

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 I ST LA PORTE, IN 46350
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 13, 14, 15, 16 & 17, 2015.</p> <p>Facility number: 000023 Provider number: 155062 AIM number: 100289400</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 8 Medicaid: 45 Other: 10 Total: 63</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 164 SS=E Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</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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	<p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by law; third party payment contract; or the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's privacy was maintained during medication pass for 2 of 8 residents observed during medication pass. (Residents #59 & #79)</p> <p>Findings include:</p> <p>1. On 4/16/15 at 8:15 a.m., RN #1 was observed preparing Resident #79's eye drop medication. At that time, the RN was observed reading the resident's</p>	F 164	F164 1. Resident #79 and #59 were not adversely affected by the alleged deficient practice. RN # 1 was immediately re-inserviced per the Director of Nursing (DNS) related to maintaining the personal privacy and confidentiality of all residents personal and clinical records. 2. All residents had the potential to be adversely affected by the alleged deficient practice. The zip log bags were immediately replaced on all medication carts with opaque brown paper bags per the Unit Managers (UM). A	05/17/2015

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	<p>medications off of a lap top computer screen on top of her medication cart. The RN left the medication cart and walked to the resident's room. At that time, RN #1 had left the computer screen open and a piece of white paper on the top of the medication cart was turned up. The computer screen had the resident's information on it as well as all of her medications and the white piece of paper was full of information regarding other residents on that unit.</p> <p>Continued observation on 4/16/15 at 8:20 a.m., indicated RN #1 was preparing medication for Resident #59. The resident's medications were observed in white plastic wrappers which were provided by the pharmacy. On the outside of each wrapper was the resident's name, medication, and the amount was listed in black lettering. RN #1 then removed the pills from the wrappers and placed them in a clear plastic zip lock bag located on the side of the cart. The resident's private information on those wrappers was viewable from the bag. The RN then left the cart and walked down the hallway to another unit to administer the resident her medication. At that time, she again left the computer screen up and open along with the white piece of paper turned over with other resident names and</p>		<p>supply of opaque brown paper bags were placed on each unit per the Central Supply Clerk and she was inserviced per the DNS to only supply the units with opaque bags. 3. Staff to be re-inserviced related to Maintaining the privacy and confidentiality of all residents including his or her personal and clinical records at all times (see attachment "Resident Privacy Inservice"). The Director of Clinical Education (DCE) or designee to complete Privacy rounds 2x/week (see attachment "Privacy/Dignity Rounds") with any identified practices to be addressed immediately. DNS or designee to complete rounds weekly. 4. DCE to present findings of the rounds to the Quality Assessment Process Improvement (QAPI) committee monthly. The QAPI committee to review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly</p>				

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	<p>information viewable to anyone passing the medication cart.</p> <p>Interview with RN #1 on 4/16/15 at 8:30 a.m., indicated she should have turned the piece of paper over and closed the computer screen</p> <p>2. On 4/16/15 at 8:43 a.m., LPN #2 was observed in the hallway preparing medication for the residents on the B-Wing. At that time, a clear plastic bag was observed on the side of the medication cart. Inside the bag there were used medication wrappers that contained resident names and their medications. The bag was visible to anyone passing the medication cart in the hallway.</p> <p>On 4/16/15 at 8:58 a.m., there was a medication cart observed on the C-Wing. There was a clear plastic white zip lock bag noted on the side of the cart. Inside the bag were used medication wrappers with resident names, the type of medication, and the amount. The clear plastic bag was viewable to anyone who walked by the medication cart.</p> <p>Interview with the Director of Nursing on 4/16/15 at 9:00 a.m., indicated the Nurses were supposed to make sure the wrappers were turned over in the zip lock bag and</p>			

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F 166 SS=D Bldg. 00	<p>not visible to everyone.</p> <p>3.1-3(o)(3)</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on record review and interview, the facility failed to ensure prompt efforts were implemented to address a resident's concern related to missing dentures for 1 of 3 residents reviewed for personal property of the 3 who met the criteria for personal property. (Resident #23)</p> <p>Finding includes:</p> <p>Resident #23 was interviewed on 4/13/15 at 11:16 a.m. The resident indicated her dentures were missing. The resident also indicated she told a staff member but could not remember the staff member's name.</p> <p>The record for Resident #23 was reviewed on 4/15/15 at 9:41 a.m. The resident was recently hospitalized and returned to the facility on 4/9/15.</p>	F 166	<p>1. Resident #23 was seen per Michigan Family Dentistry on 4/27/2015 and Medicaid Authorization for full denture replacement was received on 4/28/2015 with follow-up appointments for denture fittings scheduled. 2. A facility wide audit was conducted per the Unit Managers (UM), Assistant Director of Nursing (ADNS), and the Director to ensure all residents who use dentures have them with no other deficient practices noted. 3. Staff to be re-inserviced on the Grievance policy and procedure (see attached "Grievance Policy and Procedure Inservice"). Guardian Angels to interview their assigned residents weekly to ask if they have any missing items if a resident is missing items the Guardian Angel will complete a Grievance Form and give to Social Services. DNS or designee to review all hospital</p>	05/17/2015

