STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This Visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00120573. Survey date (s): December 11, 12, 13, 14, & 17, 2012 Facility number: 000121 Provider number: 155215 AIM number 100290940 Survey Team: Lora Brettnacher, RN, TC Christi Davidson, RN Michelle Hosteter, RN Heather Lay, RN (12/11, 12/13, 12/14, & 12/17, 2012) Janet Stanton, RN (12/11, 12/12, 12/13, & 12/14, 2012) Census bed type: SNF: 10 SNF/NF: 127 Total: 137 Census payor type: Medicare: 10 Medicaid: 102 Other: 25 Total: 137	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on 12/25/2012 by Brenda Nunan, RN.			

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F0156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation and interview, the facility failed to ensure information regarding Medicare, Medicaid, and how to contact advocacy agencies was readily accessible to residents of a locked dementia unit. This deficient practice affected 26 of 26 residents who resided on the locked dementia unit. Findings include: On 12/11/12 at 10:45 A.M., tour of the locked dementia unit was initiated. At that time, information regarding Medicare, Medicaid, and how to contact advocacy agencies was not located. On 12/17/12 at 11:00 A.M., tour of the facility was initiated with the Executive Director [ED] and the Maintenance	F0156	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; All required postings have now been posted on the Alzheimer's / Dementia secured unit as well as continuing the postings in the Main Entrance. -How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; All residents on the Alzheiners / Dementia secured unit had the potential to be affected. All required postings have now been posted on the Alzheimer's / Dementia secured unit as well as continuing the postings in the Main Entrance of the facility. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All required postings	01/16/2013

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	Supervisor. At that time, in an interview, the Executive Director indicated the information was not posted in the locked dementia unit. She indicated the information has never been posted on the locked unit and was not aware of that regulation. 3.1-3(b)(1)		will be veirfied on a daily walk through and results reported to the QAA committee monthly. -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; All required postings will be veirfied on a daily walk through and results reported to the QAA committee monthly. -By what date the systemic changes will be completed. 1/16/2013	

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F0167 SS=E	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to ensure survey results were readily accessible to the residents of a locked dementia unit. This deficient practice affected 26 of 26 residents who resided in the locked dementia unit. Findings include: On 12/11/12 at 10:45 A.M., tour of the locked dementia unit was initiated. At that time, the survey book or a sign [stating where to locate the survey book] was not observed on the unit. On 12/17/12 at 11:00 A.M., tour of the facility was initiated with the Executive Director [ED] and the Maintenance Supervisor. At that time, the facility survey book was located near the front entrance, on a wall in a hallway leading to the rehabilitation unit. However, there was no sign observed	F0167	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; All required postings have now been posted on the Alzheimer's / Dementia secured unit as well as continuing the postings in the Main Entrance. -How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; All residents on the Alzheiners / Dementia secured unit had the potential to be affected. All required postings have now been posted on the Alzheimer's / Dementia secured unit as well as continuing the postings in the Main Entrance of the facility. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All required postings will be veirfied on a daily walk through and results reported to the QAA committee monthly. -How the	01/16/2013

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	to alert residents or visitors where to locate the survey book. On 12/17/12 at 11:05 A.M., in an interview, the ED indicated the book was labeled and indicated there was no sign anywhere in the building, including the locked dementia unit, that instructed residents and family where the survey book was located. 3.1-3(b)(1)		corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; All required postings will be veirfied on a daily walk through and results reported to the QAA committee monthly. -By what date the systemic changes will be completed. 1/16/2013	

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation and interview, the facility failed to provide a resident with privacy during a blood sugar check [finger stick]. This deficient practice affected 1 of 1 resident observed during dining who received a blood sugar check at the dining room table. [Resident #95] Findings include: On 12/11/12 at 11:30 A.M., Resident #95 was observed in the unit dining room at the table with 3 other residents. At that time, Licensed Practical Nurse [LPN] #8 was observed performing a blood glucose check [finger stick] on the resident. LPN #8 did not ask the resident prior to performing the finger stick if she wanted removed from the dining room table. On 12/17/12 at 10:55 A.M., in an interview, the Director of Nursing [DoN] indicated she would not expect nursing to perform a blood glucose	F0241	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Resident #95 was not negatively affected by this finding. -How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; It is the practice of this facility that resident care will be provided in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. All blood glucose / fingerstick monitoring will be performed in an area that maintains resident dignity. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All licensed nurses have been in-serviced on maintaining resident dignity when performing care related to blood glucose monitoring. Any licensed nursing staff member found to be non-compliant with the points of in-servicing will be further educated by Nursing administration and / or	01/16/2013

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	check at the dining room table unless there was an emergency with the resident's blood sugar. On 12/17/12 at 11:30 A.M., Resident #95's record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. A nurse's monthly note, dated 11/10/12 through 12/10/12, indicated the resident was alert with impaired decision making ability. A "Diabetes" care plan, dated 10/12, included, but was not limited to, "At risk for hyper/hypoglycemia... Will exhibit no s/sx hypo/hyperglycemia... Call medical doctor [md] for blood sugar of less than 70 and greater than 400, diet per md order, insulin per md orders, labs per orders, observe for s/s hyper/hypo (hyper/hypoglycemia), report any to md, oral hypo (hypoglycemia) meds (medications) as ordered..." There was no documentation in the diabetes care plan regarding nursing staff performing blood glucose checks at the dining room table. 3.1-3(t)		progressively disciplined as appropriate. -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Nursing administration or designee will monitor licensed nurse performance of glucose checks at a minimum of two times a week to ensure resident dignity is maintained. Any concerns will be addressed immediately and corrections will be made. This monitoring will continue until there are four consecutive weeks of zero negative findings. Results of audit will be reported to the QAA committee monthly. -By what date the systemic changes will be completed. January 16, 2013	

