

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00134224.</p> <p>Complaint IN00134224 - Unsubstantiated. No deficiencies related to the allegations are cited.</p> <p>Dates of Survey: August 27, 28, 29, 30, September 3, 4, 5, and 6, 2013</p> <p>Facility number: 000012 Provider number: 155029 AIM number: 100274900</p> <p>Survey team: Karina Gates, Generalist TC Courtney Mujic, RN Tom Stauss, RN</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Census payor type: Medicare: 16 Medicaid: 82 Other: 6 Total: 104</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000	Please accept this 2567 Plan of Correction for the Complaint Survey ending September 6th, 2013 as the Provider's Letter of Credible Allegation. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction with a completion date of October 2nd, 2013.	

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=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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 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:</p>				

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	<p>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 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,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure a resident was timely notified of the effective date Medicare covered services would end and the potential liability amount for non-covered stay in the facility. This affected 1 of 3 discharged Medicare beneficiaries who were reviewed for appropriate liability and appeal notices. (Resident #43)</p> <p>Findings include:</p> <p>The Notice of Medicare Non-Coverage for Resident #43 was reviewed on 9/5/13 at 10:30 a.m. The notice indicated, "The Effective Date Coverage of Your Current (blank line) Services Will End: 3/5/13." The notice included Resident #43's Representative's signature dated 3/5/13 and did not indicate the specific potential liability amount.</p> <p>During an interview with the Social Services Director on 9/5/13 at 10:48 a.m. regarding lack of a 2 day notice, she indicated, "I wasn't here. I don't know why the 2 day notice was not given." She indicated she had no further information to provide.</p>	F000156	<p>F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?-Resident #43 no longer resides in this facilityHow will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?-All residents currently receiving services under their Medicare benefits at this facility have the potential to be affected-Business Office Manager or designee will audit current residents receiving services under their Medicare benefit to identify any resident with the potential for non-coverage of services and notify Social Services accordingly-Executive Director or designee will in-service Social Services staff according to the Checklist/Instructions for issuing a Notice of Medicare Non Coverage (NOMNC)/Determination on Continued Stay including appropriate and timely documentationWhat measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?-Executive Director or designee will in-service Social Services staff according to the</p>	10/02/2013	

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	<p>The Checklist/Instructions for issuing a Notice of Medicare Non-Coverage (NOMNC)/Determination on Continued Stay was provided by the Administrator on 9/6/13 at 11:12 a.m. It indicated, "At the signature line, the resident or authorized representative must sign. Bottom of page 2. The resident or authorized representative must fill in the date that he/she signs the document. (This is critical to demonstrating the 2-day notice requirement.)"</p> <p>3.1-4(f)(3)</p>		<p>Checklist/Instructions for issuing a Notice of Medicare Non Coverage (NOMNC)/Determination on Continued Stay including appropriate and timely documentation-Interdisciplinary Team will meet weekly to review all residents receiving services under the Medicare benefit to ensure timely notification of The Notice of Medicare Non CoverageHow 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?-Notice of Medicare Non-Coverage Letters (NOMNC) CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year.Data will be submitted to the CQI committee for follow up.-If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</p>	

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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure a resident's grievance regarding missing money was resolved timely per facility policy for 1 of 1 resident reviewed for personal property. (Resident #53)</p> <p>Findings include:</p> <p>The clinical record for Resident #53 was reviewed on 8/30/13 at 10:00 a.m. She was admitted to the facility on 7/1/13.</p> <p>The 7/8/13 Admission MDS (minimum data set) assessment indicated Resident #53 had a BIMS (brief interview for mental status) score of 15 (highest possible score indicating a resident was cognitively in tact.)</p> <p>During an interview with Resident #53 on 8/30/13 at 11:45 a.m., she indicated \$100 went missing "about a month ago" and that she reported it to the front desk.</p> <p>On 9/5/13 at 10:45 a.m., the</p>	F000166	<p>F 166 RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #53 Money was replaced by the facility and the Grievance was resolved to resident and family's satisfaction How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any resident who voices a grievance that resides in this facility has the potential to be affected by the alleged deficient practice The Interdisciplinary Team will review grievances as they are reported and work to have resolved within 48 hours Staff will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on Resident Grievances policy What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Grievance Log will be reviewed daily by Guest Relations Coordinator or designee to</p>	10/02/2013			

