

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/22/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODBRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 816 N FIRST AVE EVANSVILLE, IN47710
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F0000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of Complaint number IN00099851.</p> <p>Complaint number IN00099851: Substantiated, No deficiencies related to the allegation are cited.</p> <p>Survey dates: November 16, 17, 18, 21, 22, 2011</p> <p>Facility number: 000438 Provider number: 155390 AIM number: 100274170</p> <p>Survey team: Amy Wininger, RN, TC Diane Hancock, RN Vicki Ellis, RN Barbara Fowler, RN</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 4 Medicaid: 49 Other: 1 Total: 58</p>	F0000	<p>Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.</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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F0282 SS=D	<p>Sample: 15 Supplemental sample: 12</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/29/11 Cathy Emswiller RN</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 interview and record review, the facility failed to ensure the written plan of care was followed, for 1 of 15 sampled residents, in that medication orders were not transcribed properly and a resident did not receive medication as ordered. (#13)</p> <p>Findings include:</p> <p>The clinical record for Resident #13 was reviewed on 11/17/11 at 11:50 A.M. The clinical record indicated the diagnoses of Resident #13 included, but were not limited to, COPD [Chronic Obstructive Pulmonary Disease], Chronic Pain, Type 1 Diabetes, and Schizophrenia.</p>	F0282	<p>F282</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <ul style="list-style-type: none"> ·R13'S medical record was reviewed, physician notified and medication order corrected. <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <ul style="list-style-type: none"> ·Medical records were reviewed to ensure all orders 	12/16/2011	

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	<p>The October 2011 Physician's Recap indicated an order for, "Benztropine Mesylate [Cogentin-a medication for anti-parkinsonism symptoms] 0.5 mg [milligram] by mouth-once daily in the evening."</p> <p>A Behavioral Health Progress Note provided by the DoN [Director of Nursing], on 11/18/11 at 2:00 P.M. and dated 10/06/11, indicated, "Change Cogentin to 0.5 mg po [by mouth] TID [three times daily]."</p> <p>The Medication Administration Record [MAR] for October 2011 indicated Resident #13 received Cogentin 0.5 mg daily from October 8, 2011 through October 31, 2011 [twenty four days]. The MAR for November 2011 indicated Resident #13 received Cogentin 0.5 mg daily from November 1 through November 20, 2011 [twenty days].</p> <p>In an interview with the DoN on November 18, 2011 at 1:50 P.M., the DoN indicated, "the order, change Cogentin to 0.5 mg TID, was not transcribed right."</p> <p>In an interview with the DoN on November 21, 2011 at 3:15 P.M., the DoN indicated he forgot to change the</p>		<p>were transcribed correctly.</p> <ul style="list-style-type: none"> ·Nursing staff in-serviced on 12-1-2011 & 12-6-11 regarding transcription of orders. <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <ul style="list-style-type: none"> ·DNS/Designee will review new orders daily to ensure that orders were transcribed correctly using the match back procedure. <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <ul style="list-style-type: none"> ·DNS/Designee will audit the results of the match back procedure three (3) times a week for four (4) weeks, then two (2) times a week for three (3) months, to ensure orders are being transcribed correctly. ·The data will be analyzed for patterns and trends and action plans will be written and implemented as needed ·DNS/Designee will review the results of the match back procedure, trends, and action plans, and report findings at monthly QA meetings for three (3) months. ·The QA Committee will 		

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F0312 SS=D	<p>order on the computer and on the MAR for November.</p> <p>The policy and procedure for Medication Administration received on November 11, 2011 at 3:20 P.M. from the DoN indicated, "the policy is medications are administered as prescribed."</p> <p>3.1-35(g)(2)</p> <p>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 3 of 7 residents reviewed, who were dependent for hygiene and bathing, in the sample of 15, received showers as scheduled and/or desired, in that the showers were not routinely provided. (Residents #31, #29, #57)</p>	F0312	<p>evaluate and compliance with F-282 via the monthly DNS/Designee reports.</p> <p>·QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months.</p> <p>Date of Compliance 12/16/2011</p> <p>F312</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>·R31, R29 and R57's shower schedule was reviewed and shower schedule was revised to ensure that residents will</p>	12/16/2011	

