

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155166	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2015
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NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00176387.</p> <p>Complaint IN00176387- Substantiated. Federal/State deficiencies related to the allegations are cited at F368 and F371.</p> <p>Survey dates: August 3, 4, 5, 6, 7, 10 and 11, 2015</p> <p>Facility number: 000083 Provider number: 155166 AIM number: 100289670</p> <p>Census bed type: SNF/NF: 142 Total: 142</p> <p>Census payor type: Medicare: 18 Medicaid: 111 Other: 13 Total: 142</p> <p>Sample: 3 Supplemental Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p><b>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</b></p> <p><b>This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 9/10/15.</b></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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F 0224 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from mistreatment, related to a CNA providing rough treatment during care, threatening a resident and using foul language during care for 1 of 2 residents reviewed for abuse. (Resident #89)</p> <p>Finding includes:</p> <p>During a confidential interview with an alert and oriented resident on 8/4/15 at 2:43 p.m., the resident indicated some of the CNAs treat their roommate very badly and are rough with the roommate when they move the roommate around and also rough verbally to the roommate. After the confidential interview with the resident ended, the Executive Director (ED) was immediately notified of an anonymous reporting of abuse on the East Wing regarding a roommate</p>	F 0224	<p><b>F224 – Mistreatment/Neglect/Misappropriation</b></p> <p>It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>Resident #89's physician and family have been updated regarding this resident's statements and current status. This resident experienced no negative psychosocial reaction or outcome related to this finding.</li> </ul> <p><b>How other residents having the</b></p>	09/10/2015

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	<p>treatment by staff.</p> <p>Interview with the ED on 8/6/15 at 10:54 a.m., indicated a facility wide inservice of abuse and neglect with staff was initiated. She further indicated random interviews were completed with residents and there were a few concerns from the interviews. Separate reportable's were completed on them. The separate reportable's were requested from the Executive Director at the time.</p> <p>Review of the reportable was completed on 8/6/15 at 12:00 p.m., the report indicated a report was sent to ISDH on 8/4/15. The report read as followed:</p> <p><b>Brief Description of Incident</b> Description added: During resident interviews on 8/4/15 related to questions regarding abuse, Resident #21 reported she had witnessed her roommate Resident #89 being physically and verbally abused. The resident reported she felt they were rough when turning her roommate and the aides tone of voice and language was inappropriate with roommate. The aide Resident #21 identified as CNA #5 was no longer employed with the facility.</p> <p>Type of Injury Type of injury added: 8/4/15 nursing</p>		<p><b>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by this finding.</li> <li>· Resident and family interviews were conducted per CQI Abuse Questionnaire devised by CMS with no findings</li> <li>· ED to request permission to attend upcoming resident council meetings to encourage residents to immediately report any concern and/or allegation of abuse, neglect or mistreatment.</li> <li>· The ED/DNS/designee will be responsible for the Customer Care Program in which resident interviews are conducted weekly regarding care and services provided by staff.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· The ED/DNS/designee will be responsible for the Customer Care Program in which resident interviews are conducted weekly regarding care and services provided by staff.</li> <li>· ED to request permission to</li> </ul>	

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	<p>completed head to toe assessments with no injuries noted to either resident.</p> <p><b>Immediate Action Taken</b> Action taken added: 8/4/15 ED and DNS (Director of Nursing Services) immediately notified. Physician and families notified. Abuse protocol followed. Social Services would provide supportive contacts.</p> <p><b>Preventative Measures Taken</b> Type of preventative measures added: 8/4/15 CNA #5 identified by Resident #21 no longer worked at the facility. ED would request permission to attend the next resident council meeting to encourage residents to immediately report any concerns and/or allegations of abuse or neglect. Facility wide Abuse and Neglect education had been initiated with all staff. Social Services would provide 72 hour psychosocial follow up.</p> <p>Record review for Resident #89 was completed on 8/6/15 at 12:15 p.m. The resident's diagnoses included, but were not limited to cerebral palsy, anxiety, depression, bipolar, schizoaffective disorder, autistic and anorexia nervosa.</p> <p>A Significant Change in Status MDS (Minimum Data Set) assessment, completed on 6/4/15, indicated the</p>		<p>attend upcoming Resident council meeting to encourage residents to immediately report any concern and/or allegation of abuse, neglect or mistreatment</p> <ul style="list-style-type: none"> <li>All staff in-services will be conducted on or before 9/10/15. This in-service will review the facility Abuse Prohibition, Reporting and Investigation policy and the importance of reporting any allegation of abuse, neglect or mistreatment voiced by any resident or witnessed by any staff member to the ED immediately.</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>The ED/DNS/designee will be responsible for completing the CQI Audit Tool titled, "Abuse Prohibition and Investigation" weekly for 3 weeks and monthly for 6 months.</li> <li>If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</li> </ul>	

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	<p>resident had a BIMS (Brief Interview of Mental Status) score of 15 which indicated the resident was cognitively intact. The assessment included the resident required extensive assistance for bed mobility, toileting, personal hygiene and total assistance for transfers. The assessment further indicated the resident had an impairment on both lower extremities and used a wheelchair.</p> <p>An interview with Resident #89 dated 8/6/15 was completed by the Social Service Assistant #2 on 8/5/15. The interview read as followed:</p> <p>An interview was conducted with Resident #89 on 8/5/15 related to an abuse allegation. The Social Service Assistant #2 questioned the resident of what she had thought about CNA #5 (CNA no longer employed by the facility). The resident indicated, "she could be mean, my roommate thought she was abusive towards me." The Social Service Assistant #2 asked the resident if she thought CNA #5 was abusive, the resident responded she was not sure. The Social Service Assistant #2 asked how CNA #5 was mean to her, and the resident indicated the CNA would throw her on her bed to rough sometimes and would curse under her breath a lot. She further indicated CNA #5 would tell her</p>		<p><b>By what date the systemic changes will be completed:</b></p> <p>Compliance Date = 9/10/15.</p>		

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	<p>she would not get her out of bed because she was going to vomit and had to stay in bed. (Resident #89 had a diagnosis of anorexia nervosa). The resident indicated, "these threats were made during times that she was not making herself throw up." The Social Service Assistant #2 indicated the resident had never mentioned having issues with CNA #5. Resident #89 indicated she thought CNA #5 did not like her.</p> <p>Interview with the ED on 8/6/15 at 1:51 p.m., indicated CNA #5 no longer worked with the facility so she was unable to interview the CNA. She indicated she had received complaints from staff the CNA was verbally inappropriate with staff and the ED also indicated the CNA was verbally inappropriate with her as well. She further indicated the CNA had told her she would be moving and the ED told her it was best to leave then. She further indicated she had never had any complaints from residents regarding the CNAs care, just complaints from staff regarding her inappropriate tone and language with staff.</p> <p>A follow up was added to the reportable on 8/10/15. Follow up added: 8/10/15. During follow up visits with Resident #89 she indicated</p>			

