

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/14/2013
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NAME OF PROVIDER OR SUPPLIER  TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: June 10, 11,12,13,14, 2013</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Survey team: Dorothy Watts, RN TC Martha Saull, RN Terri Walters, RN</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 12 Medicaid: 50 Other: 16 Total: 78</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 24, 2013, by Jodi Meyer, RN</p>	F000000	<p>The creation and submission of this Plan Of Correction does not constituted an admission by this provider of an conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan Of Correction be considered the letter of credible allegation and request a desk review as of July 14, 2013.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000247 SS=D	<p>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 ensure prompt notification of a new roommate for 2 of 2 residents interviewed in stage 1 who indicated they had received a new roommate without prior notification. Resident #124, Resident #63</p> <p>Findings include;</p> <p>1. On 6/11/13 at 10:36 A.M., Resident # 124 was interviewed. He indicated he had received a new roommate last week. He also indicated he had not been given notice before he had received a roommate last week.</p> <p>On 6/13/13 at 1:08 P.M., the Social Service Director (SSD) was interviewed regarding Resident #124 receiving a roommate without notification. She indicated Resident # 124 had received a roommate, Resident #200 on 6/6/13. She indicated she had not provided notification to Resident #124 that he would be receiving a roommate prior to him receiving a roommate. She</p>	F000247	<p>F 247</p> <p><b>COMPLETION DATE 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community to ensure all residents receive notice of a roommate or a room change.</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All residents have the potential to be affected.</p> <p>All residents pending a new roommate/room change were notified by SS/Designee of pending room change or roommate change. Changes were documented in the resident medical record.</p> <p><b>How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?</b></p> <p>The IDT team will review and discuss daily during morning meeting all</p>	07/14/2013			

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	<p>indicated at that time she was suppose to notify residents of roommate changes.</p> <p>On 6/14/13 at 1:15 P.M., the SSD was unable to provide documentation of roommate notification for Resident # 124 prior to him receiving a roommate. She provided Resident #124's progress note dated 6/6/13 at 4:52 P.M., that indicated, " Resident not happy about getting a roommate. Resident states he signed a paper saying he wouldn't have a roommate. Res (resident) were informed that Social Service was out of the office and it would probably be tomorrow before we could find any such paper. Resident stated he understood the situation but still wasn't happy about it. Will continue to monitor resident and his coping with having a roommate."</p> <p>On 6/14/13 at 2:34 P.M., the SSD was interviewed regarding Resident #63 receiving a new roommate without prior notification. The SSD indicated Resident # 63 had received a new roommate on 4/24/13, Resident #118. She indicated documentation was lacking of the new roommate notification. She provided a progress note of Resident #63 dated 4/25/13. The progress</p>		<p>residents pending notifications. Any pending changes will be discussed with the resident and documented in the medical record by the SS/designee. SS/designee will report to IDT the outcome of the discussion.</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>A mandatory in-service for all management team members will be conducted on or before July 14, 2013. This in-service will be conducted by the SS consultant in order to ensure proper directions of notification guidelines.</p> <p>This verification process will ensure that all proper notifications will be in place before the change occurs.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</b></p> <p>The IDT team will monitor the resident notifications on a daily basis to identify the potential for deficient practices. To ensure compliance, the Executive Director/designee will be responsible for completion of the CQI tool weekly x 4 weeks, bimonthly times 2 months, and then quarterly until compliance is</p>				

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	<p>note of 4/25/13 at 9:46 A.M., indicated, "Resident has no issues with new roommate. She states that new roommate is very nice. Will continue to monitor." Documentation was lacking of new roommate notification until the 4/25/13 progress note.</p> <p>3.1-3(v)(2)</p>		<p>maintained for 2 consecutive quarters. The results will be reviewed by the CQI committee overseen by the Executive Director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. CQI Tool—Notification of room change.</p>		

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review the facility failed to ensure a resident's care plan was updated and revised to reflect the current assessment which revealed a decline in urinary continence for 1 of 3 reviewed for urinary incontinence. Resident #22</p> <p>Findings include:</p> <p>On 6/12/13 at 10:05 A.M., the clinical record was reviewed for resident #22. The Minimum Data Set Assessment (MDS) was reviewed and the assessment indicated a decline in urinary continence since admission to</p>	F000280	<p>F 280</p> <p><b>COMPLETION DATE 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community to ensure all resident's Care Plans are updated to reflect their current status.</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All residents have the potential to be affected.</p>	07/14/2013			