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	<p>Findings include:</p> <p>1. The clinical record of Resident #31 was reviewed on 11/16/11 at 9:55 A.M. The clinical record indicated the diagnoses included, but were not limited to, "Rheumatoid Arthritis."</p> <p>During initial tour on 11/16/11 at 9:55 A.M., Resident #31 was observed in his room, sitting in a wheelchair. During an interview with RN #1, at that time, RN #1 indicated Resident #31 was interviewable.</p> <p>The most recent MDS [Minimum Data Set Assessment], dated 09/16/11, indicated Resident #31 required extensive assistance of two staff for hygiene and bathing. The MDS further indicated Resident #31 had mild cognitive impairment.</p> <p>During an interview on 11/17/11 at 1:40 P.M., Resident #31 was queried about receiving showers. At that time, Resident #31 indicated, "I never receive a shower...only get one to two showers every two weeks...they usually tell me they are too busy..." During observation at that time, Resident #31 was observed to have very dry flaking skin on his legs.</p> <p>The September 2011 Activities of Daily Living [ADL] Flow Sheet lacked any</p>		<p>receive showers twice a week.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <ul style="list-style-type: none"> ·Alert residents were interviewed and shower schedule was revised to meet their requests. ·Facility shower schedules were reviewed and revised to ensure that residents receive showers twice a week ·Facility staff in-serviced on 11-24-11 & 12-6-2011 regarding the shower schedule revision. <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <ul style="list-style-type: none"> ·DNS/Designee will audit the showers given three (3) times weekly for four (4) weeks, then two (2) times a week for three (3) months. <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <ul style="list-style-type: none"> ·DNS/Designee will audit the showers given three times weekly for four (4) weeks, then two (2) times a week for three 				

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	<p>documentation that Resident #31 had received a shower.</p> <p>The October 2011 Activities of Daily Living [ADL] Flow Sheet lacked any documentation that Resident #31 had received a shower.</p> <p>During an interview on 11/18/11 at 11:05 A.M., CNA #1 indicated, "Yes, he [Resident #31] gets a shower whenever he asks for one."</p> <p>2. Resident #57's clinical record was observed on 11/16/11 at 11:40 a.m. The resident's Annual Minimum Data Set [MDS] assessment, dated 6/29/11, and the Quarterly MDS assessment, dated 10/20/11, indicated he required total assistance of one staff person for bathing.</p> <p>During interview with CNA #1 on 11/21/11 at 2:42 p.m., she indicated Resident #57 had a shower on Saturday, 11/19/11 and she thought his shower days were Tuesday and Saturday.</p> <p>The shower schedule for Resident #57 was provided by the Admissions Coordinator on 11/16/11 at 10:30 a.m. The schedule indicated he was to receive</p>		<p>(3) months</p> <ul style="list-style-type: none"> ·The data will be analyzed for patterns and trends and action plans will be written and implemented as needed ·DNS/Designee will review the results of the shower audits, trends, and action plans, and report findings at monthly QA meetings for three (3) months. ·The QA Committee will evaluate and compliance with F-312 via the monthly DNS/Designee reports. ·QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months. 				

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	<p>showers on Mondays and Thursdays.</p> <p>Review of the resident's ADL [activities of daily living] Flow Sheet Log for October 2011 through November 21, 2011, indicated the resident failed to receive a shower on the following scheduled dates:</p> <p>10/3/11 Monday 10/6/11 Thursday 10/10/11 Monday 10/13/11 Thursday 10/17/11 Monday 10/20/11 Thursday 10/24/11 Monday 10/27/11 Thursday 10/31/11 Monday 11/3/11 Thursday 11/7/11 Monday 11/10/11 Thursday 11/14/11 Monday 11/17/11 Thursday</p> <p>3. Resident #39's clinical record was reviewed on 11/17/11 at 1:45 p.m. The resident's Annual MDS [Minimum Data Set Assessment] assessment dated 12/7/10, and the Quarterly MDS dated 8/11/11, indicated the resident required total assistance of one person for hygiene and bathing.</p> <p>CNA #1 indicated during interview on 11/21/11 at 2:40 p.m., they usually gave</p>				