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F 0241 SS=D Bldg. 00	<p>her roommate felt the CNA was rough with her but she did not think so. The resident indicated she and the CNA just did not get along.</p> <p>Interview with the ED on 8/11/15 at 10:11 a.m., indicated she felt Resident #89 had been mistreated from CNA #5 since the resident and her roommate Resident #21 was telling the same story about the mistreatment.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure a cognitively impaired resident's dignity was maintained by dressing the resident in an institutional fashion. (Resident #26)</p> <p>Finding includes:</p> <p>During an observation on 8/3/15 at 12:15 p.m., Resident #26 was laying in bed,</p>	F 0241	<p><b>F241 – Dignity and Respect of Individuality</b> It is the practice of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #26 is receiving daily assistance with</p>	09/10/2015

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	<p>dressed in a hospital gown.</p> <p>The resident was observed again on 8/6/15 at 8:00 a.m., laying in bed, dressed in a hospital gown.</p> <p>Later that the same day on 8/6/15 at 9:56 a.m., the resident remained in a hospital gown, laying in bed.</p> <p>The record for Resident #26 was reviewed on 8/6/15 at 8:35 a.m. The resident's diagnoses included, but were not limited to, dementia.</p> <p>The 14 day MDS (Minimum Data Sheet) assessment, dated 8/3/15, indicated the resident was cognitively impaired and was a one person, extensive assist with dressing.</p> <p>Interview with CNA #1 and CNA #2 on 8/6/15 at 11:03 a.m., indicated the resident should have been dressed in his own clothes.</p> <p>Interview with the West Wing Unit Manager on 8/6/15 at 10:40 a.m., indicated the resident should not be dressed in a hospital gown and should have been dressed in his own clothes.</p> <p>3.1-3(t)</p>		<p>dressing and is wearing his personal clothing each day.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> · All residents have the potential to be affected by this finding · All residents who require assistance with dressing have been identified and will be dressed in their personal clothing to maintain each resident's dignity <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> · Unit Managers monitor resident care through rounds on their units daily which include monitoring that residents are dressed appropriately in their personal clothing and not in an institutional fashion. · Rounds are completed each shift by the Charge Nurses daily and by Department Heads Monday through Friday to monitor resident care and appropriate dress of residents. · All staff in-services will be conducted on or before 9/10/15. This in-service will review the facility policy related to Resident Dignity. This in-service will also review the importance of honoring resident personal requests and maintaining each resident individual dignity in regards to clothing/dressing.</p> <p><b>How the corrective action(s) will be monitored to ensure the</b></p>		

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F 0247 SS=A Bldg. 00	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview the facility failed to ensure a resident was notified of a change in roommate for 1 of 2 residents reviewed for Admission, Transfer, and Discharge of the 2 residents who met the criteria for Admission, Transfer, and Discharge. (Resident #21)	F 0247	<b>deficient practice will not recur; i.e., what quality assurance program will be put into place:</b> · Ongoing compliance with this corrective action will be monitored through the facility CQI Program. · Nurses will document their rounds on the "Resident Care Rounds CQI Audit Tool" daily for 4 weeks and monthly for 6 months to ensure residents are appropriately dressed. · Department Heads will document on the "Customer Care Rounds Sheet" daily for 6 months to ensure residents are dressed appropriately. · If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance Date = 9/10/15  <b>F247 – Right to Notice Before Room/Roommate Change</b>  It is the practice of this provider that a resident has the right to receive notice before the resident's room or roommate in the facility is changed.	09/10/2015
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	<p>Finding includes:</p> <p>Resident #21 was interviewed on 8/4/2015 at 2:55 p.m. At that time, the resident indicated she just assumed when she lost a roommate, she would get another one at some point, but was never actually told in advance before her current roommate arrived.</p> <p>The record for Resident #21 was reviewed on 8/6/2015 at 8:55 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, anxiety, depressive disorder, and schizophrenia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 7/21/15, indicated the resident was cognitively intact.</p> <p>The Social Service Progress Notes, for February and March 2015, lacked documentation indicating Resident #21 was notified prior to receiving a new roommate on 3/3/15. There was also no follow up documentation to indicate how Resident #21 was adapting to her new roommate.</p> <p>Interview with the Social Service Assistant (SSA) #1 on 8/6/15 at 10:10 a.m., indicated the resident received a new roommate on 3/3/15. SSA #1 indicated residents were usually notified</p>		<p><b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></b></p> <p>Resident #21 – resident and family is aware of the change in roommate and has verbalized their satisfaction with their current room assignment. This resident experienced no negative outcome related to this finding.</p> <p><b><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</i></b></p> <p>All residents experiencing a room or roommate change have the potential to be affected by this finding. A facility audit will be completed by SSD/designee. This audit will ensure all residents and/or legal representative have been given proper and timely notification related to room or roommate changes. Any errors or omissions noted during this audit will be clarified and/or corrected immediately. Room changes and roommate changes will be communicated to all responsible staff during daily meetings.</p> <p><b><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient</i></b></p>		

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	<p>verbally when receiving a new roommate and notification was documented in a progress note. SSA #1 further indicated there was no documentation indicating Resident #21 was notified in advance she was getting a new roommate.</p> <p>A policy was provided by the Nurse Consultant titled Intra-facility Transfers on 8/06/2015 at 10:00 a.m. and deemed as current. The policy indicated "... 5. The receiving roommate and/or legal representative will be notified of the new roommate prior to the move. This notification will be documented in the medical record. Social services will follow up with both the resident who moved as well as the receiving roommate within 72 hours of the move. Documentation will be placed as to the residents' adjustment to the move/ new roommate." SSD indicated on 8/6/15 at 10:25 a.m. this policy covers new admission roommates as well.</p> <p>3.1-3(v)(2)</p>		<p><b>practice does not recur:</b></p> <p>The ED/DNS/designee will be responsible for re-educating and in-servicing the SSD and other responsible staff members regarding the Intra-Facility Transfer Policy. This in-service will also include review of the facility practice related to notification and documentation for the receiving roommate and/or legal representative prior to the move. This in-servicing will be completed on or before 9/10/15. Room changes and roommate changes will be communicated to all responsible staff during daily meetings. The documentation related to room and roommate changes will be reviewed and verified during daily meetings by the IDT Team/Manager on Duty for weekends.</p> <p><b>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:</b></p> <p>The ED/SSD/designee will be responsible for completing the CQI Audit Tool titled, "Social Service Documentation" weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p>	

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F 0282 SS=E Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the current plan of care was followed as written related to fall interventions not in place for 1 of 4 residents reviewed for accidents of the 4 who met the criteria for accidents, lack of monitoring of bruising for 1 of 3 residents reviewed for non-pressure related skin conditions of the 7 who met the criteria for non-pressure related skin conditions, incorrect sliding scale insulin administration and not following blood pressure parameters with medication administration for 2 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria for unnecessary medications, and urinary catheter tubing on the floor for 1 of 4 residents reviewed for urinary catheter use of the 33 who met the criteria for urinary catheter use. (Residents #98, #127, #109, and #142)</p>	F 0282	<p><b>By whatdate the systemic changes will be completed:</b></p> <p>Compliance Date: 9/10/15.</p> <p><b>F282 – Services by Qualified Persons/Per Care Plan</b></p> <p>It is the practice of this provider that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>· Resident #98's care plan has been reviewed and all current fall interventions are in place and being followed per MD order. This resident experienced no negative outcome as a result of this finding.</li> <li>· Resident #127's family and physician were notified of the discolorations to the right forearm and back of both hands as well as</li> </ul>	09/10/2015