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	<p>The 3/17/15 Minimum Data Set (MDS) significant change assessment, indicated the resident's BIMS (Brief Interview for Mental Status) score was 15. A score of 15 indicated the resident's cognitive patterns were intact.</p> <p>Review of the 4/9/15 Clinical Health Status report, indicated the section for lower full dentures was checked "yes." Next to the above checked answer the word "missing" was hand written in next to the above. Review of the 1/30/15 admission Inventory Form, indicated the resident had upper and lower dentures at the time of admission.</p> <p>The April 2015 Progress Notes were reviewed. There were no entries related to her missing dentures in either the Nursing or the Social Service Notes.</p> <p>When interviewed on 4/15/15 at 10:48 a.m., the Social Worker indicated she was not notified or aware of the resident's concerns related to her dentures being missing until Unit Manager #1 informed her today.</p> <p>When interviewed on 4/15/15 at 12:45 p.m., Unit Manager #1 indicated Resident #23 informed her yesterday morning at breakfast time that she could not find her teeth. The Unit Manager indicated staff</p>		<p>re-admissions to the facility within 24 hours to ensure that each resident has returned with items discharged with them to the hospital and if items are missing to ensure a Grievance Form has been completed and submitted to Social Services. Results of the interviews/re-admission reviews will also be discussed 5x/week in morning meeting.4. Social Service Director of designee to present findings of the interviews and grievances to the Quality Assessment Process Improvement (QAPI) committee monthly. The QAPI committee to review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations.</p>		

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	<p>should have noted the status of the dentures in the section on the Health Status note when the resident was readmitted from the hospital.</p> <p>When interviewed on 4/15/15 at 1:08 p.m., CNA #1 indicated she worked on the hall Resident #23 resided and had taken care of the resident. The CNA indicated she was aware the resident wore dentures, however, she was not aware the resident's dentures had been missing.</p> <p>When interviewed on 4/15/15 at 1:20 p.m., the Director of Nursing indicated she had not been aware of the resident's dentures being missing.</p> <p>When interviewed on 4/16/15 at 2:59 p.m., the Social Worker indicated she talked with the resident and the residents daughter on 4/15/15. The Social Worker indicated she initiated a grievance investigation. The Social Worker indicated arrangements were made on 4/15/15 for the resident to see her own Dentist on 4/27/15.</p> <p>When interviewed on 4/16/15 at 3:16 p.m., the Director of Nursing indicated she had spoken to the LPN who completed the admission information on 4/9/15 when the resident returned from</p>			

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	<p>the hospital. The Director of Nursing indicated the LPN informed her the resident's dentures were missing at that time and she looked for them but could not locate them. The Director of Nursing indicated the LPN informed her she was not aware she was supposed to file a referral or a grievance at that time. The Director of Nursing indicated a referral or grievance should have been initiated on 4/9/15 when the resident returned to the facility and reported her dentures were missing.</p> <p>The facility policy titled "Grievance Guideline" was reviewed on 4/16/15 at 3:56 p.m. The Social Worker provided the policy and indicated the policy was current. The policy indicated all employees were responsible for ensuring customer satisfaction and a grievance system was in place to resolve issues to the satisfaction of all involved. The policy also indicated Grievance Forms were to be available for individuals, family members, and employees. The policy indicated if an employee receives a grievance they were to turn the form into the Social Service Director, Director of Nursing, or the weekend Supervisor or Charge Nurse. The policy also indicated the investigation and resolution of grievances were to be completed within (5) working days of receipt of the form.</p>			

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F 309 SS=D Bldg. 00	<p>3.1-7(a)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure bruises were assessed and monitored for 2 of 3 residents reviewed for skin conditions (non-pressure related) of the 4 residents who met the criteria for skin conditions (non-pressure related). (Residents #40 and #100)</p> <p>Findings include:</p> <p>1. On 4/13/15 at 3:32 p.m., Resident #40 was observed with a fading purple bruise to the antecubital (the elbow area) area of his right arm.</p> <p>The record for Resident #40 was reviewed on 4/14/15 at 2:29 p.m. A weekly Skin assessment dated 4/10/15 at 7:06 a.m., indicated the resident had no</p>	F 309	<p>1. Resident #40 was assessed and interviewed per the Director of Nursing (DNS) and Unit Manger (UM) related to discoloration to his antecubital area of his right arm. Resident (who has a BIMs score of 14) stated that the area was not an injury but a "permanent discoloration" after IV placement at the hospital in February 2015. Resident stated that he told the surveyor this upon assessment. Area was noted on this resident's re-admission "Clinical Health Status" assessment form dated 2/27/2015 and a "Wound Evaluation Flow Sheet" was completed and in the chart dated 2/27/2015 with area noted as healed on 3/13/2015. Area was re-measured per DNS and nurse practitioner was notified. Area documented on a "Wound Evaluation Flow Sheet"</p>	05/17/2015	