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	<p>Administrator provided a grievance form for Resident #53. It indicated, "Section I: Nature of concern: 1. States on two occasions she had money missing. One time \$60.00 & one time \$100.00." The fields labeled "Date of Concern", "Time of Concern", "Date Concern Received", "Person receiving concern", "Date", and "Department responsible for Concern" were all blank. The Administrator indicated a Facility Consultant completed Section I of the grievance form on 8/26/13. Section II indicated, "All concerns must be referred to the Department Head for Review. Department Head review and action taken: Spoke w/resident concerning \$\$\$. Resident states when she first arrived she had \$100.00 wrapped inside a \$1.00 and \$5.00 bill. \$100.00 bill was taken from resident's billfold. Resident then stated two days later she had \$60.00 taken from her billfold. Amounts seem to vary as each time resident discusses issue. Resident did state she had rings and money taken at previous facility. Department Head Signature: (Name of Guest Relations) Date: 8/28/13." Section III of the grievance form indicated "Follow up must be made with individual who voiced/wrote the concern" was blank. The Administrator stated, "We invited her</p>		<p>ensure grievances have been resolved in a timely manner The Interdisciplinary Team will review grievances as they are reported and work to have resolved within 48 hours. IDT will review each unresolved grievance during stand up meeting to ensure follow up. Staff will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on Resident Grievances policy 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 Grievance CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>		

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	<p>family in to discuss this at 11:00 a.m...This was first reported to the consultant on 8/26 (8/26/13) and followed up on 8/28 (8/28/13). I had her account statement printed off. I looked at that, and I don't think she had that much money."</p> <p>The Administrator provided statements for 2 different accounts held by Resident #53. One statement indicated that particular account was opened on 7/30/13. The other statement indicated that particular account was opened on 8/9/13.</p> <p>On 9/5/13 at 12:25 p.m., the Administrator provided a copy of the above reviewed grievance form, this time with Section III completed. Section III, completed by the Administrator on 9/5/13, indicated, "CP (care plan meeting) held 9/5/13 @ 11:00 a.m. w/resident, POA (Power of Attorney) - (name of POA) and sister (name of sister). POA clarified res (resident) had a \$100 bill upon admission & states it was stolen shortly after admission. POA & res both stated they didn't report it to anyone at the time b/c (because) she was embarrassed."</p> <p>An interview was conducted with the Administrator on 9/5/13 at 12:47 p.m.</p>						

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	<p>regarding Resident #53 using the word "taken" in her statement to Guest Relations as well as the timing for follow up to and resolution of Resident #53's grievance. She indicated, "The POA and resident were present (at the care plan meeting). The POA said she was admitted here with a \$100 bill, and it is missing, but was too embarrassed to tell anyone. She said it happened in mid July. We encouraged her to use the trust account and not keep money on her...I am treating this as potential misappropriation today because the POA was vocal and using the word stolen. Prior to today, the resident was simply using the word missing and not stolen. Today is the first indication I've had that this was willful. I did not call the POA on the 28th (8/28/13). I have no good reason for not calling her at the time. I knew she was coming in for the care plan meeting, so I decided to wait until today. I have 100 other things to take care of. The family was happy with the discussion today and our resolution, from a grievance perspective. Today, this is a grievance and a reportable, as of today. At the time, it was a grievance. There's always the potential for this to be an allegation of misappropriation. I did not suspect there was willful</p>			

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	<p>misappropriation on the 28th. I didn't even think the woman had the money."</p> <p>The Resident Grievances and Concerns policy was provided by the Administrator on 9/5/13 at 2:30 p.m. It indicated, "...Responses to resident/family shall be made as immediately as possible. Within 48 hours the problem should be resolved and each action documented.... Procedure...</p> <p>If a grievance/concern of any kind is noted, the Grievance/Concern form is used. The person receiving the concern completes Section I.</p> <p>The following information is placed on the form by the individual completing the record Date incident occurred Time incident occurred Date concern/grievance was received Department receiving the concern/grievance Detailed accounting of concern/grievance Name of person receiving the concern/grievance Date the complaint form was completed...</p> <p>The Executive Director will then complete Section III of the form</p>			

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	<p>Responses and appropriate resolutions to all complaints will be made within 72 hours."</p> <p>3.1-7(a)(2)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were developed for dental status and needs and for a diagnosis of mental retardation for 2 of 23 residents reviewed for care plans. (Resident #18 and Resident #50)</p> <p>Findings include:</p> <p>1. Resident #18's clinical record was reviewed on on 9/4/2013 at 1:00 p.m. Diagnoses included but were not limited to; malnutrition, dysphagia, esophagitis, depressive disorder,</p>	F000279	F 279 DEVELOP COMPREHENSIVE CARE PLANS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #18 Care Plan was reviewed and revised to reflect dental needs and preferences · Resident #50 Care Plan was reviewed and revised to reflect diagnosis of MR How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Any resident who has a diagnosis of	10/02/2013			

