

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/04/2015
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NAME OF PROVIDER OR SUPPLIER  SEBO'S NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00180316.</p> <p>Complaint IN00180316-Substantiated. Federal/State deficiencies related to the allegations are cited at F312.</p> <p>Survey dates: August 31, September 1, 2, 3, and 4, 2015.</p> <p>Facility number: 000366 Provider number: 155469 AIM number: 100288900</p> <p>Census bed type: SNF/NF: 115 Total: 115</p> <p>Census payor type: Medicare: 16 Medicaid: 82 Other: 17 Total: 115</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by</p>	F 0000	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. Sebos would also like to respectfully request a desk review for the citations received in the Recertification and State Licensure Survey. Thank you.</p>	
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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 0157 SS=D Bldg. 00	<p>26143, on September 13, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>			

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	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the resident's Legal Representative was notified when there was a change in the resident's condition related to a decrease in self feeding for 1 of 1 residents reviewed for notification of change of the 1 resident who met the criteria for notification of change. (Resident #93)</p> <p>Finding includes:</p> <p>On 9/1/15 at 10:20 a.m., Resident #93's son was interviewed, who was the resident's Power of Attorney. The son indicated his mother had a change in status and now needs to be fed. He indicated he was not notified promptly of the change and just "found out" she had been moved to the assisted feeding tables in the dining room and was not at her regular table anymore.</p> <p>On 9/2/15 at 4:45 p.m. the resident was observed sitting at a table in the dining room waiting on dinner to be served. She was seated at a table where other residents required assistance eating.</p> <p>On 9/3/15 at 8:10 a.m., the resident was sitting up in a wheelchair and seated at</p>	F 0157	<p>It is the practice of this facility to ensure that family and physician notification is completed timely for significant changes in physical, mental or psychosocial status or deterioration in health.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #93 family was notified of change in feeding assistance.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b></p> <p>All facility residents who have</p>	09/18/2015

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	<p>the assisted with feeding table in the dining room.</p> <p>The record for Resident #93 was reviewed on 9/03/15 at 9:29 a.m. The resident's diagnoses included but were not limited to, altered mental status, senile dementia, Alzheimer's disease, and dysphasia.</p> <p>An Occupational Therapy screen dated 7/10/15 indicated the resident's self feeding was impaired and there had been a change in her condition. The recommendation was "increased assistance needed for self feeding."</p> <p>Nursing progress notes dated 7/10/15 through 7/31/15 indicated there was no documentation the resident's son was notified of this recent change in status.</p> <p>Interview with Restorative CNA #1 on 9/03/15 at 10:29 a.m., indicated the resident was recently moved to the assisted feeding table shortly after the therapy screen. She indicated the resident was on the other side of the dining room but then she needed more help so she was moved. She indicated for the exact date, the Dietary Food Manager would have the seating chart and would be able to get it.</p>		<p>a change in condition have the potential for the alleged deficient practice.</p> <p>Facility residents have been reviewed to ensure that notification of family and physician has taken place for any change of condition.</p> <p>The IDT team will enhance the current daily clinical review to ensure that notification is completed for residents change in physical, mental and psychosocial status including any change in feeding status.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>The nursing staff was in serviced on:</p> <p>Facility Policy: "Change in a Resident's Condition or</p>				

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	<p>Interview with the Administrator on 9/03/15 at 10:58 a.m., indicated the seating chart form where the resident was sitting was not available. She indicated the resident was moved sometime shortly after July 10th, after the therapy screen.</p> <p>Interview with the Restorative Nurse on 9/3/15 at 11:00 a.m., indicated the resident was moved after that screen because therapy had not picked her up for self feeding.</p> <p>Interview with the Main Station Unit Manager on 9/3/15 at 1:15 p.m., indicated she had started her position towards the end of July and was not here when the resident was screened for feeding. She further indicated there was no documentation the resident's son was notified his mother had been moved from the regular seating in the dining room to the assisted feeding dining room.</p> <p>3.1-5(a)(2)</p>		<p>Status" related to notifications.</p> <p>The importance of notification to responsible parties, physicians, and clinical management team of residents who have had a change in condition including a change in feeding assistance.</p> <p><b>How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The Administrator/Designee will review 15 residents a week during clinical review meeting to ensure that notification of family and physician has taken place for any change of condition.</p> <p>The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly</p>	