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	<p>the facility. The MDS read as followed: 2/1/13 Admission assessment reported Resident #22 as always continent. Her cognitive status was 12 which indicated a mild cognitive impairment. The MDS assessment dated 2/15/13 MDS reported Resident # 22 as occasionally incontinent (less than 7 episodes of incontinence).The MDS reported Resident #22 was not on a toileting program or a trial toileting program. The following MDS assessments dated 2/24/13, 3/28/13, 4/25/13 and 5/13/13 reflected the same information as listed on the 2/15/13 assessment. Resident #22 continued to be assessed as occasionally incontinent (less than 7 episodes of incontinence) and Resident #22 was not reported to be on a toileting program or a trial toileting program.</p> <p>The CNA assignment sheet dated 6/11/13 was reviewed on 6/12/13 at 3:15 P.M. Resident #22 was not listed as a resident who utilized a toileting program or a resident that used Depends (incontinence brief). She was assessed as a resident that needed the assistance of 1 person to toilet.</p>		<p>Review of all incontinent residents was completed by DNS/Designee to ensure those residents were care planned and if applicable were placed on a toileting program. DNS/Designee will ensure care plan and Nurse Aid assignment sheets were updated base on the resident assessment.</p> <p>Resident # 22 Care Plan was updated immediately 6/12/2013 to include a toileting program.</p> <p><b>How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?</b></p> <p>The IDT team will review and discuss daily during morning meeting all residents in need of a toileting program. DNS/Designee will reassess all incontinent residents with a 3 day voiding pattern to ensure all residents needing bladder training have the appropriate interventions. DNS/Designee will add interventions to nurse aid assignment sheet.</p> <p><b>What measure will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>A mandatory in-service for all management team members will be conducted on or before July 14,</p>				

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	<p>Review of Residents #22's care plan, initiated on 1/28/13, read as follows: "Problem: Resident at risk for incontinence due to: muscle weakness, syncope, and dementia, receives psychotropic, antihistamines, and benzodiazepines. Goals: Resident will be free from adverse effect of incontinence. Approach: 1. Assess and document skin condition weekly and as needed. 2. Assist with elimination. 3. Assist with incontinent care as needed. 4. Check every 2 hours for incontinence. 5. Document any abnormal findings and notify MD. 6. Initiate 3 day pattern to evaluate the need for scheduled toileting program. 7. Observe signs for urinary tract infection..."</p> <p>During an interview with LPN #6 on 6/12/13 at 9:35 A.M., LPN #6 indicated that Resident #22, was continent during the day, but wore an incontinence brief during the night. LPN #6 indicated when the CNAs went to assist Resident #22 in the mornings, Resident #22's brief would be wet and Resident #22 would say, "I've already gone."</p>		<p>2013. This in-service will be conducted by the Director of Nursing to ensure proper documentation reflects the resident's current status and plan of care.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</b></p> <p>The IDT team will monitor resident care plans on a daily basis to identify the potential for deficient practices. To ensure compliance, Director of Nursing/designee will be responsible completion of the CQI tool weekly x 4 weeks, bimonthly x 2 months, and the quarterly until compliance is maintained for 2 consecutive quarters. The results will be reviews by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. CQI Tool—Care Plan Accuracy</p>				