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	<p>GERD, gastroparesis (delayed stomach emptying). A care plan related to the resident's dental status and or needs could not be found in the resident's clinical record.</p> <p>An observation of Resident #18 on 8/30/2013 at 12:06 p.m., indicated he had missing and broken upper teeth.</p> <p>A "weekly skin and weekly summary assessment", dated 9/2/2013, indicated, "oral status: tooth fragments refuses oral care".</p> <p>A Dentist visit note, dated 3/5/2013, indicated, "refused all care attempted."</p> <p>An interview with the Director of Nursing Services, on 9/5/2013 at 3:50 p.m., indicated, "He has a history of refusing dental care."</p> <p>An interview with the Administrator, on 9/4/2013 at 12:10 p.m., indicated Resident #18 did not have a care plan for dental status and or needs.</p> <p>2. Resident #50's clinical record was reviewed on 9/5/2013 at 12 p.m. Diagnoses included but were not limited to; end stage renal disease, epilepsy and recurrent seizures,</p>		<p>MR has the potential to be affected by the alleged deficient practice. Any resident who refuses dental care has the potential to be affected by the alleged deficient practice. The Interdisciplinary Team will review all current residents, new admissions and re-admissions in the clinical meeting to identify residents with a diagnosis of MR and/or dental needs including those who refuse dental services. Care Plans will be developed and/or revised accordingly. Licensed Nurses will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on completing care plans timely and accurately. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Interdisciplinary Team will review all current residents, new admissions and re-admissions in the clinical meeting to identify residents with a diagnosis of MR and/or dental needs including those who refuse dental services. Care Plans will be developed and/or revised accordingly. Licensed Nurses will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on completing care plans timely and accurately. Facility Activity Report and Progress Notes will be</p>				

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	<p>bipolar disorder, and mild mental retardation. A care plan related to the resident's diagnosis of mild mental retardation could not be found in the resident's clinical record.</p> <p>An interview with Activity Director, on 9/5/2013 at 12:15 p.m., indicated the Social Services Director should meet with the Activity Director on a resident's admission, to coordinate so that they know who has a diagnosis of mental retardation. She did not know that Resident #50 had a mental retardation diagnosis.</p> <p>An interview with the Social Services Director, on 9/6/2013 at 1:05 p.m., indicated a resident with a diagnosis of mental retardation should have a care plan directly related to the diagnosis.</p> <p>3.1-35 (a)</p>		<p>reviewed daily by Director or Nursing or designee to ensure resident dental care refusals has been documented and care planned appropriately 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 Care Planning CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</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 record review and interview, the facility failed to ensure a preference care plan was updated for choosing to wear a hospital gown instead of clothing for 1 of 23 residents reviewed for care plans. (Resident #18)</p> <p>Findings include:</p> <p>Resident #18's clinical record was reviewed on 9/4/2013 at 1:00 p.m. Diagnoses included but were not limited to; malnutrition, dysphagia, esophagitis, depressive disorder, GERD, gastroparesis (delayed stomach emptying).</p>	F000280	F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #18 Care Plan was reviewed and revised to address the preference of wearing a hospital gown How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any residents who reside in the facility and prefer to wear a hospital gown instead of clothing have the potential to be affected by the alleged deficient practice The Interdisciplinary	10/02/2013			

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	<p>Observations of Resident #18 on the following dates and times indicated he was wearing a hospital gown; on 8/30/2013 at 12:06 p.m., on 9/3/2013 at 11:20 a.m. and on 9/4/2013 at 1:57 p.m.</p> <p>An interview with CNA #11, on 9/4/2013 at 2:55 p.m., indicated he wore the hospital gown by choice, she offered him daily to wear clothes, he had clothes, but he says, "If I'm not going anywhere, why should I get dressed?"</p> <p>An interview with the D.N.S.(Director of Nursing Services), on 9/4/2013 at 3:25 p.m., indicated she wasn't sure where the clothing preference care plan was, but there should be one. She would check into it, because it could be that it "disappeared".</p> <p>A care plan, dated 12/27/2010, indicated, "Problem: Resident frequently resists care, lab draws, and refusing meds and feedings." The care plan did not refer specifically to the resident's refusal to wear clothes or preference to wear hospital gowns.</p> <p>A progress note, dated 9/4/2013 at 6:49 p.m., indicated, "DNS (Director of Nursing Services) interviewed</p>		<p>Team will review current residents to identify residents who prefer to wear a hospital gown instead of clothing and update care plans accordingly· Licensed nurses will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on completing care plans for residents who prefer wearing a hospital gown timely and accurately· Facility Activity Report and Progress Notes will be reviewed daily by Director of Nursing or designee to ensure resident preference for dressing has been care planned appropriately· Activity Director will complete Preference for Daily Customary Routines Worksheet for each new admission and each quarter for resident preferences and report findings to the appropriate discipline for care planning What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Interdisciplinary Team will review current residents to identify residents who prefer to wear a hospital gown instead of clothing and update care plans accordingly· Licensed Nurses will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on completing care plans for resident who prefer wearing a hospital gown timely</p>		