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NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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	<p>Findings include:</p> <p>1. On 8/6/15 at 4:56 p.m. Resident #98 was observed seated in his wheelchair in his room. There was no alarm observed in place to his wheelchair.</p> <p>On 8/7/15 at 2:43 p.m. Resident #98 was observed seated in his wheelchair in his room. There was no alarm observed in place to his wheelchair.</p> <p>The record for Resident #98 was reviewed on 8/6/15 at 2:20 p.m. The resident's diagnoses included, but were not limited to, hypertension, arthritis and depressive disorder.</p> <p>Review of the August 2015 Physician Order Summary indicated an order for a wheelchair alarm and to check function and placement every shift.</p> <p>Resident #98 had a care plan for risk for falls. The nursing interventions included "...personal alarm to chair, check placement and function every shift..."</p> <p>Interview with RN #1 on 8/7/15 at 2:51 p.m. indicated she was not sure why the chair alarm was not in place. She indicated the chair alarm should have been in place and she would put one in</p>		<p>this resident's blood sugar results with sliding scale insulin coverage. A head to toe assessment was completed on this resident with no other skin alterations noted. This resident has been monitored for bruising per the plan of care. This resident has been receiving his sliding scale insulin coverage without error per physician's order. This resident experienced no negative outcome as a result of this finding.</p> <ul style="list-style-type: none"> <li>Resident #109's family and physician were notified of his current blood pressures and blood pressure medication orders. This resident experienced no negative outcome as a result of this finding.</li> <li>Resident #142 is receiving necessary treatment and services related to proper placement of his catheter tubing. This resident experienced no negative outcome as a result of this finding.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>All residents that are at risk for falls, have non-pressure related skin conditions, have orders for insulin sliding scale coverage, have physician ordered medication parameters and/or</li> </ul>	

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	<p>place immediately.</p> <p>2. Resident #127's record was reviewed on 8/5/15 at 8:27 a.m. Diagnoses included, but were not limited to, vascular dementia with delusions, anxiety, diabetes mellitus and chronic pain.</p> <p>The resident's 30 day MDS (Minimum Data Set) assessment, dated 7/5/15, indicated he was severely cognitively impaired.</p> <p>Review of current Physician's Orders indicated an insulin order for Humalog (a quick acting insulin) insulin four times a day per sliding scale as follows: If BS (blood sugar) is less than 60, call MD (Physician). If BS is 61 to 150, give 0 units. If BS is 151 to 200, give 4 units. If BS is 210 to 250, give 8 units. If BS is 251 to 300, give 12 units. If BS is 301 to 350, give 16 units. If BS is 351 to 400, give 20 units. If BS is greater than 400, call MD.</p> <p>The Medication Administration Records (MARs) for July and August 2015 indicated the following dates for which the BS results were not accurately documented or the insulin given did not match the sliding scale order:</p>		<p>who have indwelling catheters have the potential to be affected by this finding.</p> <ul style="list-style-type: none"> <li>A facility audit will be conducted by the Nurse Management Team. This audit will include review of the following: <b>all care plan review</b>, skin condition review, medication administration review, blood glucose monitoring review and review of all residents with orders for indwelling catheters.</li> <li><b>Each resident care plan will be reviewed in its entirety by the Nurse Management Team.</b> Fall interventions on each resident's care plan will be compared to the physician's orders and Resident Profile to ensure all safety and fall interventions are in place as well as ensuring all are properly being utilized. The DNS and/or designee, Charge Nurses and/or Nurse Manager on the weekend will be responsible for environmental inspections of all resident rooms and equipment during daily rounds <b>to ensure fall interventions are in place. The Nurse Management Team will also review all care plans to ensure each resident care plan is an accurate reflection of each resident's current status</b></li> <li>Licensed nurses are responsible for completing a head to toe skin assessment with each</li> </ul>				

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	<p>7/14/15 9:00 p.m. - no legible number documented for BS result, no insulin given</p> <p>7/20/15 4:00 p.m. - BS 219, 4 units given, should have been 8 units</p> <p>7/21/15 4:00 p.m. - BS and insulin amount not legibly documented</p> <p>7/27/15 6:00 a.m. - BS 105 per interview with the East Wing UM (Unit Manager) on 8/5/15 at 2:30 p.m. - 4 units given</p> <p>8/1/15 4:00 p.m. - BS 214, 4 units given, should have been 8 units.</p> <p>Interview with the East Wing UM on 8/5/15 at 2:30 p.m., indicated the above dates had incomplete documentation of BS results or incorrect insulin doses given.</p> <p>Review of care plans indicated a care plan titled Risk for hyper/ hypoglycemia. The care plan included interventions of medications as indicated and observe blood sugars as indicated.</p> <p>During an observation of Resident #127, on 8/3/15 at 12:05 p.m., a reddish discoloration was noted to the inner right forearm and dark discolorations to the back of both hands.</p> <p>Resident #127 was observed, on 8/5/15 at 9:25 a.m., self propelling his wheelchair down the hall.</p>		<p>assigned Weekly Summary. Any noted skin alterations will be documented and addressed by the Charge Nurse at the time noted. Skin inspections are completed by the nurse aides during routine dressing, toileting, bathing and shower care. Any skin alterations noted will be reported immediately to the Charge Nurse for investigation and follow up. Shower sheets and Weekly Summaries will be reviewed during weekday clinical meetings by the DNS/Nurse Management Team and Nurse Manager/Charge Nurse on the weekend to ensure Weekly Summaries and shower sheets are accurately reflecting any resident skin alterations and that appropriate follow up documentation and assessments are completed per facility policy.</p> <p>· All residents with orders for sliding scale insulin coverage were reviewed to ensure blood glucose results had been accurately obtained and recorded and that sliding scale insulin has been administered per physician order. The Nurse Management Team, Charge Nurses and/or Nurse Manage on the weekend will be responsible for daily review of MARs and Blood Glucose monitoring Records to ensure accuracy with sliding scale insulin coverage.</p> <p>· All residents with medication</p>				