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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure dental recommendations related to oral surgery were followed up on for 1 of 3 residents reviewed for dental services of the 9 residents who met the criteria for dental services. (Resident #D)</p> <p>Finding includes:</p> <p>On 8/31/15 at 2:18 p.m., Resident #D was observed in her room. The resident was observed to have some missing lower teeth.</p> <p>The record for Resident #D was reviewed on 9/1/15 at 1:38 p.m. A dental evaluation dated 4/24/15 indicated the resident had some missing teeth and she had a complete upper denture but it was</p>	F 0250	<p>for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</p> <p>F 250</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Resident D Power of Attorney was contacted the same day as survey and was explained risks related to not following recommendation of oral surgery. Family understood but still declined to further treatment at this time. Resident is on hospice care. Resident record was updated at time of survey.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p>	09/18/2015	

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	<p>lost. Documentation indicated the resident could benefit from a new upper complete and lower partial denture. The resident agreed and wanted dentures made after extracting #28 retained root. The plan was to refer the resident to the Oral Surgeon to extract tooth #28 for new upper complete and lower partial dentures. The dentist's office was to be contacted for help with scheduling the Oral Surgery appointment.</p> <p>An entry was completed in the Social Service progress notes on 4/24/15 at 2:54 p.m., indicating the resident had been seen by the dentist and recommendations were placed in the chart.</p> <p>The resident was seen by the dentist on 7/10/15. The dental progress note indicated tooth #28 had not been extracted and oral surgery recommendations were made.</p> <p>An entry was completed in the Social Service progress notes on 7/14/15 at 11:15 a.m., indicating the resident was seen by the dentist on 7/10/15 and recommendations were placed in the chart.</p> <p>The resident was seen by the dentist on 8/21/15. The dental progress note indicated the resident does not have a</p>		<p>Facility residents with recommendations from the dentist have the potential to be affected by the same alleged deficient practice.</p> <p>Social Service reviewed all in house residents who were seen by our dental service provider in the last quarter. Any recommendations noted was followed up on and ensured proper documentation of information given to families is present. Social Services will maintain a tracking system to identify residents with further treatment orders are followed up on according to policy.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Social Services was educated on documentation requirements related to family education on recommendations made by dental service provider.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Social Service/Designee will review dental recommendations once received to ensure follow up and notification to family is completed per policy.</p> <p>Administrator/Designee will</p>		

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F 0279 SS=D Bldg. 00	<p>denture and needs teeth #21 and #28 extracted by an oral surgeon for new upper complete and lower partial dentures to be made in the the future.</p> <p>Documentation in the Social Service progress notes dated 8/31/15 at 9:08 a.m., indicated the resident was seen by the dentist on 8/21/15. The recommendations were placed in the chart.</p> <p>There was no documentation in the resident's record related to arranging for oral surgery and/or contacting the resident's guardian related to the recommendations.</p> <p>Interview with Social Service employee #1 on 9/3/15 at 9:00 a.m., indicated he would follow up with the resident's guardian. He also indicated there was no documentation to indicate if the guardian was contacted in April at the time of the original recommendation.</p> <p>3.1-34(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the</p>		<p>summarize tracking tool monthly and bring to Quality Assurance Committee for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.</p>	

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	<p>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, record review and interview, the facility failed to ensure a care plan was initiated related to tracheostomy care for 1 of 1 residents reviewed for tracheostomy care. (Resident #64)</p> <p>Finding includes:</p> <p>On 9/1/15 at 1:25 p.m., Resident #64 was observed in his room in bed. The resident was observed to have a tracheostomy (an opening in the neck to assist with breathing).</p> <p>The record for Resident #64 was reviewed on 9/1/15 at 2:12 p.m. The resident's diagnoses included, but were</p>	F 0279	<p>It is the practice of this facility to ensure that comprehensive care plans are developed for residents to meet their medical, nursing, and mental and psychosocial needs. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #64 plan of care was updated to include tracheostomy care. Resident #64 suffered no ill effects from this alleged deficient practice. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b> All facility residents have the potential to be affected by the same alleged deficient</p>	09/18/2015

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F 0312 SS=D Bldg. 00	<p>not limited to, tracheostomy and chronic respiratory failure.</p> <p>The 7/23/15 Admission Minimum Data Set (MDS) assessment, indicated the resident was receiving tracheostomy care.</p> <p>The plan of care dated 7/30/15 was reviewed. There was no current care plan related to the resident's tracheostomy and tracheostomy care.</p> <p>Interview with the MDS Coordinator on 9/4/15 at 12:05 p.m., indicated the resident had no care plan related to his tracheostomy until today.</p> <p>3.1-35(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the</p>		<p>practice. MDS Team reviewed care plans for residents admitted within the last 6 months to ensure care plans are in place for services provided. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> MDS team and the nursing staff were educated on the importance of reviewing services rendered upon admit and any change of condition while under our care and ensuring that a care plan is in place for each service provided. <b>How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>Per the MDS schedule, The MDS/Nurse Designee will audit residents care plans to ensure care plans are in place for each service provided. The Administrator/designee will present a summary of the audit to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting.</p>		

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	<p>necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to ensure incontinence care was provided in a timely manner as well as ensuring dependent residents were checked for incontinence at least every two hours for 2 of 3 residents reviewed for urinary incontinence of the 3 who met the criteria for urinary incontinence. (Residents #C and #D)</p> <p>Findings include:</p> <p>1. On 8/31/15 at 1:26 p.m., Resident #D was observed seated in her wheelchair in her room. There was a puddle of yellow liquid underneath the resident's wheelchair. At 1:47 p.m., the resident remained seated in her wheelchair with the puddle of yellow liquid underneath her wheelchair. At 1:50 p.m., LPN #2 entered the resident's room and indicated that she would get the resident's CNA and gather supplies for incontinence care. When CNA #3 transferred the resident from her wheelchair to the bed, the seat of her pants were wet as well as the seat cushion in the resident's wheelchair. The resident's brief was saturated with urine and stool was present as well. Interview with the CNA at the time, indicated he</p>	F 0312	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>LPN #1 immediately assisted R#D when she observed R#D's incontinence.</p> <p>R#C was provided incontinent care by assigned aide on 9/1/15 and 9/2/15.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. The MDS of all residents was audited to identify like residents. A list was compiled for identification of residents who are dependent and incontinent.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Director of Nursing in serviced individual nurses, restorative staff, therapy staff, C.N.A.s, and activity staff in regards to:</p>	09/18/2015

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	<p>checked the resident before lunch but didn't give a time.</p> <p>The record for Resident #D was reviewed on 9/1/15 at 1:38 p.m. The Quarterly Minimum Data Set (MDS) assessment indicated the resident needed extensive assist for toilet use and was frequently incontinent of urine.</p> <p>Interview with LPN #2 on 9/4/15 at 10:15 a.m., indicated as soon as she saw the resident she assisted with care and got her CNA. She also indicated the resident should have been toileted in a more timely manner.</p> <p>2. On 09/01/2015 at 9:00 a.m., Resident #C was observed with wet pants while working with the Restorative Department outside of the Rainbow room.</p> <p>On 09/02/2015 at 12:55 p.m. thru 3:31 p.m., the resident was observed seated in his wheelchair in the activities room. The resident remained in the activities room during the above observations without staff checking for incontinence or taking him to his room. The resident did not leave the activity room until 3:57 p.m., and at that time was taken straight to the dining room.</p> <p>On 09/03/2015 at 8:02 a.m., CNA #1 was asked how they check the residents for</p>		<ul style="list-style-type: none"> <li>· Routine observation of residents that are incontinent to ensure residents are clean and dry.</li> <li>· Incontinent checks should occur before and after any activity including therapy, restorative sessions, activities, and meals.</li> <li>· Residents should be observed every two hours to ensure residents are clean and dry.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Seven days a week the DON/designee will observe five dependent/incontinent residents on alternating shifts and during meals, restorative sessions, activities, and therapy to ensure all shifts are included and observe residents to ensure they are clean and dry. Residents noted with incontinence will immediately be provided incontinent care.</p> <p>The DON/Designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.</p>	

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	<p>incontinence care. She indicated they check all the residents every two hours or as needed regardless of where the residents were at. She further indicated they take the residents to their room for privacy and do an incontinence check and change if necessary, then they take the resident back to where they picked them up. She further indicated that the facility has in-services every month regarding incontinence care.</p> <p>On 09/03/2015 at 12:45 p.m., the resident was observed seated in his wheelchair with wet pants, outside of the nurses station.</p> <p>The record for Resident #C was reviewed on 09/02/2015 at 4:11 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, hyperlipidemia, cerebrovascular accident, non Alzheimer dementia, senile with depression, dysphagia, seizure disorder, and hemiplegia.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated 08/28/2015 indicated the resident needed extensive assist with 2 person physical assist for transfers and toilet use. The resident was always incontinent of bowel and bladder.</p> <p>The bowel and bladder assessment dated</p>			