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	Resident about choices of clothing. Resident states that he does not want to wear clothing prefers gowns also stated, 'if I wanted clothes on I would tell you'...Care plan reviewed and updated." 3.1-35(d)(2)(B)		and accurately Facility Activity Report and Progress Notes will be reviewed daily by Director of Nursing or designee to ensure resident preference for dressing has been care planned appropriately. Activity Director will complete Preference for Daily Customary Routines Worksheet for each new admission and each quarter for resident preferences and report findings to the appropriate discipline for care planning MDS Coordinator will report daily in morning stand up meeting which residents are due for annual, quarterly or change of condition care plan review 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 Care Plan Review CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. An Accommodation of Needs CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance		

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure a resident with dentures was provided his dentures for 1 of 3 resident's reviewed of 3 who met the criteria for dental status and services. (Resident #17)</p> <p>Findings include:</p> <p>The clinical record for Resident #17 was reviewed on 9/4/13 at 1:30 p.m.</p> <p>The diagnoses and conditions for Resident #17 included, but were not limited to: impaired mobility, metabolic encephalopathy, cancer, weakness, confusion, and left below knee amputation.</p> <p>During an interview with Resident #17 on 8/29/13 at 2:25 p.m., he indicated he had chewing/eating problems as well as denture problems. He indicated he could not eat cheese and some meats because he did not have dentures. He stated, "I have no teeth at all." Resident #17 was observed</p>	F000312	<p>F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?· Resident #17 dentures were located, cleaned, and placed appropriately and documented on Resident Care Sheet/Profile How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?· Any resident who resides in the facility who wears dentures has the potential to be affected by the alleged deficient practice· Nursing staff will be in-serviced by Staff Development Coordinator and/or designee by October 2nd, 2013 on ADL care including oral/denture care· Nurse Managers and/or designee will audit current residents to check for appropriate denture care/placement and will immediately correct as needed· ADL Skills Validation which includes oral care will be completed with CNAs by October 2nd, 2013</p>	10/02/2013			

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	<p>with no teeth or dentures in his mouth.</p> <p>The 7/12/13 quarterly MDS (minimum data set) assessment for Resident #17 indicated he was an extensive assist of 1 person for personal hygiene.</p> <p>The 12/28/12 Initial Oral Assessment for Resident #17 indicated he had full upper and lower dentures.</p> <p>During another interview with Resident #17 on 9/4/13 at 3:07 p.m. regarding his dentures, he indicated he used to have dentures, but they were lost. Again, Resident #17 was observed with no dentures or teeth in his mouth.</p> <p>During an interview with 2nd Floor Nurse, RN #7, on 9/4/13 at 3:16 p.m., she indicated Resident #17 was moved to the 2nd Floor from the 1st Floor on 8/26/13, and she didn't know him to have upper or lower dentures.</p> <p>During an interview with the 2nd Floor Unit Manager on 9/4/13 at 3:30 p.m., she stated, "I have not known him to wear dentures. He has broken teeth in his mouth." At this time, the 2nd Floor Unit Manager went into Resident #17's room, looked in his</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nursing staff will be in-serviced by Staff Development Coordinator and/or designee by October 2nd, 2013 on ADL care including oral/denture care- Nurse Managers and/or designee will conduct rounds daily to check for appropriate denture care/placement and will immediately correct as needed. Resident Care Sheets/Profiles will be reviewed by Nurse Managers weekly and updated according to resident care plan. ADL Skills Validation which includes oral care will be completed with CNAs by October 2nd, 2013 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? An ADL CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>		

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	<p>mouth, came out of his room and stated, "He doesn't (have broken teeth in his mouth). If this was a test, I'd fail."</p> <p>During an interview with LPN #8, who cared for Resident #17 while he resided on the 1st Floor, on 9/4/13 at 4:00 p.m., she indicated she remembered him having dentures when he resided on the 1st Floor.</p> <p>During an interview with the 1st Floor Unit Manager on 9/4/13 at 4:07 p.m. regarding whether or not Resident #17 had dentures, she stated, "I really don't remember if he had dentures or not."</p> <p>During an interview with the SSD (Social Services Director) on 9/5/13 at 10:58 a.m. regarding Resident #17's lost dentures, she indicated, "(Name of Resident #17) has dentures. They found them yesterday."</p> <p>During another interview with the 2nd Floor Unit Manager on 9/5/13 at 11:05 a.m., she indicated, "His CNA (Certified Nursing Assistant) found his dentures yesterday in his drawer underneath some stuff. He has them in now. It is everyone's responsibility to make sure he has what he needs." She indicated she thought the reason</p>			