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	<p><b>Discolorations remain to both hands and right forearm.</b></p> <p>The following skin areas were documented upon admission on 6/9/15:                      - right hand bruise: 3 x 2.5 cm - will not be following with weekly measurements                      - left hand bruise: 7.5 x 5 cm - will not be following with weekly measurements                      - left hand 2nd knuckle scabbed area                      - right elbow bruise: 6 x 5 cm - will not be following with weekly measurements</p> <p>The record lacked documentation to indicate the areas were monitored at all after the original admission assessment.</p> <p>Interview, on 8/5/15 at 1:46 p.m., with the RN #2 indicated, "If a new bruise was found or present upon admission, nursing staff charted on it for 72 hours unless there was an issue noted. After that, then staff would not continue to chart. Charting should, however, still reflect current resident areas on the Weekly Skin Assessments instead of charting "none" on the section which reads "Indicate any areas of skin integrity alteration the resident currently has.". Open events charting comes up on printed shift reports, but once events are closed, they do not show up any longer for staff to see. If staff sees a bruise, they could go look up closed events." She indicated she</p>		<p>parameters were reviewed to ensure vital signs have been obtained prior to medication administration and that medications were administered within the ordered parameters. The Nurse Management Team and Nurse Manager/Charge Nurse on the weekend will be responsible for daily review of MARs to ensure medications are administered as ordered.</p> <ul style="list-style-type: none"> <li>All residents with indwelling catheters were reviewed. The DNS/Nurse Management Team and Customer Care Reps through daily rounds will be responsible for ensuring that any resident utilizing an indwelling catheter receives proper care and treatment to prevent infections and to assist with proper placement of catheter tubing to prevent dragging on the floor.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>All nursing staff will be in-serviced on or before 9/10/15. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to the fall management program, <b>care plan review and updating</b>, skin assessments and ongoing monitoring of non-pressure related skin issues.</li> </ul>		

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	<p>agreed if bruises were not currently being monitored through documentation, staff would not necessarily know if bruising was new or old. No Skin System documentation was currently available on the form for 72 hour Admission Assessment charting. She further indicated no documentation of any follow up charting was found for Resident #127's bruising after admission.</p> <p>3. The record for Resident #109 was reviewed on 8/6/15 at 9:14 a.m. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure), depression, anxiety and dementia.</p> <p>The Quarterly MDS (Minimum Data Sheet) assessment, dated 6/26/15, indicated the resident's active diagnoses included, but were not limited to, hypertension.</p> <p>The current Physician's Order Sheet indicated to give enalapril maleate (medication used to treat high blood pressure) 2.5 mg (milligrams) by mouth at bedtime. Hold if B/P (Blood Pressure) less than 120/80.</p> <p>The July and August MAR (Medication Administration Record) indicated on the following dates the blood pressure medication, enalapril maleate was given</p>		<p>This in-service will also include medication administration including obtaining, recording blood glucose results and following physician orders related to sliding scale insulin administration as well as administering medications with physician ordered parameters. The in-service will also review best practices for care and treatment of residents with indwelling catheters.</p> <ul style="list-style-type: none"> <li>· The DNS and/or designee will be responsible for environmental inspections of all resident rooms and equipment to ensure fall prevention interventions are in place and being utilized properly. <b><i>The IDT and Nurse Management Team is responsible for reviewing and updating care plans with any change in resident condition and/or changes in care or treatment.</i></b></li> <li>· The DNS/Nurse Management Team, Nurse Manager and/or Charge Nurse on the weekend will review Weekly Summaries and shower sheets daily to ensure they are accurately reflecting any resident skin alterations and that appropriate follow up documentation and assessments are completed per facility policy.</li> <li>· The Nurse Management Team, Nurse Manager and/or</li> </ul>		

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	<p>at 9 p.m. outside the ordered blood pressure parameter: -7/1/15, B/P: 120/72 -7/2/15, B/P: 120/78 -7/4/15, B/P: 118/70 -7/5/15, B/P: 126/74 -7/8/15, B/P: 114/72 -7/9/15, B/P: 128/78 -7/10/15, B/P: 132/78 -7/12/15, B/P: 134/76 -7/15/15, B/P: 130/70 -7/17/15, B/P: 134/56 -7/18/15, B/P: 72/60 -7/19/15, B/P: 126/72 -7/20/15, B/P: 130/78 -7/28/15, B/P: 100/60 -7/29/15, B/P: 104/60 -7/30/15, B/P: 108/52 -7/31/15, B/P: 130/60 -8/1/15, B/P: 116/82 -8/2/15, B/P: 119/99 -8/3/15, B/P: 111/92 -8/4/15, B/P: 114/72</p> <p>Interview with the West Wing Unit Manager, on 8/6/15 at 10:35 a.m., indicated according to the B/P parameters, the medication should not have been administered on the above dates.</p> <p>4. On 8/6/15 at 5:19 p.m., Resident #142's urinary catheter tubing was observed to be dragging on the floor</p>		<p>Charge Nurse on the weekend will be responsible for daily review of MARs and Blood Glucose monitoring Records to ensure accuracy with sliding scale insulin coverage.</p> <ul style="list-style-type: none"> <li>The Nurse Management Team, Nurse Manager and/or Charge Nurse on the weekend will be responsible for daily review of MARs to ensure medications are administered as ordered.</li> <li>The DNS/Nurse Management Team and Customer Care Reps will be responsible for ensuring that any resident utilizing an indwelling catheter receives proper care and treatment to prevent infections and to assist with proper placement of catheter tubing to prevent dragging on the floor through daily nursing and Customer Care Rounds.</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>The DNS/designee will be responsible for completing the following CQI Audit Tools: "Fall</li> </ul>				

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	<p>while the resident self propelled down the hallway.</p> <p>Resident #142's urinary catheter tubing was observed again on 8/7/15 at 9:06 a.m. dragging on the floor while the resident self propelled in the lobby area.</p> <p>The record for Resident #142 was reviewed on 8/7/15 at 9:11 a.m. The resident's diagnoses included, but were not limited to, urinary obstruction, urine retention and diabetes mellitus.</p> <p>The resident's care plan, dated 9/10/13, indicated the resident requires a suprapubic catheter (indwelling urinary catheter) related to a renal (kidney) disorder. Interventions indicated to not allow tubing or any part of the drainage system to touch the floor.</p> <p>During an observation on 8/7/15 at 9:46 a.m., several staff members socialized with the resident.</p> <p>Interviews with CNA #4, RN #2, and Activity Assistant #1 on 8/7/15 at 9:48 a.m., indicated they had not noticed the urinary catheter tubing was laying on the ground.</p> <p>Interview with the DNS (Director of Nursing Services), on 8/7/15 at 11:08</p>		<p>Program", "<b>Care Plan Updating</b>" "Bruises" and "Catheter" weekly for 4 weeks and then monthly for 6 months. The DNS/designee will review the MARs and Blood Glucose Monitoring Records daily for 4 weeks and weekly for 6 months.</p> <ul style="list-style-type: none"> <li>If threshold of 90% is not met, an action plan will be developed.</li> <li>Findings will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>By what date the systemic changes will be completed:</b></p> <p>Compliance Date = 9/10/15</p>	