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	<p>08/28/2015 indicated the resident used incontinent briefs and was always incontinent. The resident needed assist of 2 to toilet.</p> <p>The care plan dated 06/11/2015 indicated the resident has a communication impairment as evidence by having difficulty verbalizing content. The nursing interventions were to anticipate the resident's needs. The resident had a Brief Interview for Mental Status (BIMS) of 05/15, indicating cognitive impairment.</p> <p>The care plan dated 09/24/2015 indicated the resident experienced bowel and bladder incontinence. The goal for the resident was to remain clean, dry, and odor free. The nursing interventions were to provide incontinence care after each incontinent episode, use incontinent brief to enhance dignity and hygiene.</p> <p>Interview with CNA #2 on 09/03/2015 at 12:59 p.m., indicated the resident was a little wet, and his pants were wet. She further indicated the facility has a check and change policy and the residents should be checked no matter where they are.</p> <p>Interview with Assistant Director of Nursing (ADON) on 09/03/2015 at 2:47</p>			

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F 0323 SS=D Bldg. 00	<p>p.m., indicated the facilities checking and changing policy was the same as their wound in-services.</p> <p>Review of the current Wound In-service policy provided by the ADON on 9/04-15 at 11:40 a.m., ....11. Toileting and Incontinence Care: Residents should be checked every two hours and as needed with toileting and or incontinence care provided.</p> <p>This Federal tag relates to Complaint IN00180316.</p> <p>3.1-38(a)(3)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure each resident with a history of falls was free from accidents related removing leg rests when the resident was seated at a table for 1 of 3 residents reviewed for accidents of the 6 residents who met the criteria for accidents. (Resident #78)</p>	F 0323	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Resident #78 leg rests were removed during meals. In addition, staff were in serviced on Resident #78 specific needs.</p>	09/18/2015			

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	<p>Finding includes:</p> <p>On 9/01/15 at 1:32 p.m., Resident #78 was observed seated in his wheelchair at a table in the Daisy Lane dining room. At that time, the resident's leg rests were attached to the chair and lifted straight up.</p> <p>On 9/2/15 at 10:00 a.m., the resident was observed seated in his wheelchair at a table in Daisy Lane dining room. At that time, the resident's leg rests were attached to the chair and lifted straight up.</p> <p>On 9/2/15 at 2:15 p.m., the resident was observed seated in his wheelchair at a table in the Daisy Lane dining room. At that time, the resident's leg rests were attached to the chair and lifted straight up. The resident attempted to stand on his own two times, each time he was able to stand up with the leg rests attached to the chair.</p> <p>On 9/03/15 at 1:24 p.m., the resident was observed seated in his wheelchair at a table in the Daisy Lane dining room. At that time, the resident's leg rests were attached to the chair and lifted straight up. The resident attempted to stand on his own three times. The resident stood</p>		<p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. The list of all fall interventions was updated and audited to ensure fall interventions were in place and being followed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Director of Nursing in serviced the nursing staff on:</p> <ul style="list-style-type: none"> <li>· Where to find updated fall interventions.</li> <li>· Following the care card for individualized needs.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>The DON/designee will audit 15 residents a week to ensure that fall interventions are in place.</p> <p>The DON/Designee will present a summary of the audits to the Quality Assurance committee monthly for</p>	

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	<p>up with the leg rests attached to the chair.</p> <p>The record for Resident #78 was reviewed on 9/02/15 at 2:28 p.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, dementia, difficulty walking, muscle weakness, lack of coordination, anxiety, and agitation.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated 6/24/15 indicated the resident was not alert and oriented with both short and long term memory problems. The resident was severely impaired for decision making. The resident needed extensive assistance with two person physical for transfers. The resident had a history of one fall with no injury since the last assessment.</p> <p>Nursing Progress Notes dated 6/25/15 at 2:30 p.m., indicated "Staff witnessed the resident stand up and attempted to step to the left side of the chair. The resident tipped over leg rest. Writer observed resident in dining area lying on left side of body on the floor."</p> <p>The Fall Follow-up was reviewed. The Post Fall Management Quality Assurance form dated 7/3/15 indicated the plan of action was to remove the leg rests. The Management Follow-up to Incidents form</p>		nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.		

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F 0329 SS=D Bldg. 00	<p>indicated the post fall interventions were to have the leg rests to the wheelchair removed when the resident was seated at table in the dining room. The leg rests were to be used during transports of the resident.</p> <p>The Fall Event dated 8/27/15 at 9:20 a.m., indicated the resident was witnessed to stand up from his wheelchair and fell to the floor. The resident sustained a bruise to his right forehead and a skin tear to his right forearm.</p> <p>Interview with the Director of Rehab on 9/03/15 at 1:43 p.m., indicated after the fall on 6/25/15 the interventions put into place at that time were to have the leg rests removed from the wheelchair while seated at a table. He further indicated the decision was a cumulative consensus with the entire Inter-Disciplinary Team (IDT) team.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive</p>			

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	<p>dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a Gradual Dose Reduction (GDR) was at least attempted for each resident yearly related to anti-depressant medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #93)</p> <p>Finding includes:</p> <p>The record for Resident #93 was reviewed on 9/03/15 at 9:29 a.m. The resident's diagnoses included but were not limited to, altered mental status, senile dementia, Alzheimer's disease, psychotic disorder with delusions, hallucinations, vascular dementia, psychological disturbance, and</p>	F 0329	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Psych services reviewed R#93's medical record and new orders were obtained to reduce the antidepressant dose.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. A full house audit was completed for all central nervous system agents</p>	09/18/2015

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	<p>non-organic psychosis.</p> <p>Physician Orders dated 2/11/14 indicated Zoloft (an anti-depressant medication) 50 milligrams (mg) daily.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 7/2/15 indicated the resident was not alert and oriented. The resident received an anti-depressant medication for 7 days.</p> <p>The resident was being seen by an outside Psychological company contracted by the facility. Review of the progress notes dated 2/2015 through 8/2015 by a Nurse Practitioner, indicated there was no documentation or information regarding a dose reduction for the Zoloft or that it was contraindicated to reduce at that time.</p> <p>Interview with the Director of Nursing on 9/03/15 at 2:44 p.m. indicated the Nurse Practitioner was focusing on decreasing the resident's Namenda (a medication used for dementia) and Seroquel (an anti-psychotic medication). She further indicated the resident was started on the Zoloft on 2/11/14 and there had been no attempts to reduce the Zoloft since it had been initiated. She indicated there was no documentation from the Nurse Practitioner or the Physician to indicate</p>		<p>(antidepressants, antipsychotics, psychotherapeutic agents, barbiturates, anxiolytics, sedatives, hypnotics, benzodiazepines, and anticonvulsants when used as psychotherapeutic agent) to identify any medications that have not been reduced.</p> <p>Any residents with medications identified during auditing have been reported to the primary care physician and as appropriate, psych services for assessment. If a GDR is contraindicated the physician/psych services has documented failed attempts with reason/s or new orders to reduce/discontinue.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Director of Nursing/designee will be tracking all new antidepressants ordered and/or new residents with orders for central nervous system agents to ensure reductions are attempted timely and/or documentation is entered with specific rationale of contraindications for drug reductions.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p>		

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F 0412 SS=D Bldg. 00	<p>decreasing the Zoloft would be contraindicated while attempting to reduce the Seroquel.</p> <p>3.1-48(b)(2)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident had a follow-up visit with the dentist after receiving new dentures for 1 of 3 residents reviewed for dental of the 9 residents who met the criteria for dental. (Resident #42)</p>	F 0412	<p>Monthly the DON/designee will audit 15 psychotherapeutic agents that are due for reductions to ensure orders are obtained for reductions or documentation is entered with specific rationale of contraindications for drug reductions.</p> <p>The Director of Nursing will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Resident #42 has follow-up appointment with dental service provider on 9/18/15.</p>	09/18/2015			

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	<p>Finding includes:</p> <p>On 9/115 at 8:42 a.m., Resident #42 was observed walking down the hallway toward her room. She indicated she had just eaten breakfast. The resident was edentulous (without teeth).</p> <p>On 9/2/15 at 1:10 p.m., Resident #42 was observed in bed. At that time, she had her upper dentures in her mouth. The dentures were loose and slipping, they did not fit correctly while she spoke.</p> <p>On 9/3/15 at 8:15 a.m., the resident was observed eating breakfast. At that time, she was observed with both her upper and lower dentures in her mouth. While speaking to the resident, the upper denture were observed to slip downward and were fitting loosely in her mouth.</p> <p>The record for Resident #42 was reviewed on 9/02/15 at 10:42 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, depressive disorder, senile dementia, and tooth pulp degeneration.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated 4/13/15 indicated the resident was not alert and oriented and was edentulous.</p>		<p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>Facility residents with new denture placement have the potential to be affected by the same alleged deficient practice.</p> <p>Social Service has reviewed all in house residents who were seen by our dental service provider in the last quarter. Any resident with new dentures received were observed for proper fit. Social Services will maintain a tracking system to identify residents with further treatment needs or requests.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Nursing Staff and social services were educated on monitoring for fit and comfort related to dental apparel.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Social Service/Designee will review 6 residents with dentures weekly to ensure proper fit to observe for</p>	
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	<p>The Quarterly MDS assessment dated 8/24/15 indicated the resident had no oral problems.</p> <p>A dental consult dated 4/24/15 indicated the resident's upper and lower dentures were delivered. The upper dentures were adjusted at the buccal portion of the tissue side of the dentures.</p> <p>Interview with the Special Care Unit Evening Supervisor on 9/02/15 at 1:24 p.m., indicated she was the Supervisor for the unit and also worked the floor. She indicated the resident received her dentures about 3 months ago and when she received them they did not fit correctly. She further indicated she was on the list for the dentist to see again to get the dentures fixed.</p> <p>A list provided by the Administrator indicated the Dentist had visited the facility on 4/24/15, 5/22/15, 6/27/15, 7/10/15, and 8/21/15, however, the resident had not seen him after receiving the new dentures.</p> <p>Interview with the Administrator on 9/02/15 at 2:48 p.m., indicated the resident was seen by the dentist in March and April of 2015. She further indicated she had not seen the dentist since the note</p>		<p>discomfort and refer as needed.</p> <p>Administrator/Designee will summarize tracking tool monthly and bring to Quality Assurance Committee for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.</p>	

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F 0463 SS=D Bldg. 00	<p>from April 2015 which indicated the dentures fit good.</p> <p>Continued interview with the Administrator on 9/02/15 at 3:15 p.m., indicated the resident does not eat with her dentures but when questioned why, she did not know the answer. She further indicated the Unit Director for the Special Care Unit indicated the resident's dentures had not been fitting correctly for about 30 days. She further indicated she did not know why the resident was not seen on 8/21/15 when the dentist was last at the facility, which would have been within the last 30 days.</p> <p>3.1-24(a)(3)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to ensure that the call light system was properly functioning in a residents room. (Room D-54)</p>	F 0463	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Resident Room D-54 call light was</p>	09/18/2015

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	<p>Finding includes:</p> <p>During a room observation on 09/01/2015 at 8:21 a.m., the call light button was pressed in the room and it did not light up outside of the resident's room, or at the nurses station. The Maintenance man came in the room and pressed the call light button and it did not light up.</p> <p>An interview with the Maintenance man at that time, indicated the call light cord and push button were no good. He also indicated he could hear the call light rattle on the inside, indicating it probably was crushed between the wall and the bed at one time. He further indicated the call light should have been functioning.</p> <p>3.1-19(u)(1)</p>		<p>replaced at time of observation. Residents who occupied this room suffered no ill effects from this alleged deficient practice.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents with a call light in their room have the potential to be affected by the same alleged deficient practice.</p> <p>Staff rounds were completed during Survey to ensure all resident rooms were properly equipped with functioning call lights.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Facility staff was educated on the importance of checking the resident call light system for proper placement and function when entering a resident room.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Facility Guardian Angel managers will complete weekly audit of their assigned rooms to ensure call light is</p>				

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to dusty fan blades and covers, marred walls and doors, discolored floor tile, rusted bolts on toilets, torn and/or frayed floor mats and urine odors in bathrooms on 3 of 3 units throughout the facility and the main kitchen. (The Main Kitchen, the Main Unit, Daisy Lane Unit and Bakersfield)</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation tour on 9/3/15 at 3:10 p.m., with the Dietary Food Manager, a fan attached to the wall in the dish area was observed to have an</p>	F 0465	<p>properly functioning. These audits will be turned into Administrator for review.</p> <p>Administrator/Designee will summarize tracking tool monthly and bring to Quality Assurance Committee for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Kitchen fan attached to the wall was cleaned. Room B-59 bathroom floor was deep cleaned. Room D-54 bathroom floor was deep cleaned. Room B-62 ceiling tile replaced, and room was placed on maintenance schedule for wall paper removal and painting. Room C-6 bathroom wall was touched up with paint on wall and door frame. Room C-9 bathroom door frame was touched up with paint.</p>	09/18/2015	

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	<p>accumulation of dust on the fan cover and fan blades.</p> <p>Interview with the Dietary Food Manager at the time, indicated the fan cover and blades were in need of cleaning and she would notify Maintenance right away.</p> <p>2. During the initial tour on 09/01/2015 at 8:42 a.m., the following was observed:</p> <p>a. A strong urine odor was observed in the bathroom of Room B-59.</p> <p>On 09/02/2015 at 8:55 a.m., a strong urine odor was observed in the bathroom. Two residents shared this bathroom.</p> <p>b. There was a strong urine odor was observed in the bathroom of Room D-54.</p> <p>On 09/02/2015 at 9:05 a.m., a strong urine odor was observed in the bathroom. Four residents shared this bathroom.</p> <p>3. During the Environmental tour on 09/04/2015 at 12:01 p.m., with the Corporate Facility Engineer, Maintenance Director, and the Environmental Services Director, the following was observed on Bakersfield (B), Cherry Lane (C), and Daisy Lane (D):</p> <p>The Bakersfield Unit:</p>		<p>Room C-13 bathroom wall was touched up with paint, floor mat was replaced.</p> <p>Room C-14 was placed on rotation for wall paper removal and painting.</p> <p>Room D-44 bathroom door was cleaned, register behind bed was painted.</p> <p>Room D-46 bathroom door frame was touched up.</p> <p>Room D-47 bathroom door frame was touched up.</p> <p>Room D-49 bathroom door frame was sanded &amp; touched up, ceiling vent was cleaned.</p> <p>Room D-50 bedroom and bathroom door frames were touched up, toilet base bolts were replaced.</p> <p>Room D-53 bedroom and bathroom door frames were touched up.</p> <p>Room D-54 bathroom door was cleaned, ceiling vent was cleaned, and the toilet base bolts were replaced.</p> <p>Room D-57 bathroom and bedroom door frame was touched up, ceiling vent in bathroom was cleaned.</p> <p>Bathroom tile and grout in rooms C-6,C-13,C-14,C-17, D-46, D-47, D-49, D-50, D-53, D-54 and D-57 were placed on maintenance request for repair or grout replacement.</p> <p>Doors for rooms C-9,C-30,D-44, D-46,D-47,D-49,D-50, D-53, D-54,D-57 bathrooms and bedrooms were inspected for loose, broken or splintered surfaces to ensure a functional and sanitary environment.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient</b></p>		

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	<p>a.. The wall located between the two beds in Room B-62 had wallpaper peeling and the paint was chipped. There were brown stained ceiling tiles. Two residents resided in this room.</p> <p>The Cherry Lane Unit:</p> <p>a. The grout throughout the bathroom floor tiles in Room C-6 was discolored and stained. The bathroom wall next to the trash can was marred, and the paint on the bathroom door frame was chipped. Two residents shared this bathroom.</p> <p>b. The inside of the bathroom door frame and baseboard were marred in Room C-9. Two residents shared this room.</p> <p>c. The grout between the bathroom floor tile in Room C-13 was discolored and stained around the toilet. The wall next to the trash can was marred. The bedside floor mat was torn next to bed-2. Two residents resided in this room.</p> <p>d. The grout throughout the bathroom floor tile in Room C-14 was discolored and dirty. The wallpaper behind the head of bed 2 was frayed. Two residents shared this room.</p> <p>e. The grout between the bathroom floor</p>		<p><b>practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Housekeeping was in-serviced on proper room cleaning, including the vents, bathroom floors, and washing bathroom doors. Housekeeping Supervisor will audit five rooms weekly to ensure proper cleaning of rooms takes place. Maintenance schedule was reviewed to ensure that timely inspection of each resident room is added to the schedule for repairs. Schedule of preventative room maintenance will be reviewed weekly by Administrator to ensure rooms are tended to timely. Facility staff were in-serviced on maintenance service forms and their use to report any damage to walls or furniture. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Housekeeping Supervisor will review 5 rooms a week to ensure proper cleaning takes place. Maintenance Supervisor will review preventative maintenance schedule weekly with Administrator to ensure rooms are tended to timely. Housekeeping Supervisor and Administrator will summarize</p>	

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	<p>tile in Room C-17 was discolored around the shower drain. One resident shared this bathroom.</p> <p>f. The base of the bathroom door in Room C-30 was scratched and marred. Two residents shared this bathroom.</p> <p>The Daisy Lane Unit:</p> <p>a. The bedroom and bathroom door frame in Room D-44 was marred and rusty. The register behind the bed was marred near bed 2. Two residents resided in this room.</p> <p>b. The grout between the bathroom floor tile in Room D-46 was discolored. The bedroom door frame was marred. The bathroom door and door frame was marred. Two residents resided in this room.</p> <p>c. The grout between the bathroom floor tile in Room D-47 was discolored. The bedroom door frame was marred. The bathroom door and door frame was marred. Two residents resided in this room.</p> <p>d. The grout between the bathroom floor tile in Room D-49 was discolored. The bedroom and bathroom doors were marred. The bathroom door frame was</p>		<p>tracking tool monthly and bring to Quality Assurance Committee. The results of the audit will be presented to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.</p>	

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	<p>rusty at the base. The ceiling vent in the residents room was dusty. Two residents resided in this room.</p> <p>e. The grout between the bathroom floor tile in Room D-50 was discolored. The bedroom and bathroom door frames were marred. The toilet base had urine stained rusted bolts. Two residents resided in this room.</p> <p>f. The grout between the bathroom floor tile in Room D-53 was discolored. The bathroom and bedroom doors were marred. Two residents resided in this room.</p> <p>g. The grout between the bathroom floor tile in Room D-53 was discolored. The bathroom and bedroom doors were marred. Two residents resided in this room.</p> <p>h. The grout between the bathroom floor tile in Room D-54 was discolored. The inside of the bathroom door was marred and sticky. The ceiling vent in the residents room was dusty. The toilet base had rusted bolts. Two residents resided in this room.</p> <p>i. The inside of the bathroom door in Room D-54 was marred and sticky. The toilet base had rusted bolts. Two</p>			

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F 0520 SS=D Bldg. 00	<p>residents shared bathroom.</p> <p>j. The grout between the bathroom floor tile in Room D-57 was discolored. The bathroom vent was dusty and dirty. The inside of the bathroom door and door frame was marred. One resident shared this bathroom.</p> <p>Interview with the Corporate Facility Engineer, Maintenance Director, and Environmental Service Director at that time, indicated that all the above areas observed during the environmental tour was in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p>			

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	<p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, record review and interview, the facility failed to identify the non-compliance of incontinence care related to dependent residents.</p> <p>Finding includes:</p> <p>Interview with the Medical Records Director on 9/1/15 at 1:20 p.m., indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Administrator, the Director of Nursing, Social Service, Dietary, Activities, Nursing, as well as the Medical Director. The Medical Records Director indicated at the time, incontinence was addressed during QAA meetings, however, she was unsure if a plan of action had been implemented and put into place.</p> <p>Interview with the Administrator and the Restorative Director on 9/4/15 at 1:38 p.m., indicated QAA addressed toileting and had implemented plan of care, however, it was related to strengthening</p>	F 0520	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident #D had no adverse effects having his ADL care provided.</p> <p>Resident #C had no adverse effects having his ADL care provided.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b></p> <p>All facility residents have the potential be affected by the alleged deficient practices.</p> <p>CNA #3 was educated related to compliance of incontinence care for</p>	09/18/2015

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	<p>and ensuring call lights were being answered in a timely manner. Further interview with the Administrator at the time indicated, she did not see a concern with incontinence care and/or toileting related to dependent residents.</p> <p>On 8/31/15 at 1:26 p.m., Resident #D was observed seated in her wheelchair in her room. There was a puddle of yellow liquid underneath the resident's wheelchair. At 1:47 p.m., the resident remained seated in her wheelchair with the puddle of yellow liquid underneath her wheelchair. At 1:50 p.m., LPN #2 entered the resident's room and indicated that she would get the resident's CNA and gather supplies for incontinence care. When CNA #3 transferred the resident from her wheelchair to the bed, the seat of her pants were wet as well as the seat cushion in the resident's wheelchair. The resident's brief was saturated with urine and stool was present as well. Interview with the CNA at the time, indicated he checked the resident before lunch but didn't give a time</p> <p>On 09/01/2015 at 9:00 a.m., Resident #C was observed with wet pants while working with the Restorative Department outside of the Rainbow room.</p> <p>On 09/02/2015 at 12:55 p.m. thru 3:31</p>		<p>dependent residents.</p> <p>Restorative Department was educated related to compliance of incontinence care for dependent residents.</p> <p>Nursing Staff were educated on the importance of routine checks for incontinence needs during activity time for dependent residents.</p> <p><b>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The DON/Designee conducted educational training nursing and non-nursing staff on the importance of incontinence care for dependent residents.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put in place:</b></p>				

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	<p>p.m., the resident was observed seated in his wheelchair in the activities room. The resident remained in the activities room during the above observations without staff checking for incontinence or taking him to his room. The resident did not leave the activity room until 3:57 p.m., and at that time was taken straight to the dining room.</p> <p>On 09/03/2015 at 8:02 a.m., CNA #1 was asked how they check the residents for incontinence care. She indicated they check all the residents every two hours or as needed regardless of where the residents were at. She further indicated they take the residents to their room for privacy and do an incontinence check and change if necessary, then they take the resident back to where they picked them up. She further indicated that the facility has in-services every month regarding incontinence care.</p> <p>On 09/03/2015 at 12:45 p.m., the resident was observed seated in his wheelchair with wet pants, outside of the nurses station.</p> <p>Continued interview with the Administrator on 9/04/2015 at 1:56 p.m., indicated the QAA had not identified a concern related to incontinence care and/or toileting dependent residents.</p>		<p>Don/Designee will observe 5 dependent /incontinent residents, 7 days a week on alternating shifts and during meals, restorative sessions, activities and therapy to ensure they are clean and dry.</p> <p>The Committee will track/trend results of the observations identified trends/patterns will require the development of a performance action plan that will be monitored by the committee at each meeting.</p>		

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	3.1-52(b)(2)				