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	<p>his dentures weren't in for the last week was because of the room change.</p> <p>The 12/12/12 self care deficit care plan for Resident #17 indicated he had a self care deficit related to impaired mobility, metabolic encephalopathy, cancer, weakness, confusion, and left bilateral knee amputation. The goal was, "Resident will be in clean clothes, odor free with all ADL needs met daily." Approaches were to "Provide denture/oral care at least two times daily" and "Set up hygiene/grooming equipment in easy reach."</p> <p>3.1-38(a)(3)(C)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure a resident was adequately protected from a fall, for 1 of 3 resident reviewed for falls (Resident # 28), and failed to keep a medication cart locked during a routine observation with potential to affect 10 residents who were cognitively impaired, mobile and lived on the second floor (Residents # 47, 143, 141, 135, 4, 51, 46, 90, 40, 153).</p> <p>Findings include:</p> <p>1. Resident #28's clinical record was reviewed on 9/5/2013 at 10 a.m. Diagnoses included but were not limited to; cellulitis (infection), diabetes, asthma, venous thrombosis, colon cancer. The resident was admitted to the facility on 7/26/2013.</p> <p>A document, provided by the Administrator, on 9/5/2013 at 10:00 a.m., indicated, "Report of Incident:...Date of incident: 8/28/2013</p>	F000323	<p>F 323 FREE OF ACCIDENTN HAZARDS/SUPERVISION/DEVI CESWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?· Resident #28 Care plan was reviewed and revised to address fall precautions· Residents #47, 51, 143, 141, 135, 4, 46, 90, 40, and 153 did not suffer any ill effectsHow will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?· Any resident who uses a wheelchair for mobility that resides in this facility has the potential to be affected by the alleged deficient practice· Any resident that has a BIMS less than 10 and is ambulatory that resides in this facility has the potential to be affected by the alleged deficient practiceThe Interdisciplinary Team will review current residents to identify residents that utilize a wheelchair for mobility to assess need for foot pedals and/or those that self-propel in wheelchair and revise care plan and Resident Care Sheets/Profile</p>	10/02/2013			

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	<p>at 8:13 p.m...Brief description of incident: ...Resident was in wheelchair being pushed by CNA in hallway. Resident leaned forward and fell out of chair onto floor. Resident complained of pain in bilateral lower legs...Type of injury:...fractures of bilateral tibias."</p> <p>An MDS (Minimum Data Set) 14 day assessment, dated 8/7/2013, indicated, "locomotion: how resident propels themselves once in wheelchair: support needed: 1 person physical assist."</p> <p>An interview with the resident, on 9/4/2013 at 3:35 p.m., indicated she was "doing just fine." When asked if she had just had a fall and broke both her legs she responded, "No, I didn't break them, I just fractured them. But its no problem, I'm fine now."</p> <p>A nurses note, dated 8/28/2013 at 2:34 p.m., indicated, "Notified by staff that resident was on the floor. C/O (complains of) pain bilaterally to legs. Staff stated that she was pushing resident down the hall when (sic) resident slump (sic) over in chair landing on knees and hit her head on the floor. NP (Nurse Practitioner) assessed and ordered to send resident to ER (emergency room). VS</p>		<p>to address fall precautions Licensed Staff will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on Safety/Hazards to include locking medication carts and Nursing Staff will be in-serviced on safety including fall precautions and assisting residents with mobility What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Interdisciplinary Team will review current residents to identify residents that utilize a wheelchair for mobility to assess need for foot pedals and/or those that self-propel in wheelchair and revise care plan and Resident Care Sheets/Profile to address fall precautions Licensed Staff will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on Safety/Hazards to include locking medication carts and Nursing Staff will be in-serviced on safety including fall precautions and assisting residents with mobilityThe Interdisciplinary Team will review falls in clinical meeting to determine appropriateness of interventions and revise care plan and resident care sheet accordingly Licensed Nursing Staff will conduct rounds each shift to ensure fall interventions are present and to ensure medication carts are</p>		

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	<p>(vital signs) complete and WNL (within normal limits) . BS (blood sugar) taken.</p> <p>Another note, at 7:23 p.m., indicated "Res returned from hosp (hospital) with dx (diagnosis of) bilat tibial fxs (both lower legs broken). res c/o's pain in both legs and given prn (as necessary) pain med per order. Res has splints to bilat lower extremities d/t bilat tibial fxs. res incontinent of bowel and f/c drains yellow urine. res resting in bed with call light in reach."</p> <p>A care plan, dated 8/5/2013, indicated, "Resident is at risk for fall due to: Hx of falls with fracture. Dx arthritis, hypoglycemic, antidepressant, and Narcotic med use as well as incontinence and assistive devices. Goal: Resident will be free from fall related injury. Approaches: dated 8/5/2013; Call light in reach. Non skid footwear. Personal items in reach. Therapy screen as needed. Dated 8/29/2013; Pedal to w/c (wheelchair) and orthostatic B/P (blood pressure)."</p> <p>ISDH follow-up report, dated 9/2/2013, indicated, "Follow up: Investigation completed. Resident returned from hospital same day and assessed for change in condition."</p>		<p>locked 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?An Environmental Safety CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. A Fall Program CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive DirectorIf a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>				