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F 0309 SS=D Bldg. 00	<p>a.m., indicated the urinary tubing should not have been touching the ground. She further indicated that staff should have noticed the tube on the ground and removed from the tubing from the floor.</p> <p>Interview again with the DNS, on 8/7/15 at 12:08 p.m., indicated there was not a current policy on infection control related to the urinary catheter tubing dragging on the floor.</p> <p>3.1-35(g)(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, interview and record review, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non-pressure related skin conditions of the 7 residents who met the criteria for non-pressure related skin conditions. (Resident #127)</p>	F 0309	<p><b>F309 – Provide Care/Services for Highest Well-Being</b></p> <p>It is the practice of this provider that each resident receive and be provided with 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</p>	09/10/2015

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	<p>Finding includes:</p> <p>During an observation of Resident #127 on 8/3/15 at 12:05 p.m., a reddish discoloration was noted to the inner right forearm and dark discolorations to the back of both hands.</p> <p>Resident #127 was observed on 8/5/15 at 9:25 a.m. self propelling his wheelchair down the hall. Discolorations remain to both hands and right forearm.</p> <p>Resident #127's record was reviewed on 8/5/15 at 8:27 a.m. Diagnoses included, but were not limited to, vascular dementia with delusions, anxiety, chronic kidney disease, diabetes mellitus, and peripheral vascular disease.</p> <p>The resident's 30 day MDS (Minimum Data Set) assessment, dated 7/5/15, indicated he was severely cognitively impaired.</p> <p>The following skin areas were documented upon admission on 6/9/15: - right hand bruise: 3 x 2.5 cm (centimeters) - will not be following with weekly measurements - left hand bruise: 7.5 x 5 cm - will not be following with weekly measurements</p>		<p>plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>Resident #127's family and physician were notified of the discolorations to the right forearm and back of both hands as well as this resident's blood sugar results with sliding scale insulin coverage. A head to toe assessment was completed on this resident with no other skin alterations noted. This resident has been monitored for bruising per the plan of care.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>All residents are at risk to be affected by this finding.</li> <li>Weekly Skin Assessments will be completed on all residents as well as skin inspections during routine bathing and shower care. Any new skin issues noted such as bruising or discolorations will be promptly investigated and followed up per facility policy. A Non Pressure Skin Evaluation Report will be completed to ensure all skin areas are assessed and monitored closely</li> </ul>				

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	<p>- left hand 2nd knuckle scabbed area - right elbow bruise: 6 x 5 cm - will not be following with weekly measurements</p> <p>The record lacked documentation to indicate the areas were monitored at all after the original admission assessment.</p> <p>Interview, on 8/5/15 at 1:46 p.m., with the RN #2 indicated, "If a new bruise was found or present upon admission, nursing staff charted on it for 72 hours unless there was an issue noted. After that, then staff would not continue to chart. Charting should, however, still reflect current resident areas on the Weekly Skin Assessments instead of charting "none" on the section which reads "Indicate any areas of skin integrity alteration the resident currently has." Open events charting comes up on printed shift reports, but once events are closed, they do not show up any longer for staff to see. If staff sees a bruise, they could go look up closed events." She indicated she agreed if bruises were not currently being monitored through documentation, staff would not necessarily know if bruising was new or old. No Skin System documentation was currently available on the form for 72 hour Admission Assessment charting. She further indicated no documentation of any follow up charting was found for Resident</p>		<p>until resolved.</p> <ul style="list-style-type: none"> <li>· Shower sheets and Weekly Summaries will be reviewed during weekday clinical meetings by the DNS/Nurse Management Team, Nurse Manager and/or Charge Nurse on the weekend to ensure Weekly Summaries and shower sheets are completed and are accurately reflecting any resident skin alterations and that appropriate follow up documentation and assessments are completed per facility policy.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Ongoing compliance with this corrective action will be monitored through the facility CQI Program.</li> <li>· A nursing in-service will be held on or before 9/10/15. The DNS/designee will be responsible for conducting this in-service.</li> <li>· This in-service will include review of the Skin Management Policy.</li> <li>· Shower sheets and Weekly Summaries will be reviewed during weekday clinical meetings by the DNS/Nurse Management Team and Charge Nurse on the weekend to ensure Weekly</li> </ul>	

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F 0315 SS=D Bldg. 00	#127's bruising after admission.  A policy titled "Skin Management Program" was provided by the DON (Director of Nursing) on 8/5/15 at 1:40 p.m. and deemed as current. The policy indicated, ".... Procedure: 1. A head to toe assessment will be completed by a licensed nurse upon admission/ re-admission and weekly ... All alterations in skin integrity will be documented in the medical record...."  3.1-37(a)  483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an		Summaries and shower sheets are completed and are accurately reflecting any resident skin alterations and that appropriate follow up documentation and assessments are completed per facility policy.  <b>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:</b>  · The DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Bruises" daily for 4 weeks and weekly for 6 months to monitor for ongoing compliance.  · If threshold of 90% s not met, an action plan will be developed.  · Findings will be submitted to the CQI Committee for review and follow up.  <b>By what date the systemic changes will be completed:</b>  Compliance Date = 9/10/15		

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	<p>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident with a urinary catheter received necessary treatment and services to prevent urinary tract infections, related to the placement of the urinary catheter tubing for 1 of 4 residents reviewed for urinary catheter use out of the 33 residents that met the criteria for urinary catheter use. (Resident #142)</p> <p>Finding includes:</p> <p>On 8/6/15 at 5:19 p.m., Resident #142's urinary catheter tubing was dragging on the floor while the resident self propelled down the hallway.</p> <p>On 8/7/15 at 9:06 a.m., Resident #142's urinary catheter tubing was dragging on the floor while the resident self propelled in the lobby area.</p> <p>During an observation on 8/7/15 at 9:46 a.m., several staff members socialized with the resident.</p>	F 0315	<p><b>F315 – No Catheter, Prevent UTI, Restore Bladder</b> It is the practice of this provider to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> · Resident #142 is receiving necessary treatment and services related to proper placement of his catheter tubing. This resident experienced no negative outcome as a result of this finding. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> · All residents with indwelling catheters were reviewed. The DNS/Nurse Management Team</p>	09/10/2015

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	<p>The record for Resident #142 was reviewed on 8/7/15 at 9:11 a.m. The resident's diagnoses included, but were not limited to, urinary obstruction, urine retention and diabetes mellitus.</p> <p>The resident was readmitted on 7/13/15, and the Significant Change Minimum Data Set (MDS) assessment completed on 7/22/15, indicated the resident had a indwelling catheter.</p> <p>The resident's care plan, dated 9/10/13, indicated the resident requires a suprapubic catheter (indwelling urinary catheter) related to a renal (kidney) disorder. Interventions indicated to not allow tubing or any part of the drainage system to touch the floor.</p> <p>Interview with CNA #4, RN #2, and Activity Assistant #1 on 8/7/15 at 9:48 a.m., indicated they had not noticed the urinary catheter tubing was laying on the ground.</p> <p>Interview with the DNS (Director of Nursing Services) on 8/7/15 at 11:08 a.m., indicated the urinary tubing should not have been touching the ground. She further indicated that staff should have noticed the tube on the ground and removed from tubing from the floor.</p>		<p>and Customer Care Reps will be responsible for ensuring that any resident utilizing an indwelling catheter receives proper care and treatment to prevent infections and to assist with proper placement of catheter tubing to prevent dragging on the floor during daily rounds. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> · All nursing staff will be in-serviced on or before 9/10/15. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to care and treatment of residents with indwelling catheters including proper place of catheter tubing at all times. · The DNS/Nurse Management Team and Customer Care Reps will be responsible for ensuring that any resident utilizing an indwelling catheter receives proper care and treatment to prevent infections and to assist with proper placement of catheter tubing to prevent dragging on the floor during daily rounds. <b>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:</b> · Ongoing compliance with this corrective action will be monitored through the facility CQI program. · The DNS/designee will be responsible</p>		