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	<p>Resident #39 a good bed bath due to her contractures.</p> <p>The shower list, provided by the Admissions Coordinator on 11/16/11 at 10:30 a.m., indicated Resident #39 was scheduled for showers on Mondays and Thursdays.</p> <p>Review of the resident's ADL Flow Sheet Log for October 2011 through November 21, 2011, indicated the resident had not received a shower during that time.</p> <p>Interview with the Director of Nurses on 11/21/11 at 4:30 p.m. indicated he didn't know why they wouldn't give the resident a shower.</p> <p>The policy and procedure of ADL care was requested on 11/22/11 at 10:50 A.M.. The DoN [Director of Nursing] at that time, there was no specific policy for ADL care.</p> <p>3.1-38(a)(3)</p>				

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F0356 SS=C	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure staffing information was posted, for 4 of 4 days the staffing posting was reviewed (11/16, 11/17, 11/18, 11/21/11). This had the potential to affect 58 of 58 residents and/or their families who reside in the facility census of 58.</p>	F0356	<p>F356 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <ul style="list-style-type: none"> ·The staffing schedule was immediately posted on 11/21/11. Other residents having the 	12/16/2011	

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	<p>Findings include:</p> <p>During the environmental tour on 11/21/11 at 11:00 A.M., the posting for daily staffing was not observed.</p> <p>During an interview on 11/21/11 at 11:15 A.M., the DoN [Director of Nursing] indicated there was not a daily staffing posting and had not been on 11/16, 11/17, 11/18, and 11/21/11.</p> <p>In an interview with the Regional Nurse Consultant on 11/21/11 at 2:35 P.M., she indicated there was no specific policy and procedure for the posting the daily staffing information and "we should be following the Federal regulation."</p> <p>3.1-13(a)</p>		<p>potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <ul style="list-style-type: none"> ·The staffing schedule was immediately posted on 11/21/11. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: <ul style="list-style-type: none"> ·Staffing schedule was posted immediately on 11/21/11. DNS/Designee will ensure the staffing schedule is posted daily. ·The Manager of the Day (MOD) will ensure the staffing schedule is posted on week ends and holidays. ·Staffing schedule will be added to MOD list for week end duty. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: <ul style="list-style-type: none"> ·DNS/Designee will audit the staffing schedule is posted three (3) times weekly for four (4) weeks, then two (2) times a week for three (3) months <ul style="list-style-type: none"> ·The data will be analyzed for patterns and trends and action plans will be written and implemented as needed ·The ED/DNS/Designee will 		

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F0363 SS=E	<p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure menus were followed for 2 of 10 residents on selective menus (#45, #3), for 4 of 4 lunch trays observed who requested alternates (#7, #40, #42, #37), and for 8 of 8 residents served pureed diets (#8, #24, #26, #22, #49, #50, #56, #61), in that a resident requested an item on the selective menu and was provided something else, the alternate for a meal was not prepared, and the recipe for pureed diets was not followed.</p> <p>Findings include:</p>	F0363	<p>ensure that the staffing schedule is posted daily.</p> <ul style="list-style-type: none"> -DNS/Designee will review the results of the audits, trends, and action plans, and report findings at monthly QA meetings for three (3) months. -The QA Committee will evaluate and compliance with F-356 via the monthly DNS/Designee reports. -QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months. <p>F363 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <ul style="list-style-type: none"> -Menus will meet the nutritional needs of the residents, be prepared in advance and followed as written. -Corrective action was immediately conducted by the DSM by providing education with the cook on duty on following menus, including selective menus, spreadsheets & recipes. Resident #45 was provided grilled steak for lunch on 	12/16/2011

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	<p>1. On 11/18/11 at 12:25 p.m., the 300 unit meal delivery was observed. Resident #45 was observed to receive his meal. His printed out tray card indicated he had ordered the alternate entree, grilled steak. His plate was observed to have Turkey Tetrazzini for the entree. Resident #3 was served the alternate of baked Tator Tots. The menu, dated 11/18/11, and reviewed on 11/18/11 at 12:25 p.m., indicated ketchup was to be served with the Tator Tots and he did not receive any ketchup.</p> <p>2. On 11/21/11 at 9:35 a.m., Cook #1 was observed to prepare the puree meat for the noon meal 11/21/11. She had one bag of "Beef Hamburger Puree" in a bowl. She was following the recipe for "SS Pur Pork." The recipe was reviewed at that time and called for 2 cups of water with 2 teaspoons Base Chicken Low Sodium, 2 1/2 pounds of Pork Puree Pot Roast Cooked, Enhancer Natural Puree Shaper 1 1/3 cups, Spice Garlic Granulated 3/4 teaspoon, and Spice Thyme Ground 3/4 teaspoon. The Cook combined the Beef Hamburger Puree with the water combined with 3/4 teaspoon of Beef Base, Enhancer Natural Puree Shaper 1 1/3 cups, Spice Onion Granulated 3/4 teaspoon, and Spice Thyme Ground 3/4 teaspoon.</p>		<p>11/18/11 after turkey tetrazzini was initially served. Resident #3 was provided ketchup for the tator tots for lunch on 11/18/11; selective menu did not indicate request for ketchup initially.</p> <p>-In-service was given to all cooks and diet aides on following menus and spreadsheets as written, selective menus, and the Living Centers Policy on preparation responsibilities. Completed: 12/8/2011</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>-The Dietary Services Manager will monitor five (5) times per week for four (4) weeks, then two (2) times a week for three (3) months the following</p> <p>-tray line for menu selection compliance</p> <p>-spreadsheets to the written menu compliance</p> <p>-standard recipes- especially with pureeing compliance</p> <p>-The DSM will monitor tray tickets daily for completeness five (5) times per week for four (4) weeks, then two (2) times a week for three (3) months.</p> <p>-The Registered Dietitian</p>		

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	<p>Review of the 11/21/11 menu, on 11/21/11 at 11:30 a.m., indicated Roast beef was substituted for Roast Pork for regular diets, controlled carbohydrate diets, and mechanical soft diets. The Dietitian indicated, at that time, puree diets were supposed to have received pork, as their puree meat came pre-made.</p> <p>A list of puree diets was provided by the Dietary Service Manager on 11/22/11 at 8:30 a.m. The list indicated the following residents received puree diets: #8, #24, #26, #22, #49, #50, #56, #61.</p> <p>3. The tray line was observed on 11/21/11 from 11:35 a.m. to 12:15 p.m. The following residents' tray cards indicated they were to be served the alternate vegetable, California Blend Vegetables: Residents #7, #40, #42, #37. The cook indicated she had not prepared the California Blend Vegetables. The Dietitian and Cook decided to slice some tomatoes to serve the residents who were to be served the California Blend Vegetables.</p> <p>4. The Resident Council Minutes were reviewed on 11/21/11 at 3:35 p.m. The following concerns were noted: 5/2/11 2:00 p.m. "Cannot get alternates." 10/5/11 2:00 p.m. "They don't have items on alternate menu and they run out of</p>		<p>during visits will monitor for menu/spreadsheet compliance.</p> <ul style="list-style-type: none"> ·The data will be analyzed for patterns and trends, with action plans be written and implemented as needed. ·DSM/Designee will review the results of the audits, trends, and action plans, and report findings at monthly QA meetings for three (3) months. ·The QA Committee will evaluate and compliance with F-363 via the monthly DSM/Designee reports. ·QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months. 		

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F0371 SS=E	<p>dessert."</p> <p>5. The Director of Nurses provided a policy and procedure for "Preparation Responsibilities," no date, on 11/21/11 at 3:20 p.m. The policy and procedure included, but was not limited to, the following: "The Director of Dining or designee will see that food items are prepared according to standardized recipes and in sufficient quantity using correct methods. Recipes are provided for the current menus and should be accessible to, and used by, the Dining Services department..."</p> <p>3.1-20(i)(4)</p> <p>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, interview and record review, the facility failed to ensure food was stored and prepared under sanitary conditions, for 1 of 1 kitchen observed. This had the potential to affect 54 residents who consumed meals in the facility.</p>	F0371	<p>F371 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: ·The facility will store, prepare, distribute and serve food under sanitary conditions.</p>	12/16/2011	

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	<p>Findings include:</p> <p>1. During the initial kitchen tour on 11/16/11 at 9:35 a.m., the following observations were made: 1 of pans observed had numerous deep pits on the cooking surface. Boxes were observed stored on the floor of the walk-in freezer. Gnats were observed flying around the food storage area.</p> <p>2. On 11/21/11 at 8:50 a.m., a box with a plastic bag full of strawberries was observed setting on a sink ledge in the food preparation area. The strawberries were frozen. Cook #1 indicated, "the strawberries are for tomorrow...when I get done here I'm going to put them up..."</p> <p>On 11/21/11 at 9:35 a.m., the strawberries were still setting on the edge of the sink.</p> <p>On 11/21/11 at 9:55 a.m., the strawberries remained on the edge of the sink.</p> <p>A policy and procedure for "Thawing," dated 2011, was provided by the Registered Dietitian on 11/21/11 at 3:20 p.m. The policy and procedure included, but was not limited to, the following direction: "Use the following guidelines to thaw</p>		<ul style="list-style-type: none"> ·The pan with deep pits on cooking surface was discarded immediately. ·The boxes on the freezer floor were removed from the floor immediately. ·Maintenance was notified of the gnat problem near the food storage area & the exterminator was contacted on 12/22/2011 about the gnats. ·The strawberries thawing at room temperature were discarded immediately & were not served to any resident. ·Maintenance was notified immediately of the dish machine rinse temperature at 177F. The dish machine cycle was completed two additional times & reached the required rinse temperature for sanitizing. ·The DSM immediately provided corrective action & education to the dietary staff on duty 11/21/11 and an in-service to all cooks & dining aides on sanitation, storage and thawing procedures and dish washing on: 12/8/2011 These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: <ul style="list-style-type: none"> ·The Dietary Services Manager will monitor five (5) times per week for four (4) 		

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	<p>frozen foods:</p> <ul style="list-style-type: none"> -Thaw frozen foods under refrigeration that maintains the food temperature at 41 [degrees] F [Fahrenheit] or lower -Thaw foods in shallow pans to catch drippings -Thaw at least three days prior to use" <p>For emergency thawing:</p> <ul style="list-style-type: none"> "-Thaw completely submerged under cold running water (at a temperature of 70 [degrees] F or less) with sufficient water velocity to agitate and float off loose particles in an overflow -Monitor temperature of food to assure that no part exceeds 41 [degrees] F" <p>"Important! Never thaw any food item at room temperature."</p> <p>3. During observation of the dishwasher wash and rinse cycle, on 11/21/11 at 9:45 a.m., the rinse temperature failed to reach 180 degrees; it reached only 177 degrees. The Dietary Service Manager indicated the only chemical in the rinse cycle was a rinse aid, not a sanitizer.</p> <p>3.1-21(i)(3)</p>		<p>weeks, then two (2) times a week for 3 months the following:</p> <ul style="list-style-type: none"> ·storage, preparation, and distribution of food in sanitary conditions ·inspection of cooking utensils for proper surfaces ·kitchen sanitation rounds ·gnats in kitchen area ·dish machine temperatures ·The data will be analyzed for patterns and trends, with action plans be written and implemented as needed. ·DSM/Designee will review the results of the audits, trends, and action plans, and report findings at monthly QA meetings for three (3) months. ·The QA Committee will evaluate and compliance with F-371 via the monthly DSM/Designee reports. ·QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months. 		

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interview and record review, the facility failed to ensure residents of the facility had completed first-step and second-step tuberculosis skin test for 2 of 15 sampled residents reviewed for</p>	F0441	<p>F441</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient</p>	12/16/2011

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	<p>tuberculosis testing in a facility sample of 15. (Residents #6, #9)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #6 was reviewed on 11/16/11 at 11:40 A.M. The clinical record indicated the diagnoses of Resident #6 included, but were not limited to, Diabetes Mellitus Type II.</p> <p>An Immunization Report provided by RN #1 on 11/16/11 at 12:30 P.M. indicated, Resident #6 received a PPD on 08/09/11 in the left forearm with a result "negative (0.0 mm [millimeter])." The Report lacked any documentation that a second PPD had been administered.</p> <p>In an interview with the DoN on 11/17/11 at 4:55 P.M., he indicated, "There was not a second one done."</p> <p>2. Resident #9's clinical record was reviewed on 11/18/11 at 11:55 a.m. The resident was admitted on 10/27/11. The record failed to indicate a PPD was administered on or prior to admission. The only PPD test for tuberculosis was dated 11/17/11 as administered. The record was reviewed with RN #1 on 11/18/11 at 3:00 p.m. At 3:37 p.m. on 11/18/11, RN #1 provided a hospital record that indicated the resident had been</p>		<p>practice are as follows:</p> <ul style="list-style-type: none"> ·R6 and R9 had their immunization record reviewed and PPD was administered if indicated <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <ul style="list-style-type: none"> ·PPD documentation was reviewed on facility residents and if second step PPD was not recorded as given the PPD was administered <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <ul style="list-style-type: none"> ·Staff was in-serviced on PPD and second step procedures on 12-6-11. ·DNS/Designee will review all new admissions to ensure that second step PPD is administrated. <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <ul style="list-style-type: none"> ·DNS/Designee will audit the PPDs three (3) times weekly for four (4) weeks, then two (2) times a week for three (3) 		

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F0514 SS=D	<p>administered the PPD on 10/27/11 at the hospital. There was no indication the PPD was ever read.</p> <p>The Tuberculosis Screening-Administration and Interpretation of Tuberculin Skin Tests Policy and Procedure was provided by the DoN on 11/21/11 at 3:20 P.M. The policy indicated, "...Policy Interpretation and Implementation...3. Individuals with <10 mm of induration, unless otherwise indicated, will receive a booster of 0.1 ml [milliliter] (5 tuberculin units) of PPD [Purified Protein Derivative] on to two weeks after the initial TST [Tuberculin Skin Test].</p> <p>3.1-18(f)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>		<p>months.</p> <ul style="list-style-type: none"> ·The data will be analyzed for patterns and trends and action plans will be written and implemented as needed ·DNS/Designee will review the results of the PPD audits, trends, and action plans, and report findings at monthly QA meetings for three (3) months. ·The QA Committee will evaluate and compliance with F-441 via the monthly DNS/Designee reports. ·QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months. 		

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	<p>Based on interview and record review, the facility failed to ensure clinical records were complete and accurately documented for 2 of 15 sampled residents, who received as needed medications, in that Resident #6 received Ambien [a hypnotic medication] and Resident #13 received Lortab (a narcotic pain medication) and it was not accurately documented.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #6 was reviewed on 11/16/11 at 11:40 A.M. The clinical record indicated the diagnoses of Resident #6 included, but were not limited to, Insomnia.</p> <p>The October 2011 Physician's Order Recap included, but was not limited to, an order for, "Zolpidem Tartrate [Ambien, a hypnotic medication] by mouth Dose: 10 mg [milligrams] Give one tablet by mouth as needed at bedtime."</p> <p>The September 2011 Medication Administration Record [MAR] indicated Resident #6 received Zolpidem Tartrate 10 mg on September 30, 2011.</p> <p>The September 2011 PRN [as needed] Sheet indicated Ambien 10 mg on September 1 and 16, 2011. The PRN Sheet lacked any documentation that</p>	F0514	<p>F514 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <ul style="list-style-type: none"> ·R6 medical record was reviewed and physician contacted for change of Ambien to routine. ·R13 medical record was reviewed and physician contacted for change of Lortab to routine. <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <ul style="list-style-type: none"> ·All PRN medications were reviewed, physicians notified and medications were changed to routine or discontinued as indicated. ·Nursing staff was educated on 12-6-11 regarding documentation of PRN medication. <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <ul style="list-style-type: none"> ·Nursing staff was educated on 12-6-11 regarding documentation of PRN medication. <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the</p>	12/16/2011	

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	<p>Ambien 10 mg had been administered any other time in September, 2011.</p> <p>The October 2011 MAR indicated Resident #6 received Zolpidem Tartrate 10 mg on October 6, 10, 13, 20, 28, 2011.</p> <p>The October 2011 PRN [as needed] Sheet lacked any documentation that Ambien 10 mg had been administered.</p> <p>The Controlled Drug Record for Zolpidem Tartrate dated 09/27/11 through 10/27/11 indicated Zolpidem Tartrate had been administered to Resident #6 on September 27, 28, 30, 2011 and on October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 2011.</p> <p>In an interview with the DoN [Director of Nursing] on 11/17/11 at 4:55 P.M., he indicated, "The nurses have been told to chart the PRN's [as needed medication] on the MAR and the PRN sheet."</p> <p>2. The clinical record for Resident #13 was reviewed on 11/17/11 at 11:50 A.M. The clinical record indicated the diagnoses of Resident #13 included, but were not limited to, COPD [Chronic Obstructive Pulmonary Disease], Chronic Pain, Type 1 Diabetes, and Schizophrenia.</p> <p>The October physicians recap for</p>		<p>deficient practice will not recur per the following:</p> <ul style="list-style-type: none"> -DNS/Designee will audit PRN medication sheets three (3) times weekly for four (4) weeks, then two (2) times a week for three (3) months. -The data will be analyzed for patterns and trends and action plans will be written and implemented as needed -DNS/Designee will review the results of the PRN medication sheet audits, trends, and action plans, and report findings at monthly QA meetings for three (3) months. -The QA Committee will evaluate and compliance with F-514 via the monthly DNS/Designee reports. -QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months. 				

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	<p>Resident #13 indicated an order for Lortab 7.5/500 mg [milligrams] tablet by mouth every 6 hours as needed for pain.</p> <p>The Controlled Drug Record indicated, Resident #13 received Lortab 7.5/500mg by mouth as needed for pain on 10/11/11 at 10:00 A.M., 10/12/11 at 1:00 P.M., 10/13/11 at 12:00 P.M., 10/14/11 at 11:00 P.M., 10/11/11 at 12:00 P.M., 10/16/11 at 1:00 P.M., 10/17/11 at 12:00 P.M., 10/20/11 at 12:01 P.M., 10/22/11 at 1:00 P.M., 10/23/11 at 12:00 P.M., 10/24/11 at 7:30 P.M., 10/25/11 at 11:30 P.M., 10/26//11 at 4:00 P.M., 10/27/11 at 12:30 A.M., 10/29/11 1:00 P.M., 10/29/11 11:30 P.M., 10/30/11 at 11:10 P.M., 10/31/11 at 10:00 P.M.</p> <p>The October 2011 MAR lacked any documentation of Lortab 7.5/500 mg being administered on 10/12/11 at 1:00, 10/14/11 at 11:00 P.M., 10/16/11 at 1:00 P.M., 10/22/11 at 1:00 P.M., 10/27/11 at 12:30 A.M., 10/29/11 at 11:30 P.M., 10/30/11 at 11:10 P.M., 10/31/11 at 10:00 P.M.</p> <p>The Medication Administration General Guidelines Policy and Procedure, provided by the DoN on 11/21/11 at 3:20 P.M. indicated, "...Documentation: ...5. When PRN medications are administered, the following documentation is provided:</p>			

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	<p>a. Date and time of administration, dose, route of administration...b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording administration and signature or initials of person recording effects..."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				