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	<p>During an interview with MDS coordinator on 6/12/13 at 11:18 A.M., the MDS coordinator indicated Resident #22's care plan should have been updated. The care plan for Resident #22 should have been revised from at risk for incontinence care plan to a care plan for incontinence. The MDS coordinator also indicated Resident #22 should have been assessed and then placed on a toileting program.</p> <p>3.1-35(d)(2)(b)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide a bed appropriate to a resident's needs for 1 of 1 resident interviewed who had requested a bed type change. Resident #63</p> <p>Findings include:</p> <p>On 6/10/13 at 3:56 P.M., Resident #63 was observed in her room sitting in an over sized wheelchair. She was receiving oxygen and had a tracheotomy. Her bed was a standard hospital bed. During interview at that time, she indicated there was a problem with her bed. She indicated the mattress "slides" and she was not sure if it was a problem with the bed frame or the mattress. She indicated she had told the Director of Nursing (DON) about her bed problem approximately 1 month ago. Resident #63 indicated the DON had observed the problem of the bed sliding. She also indicated</p>	F000309	<p><b>F309</b></p> <p><b>COMPLETION DATE 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community to provide care/services for the resident's to attain or maintain the highest practical physical, mental psycho social well being.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All residents needing bariatric beds have the potential to be affected.</p> <p>All residents were observed by the DNS/designee to ensure residents were in appropriate fitting bed. New beds were obtained if necessary.</p> <p>Resident #63 was immediately evaluated for an appropriate bed and a bariatric bed put in place at that time. 6/13/2013</p>	07/14/2013			

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	<p>Maintenance staff #1 had also been aware of the problem.</p> <p>On 6/13/13 at 8:36 A.M., the DON was made aware of Resident # 63's bed problem. At that time the DON indicated she had been aware of the problem. She indicated to the resident at that time that she had a bariatric bed for her. The DON also indicated at that time she would have Maintenance staff #1 change her bed to a bariatric bed.</p> <p>On 6/14/13 at 8:17 A.M., Resident #63 was observed to have a different bed than a hospital sized bed. The new bed had a wider mattress. The resident indicated at that time she had slept in her new bed last night for the first time. She also indicated she had slept more comfortably than previously in her standard hospital bed.</p> <p>On 6/14/13 at 8:30 A.M., the Social Service Director (SSD) was interviewed. She indicated Resident # 63's (hospital sized) bed's mattress had slipped when she was in bed. She indicated the facility had now provided the resident with a bariatric bed. She indicated the bariatric bed had been at the facility before it had been provided to Resident #63.</p>		<p><b>How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?</b></p> <p>The IDT team will discuss daily during morning meeting all residents needing adaptive equipment for their highest well being.</p> <p>Executive Director/Designee will ensure appropriate equipment is provided as needed.</p> <p><b>What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>A mandatory in-service for all team members will be conducted on or before July 14, 2013. This in-service will be conducted by Social Service Director, Director of Nursing, and Maintenance Director to ensure the proper guidelines are in place for grievance and adaptive equipment needs.</p> <p>This process will ensure procedures are in place to provide care/services for highest well being.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</b></p>		

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	<p>On 6/14/13 at 9:45 A.M., during interview with the DON, she indicated the resident's weight fluctuates. The DON at that time did not provide any information regarding her bariatric bed placement.</p> <p>Review of the Resident #63's weights from facility documentation entitled, " Vitals Report" (6/11/13 at 9:10 A.M.) indicated a weight on 5/6/13 of 317 lbs [pounds] and a weight of 319 lbs on 6/5/13.</p> <p>Resident #63's current Minimum Data Set Assessment (MDS) dated 3/29/13 indicated a cognitive summary score of 15 (cognition intact). The MDS also indicated extensive assistance needed by 2 or more staff for bed mobility.</p> <p>On 6/14/13 at 4:05 P.M., information provided by the Administrator regarding Resident #63's new bed the GS9 FX600 was reviewed. That information included but was not limited to: "... The innovative CS9 FX600 adjusts from 36" to 39" or 42" to accommodate a variety of residents offering facilities the utmost in flexibility. The frame can easily be adjusted without any tools and</p>		<p>The IDT team will review all grievance and maintenance request on a daily basis to identify the potential for deficient practices. To ensure compliance, the Social Service director and Maintenance director will be responsible for completion of the CQI too weekly x 4 weeks, bimonthly x 2 months, and the quarterly until compliance is maintained for 2 consecutive quarters. The results will be reviewed by the CQI committee overseen by the Executive Director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. CQI tool Grievance evaluation process</p>				

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	support up to 600 pounds for a truly versatile long term-care bed..."  3.1-37(a)						

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review the facility failed to ensure a resident identified as occasionally incontinent had a toileting program in place to prevent further urinary continence decline for 1 of 3 reviewed for urinary incontinence. Resident #22</p> <p>Findings include:</p> <p>On 6/12/13 at 10:05 A.M., the clinical record was reviewed for Resident #22.</p> <p>The Minimum Data Set Assessment (MDS) showed a decline in urinary continence since admission to the facility. The MDS read as followed: 2/1/13 Admission assessment reported Resident #22 as always continent. Her cognitive status was 12 which indicated a mild cognitive impairment.</p>	F000315	<p><b>F 315</b></p> <p><b>COMPLETION DATE 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community to ensure a resident identified with an occasionally incontinent episode has a toileting program in place to prevent further urinary continent decline/UTI</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All residents have the potential to be affected.</p> <p>Review of all incontinent residents was completed by Designee to ensure those residents were care planned and if applicable were placed on a toileting program.</p>	07/14/2013			

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	<p>The MDS assessment dated 2/15/13 MDS reported Resident # 22 as occasionally incontinent (less than 7 episodes of incontinence).The MDS reported Resident #22 was not on a toileting program or a trial toileting program.</p> <p>The following MDS assessments dated 2/24/13, 3/28/13, 4/25/13 and 5/13/13 reflected the same information as listed on the 2/15/13 assessment. Resident #22 continued to be assessed as occasionally incontinent (less than 7 episodes of incontinence) and Resident #22 was not reported to be on a toileting program or a trial toileting program.</p> <p>The CNA assignment sheet dated 6/11/13 was reviewed on 6/12/13 at 3:15 P.M. Resident #22 was not listed as a resident who utilized a toileting program or a resident that used Depends (incontinence brief). She was assessed as a resident that needed the assistance of 1 person to toilet.</p> <p>Review of Residents #22's care plan, initiated on 1/28/13, read as follows: "Problem: Resident at risk for incontinence due to: muscle weakness, syncope, and dementia, receives psychotropic, antihistamines, and benzodiazepines.</p>		<p>Resident #22 care plan was reviewed and updated on 6/12/2013 to include a toileting program. Resident #22 was started on the toileting program 6/12/2013.</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>The IDT team will review and discuss daily during morning meeting all resident's urinary continent declines/UTI that need a toileting program. The DNS/Designee will add interventions to the Nurse Aid assignment sheets.</p> <p><b>What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>A mandatory in-service for all nursing team members will be conducted on or before July 14, 2013. This in-service will be conducted by the Director of Nursing/Designee to ensure the proper assessment tools are in place to maintain and prevent urinary decline/UTI as well as updating of care plans to reflect the current status of the resident.</p> <p><b>How will the corrective action be monitored to ensure the deficient</b></p>				

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	<p>Goals: Resident will be free from adverse effect of incontinence. Approach:</p> <ol style="list-style-type: none"> <li>1. Assess and document skin condition weekly and as needed.</li> <li>2. Assist with elimination.</li> <li>3. Assist with incontinent care as needed.</li> <li>4. Check every 2 hours for incontinence.</li> <li>5. Document any abnormal findings and notify MD.</li> <li>6. Initiate 3 day pattern to evaluate the need for scheduled toileting program.</li> <li>7. Observe signs for urinary tract infection..."</li> </ol> <p>During an interview with LPN #6 on 6/12/13 at 9:35 A.M., LPN #6 indicated that Resident #22, was continent during the day, but wore an incontinence brief during the night. LPN #6 indicated when the CNAs went to assist Resident #22 in the mornings, Resident #22's brief would be wet and Resident #22 would say, "I've already gone."</p> <p>During an interview with MDS coordinator on 6/12/13 at 11:18 A.M., the MDS coordinator indicated Resident #22's care plan should have been updated. The care plan for Resident #22 should have been</p>		<p><b>practice will not recur and what quality assurance program will be put in place?</b></p> <p>The IDT team will monitor the urinary status of residents on a daily basis to identify the potential for deficient practices. To ensure compliance, the Director of Nursing/designee will be responsible for completion of the CQI tool weekly x4 weeks, bimonthly x 2 months, and then quarterly until compliance is maintained for 2 consecutive quarters. The results will be reviewed by the CQI committee overseen by the Executive Director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. CQI Tool—Incontinent program</p>				

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	<p>revised from at risk for incontinence care plan to a care plan for incontinence. The MDS coordinator also indicated Resident #22 should have been assessed and placed on a toileting program.</p> <p>3.1-41(a)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure adequate supervision was provided to prevent repeated falls for 1 of 2 residents reviewed for falls. Resident #117</p> <p>Findings include:</p> <p>During initial tour of the facility on 6/10/13 at 7:30 A.M., the following was observed: the front entrance was located near the 300/400 Unit nursing station. The 300 Unit and the 400 Unit halls were in the shape of an "L", with the nursing station observed at the juncture of the two halls.</p> <p>The clinical record of Resident #117 was reviewed on 6/12/13 at 9 A.M. The resident was admitted to the facility on 5/10/13. Diagnoses included, but were not limited to, the following: Alzheimer's disease, arthritis and congestive heart failure. The MDS (minimum data set assessment) dated 5/17/13 indicated the following for the resident: unable</p>	F000323	<p><b>F 323</b></p> <p><b>COMPLETION DATE 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community to ensure that the resident environment remains as free of accident hazards as possible and adequate supervision.</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All residents who are at risk for falls have the potential to be affected.</p> <p>Resident #117 was immediately assessed by the nursing team and well as the therapy team. The appropriate equipment was put in place for positive outcomes and free of accidents.</p> <p>Care plans will be reviewed to ensure all residents who are at a fall risk were reviewed by the nursing team to ensure fall interventions</p>	07/14/2013			

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	<p>to complete the interview for cognitive impairment; transfer required extensive assistance as well as walking in room and corridor; in the last 7 days, the resident had been on an antibiotic and a diuretic; balance: the resident was only able to stabilize with human assistance in moving from a seated to standing position and walking; the resident had no history of falls since admission.</p> <p>A Fall Risk Assessment dated 5/23/13 at 2:59 P.M., indicated the following: "new admission; age 80 or above; receives antihistamines and/or antihypertensive, diuretics; is incontinent of urine or bowel; has diagnosis of and/or demonstrates evidence of impaired gait/balance; uses an assistive device of rolling walker; is non-compliant or has history of non compliance (sic); is confused and/or disoriented." The form directs "If any answer above is yes, the resident is at risk for experiencing a fall... "</p> <p>Nurses notes dated 5/28/13 at 9:30 A.M., indicated the following: "Resident was attempting to stand up out of wheelchair to go into another resident's room. Staff was unable to get to the resident before resident fell forward onto the floor hitting his head.</p>		<p>were in place to protect the resident and to ensure care plan and Nurse Aid assignment sheets were accurate.</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>The IDT team will review and discuss daily during morning meeting all residents needing proactive devices/tools to be put in place to ensure the safety of our residents. Charge nurse/designee will complete a fall investigation with each fall that occurs. Appropriate intervention will be put into place after each incident, documented and the fall investigation sheet.</p> <p><b>What measures will be put in place for what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>A mandatory in-service for all nursing team members will be conducted on or before July 14, 2013. This in-service will be conducted by the Director of nursing and Rehab director in order to ensure we have the appropriate tools in place to prevent accidents and maintain safety for our residents.</p>				

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	<p>Resident noted to have raised bump to L (left) forehead and skin tear to his L arm..."</p> <p>Nurses notes dated 6/10/13 at 9:19 A.M., indicated the following: "IDT (Interdisciplinary Team) note for fall that occurred on 6/9/13 at 8:58 P.M. Resident was up in w/c prior to fall. Resident attempted to stand up and step over w/c foot pedals. Resident fell before staff could reach him..."</p> <p>On 6/12/13 at 9:10 A.M., the clinical record was reviewed. Nurses notes dated 5/28/13 at 3:16 A.M., indicated the following: "Resident stood up from w/c (wheelchair) without staff assist. Alarm in use with audible sound functioning. Fall witnessed by staff..."</p> <p>On 6/12/13 at 11:11 A.M., the resident was observed to reside on the 300 Unit hall.</p> <p>On 6/13/13 at 3:18 P.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure for "Fall Management Program." The policy was dated 6/12 (sic) and included, but was not limited to, the following: "All falls will be discussed by the interdisciplinary team the next business day morning</p>		<p>This process will ensure that all team members are aware of the prevention of accidents.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</b></p> <p>The IDT team will monitor resident needs on a daily basis to identify the potential for deficient practices. To ensure compliance, the Director of Nursing/designee will be responsible for completion of the CQI tool weekly x4 weeks, bimonthly x 2 months, and the quarterly until compliance is maintained for 2 consecutive quarters. The results will be reviewed by the CQI committee overseen by the Executive director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>CQI Tool—Safety/hazardous</p>				

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	<p>(sic) after the day of the fall to determine other possible interventions to prevent future falls."</p> <p>On 6/13/13 at 4:09 P.M., the DON (Director of Nursing) was interviewed. She indicated on 5/28/13, the resident had 2 falls. She indicated the first fall was at 3:16 A.M., and at the time the resident had a pad alarm in his wc (wheelchair). She indicated the resident stood up from his wc without staff assistance in the 300 Unit hallway. The DON indicated the pad alarm did sound and the resident fell before the nurse could get to him. She indicated the staff did witness the fall. The DON indicated the resident likes to be up at night because the resident used to work at night. The DON indicated the new intervention after that fall was to apply a pull tab alarm and the pressure alarm was discontinued.</p> <p>The "Event Report" dated 5/28/13 at 3:12 A.M. (as the time of the event) , was reviewed on 6/14/13 at 9 A.M., and included, but was not limited to, the following: "Document any environmental factors observed in area of fall: W/C foot pedals down..." The "notes" on the event form were dated 5/28/13 and timed 3:16 A.M.</p>						

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	<p>During the interview, the DON indicated the resident's second fall was on 5/28/13 at 9:41 A.M. She indicated the resident was again, in his w/c and attempted to stand up. She indicated staff was unable to get to the resident in time before he stood, fell and hit his head. She indicated the resident received a raised bump to his left forehead and a skin tear to his left arm. The DON indicated the intervention added was a drop seat cushion in the wheelchair. The DON indicated the pull tab alarm was functioning at the time of that fall and that was a witnessed fall.</p> <p>The "Event Report" dated 5/28/13 at 9:41 A.M. was reviewed on 6/14/13 at 9 A.M. and included, but was not limited to, the following: "...location of fall: 400 hallway...Has the resident had any medication changes within the past 7 days? Increase in Lasix (diuretic) for 3 days then returned to previous..."</p> <p>During the interview, the DON indicated the resident's third fall was on 6/9/13 at 8:58 P.M. She indicated that fall occurred at the front entrance of the building. The DON indicated the resident was in his wheelchair and attempted to stand up and step over the w/c foot pedals. She indicated the</p>			

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	<p>resident's pull tab alarm did sound but staff was unable to reach the resident before he fell. She indicated the additional intervention in place after that fall was to remove the swing away wheelchair foot pedals and use a "super-low hemi wc."</p> <p>The "Event Report" dated 6/9/13 at 8:58 P.M., was reviewed on 6/14/13 at 9 A.M. and included, but was not limited to, the following: "Has the resident had any medication changes within the past 7 days? ATB (antibiotic) for pneumonia..."</p> <p>On 6/14/13 at 1 P.M., the DON was interviewed. She was made aware of the resident's three witnessed falls and provided no additional information.</p> <p>3.1-45(a)(2)</p>				

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F000329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive 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 interview and record review, the facility failed to ensure anti-anxiety medications were reviewed routinely for gradual dose reductions for 1 of 10 residents reviewed for unnecessary drugs who met the criteria for unnecessary drugs in stage 2. Resident # 17</p> <p>Findings include:</p> <p>On 6/13/13 at 4:03 P.M., Resident # 17's clinical record was reviewed.</p>	F000329	<p><b>F 329</b></p> <p><b>COMPLETION DATE: 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community to ensure that Drug regimen is reviewed routinely for gradual dose reductions per state guidelines.</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the</b></p>	07/14/2013	