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F 0323 SS=D Bldg. 00	<p>Interview with the DNS on 8/7/15 at 12:08 p.m., indicated there was not a current policy on infection control related to the urinary catheter tubing dragging on the floor.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for 1 of 4 residents reviewed for accidents of the 4 who met the criteria for accidents. (Resident #98)</p> <p>Finding includes:</p> <p>On 8/6/15 at 4:56 p.m. Resident #98 was seated in his wheelchair in his room. There was no alarm observed in place to his wheelchair.</p>	F 0323	<p>for completing the following CQI Audit Tools: "Catheter" weekly for 4 weeks and then monthly for 6 months. The DNS/designee will review the MARs and Blood Glucose Monitoring Records daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance Date = 9/10/15</p> <p><b>F323 – Free of Accident Hazards/Supervision/Devices</b></p> <p>It is the practice of this facility 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><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p>	09/10/2015

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	<p>On 8/7/15 at 2:43 p.m. Resident #98 was seated in his wheelchair in his room. There was no alarm observed in place to his wheelchair.</p> <p>Interview with Resident #98 on 8/7/15 at 2:43 p.m. indicated he did not have an alarm for his wheelchair. He indicated he did not have one because he did not need one and did not try to get up unassisted anymore.</p> <p>The record for Resident #98 was reviewed on 8/6/15 at 2:20 p.m. The resident's diagnoses included, but were not limited to, hypertension, arthritis and depressive disorder.</p> <p>The Significant Change Minimum Data Set assessment, dated 7/10/15, indicated the resident was cognitively intact.</p> <p>A Progress Note, dated 7/8/15, indicated the resident was found sitting on the bathroom floor and had attempted to transfer himself from the toilet.</p> <p>A Progress Note, dated 7/9/15, indicated the Interdisciplinary Team (IDT) had met to discuss the resident's fall on 7/8/15. The note further indicated the Physician had been notified and a new order for a personal alarm to the wheelchair was received.</p>				<ul style="list-style-type: none"> <li>· Resident #98's care plan has been reviewed and all current fall interventions are in place and being followed per MD order. This resident experienced no negative outcome as a result of this finding.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· All resident fall care plans will be reviewed by the Nurse Management Team. The prevention interventions on each resident's fall care plan will be compared to the physician's orders and Resident Profile to ensure all safety and fall interventions are in place and properly being utilized.</li> <li>· The DNS and/or designee will be responsible for environmental inspections of all resident rooms and equipment.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· All nursing staff will be in-serviced on or before 9/10/15. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to the fall management</li> </ul>		

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	<p>The August 2015 Physician Order Summary indicated an order for a wheelchair alarm and to check function and placement every shift.</p> <p>The August 2015 Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated the wheelchair alarm had been signed off as in place and functioning every shift.</p> <p>Resident #98 had a care plan for risk for falls. The nursing interventions included "...personal alarm to chair, check placement and function every shift..."</p> <p>Interview with CNA #3, on 8/10/15 at 2:20 p.m., indicated she was unsure if the resident was to have a wheelchair alarm in place. She indicated he had not had any falls that she was aware of and did not think he had a chair alarm.</p> <p>Interview with RN #1, on 8/7/15 at 2:51 p.m., indicated she was not sure why the chair alarm was not in place. She indicated the chair alarm should have been in place and she would put one in place immediately.</p> <p>3.1-45(a)(2)</p>		<p>program and the importance of following all fall prevention interventions per each resident's individual plan of care.</p> <ul style="list-style-type: none"> <li>The DNS and/or designee, Charge Nurses and/or Weekend Nurse Manager will be responsible for environmental inspections of all resident rooms and equipment to ensure fall prevention interventions are in place and being utilized properly during daily rounds.</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>The DNS/designee will be responsible for completing the following CQI Audit Tools: "Fall Program" weekly for 4 weeks and then monthly for 6 months.</li> <li>If threshold of 90% is not met, an action plan will be developed.</li> <li>Findings will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>By what date the systemic</b></p>				

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F 0368 SS=E Bldg. 00	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents' were offered snacks daily at bedtime. This potentially affected 51 of 60 residents with oral diet orders for evening snack, who resided in the healthcare facility. This included Resident #E and Resident #F.</p> <p>Findings include: During on observation on 8/7/15 at 5:02 a.m., outside the kitchen door were 51 evening snacks or drinks labeled "eve</p>	F 0368	<p><b>changes will be completed:</b></p> <p>Compliance Date = 9/10/15</p> <p><b>F368 – Frequency of Meals/Snacks at Bedtime</b></p> <p>It is the practice of this provider to offer nourishing snacks at bedtime daily.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>All residents are being</p>	09/10/2015

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	<p>8/6/15" with the resident's name, room number and diet order in several metal serving containers.</p> <p>Interview with Dietary Manager on 8/7/15 at 7:12 a.m., indicated eve snacks are prepared earlier in the day and labeled with the resident's name, room number and diet order. If the snacks and drinks are not consumed, the snacks and drinks are brought back to the kitchen in the metal serving containers to be dumped in the garbage. He further indicated that eve (evening) and hs (bedtime) snacks are labeled the same.</p> <p>Interview with the DNS (Director of Nursing Services) on 8/7/15 at 7:32 a.m., indicated the kitchen staff delivers the evening snacks to each unit after 7 p.m. The CNA's and Nursing staff distribute the snacks to the residents as indicated on each label. The nurse then documents in the MAR (Medication Administration Record) on the percentage of the snack consumed.</p> <p>An interview with Resident #E on 8/7/15 at 9:44 a.m., indicated he was not offered a snack last night.</p> <p>The record for Resident #E was reviewed on 8/7/15 at 9:30 a.m. The Quarterly MDS (Minimum Data Set) assessment completed on 6/17/15, indicated the resident is cognitive.</p> <p>Interview with Resident #F on 8/7/15 at 9:45 a.m., indicated she was not offered a</p>		<p>offered bedtime snacks.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by this finding.</li> <li>· A facility audit will be completed by the Nurse Management Team. This audit will review all residents with oral diet orders for evening snacks.</li> <li>· The Nurse Management Team/designee will be responsible for daily review of MARs to ensure evening snacks are offered and that consumption of evening snacks is being documented.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· A mandatory nursing in-service will be conducted by the DNS/designee on or before 9/10/15.</li> <li>· This in-service will include review of the facility policy related to evening snack distribution and documentation of consumption on the MAR.</li> </ul>				