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	<p>New orders noted for resident to be non-weight bearing until ortho follow up appointment on 9/4/2013. IDTmet and reviewed resident fall and condition. Root cause of fall determined by NP and IDT to be change in blood pressure. New orders received for blood pressure monitoring to evaluate for orthostatic hypotension. Care plan and resident care sheet updated. Social services and Nursing will continue to observe."</p> <p>A handwritten note, provided by the Administrator on 9/5/2013 at 10:15 a.m., dated 8/28/2013, indicated "I, (CNA #12) was pushing (Resident #28) down the hall and she slump over and fell out of her chair."</p> <p>An interview with CNA #12, on 9/5/2013 at 10:50 a.m., indicated, "We were coming from therapy down the hallway, we were right by the elevator, and before I knew it she (Resident #28) had slumped out of the chair, it just happened so fast, she just went over. She had said she was kind of tired. She always needed assistance in someone pushing her wheelchair. She needs assistance getting in and out of wheelchair, she needs pushed in the wheelchair. We were bringing her down to get her weight. She didn't tell me she was</p>						

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	lightheaded, she just said she was tired. There were no foot pedals on the wheelchair when she fell, that was not typical. She usually had foot pedals on her wheelchairs. I think they had been working with her, and taken the foot pedals off. They (the therapists) usually put the foot pedals back on in therapy. I didn't notice the foot pedals weren't on the wheelchair until after she had fallen. I asked for a nurse to come down the hall, I got down on the floor and sat with her until the paramedics came. She did say she was feeling lightheaded, but that was after she fell when the nurse and unit manager were asking her what happened, assessing her. She (the resident) could talk to me the whole time. She didn't lose consciousness. She hit her front right portion of her head on the floor. She had a gait belt on and I tried to grab it from behind to stop her from falling. She can't go from straight from lying down to sitting up at the side of the bed. I have to give her a couple minutes once she's sitting up at the side of her bed. I go do something else and come back. I have to give her time to regroup, because she's said she'll get lightheaded or dizzy. This is her normal, every morning routine if I'm getting her up and putting her in her chair. She hasn't			

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	<p>had any other falls while she's been here that I'm aware of. Right now, she hasn't been able to get out of bed at all. Not even a hooyer lift. She hasn't been able to go down to activities or therapy. Previous to her breaking her legs she didn't do much for activities except going down to eat in the dining room. She has always kind of stayed in her bed and read books, newspapers, she likes to keep herself in her room. She hasn't complained of pain, its just awkward when turning her with the splints (on her legs) in the way."</p> <p>An interview with the Therapy Manager, on 9/5/2013 at 11:52 a.m., indicated she (Resident #28) fell because her legs just dropped. She normally had her foot pedals on, but they were going to just go really quickly and weigh her and bring her back. Because a CNA came and got her, it would be the CNA's responsibility to ensure the foot pedals were on, even though she could keep her legs up, hold them up. If a therapist was bringing her back to her room they would always ensure she had them on first.</p> <p>2. An observation, on 8/27/2013 at 11:45 a.m., indicated an unlocked medication cart was located on the</p>			

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	<p>second floor between room 229 and a 'Clean Linen' room. Unit Manager #2 came up at 11:46 a.m. and indicated, "I did that, I left it open. I'm sorry." She was observed to be out of view of the medication cart for approximately one minute before walking out of a resident's room located approximately 30 feet away from the medication cart. Unit Manager #2 immediately locked the medication cart. The following medications and supplies were observed, at 1:20 p.m., in the "Team Two" medication cart; blood thinners, antipsychotics, insulins, eye drops, bronchodilators, non-controlled pain relievers, diuretics, antibiotics, nasal sprays, and lancets.</p> <p>A document, provided by the Administrator on 8/28/2013 at 10:15 a.m., indicated, "BIMS (basic interview for mental status) less than 10 (not cognitive) and independently ambulatory; Residents; # 47, 143, 141, 135, 4, 51, 46, 90, 40, 153."</p> <p>An interview with Unit Manager #2, on 8/27/2013 at 1:00 p.m., indicated she only left the cart unlocked, "for 20 seconds."</p> <p>3.1-45(a)(2)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to ensure a resident with significant weight loss was provided and received the physician ordered diet for 1 of 3 residents reviewed of 4 who met the criteria for nutrition. (Resident #17)</p> <p>Findings include:</p> <p>The clinical record for Resident #17 was reviewed on 9/4/13 at 1:30 p.m.</p> <p>The diagnoses and conditions for Resident #17 included, but were not limited to: impaired mobility, metabolic encephalopathy, cancer, weakness, confusion, and left below knee amputation, and dysphagia.</p> <p>The weight (in pounds) for Resident #17 was as follows:</p> <p>6/5/13=146</p>	F000325	<p>F 325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident # 17 physician was notified and diet order was clarified and Registered Dietitian was notified of order How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Any resident who receives meals from the dietary department at this facility has the potential to be affected by the alleged deficient practice The Interdisciplinary Team will review all new admissions and re-admissions in the clinical meeting to identify residents diet orders Registered Dietician/Dietary Manager and/or Designee will review current residents to ensure diet that is specified on tray card matches</p>	10/02/2013

