sunday and report abnormal findings to the executive director. These findings will be logged in the maintenance repair log and audited daily to ensure they are completed.</p> <p>The facility has created a maintenance repair and evaluation schedule. The maintenance director will evaluate facility areas on a scheduled basis ensuring they present as a homelike environment. Items identified that are in need of repair will be logged and scheduled for repair.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>An Environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month and monthly for 6 months by the maintenance supervisor or designee</p>				

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F000280 SS=D	<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 interview and record review, the facility failed to update an ADL (Activities of Daily Living) Care Plan for</p>	F000280	<p>The Environmental CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/30/2014.</p> <p>F280 Right to Participate Planning Care-revise CP</p> <p>It is the practice of this provider to</p>	06/30/2014

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	<p>1 of 3 residents reviewed of 4 who met the criteria for choices. (Resident #279)</p> <p>Findings include:</p> <p>The clinical record for Resident #279 was reviewed on 5/30/14 at 11:05 a.m. The diagnoses for Resident #279 included, but were not limited to, venous insufficiency, diabetes mellitus, arterial fibrillation, and cellulitis.</p> <p>During an interview with Resident #279, on 5/29/14 at 10:14 a.m., Resident #279 indicated they would always prefer to have a bed bath as their method of bathing.</p> <p>A review of the document, Preferences for Daily Customary Routines, dated and signed by Resident #279 on 5/25/14, indicated Resident #279 was used to taking/getting a sponge bath. The document also indicated it was very important to Resident #279 to choose what type of bathing they had.</p> <p>On 5/30/14, at 1:05 p.m., the Activity Director indicated a Resident's bathing preferences were put into care plans and the document, Preferences for Daily Customary Routines, indicated the information was put in a care plan.</p>		<p>ensure that all alleged violations involving Right to Participate Planning Care-revise CP are in accordance with State and Federal law.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Resident #279s care plan was updated with her preference of having a bed bath as their preference.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who reside in the facility have the potential to be affected by the same deficient practice</p> <p>SDC or designee to educate facility nurses and IDT team on resident comprehensive care plans and preferences on before 6/30/2014.</p> <p>The facility department head team or designee will complete a house audit identifying all residents bathing or shower preferences and ensure the care plans are accurate and up to date.</p> <p>The activities director or designee will complete a preferences</p>	

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	<p>At 1:15 p.m., on 5/30/14, CNA #11 indicated a Resident's bathing preferences were on a care plan.</p> <p>A review of an ADL Care Plan, dated 5/21/14, indicated an intervention, "Provide shower two times per week, partial bath in between."</p> <p>During an interview with the Director of Nursing Specialist, on 5/30/14 at 2:29 p.m., he indicated the care plan should reflect the resident's preferences.</p> <p>3.1-35(b)(2)</p>		<p>flow-sheet upon admission and with significant change. These residents' preferences will be brought to the IDT team for review. The care plans will be updated and re-evaluated upon admission, quarterly, and with significant change.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>SDC or designee to educate facility nurses and IDT team on resident comprehensive care plans and preferences on before 6/30/2014.</p> <p>The activities director will complete a preferences flow-sheet upon admission and with significant change. These residents' preferences will be brought to the IDT team for review. The care plans will be updated and re-evaluated upon admission, quarterly, and with significant change</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>A resident preference CQI audit tool will be completed for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee</p>	

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 developing.</p> <p>Based on observation, interview, and record review, the facility failed to provide side rails as ordered and care planned to a resident with a stage 3 pressure ulcer and failed to follow up on a Physician's Order in a timely manner for 2 of 3 residents reviewed of 3 who met the criteria for Stage 3 or 4 pressure</p>	F000314	<p>The resident preference CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/30/2014</p> <p>F314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>It is the practice of this provider to ensure that all alleged violations involving TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES are in accordance with State and Federal law.</p>	06/30/2014	

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	<p>ulcers. (Resident #'s 84 and 277)</p> <p>Findings include:</p> <p>1) The clinical record for Resident #277 was reviewed on 5/28/14 at 10:55 a.m. The diagnoses for Resident #277 included, but were not limited to, stage 3 pressure ulcer lower back (sacrum).</p> <p>The 5/23/14 Wound Care Specialists of Indiana Progress Note indicated, "Patient presents with open area on coccyx....Location: Sacrum/coccyx...Integumentary (Hair, Skin) Wound #1 Sacral is a Stage 3 Pressure Ulcer and has received a status of Not healed. Initial wound encounter measurements are 0.2 cm length x 0.1 cm width x 0.1 cm depth, with an area of 0.02 sq cm and a volume of 0.002 cubic cm. There is a scant amount of serous drainage noted which has no odor. The patient reports a wound pain of level 0. The wound margin is well defined. Wound bed is 76-100% granulation. The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal."</p> <p>The 5/19/14 skin integrity care plan indicated, "Resident has impaired skin integrity: Stage 3 coccyx." The goal, with a target date of 8/19/14, indicated,</p>		<p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Resident #277's side rails were placed on his bed. Resident 277's care plan was reviewed to ensure all care planned items were in place</p> <p>Resident #84 no longer has an order for the protective boot and soles. The residents care plan was reviewed to ensure all interventions were current and in place.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who resident in the facility and have wounds have the potential to be affected by the alleged deficient practice</p> <p>Nursing staff and the facility department head team have been educated on wound care plans and ensuring interventions are in place by the SDC or designee by 6/30/14.</p> <p>The therapy department was educated on timely ordering of supplies and devices by the Rehab Manager or designee on or before 6/30/2014</p> <p>A house audit was completed by the wound nurse or designee on all</p>	