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	<p>snack last night.</p> <p>The record for Resident #F was reviewed on 8/7/15 at 9:31 a.m. The Significant Change MDS assessment completed on 6/12/15, indicated the resident was cognitive.</p> <p>A policy titled, "Bedtime Snacks," was provided by the East Wing Manager on 8/7/15 at 8:41 a.m. and deemed as current. The policy indicated, "...PROCEDURE...2. H.S. snacks must be offered and documented on the Medication Administration Record (MAR)...."</p> <p>This Federal Tag relates to Complaint IN00176387. 3.1-21(e)</p>		<ul style="list-style-type: none"> <li>· The Nurse Management Team/designee will be responsible for daily review of MARs to ensure evening snacks are offered and that consumption of evening snacks is being documented.</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>· Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>· The DNS/designee will be responsible for completion of the CQI Audit Tool titled, "HS Snacks" daily for 4 weeks and weekly for 6 months to monitor for ongoing compliance.</li> <li>· If threshold of 90% is not met, an action plan will be developed.</li> <li>· Findings will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>By what date the systemic changes will be completed:</b></p> <p>Compliance Date = 9/10/15</p>	

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F 0371 SS=E Bldg. 00	<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 store and label food properly in the refrigerator and the dry storage area, maintain complete food and refrigerator temperature and sanitization logs and failed to serve food at the proper temperature for 1 of 1 kitchens observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During initial tour on 8/3/15 from 9:14 a.m. until 9:50 a.m. with the Dietician Consultant and the Dietary Manager, the following was observed: <ol style="list-style-type: none"> <li>a. In the refrigerator, orange juice and milk crates were stored on the floor.</li> <li>b. In the freezer, 2 packages of french fries and a package of fish was undated and exposed to air. A container of ice cream was opened and exposed to the air.</li> <li>c. In the dry storage area, a pan of cornbread was unlabeled and undated.</li> </ol> </li> </ol>	F 0371	<p><b>F371 – Food Procure, Store/Prepare/Serve – Sanitary</b></p> <p>It is the practice of this provider to:</p> <ol style="list-style-type: none"> <li>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</li> <li>(2) Store, prepare, distribute and serve food under sanitary conditions</li> </ol> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice:</b></p> <ul style="list-style-type: none"> <li>· Orange juice and milk crates are no longer being stored on the floor.</li> <li>· The 2 packages of french fries and a package of fish identified during the tour have been discarded.</li> <li>· The pan of cornbread in the dry storage area identified during</li> </ul>	09/10/2015

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	<p>Interview with the Dietician Consultant on 8/3/15 during the time of the initial tour, indicated all foods should have a label, closed and dated.</p> <p>Interview with the Dietary Manager on 8/3/15 at the time of the initial tour, indicated nothing should be stored on the floor, the orange juice and the milk should have been stored on the bottom shelf.</p> <p>d. Review of the food temperature logs were incomplete with the following dates missing food temperatures:                      -5/8/15, dinner                      -5/1/15, lunch                      -4/21/15,lunch                      -4/13/15, breakfast and lunch                      -4/17/15, dinner                      -4/18/15, breakfast and lunch                      -4/19/15, breakfast and lunch                      -4/10/15, breakfast and lunch                      -4/11/15, breakfast and lunch                      -4/5/15, dinner                      -4/3/15, breakfast                      -4/1/15, breakfast                      -3/31/15, breakfast and lunch                      -3/30/15, breakfast and lunch                      -3/28/15, breakfast and lunch                      -3/27/15, breakfast and lunch                      -3/24/15, breakfast and lunch                      -3/23/15, breakfast and lunch                      -3/19/15, lunch and dinner</p>		<p>the tour has been discarded.</p> <ul style="list-style-type: none"> <li>· All food is being stored and labeled properly in the refrigerator and dry storage areas.</li> <li>· All food and refrigerator temperatures are being properly obtained and accurately recorded on the logs.</li> <li>· All Sanitization Logs are being properly maintained.</li> <li>· All food is being properly served at appropriate temperatures.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by this finding.</li> <li>· Dietary Staff is utilizing proper technique and sanitary conditions for food storage.</li> <li>· Food and Refrigerator Temperature Logs are being recorded by Dietary Staff per policy.</li> <li>· Dietary Staff is completing the Sanitation Logs per policy.</li> <li>· All food is being prepared and served to residents at proper</li> </ul>	

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	<p>-3/16/15, breakfast, lunch and dinner -3/15/15, breakfast, lunch and dinner -3/13/15, breakfast, lunch and dinner -3/12/15, breakfast, lunch and dinner -3/11/15, dinner -3/10/15, dinner -3/9/15, dinner -3/2/15, breakfast</p> <p>e. Review of the freezer, milk cooler-door side, milk cooler-window side, reach in cooler window serving, reach in cooler prep area and the walk in cooler temperature logs were incomplete with the following dates and times: -7/17/15, 5 a.m. -7/18/15, 5 a.m. -7/19/15, 7 p.m. -7/20/15, 5 a.m. and 7 p.m. -7/21/15, 7 p.m. -7/22/15, 7 p.m. -7/23/15, 7 p.m. -7/24/15, 5 a.m. and 7 p.m. -7/25/15, 5 a.m. and 7 p.m. -7/26/15, 7 p.m. -7/28/15, 7 p.m. -7/29/15, 7 p.m.</p> <p>f. Review of the sanitizing bucket concentration logs were incomplete on the following dates and times: -7/17/15, 6 a.m. -7/18/15, 6 a.m. -7/19/15, 1 p.m. and 5 p.m.</p>		<p>temperatures.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· A Dietary staff in-service will be conducted by ED/DNS/designee on or before 9/10/15.</li> <li>· This in-service will include review of the policy related to food storage practices, maintenance of Refrigerator Temperature and Sanitation Logs and General Food Preparation and Handling related to serving food at proper temperatures.</li> <li>· The DM/designee is responsible for checking Food and Refrigerator Temperature Logs daily to ensure accurate recording.</li> <li>· Sanitation Logs are checked daily by the DM/designee to ensure sanitizing bucket concentration logs are completed per policy.</li> <li>· DM/designee will check food temperatures prior to each meal service daily to ensure all food is being served at acceptable temperatures.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the</b></p>	