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F0247 SS=E	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to give notice to 3 of 11 residents who received a roommate changes (Resident A, Resident B, and Resident C). Findings: 1) Resident A's record was reviewed on 12/14/2012 at 1:46 P.M. Resident A was admitted to the facility on 8/30/2010 and had current diagnoses which included, but were not limited to, Alzheimer's disease and dementia. A progress note, dated 12/5/2012, indicated Resident A was alert but not oriented. Her son was her legal representative. During an interview on 12/13/2012 at 10:00 A.M., the Executive Director (ED) indicated there had been several room changes due to remodeling. She indicated she personally notified the families of the residents involved and Social Service staff should have documented in each residents' chart. During an interview on 12/13/2012 at 12:55 P.M., Social Service (SS) #18	F0247	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Social Services will contact the affected Residents A, B, C with ability to understand and primary family contact or responsible party (Power of Attorney, Health Care Representative, Legal Guardian, ect.) of Resident A, B, C who did not recieve notification of room change for follow up on current roommate situation. Social Services will address and concerns / make any necessary adjustments and follow up will be documented in Residents A, B, C medical charts. -How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; Residents will be assessed for compatibility and suitability to share a room by Social Services, Nursing, Admissions, or Administration prior to any room move. All Residents with ability to understand and primary family contact of responsible party of residents (Power of Attorney, Health Care Representative, Legal Guardian, ect.) who may receive a new roommate will be	01/16/2013

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	indicated she was given a list by the ED. It had the names of the residents who had been moved out of their rooms due to the construction. She was told to document the room change and that the families were notified. Three of the residents were moved into other residents' rooms. SS #18 indicated those three residents (which included Resident A) or their families were not given any notification regarding receiving a new roommate because she was not aware it was required. A document titled "Room Moves for Construction at Plainfield Healthcare 2012" provided by Assisted Director of Nursing (ADON) #6 on 12/13/2012 at 9:00 A.M., indicated Resident A received a new roommate during the construction period. During an interview on 12/13/2012 at 1:27 P.M., The ED, ADON #6 (Assistant Director of Nursing), and SS #18 were asked to provide documentation which included all the residents who were relocated to other rooms, documentation of the resident and/or family being informed, and documentation of notification for the residents who received those residents as new roommates.		notified of potential new roommate prior to any room move by nursing facility staff from Social Services, Admissions, Nursing, Housekeeping departments or Administration. Residents (with ability to understand) and primary family contact of responsible party will be given option of declining or accepting new roommate. Resident notification of roommate change will be documented in Social Services section of resident's medical chart. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; The nursing facility policy pertaining to room transfers will be revised to reflect the above-stated corrective actions and reviewed with nursing facility staff from affected departments (Social Services, Admissions, Nursing, Housekeeping). -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The deficiencied will be addressed in the 1/17/13 Quality Assurance meeting by completing a revised resident transfer / roommate change policy. A follow-up audit for documentation of new room moves involving a roommate change will be completed and reported at the subsequent Quality Assurance meeting. -By	

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	During an interview on 12/14/2012 at 10:30 A.M., the ED indicated the facility did not provide a notice to Resident A or her family before they moved a resident into her room. During an interview on 12/17/2012 at 12:18 P.M., Resident A's legal representative indicated he was not notified of his mother having a new room mate. 2) Resident B's record was reviewed on 12/14/2012 at 2:20 P.M. Resident B was admitted to the facility on 11/14/12 and had current diagnoses which included, but were not limited to, dementia with behavior disturbances. During an interview on 12/13/2012 at 10:00 A.M., the Executive Director (ED) indicated there had been several room changes due to remodeling. She indicated she personally notified the families of the residents involved and Social Service staff should have documented in each residents' chart. During an interview on 12/13/2012 at 12:55 P.M., Social Service (SS) #18 indicated she was given a list by the ED. It had the names of the residents who had been moved out of their rooms due to the construction. She		what date the systemic changes will be completed. The systemic changes will be completed by 1/17/2013	

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	was told to document the room change and that the families were notified. Three of the residents were moved into other residents' rooms. SS #18 indicated those three residents (which included Resident B) or their families were not given any notification regarding receiving a new roommate because she was not aware it was required. A document titled "Room Moves for Construction at Plainfield Healthcare 2012" provided by Assisted Director of Nursing (ADON) #6 on 12/13/2012 at 9:00 A.M. indicated Resident B received a new room mate during the construction period During an interview on 12/13/2012 at 1:27 P.M., The ED, ADON #6 (Assistant Director of Nursing), and SS #18 were asked to provide documentation which included all the residents who were relocated to other rooms, documentation of the resident and/or family being informed of the room change, and documentation of notification for the residents who received those residents as new room mates. During an interview on 12/14/2012 at 10:30 A.M., the ED indicated the facility did not provide a notice to			

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	Resident B or her family before they moved a resident into her room. 3. Resident C's record was reviewed 12/14/2012 at 9:30 A.M. Resident C was admitted to the facility on 10/16/2008 and had current diagnoses, which included but were not limited to, Parkinson's disease and heart disease. Resident C was alert and oriented. During an interview on 12/13/2012 at 10:00 A.M., the Executive Director (ED) indicated there had been several room changes due to remodeling. She indicated she personally notified the families of the residents involved and Social Service staff should have documented in each residents' chart. During an interview on 12/13/2012 at 12:55 P.M., Social Service (SS) #18 indicated she was given a list by the ED. It had the names of the residents who had been moved out of their rooms due to the construction. She was told to document the room change and that the families were notified. Three of the residents were moved into other residents' rooms. SS #18 indicated those three residents (which included Resident C) or their families were not given any notification regarding receiving a new			

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	roommate because she was not aware it was required. A document titled "Room Moves for Construction at Plainfield Healthcare 2012" provided by Assisted Director of Nursing (ADON) #6 on 12/13/2012 at 9:00 A.M., indicated Resident C received a new roommate during the construction period. During an interview on 12/13/2012 at 1:27 P.M., The ED, ADON #6 (Assistant Director of Nursing), and SS #18 were asked to provide documentation which included all the residents who were relocated to other rooms, documentation of the resident and/or family being informed, and documentation of notification for the residents who received those residents as new room mates. During an interview on 12/14/2012 at 10:30 A.M., the ED indicated the facility did not provide a notice to Resident C or his family before they moved a resident into his room. Review of a current facility policy titled "Admissions Policies" provided on 12/13/2012 at 11:30 A.M., indicated, "The Social Worker or Admissions Coordinator is responsible for all room assignments.			