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	<p>bruises.</p> <p>The charting book was reviewed, there was no Wound Evaluation sheets indicating the resident had bruising to the right antecubital area.</p> <p>Interview with the Director of Nursing on 4/16/15 at 11:08 a.m., indicated the resident was due for a weekly skin assessment on 4/17/15. She indicated the resident had no current Wound Evaluation sheet. She indicated the resident was alert and oriented didn't need help for activities of daily living, and she wouldn't necessarily depend on the CNA's to tell staff because they do very little for the resident.</p> <p>A Wound evaluation sheet completed on 4/16/15, indicated the following:</p> <p>Discoloration right antecubital 2 centimeter (cm) x 2 cm. Discoloration-reddish wide spread petechiae with 2 cm x 2 cm bluish area to center.</p> <p>2. On 4/14/15 at 9:11 a.m., Resident #100 was observed with a reddish/purple bruise to his right forearm.</p> <p>The record for Resident #100 was reviewed on 4/14/15 at 2:48 p.m. The</p>		<p>(Attachment "Wound Evaluation Flow Sheet") and will be reviewed per the liscensed nurse weekly x 4 weeks and if no changes are noted the are will be considered healed. Resident #100 was also assessed for area to his right forearm per the DNS and UM. This resident (who has a BIMs score of 15) also stated that the area was not a new injury and was there prior to admission and has not changed since he had an IV in the hospital. This area was noted on this resident's admission "Clinical Health Status" assessment form dated 3/26/2015 and a "Wound Evaluation Flow Sheet" was completed and in the chart dated 3/26/2015 with area noted as healed on 4/2/2015. Area was re-measured per DNS and nurse practitioner was notified on . Area documented on a "Wound Evaluation Flow Sheet." Resident was discharged from the facility to home on 4/17/2015.2. A facility wide audit was conducted per the Unit Managers (UM), Assistant Director of Nursing (ADNS), and the Director of Nursing Services (DNS) to identify any other residents with skin issues not previously identified or monitored with no other issues noted. 3. Licensed Nursing staff to be re-inserviced related to skin assessment procedures, completion of the Wound Evaluation Flow sheet and continued monitoring of areas</p>		

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	<p>resident's diagnoses included, but was not limited to, chronic ischemic heart disease and hypertension.</p> <p>The 4/11/15 weekly Skin assessment indicated there was no documentation of bruises.</p> <p>The charting book was reviewed. There was no Wound evaluation flow sheet related to the bruising.</p> <p>Interview with the Director of Nursing on 4/16/15 at 11:08 a.m., indicated the resident had weekly lab draws and more than likely that was where the area was from. She indicated a sheet was not initiated due to the resident being in between weekly skin assessments. She indicated the resident was very independent and required very little assist from staff.</p> <p>The 4/16/15 Wound evaluation sheet, indicated the following:</p> <p>Discoloration to the right forearm 5 centimeters (cm) x 3 cm Reddish blue discoloration to right forearm</p> <p>3.1-37(a)</p>		<p>identified (see attachments, "Wound Evaluation Flow Sheet," and "Skin Assessment Guidelines"). CNAs to be re-inserviced related to observing daily for changes in skin integrity and reporting to the nurses any changes noted (Attachment "Know your Skin- CNA Education"). The UM will also assess 10% of residents weekly to ensure all non-pressure related skin conditions are identified, assessed, documented on the "Wound Evaluation Flow sheet" and monitored weekly. If area noted is a bruise or discoloration with no identified change in range of motion or pain associated with the area the area will be assessed and documented on the "Wound Evaluation Flow sheet" and monitored weekly 4 weeks and if no decline in condition is noted related to the area the area will be considered healed. The DNS will complete weekly rounds of all residents who have had labs drawn and random monthly rounds of other residents in the facility.4. DNS to present findings of the rounds to the Quality Assessment Process Improvement (QAPI) committee monthly. The QAPI committee to review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is</p>				

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F 325 SS=D Bldg. 00	<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, record review and interview, the facility failed to ensure the Registered Dietitian's (RD) recommendations were acted upon for a resident with underweight status for 1 of 3 residents reviewed for nutrition of the 6 residents who met the criteria for nutrition. (Resident #56)</p> <p>Finding includes: On 4/15/15 at 12:29 p.m., Resident #56 was observed eating lunch. At that time, her food was noted to be in bowls. She received mixed vegetables, chicken, and potatoes. The record for Resident #56 was reviewed on 4/15/15 at 10:11 a.m. The resident's diagnoses included, but were not limited to, blindness both eyes,</p>	F 325	<p>considered a trend), then results will be reviewed quarterly</p> <p>F325 1. Registered Dietician reviewed affected resident to ensure recommendations remain appropriate. MD notified regarding missed dietary recommendations for resident #56 on 4/17/15 with new orders received and implemented per those recommendations.2. All dietary recommendations for the last 90 days were reviewed per the Registered Dietician (RD), DNS and UM to ensure that all recommendations were completed timely with no other issues identified. 3. Nursing administration was re-educated by the Registered Dietician regarding best practice guidelines to follow up with appropriate documentation and procedural follow through RD recommendations. After the RD visits the facility she will provide a copy of her recommendations to both UMs, the ADNS, & DNS who</p>	05/17/2015			

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	<p>anxiety, urinary frequency, depressive disorder, constipation, and hypothyroidism.</p> <p>Physician Orders on the current 4/2015 recap, indicated the resident was to receive a regular diet with mechanical soft texture and to place the food in individual bowls. Another order dated 8/2/13 indicated 2 cal supplement 90 cc (cubic centimeters) twice a day and fortified foods with all meals.</p> <p>The resident's current weight indicated she weighed 92 pounds on 4/10/15. The resident's height was 63 inches. Further review of the weights indicated the resident's weight was 95 pounds on 2/27/15, 3/9/15, and 3/16/15.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/21/15, indicated the resident was not alert and oriented and had memory problems. The resident required assistance with eating. Her weight was recorded as 95 pounds with weight loss noted.</p> <p>A Dietary Progress Note dated 2/2/15 by the RD, indicated continued weight loss, unplanned and undesirable. The resident's Body Mass Index (BMI) was 17 indicating underweight status. The current diet order was mechanical soft.</p>		<p>will act as back-up if the UM are unavailable to ensure all dietary recommendations are completed timely. B. The DNS or designee will review MD orders 7x/week with daily start-up to ensure either follow up for recommendation has been completed or proper documentation completed with supporting progress notes with reasoning of why RD recommendation was declined by MD. C. Dietary manager/designee will complete an audit within 72 hours after RD recommendation have been submitted and report any issues during morning meetings. 4. The Dietary Manager will report any trends to the QAPI Committee on a monthly basis for recommendations and resolutions. Results of these reviews and audits will be reviewed monthly at the QAPI meeting times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2015
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	<p>Oral intake was 41% of meals. The resident seemed to be tolerating current diet texture. RD observed during lunch today and the resident does seem to prefer liquids and smooth textures. Resident does have 2 cal supplement order 90 cc twice daily as well as fortified foods at all meals. Recommend to discontinue fortified foods at all meals and increase 2 cal supplement to 120 cc three times a day and add health shakes at lunch and dinner.</p> <p>Nursing Progress Notes dated 2/4/15, indicated there was no evidence the RD recommendations had been followed.</p> <p>The current and updated 2/2015 care plan, indicated the resident was currently at nutritional risk due to history of weight loss, and underweight BMI status for her age. The Nursing approaches were to provide 2 Cal supplement as ordered, diet as ordered, and fortified foods as ordered.</p> <p>Interview with the RD on 4/16/15 at 2:00 p.m., indicated she had made the recommendations and they had not been followed through. She further indicated her last note was in 2/2015 and she had not followed up with the recommendations to see if they had been implemented.</p>			

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F 329 SS=D Bldg. 00	<p>Interview with the A-Wing Unit Manager on 4/16/15 at 2:49 p.m., indicated the RD recommendations had not been implemented.</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a gradual dose reduction was attempted at least yearly</p>	F 329	F3291. A review of resident #29's psychotropic medications was completed per the pharmacist on 5/4/2015 with a recommendation	05/17/2015			

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	<p>for an antidepressant medication, for 1 of 5 residents reviewed for unnecessary medications. (Resident #29)</p> <p>Finding includes:</p> <p>The record for Resident #29 was reviewed on 4/14/15 at 2:35 p.m. The resident's diagnoses included, but were not limited to, depressive psychosis and depressive disorder.</p> <p>Physician Orders dated 4/11/13 and on the current 4/2015 recap, indicated Celexa (an antidepressant medication) 10 milligrams (mg) daily. Also noted was another antidepressant medication of Wellbutrin 150 mg twice a day with an original order date of 3/15/13.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 4/6/15, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 14. The resident received an antidepressant medication for 7 days. The resident had only the concern of feeling tired or having little energy for his mood and had no thoughts that he would be better off dead or of hurting himself.</p> <p>The Quarterly 8/20/14 MDS assessment also indicated the resident had no thoughts he would be better off dead or</p>		<p>for reduction submitted to the resident's primary physician. An order to reduce his Wellbutrin was received and completed on 5/5/2015 per the nurse practitioner.2. The facility pharmacist completed a review of all resident's psychotropic medications on 5/4/2015 to ensure that all residents on psychotropic medications have received a gradual dose reduction attempt per federal guidelines or that appropriate documentation is in place to state a reduction is clinically contraindicated with recommendations submitted to the physician if required.3. Interdisciplinary team to meet monthly to review all resident's with psychotropic medications to ensure that a gradual dose reduction has been attempted per federal guidelines or that appropriate documentation is in place to state a reduction is clinically contraindicated (See attachment "<u>Monthly Psychotropic Medication Review</u>").4. Social Services Director to present findings monthly meeting to the Quality Assessment Process Improvement (QAPI) committee monthly. The QAPI committee to review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations.</p>				

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	<p>of hurting himself.</p> <p>A clinical letter to the Physician dated 6/2014, by the pharmacist, indicated the resident was receiving 2 antidepressants and it was recommended to reduce the Celexa and then ultimately discontinue it. The Physician's response indicated "Rejected" and there was a handwritten note at the bottom of the page which indicated "Suicidal past".</p> <p>Another clinical letter to the Physician dated 7/2014, indicated the same recommendation as above. This time the letter was directed to the contracted mental health facility in which the resident was receiving services from on a monthly basis. The Physician's response was again "Rejected" and a handwritten note at the bottom of the page indicated "Becomes suicidal, likely deterioration."</p> <p>The Medication Administration Records for the month of March and April 2015 were reviewed. The resident was currently receiving the Celexa 10 mg daily and the Wellbutrin 150 mg three times a day. Neither dose had been reduced.</p> <p>Social Service Progress Notes from 10/2014 until 4/2015, indicated the resident's depression scale was minimal.</p>			

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	<p>There were no documented events of any suicidal thoughts or attempts by the resident. The resident was currently being seen by the outside contracted mental health service for all of his psych needs.</p> <p>Nursing Progress Notes from 10/2014 until 4/2015, indicated there was no evidence of any documentation the resident had suicidal thoughts.</p> <p>The 7/23/14 mental health facility note was reviewed. The progress note indicated, "The patient is in his room in his recliner. He states his mood is good. He just passed the anniversary of his son's death and typically has a difficult time so he is doing well. GDR (Gradual Dose Reduction) recommendation from the pharmacist is declined due to the patient's suicidal history. He is optimal without adverse consequences on this medication."</p> <p>Another mental health facility note dated 3/18/15, indicated the resident had a history of suicidal ideation, however, nothing indicated ongoing thoughts or plans over the last couple of years. No new behavioral disruptions or distress were reported. The resident reported eating and sleeping adequately.</p>			

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F 371 SS=E Bldg. 00	<p>Interview with the Social Service Director on 4/17/15 at 10:38 a.m., indicated the resident currently had not had any active suicidal thoughts in the last year that she was aware of.</p> <p>Interview with the A-Wing Unit Manager on 4/17/15 at 10:15 a.m., indicated the resident had not had any suicidal thoughts since he had been here.</p> <p>3.1-48(b)(2)</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 interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to an accumulation of dirt, dust, and debris on counters, floor, shelves, food preparation equipment, and cabinets in 1 of 1 Kitchens. The facility also failed to</p>	F 371	F 371Food procure, store/prepare/serve-sanitary. The state surveyor allegedly based on observation, record review, and interview. The facility allegedly failed to ensure food was stored and prepared under sanitary conditions related to an accumulation of dirt, dust, and debris on counters, floor, shelves,	05/17/2015

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	<p>ensure supplements and thickened water containers in Unit refrigerators were discarded within 72 hours of being opened on 2 of 3 Units . (The Main Kitchen) (Units B & C)</p> <p>Findings include:</p> <p>1. The following was observed during the Kitchen Sanitation tour on 4/13/15, at 9:05 a.m., with the Dietary Manager:</p> <p>a. There was an accumulation of debris on the floor under the coffee area counter. The floor was also dirty. Coffee supplies were stored on the shelves under the counter.</p> <p>b. There was an accumulation of dust and grease on the slats of the oven/store hoods.</p> <p>c. There was an accumulation of grease and dirt on the lid of a large white plastic container of salad oil stored on a silver stool next to the stove/oven. The silver stool was also dirty.</p> <p>d. There was spillage on the sides and back of the Food Prep counter. There was also an accumulation of grease and dust on the electric cord which extended from the counter to the floor. The electric box on the floor was also dirty</p>		<p>food preparation equipment, and cabinets in 1 of 1 kitchens. The facility allegedly failed to ensure supplements and thickened water containers in unit refrigerators were discarded within 72 hours of being opened on 2 of 3 units. The corrective actions initiated for the above F tag are as follows for the alleged deficient practice. 1. Kitchen cleaning was immediately initiated to correct issues noted during the survey.. All dietary staff will be re-educated on proper cleaning protocols and use of the Daily, Weekly, and Monthly Checklists (attached), to document all cleaning activities. The containers of 2.0 high calorie liquid supplement in question were immediately discarded. Dietary immediately replaced the discarded 2 cal supplement with properly labeled open date and use by dates. All dietary staff and nursing staff will be re-educated on proper labeling protocols. New labels will be placed on all containers of 2.0 high calorie liquid supplement prior to delivery to the nurses stations by dietary staff to avoid any confusions regarding received date, open date, and use by date. 2. No negative resident impact was noted. 3. Dietary designee will audit the nutrition refrigerator on nursing units discarding any unlabeled or expired date open supplements. Dietary designee will complete kitchen cleaning daily and document on checklists</p>		

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	<p>and dusty. A silver food prep table was up against the back of the counter.</p> <p>e. There was an accumulation of dust on the two fans in the walk in cooler.</p> <p>f. There was an accumulation of dust on the legs of the mixer stand.</p> <p>g. There were two long plastic empty containers on a shelf under the counter next to the stove/oven. There was dust and debris on the two containers.</p> <p>h. There was spillage on the wall behind the oven/stove area.</p> <p>When interviewed at this time, the Dietary Manager indicated the above areas were in need of cleaning.</p> <p>2. The Nourishment refrigerator on the (B) wing was checked on 4/16/15 at 10:46 a.m., with the Assistant Director of Nursing. The following was observed:</p> <p>a. There was an open box of thickened juice. A date of 3/31 was written on the box. There were no other dates written on the box. The Assistant Director of Nursing indicated the 3/31 date was the date the thickened juice was received by the Dietary Department and there should have been a second date which indicated</p>		<p>Dietary manager will audit the actual cleaning and checklists along with refrigerator audits 5 days a week for the first 30 days. Then three time a week for 30 days then once a week for 30 days. 4. The Executive Director will monitor compliance through review of all audits and checklists weekly. The Dietary Manager will report any trends to the QAPI Committee on a monthly basis for recommendations and resolutions. Results of these reviews and audits will be reviewed monthly at the QAPI meeting times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly. The above plan of correction will be in compliance by 5/17/15. Golden Living Center LaPorte is officially requesting a desk review for this plan of correction.</p>		

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	<p>the date the box was opened on each container.</p> <p>3. The Nourishment refrigerator on the (C) wing was checked on 4/16/15 at 10:31 a.m., with RN #1. The following was observed:</p> <p>a. There was an open box of a 2.0 high calorie liquid supplement in the refrigerator. There was a date of 4/7 written on the box. There were no other dates written on the box. There was also a box of thickened water in the refrigerator with a date of 3/31 written on it and no other dates.</p> <p>RN #1 confirmed the dates of 4/7 and 3/31 were the dates the Dietary Department received the items. The RN also indicated staff were to write another date on each box when they were first opened and the above two boxes were not labeled with the dates they were opened. RN#1 indicated the boxes were to be discarded 72 hours after they were first opened.</p> <p>When interviewed on 4/16/15 at 1:32 p.m., the Registered Dietitian indicated the Dietary staff mark each box with the date the facility received them and the Nursing staff were responsible to date the items when they were first opened. The</p>			

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F 431 SS=D Bldg. 00	<p>Registered Dietitian also indicated the items were to be discarded 72 hours after they were opened.</p> <p>The facility guideline titled "Shelf Life of House Supplements and Thickened Liquids" was reviewed on 4/16/15 at 2:00 p.m. The Registered Dietitian provided the policy and indicated the policy was current. The policy indicated Med pass 2.0 supplement packages were to be dated, and refrigerated at the time they were opened and then were to be used within (3) days. The policy also indicated thickened juices and beverages were to be dated and refrigerated when they were opened and were to be used within (5) days.</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt</p>			

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	<p>and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure expired medications were discarded after they were opened for 1 of 3 Units. (The A-Wing)</p> <p>Finding includes:</p> <p>On 4/17/15 at 10:11 a.m., LPN #3 was</p>	F 431	F4311. Identified bottles were removed and destroyed immediately per facility policy and re-ordered per licensed nurse.2. A complete facility audit of all medication storage areas was completed per the Director of Nursing Services (DNS), Assitand Director of Nursing (ADNS), and the Unit Manger (UM) with no other deficient	05/17/2015			

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F 441 SS=E Bldg. 00	<p>observed by the A-wing medication cart. At that time inside the med cart, there was one multi vial of Novolog Insulin with a date opened of 3/9/15. Another vial of Novolog Insulin with a date opened of 3/14/15 and a vial of Humalog Insulin with a date opened of 3/7/15.</p> <p>The current 11/2011 revised Medications with Shortened Expiration Dates policy provided by the Director of Nursing, indicated Novolog Insulin and Humalog Insulin expired 28 days after opening or removing from the refrigerator whichever comes first.</p> <p>Interview with the A-Wing Unit Manager on 4/17/15 at 10:15 a.m., indicated the vials of insulin were expired and should have been discarded.</p> <p>3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an</p>		<p>practices identified.3. Licensed Nurses are to be re-inserviced per the Director of Clinical Education (DCE) or designee on the policy and procedure for medication storage (see attached "Storage of Medication Policy Inservice") and completion of the "Medication Storage Audit" (see attached "Medication Storage Audit Form"). The 11-7 shift licensed nurse on each unit is to perform a medication cart and medication refrigerator audit daily, utilizing the "Medication Storage Audit" form. If expired medications or incorrectly labeled medications are identified they are to be immediately removed per the licensed nurse and destroyed/disposed of per facility policy and re-ordered from the pharmacy immediately. The DNS, ADNS, UM, and DCE (or their designee) are each assigned to a medication cart and a medication refrigerator with a Medication Storage Audit to be completed on assigned areas 2x/week utilizing the "Medication Storage Audit" tool.4. The DCE or designee will report results of the audits monthly to the QAPI committee for revision of the action plan if any trends or patterns are noted (3 deficient practices in 1 month will be considered a trend).</p>		

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	<p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure urinals were stored properly in resident rooms for 2 residents who resided on the A wing. The facility also failed to ensure</p>	F 441	1. Care plans initiated per the Director of Nursing (DNS) on 4/16/15 for identified residents with urinals not stored per policy. Identified residents #23, #35, and # 99 assessed per Unit Mangers	05/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155062		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LAPORTE				STREET ADDRESS, CITY, STATE, ZIP CODE 1700 I ST LA PORTE, IN 46350			
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	<p>handwashing was completed after glove removal as well as during dressing changes for 1 of 1 treatments observed and contaminating a sterile field for 1 of 1 observations of tracheostomy care. (Residents #23, #35, #69, and #99)</p> <p>Findings include:</p> <p>1. On 4/14/15 at 9:11 a.m., there was an empty urinal on the floor next to bed 2 in Room 13. The urinal was next to the resident's night stand. The urinal had no lid, was not covered nor in a plastic bag.</p> <p>Interview with the Director of Nursing on 4/17/15 at 1:30 p.m., indicated the resident preferred his urinal on the floor or near his trash can. She indicated a care plan would be initiated for the resident's preference.</p> <p>2. On 4/14/15 at 9:13 a.m., there was a urinal on the night stand for bed 2 in Room 17. The urinal was not covered at this time.</p> <p>Interview with the Director of Nursing on 4/17/15 at 1:30 p.m., indicated the resident preferred his urinal within reach and/or on the nightstand. She indicated a care plan would be initiated for the resident's preference.</p>		<p>(UM) for adverse affects related to alleged deficient practices with none noted. LPN #1 re-inserviced per the DNS on Dressing Change Procedures on 4/16/2015. LPN #4 re-inserviced per DNS on Handwashing Policy and Procedures on 4/15/2015. LPN #2 immediately re-inserviced per DNS on maintaining sterile field with Tracheostomy care on 4/16/2015. 2.Facility wide infection control rounds completed per the Director of Nursing (DNS), Director of Clinical Education (DCE) and Unit Manager (UM) to identify any other deficient practices with deficiencies corrected as identified.3. Nursing staff to be re-inserviced on infection control focusing on handwashing, glove utilization, maintaining sterile fields with tracheostomy care utilizing the "Tracheostomy Care Competency (see attachment "Tracheostomy Care Competency)", and dressing changes utilizing the "Clean Dressing Change Competency" (see attachment "Clean Dressing Change Competency") checklist on all 3 shifts with 10% of the nurses weekly x 4 weeks and then 10% monthly until 100% compliance has been reached for 3 consecutive months. DCE or designee to do infection control rounds 2x/week focusing on handwashing and storage of urinary devices. DNS to do monthly infection control rounds.</p>				

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	<p>The Bloodborne Pathogens Exposure Control Plan-Patient/Resident Care policy was reviewed on 4/17/15 at 11:30 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated the following: "Utensils (bedpans, urinals, emesis basins, etc.) are to be washed with antimicrobial soap and water and returned to the same patient/resident."</p> <p>3. On 4/16/15 at 9:37 a.m., LPN #1 was observed doing a treatment change for Resident #99. The LPN had washed her hands with soap and water and applied clean gloves to both of her hands. She then removed the old dressing from the resident's pressure ulcer which was located on his coccyx and threw it away in the plastic bag. The LPN cleansed the wound with wound cleanser using a gauze sponge. She then used her scissors that another staff member had brought into the room and cut a piece of Calcium Alginaid (a medicated sponge). The LPN packed the wound with the gauze sponge by using a tip applicator. She then applied an adhesive foam dressing over the entire pressure sore. At that time, she removed her right hand glove and grabbed for a pen and dated the foam dressing. She then removed the other glove and placed everything into the</p>		<p>4. The DCE or designee will report results of the audits and infection control rounds monthly to the QAA committee for revision of the action plan if any trends or patterns are noted (3 deficient practices in 1 month will be considered a trend).</p>				

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	<p>plastic bag and tied it shut and walked out of the room. The LPN was not observed changing her gloves at all during the entire treatment nor washing her hands with soap and water.</p> <p>The current 3/10/15 Clean Dressing Change policy provided by the Director of Nursing, indicated Nurses were to don clean gloves and remove old/soiled dressing. Remove gloves and wash hands and don another pair of clean gloves and clean the wound and provide any treatments. After the treatment, Nurses were to remove gloves and wash hands with soap and water.</p> <p>Interview with LPN #1 on 4/16/15 at 9:50 a.m., indicated she usually changed her gloves and washed her hands at least 4 times during the treatment, however, she did not change her gloves at all, only once.</p> <p>Interview with the Director of Nursing on 4/16/15 at 11:55 a.m., indicated the LPN should have changed her gloves and washed her hands after the removal of the old dressing and before she cleansed the wound and placed the new gauze sponge over it.</p> <p>4. On 4/15/15 at 3:36 p.m., LPN #4 was observed passing medication to Resident</p>			

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	<p>#35. The resident was to receive a nasal spray. The LPN donned clean gloves to both hands before entering the room. She administered the resident her oral medication then administered the nasal spray. She then left the room and removed her gloves outside of the room by the medication cart and threw them away in the garbage can. She placed the nasal spray back into the bottle and put it back in med cart. The LPN signed the medications out on the computer and then pushed her cart down the hallway to another room. She was observed to grab a plastic med cup from the side and placed it on top of the cart. The LPN then reached for the bottle of alcohol gel and used it to both of her hands.</p> <p>5. On 4/15/15 at 3:51 p.m., LPN #4 was observed preparing medications for Resident #23. At that time, she placed the resident's medications into a plastic med cup and mixed them in pudding. The resident also had an inhaler in which she was going to receive. Another nurse came over to her and told her she had a phone call about a resident. LPN #4 left the medication cart at that time. She returned and indicated she had to go to C-Wing and check something out in the resident's chart. At 3:56 p.m., the LPN returned to her medication cart. She indicated that she had washed her hands</p>			

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	<p>with soap and water at the sink by the Nurse's station. She then picked up the medications that were mixed with pudding and the inhaler and walked into the resident's room. She administered the resident her oral medications. She then placed clean gloves to both of her hands and administered the inhaler to the resident. She handed the resident a cup of water and asked her to swish and spit the water out. The LPN walked into the bathroom and threw away the cup of water. She then walked out of the room with her gloved hands and over to the medication cart where she removed them and discarded them in the garbage can on the side of the cart. At that time, there was a man from the pharmacy waiting for the Nurse to finish and was asking for her signature for some medications. LPN #4 reached in her pocket grabbed a pen and signed for the medications. She then signed the meds out on the computer and started to push her medication cart down to the next room. The LPN did not wash her hands with soap and water or use alcohol gel after she removed the gloves.</p> <p>The current 8/2014 Handwashing/Hand Hygiene policy provided by the Director of Nursing, indicated to use an alcohol based hand rub or antimicrobial soap and water before and after direct contact with residents, before preparing or handling</p>			

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	<p>medications, and after removing gloves.</p> <p>Interview with LPN #4 on 4/15/15 at 4:13 p.m., indicated she did not wash her hands or use alcohol gel immediately after removing her gloves for both residents.</p> <p>6. On 4/16/15 at 10:50 a.m., LPN #2 was observed providing tracheostomy (a surgical procedure to create an opening through the neck into the windpipe) care for Resident #69. The LPN was observed walking into Resident #69's room, she then gathered supplies and placed them onto the resident's unclean bedside table. She then washed her hands, returned to the resident's bedside and donned clean gloves. She proceeded to remove the soiled pre-cut dressing surrounding the resident's stoma (surgical opening), she then unhooked the breathing tube from the inner cannula and then proceeded to remove the inner cannula. LPN #2 then asked the resident to hold the breathing tube up to her neck as she prepared the trach care equipment. The LPN removed her soiled gloves, washed her hands, and then opened the trach care kit. After opening the kit she placed the package containing the sterile gloves onto the resident's unclean bedside table, she then removed the sterile drape from the kit, opened it, then placed the sterile drape in the center of the unclean bedside table.</p>			
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	<p>She then picked up the packaged sterile gloves from the unclean bedside table and placed them in the center of the sterile drape and proceeded to open them. She donned the sterile gloves then proceeded to remove the remainder of the contents from the care kit, and placed them in the middle of the sterile drape. The LPN then proceeded to provide trach care. Upon completing trach care, she then applied a pre-cut dressing around the stoma, removed her dirty gloves, then washed her hands. She returned to the resident's bedside, donned sterile gloves, replaced the inner cannula, and then reconnected the resident's breathing tube to the inner cannula. The LPN then removed her soiled gloves and disposed of all disposable equipment into the resident's bedside trash can.</p> <p>Review of the current General Infection Control Guidelines provided by the Director of Nursing (DON) on 4/16/2015 at 1:30 p.m., indicated "Observe (standard) universal precautions and sterile technique (asepsis) standards as approved by the appropriate facility committee.</p> <p>Interview with the DON at the time, indicated LPN #2 should have maintained sterile technique during trach care.</p>			

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F 465 SS=D Bldg. 00	<p>3.1-18(a) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls, discolored caulking, and dusty ceiling vents on 3 of 4 wings throughout the facility. The facility also failed to maintain a sanitary environment in 1 of 1 kitchens related to dust and debris and dried food spillage. (A, B, and C wings and the Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Environmental tour on 4/17/15 at 9:45 a.m., with the Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>A wing</p>	F 465	<p>F 465 1. Kitchen cleaning was immediately initiated to correct issues noted during the survey. All alleged marred walls, caulking and dusty ceiling vents were properly repaired/cleaned. 2. 100% audit of entire facility completed with oth 3. All dietary staff will be re-educated on proper cleaning protocols and use of the Daily, Weekly, and Monthly Checklists (attached), to document all cleaning activities. All department heads/designee will be re-educated on completing guardian angel program rounds on all resident rooms with documentation. All housekeeping staff will be re-educated on proper cleaning of exterior portion of ceiling vents. Environmental Supervisor to complete rounds weekly</p>	05/17/2015

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	<p>a. The bathroom in Room 4 had cracked and discolored caulking around the toilet. Two residents resided in this room.</p> <p>b. The wall behind the head of bed 2 in Room 10 was gouged and the wall paper was peeling. There were paint chips on the floor register. One resident resided in this room.</p> <p>c. The bathroom in Room 15 had a dusty ceiling vent and discolored and peeling caulk around the base of the toilet. Two residents resided in this room.</p> <p>B wing</p> <p>a. The bathroom in Room 2 was observed to have peeling caulk around the base of the toilet. A dirty ceiling vent was also observed and the wall was marred above the base board. Two residents resided in this room.</p> <p>C wing</p> <p>a. In Room 39, the closet door was off track for bed two. The base of the closet door was paint chipped and marred around the edge of the wall. The back of the door to the room was paint chipped and marred. Two residents resided in this room.</p>		<p>utilizing the Environmental Rounds form (see "Environmental Inservice and rounds attachment"). Guardian Angel rounds will be completed two times a week by department heads/designee looking at resident environment. The Executive Director will monitor compliance through review of all audits and checklists weekly. Dietary designee will complete kitchen cleaning daily and document on checklists Dietary manager will audit the actual cleaning and checklists 5 days a week for the first 30 days. Then three time a week for 30 days then once a week for 30 days. The Executive Director will monitor compliance through review of all audits and checklists weekly. 4. DSM and ED will report any trends noted on rounds/audits to the QAPI Committee on a monthly basis for review, recommendations and resolutions. Results of these reviews and audits will be reviewed monthly at the QAPI meeting times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly.</p>		

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	<p>Interview with the Maintenance and Housekeeping Supervisors at the time, indicated all of the above were in need of cleaning and/or repair.</p> <p>2. During the Kitchen Sanitation tour on 4/13/15 at 9:05 a.m., the following was observed:</p> <p>a. The pipes under and around the hand washing sink had an accumulation of dust and debris.</p> <p>b. There was dried spillage on the metal box on the wall next to the hand washing sink.</p> <p>c. There was spillage on the wall behind the metal rack with condiments and closed bags of bread stored on it.</p> <p>d. There was spillage on the wall behind as well as on the floor next to the three compartment sink.</p> <p>When interviewed during the Kitchen Sanitation tour, the Dietary Manager indicated the above areas were in need of cleaning.</p> <p>3.1-19(f)</p>			

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

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