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	<p>-7/20/15, 6 a.m., 1 p.m. and 5 p.m. -7/21/15, 1 p.m. and 5 p.m. -7/24/15, 6 a.m., 1 p.m. and 5 p.m. -7/25/15, 6 a.m., 1 p.m. and 5 p.m. -7/26/15, 1 p.m. and 5 p.m. -7/28/15, 1 p.m. and 5 p.m. -7/29/15, 1 p.m. and 5 p.m. -7/30/15, 6 a.m., 1 p.m. and 5 p.m. -7/31/15, 6 a.m., 1 p.m. and 5 p.m.</p> <p>Interview with Dietary Manager on 8/3/15 during the initial tour indicated the logs were incomplete and should have been completed at the times on the logs.</p> <p>2. On 8/6/15 at 11:59 a.m., the puree layered salad was tempted by the Dietary Manager at 43 degrees Fahrenheit and the mechanical layered salad was tempted at 44 degrees Fahrenheit.</p> <p>Observation on 8/6/15 at 12:20 p.m., the pureed and mechanical soft layered salads were served at the improper temperatures.</p> <p>Interview with Dietary Manager on 8/6/15 at 12:20 p.m., indicated the layered salad should not have been served at that temperature, it was too warm. He indicated it should have been cooled down to serve at 41 degrees Fahrenheit.</p>		<p><b>deficient practice will not recur; i.e., what quality assurance program will be put into place:</b></p> <ul style="list-style-type: none"> <li>Ongoing compliance with this corrective action will be monitored through the facility CQI Program.</li> <li>The DM/designee will be responsible for completion of the CQI Audit Tool titled, "Weekly Temp Record" with each meal for 6 months to monitor for ongoing compliance.</li> <li>The DM/designee will be responsible for checking Food and Refrigerator Temperature Logs as well as Sanitation Logs daily to ensure Logs are completed daily and checklists are completed as assigned.</li> <li>If threshold of 90% is not met, an action plan will be developed. If threshold of 100% is not met related to Food Temps, an action plan will be developed.</li> <li>Findings will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>By what date the systemic changes will be completed:</b></p> <p>Compliance Date = 9/10/15</p>	

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	<p>A policy titled, "Food Storage," provided by the Dietary Consultant on 8/3/15 at 10:20 a.m. and deemed as current. The policy indicated, "...PROCEDURE...3. Food items will be stored on shelves, with heavier and bulkier items stored on lower shelves...15. Refrigeration:...f) All foods should be covered or wrapped tightly, labeled and dated...16. Frozen Foods:...d) Foods should be covered or wrapped tightly, labeled and dated.</p> <p>A policy titled, "Cleaning Cloths, Mops and Buckets," provided by the Dietary Consultant on 8/4/15 at 3:00 p.m. and deemed as current. The policy indicated, "...PROCEDURE...4....The solution will be tested and documented at a minimum of 3 times daily..."</p> <p>A policy titled, "Food Temperatures," provided by the Director of Nursing Services on 8/7/15 at 8:15 a.m. and deemed as current. The policy indicated, "...PROCEDURE 1. Hot foods that are potentially hazardous will leave the kitchen (or steam table) at or above 13 degrees Fahrenheit, and cold foods at or below 41 degrees Fahrenheit."</p> <p>This Federal Tag relates to Complaint IN00176387.</p> <p>3.1-21(a)(2)</p>			

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F 0465 SS=E Bldg. 00	<p>3.1-21(i)(2) 3.1-21(i)(3)</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 the resident's environment was clean and in good repair related to dented closet doors, unsafe windowsill corners, dirty privacy curtains and pooled water on the floor for 2 of 2 wings. (East Wing and West Wing)</p> <p>Findings include:</p> <p>On 8/11/15 from 10:11 a.m. until 10:50 a.m., the following was observed on the Environmental Tour with the Maintenance Manager:</p> <p>1. East Wing</p> <p>a. In Room #108, the windowsill's corners chipped and had an exposed staple. There were two residents who resided in this room.</p> <p>b. In Room #132, the closet door was marred. There was one resident who</p>	F 0465	<p><b>F465 – Safe/Functional/Sanitary/Comfortable/Environment</b> It is the practice of this provider to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> · Dented and marred closet doors and walls identified during the tour have been either repaired or replaced - #132, #133, #137, #210 · <b>The inside of the bathroom door has been repaired in room #207</b> · <b>The inside and the outside of the bathroom door has been repaired in room #248</b> · Unsafe windowsill corners identified during the tour have been repaired – Room #108, · Dirty privacy curtains identified during the tour have been properly cleaned – Room #221, #222 · Pooled water that was noted on the floor during the tour has been</p>	09/10/2015

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	<p>resided in this room.</p> <p>c. In Room #133, the closet door marred and dented, and part of the wall near the closet door was marred/coming away from cove base. There were two residents who resided in this room.</p> <p>d. In Room #137, the room door handle was loose. There was on one resident who resided in this room.</p> <p>e. In Room #146, the caulking between the sink and the wall was cracked. There were two residents who resided in this room.</p> <p>2. West Wing</p> <p>a. In Room #207, the inside of the bathroom door was marred. There were three residents who share this bathroom.</p> <p>b. In Room #210, the inside of the bathroom door was marred. There were four residents who share this bathroom.</p> <p>c. In Room #227, a water puddle was observed on the floor, to the right of the toilet. There were four residents who shared this bathroom.</p> <p>d. In Room #248, the inside and the outside of the bathroom door was marred.</p>		<p>addressed and cleaned up – Room #227 · The room door handle was repaired in room #137. · The caulking between the sink and the wall was repaired in room #146. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> · All residents have the potential to be affected by this finding. · All closet doors, unsafe windowsill corners, dirty privacy curtains, resident room flooring, room door handles and caulking between the sink and wall have been observed for the above listed concerns and all repairs were made where needed. · The ED/Maintenance/designee will conduct Environmental Inspections no less than five times per week. · These Environmental Inspections will include inspections/observations of all resident rooms, bathrooms and common areas in need of repair. · Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. · The ED/designee will review Maintenance Logs/Requests and Housekeeping Request to ensure all necessary repairs, cleaning and/or corrections have been</p>	

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	<p>There were two residents who resided in this room.</p> <p>e. In Room #221, there were black marks on the privacy curtain by bed #1. There were two residents who resided in this room.</p> <p>f. In Room #222, both privacy curtains were dirty and were stained. There were two residents who resided in this room.</p> <p>Interview on 8/11/15 with the Maintenance Manager during the tour, indicated all areas were in need of repair or in needed to be cleaned.</p> <p>3.1-19(f)</p>		<p>completed. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> · A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 9/10/15. · This in-service will include review of the facility policy related to notification to the Maintenance Department for repair or maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment. · The facility will conduct Environmental Inspections no less than five times per week. These Environmental Inspections will include inspections/observations of all resident rooms, bathrooms and common areas. Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. · The ED/designee will review Maintenance Logs/Requests and Housekeeping Requests to ensure all necessary repairs and corrections have been completed. <b>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:</b> · Ongoing compliance with this corrective</p>	

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			<p>action will be monitored through the facility CQI program. To ensure ongoing compliance with this corrective action and to ensure the environment is safe/functional/sanitary and comfortable, the ED/DNS/designee will be responsible for completion of the CQI tool titled "Quality Control Inspection-Housekeeping" no less than five times per week for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance Date = 9/10/15</p>		