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	<p>8/7/13=149 8/26/13=132 (11.4% loss in 19 days)</p> <p>Resident #17 had a BMI (body mass index) of 19.5, indicating he was underweight.</p> <p>The 8/26/13 progress note indicated, "Res (resident) readmitted from (name of hospital) d/t (due to) sepsis rt (related to) urinary tract obstruction and had urethral stent placed. ...noted to have difficulty swallowing secretions at this time...md notified of readmission and ongoing additional dgx (diagnoses) from hospitalization (sbo (small bowel obstruction) s/p (status post) ileus (intestinal obstruction), metabolic encephalopathy, dysphagia)..."</p> <p>The 8/29/13 IDT (interdisciplinary team) progress note indicated, "IDT met for cp (care plan meeting). RD (Registered Dietician) and res brother discussed res weight loss. res preferences/dislikes. RD will follow up with res. RSM (Rehabilitation Services Manager) explained res is receiving s/t (speech therapy) d/t difficulty swallowing. res speech is also poor at this time...."</p> <p>The 8/30/13 Physician Telephone Order indicated "Add fortified foods</p>		<p>physicians order in residents' medical record· Licensed Nurses and Dietary Staff will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on communication to dietary staff on change in diet orders and new admission diet orders What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Interdisciplinary Team will review all new admissions and re-admissions in the clinical meeting to identify residents diet orders Registered Dietician/Dietary Manager and/or Designee will review current residents to ensure diet that is specified on tray card matches physicians' order in residents' medical record· Licensed Nurses and Dietary Staff will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on communication to dietary staff on change in diet orders and new admission diet orders · Residents who are experiencing significant weight loss will be reviewed weekly by Interdisciplinary Team to ensure residents are receiving diets as ordered by physician 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 Dietitian</p>		

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	<p>and ice cream with dinner. D/C (discontinue) diet of NAS (no added salt). Diet order: mech (mechanical) soft, fortified foods (symbol for "with") ice cream at dinner. Weekly wts (weights) x 4."</p> <p>An interview was conducted with the RD, who also served as the current Dietary Manager, on 9/5/13 at 2:29 p.m. regarding Resident #17's weight loss and diet orders. She indicated, "We had a care plan (meeting) about his weight loss. We are thinking about liberalizing his diet and adding fortified foods." Regarding whether a liberalized diet and fortified foods had already been implemented in light of his 8/30/13 physician's orders to do so, she indicated she was unaware of the 8/30/13 diet orders for Resident #17. She stated, "I didn't know about the ice cream with dinner and fortified foods." She indicated Resident #17 was not getting ice cream with dinner. The RD indicated his dinner meal ticket should list ice cream under preferences. She further indicated for fortified foods, "We make mighty milk and fortified cereal, which is oatmeal or cream of wheat with margarine and brown sugar, for breakfast." Regarding why she was unaware of the new diet orders, she indicated, "I would normally receive</p>		<p>Recommendations CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>	

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	<p>the yellow order slip from nursing. My staff would put it on my desk. I should have been checking on him too, because he's had the weight loss. His meal tickets should say fortified, mech soft. The discontinuation of the NAS would allow him to have a packet of salt on his trays, which a lot of residents like."</p> <p>Review of Resident #17's meal tickets from 8/31/13 to 9/4/13 with the RD indicated there was no discontinuation of the NAS diet, no addition of fortified foods and no ice cream with dinner.</p> <p>During an interview with Resident #17 on 9/4/13 at 3:07 p.m. regarding whether he was receiving ice cream with dinner daily, he indicated, "Sometimes."</p> <p>3.1-46(a)(1)</p>			