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	Patients/Family/Legal Representatives will be notified prior to any change of room or roommate. The Social Worker will document notification of all room changes in the patient's medical record. . ." This Federal Tag relates to complaint IN00120573. 3.1-3(v)(2)			

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F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based observation, interview and record review, the facility failed to complete a significant change MDS (Minimum Data Set Assessment) for 1 of 38 residents (Resident #22).	F0272	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Resident #22 was not negatively affected by this finding. -How other	01/16/2013

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	Findings: Resident #22's record was reviewed on 12/14/2012 at 3:00 P.M. Resident was admitted to the facility on 7/13/2012 and had current diagnoses which included, but were not limited to, dementia, agitation, muscle weakness, and anxiety Resident #22's most current Minimum Data Set Assessment (MDS) was a quarterly MDS dated 9/26/2012. This MDS indicated Resident #22 required extensive assistance of one person for bed mobility and transfers. He required limited assist of one staff for locomotion. During an observation on 12/14/2012 at 3:00 P.M., Resident #22 was observed walking around the activity/dining area and sitting and standing up from sitting without assistance. During an interview on 12/17/2012 at 10:43 A.M., RN (Registered Nurse) #19 indicated Resident #22 had been sick at the time of the last assessment. His status had been improved for about a month. She indicated the nurse's made monthly nursing notes. It was her expectation		residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; It is the practice of this facility that residents who meet criteria set forth by the Resident Assessment Instrument (RAI) for a Significant Change Minimum Data Set (MDS) Assessment will have a Significant Change Comprehensive Assessment completed. All residents have the potential to be at risk for deficient practice. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All licensed nurses have been in-serviced on RAI criteria for significant change. All licensed nurses have been in-serviced on reporting significant change in resident assessment to Nursing administration. Nursing administration will report significant changes in residents' assessments to the facility MDS Coordinators. -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; A facility interdisciplinary team, including, but not limited to Nursing administration, MDS Coordinators, and Director of Rehabilitation or designee, will meet at a minimum of weekly to review residents who	

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	the MDS staff would check their notes. They did not have a method to inform the MDS staff of resident improvements. They would let someone know if there was a decline. She indicated Resident #22's care plan did not match his current status. A nurse's assessment note, dated 11/13/2012 through 12/14/12, indicated Resident #22 was independent with transfers and locomotion. He required limited assistance of one staff for bed mobility. A nurse's assessment note, dated 10/10/2012 through 11/13/2012, indicated Resident #22 was independent with transfers and locomotion. He required limited assist of one staff for bed mobility. A nurse's assessment note, dated from 9/14/2012 through 10/10/2012, indicated Resident #22 required extensive assist for bed mobility and transfers. He needed limited assist for locomotion. During an interview on 12/17/2012 at 11:33 A.M., The MDS Coordinator indicated she would look at the charting for scheduled assessments. She and her staff were dependent on the nurses reporting to them if there was a decline or an improvement between scheduled assessments.		demonstrate a significant change in their assessment. Based on outcome of interdisciplinary team meeting, MDS Coordinators will review resident medical record and complete MDS Comprehensive Assessment if RAI Significant Change criteria is met. A copy of meeting minutes will be forwarded to the QA commitee weekly. -By what date the systemic changes will be completed. January 16, 2013	

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	The MDS Coordinator indicated her staff did not have time to look at every chart every day. 3.1-31(d)(1)			

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F0323 SS=D	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 provide a safe transfer for 1 of 1 residents observed being transferred by a stand up lift in sample of 35. (Resident # 33) Findings include: In an observation on 12/13/12 at 12:15 P.M., LPN (Licensed Practicing Nurse) #11 and CNA (Certified Nursing Aide) #12 transferred Resident #33 with a stand up lift. LPN #11 placed the lift belt on the resident. The belt was loose between chest and waist area. The belt began to slide up and the resident's arms were in an awkward position with the sling underneath her armpits. The resident's hands turned outwards on the hand bars and were twisted. The resident said, "Ouch that hurts, you're going to break my arm," and she let go of one of the hand bars due to the hand being twisted. LPN #11 indicated to CNA #12 she was not sure which button to push to operate	F0323	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Resident #33 was not negatively affected by this finding. -How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; It is the practice of this facility that the resident's environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. All residents who are transferred with a mechanical lift will be transferred in a safe, accident free manner. Residents who meet criteria for transfer with a mechanical lift have been identified by Nursing Administration. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All nursing staff has been in-serviced on the appropriate usage of mechanical lifts and safe transfer technique. A Mechanical Lift Competency Skills Check Exam has been completed by all	01/16/2013

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	the lift. In an interview on 12/17/12 at 9 A.M. the Director of Nursing (DON) indicated the stand up lift should be used for a resident who was cognitively aware enough to hold the belt tight under their arms and was able to hold on to the grab bar. She indicated the belt should be somewhat loose as the resident should keep their arms tight and grab the hand bars. In an interview with the Assistant Director of Nursing (ADON)) #13 on 12/17/12 at 10:15 A. M., she indicated need for using the lift was assessed and determined by therapy. In an interview with the ADON #13, on 12/17/12 at 10:45 A. M , she indicated the nursing monthly assessment should indicate current transfer status. The nursing monthly assessment for 12/5/12 indicated the resident was an extensive assist of one person. ADON #13 indicated she expected the nurse to document in the nurses notes, notify the physician and therapy of change in condition relating to the the resident being weaker in her ability to stand. She indicated the nurses notes had not reflected this change.		nursing staff. Training and documentation of training will continue to be conducted as part of new hire orientation process for nursing staff. A Mechanical Lift Competency Skills Check Exam will be completed for all new hire nursing staff during the orientation process and will be conducted annually for all nursing staff. A Resident Transfer Assessment Form will be completed by Licensed Nursing staff for all residents upon admission to the facility. The Resident Transfer Assessment Form identifies resident transfer abilities. Upon completion, this form will be forwarded to the Director of Rehab or designee for review as part of the resident admission therapy screening process. Determination of a resident's transfer status will be a collaborative decision based on licensed nurse and therapy department assessment. Resident transfer status will be communicated to the Certified Nursing Assistants by way of CNA assignment sheets. The Resident Transfer Assessment Form will be reviewed and updated at a minimum of quarterly and with resident change in condition. Referrals to Therapy Department or changes in resident transfer status will be based on Resident Transfer Assessment. All licensed nurses and therapy department employees have been in-serviced	

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	The annual MDS (Minimum Data Set) for 11/13/12, indicated the resident was a two person physical assist with the resident helping and staff providing weight bearing assistance. The care plan, dated 11/13/12, for ADL (Activities of Daily Living) assistance indicated the resident requires assistance with transfers using the stand-up lift and minimum of two staff and as needed stand-up lift therapy per order. In an interview with the DON, on 12/17/12 at 1:45 P.M., she indicated when a resident was admitted the therapy department screened for needs related to use of a mechanical lift. She indicated therapy communicated to nursing verbally what kind of lift or assistance was needed. She indicated she expected the nurse to notify therapy or physician and document in the nurses notes when a resident displayed unusual weakness. She indicated the resident had pneumonia which could have contributed to weakness. In an interview with physical therapy on 12/17/12 at 2:15 PM., Physical Therapist # 17 indicated she had not been working with the resident in		on the Resident Transfer Assessment Form -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Any resident injury occurring as a result of a transfer will be investigated immediately and corrective action will be made. All resident accidents / incidents will be presented quarterly to the Quality Assurance Committee. Corrective Action will be initiated for any identified deficient practice. -By what date the systemic changes will be completed. January 16, 2013	