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	<p>"Wound will be free from signs of complications and will heal without complications." An approach, with a start date of 5/19/14, was "2 (two) 1/2 side rails for mobility." The discipline indicated was "Nursing."</p> <p>The Physician Order Report, signed by Nurse Practitioner (NP) #9 on 6/2/14, indicated, "Order Type: General...Start Date: 5/19/14...End Date: Open Ended...Description: Positioning/Devices: 1/2 siderails x 2 while in bed to: enhance bed mobility."</p> <p>An observation was made of Resident #277 lying in bed in his room on 6/2/14 at 2:21 p.m. No side rails were observed on either side of his bed.</p> <p>An interview and observation of Resident #277 lying in bed in his room was made with LPN #11 and RN #12 on 6/2/14 at 2:24 p.m. LPN #11 stated, "No, there are no side rails on his bed." RN #12 stated, "No, there are no side rails on his bed. I think he's been in that room and bed since he came back (from the hospital on 5/31/14)." RN #12 reviewed Resident #277's orders on her computer and stated, "Yes, I see the order for two 1/2 side rails for bed mobility effective 5/19 (5/19/14)." At this time, Unit Manager #18 approached the scene and indicated,</p>		<p>residents with wounds ensuring all interventions are in place per care plan.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Nursing staff and the facility department head team have been educated on wound care plans and ensuring interventions are in place by the SDC or designee by 6/30/14.</p> <p>The therapy department was educated on timely ordering of supplies and devices by the Rehab Manager or designee on or before 6/30/2014</p> <p>When a resident readmits to the facility a house supervisor will review the residents care plan upon admission. The house supervisor will audit the interventions ensuring all care planned interventions are in place at the time of readmission.</p> <p>The Rehab manager will meet with the therapy department 5 times a week. The Rehab manager will discuss with the therapy team any new interventions or devices that have been ordered by a physician. The therapy manager will log these devices and ensure they are ordered and arrive at the facility in a timely manner.</p>	

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	<p>"It's on the work order to be put on today. When he (Resident #277) came back, we weren't expecting him to be on isolation, and since he was, we had to give him his own room, and maintenance isn't here on the weekend."</p> <p>During another interview with Unit Manager #18 on 6/2/14 at 2:44 p.m., he indicated, "He has an order for it (side rails) to be in place, and it wasn't....Maintenance is typically the only ones who move furniture." Regarding whether maintenance are the only staff capable of moving furniture in the facility, he indicated, "I'm not saying that."</p> <p>2. The clinical record for Resident #84 was reviewed on 6/2/14 at 11:05 a.m. The diagnoses for Resident #84 included, but were not limited to, acute kidney injury, diabetes mellitus, arterial fibrillation, leukocytosis, peripheral vascular disease, and rhabdomyolysis</p> <p>A Progress Note, dated 12/16/14 at 6:56 a.m., indicated, "...CNA on duty reported new open area on resident's left heel....Resident denied any pain to area and said that he had reported a "squishy" area on his heel earlier in the week...."</p> <p>A review of a Progress Note Details from [Name of Wound Care Company], dated</p>		<p>The IDT will review residents with wounds on a weekly basis. The IDT team will review the residents care plan and ensure all interventions are in place in the resident's room per care plan.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>A wound intervention CQI audit tool will be completed for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee</p> <p>The wound intervention CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 6/30/2014</p>	

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	<p>1/3/14, indicated "...General Notes: Obtain [name of sole] soles for [name of shoe] shoe....[Name of shoe] in but do not have [name of sole] sole; will order proper sole to allow for offloading of heel ulcers as these soles will increase pressure on affected areas. Discussed with PT [Physical Therapy] on rounds"</p> <p>A Physician's Order, dated 1/3/14, indicated to "...Obtain [name of soles] soles or equivalent [sic] for surgical shoes; shoes have a portion of sole removable to offload pressure area on heel."</p> <p>A Progress Note Details from [Name of Wound Care Company], dated 1/10/14, indicated, "...Wound #1 Left heel is a Necrotic Tissue (unstageable) Pressure Ulcer....Wound #2 Right Lateral Heel is a Stage 2 Pressure Ulcer....Spooke [sic] with PT re. [sic] [name of shoe/boot] boots; suitable to use when walking but have no allowance for offloading of heels; will place additional pressure on heel ulcers while in use. Will order [name of sole] soles and remove pegs which overlie [sic] pressure areas to offload."</p> <p>A document titled, Adjustment Sheet: Orthotic/Prosthetic, indicated, on 1/14/14 "[Name of a member of the Therapy</p>			

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	<p>Department] stops [sic] me and stated the wound nurse wants [name of soles] for [name of Resident #84] shoes. [Name of member of therapy department] wanted to see pictures before they were ordered." The document also indicated on 1/15/14, "Brought over pictures of of [sic] [name of soles] for [name of shoes] heel shoe....She stated she will show nurse." The document further indicated on 1/17/14, "Received OK...will order this date."</p> <p>A Progress Note Details from [Name of Wound Care Company], dated 1/17/14, indicated, "...Wound #1 Left heel is a Necrotic Tissue (unstageable) Pressure Ulcer....Wound #2 Right, Lateral Heel is a Necrotic Tissue (unstageable) Pressure Ulcer...."</p> <p>A Progress Note Details from [Name of Wound Care Company], dated 1/24/14, indicated, "...Wound #1 Left heel is a Necrotic Tissue (unstageable) Pressure Ulcer....Wound #2 Right, Lateral Heel is a Necrotic Tissue (unstageable) Pressure Ulcer....[Name of soles] soles in but do ot [sic] shoes, so resident is walking with [name of shoe] without sole pegs removed, causing additional pressure and explaining deterioration of heel ulcers. Avoid use of walking shoes until proper offloading footwear is available...." The</p>			

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F000323	<p>Progress Note was dated and signed on 1/24/14 at 10:02 a.m.</p> <p>A PT Daily Treatment Note, dated and signed on 1/24/14 at 5:11 p.m., indicated Resident #84 ambulated 50 and 90 feet using a rolling walker and bil [bilateral] LE [lower extremity] pressure relief shoes with SBA/min assist [Stand By Assist/Minimal Assistance].</p> <p>During an interview with the Rehab Manager, on 6/3/14 at 10:12 a.m., she indicated the soles should've been ordered sooner than they were. The Wound Care Medical Doctor indicated in the Progress Note Detail from 1/3/14 that he spoke to PT that day about ordering the soles for the shoes. The Rehab Manager was unsure why the order was not followed up on sooner.</p> <p>On 6/4/14, at 11:12 a.m., the Director of Nursing Specialist indicated PT/Therapy was in charge of ordering the correct soles for the shoes and he was unsure why they weren't ordered sooner.</p> <p>3.1-40(a)(2)</p> <p>483.25(h)</p>			

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SS=D	<p>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to implement a fall intervention as care planned for 1 of 3 residents of 3 who met the criteria for accidents. (Resident #117). To ensure a supply closet containing sharps and chemicals was locked. This had the potential to affect 20 cognitively impaired, mobile residents on the South Unit. Failed to ensure a bottle of medication was supervised and inaccessible to residents who had cognitive impairment. This had the potential to affect 4 of 19 residents living on the south unit. The facility failed to ensure a ladder was not blocking Fire Doors in the "B" hallway and water temperatures were maintained at a safe temperature level in 3 rooms on the "C" hallway. This affected 14 residents residing on "B" hallway and 2 of 5 residents residing in 3 rooms on "C" hallway.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #117 was reviewed on 5/30/14 at 1:00 p.m.</p>	F000323	<p>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>It is the practice of this provider to ensure that all alleged violations involving free of accident hazards/supervision/devices are in accordance with State and Federal law.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Resident #117s (albino)care plan was reviewed for appropriate fall interventions. The resident's son had moved the reacher because the resident no longer uses it. The reacher was discontinued and the residents fall care plan was reviewed and updated. The resident's son was educated on not removing or disabling the residents fall interventions.</p> <p>No residents were affected by the alleged unlocked supply room door.</p> <p>No residents were affected by the alleged bottle of medication on the south unit medication cart. QMA # 6</p>	06/30/2014
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	<p>The diagnoses for Resident #117 included, but were not limited to, heart failure.</p> <p>The 5/24/14 Fall Event indicated Resident #117 had an unwitnessed fall in her room next to her bed.</p> <p>The 7/13/11 fall care plan, revised 5/27/14, indicated Resident #117 was at risk for falls and had a history of falls. An approach, with a start date of 12/10/10, indicated, "Reacher at bedside."</p> <p>The 5/1/14 -5/30/14 Physician Order Report indicated, "Order Type: General...Start Date: 11/29/13...End Date: Open Ended...Description: May keep reacher at bedside Q (every) Shift."</p> <p>An observation of Resident #117 lying in bed in her room was made on 5/30/14 at 1:33 p.m. A reacher was observed on top of her roommate's closet, but no reacher was observed next to her bed. At this time, an interview and observation was made with LPN #13. LPN #13 stated, "I don't see her reacher. She usually uses it when she's in her chair. I'll go get her one. There's a reacher on top of (name of roommate's) closet." LPN #13 took the reacher from the top of the closet and placed it next to Resident #117's</p>		<p>(Kathy) was educated on proper medication storage.</p> <p>No residents were affected by the alleged ladder blocking the fire door. The maintenance director was educated on fire door safety</p> <p>No residents were affected by the alleged out of range water temps. The maintenance director was educated on water temp notification and repair safety.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents who are at risk for falls have the potential to be affected by the alleged deficient practice of the missing fall intervention</p> <p>20 residents titled as cognitively impaired and mobile have the potential to be affected by the alleged unlocked supply room door.</p> <p>All cognitively impaired residents who are mobile have the potential to be affected by the alleged unsupervised bottle of medication on the medication cart.</p> <p>All residents who reside in the facility have the potential to be affected by the alleged blocked fire door.</p>	

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	<p>roommate. LPN #13 left the room. A few minutes later, LPN #13 went to the nurse's station, got a reacher out of a fall box underneath the desk, went back to Resident #117's room, and put it by Resident #117's bedside. LPN #13 indicated, "I looked and (name of Resident #117's roommate) does not have a reacher, so it probably just got put up there."</p> <p>2) A tour of the facility was conducted on 5/27/14 at 11:00 a.m.</p> <p>The door to the Supply Room on D Hall was unlocked. The following contents were observed inside of the Supply Room: blue razors, nail clippers, orange sticks (sharp wooden sticks used to clean underneath fingernails), body wash, perineal care, shave cream, and denture cream. The Maintenance Director approached the scene during this observation. He indicated, "It should latch. It must be broken." He fiddled with the lock a bit and stated, "Oh, it was unlocked from inside. They probably didn't realize they did it."</p> <p>The Administrator provided the MSDS's (Material Safety Data Sheets) for the above chemicals on 5/28/14 at 3:00 p.m. The Shampoo/Body Wash, Soothe & Cool MSDS indicated, "Health Hazards:</p>		<p>All residents who reside in the facility have the potential to be affected by the alleged out of range water temps.</p> <p>The maintenance staff was educated on water temp safety and fire door safety by the ED or designee on or before 6/30/14.</p> <p>Nursing staff were educated on medication storage and hazard storage including the supply room by the SCD or designee on or before 6/30/14</p> <p>An audit was completed by the maintenance supervisor of all supply room doors to ensure all doors properly locked.</p> <p>Nursing staff were educated on fall prevention, intervention placement, and fall care plans by the SDC or designee on or before 6/30/14</p> <p>Water temps were checked throughout the facility to ensure they are in appropriate range by the maintenance supervisor.</p> <p>All residents who had falls in the last 30 days were audited to ensure all interventions were in place per fall care plan by the DNS or designee.</p> <p>All medication carts were audited by dns or designee to ensure no medications were left unsupervised</p>	

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	<p>Acute or Chronic: Eye contact may cause temporary moderate irritation. Ingestion may result in gastric disturbances." The Shave Cream MSDS indicated, "Ingestion: Product is essentially nontoxic. May cause nausea, vomiting, and/or diarrhea." The Perineal Wash MSDS indicated, "Health Effects - Eyes: Avoid eye contact; this product is a primary eye irritant." The Denture Adhesive Cream MSDS indicated, "Ingestion of large amounts may cause nausea or vomiting. Esophageal blockage could occur in rare cases. Health Hazards: Acute: May cause transient eye irritation."</p> <p>An interview was conducted with the Administrator on 5/28/14 at 1:39 p.m. regarding the unlocked supply closet. He indicated, "We try to ensure it is locked and latched at all times."</p> <p>The Housekeeping and Material Storage Policy was provided by the Administrator on 5/29/14 at 10:14 a.m. It indicated, "Proper storage procedures are required for all materials, products, flammables and compressed gases to prevent fires, keep exits and aisles clear and avoid injuries and illnesses."</p> <p>On 5/28/14 at 3:00 p.m., the Administrator provided a list of 20</p>		<p>All fire doors were audited by the maintenance supervisor to ensure fire doors were not blocked.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The maintenance staff was educated on water temp safety and fire door safety by the ED or designee on or before 6/30/14.</p> <p>Nursing staff were educated on medication storage and hazard storage including the supply room by the SCD or designee on or before 6/30/14</p> <p>Nursing staff were educated on fall prevention, intervention placement, and fall care plans by the SDC or designee on or before 6/30/14</p> <p>The house supervisor or designee will check the supply room door daily each shift to ensure it latches and locks appropriately. If correction action is needed maintenance will be contacted</p> <p>The house supervisor or designee will round daily to ensure fire doors are not blocked</p> <p>The maintenance supervisor or designee will complete daily water temp checks ensure water temperatures are within appropriate range.</p>	

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	<p>residents entitled, "Cognitively impaired residents who are mobile on South unit."</p> <p>3) An observation, on 5/28/2014 at 10:02 a.m., indicated there was a bottle sitting on top of the south unit medication cart #2. There was no staff in view of the medication cart. The bottle was labelled "amoxicillin and clavulanate potassium for oral suspension 250mg/62.5mg per 5 ml". The bottle was cold like it had been recently refrigerated. The bottle was approximately 1/4 full. The medication cart was locked. At 10:06 a.m., QMA #6 walked up to the medication cart. QMA #6 indicated, "This medication is expired as of today. I left it on here because I just gave a dose (from it) and I didn't want to put it back into the refridgerator because it is labelled that it expires today, so I need to find out what to do with it." QMA #6 then walked away from the medication cart with the bottle in her hands.</p> <p>An interview, on 5/28/2014 at 10:31 a.m., with RN #5, indicated "I'm in charge of the unit right now. She (QMA #5) should not have just left the medication there on the cart."</p> <p>A list, provided by the DNS, on 6/5/2014 at 11 a.m., indicated, "Independently Mobile residents with Impaired cognition</p>		<p>The facility will disable the hot water and announce to staff with future hot water repairs.</p> <p>The house supervisor will round each shift monitoring for unsupervised medications</p> <p>The department head team or house supervisor will round daily completing random audits of resident rooms ensuring fall interventions are in place per care plan.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>A safety/hazard intervention CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for 2 months, and then monthly for 3 months by a nurse manager or designee</p> <p>The safety/hazard CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

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	<p>rooms 100-113: Resident #32- BIMS (Brief Interview for Mental Status) score 2, Resident #46 BIMS score 5, Resident #58 BIMS score 5, Resident #88 BIMS score 2.</p> <p>A policy, provided by the DNS (Director of Nursing Services), on 6/5/2014 at 11:00 a.m. indicated, "10.02 Medication Dispensing: No medications are to remain on top of the cart in an accessible fashion while the cart is unattended."</p> <p>4) During the initial tour, on 5/27/14 at 10:35 a.m., a step ladder was observed in the doorway of two Fire Doors leading into rooms #115-124, in the middle of "B" hallway. The ladder remained in the middle of the hallway, blocking the Fire Doors, until 10:43 a.m., when the Clinical Education Coordinator removed the ladder from the middle of the hallway. A red sign was noted on each Fire Door. The sign indicated, "Do Not Block Door...."</p> <p>During an interview with Clinical Education Coordinator, on 5/27/14 at 10:44 a.m., she indicated she moved the ladder because it was a safety hazard and was blocking the Fire Doors.</p> <p>On 5/27/14, at 10:45 a.m., the Executive Director indicated Fire Doors should not</p>		Date of Compliance 6/30/2014	

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	<p>be blocked.</p> <p>A policy titled, Ladder Safety dated 11/1/08, was received from the Executive Director, on 6/3/14 at 2:20 p.m. The policy indicated, "...Never place a ladder in front of a door that opens towards it...." The Executive Director indicated, at the date/time noted, there was not a specific policy on blocking Fire Doors with objects.</p> <p>5) During a random observation of Resident #225's room, on 5/27/14 at 2:25 p.m., the bathroom facet had a water temperature reading of 126.5 degrees Fahrenheit. Four other Resident's bathroom water temperature was also checked at this time. Residents #122 and #40's bathroom faucet water temperature read 130.1 degrees Fahrenheit and Residents #140 and #251's bathroom faucet water temperature read 122.1 degrees Fahrenheit.</p> <p>During an interview with the Maintenance Director, at 2:41 p.m. on 5/27/14, he indicated the bathroom water temperature listed above were too hot and he doesn't deny the accuracy of the temperatures because he turned off the regulator for the temperature control around 11:00 a.m. The Maintenance Director indicated he was unsure if he</p>			

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	<p>told any staff members/residents not to use the bathroom sinks due to hot water. The Maintenance Director also indicated he just turned off the hot water now because he forgot to turned it off earlier when he turned the regulator off. He further indicated the water temperatures should be below 120 degrees Fahrenheit.</p> <p>At 2:55 p.m., on 5/27/14, RN #3 indicated Residents #225 and #251 were able to get themselves to the bathroom, while the other three residents were not.</p> <p>The following bathroom water temperatures were observed with the Maintenance Director, at 3:00 p.m., on 5/27/14 :</p> <p>Residents #122 and #40's room: 132.1 degrees Fahrenheit Residents #140 and #251's room: 133.5 degrees Fahrenheit Resident #225's room: 131.5 degrees Fahrenheit.</p> <p>On 5/27/14, at 3:05 p.m., during an interview with the Executive Director and the Maintenance Director, the Maintenance Director indicated the unsafe water temperatures were his fault because he forgot to turn off the hot water when he turned off the regulator at 11:00 a.m.</p>			

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F000325 SS=D	<p>3.1-19(c) 3.1-45(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to ensure a resident at risk for aspiration was not fed contrary to therapy recommendations for 1 of 1 resident randomly observed. (Resident #164)</p> <p>Findings include:</p> <p>The clinical record for Resident #164 was reviewed on 5/28/14 at 11:00 a.m. The diagnoses for Resident #164 included, but were not limited to, dysphagia.</p> <p>The 5/17/14 therapy progress note written by SLP (Speech Language Pathologist) #19 indicated, "Pt (patient) to use aspiration precautions with thin liquids</p>	F000325	<p>F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE It is the practice of this provider to ensure that all alleged violations involving MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE are provided in accordance with State and Federal law through established procedures. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The resident 164 no longer resides in the facility. Prior to discharge the residents CP and CNA sheet were reviewed and updated with the appropriate precautions. How will you identify other residents having the potential to be affected by the same deficient</p>	06/30/2014

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	<p>including using a straw, chin tuck and small, single sips...."</p> <p>The 5/26/14 ST-Therapist Progress note indicated, "Goal Name: SW-Airway Protection Current Level of Function: The patient completes chin tuck with mild impairment (35-49% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped; cueing and intermittent supervision for carryover). SW-Safe Swallow (staff) Current Level of Function: Tha (sic) patient exhibits safe swallow exhibiting mild impairment (25-35% impairment; risk of aspiration on liquids, mild oral residue and may need meats ground or chopped; cueing and intermittent supervision for carry over) using swallow strategies/precautions as instructed by staff and/or caregivers....Patient/Caregiver Training: Edu (educated) re (regarding); safe swallow precautions. Remaining Functional Deficits/Underlying Impairments: Dysphagia. Impact on Burden of Care/Daily Life: Requires cueing/assist for safe intake." This note was electronically signed by ST #19 on 5/27/14.</p> <p>On 5/28/14 at 10:05 a.m., Resident #164 was observed lying in his bed with his</p>		<p>practice and what corrective action will be taken? All residents who have aspiration precautions have the potential to be affected by the alleged deficient practice. Facility nursing staff will be re-educated on aspiration precautions by the SDC or designee on or before 6/30/14 Therapy staff will be educated on proper notification of aspiration risk and precautions by the rehab manager or designee 6/30/14 All residents who have aspiration precautions have had their care plans audited to ensure they are accurate and up to date with current interventions. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Facility nursing staff will be re-educated on aspiration precautions by the SDC or designee on or before 6/30/14 Therapy staff will be educated on proper notification of aspiration risk and precautions by the rehab manager or designee 6/30/14 When a resident is evaluated by therapy and is deemed an aspiration risk the MD will be notified and an therapy to nursing communication form will be completed. The communication form will be reviewed by the shift house supervisor and a aspiration care plan will be created and updated with current interventions. These interventions will be placed on the</p>	

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	<p>eyes closed. Upon entrance to Resident #164's room, Resident #164 suddenly jerked forward, coughed, and projectiled a brown, 25 cent gum ball sized object from his mouth, then stated, "Help." CNA #17 entered the room, put on gloves, went over to the bed, and stated, "Oh my gosh!" CNA #17 came out of the room and indicated, "He had a mouth full of sausage with a little saliva and phlegm. They feed him. He doesn't eat on his own." Regarding who fed Resident #164 that morning, she stated, "I think (name of CNA #14) is his aide."</p> <p>An interview was conducted with LPN #10 on 5/28/14 at 10:14 a.m. She stated, "He has been having a decrease in swallowing. Speech therapy has worked with him. Speech therapy fed him this morning. She said she gave him one bite, and he said no more. I tried to give him his meds (medications) this morning. He said he didn't want them, because he was having trouble swallowing. I talked to him about it, and he said he had problems swallowing breakfast this morning, so he didn't want his meds. The sausage is probably the bite they (speech therapy) thought he swallowed." Regarding whether Resident #164 was supposed to receive a breakfast tray that morning, she stated, "Yes, he was supposed to get a tray. About 9:30, I got the orders</p>		<p>cna assignment sheet so that staff is aware of these precautions. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A aspiration precaution CQI audit tool will be completed for six months with audits being completed once weekly for one month and then monthly for 6 months by a nurse manager or designee The aspiration precaution audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 06/30/14.</p>	

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	<p>changed. It (new order) exists, it just hasn't made it's way to me."</p> <p>An interview was conducted with Speech Therapist #15 on 5/28/14 at 10:20 a.m. regarding her evaluation of Resident #164 that morning. She indicated, "I went in his room. I asked him if he wanted to eat. I got his tray, set him up, asked if he wanted anything. I scooped up some oatmeal, brushed it on his lip. He took a little, but wouldn't really open his mouth. I found his nurse (LPN #10), and asked about his alertness level. She informed he was on morphine every 2 hours. I went back in, didn't do anymore, talked with the Rehab (Rehabilitation) Director, and documented if he is awake and alert, he can try to eat, but he wasn't able to maintain alertness level to eat this morning. He was not safe to eat this morning. This was about, a little after 8:00 (a.m.)" Regarding whether Resident #164 was safe to finish eating breakfast after she left, she indicated, "If he was awake and alert, he could finish eating. One of his goals was a chin tuck, and he wasn't alert enough to do the chin tuck." Regarding how nursing staff would know about a chin tuck intervention during feeding for Resident #164, she stated, "I'm assuming staff know about the chin tuck by the Speech Therapist who usually sees him." ST #15 provided a copy of the</p>			

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	<p>note she made from that morning's evaluation of Resident #64. It indicated, "ST attempted feed, resident required total assist. Resident is unable to fully waken in order to consume breakfast. Resident is not able to complete chin tuck or any compensatory strategies to protect airway. ST provide (sic) tactile cueing with spoon to lip to encourage mouth opening. Resident keeps mouth shut to spoon. ST discussed residents status with nsg (nursing). Nsg reports resident has been given morphine every two hours beginning yesterday. Resident not accepting bolus at this time in order to safely swallow. Resident should be awake and alert in order to safely consume diet."</p> <p>An interview was conducted with CNA #14 on 5/28/14 at 10:26 a.m. regarding her feeding of Resident #164 after the Speech Therapist already tried. She indicated, "I didn't know he was a feed. I went in there, and tried to feed him. I did try to feed him, and he ate one bite of eggs, one bite of toast, one bite of grits and one bite of sausage. Then I tried to give him some milk, and he said he was about to vomit. I stepped back, and he said he was okay. When I walked in this morning, I started feeding him. No one told me he worked with speech therapy this morning, and he couldn't eat. When I</p>			

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	<p>got in there this morning, his tray was already there in his room. I was just going around helping feed."</p> <p>A second interview was conducted with CNA #14 on 5/28/14 at 10:48 a.m. to further clarify her understanding of Resident #164's swallowing condition. She indicated, "I've never fed him before today. There's no particular way he's supposed to eat. I know he eats really slowly, and I try to give him drinks in between. I don't know anything about him doing a chin tuck while eating. (Name of LPN #10) told me to just make sure he's sitting up in the bed. Before this morning, I was told he was independent, and could eat by himself. I set his tray up this morning, but he didn't touch it. I started feeding him, because he didn't really feed himself, so I figured he needed some extra help." Regarding Resident #164's alertness level while feeding him, she indicated, " He didn't seem that alert. His eyes were really low. He was like 50/50. No specific instructions were given to me regarding feeding him before this morning. When (name of LPN #10) said he coughed up a piece of sausage, I told her what happened." Regarding whether she checked Resident #164's mouth for pocketed food prior to leaving his room, she indicated, "I didn't check his mouth</p>			

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	<p>before I left. He said he was about to throw up, so I put the bath blanket around his neck. I stayed for a minute. He said he was okay and going back to sleep. I tried to give him milk one more time. He wouldn't take it, so I left. I know he threw up yesterday."</p> <p>Another interview was conducted with LPN #10 on 6/4/14 at 2:32 p.m. to further clarify what information regarding feeding Resident #164 she relayed to CNA #14 after she spoke with ST #15 and prior to CNA #14 feeding him the morning of 5/28/14. She indicated, "I hadn't seen the CNA, (name of CNA #14), yet, to tell her about what speech had told me that morning. When I did see her, she had already fed him, and I informed her then that speech said he was having difficulty swallowing, and that he needs to be fully alert, erect in bed. We discussed with speech afterwards what needed to be done afterwards...orders for small bites, small sips, fully alert. (Name of CNA #14) doesn't normally work with him. He was on a different hall the earlier week, so she didn't know about the decline. The first time I had talked to (name of CNA #14) about his condition was when I was telling her about speech therapy and what happened that morning. By then, she had already fed him and he'd already coughed up the sausage."</p>			

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F000327 SS=D	<p>3.1-46(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview, and record review, the facility failed to implement hydration interventions for a resident at risk for dehydration for 1 of 3 residents reviewed of 3 who met the criteria for death. (Resident #269)</p> <p>Findings include:</p> <p>The clinical record for Resident #269 was reviewed on 6/5/13 at 2:00 p.m. He was admitted to the facility on 4/29/14. The diagnoses for Resident #269 included, but were not limited to: anemia, leukocytosis and severe malnutrition.</p> <p>The 5/1/14 Dehydration/Fluid Maintenance care plan for Resident #269 indicated, "At risk for fluid imbalance related to impaired mobility and</p>	F000327	<p>F327 SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>It is the practice of this provider to ensure that all alleged violations involving sufficient fluid to maintain hydration are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Resident #269 no longer resides in the facility</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who reside in the</p>	06/30/2014
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	<p>cognitive deficits." The goal, with a target date of 8/1/14, indicated, "Resident will be free from signs and symptoms of fluid volume deficit." Three approaches indicated were to, "Document and notify MD of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decreased blood pressure, weak/rapid pulse, change in mental status, decreased urine output, abnormal labs, poor skin turgor. Encourage fluids. Vital signs as ordered/needed."</p> <p>The 5/25/14, 9:21 a.m. nurse practitioner note written by NP #8 indicated, "Pt (patient) was being seen d/t dysuria (sic) (painful or difficult urination) and diarrhea. Patient stated that symptoms have been going for a couple of days. Pt was also seen d/t review of CBC (lab). Assessment and plan...Hx (history) of UTI (urinary tract infection): Draw UA/CS (urinalysis), Diarrhea (sic): Order stool for C-diff."</p> <p>The 5/25/14, 2:42 p.m. nurses note indicated, "(Name of NP #8) in facility today, new order received and noted for UA/C&S and may cath if needed and to collect stool to r/o (rule out) C-diff. Resident only had a trace of bm (bowel movement) in brief. Writer tried to collect urine via straight cath but no</p>		<p>facility have the potential to be affected by the alleged deficient practice.</p> <p>Facility nursing staff will be educated on hydration, s/s of fluid imbalance and MD notification by the SDC on designee on or before 6/30/14.</p> <p>Resident who have experienced a significant change in the last 2 weeks have been audited to ensure appropriate hydration interventions are in place by DNS/designee.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Facility nursing staff will be educated on hydration, s/s of fluid imbalance and MD notification by the SDC on designee on or before 6/30/14.</p> <p>When a resident experiences a significant change in hydration status the nurse assess the resident will notify the physician and family. The nurse will document a nursing note with assessment findings, notifications, and actions taken. The resident will then be placed significant change hot charting in which an assessment will be performed and documented each shift until the condition has stabilized. The nurse management team will review the facility activity</p>	

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	<p>results noted. Will inform oncoming shift."</p> <p>There were no 5/25/14 or 5/26/14 progress notes to indicate Resident #269 was being monitored or assessed for signs and symptoms of fluid volume deficit as care planned, encouraged fluids as care planned, or vital signs taken as care planned, or any MD notification of hydration status, even though Resident #164's condition was recognized by NP #8 as potential C-diff and dysuria for "a couple of days." The only progress note on 5/26/14 indicated, "Labs called to MD. NO new orders written." The labs referenced were from 5/23/14.</p> <p>The 5/27/14, 12:28 p.m. social services note indicated, "Note new orders written today. DNR (do not resuscitate) paperwork signed and placed on chart. CP (care plan) updated. Waiting for return call from res guardian re: hospice. Will continue to provide support."</p> <p>The 5/27/14, 4:04 p.m. nurses note indicted, "Res on isolation for cdiff. First dose of flagyl (antibiotic) given. Also hospice to eval (evaluate) and tx (treat.) Nurse to cont (continue) to monitor."</p> <p>The 5/27/14, 12:55 p.m. nurse practitioner note, written by NP #9,</p>		<p>report 5 times a week reviewing nursing documentation and significant change hot charting events ensuring assessments are being completed and documented. On Saturdays and Sundays the house supervisor will round and speak with facility nurses and identify residents who have experienced a significant change and ensure appropriate hydration measures are in place. The nurse management team will discontinue these significant change hot charting events once the resident's condition has stabilized</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>A hydration CQI audit tool will be completed for six months with audits being completed once weekly for one month and then monthly for 6 months by a nurse manager or designee</p> <p>A hydration CQI tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the</p>	

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	<p>indicated, "Patient has had a history of leukocytosis 13.1, 13.5, now 56.4. I was asked to see him. He was lying very comfortably on his bed and did not want to move. He is not eating or drinking well and is dehydrated for sure. At the time I spoke to him I did not know he was having diarrhea or that a specimen had been sent but I did know he was not doing well and was a full code and last week we sought for a POA (power of attorney) and one was appointed. I asked the patient if he wanted to go to hospital or be kept comfortable and he stated he did not want to go to hospital and wanted to stay right here. I called his POA and told her what was occurring and she asked for a hospice evaluation and asked us to fax her the DNR papers which I turned over to the SS (social services) department and it was immediately accomplished. We found out his c-diff was positive later that day and he was moved on the evening shift into a private room on north station, he passed away later that evening." This note was edited on 5/28/14 at 5:41 p.m.</p> <p>The 5/28/14, 2:01 a.m. nurses note indicated, "at 150 am res noted without respiration per auscultation, heart rate absent, cold to touch, resident DNR, notified family verified motruary, family opted not to come to facility..."</p>		<p>responsible employee. Date of Compliance 06/30/14.</p>	

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	<p>The 5/23/14 through 6/5/14 Vitals Report for Resident #269 indicated the following urine output:</p> <p>5/23/14, 1:23 a.m.- large 5/24/14, 2:49 a.m.- large 5/25/14, 1:21 a.m.- medium 5/26/14, 2:00 a.m.-small 5/26/14, 4:39 p.m.- large 5/27/14, 2:27 a.m.- large</p> <p>An interview was conducted with the DNS on 6/5/14 at 11:19 a.m. regarding Resident #269's hydration status in the couple of days leading up to his death on 5/28/14 and what assessments and measures were put in place to ensure adequate hydration. He indicated, "We were waiting for those 2 tests to come back. He had a normal BMP (basic metabolic panel) on 5/23/14 showing a normal hydration status." Regarding his urine output, he indicated, "With his urine output, there were no parameters to call the MD. I would say he needs to go a day without urine output to notify the MD. There's no order to notify. His urine output looks normal for him to me. It would be nice to have an amount." Regarding what nursing measures he would expect nursing staff to implement for Resident #269, given his condition (possible C-diff, dysuria) the morning of</p>			
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	<p>5/25/14, he indicated, "Just to ensure he ate and drank. It would have been beneficial to see more vitals in that time frame to have a depiction of what his condition was. They were good on the 27th when the NP took them. We can't do a whole lot in the time frame until the test results come back." Regarding whether vitals were taken by nursing on 5/25/14 or 5/26/14 as care planned, he indicated, "There are no vitals in the computer."</p> <p>A telephone interview was conducted with NP #9 on 6/5/14 at 11:54 a.m. regarding Resident #269's hydration status prior to his death and her 5/27/14 visit. She indicated, "I'm sure he was dehydrated...When I came in, I was notified to see him. (Name of NP #8's) dictation was not done. They continued to notice patient wasnt doing well. I'm sure he was getting dehydrated in that time. He didn't want to eat or drink. I encouraged them to force fluids. He wouldnt take water with meds. I talked to him about hospitalization or starting IV fluids there. He told me he didn't want anything, just to be comfortable, and he patted my hand and smiled and said 'leave me alone.'"</p> <p>3.1-46(b)</p>			

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure an enteral tube medication was administered correctly for 1 of 1 residents randomly observed for enteral tube medication administration. (Resident #148)</p> <p>Findings include:</p> <p>During a medication administration observation with LPN #12, on 5/30/14 at 11:25 a.m., LPN #12 crushed Resident #148's tramadol (pain medication) and placed it in a medication cup. LPN #12 then mixed the tramadol with water and then poured 2 other medication cups full of water, approximately 30 milliliters of water each. She took all three cups into Resident #148's room.</p> <p>LPN #12 poured the medication cup of water mixed with the tramadol, into the enteral tube and let the medication with water go through the enteral tube. Then LPN #12 poured one of the other medication cups with approximately 30</p>	F000333	<p>F333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>It is the practice of this provider to ensure that all alleged violations involving residents free of significant med errors are provided in accordance with State and Federal law through established procedures.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>The employee who failed to administer 30 milliliters of water during the g-tube med administration for resident #148 (LPN #12) was re-educated on g-tube medication administration</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who have g-tube medications have the potential to be affected by the alleged deficient practice.</p>	06/30/2014

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	<p>milliliters into the enteral tube. After the water went through the tube, LPN #12 capped off Resident #148's enteral tube and proceeded to de-glove, wash her hands, and leave Resident #148's room.</p> <p>A review of Resident #148's current Physician's Orders, indicated an order to flush the enteral tube with at least 30 milliliters of water before and after each medication administration.</p> <p>A review of a policy titled, Enteral Tube-Medication Administration, dated 3/2013 and received from the Clinical Education Coordinator on 5/30/14 at 2:13 p.m., indicated the following, "...10. Flush tubing with 30 cc (milliliters) of water 11. Administer each medication, as ordered...13. Upon completion [sic] flush tubing with 30 cc of water...."</p> <p>During an interview with the Clinical Education Coordinator, on 5/30/14 at 2:14 p.m., she indicated LPN #12 indicated she knew she messed up and forgot to do the 30 milliliters of water prior to the medication administration.</p> <p>3.1-48(c)(2)</p>		<p>Facility nurses will be re-educated on g-tube med administration by the SDC or designee on or before 06/30/14.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Facility nurses will be re-educated on g-tube med administration by the SDC or designee on or before 06/30/14</p> <p>All facility nurses will be required to complete and pass g-tube medication administration skills validation on or before 6/30/14</p> <p>House supervisor or designee will round each shift to ensure enteral tube medication is administered per policy.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>The SDC or designee will complete random g-tube medication pass skills validations 3 times a week x 4 weeks then once monthly times 6 months.</p> <p>The g-tube medication administration skills validations will be reviewed monthly by the CQI Committee for</p>	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin</p>		<p>six months after which the CQI team will re-evaluate the continued need for the audit. If a 100 % threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 06/30/14</p>	

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
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	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to maintain proper infection control practices for oxygen tubing. this affected 1 of 1 residents randomly observed for infection control (Resident #225).</p> <p>Findings include:</p> <p>During a random observation, on 5/27/14 at 1:50 p.m., Resident #225 was observed with her oxygen tubing on the floor next to her wheelchair, in her room. Resident #225 then wheeled over her oxygen tubing while she moved her wheelchair to the bathroom.</p> <p>On 5/27/14 at 2:50 p.m., Resident #225 was observed sitting in the hallway near her room, her oxygen tubing was observed on the floor next to her wheelchair.</p> <p>At 12:30 p.m., on 6/3/14, Resident #225</p>	F000441	<p>F441 Infection Control, Prevent spread, Linens</p> <p>It is the practice of this provider to ensure that all alleged violations involving infection control, prevention spread, and linens are in accordance with State and Federal law.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>Resident # 225's o2 tubing was replaced and a bag was placed on her w/c to contain the excess tubing</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who utilize oxygen have the potential to be affected by the alleged deficient practice.</p>	06/30/2014

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	<p>was observed sitting the Main Dining Room. Resident #225's oxygen tubing was laying on the floor next to her wheelchair.</p> <p>During an interview with the Clinical Educator Coordinator, on 6/4/14 at 10:37 a.m., she indicated a Resident's oxygen tubing should not be on the floor because it was an infection control issue.</p> <p>On 6/4/14 at 12:33 p.m., the Clinical Educator Coordinator indicated she was unable to locate a specific policy related oxygen tubing and infection control, but the oxygen tubing should not be laying on the floor because it presented an infection control issue.</p> <p>3.1-18(a)</p>		<p>SDC or designee will educate facility staff on proper infection control techniques including maintenance of oxygen tubing on or before 6/30/14</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>SDC or designee will educate facility staff on proper infection control techniques including maintenance of oxygen tubing on or before 6/30/14</p> <p>All residents who have oxygen will have a bag placed at their bedside and on their w/es to contain excess oxygen tubing.</p> <p>The house supervisor or designee will round each shift to ensure oxygen tubing is in appropriate placement and not touching the floor.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>A infection control oxygen CQI audit tool will be completed for six months with audits being completed once weekly for one month and then monthly for 6 months by a nurse manager or designee</p> <p>The infection control oxygen CQI</p>		

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F000514 SS=A	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure a facility Resident Census and Condition report was accurately completed. This had the potential to affect 3 of 8 residents who were identified as having pressure ulcers.</p>	F000514	<p>audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 06/30/14</p> <p>N/A</p>	06/30/2014

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	<p>Findings include:</p> <p>On 5/27/14 at 12:27 p.m., the facility Administrator provided a completed Resident Census and Condition document to the survey team. In Section D of the document, the number of pressure ulcers in the facility were listed as "5."</p> <p>On 5/27/14, an unidentified nursing staff member provided a facility document titled "DQ wounds" which indicated the current number of facility residents having pressure ulcers as 8.</p> <p>On 6/4/14 at 1:29 p.m., the DON-S indicated the "DQ wounds" report was the actual number of residents with pressure ulcers as of 5/27/14.</p> <p>On 6/4/14 at 12:18 p.m., the MDS coordinator indicated she was the one who completed the Census and Condition report. She indicated she utilized "closed MDS records" to complete the number of current facility residents with pressure ulcers. She indicated the number 5 was "not an accurate representation" of the actual number of residents with pressure ulcers as of 5/27/14. She indicated the number should have been listed as 8 residents with pressure ulcers as of 5/27/14.</p>			

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

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