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 of 4 residents observed during medication administration. 2 errors in medication administration were observed during 27 opportunities for error, resulting in a 7.41% error rate in medication administration. (Resident #98 and Resident #53.)</p> <p>Findings include:</p> <p>1. An observation, on 9/6/2013 at 9:37 a.m., indicated Resident #98 was given two 5mg tablets of oxybutynin (a medication used for overactive bladder) by LPN #9. The resident took the pills by mouth.</p> <p>Resident #53's MD order recap for the month of September indicated, "oxybutynin 5mg tab po (by mouth) daily."</p> <p>An interview with the 2nd floor Unit Manager, on 9/6/2013 at 11:40 a.m., indicated the LPN #9 incorrectly</p>	F000332	<p>F 332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #98 physician was notified of medication error, clarification order was received and pharmacy was notified. Resident # 53 physician was notified of error in medication administration and no new orders were received. LPN #9 and LPN #8 were educated on proper medication administration How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any resident who resides in the facility and receives medication has the potential to be affected by the alleged deficient practice The Interdisciplinary Team will review medication orders at clinical meeting for changes in current medication doses and will ensure medication change stickers have been utilized. Licensed Nurses will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on medication</p>	10/02/2013

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	<p>administered Resident #98's oxybutynin. The MD was in the building and was notified The incident occurred because the previous dose was 10mg, and it should have now been 5mg. The MD indicated resident was not harmed from this because she was prescribed and received routinely the 10mg dose up until recently. He would clarify with a new order.</p> <p>2. An observation, on 9/6/2013 at 9:47 a.m., indicated Resident #53 was given the medication Fluticasone (a corticosteroid nasal spray) by LPN #8. LPN #8 delivered one spray in the resident's right nostril. Then, LPN #8 delivered two quick and shortened sprays in the resident's left nostril, without waiting any length of time between the sprays.</p> <p>Resident #53's MD order recap for the month of September indicated, "Fluticasone 50mcg spray, instill 2 sprays into each nostril once daily."</p> <p>An interview with the 1st floor Unit Manager, on 9/6/2013 at 12:55 p.m., indicated LPN #8 should have sprayed the 2 sprays separately, not on one inhalation, as observed during Resident #53's med pass.</p>		<p>administration · Licensed Nurses will complete medication administration Skills Validation to ensure all 5 rights are followed What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Interdisciplinary Team will review medication orders at clinical meeting for changes in current medication doses and will ensure medication change stickers have been utilized · Licensed Nurses will be in-serviced by October 2nd, 2013 by the Staff Development Coordinator or designee on medication administration · Licensed Nurses will complete medication administration Skills Validation to ensure all 5 rights are followed 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 Medication Administration CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>				

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	<p>An interview with the Director of Nursing Services, on 9/6/2013 at 1:55 p.m., indicated the nurse should have waited a full minute between sprays if the medication was a steroid.</p> <p>A medication information resource for Fluticasone, written by the manufacturer, indicated, "How to use this medicine:...If you are using more than 1 spray, wait for 1 to 2 minutes between sprays."</p> <p>3. The medication pass observation, completed on 9/6/13, had 27 opportunities for error. There were two errors observed and confirmed. This resulted in an error rate of 7.41%, greater than 5%.</p> <p>3.1-48(c)(1)</p>				

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as 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 and interview, the facility failed to ensure a staff</p>	F000441	F 441 INFECTION CONTROL, PREVENT SPREAD,	10/02/2013			

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	<p>member utilized appropriate self hygiene behavior, during 1 of 1 random observations of a medication cart. This had the potential to affect 26 of 26 residents receiving medication from the Team 1 medication cart.</p> <p>Findings include:</p> <p>An observation, on 8/27/2013 at 11:54 a.m., indicated RN #7 was behind the nurses station on the 2nd floor, standing at the "Team 1" medication cart. She was observed to take out a pair of nail clippers, and clip her own fingernail twice over the open drawer of the med cart. Her fingernail clippings were observed to fall into the open drawer. She then placed the nail clippers back into the med cart drawer.</p> <p>An interview with the Staff Development Coordinator, on 9/5/2013 at 4:10 p.m., indicated, "I can do some education on that (clipping nails at med cart). She (RN #7) most definitely should not have done that."</p> <p>An interview with the Director of Nursing, on 9/6/2013 at 2:20 p.m., during the exit conference, indicated, "I can't believe the nurse clipped her</p>		<p>LINENSWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?· Second floor Team1 medication cart was sanitized· RN # 7 received education on appropriate self-hygiene behavior in regards to infection control policyHow will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?· Any resident who resides in the facility and receives medication from 2nd floor team 1 medication cart has the potential to be affected by the alleged deficient practice· Nursing Staff will be in-serviced by Staff Development Coordinator and/or designee by October 2nd, 2013 on infection control· Nurse Managers and/or designee will conduct rounds daily to check for appropriate self-hygiene behaviors for staff and will immediately correct as neededWhat measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?· Nursing Staff will be in-serviced by Staff Development Coordinator and/or designee by October 2nd, 2013 on infection control· Nurse Managers and/or designee will conduct rounds daily to check for appropriate self-hygiene behaviors for staff and will</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	nails into the medication cart." 3.1-18(a)		immediately correct as needed 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?An Infection Control CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance		