

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
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NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18325 BAILEY AVE SOUTH BEND, IN 46637
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00191743.</p> <p>Survey dates: January 21, 22, 25, 26 and 27, 2016</p> <p>Facility number: 004732 Provider number: 155752 AIM number: 200808300</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 3 Medicaid: 14 Other: 10 Total: 27</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC16.2-3.1.</p> <p>Quality Review completed by 14454 on February 3, 2016.</p>	F 0000		
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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 0241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation and interview, the facility failed to maintain or enhance each residents dignity and respect related to staff calling residents feeders. This affected 7 of 19 residents in the assisted dinning room.</p> <p>Findings include:</p> <p>On 1-21-16 at 12:14 P.M., CNA (Certified Nursing Assistant) #15 indicated "...the feeders sit over there...."</p> <p>On 1-22-16 at 12:12 P.M., the DM (Dietary Manager) was heard in the assisted dining room talking to CNA # 15 "... are the feeders together...."</p> <p>On 1-27-16 at 3:00 P.M., the undated policy titled " Your Rights and Protections as a Nursing Home Resident" was provided by the Administrator, who indicated this was the current policy. The policy indicated "You have the right to be</p>	F 0241	<p>F241</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1. Immediate actions taken for those residents identified:</p> <p>1. This deficient practice affected 7 out of 19 residents when identified staff was educated on the policy "Your Rights and Protections as a Nursing Home Resident"</p> <p>1. How the facility identified other residents:</p> <p>1. All residents who receive assistance with feeding/dining</p>	02/26/2016
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F 0278 SS=D Bldg. 00	<p>treated with dignity and respect..."</p> <p>During an interview on 1-27-16 at 4:30 P.M., the Administrator indicated the residents should not to be referred to as feeders.</p> <p>3.1-3(t)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p>		<p>havethe potential to be affected by this deficient practice.</p> <p>1.Measuresput into place/ System changes:</p> <p>1.In-servicepresented on 2/10/16 and 2/11/16 reviewed resident rights anddignity</p> <p>2.Administrator/Designee will observe one meal daily at different times of the day.</p> <p>1.How thecorrective actions will be monitored:</p> <p>1.Administrator/Designee will audit dining service daily x 1month, weekly x1 month, and monthly x4 months (Attachment 1)</p> <p>(5) The results of these audits will be reviewed in QualityAssurance Meeting monthly x 6 months</p> <p>Date of compliance: 2/26/2016</p>	

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	<p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview and record review, the facility failed to ensure the MDS (Minimum Data Set) dental assessment was accurate for 2 of 2 residents reviewed for Dental Status. (Resident #31)</p> <p>Finding includes:</p> <p>1. On 1-22-16 at 12:45 P.M., Resident #31 was heard telling staff he could not eat his salad because he didn't have any bottom teeth.</p> <p>During an interview on 1-22-16 at 1:13 P.M., Resident #31 indicated he had no bottom dentures. Observation at this time of Resident #31's lower jaw indicated he did not have bottom dentures.</p> <p>On 1-25-16 at 12:09 P.M., a clinical</p>	F 0278	<p>F278</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(1) Immediate actions taken for those residents identified:</p> <p>1. Resident #31 – resident was assessed for dental issues, was scheduled for a visit with the dentist, was care planned, and MDS completed</p> <p>2. Resident #15 – Administrator interviewed</p>	02/26/2016

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	<p>record review was conducted for Resident #31. Resident #31 was admitted to the facility on 9-17-15. The admission MDS (Minimum Data Set) assessment, dated 9-24-15, and the significant change in status MDS assessment, dated 12-3-15, indicated no dental abnormalities.</p> <p>During an interview on 1-25-16 at 2:30 P.M., the Social Services Director indicated "I don't know about his denture issues...."</p> <p>During an interview on 1-26-16 1:36 P.M., the MDS Coordinator indicated "I don't know if he came in with bottom dentures or not..."</p> <p>During an interview on 1-27-16 at 1:19 P.M., the MDS Coordinator indicated "... I missed that he didn't have his bottom teeth...."</p> <p>2. On 1-22-2016 at 9:55 A.M., Resident #15 was observed not wearing dentures and without natural teeth. The resident indicated she does have dentures, but does not want to wear them.</p> <p>On 1-25-2016 at 1:16 P.M., during a second interview, Resident #15 indicated she has dentures, but does not like to</p>		<p>resident regarding her preference for dentures, called POA regarding preference for dentures; both decided they did not want dentures as resident refused to wear them and did not want to be seen by dentist. MDS initiated and completed a dental care plan.</p> <p>(2)How the facility identified other residents:</p> <p>1.The MDS Coordinator/Designee will review all resident care plans, will assess all resident for dental care, and will care plan if necessary</p> <p>(3)Measures put into place/ System changes:</p> <p>1. Admission nurse will complete a dental assessment upon admission and as needed (Attachment 2)</p> <p>2. MDS Coordinator/Designee will review all dental assessments completed</p> <p>(4)How the corrective actions will be monitored:</p> <p>1. MDS Coordinator/Designee will audit all dental assessments after admission, readmission, quarterly, annually, and with change of condition; this will be ongoing (Attachment 3)</p> <p>(5) The results of these audits will be reviewed in Quality Assurance Meeting</p>				

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	<p>wear them and never wanted them.</p> <p>On 1-25-2016 at 1:11 P.M., review of Resident #15's most recent MDS (Minimum Data Set) assessment, dated 12-9-2015, indicated a BIMS (Brief Interview for Mental Status) of 6, indicating severe impairment. Diagnoses included, but were not limited to, dementia, diabetes mellitus and atherosclerosis. The MDS assessment did not indicate the resident's oral status had been reviewed. Review of the resident's care plans indicated there were none which addressed the resident's oral status.</p> <p>On 1-26-2016 at 1:10 P.M., during an interview, the Administrative Director indicated Resident #15 should have an active care plan to address her oral status and her decision to not wear dentures.</p> <p>01/26/2016 1:36:14 PM interview with the MDS Coordinator, indicated he does a visual assessment of a resident's mouth to see if there are dental issues.</p> <p>3.1-31(d)</p>		<p>monthly x 6 months Date of compliance: 2/26/2016</p>	

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to ensure a care plan was developed related to the use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #33) The facility also failed to ensure a care plan was developed to address a resident with a contracture for 1 of 1 residents. (Resident #12)</p> <p>Finding includes:</p> <p>1. On 1-26-16 at 9:46 A.M., the clinical record for Resident #33 was reviewed.</p>	F 0279	<p>F279</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(1) Immediate actions taken for</p>	02/26/2016	

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	<p>Resident #33 was admitted to the facility, on 5-22-15. The diagnoses included, but were not limited to, dementia with behaviors, anxiety, major depressive disorder and Alzheimer's disease.</p> <p>The Physicians orders indicated "...5-25-15 Escitalopram [Lexapro - antidepressant medication] 10 mg [milligrams] tablet give 1 tablet orally once a day...11-12-15 Risperidone [Risperdal - antipsychotic medication] 0.25 mg tablet give 1 tablet by mouth daily...11-11-15 Lorazepam [Ativan - antianxiety medication] 0.5 mg tablet give 1 tablet by mouth every morning & bedtime as needed for agitation/anxiety...."</p> <p>The annual MDS (Minimum Data Set) assessment, dated 10/28/15, under the CAA's (Care Area Assessment) indicated psychotropic drugs would be address in the resident's care plan.</p> <p>Resident #33's care plans indicated no documentation of a care plan related to her use of an antidepressant, antipsychotic or antianxiety medication.</p> <p>On 1-26-16 at 1:26 P.M., an interview with the MDS (Minimum Data Set) coordinator was conducted. The MDS coordinator indicated "...I am in charge of</p>		<p>those residents identified:</p> <p>1.Resident#33 – psychotropic medications were reviewed by Psychiatric NursePractitioner and were care planned as needed</p> <p>2.Resident#12 – Therapy screened resident and made recommendations as necessary, care plan initiated by MDS coordinator.</p> <p>(2)How the facility identified other residents:</p> <p>1.Thefacility will assess all residents who are on psychotropicmedications and will care plan as needed</p> <p>2.Thefacility will have therapy assess/screen all residents forcontractures and care plan as needed</p> <p>(3)Measures put into place/ System changes:</p> <p>1.Anew contract with a Psychiatric Nurse Practitioner has been signed;will meet with Consultant Pharmacist monthly to initiated gradualdose reduction and make recommendations as needed</p> <p>2.Therapywill screen all new residents for contractures and makerecommendations as needed</p> <p>(4)How the corrective actions will be monitored:</p> <p>1.SocialServices Director/Designee will review 24 hour sheet and</p>		

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	<p>making sure a care plan gets done...If a resident is started on a new medication...usually it trickles down to me...before a month ago they weren't really getting to me...No, she [Resident #33] does not have a care plan related to those meds...."</p> <p>On 1-27-16 at 2:25 P.M., an interview with the ED (Executive Director) was conducted. The ED indicated "Yes...all psychotropic medications...risperdal, lexapro, ativan...should all be care planned...."</p> <p>2. On 1-27-2016 at 10:02 A.M., Resident #12 was observed in her room in her bed after she was bathed, holding a wash cloth in her in her right hand which was contracted.</p> <p>On 1-27-2016 at 11:59 A.M., Resident #12 was observed in the activity room in a Baroda chair, holding a wash cloth in her contracted right hand.</p> <p>On 1-27-2016 at 10:17, Resident #12's records were reviewed. The most recent MDS assessment, dated 10-28-2015, indicated a BIMS score could not be determined due to the resident was rarely if ever understood. The resident had impairment of one side to the upper and lower extremities. Diagnoses included but were not limited to cerebrovascular</p>		<p>physicianorders daily to ensure any change or new medication orders touupdate care plan and document focus behaviors; this will be ongoing(Attachment 4)</p> <p>2.MDSCoordinator/Designee will review 24 hour sheet and physician ordersdaily to ensure any changes or new orders are updated per careplan; this will be ongoing (Attachment 4)</p> <p>3.Pharmacyconsultant will audit charts monthly and present report in monthlyQA meeting this will be ongoing.</p> <p>(5) The results of these audits will be reviewed in QualityAssurance Meeting monthly x6 months.</p> <p>Dateof compliance: 2/26/2016</p>				

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	<p>accident, hemiplegia, and seizure disorder.</p> <p>The resident's history and physical assessment, dated 6-24-2014, indicated Resident #12 had an upper right extremity chronic contracture. The resident had a cerebral vascular accident on 12-8-2011, resulting in right hemiparesis, dysphagia, ad aphasia.</p> <p>The most recent rehabilitation screen, dated 5-22-2015, indicated there were no physical therapy orders requested, and signed by the physician.</p> <p>On 1-27-2016 at 11:00, resident #12's care plans were reviewed. There were no care plans which addressed the resident's right hand contracture.</p> <p>On 1-27-2015 at 12:00 P.M., an interview with the Administrative Director indicated the resident does have a contracture to the right hand and holds a wash cloth in the hand. The Administrative Director indicated Resident #12 does not have, but should have a care plan to address the resident's contracture to the right hand.</p> <p>3.1-35(a)</p>			

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F 0282 SS=D 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 record review and interview, the facility failed follow the physician's order related to obtaining weights for 1 of 3 residents reviewed for nutrition. (Resident #31)</p> <p>Finding includes:</p> <p>On 1-25-16 at 12:09 P.M., a clinical record review was conducted for Resident #31. Resident #31 was admitted to the facility on 9-17-15, with diagnosis that include but not limited to heart failure, not specified.</p> <p>The Physicians orders for October 2015 and November 2015 indicated "daily weight." Physicians orders for December 2015 and January 2016 indicated "weekly weight."</p> <p>Review of the MAR (Medication Administration Record) for October 2015</p>	F 0282	<p>F282</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(1) Immediate actions taken for those residents identified:</p> <p>1. Resident #31 – weight taken on resident when identified to obtain new baseline weight</p> <p>(2) How the facility identified other residents:</p> <p>a) Facility has weighed and reweighed all residents.,</p>	02/26/2016

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	<p>and November 2015 indicated " ...daily weight.... " The MAR record for December 2015 and January 2016 indicated "...weekly weight..." There was no documentation on the MARs to indicate any weights obtained.</p> <p>Weight documentation on the vitals record from 9-17-15 to 1-21-16 indicated</p> <p>9/17/15 179 lbs (pounds) 9/22/15 185.9 lbs 10/7/15 179.2 lbs 11/9/15 162.2 lbs 12/2/15 174.8 lbs 12/5/15 174.8 lbs 12/21/15 180.3 lbs 1/1/16 177.0 lbs 1/21/16 179.4 lbs</p> <p>Dietary progress note, dated 9-18-15, indicated "...Admission Nutrition Assessment ...he will be weighed daily due to CHF[Congestive Heart Failure]...."</p> <p>During an interview on 1-26-16 at 1:03 P.M., the Administrator indicated "... the MDS (Minimum Data Set) Coordinator is in charge of weights...the nurse takes the order then informs the DON [Director of Nursing] and she informs the MDS Coordinator...if weights are ordered daily or weekly they should be documented...."</p>		<p>completed on 2/10/16 to obtain baseline weight</p> <p>b)Dietician has reviewed all weights and made monthly recommendations as needed</p> <p>(3)Measures put into place/ System changes:</p> <p>a) Weight program has been assigned to a designated nurse</p> <p>b) Designated weight nurse will initiate and conduct weekly weight meetings with IDT</p> <p>c) Restorative nurse aide will be responsible for obtaining weekly and monthly weights and re-weights; this will be ongoing</p> <p>(4)How the corrective actions will be monitored:</p> <p>a)Dietician will audit weights during weekly meeting and present report in monthly QA meeting</p> <p>(5) The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months.</p> <p>Date of compliance: 2/26/16</p>	

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	<p>During a interview on 1-26-16 at 1:30 P.M., the MDS Coordinator indicated "... I think new residents get daily weights for 3 days then weekly for a month, then if stable monthly... when we get a new admission I look at orders for weights...."</p> <p>During an interview on 1-26-16 at 2:30 P.M., the Administrator indicated "... the MDS Coordinator is in charge of making sure weights get done and put in system...."</p> <p>During an interview on 1-27-16 at 11:03 A.M., the RD (Registered Dietician) indicated "... the person in charge of the weights doesn't grasp the importance of it ...yes Resident #31 was on daily weights, then weekly...."</p> <p>During an interview on 1-27-16 at 1:24 P.M., the MDS Coordinator indicated "... I wait for the RD weekly assessment to say I don't have weights before I follow up if weights were done...."</p> <p>On 1-27-16 at 8:45 A.M., the Administrator provided the policy titled "Physicians Orders," dated 1-6-15, and indicated it was the policy currently used by the facility. The policy indicated "...7. New orders will be reviewed weekly as part of the assurance for appropriateness,</p>			

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F 0314 SS=G Bldg. 00	<p>accuracy and completeness. 8. A monthly review of physicians orders will be completed to assure appropriateness, accuracy, and completeness. 9. Adherence to following physicians orders will be reviewed during the QA (Quality Assurance) process...."</p> <p>3.1-35 (g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure a resident, who was at risk of development of pressure ulcers, was consistently assessed, monitored and reevaluated to ensure the pressure ulcer didn't progress to a higher stage, for 1 of 2 residents reviewed for pressure ulcers. Resident #5 developed a Stage II pressure</p>	F 0314	<p>F314 The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set</i></p>	02/26/2016

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	<p>ulcer which progressed to a Stage IV.</p> <p>Finding includes:</p> <p>On 1-21-16 at 3:53 P.M., during a staff interview, LPN #13 indicated, "...she [Resident #5] has a Stage 4 pressure ulcer to her coccyx...I believe she had it upon admission but I am not sure...we didn't catch it until later so now we own it...I don't know exactly when we discovered it [pressure ulcer] but it was unstageable when we found it..."</p> <p>On 1-25-2016 at 12:27 P.M., a record review for Resident #5 was conducted. Resident #5 had an original admission date of 7-30-2015. Resident #5 was readmitted on 10-29-2015, after a 5 day hospitalization for an upper GI (gastro-intestinal) bleed. The diagnoses included, but were not limited to, small vessel cerebrovascular disease, HOH (hard of hearing), chronic anemia, general weakness, left radial head fracture, chronic A-fib (Atrial fibrillation), hyperlipidemia, chronic pain, chronic right hip infection, gastritis, vertigo and anxiety.</p> <p>A Braden Scale assessment for prediction of pressure sore risk, dated 11-5-2015, indicated a score of 13-Moderate risk with interventions initiated of pressure</p>		<p><i>forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(1)Immediate actions taken for those residents identified:</p> <p>1.Resident #5 – re in-serviced nursing staff on skin assessmentsand proper wound care</p> <p>(2)How the facility identified other residents:</p> <p>1.Thefacility will assess residents for signs and symptoms of pressureulcers utilizing Braden Scale and will identify residents if anyfindings.</p> <p>2.Thefacility will review the medical record and physician orders todetermine if other residents are on treatment for pressure ulcerand that care plan is in place</p> <p>(3)Measures put into place/ System changes:</p> <p>1.A new 24 hour report system was initiated on 1/15/16(Attachment 4)</p> <p>2.A newskin report was initiated on 1/15/16 and was in-serviced on 1/22/16(Attachment 5)</p> <p>3.Thefacility developed a wound care program and designated a woundnurse, this program was initiated 1/14/16.</p> <p>4.Medicationsand</p>				

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	<p>reducing device for chair, pressure reducing device for bed and applications of ointments/medications other than to feet.</p> <p>The MDS (Minimum Date Set) assessment, dated 11-5-2015, indicated Resident #5 had a BIMS (Brief Interview for Mental Status) of 00/15, indicating severe cognitive deficit. The MDS assessment indicated the resident was at risk to develop pressure ulcers.</p> <p>An MDS assessment, dated 11-12-2015, indicated Resident #5 had one Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough, May also present as an intact or open/ruptured serum filled blister.) pressure ulcers, on 11-11-2015.</p> <p>An MDS assessment, dated 11-26-2015, indicated, one Stage 2 pressure ulcers, dated 11-18-15. The assessment also indicated one unstageable (Full thickness loss in which the base of the ulcer is covered by slough and/or eschar in the ulcer bed.) pressure ulcers.</p> <p>A care plan, dated 11-20-2015, indicated, "...Problem...Fragile Skin...Resident [#5] has impaired skin integrity as evidenced by: 11/18/15, stage three pressure ulcer to</p>		<p>Treatment Administration policy and procedure reviewed with nursing staff on 2/10/16 and 2/11/16</p> <p>5.24 hour report system, skin reporting system, and wound care program were all re in-serviced with nursing staff on 2/10/16 and 2/11/16</p> <p>(4) How the corrective actions will be monitored:</p> <p>1. Director of Nursing/Designee will check the 24 hour shift report daily this will be ongoing (Attachment 4)</p> <p>2. Director of Nursing /Designee will do a 24 hour audit for TAR and physician orders daily ongoing (Attachment 6)</p> <p>(5) The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months.</p> <p>Date of compliance: 2/26/2016</p>	

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	<p>coccyx; 3.4x3.3x1.8cm, slough present, scant exudate, pain...Goal...Resident's impaired skin integrity will exhibit signs of healing within the next 30 days...Approach...Start date: 11/20/2015...Monitor at contacts for skin condition changes. Inform charge nurse immediately if noted...Skin assessment q [every] 7 days...."</p> <p>A care plan, dated 11-30-2015, indicated, "...Problem...Pressure Ulcer...Resident [#5] is at risk for pressure ulcer R/T [related to] decreased mobility and awareness...Approach...start date 11/30/2015...Conduct a total body skin inspection weekly...Monitor at contacts for s/s [signs and symptoms] of skin condition changes. Report any signs of skin breakdown [sore, tender, red, or broken areas] to charge nurse immediately if noted...."</p> <p>Resident #5's progress note 's indicated the following entries:</p> <p>"11-06-2015 at 10:16 PM...Resident during care CNA [Certified Nursing Assistant] noted redness to bilat [bilateral] buttock [sic] area. Skin remains intact. No indication of pain noted. Area irregular. [Physicians name] notified to apply protective cream to area every shift."</p>			

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	<p>"11-07-2015 at 1:11 AM...Bilat [bilateral] redness to buttocks house protective cream continue to be used."</p> <p>"11-11-2015 at 2:18 AM...slight breakdown of skin noted to coccyx area."</p> <p>A dietary progress note, dated 11-11-2015 at 5:12 PM, indicated, "...Skin free of pressure areas...."</p> <p>"11-13-2015 at 3:46 PM...resident called out for help and requested this writer to look at 'my butt'. Dressing to coccyx had drainage light red and yellow. Area cleaned and dried and foam dressings changed....Complaint of pain"</p> <p>"11-13-2015 at 10:37 PM...Skin intact TX [treatment] continued to coccyx area...."</p> <p>There was no documentation to indicate the pressure ulcers were assessed, monitored or evaluated from 11-13-15 until 11-18-15, when the the physician was notified of worsening pressure ulcers.</p> <p>"11-18-2015 at 9:15 PM...Called and spoke to [physicians name] that resident has yellowish sloughing stage 2 pressure ulcer to mid coccyx area and multiple</p>			

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	<p>stage 2 pressure ulcers to sacrum area and around anal area...new treatment orders received for buttocks...calazime cream applied to areas without yellowish sloughing, coccyx area that has sloughing tissue applied santyl ointment and dry dressing...."</p> <p>"11-19-2015 at 4:33 PM...Clarification for pressure ulcer on coccyx, sacral area, noted to be stage 3 [Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.] with measurements of 3.4X3.3X1.8 cm. Treatment continued as ordered on 11-18-15."</p> <p>"11-19-2015 at 4:36 PM...Treatment orders as follow: Apply santyl to wound bed and cover with dry dressing until slough is resolved, the call [physician name] for new treatment orders. Turn Q [every] 2 hours while in bed. Use pressure relieving device for W/C [wheelchair]."</p> <p>"11-19-2015 at 10:45 PM...TX continued to coccyx area. C/O [complaint of] of back pain...."</p> <p>"11-27-2015 at 4:14 PM...Dressing</p>			

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	<p>changed to coccyx. Cleaned with normal saline, santyl applied to slough followed by packed with calcium alginate sliver into tunneling areas...."</p> <p>"11-27-2015 at 9:26 PM...incontinent of bowel and bladder...resident attempts to take brief off multiple times throughout the shift, reminded not to take brief off and to keep hands out of groin area...."</p> <p>"11-30-2015 at 6:38 PM...Skin: stage III pressure area on coccyx...." (A Dietary note)</p> <p>"12-11-2015 at 12:00 AM...takes brief off throughout shift and will place hands in groin area...removes dressing to coccyx area frequently...."</p> <p>"1-9-2016 at 6:22 PM...tx [treatment] to buttocks was refused by resident 3 attempts were made...."</p> <p>"1-10-2016 at 10:51 PM...stage 4 [Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling.] pressure ulcer to midline coccyx. measurements are 4.0cm [centimeters] x 3.0cm x 1.6 cm; undermining noted at the 12 o'clock 3.0cm, 3 o'clock 3.0 cm, and 10 o'clock</p>			

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	<p>3.6 cm. At 6 o'clock maceration noted to be 1.0 cm and sloughing tissue noted from the 5-9 o'clock position, wound bled while cleansing with normal saline. tissue is pink from the 9-5 o'clock area. wound edges are rolled...."</p> <p>A Skin Integrity Events, Pressure Sore assessment, dated 11-18-2015 completed 04:18 AM, indicated, "...Pressure Ulcer-Location and Size...5x5x0.2cm stage 2 to mid coccyx area, 3 stage 2 on left and right buttocks, 2 stage 2 next to rectum...Character of Wound Bed...Slough-yellow or white tissue that adheres to the ulcer bed in strings or thick clump, or is mucinous...Describe...coccyx pressure ulcer has yellowish sloughing noted...Does resident exhibit or complain of pain at the site?...4-Moderate Pain-Distressing/Miserable...Notification Guidelines...Notify MD[Medical Doctor]/NP[Nurse Practitioner]/PA[Physician Assistant] immediately by phone or beeper for any of the following...New Pressure Sore...Notifications...Physician Notified: No...."</p> <p>A Skin Integrity Events, Pressure Sore assessment, dated 11-19-2015 completed 3:50 PM, indicated, "...Description coccyx stage 3 pressure ulcer...Pressure Ulcer-Location and Size...coccyx, mid,</p>			

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	<p>sacral area, 3.4cmX3.3cmX1.8cm...Notifications...Physician Notified: No...."</p> <p>On 12-22-2015, Resident #5 was admitted to Hospice care. The initial assessment, dated 12-22-2015, indicated, "Unstageable wound to coccyx."</p> <p>A physician progress note, dated 1-5-2016, indicated diagnosis of, but not limited to, end stage Alzheimer's dementia and malnutrition.</p> <p>Skin sheets available for review were dated 11-18-2015, 11-19-2015, 01-15-16 and 01-21-16.</p> <p>Record review of Resident #5's Medication Record for November 1-30, 2015, indicated a treatment, "Calazime ointment to buttocks twice daily...started on the 6p-6a [6 PM to 6AM] shift and Santyl ointment to yellow sloughing areas on buttocks twice a day, call md [Medical Doctor] when yellow areas are gone for new treatment orders...started on the 6p-6a [6 PM to 6 AM] shift." No other treatment orders related to pressure ulcers noted.</p> <p>On 1-26-2016 at 8:22 A.M., during an interview, the DON (Director of Nursing) indicated, "We didn't have a good system</p>			

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	<p>in place for skin issues. We were switching between charting on the computer instead of the paper chart. I think the nurses were confused as to where they should document. We did not have a 24 hour nurse report sheet until recently. There was lack of communication. I have implemented a wound book and I round on them weekly. My first documentation related to her [Resident #5] pressure ulcer is dated 01-15-16."</p> <p>On 1-26-2016 at 11:00 A.M., an observation of the Stage 4 pressure ulceration to Resident #5's coccyx was conducted with Hospice nurse. Resident #5 was rolled to her right side while in bed. Resident #5 complained of pain to the area while the observation was being conducted. An open area to the coccyx was observed to be pink in color with no foul smell or drainage noted. The open area was round and deep, about the size of a golf ball and had tunneling to the surrounding tissue.</p> <p>On 1-27-2016 at 8:30 A.M., a review of the policy "Pressure Ulcer Risk" initiated: 10/1/2015, received from the Administrator at this time, indicated, "...Preparation...Review current Braden Scale and/or facility risk assessment tool...General Guidelines...If pressure</p>			

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F 0323 SS=D Bldg. 00	<p>ulcers are not treated when discovered, they have the potential to become larger, painful and infected...Routinely assess and document the condition of the resident's skin for any signs and symptom of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the nurse...Documentation...The condition of the resident's skin [i.e. [example], the size and location of any red or tender areas], if identified...."</p> <p>3.1-40(a)(1)</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, interview and record review, the facility failed to conduct a root cause analysis, provide adequate supervision and consistently develop and implement interventions to ensure a resident was free from recurring falls for 1 of 1 residents reviewed for falls. (Resident #5)</p> <p>Finding includes:</p>	F 0323	<p>F323 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of</p>	02/26/2016

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	<p>On 1-21-2016 at 10:00 A.M., Resident #5 was observed in her bed. Fall mats were on either side of the bed. The bed was in the lowest position. A clip alarm was on Resident # 5's wheelchair.</p> <p>On 1-25-2016 at 12:27 P.M., a record review for Resident #5 was conducted. Resident #5 had an original admission date of 7-30-2015. Resident #5 was readmitted on 10-29-2015, after a 5 day hospitalization for an upper GI (gastro-intestinal) bleed. The diagnoses were, but not limited to, small vessel cerebrovascular disease , HOH (hard of hearing), chronic anemia, general weakness, left radial head fracture, chronic A-fib (Atrial fibrillation), hyperlipidemia, chronic pain, chronic right hip infection, gastritis, vertigo and anxiety.</p> <p>The Admission MDS (Minimum Date Set) assessment, dated 8-5-2015, indicated Resident #5 had a BIMS (Brief Interview for Mental Status) of 00/15, indicating severe cognitive deficit. Resident #5 was coded as an Extensive assist of 2 people for transfers and balance assessment indicated "Not Steady, only able to stabilize with human assistance."</p>		<p><i>deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(1)Immediate actions taken for those residents identified:</p> <p>1.Resident#5 – reviewed all resident care plans related to falls andconcluded that with resident decline in condition and hospice careresident was no longer at risk for falls</p> <p>(2)How the facility identified other residents:</p> <p>1.Facilitywill assess all residents for fall risk</p> <p>1.ifidentified as fall risk care plan will be initiated andinterventions will be placed as necessary</p> <p>(3)Measures put into place/ System changes:</p> <p>1.Facilityreviewed and will initiate a new fall prevention program and have designates one nurse to be in charge</p> <p>2.In-servicepresented on 2/10/16 covered fall program and reporting of fallsand interventions</p> <p>(4)How the corrective actions will be monitored:</p> <p>1.Directorof Nursing/Designee will audit 24 hour book and new fall events toensure that all interventions are in place and care plans have beeninitiated</p> <p>2.At dailymorning meeting each fall will be reviewed by</p>				

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	<p>Resident #5's fall incidents and care plans were as follows:</p> <p>*Fall, dated 8-3-2015, no safety event for review.</p> <p>*Fall, dated 8-6-2015 at 07:40 PM, indicated, "...Found on the floor...in resident room...unwitnessed fall...complaint of pain...4-moderate pain to back. Indicate measures taken...bed alarm...chair alarm...personal alarm...rest...Outcome of Interventions...Interventions Somewhat Effective, describe below...The resident still wont [sic] use call light but hollers out...."</p> <p>A care plan, dated 8-6-2015, indicated, "...Problem...Falls...Resident at risk for falling R/T [related to] weakness...Goal...Resident will remain free from injury...Approach...Provide extensive assist of one to two staff with a gait belt for stand and pivot transfers...Equip resident with device that monitors rising: Sensor alarm to bed Tab alarm to w/c [wheelchair]"</p> <p>A care plan, dated 8-6-2015, indicated, "...Problem...Falls...Resident had a fall on: 8/3/15...Cause of fall: resident slipped to floor during w/c [wheelchair] transfer...Goal...Resident remains at risk</p>		<p>the IDT</p> <p>3.Fallmeetings will be held by IDT weekly; this will be ongoing</p> <p>4.MDS willaudit fall report/events daily to ensure that all falls aredocumented and care planned as necessary (Attachment 7)</p> <p>(5) The results of these audits will be reviewed in QualityAssurance Meeting monthly x6 months.</p> <p>Date of compliance: 2/26/2016</p>	
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	<p>for falls, but will not sustain serious injury related to the fall...Approach Start Date; 08/06/2015...Current fall prevention program includes: tab alarm to w/c; sensor alarm to bed...New intervention includes: [no new intervention noted]...."</p> <p>*Fall, dated 8-10-2015 at 12:48 AM, indicated, "...witness fall with no injury...resident room...tyrig [sic] to get up out the bed...Interventions-An Immediate measure must be taken...Indicated measures taken...None of Above...." No interventions noted.</p> <p>A care plan, dated 8-12-2015, indicated, "...Problem...Cognitive Loss/Dementia...Resident has impaired decision making R/T [related to] Alzheimer's. She is having difficulties with recall of recent events and memory recall...Approach...provide cues and supervision for ADL's [Activities of Daily Living] and activities...."</p> <p>A care plan, dated 8-13-2015, indicated, "...Problem...Falls...Resident had a fall on: 8/6/15...Cause of fall: resident self transferring OOB [out of bed]...Approach...New intervention includes: [no new intervention noted]...."</p> <p>A care plan, dated 8-13-2015, indicated,</p>			

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	<p>"...Problem...Falls...Resident had a fall on: 8/10/15...Cause of fall: resident self transferring OOB [out of bed]...New intervention: check UA [urinary analysis]..."</p> <p>*Fall, dated 8-14-2015 at 3:31 AM, indicated, "...witnessed fall with no injury...resident room...Indicated measures taken...rest...other-toileting and fluids...Interventions Ineffective, describe below...Resident cont [continues] to get out of bed wanting to use the toilet...."</p> <p>A care plan, dated 8-14-2015, indicated, "...Problem...Falls...Resident had a fall on : 8/14/14 [sic]...Cause of fall: lost balance while transferring with staff assist...Approach...New intervention includes: OT [occupational therapy] screen...."</p> <p>*Fall, dated 9-2-2015, no safety event for review. Neurochecks incomplete.</p> <p>A care plan, dated 9-3-2015, indicated, "...Problem...Falls...Resident had a fall on: 9/2/15...Cause of fall: unknown at this time...Investigation ongoing...Noted injury: Distal radial fx [fracture], traumatic closed nondisplaced fx of distal end of Right fibula...New intervention includes: continue to answer call light or calling out as quickly as possible, as</p>			

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	<p>resident habitually removes tab alarms...."</p> <p>*Fall, dated 9-11-2015 at 3:00 AM, indicated, "...heard resident calling for help, found resident on floor, no pants on, no brief on, and urine on floor...resident room...Indicate measures taken...Other-door staying open...." Neurochecks incomplete.</p> <p>*Fall, dated 9-30-2015 at 11:07 AM, indicated, "...resident lying on floor at bedside...resident room...unwitnessed fall...Indicate measures taken...Other-non skid socks...Interventions Somewhat Effective, describe below...resident non compliant with transfers...." No neurochecks to review.</p> <p>A care plan, dated 10-1-2015, indicated, "...Problem...Falls...Resident had a fall on: 9/30/15...Cause of fall: res [resident] attempt to self transfer...New intervention includes; non slip socks added 9/30/15; sensor pad added to w/c at all times...."</p> <p>*Fall, dated 11-2-2015, no safety event to review.</p> <p>A care plan, dated 11-5-2015, indicated, "...Problem...Falls...Resident had a fall on: 11/2/5 [sic]...Cause of fall: lowered to ground [floor mat] by staff while resident</p>			

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	<p>being resistive to cares...New intervention includes: sensor pad to bed...."</p> <p>*Fall, dated 11-11-15 at 12:10 PM, indicated, "...witnessed fall...resident room...sitting in w/c...Pain...yes, 4-moderate pain...Injury noted...skin tear..Indicate measures taken...[no boxes checked]...Interventions Ineffective, describe below...removes alarm...."</p> <p>A care plan, dated 11-12-2015, indicated, "...Problem...Falls...Resident had a fall on: 11/11/15 11:30 am...Cause of fall: res [resident] attempted to self transfer from w/c...Noted injury: skin tear L [left] hand 0.8 cm [centimeter], flap intact...C/O [complaint of] L arm pain, no decreased ROM [range of motion] noted, xry [sic] ordered...New intervention includes: staff to attempt to answers resident's calls for help as soon as possible...."</p> <p>*Fall, dated 11-17-2015 at 8:30 AM, indicated, "...fall...hallway...up in w/c for breakfast...unwitnessed...Indicate measures taken...Personal Alarm...Interventions Ineffective, describe below...Resident knows how to take alarm off and on...." Neurochecks incomplete.</p> <p>A care plan, dated 11-19-2015, indicated,</p>			

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	<p>"...Problem...Falls...Resident had a fall on: 11/17/17 [sic]...Cause of fall: unwitnessed; per 11/17 report, the resident statet [sic] she wanted to go back to bed on way to bkfst [breakfast]. When informed it was time for bkfst, the resident apparently leaned forward and fell to the floor...New intervention includes: staff to comply with resident's wishes as she states them...."</p> <p>An update to the care plan, dated 8-6-2015, indicated, "...Approach start date: 11/17/2015...Resident has shown inability to wait for staff assistance when she has a need and will attempt to self transfer by herself. Staff are to attempt to assist the resident, but this resident is now care planned to allow resident to self transfer.</p> <p>*Fall, dated 11-23-2015 at 10:15 PM, indicated, "...Unwitnessed fall...resident room...Indicate measures taken...Bed alarm...."</p> <p>*Fall, dated 11-29-2015, no safety event to review.</p> <p>*Fall, dated 12-4-2015, no safety event to review.</p> <p>A care plan, dated 12-7-2015, indicated, "...Problem...Falls...Resident has a fall</p>			

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	<p>on: 11/23/15...Cause of fall: unwitnessed, last seen in bed...." No new interventions noted.</p> <p>A care plan, dated 12-7-2015, indicated, "...Problem...Falls...Resident had a fall on: 11/29/15...Cause of fall: resident lowered herself to floor onto fall mat...." No new interventions noted.</p> <p>A care plan, dated 12-7-2015, indicated, "...Problem...Falls...Resident had a fall on 12/4/15...Cause of fall: Resident witnessed to lower herself to ground...Approach...Staff to monitor resident frequently for unmet needs and potential for attempted self transfers...."</p> <p>*Fall, dated 12-9-2015 at 5:23 PM, indicated, "...fall...resident room...unwitnessed...Pain...No...Indicate measures taken...Adaptive Equipment...Analgesics...Bed Alarm...Intervention Ineffective, describe below...resident removes alarms or turns them off...." No neurochecks for review.</p> <p>A care plan, dated 12-10-2015, indicated, "...Problem...Falls...Resident had a fall on 12/09/15...Cause of fall...resident removed herself from bed...Approach...New intervention includes: ER [emergency room] visit for potential UTI [urinary tract infection]...."</p>			

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	<p>*Fall, dated 12-14-2015 at 5:44 PM, indicated, "...resident calling out and put herself on the floor...resident room...witnessed fall...Indicate measures taken [no boxes checked]...."</p> <p>A care plan, dated 12-16-2015, indicated, "...Problem...Falls...Resident had a fall on 12/14/15...Cause of fall: resident placed herself on floor from w/c [wheelchair]...." No new interventions noted.</p> <p>On 1-27-2016 at 4:15 P.M., during an interview, the Administrator indicated that an immediate intervention should be put in place after each fall and documentation should be completed.</p> <p>On 1-27-2016 at 3:43 P.M., a policy entitled "Falls" and initiated 7-13-2015, received from the Administrator at this time, indicated, "...Assessment and Recognition...The staff will evaluate and document falls that occur while the individual is in the facility...Cause Identification...The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified...Treatment/Management...Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent</p>			

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F 0325 SS=G Bldg. 00	<p>falls and to address risks of serious consequences of falling...If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions...Monitoring and Follow-Up...The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling...."</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to assess and develop, evaluate and revise interventions for significant weight loss for 1 of 3 residents reviewed for weight loss. Resident #5 had a weight loss of 24.7 % in 174 days.</p>	F 0325	<p>F325 The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the</i></p>	02/26/2016

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	<p>Finding includes:</p> <p>On 1-22-2016 at 9:13 A.M., a record review for Resident #5 was conducted. Resident #5 had an original admission date of 7-30-2015. Resident #5 was readmitted, on 10-29-2015, after a 5 day hospitalization for an upper GI (gastro-intestinal) bleed. The diagnoses included, but were not limited to, small vessel cerebrovascular disease, HOH (hard of hearing), chronic anemia, general weakness, left radial head fracture, chronic A-fib (Atrial fibrillation), hyperlipidemia, chronic pain, chronic right hip infection, gastritis, vertigo and anxiety.</p> <p>Resident #5 had an admission weight of 137.9 pounds and a weight that was recorded on 1-21-2016 of 103.8 pounds, indicating a 24.7% weight loss in the last 174 days and a current BMI (Body Mass Index) of 17.31.</p> <p>The MDS (Minimum Data Set) assessment, dated 11-5-2015, indicated Resident #5 had a BIMS (Brief Interview for Mental Status) of 00/15, indicating severe cognitive deficit and a functional assessment for eating of supervision with set up help only.</p> <p>An MDS assessment, dated 11-12-2015,</p>		<p><i>facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(1) Immediate actions taken for those residents identified:</p> <p>1. Resident #5 – when identified resident was currently on hospice, therefore was not being weighed weekly</p> <p>(2) How the facility identified other residents:</p> <p>a) Facility has weighed and reweighed all residents., completed on 2/10/16 to obtain baseline weight</p> <p>1. Dietician has reviewed all weights and made monthly recommendations as needed</p> <p>(3) Measures put into place/ System changes:</p> <p>a) Weight program has been assigned to a designated nurse and weights will be designated to restorative nurse aide.</p> <p>b) Designated weight nurse will initiate and conduct weekly weight meetings with IDT</p> <p>(4) How the corrective actions will be monitored:</p> <p>a) Dietician will audit weights during weekly weight meetings; this will be ongoing</p> <p>b) Dietician to present findings during weekly weight meetings and monthly QA.</p>				

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	<p>indicated a functional assessment for eating of limited assistance.</p> <p>An MDS assessment, dated 12-22-2015, a significant change assessment of extensive assistance for eating.</p> <p>The nutritional care plans indicated the following:</p> <p>A care plan, dated 8-5-2015, indicated, "...Problem...Nutritional Status...At risk for weight loss related to cognitive deficits, and less than 75% meal acceptance...Goal...[Resident #5 name] will have stable weights +-5 lbs [pounds] of 140 lbs...Approach...regular diet...monitor weights...."</p> <p>A care plan, dated 11-30-2015, indicated, "...Problem...Nutritional Status...Poor meal acceptance and meal tolerance, significant weight loss, pressure area, advanced cognitive deficits...Weight 11/30/15 117.1 lbs....12/15/15 114.8 lbs...Approach...start date 12/09/2015...trial mechanical soft diet with ground meat, gravy on meat...start date 11/30/2015...weekly weights...start date 11/30/2015...Notify family and physician of weight loss...."</p> <p>A physician progress note, dated 1-5-2016, indicated diagnoses of, but not</p>		<p>(5) The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months. Date of compliance: 2/26/16</p>	

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	<p>limited to, end stage Alzheimer's dementia and malnutrition.</p> <p>On 1-26-2016 at 9:59 A.M., during an interview, the MDS coordinator indicated, "...she doesn't want to do anything for herself...the staff have to feed her now and she refuses to eat most of the time...."</p> <p>On 1-26-2016 at 1:05 P.M., a record review of the Consultant Dietitian notes for Resident #5, dated 12-20-2015, indicated, "...Observation...Hospice...weight this week 114.8 lbs., weight is down again, this week...2 cal [a supplement] 120 cc [cubic centimeters] QID [four times a day], and she is refusing this often. Meal acceptance poor...."</p> <p>On 1-27-2016 at 11:04 A.M., during an interview, the Consulting Dietician indicated, "...The MDS coordinator is in charge of getting the weekly weights....I don't always have them when I arrive at the facility and have to wait until the next week to evaluate the residents...weekly weights have not been getting done and we have not been having a meeting with other department heads related to weights or skin since before August...we used to but we don't anymore...we are going to start next week...I have asked for a</p>						

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	<p>reweigh on her [Resident #5] today....if repeated refusal of a supplement is noted, I usually make a change but I didn't have her weights to evaluate her...."</p> <p>On 1-27-2016 at 2:31 P.M., during an interview, the Consulting Dietician indicated, "...her [Resident #5] weight is 102 pounds today...."</p> <p>On 1-27-2016 at 8:15 A.M., Resident #5 was observed to be lying in her bed and the Activity Director was assisting Resident #5 with her eating her breakfast. Resident #5 was not accepting the meal well.</p> <p>The current policy entitled, "Policy and Procedure Nutrition Alert Program," with a revision date of 11/1/2013, was received from the Administrator on 1-26-2016 at 2:00 P.M. The policy indicated, "...Procedure...3. Weight trends will be reviewed by an interdisciplinary team at least monthly...4. Resident with indicators of weight change will be included in the Nutrition Alert Program...Significant weight change will be defined based on the following parameters:...Interval...6 months...% loss/gain 10%...d. Residents with acute or chronic wounds;...6. The nutrition alert team shall consist of, but not limited to: Dietary Manager, RD/LD (when</p>			

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F 0364 SS=D Bldg. 00	<p>available), Director of Nursing Services, Restorative Aid(s), and Therapy Services Manager...."</p> <p>3.1-46(a)(1)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to ensure food was prepared to conserve the nutritive value related to pureed food preparation. This had the potential to effect 5 of 5 pureed meals prepared.</p> <p>Findings include:</p> <p>On 1-21-16 at 11:24 A.M., during pureed meal preparation the following was observed:</p> <p>Employee #12 was observed placing 5 scoops of rice, a unmeasured amount of water, and 2 scoops of thickener into the puree bowl, blended it and placed it into a pan. Employee #12 then placed 5</p>	F 0364	<p>F364 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>(1) Immediate actions taken for those residents identified: 1. Dietary staff was immediately in-serviced on proper preparation of all pureed</p>	02/26/2016

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	<p>pieces of chicken and a unmeasured amount of water into the puree bowl, blended it and placed it into a pan. Employee #12 added 5 scoops of peas and 2 scoops of thickener to the puree bowl, blended it and placed it into a pan. Employee#12 indicated at this time "...yes we do have a recipe book ... but I don't use it..."</p> <p>During an interview on 1-21-16 at 1:09 P.M., the DM (Dietary Manager) indicated "...recipes should be followed when making pureed meals....pureed meals are a serious business...someone can aspirate and die from the wrong pureed meal...."</p> <p>3.1-21(a)(1)</p>		<p>food</p> <p>(2)How the facility identified other residents:</p> <p>a) All residents who are prescribed an alterreddiet have the potential to be affected by the deficientpractice</p> <p>(3)Measures put into place/ System changes:</p> <p>1.Allstaff was in-serviced on proper preparation and sanitation. Staffwas in-serviced on proper preparation and holding temperatures forall menu items and diets, as well as how to properly take andrecord temperatures in the log.</p> <p>2.Staffin-serviced on following recipes to ensure proper consistency isachieved</p> <p>(4)How the corrective actions will be monitored:</p> <p>a) Logs will be monitored daily by the DietaryManager/Desginee; this will be ongoing</p> <p>b) Hand washing audits will be performed by theDietary Manager/Designee weekly; this willbe ongoing (Attachment 8)</p> <p>c) Dietary Manager/Designee will audit preparationof pureed recipes daily x1 month, weekly x1 month, monthlyx4 months.</p> <p>(5) The results of these audits will be reviewed in QualityAssurance Meeting monthly x6 months.</p> <p>Date of compliance: 2/26/16</p>		

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F 0371 SS=F 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, interview and record review, the facility failed to serve food in a sanitary manner for 1 of 1 kitchens and 1 of 2 dining rooms. This had the potential to effect 26 of 27 residents who received meals from the kitchen.</p> <p>Finding includes:</p> <p>On 1-21-16 between 10:41 A.M. and 12:15 P.M., during the initial kitchen tour, the following was observed:</p> <p>In the dry storage room: a box of cream of wheat open to air.</p> <p>Stored on the top shelf, 12 inches from the ceiling, 2 insulated carafes</p> <p>In the reach in cooler: a container of liquid cheese dated 1-15-16. A bag containing 4 red peppers with no date. A bag with 4 green peppers dated 1-7-16. A bag with a half of head of green cabbage dated 12-3-15. Employee #12 indicated at this time "we keep things 3</p>	F 0371	<p>F371 The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> (1) Immediate actions taken for those residents identified: 1. All staff re in-serviced on proper hand washing techniques and proper food safety (2) How the facility identified other residents: 1. All residents being served meals by employees have the potential to be affected by this deficient practice (3) Measures put into place/ System changes: 1. All staff received training</p>	02/26/2016

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	<p>days after opening...."</p> <p>In the cupboard to the right of the stove: a open, undated, bag of powdered sugar.</p> <p>Bottom cabinet to the left of the three compartment sink, with top layer of wood broken off at the bottom.</p> <p>Veneer counter top to left of three compartment sink apart at edges, exposing wood underneath.</p> <p>Bottom corner cabinet to the right of stove missing a door.</p> <p>Employee # 12 was observed to put on gloves half way through making pureed rice, without washing her hands.</p> <p>Employee # 12 was observed to remove the food thermometer from the sanitizing solution, wipe it off with a paper towel from off the shelf, then temp the rice.</p> <p>Employee # 12 was observed to put on gloves, with out washing hands, and puree sweet and sour chicken.</p> <p>Employee #12 was observed to wash hands for 8 seconds then put on gloves and prepared mechanical soft sweet and sour chicken.</p>		<p>on proper food safety and sanitation techniques.</p> <p>2. Director of Nursing/Designee will audit all employees on proper hand washing procedure</p> <p>(4) How the corrective actions will be monitored:</p> <p>1. Director of Nursing/Designee will audit hand washing daily x1 month and 3x week x1 month, bi-weekly for 1 month, and monthly for 3 months (Attachment 8)</p> <p>2. Dietary Manager/Designee will audit proper hand washing and cleaningsanitation daily x1 month and 3x week x1 month, bi-weekly for 1 month, and monthly for 3 months (Attachment 8)</p> <p>(5) The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months.</p> <p>Date of compliance: 2/26/16</p>		

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	<p>Employee #12 was observed to remove the food thermometer from the sanitizing solution, wipe it off with a paper towel, temped the sweet and sour chicken, wiped the thermometer off with the previously used paper towel, temped the rice, wiped the thermometer off with the previously used paper towel, temped the pureed chicken, wiped the thermometer off with a paper towel, temped the peas, wiped the thermometer with the previously used paper towel, temped the mechanical soft sweet and sour chicken, wiped the thermometer off with a paper towel.</p> <p>Employee #12 was observed to wash her hands for 7 seconds, then pureed peas.</p> <p>Employee # 9 was observed putting a butter knife away while holding it by the clean end.</p> <p>Employee #9 was observed, with gloves on, to carry two trays, reach into drawers get plastic cups from storage room, then with same gloves, reach in bag of powdered sugar and sprinkle it on brownies, then cut brownies and placed them on plates.</p> <p>During an interview on 1-21-16 at 1:09 P.M., the DM (Dietary Manager) indicated "...leftovers are kept for 3</p>			

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	<p>days...vegetables we keep for a week...open food should be labeled and dated... items should be stored 18 inches from ceiling...hand washing should be done for 20 seconds or sing happy birthday twice and should be performed frequently...."</p> <p>On 1/21/16 between 12:33 P.M., and 12:50 P.M., during the lunch meal in the assisted dining room the following was observed:</p> <p>At 12:36 P.M., Employee #14 was observed to wash her hands for 8 seconds then assist a resident with their lunch.</p> <p>At 12:39 P.M., Employee #8 was observed to wash her hands for 5 seconds then serve a resident their lunch plate.</p> <p>At 12:40 P.M., Employee #8 was observed to wash her hands for 12 seconds then serve a resident their lunch plate.</p> <p>At 12:41 P.M., Employee # 15 was observed to wash her hands for 9 seconds, pulled her pants up and her top down, sat down to assist a resident with his meal, leaning on her forearms on table, then was observed to reach across table to the other end to hand a drink to a resident.</p>			

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	<p>At 12:43 P.M., Employee # 15 was observed to drop straws in wrappers, from a cabinet, onto the floor pick them up and put them back in the box. She then took some to a table, pulled her pants up and top down, sat down to assist a resident with his meal.</p> <p>On 1-21-16 at 4:09 P.M., review of the "Dish Machine Daily Temperature Record Log and the Senova Temperature Dish Machine Log" for the month of January 2016, provide by the DM indicated that dishwasher wash and rinse temperatures had not been recorded 39 times out of 61 times.</p> <p>On 1-21-16 at 4:15 P.M., review of the "Ice Cream freezer Temperature Log, Vegetable Freezer Temperature Log, 2 Door Freezer Temperature Log, and Refrigerator Temperature Log" for the month of January 2016, provided by the DM indicated that temperatures had not been recorded 118 out of 164 times.</p> <p>On 1-27-16 at 2:58 P.M., review of the undated policies titled "Handwashing and Food Receiving and Storage" provided by the Administrator, who stated it was the current policy, indicated "...B... 3. Vigorously scrub hands and arms for 15 seconds...7. All foods stored in the</p>			

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F 0456 SS=F Bldg. 00	<p>refrigerator or freezer will be covered, labeled and dated"</p> <p>During an interview on 1-27-16 at 3:20 P.M., the DM indicated "... temperature logs should be complete ...thermometer probes should be cleaned with a new probe wipe after each time, not with a paper towel ... silver ware should be touched by the handle not the clean end ... I expect the kitchen to be in a clean, maintained, and working order...."</p> <p>3.1-21(i)(2)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to maintain the dishwasher, three compartment sink, and stove, in a safe operating condition. This related to a broken dishwasher, leaking three compartment sink, and a broken stove. This had the potential to effect 26 of 27 residents that received meals from the kitchen.</p>	F 0456	<p>F456 The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of</i></p>	02/26/2016

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	<p>Findings include:</p> <p>During an interview on 1-21-16 at 10:41 A.M., Employee #12 indicated "...the gauges on the dishwasher haven't been working for about two months..."</p> <p>On 1-21-16 a 10:42 A.M., the wash cycle temperature gauge on the dishwasher was observed to have a crack across the entire gauge and did not move from 156 degrees F (Fahrenheit) before, during or after the wash cycle.</p> <p>During an interview on 1-21-16 at 11:10 A.M., Employee #12 indicated "... the three compartment sink leaks so we don't use it ... it has been leaking awhile ... since around the end of December...."</p> <p>On 1-21-16 at 11:11 A.M., a bucket was observed sitting under the last section of the three compartment sinks drain pipe, with water dripping into it..</p> <p>On 1-21-16 at 11:24 A.M., the wash cycle temperature gauge on the dishwasher was observed to not move from 156 degrees F, before, during or after the wash cycle.</p> <p>On 1-21-16 at 11:35 A.M., the wash cycle temperature gauge on the dishwasher was observed to not move</p>		<p><i>deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(1)Immediate actions taken for those residents identified:</p> <p>1.Allequipment recognized was immediately documented in a work order,put on order or repaired at that time.</p> <p>(2)How the facility identified other residents:</p> <p>1.Allresidents who are served food have the potential to be affected bythis deficient practice.</p> <p>(3)Measures put into place/ System changes:</p> <p>1.Newrange stove has been ordered and will be delivered no later than2/21/16</p> <p>2.Dishwasherwas fixed immediately and temperatures are monitored at meal times;this will be ongoing</p> <p>3.Threecompartment sink was immediately fixed when recognized</p> <p>(4)How the corrective actions will be monitored:</p> <p>1.DietaryManager/Designee will audit equipment and temperature logs eachmeal; this will be ongoing (Attachment 10)</p> <p>(5) The results of these audits will be reviewed in QualityAssurance Meeting monthly x6 months.</p>		

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	<p>from 156 degrees F, before, during or after the wash cycle.</p> <p>On 1-21-16 at 12:01 P.M., a sign posted above stove was observed to read "right 2 eyes not working." During an interview at this time with Employee # 12 she indicated "... right two burners of stove haven't worked in a while..."</p> <p>During an interview on 1-21-16 at 1:09 P.M., the DM (Dietary Manager) indicated "... I have been here for 4 days ... I didn't know the gauges on the dishwasher didn't work... the dishwasher is not working correctly...."</p> <p>During an interview on 1-21-16 at 4:10 P.M., the Corporate Nurse indicated " ... I have know about gauges not working for approximately 2-3 weeks ...they tried today to get it to hit temp but it was not hitting temp ... we purchased the building in September, we know about the issues in the kitchen...."</p> <p>During an interview on 1-22-16 at 8:52 A.M., the Administrator indicated "...we have know that the dishwasher was broke for about 3 weeks...."</p> <p>During an interview on 1-27-16 at 3:20 P.M., the DM indicated " ... I expect the kitchen to be in a clean, maintained, and</p>		Date of compliance: 2/26/16	

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F 9999 Bldg. 00	<p>working order...."</p> <p>3.1-19 (bb)</p> <p>3.1-14 PERSONNEL</p> <p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (4) past employment, experience, and education if applicable (7) documentation of orientation to the facility and to the specific job skills</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of physical exams, criminal history checks, references , general and job specific orientations were complete for 5 of 10 employee records</p>	F 9999	<p>F9999 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. 1. Immediate actions taken for those staff identified: a. Employee files for #16, #17, #15, #19, #20 have been updated to include missing information 2. How the facility identified other staff: a. All employee files and pre-employment checklists were reviewed and updated to meet state and federal regulations 3. Measures put</p>	02/26/2016

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	<p>reviewed (Employees #16, #17, #15, #19, and #20)</p> <p>Findings include:</p> <p>On 1-27-16 at 10:00 A.M., review of the employment file for Employee #16, date of hire 3-23-15, indicated that a pre employment physical exam.</p> <p>On 1-27-16 at 10:10 A.M., review of the employment file for Employee #17, date of hire 12-17-15, indicated that general orientation and job specific orientation was missing from his employee file.</p> <p>On 1-27-16 at 10:20 A.M., review of the employment file for Employee #15, date of hire 8-13-15, indicated that her general orientation and job specific orientation was missing from her employee file.</p> <p>On 1-27-16 at 10:50 A.M., review of the employment file for Employee #19, date of hire 6-26-15, indicated that her general orientation and job specific orientation was missing from her employee file.</p> <p>On 1-27-16 at 11:00 A.M., review of the employment file for Employee#20, date of hire 12-17-15, indicated that her references, general orientation, and job specific orientation was missing from her employee file.</p>		<p>into place/systems changes:</p> <p>a. Human Resources Manager created a pre-employment checklist (Attachment 11)</p> <p>b. Prior to employment there will be a TB, physical, and complete orientation with job description 4. How the corrective action will be monitored:</p> <p>a. Administrator/designee will audit new hire employee files for the month and long term and employees; audit 5 files per month, including all new employees hired within that month, x 6 months (Attachment 12) 5. The results if these audits will be reviewed in Quality Assurance Meeting monthly x6. Date of compliance: 02/26/2016</p>	

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NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18325 BAILEY AVE SOUTH BEND, IN 46637
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	<p>On 1-27-16 at 11:10 A.M., review of the employment file for the Administrator, date of hire 10-26-15, indicated that her general orientation and job specific orientation was missing from her employee file.</p> <p>On 1-27-16 at 1:00 P.M., review of the undated policy titled " Employment" provided by the BOM (Business Office Manager) who stated this was the current policy, indicated " ...2. The facility will abide by all appropriate regulations specified by the stat or federal government...G. Documentation that references were verified....</p> <p>During an interview on 1-27-16 at 12:12 P.M., the Administrator indicated "... when the new company took over in September 2015, new employees did not have physicals completed... all new employees should have pre employment physicals, references, general and job specific orientations...."</p> <p>3.1-14(q)(4) 3.1-14-(q)(7)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility</p>			

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	<p>within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date, given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p>			

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	<p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of TB (tubercular) testing, was complete for 5 of 10 employee records reviewed (Employees # 16, #18, #13, #19, and #20).</p> <p>Finding includes:</p> <p>On 1-27-16 at 10:00 A.M., review of the employment file for Employee #16, date of hire 3-23-15, indicated that a pre employment physical exam and 1st and 2nd step TB testing was missing from her employee file.</p> <p>On 1-27-16 at 10:30 A.M., review of the employment file for Employee # 18, date of hire 10-27-15, indicated that her annual TB testing was missing from her employee file.</p> <p>On 1-27-16 at 10:40 A.M., review of the employment file for Employee #13, date of hire 10-28-13, indicated that her annual TB testing was missing from her employee file.</p> <p>On 1-27-16 at 10:50 A.M., review of the employment file for Employee #19, date of hire 6-26-15, indicated that her 1st and</p>			

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	<p>2nd step TB testing was missing from her employee file.</p> <p>On 1-27-16 at 11:00 A.M., review of the employment file for Employee#20, date of hire 12-17-15, indicated that her 1st and 2nd step TB testing was missing from her employee file.</p> <p>On 1-27-16 at 1:00 P.M., review of the undated policy titled " Employment" provided by the BOM (Business Office Manager) who stated this was the current policy, indicated " ...2. The facility will abide by all appropriate regulations specified by the stat or federal government...14. A employment may begin after a negative first step Mantoux tuberculin test has been performed and read ... unless the employee has a documented negative PPD (purified protein derivative) during the past 12 months... shall be tested using the 2 step method..."</p> <p>During an interview on 1-27-16 at 12:12 P.M., the Administrator indicated "... all new employees should have fist and second step TB testing and all currnet employees should have annual TB's..."</p> <p>3.1-14(t)(1)</p>			

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

PRINTED: 03/02/2016

FORM APPROVED

OMB NO. 0938-0391

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