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	regard to transfers. She indicated she was not aware of increased weakness. She indicated the resident had pain in her right hip post surgery that could have potentially affected the resident's ability to bear weight during transfer. The physical therapists notes from 12/6/12 indicated, "...Remaining impairments: Decreased ROM (range of motion) , Strength impairments, and Postural alignment/control...." The manufacturer's guide for the stand up lift was provided by the DON on 12-17-12 at 10 A.M. She indicated all nurses and CNA's received training for the lifts. The manufacturer's guide indicated, on page 9 under operating instructions, "...Warning : The (name of type of lift) sling is not suitable for patients who have involuntary movements, or patients with limited postural control..." The training documentation for nurses indicated, "...mechanical lifts: date of review, proficiency demonstrated, orientee initials, mentor initials, and comments..." 3.1-45(a)(2)			

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F0334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview, the facility failed to obtain annual consents for influenza and pneumococcal vaccines, and the facility failed to educate residents annually regarding the risks and benefits of the influenza and pneumococcal vaccines for 5 of 5 records reviewed for influenza and pneumococcal program. (Residents #103, #17, #128, #33, #148) Findings include: 1. The record for Resident #103 was reviewed on 12/13/12 at 1:47 p.m.	F0334	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Residents #103, #17, #128, #33, and #148 were not negatively affected by the finding. -How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; It is the policy of this facility that all residents and / or legal representative will be educated regarding the risks and benefits of Influenza and Pneumococcal vaccination, all residents and / or legal representative will have the	01/16/2013

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	Diagnoses included, but were not limited to, dementia, Alzheimer's, blindness, osteoarthritis and depression. A Medication Administration Record [MAR] for Resident #103 indicated the annual flu vaccine was administered on 10/14/12. The record lacked documentation of an annual consent, and the record lacked documentation that education regarding the risks and benefits of the influenza vaccine was provided prior to administering the vaccine. 2. The record for Resident #17 was reviewed on 12/14/12 at 9:47 a.m. Diagnoses included, but were not limited to, emphysema, anxiety, depression, hypertension and dementia. A MAR for Resident #17 indicated the annual flu vaccine was administered on 10/8/12. The record lacked documentation of an annual consent, and the record lacked documentation that education regarding the risks and benefits of the influenza vaccine was provided prior		opportunity to consent or decline the Influenza and Pneumococcal vaccine on an annual basis, and all residents' medical records will contain documentation of annual education, consent or declination, and administration of the Influenza and Pneumococcal Vaccine if consented too by the resident or legal representative. An audit of all Influenza consent forms has been conducted. Residents, or legal representative of residents who had declined the Influenza Vaccine prior to 2012 were educated on risks and benefits of the vaccine. An updated consent form was obtained and placed in the residents' medical records. Influenza Vaccines were administered to residents who requested Influenza vaccine administration. An audit was conducted of all Pneumococcal vaccine consent forms. Residents and / or legal representative were educated on the risks and benefits of the vaccine. An updated consent form was obtained and placed in the residents' medical record. Pneumococcal vaccines were administered to residents who requested pneumococcal vaccine administration. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; Education regarding the risks and benefits of the Influenza and	

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	to administering the vaccine. 3. The record for Resident #128 was reviewed on 12/14/12 at 9:56 a.m. Diagnoses included, but were not limited to, hypertension, breast cancer, low back pain, renal failure and neuropathy. An Immunization Record for Resident #128 indicated, "Flu Vaccine..Date [blank]...Vaccine Given [blank]...By Whom [blank]...Pneumonia Vaccine...Date [blank]...Medicine Given [blank]...By Whom [blank]...." The record lacked documentation of an annual consent or declination, and the record lacked documentation that education regarding the risks and benefits of the influenza and pneumococcal vaccines was provided annually. 4. The record for Resident #33 was reviewed on 12/14/12 10:04 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, major depressive disorder and dementia. A MAR for Resident #33 indicated the annual flu vaccine was administered		Pneumococcal vaccines will continue to be provided to residents and / or legal representative at the time of admission to the facility. An Influenza and Pneumococcal Vaccine consent form will be obtained at the time of admission. Licensed nursing staff will administer the Influenza and / or Pneumococcal vaccine at the time of admission unless medically contraindicated or admission occurs outside of vaccination period for Influenza. All licensed nurses have been in-serviced on Facility Influenza and Pneumococcal vaccination policies and procedures. Education regarding risks and benefits of vaccine administration, consent or declination of vaccines, and documentation of vaccine administration will be conducted for all residents on an annual basis for Influenza and Pneumococcal vaccines or at any time when requested by a resident or legal representative. -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Director of Nursing or designee will be responsible for monitoring and tracking of Influenza and Pneumococcal Vaccination education, consent, and administration. Policies and Procedures related to facility	

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	on 10/14/12. The record lacked documentation of an annual consent, and the record lacked documentation that education regarding the risks and benefits of the influenza vaccine was provided prior to administering the vaccine. 5. The record for Resident #148 was reviewed on 12/14/12 at 10:12 a.m. Diagnoses included, but were not limited to, coronary artery disease, hyperglycemia, chronic obstructive pulmonary disease, diabetes type II and dementia. An Immunization Record for Resident #148 indicated, "Flu Vaccine..Date [blank]...Vaccine Given [blank]...By Whom [blank]...Pneumonia Vaccine...Date [blank]...Medicine Given [blank]...By Whom [blank]...." The record lacked documentation of an annual consent or declination, and the record lacked documentation that education regarding the risks and benefits of the influenza and pneumococcal vaccines was provided annually. During an interview on 12/14/12 at 10:19 a.m., the Director of Nursing		vaccination program and facility vaccination tracking documentation will be monitored quarterly by the Quality Assurance Committee. Any deficient practice identified by the committee will have corrective action initiated. -By what date the systemic changes will be completed. January 16, 2013	

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	[DoN] indicted a resident's or resident's family's consent was obtained upon admission to the facility. At the time of admission the resident or the resident's family was provided education regarding the risks and benefits of the influenza and pneumococcal vaccines. The DoN was requested to provided documentation of annual consents or declinations for the vaccines. The DoN was requested to provide documentation that the resident or resident's family was provided information regarding the risks and benefits of the vaccines. As of the exit from the facility on 12/17/12 at 4:30 p.m., the DoN did not provide documentation of annual consents or annual declinations for the influenza and pneumococcal vaccinations. During an interview on 12/14/12 at 11:55 a.m., the DoN indicated the facility obtained consents or declinations for the pneumococcal and influenza vaccines upon admission to the facility only and not on an annual basis. The DoN indicated the nurses educated the residents before administering the vaccine, but did not document the education and did not obtain current, yearly consents or declinations.			

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	During an interview on 12/17/12 at 2:35 p.m., LPN #16 indicated influenza and pneumococcal vaccination consents or declinations were obtained upon the resident's admission to the facility. LPN #16 indicated if a resident had declined in the past, the vaccines were not offered every year to those residents. LPN #16 indicated annual consents were not obtained for residents that had consented upon admission. As of the exit from the facility on 12/17/12 at 4:30 p.m., the DoN did not provide documentation of annual consents or annual declinations for the influenza and pneumococcal vaccinations. A facility policy obtained from the Executive Director on 12/11/12 in the entrance conference indicated, "Influenza Vaccination Program...Our annual Flu Vaccine Program protects patients from the influenza Virus...Planning...early September the center will begin review of the influenza Program...Who will coordinate the program...What educational information is needed and from where obtained? (Local Public Health Department will have the most current information)...Review of the medical			

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	record for status of influenza consent and plan for contacting patient/family...to determine acceptance or declination of vaccine. (Patient's POA [power of attorney] or Responsible Party recommends Consent upon admission for the annual flu vaccine program...." 3.1-13(a)			

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F0371 SS=F	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 follow proper sanitation and food handling practices and failed to properly store and label food items in 2 of 4 dining areas [Orchard and the main dining room] and in 1 of 1 kitchen. This deficient practice had the potential to affect 135 of 137 residents who received food from the facility kitchen. Findings include: 1. On 12/11/12 at 11:30 A.M., dining observation was initiated on the Orchard unit dining room. On 12/11/12 at 11:35 A.M., a metal bowl of ice was observed on a rolling drink cart in the dining room. At that time, a resident was observed removing ice from the bowl with her bare hands. On 12/11/12 at 11:40 A.M., Certified Nursing Assistant [CNA] #10 was	F0371	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; No residents were negatively affected by this finding. -How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; It is the policy of the facility to procure, store, prepare, distribute, and serve food under sanitary conditions. All residents had the potential to be affected by deficient produce. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All dietary staff have been inserviced on properly procuring, storing, preparing, distributing, and serving food. Inservicing included specifics on safe food handling, labeling, kitchen sanitation, glove use, handwashing, and dress code. -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Dietary Manager or	01/16/2013

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	observed removing ice from the bowl with a plastic cup. On 12/11/12 at 11:50 A.M., a visitor was observed removing ice from the bowel with a plastic cup. The ice bowl was not removed until after lunch was finished. 2. During the initial kitchen observation in the main kitchen on 12/11/12 at 10:35, with the Dietary Supervisor and Dietary Manager in attendance, the following was observed: A. Three glasses containing a white colored liquid were stored in the large cooler next to the steam table. The glasses were not labeled and not dated The Dietary Manager identified the contents as Lactose free milk. She indicated "They [the staff] know they are supposed to label them." B. A three-tier cart by the preparation table had 4 pitchers containing various colored liquids. The pitchers were not labeled or dated. C. Eight trays with bowls of fruit,		Supervisor will monitor Dietary Preformance at least two times a week to ensure standards are maintained. Any concerns will be addressed immediately and corrections made. This monitoring will continue until there are four consecutive weeks of observation with no findings. Reports of audits will be reported to QAA committee monthly. -By what date the systemic changes will be completed. 1/16/2013	

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	beets, cottage cheese were stored in the window-front refrigerator at the opposite end of the preparation table. The individual bowls were not covered, nor were the entire trays covered. The Dietary manager indicated "The bowls are covered when they go on the line to be put on trays." 3. On 12/11/12 at 11:20 A.M., the following was observed during the lunch meal tray preparation: Dietary Aide #4 was observed with disposable gloves on, tearing a flat of bread rolls apart, and placing them into a metal pan. She stopped for a moment as another aide was talking with her, took a paper with a resident seating diagram from the other aide, and looked at it. She handed it back to the other aide, then went back to separating the rolls with the same gloves. After she finished, she took the gloves off. Without washing her hands, she got a container of ice cream from freezer and some other supplies from other areas in the kitchen to place near the serving line. She put new gloves on without performing a hand wash. Dietary Aide #4 was wearing a sweat "hoodie' with sleeves that covered her wrists to top of her hands--the sleeves were			

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	loose and floppy. During the tray prep, Dietary Aide #4 was observed using her gloved hands to put lids on plates by picking them up from the inside surface, and placing them over the hot food plate on the tray. She was also handling the trays to place into the carts, and the plastic lids to cover fruit and cottage cheese bowls. At 11:30 A.M., Dietary Aide #4 was observed to empty a cart with trays left from breakfast onto another cart in kitchen. She pulled the cart into kitchen to load with more lunch trays. She did not remove gloves she had on, and did not wash her hands. With the same gloves, she started covering and loading more lunch trays into cart. She continued to handle the plate covers by placing fingers inside lid (lids stacked upside down at end of service line) and lifting cover to place over food. At 11:35 A.M., Dietary Aide #4 brought another open rack cart into kitchen with same gloved hands. She did not remove the gloves, and did not do a hand wash. She started handling trays and plate lids as before, but used tongs to place rolls on plates.			

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	At 11:40 A.M., plates containing the main entree, for residents in the main dining room next to the kitchen, were not covered when taken from kitchen window out to residents at tables. Bowls of fruit, beets, cottage cheese were not covered when taken from kitchen window out to residents in the main dining room. Dietary Aide #4 was not covering the plates with the plate covers or the bowls with plastic lids at window; nursing staff in the dining room were not placing plate covers or lids over the food before delivering the food to the residents in the main dining room. At 11:50 A.M., Dietary Aide #4 continued to wear the same gloves, and continued to handle trays in the same manner. At 11:55 A.M., Dietary Aide #4 was observed dragging sweat hoodie sleeve across the lip of the pan holding rolls. At 12:04 P.M., Dietary Aide #4 was observed resting her sleeved arm on rim/lip of pan holding rolls. She used her left gloved hand to adjust the collar of the hoodie. The gloves had not been changed since the start of the lunch meal tray preparation at			

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	11:20 A.M. At 12:10 P.M., Dietary Aide #4 brought an open wire rack cart into kitchen for trays to other units. She did not take the gloves off, or do hand wash before preparing more trays and loading them onto rack. She continued using her gloved hand to pick up the lids by the inside area to cover plates. 4. On 12/12/12 at 10:57 A.M., a three tier cart with 4 pitchers with tags that indicated "Wednesday," containing different colored fluids, was observed on the Rehab unit across from the nursing station. The pitcher tags did not indicate what kind of liquid each contained (i.e. juice, lemonade, tea, etc.). 5. On 12/13/12 at 10:50 A.M., three trays with small bowls were observed to be stacked on a prep table behind the main kitchen cooking/serving area. The top layer of bowls had been filled with scoops of vanilla and chocolate pudding. All of the bowls of pudding on the top layer of trays were uncovered. A large bucket of liquid was sitting on counter next to the trays/bowls of pudding. The Dietary Manager indicated she did not know why the bucket was left there, and			

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	thought it was some sanitizing solution. In an interview at that time, the Dietary Supervisor and Dietary Manager indicated that only the Supervisor had received "Serv-Safe" training on kitchen sanitation and safe food handling procedures. The Dietary Supervisor indicated she asked the new corporation to provide such training for all dietary staff. The Dietary Manager indicated the new corporation started a book in June 2012 when they took over, with information on inservices to be provided by each department. She indicated the book listed inservices given, and would provide a copy of inservices that were provided to kitchen staff with the agenda/subjects covered. In an interview on 12/14/12 at 9:40 A.M., Dietary Aide #4 indicated she had worked in the facility kitchen for a couple of years, and in several different positions. She indicated she had not had any training in safe food handling/kitchen sanitation procedures. She stated, "We all just kind of learned it by ourselves." She indicated kitchen staff had not had any inservicing or training since the new corporation took over. She			

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	indicated she realized she did not use gloves correctly on Monday, but was not aware that she touched non-food items then touched food items or dishware surfaces close to food. She stated "that's why I used the tongs for the bread rolls." Dietary Aide #4 stated there was another Dietary Aide who "just doesn't get it--we've tried to train her but she keeps putting dishes back with the clean ones." Dietary Aide #4 indicated she had never seen a policy/procedure related to safe food handling, kitchen sanitation,glove use or hand washing procedures. In an interview on 12/14/12 at 10:22 AM., the Dietary Manager indicated she could not find any other information related to when inservices were given, or what subjects were covered. She stated she and the Dietary Supervisor did "occasional observations" of dietary staff performing their duties, and that the staff are "corrected" through a 1:1 at the time they would observe an error in technique, etc. She did not keep any documentation of 1:1 training/inservicing done. At that time, the Dietary Manager provided an inservice sign-in sheet for inservice dated 9/11/12 for "Tray			

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	Accuracy," listing the information presented and a post-test. She also provided a paper, which was not dated, titled "Inservice: Proper Use of Gloves, Utensils, and Thermometers" The Dietary Manager could not say when the inservice was actually given, and there was no accompanying sign-in sheet. The paper included, but was not limited to, the following information: "OBJECTIVE: The participants will know and understand when the use of gloves or utensils is required and how to properly use gloves and utensils. PURPOSE: To teach dietary staff when to wear gloves and use utensils when handling and preparing food...PREPARATION: ...Gloves or utensils should be used at the following times: ...3. When used, single use gloves will be worn for only one task, such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation... Whenever possible, use utensils such as tongs, spoons, and spatulas instead of the gloves to avoid getting a false sense of security with the gloves and over using the gloves... REMEMBER: Even when using			

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	gloves and utensils, HANDS must still be WASHED at the proper times. Hands must be washed before putting on gloves." Undated papers, which the Dietary Manager stated were "also given as inservices" included: "Employee Food Safety Basics." The paper indicated "... Wash hands often...." "Cross-Contamination." The paper indicated "... Cross-contamination can be controlled by adhering to safe food handling practices...." There were no inservice attendance sign-in sheets for dietary staff, and no dates indicating when the inservices were given. The Dietary Manager indicated she was not aware of other Policies/Procedures related to glove use, hand-washing, labeling and dating foods, and was unaware of other inservices. 3.1-21(i)(2) 3.1-21(i)(3)			

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation and interview, the facility failed to ensure medications were labeled after opening for 1 of 6 medication carts,	F0431	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; There were no residents affected by the	01/16/2013

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	and failed to dispose of expired drugs for 1 of 11 vial of insulin. Findings include: The medication rooms, and the medication carts for Orchard, The Grove, Rehabilitation, and the Caring Hands units were toured with the Director of Nursing (DON) on 12/15/12 at 11:00 A.M. Twenty five medication punch cards containing discontinued non-narcotic medications were observed on shelves in the Grove medication room. In an interview with the DON , she indicated at 11:05 A.M., on 12/15/12 , the pharmacy came weekly to obtain the medications. She also indicated they do not have a method of tracking disposed/returned medications. In observing the medication carts on the Grove, it was found that 1 of 3 medication carts contained 1 of 11 bottles of expired insulin. The Lantus had a open date of 11/13/12. A medication of Advair Diskus was stored in the medication cart on the Rehab unit with no open date indicated.		negative finding. How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; It is the policy of this facility that medications are properly labeled and that expired or discontinued medications are disposed of according to currently accepted professional principles. All residents have the potential to be affected by deficient practice. A policy on medication labeling has been implemented. A policy on drug disposition has been implemented. An audit has been conducted of all medication carts and medication storage areas. All medications have been properly labeled. All medications which have expired or been discontinued have been disposed of or returned to pharmacy per facility policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All licensed nurses have been in-serviced on facility policy of medication labeling and drug disposition. Any staff found to be non-compliant with the points of in-servicing will be further educated by Nursing administration and / or progressively disciplined as appropriate. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put	

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	The medication cart for the Caring Hands unit contained a bottle of nasal spray with an open date of 6/27/12. The order indicated to the medication was to be used twice a day for seven days. The DON reviewed the resident's chart and indicated the medication order was discontinued and the mediation should not have remained in the cart. The Orchard unit mediation refrigerator had a multi dose vial of Tuberculin with no open date on it. The Rehabilitation unit medication refrigerator had a multi dose vial of Pneumovac that had no open date on it. In an interview with the DON ,on 12/15/12 at 11:20 A.M., she indicated they dispose of insulin 30 days after opening. She also indicated the Tuberculin and Pneumovac without an open date on it. A policy for disposal of medications, pharmacy return of medications and labeling of medications was requested from the DON on 12/15/12 at 11:50 A.M. In an interview with the DON ,on		into place; Nursing administration or designee will audit medication carts and medication storage areas at a minimum of two times weekly to ensure that all medications are properly labeled and that expired or discontinued medications have been disposed. Any concerns will be addressed immediately and corrective action will be taken. This monitoring will continue until there are four consecutive weeks of zero negative findings. At that time Nursing administration or designee will conduct a random audit at a minimum of a weekly basis to determine compliance with facility medication labeling and drug disposition policies. Policies and Procedures related to medication labeling and drug disposition and results of audits will be reviewed quarterly by the Quality Assurance Committee. Any deficient practice identified by the committee will have corrective action initiated. By what date the systemic changes will be completed. January 16, 2013	

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	12/15/12 at 2:40 P.M., she indicated the facility did not have any pharmacy policies relating to the labeling, returning and disposal of medications. 3.1-25(j)(k)(l) 3.1-25 (o)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to	F0441	What corrective actions will be accomplished for those residents	01/16/2013

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	follow infection control practices related to lack of hand washing prior to assisting to feed a resident [Resident #102 and #85] and lack of hand washing prior to instilling eye drops in 2 of 5 residents observed who received eye drops. [Residents #33 and #163]. Findings include: 1. On 12/11/12 at 11:55 A.M., during dining obsevation, Certified Nursing Assistant [CNA] #7 was observed coming from the facility hallway into the nursing unit. At that time, CNA #7 went to thedining room table and began to assist Residents #102 and #85 with their meal. she was not observed to have performed haned hygiene or hand washing. On 12/17/2012 at 11:15 A.M., in an interview, CNA #7 indicated hand washing should be completed prior to feeding a resident.		found to have been affected by the deficient practice; Residents #33 and #163 were not negatively affected by this finding. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; It is the policy of this facility that all staff members follow infection control practices related to hand washing. All residents have been identified to be at risk of deficient practice. All nursing staff members have been in-serviced on the facility hand washing policy and procedure. All nursing staff members have completed a Hand washing Competency Exam. All licensed nurses have been in-serviced on facility infection control practices related to medication administration. All dietary staff have been in-serviced on sanitation, glove use, and handwashing policies and procedures. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; The facility hand-washing policy and procedure and Hand washing Competency Exam will be included in the new hire general orientation program for all staff members. The facility Medication Administration policy will be included in the new hire general orientation program for all licensed nursing staff members.	

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	2. The medication pass was done with LPN #11 on 12/13/12 at 1:30 P.M. LPN #11 placed a bottle of eye drops for Resident #163 and a tissue into her nursing uniform pocket. LPN #11 did not wash or sanitize her hands		All staff will receive annual training on the facility hand-washing policy and procedure and will complete the Hand washing Competency Exam on an annual basis. Licensed nursing staff will receive training on an annual basis on the facility policy for medication administration. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Director of Nursing or designee will continue to document facility infection rates at a minimum of a monthly basis. In-servicing related to infection control will be conducted as identified by need according to facility infection control tracking. Facility infection control policy and procedures, monthly infection percentages, and facility infection tracking documentation will be reviewed quarterly by the Quality Assurance Committee. Any deficient practice identified by the committee will have corrective action initiated. By what date the systemic changes will be completed. January 16, 2013	

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	before putting on gloves to give the eye drops to Resident #163. LPN #11 put on the gloves and gave the eye drops to Resident #163, then wiped the eyes of the resident with the tissue that was in her nursing uniform pocket. LPN #11 then went into restroom and washed hands for five seconds. In an interview with the Director of Nursing (DON,) on 12-16-12 at 9:45 A.M., she indicated she expected the nurse to hand wash for 15 seconds. She also indicated the nurse should not have used a Kleenex that had been in her pocket to wipe a resident's eyes. The hand washing policy provided by the DON on 12-17-12 at 10 A.M., dated 8/14/08 indicated, "Appropriate ten to fifteen second hand wash with antimicrobial or non-antimicrobial soap and water must be performed...The use of gloves does not replace hand washing..." The Medication Administration policy provided by the DON on 12-17-12 at 10 A.M. indicated, "...Established facility infection control procedures must be followed during the administration of medication (e.g., hand washing, antiseptic technique,			

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	gloves, isolation precautions, etc.)...." 3.1-18(a) 3.1-18(l)			

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F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview, and record review, the facility's Quality Assessment Committee failed to identify and implement appropriate interventions for deficient practices with infection control, influenza and penumococcal vaccinations, and the disposition of expired or discontinued medications. Findings include:	F0520	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; No residents were negatively affected by this finding. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; It is the practice of this facility that the Quality Assurance Committee will identify and implement appropriate interventions for deficient	01/16/2013

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	1. On 12/11/12 at 11:55 A.M., during dining observation, Certified Nursing Assistant [CNA] #7 was observed coming from the facility hallway into the nursing unit. At that time, CNA #7 went to the dining room table and began to assist Residents #102 and #85 with their meal. She was not observed to have performed hand hygiene or hand washing. On 12/17/12 at 11:15 A.M., in an interview, CNA #7 indicated hand washing should be completed prior to feeding a resident. 2. The medication pass was done with LPN #11 on 12/13/12 at 1:30 P.M. LPN #11 placed a bottle of eye drops for Resident #163 and a tissue into her nursing uniform pocket. LPN #11 did not wash or sanitize her hands before putting on gloves to give the eye drops to Resident #163. LPN #11 put on the gloves and gave the eye drops to Resident #163, then wiped the eyes of the resident with the tissue that was in her nursing uniform pocket. LPN #11 then went into restroom and washed hands for five seconds. In an interview with the Director of		practices identified in the facility. All residents in the facility have been identified as being at risk for deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All nursing staff have been inserviced on infection control related to handwashing. All licensed nursing staff have been inserviced on infection control related to medication administration and facility Influenza and Pneumococcal Vaccination policies. A facility policy has been developed for medication labeling and drug disposition. All nursing staff have been inserviced on the medication labeling and drug disposition policy. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Facility Infection Control policies and procedures, monthly infection rates, and infection tracking documentation will be reviewed quarterly by the Quality Assurance Committee.Facility Influenza and Pneumococcal Vaccination policies and procedures and vaccination tracking documentation will be reviewed quarterly by the Quality Assurance Committee. Facility policies and procedures on medication labeling and drug	

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	Nursing (DON,) on 12-16-12 at 9:45 A.M., she indicated she expected the nurse to hand wash for 15 seconds. She also indicated the nurse should not have used a Kleenex that had been in her pocket to wipe a resident's eyes. The hand washing policy provided by the DON on 12-17-12 at 10 A.M., dated 8/14/08 indicated, "Appropriate ten to fifteen second hand wash with antimicrobial or non-antimicrobial soap and water must be performed...The use of gloves does not replace hand washing..." The Medication Administration policy provided by the DON on 12-17-12 at 10 A.M. indicated, "...Established facility infection control procedures must be followed during the administration of medication (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.)...." 3. The record for Resident #103 was reviewed on 12/13/12 at 1:47 p.m. Diagnoses included, but were not limited to, dementia, Alzheimer's, blindness, osteoarthritis and depression. A Medication Administration Record		disposition will be reviewed quarterly by the Quality Assurance Committee. Any deficient practice related to infection control, Influenza and Pneumococcal vaccination, medication labeling, and /or drug disposition identified by the Quality Assurance Committee will have corrective action initiated. By what date the systemic changes will be completed. January 16, 2013	

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	[MAR] for Resident #103 indicated the annual flu vaccine was administered on 10/14/12. The record lacked documentation of an annual consent, and the record lacked documentation that education regarding the risks and benefits of the influenza vaccine was provided prior to administering the vaccine. 4. The record for Resident #17 was reviewed on 12/14/12 at 9:47 a.m. Diagnoses included, but were not limited to, emphysema, anxiety, depression, hypertension and dementia. A MAR for Resident #17 indicated the annual flu vaccine was administered on 10/8/12. The record lacked documentation of an annual consent, and the record lacked documentation that education regarding the risks and benefits of the influenza vaccine was provided prior to administering the vaccine. 5. The record for Resident #128 was reviewed on 12/14/12 at 9:56 a.m. Diagnoses included, but were not limited to, hypertension, breast			

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	cancer, low back pain, renal failure and neuropathy. An Immunization Record for Resident #128 indicated, "Flu Vaccine..Date [blank]...Vaccine Given [blank]...By Whom [blank]...Pneumonia Vaccine...Date [blank]...Medicine Given [blank]...By Whom [blank]...." The record lacked documentation of an annual consent or declination, and the record lacked documentation that education regarding the risks and benefits of the influenza and pneumococcal vaccines was provided annually. 6. The record for Resident #33 was reviewed on 12/14/12 10:04 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, major depressive disorder and dementia. A MAR for Resident #33 indicated the annual flu vaccine was administered on 10/14/12. The record lacked documentation of an annual consent, and the record lacked documentation that education regarding the risks and benefits of the influenza vaccine was provided prior			

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	to administering the vaccine. 7. The record for Resident #148 was reviewed on 12/14/12 at 10:12 a.m. Diagnoses included, but were not limited to, coronary artery disease, hyperglycemia, chronic obstructive pulmonary disease, diabetes type II and dementia. An Immunization Record for Resident #148 indicated, "Flu Vaccine..Date [blank]...Vaccine Given [blank]...By Whom [blank]...Pneumonia Vaccine...Date [blank]...Medicine Given [blank]...By Whom [blank]...." The record lacked documentation of an annual consent or declination, and the record lacked documentation that education regarding the risks and benefits of the influenza and pneumococcal vaccines was provided annually. During an interview on 12/14/12 at 10:19 a.m., the Director of Nursing [DoN] indicted a resident's or resident's family's consent was obtained upon admission to the facility. At the time of admission the resident or the resident's family was provided education regarding the risks and benefits of the influenza and			

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	pneumococcal vaccines. The DoN was requested to provided documentation of annual consents or declinations for the vaccines. The DoN was requested to provide documentation that the resident or resident's family was provided information regarding the risks and benefits of the vaccines. During an interview on 12/14/12 at 11:55 a.m., the DoN indicated the facility obtained consents or declinations for the pneumococcal and influenza vaccines upon admission to the facility only and not on an annual basis. The DoN indicated the nurses educate the residents before administering the vaccine, but do not document the education and do not obtain current, yearly consents or declinations. During an interview on 12/17/12 at 2:35 p.m., LPN #16 indicated influenza and pneumococcal vaccination consents or declinations were obtained upon the resident's admission to the facility. LPN #16 indicated if a resident has declined in the past, the vaccines were not offered every year to those residents. LPN #16 indicated annual consents were not obtained for residents that had consented upon admission.			

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	As of the exit from the facility on 12/17/12 at 4:30 p.m., the DoN did not provide documentation of annual consents or annual declinations for the influenza and pneumococcal vaccinations. A facility policy obtained from the Executive Director on 12/11/12 in the entrance conference indicated, "Influenza Vaccination Program...Our annual Flu Vaccine Program protects patients from the influenza Virus...Planning...early September the center will begin review of the influenza Program...Who will coordinate the program...What educational information is needed and from where obtained? (Local Public Health Department will have the most current information)...Review of the medical record for status of influenza consent and plan for contacting patient/family...to determine acceptance or declination of vaccine. (Patient's POA [power of attorney] or Responsible Party recommends Consent upon admission for the annual flu vaccine program...." During an interview on 12/17/2012 at 2:20 P.M. the ED (Executive Director) indicated LPN (Licensed Practical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/17/2012
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	Nurse) #16, (Quality Assessment Coordinator [QA] would be able to answer questions regarding QA. LPN was queried regarding the facility's influenza and pneumococcal program. She indicated the facility's QA committee was not aware of any deficiencies regarding influenza consents and administration, infection control issues, or the disposal of expired and discontinued medications. Other than annually inservicing staff on hand washing and touching on a few infection control issues with dietary nothing else was being done. As far as immunizations, unless families or nurses requested the immunization they wouldn't know if a resident who declined in the past would want an immunization. Regarding the medications, she indicated she believed they were to be sent back by two weeks after they were expired or discontinued. Nursing and pharmacy were supposed to track this. Pharmacy was to check medication rooms and carts but beyond that the committee was not aware of the deficient practice. 3.1-52(b)(2)			

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