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	<p>Her diagnoses included, but were not limited to, anxiety and a history of falls. She had an admission date of 12/28/05 and a readmission date of 10/17/11.</p> <p>Her current June 2013 physician orders included, but was not limited to, Xanax (an anti-anxiety medication) 0.25 mg- take 1/2 tablet (0.125 mg) twice a day. Also an order for Xanax 0.25 mg - take 1 tablet at bedtime.</p> <p>On 6/14/13 at 4:13 P.M., the Director of Nursing (DON) was interviewed regarding the gradual dose reduction of Xanax. She indicated Resident #17's last admission had been on 10/7/11. She indicated at that time she had an order for Xanax 0.25 mg take 0.125 mg twice a day and 0.25 mg at bedtime. She provided a pharmacy recommendation to the physician dated 4/20/12, which had indicated, "...Resident's condition had not stabilized or improved, further monitoring required." The documentation indicated the physician had not indicated a change in the Xanax dosage.</p> <p>On 6/14/13 at 4:45 P.M., the DON indicated she was unable to provide a recommendation or documentation of an attempted dose reduction since</p>		<p><b>deficient practice?</b></p> <p>All residents receiving anti-anxiety medication have the potential to be affected.</p> <p>Resident # 17 drug regimen was reviewed immediately by her primary physician 6/13/2013. At that time no further reduction were recommended.</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>The IDT team will review and discuss daily during morning meeting as well as review monthly with primary physician. All residents that meet the requirement for an attempted GDR per consultant pharmacist or that have exhibited behavioral symptoms which warrant a psychotropic medication reduction, will have a reduction attempted per physician order with documentation supportive of the attempt or rationale not to proceed with a reduction by the IDT and determined by the physician.</p> <p><b>What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>A mandatory in-service for nursing</p>		

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	<p>the 4/20/12 dated pharmacy recommendation regarding Xanax.</p> <p>A facility policy entitled ASC (American Senior Communities) Psychotropic Medication Management Program (no policy date) was received and reviewed on 6/14/13 at 4:35 P.M. The policy included, but was not limited to, "...2.b. for residents who use anxiolytic medications a GDR (gradual dose reduction) must be initiated per the following guidelines:... -After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician..."</p> <p>3.1-48(a)(2)</p>		<p>team members and Social service will be conducted on or before July 14, 2013. This mandatory in-service will be conducted by the Executive director and Social Service consultant regarding protocol for GDR and completion of behavior monthly summaries, as well as documentation as it relates to clinically contraindicated reductions.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</b></p> <p>The IDT team will monitor resident drug regimen usage on a daily basis along with the pharmacy reports to identify the potential for deficient practices. To ensure compliance, the Director of Nursing/designee will be responsible for completion of the CQI tool weekly x 4 weeks, bimonthly x 2 months, and then quarterly until compliance is maintained. The results will be reviewed by CQI committee overseen by the Executive Director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>CQI Tool—GDR/pharmacy protocol</b></p>		

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure an appropriate dishwasher temperature was maintained and staff was aware of appropriate dishwasher temperatures and/ or food sanitation practices were utilized by staff for 1 of 3 kitchen observations.</p> <p>Findings include:</p> <p>1. On 6/13/13 at 9:16 A.M., Dietary staff #1 was observed running the dishwasher. The Food Service Manager (FSM) indicated the dishwasher was a low temperature dishwasher. She indicated the dishwasher used cold chemicals. At that time during interview, Dietary staff #1 indicated the wash cycle should be 125 F (Fahrenheit) and the rinse cycle should be 150 F. The wash and rinse cycle of the dishwasher were observed to be 118 F (wash) and 128 F (rinse) by reading the dial of the dishwasher. The FSM indicated she did not know what the</p>	F000371	<p><b>F 371</b></p> <p><b>COMPLETION DATE: 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community to store, prepare, distribute and serve food under sanitary conditions.</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All residents have the potential to be affected.</p> <p>Team member #1 and Team member # 2 were immediately educated on the proper procedures for food service under sanitation guidelines.</p> <p><b>What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>A mandatory in-service for all dietary team members will be</p>	07/14/2013			

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	<p>temperature of wash and rinse cycle of the dishwasher should be. She indicated she was used to high temperature dishwashers.</p> <p>On 6/13/13 at 9:20 A.M., Dietary staff #1 indicated she would use test strips for the dishwasher. Dietary staff #1 dipped a T strip (disposable temperature sensors) in the water running outside of the dishwasher. Dietary staff #1 indicated the T strip should turn green. When she removed the T strip from the water it had not turned green. The FSM at that time retrieved the directions for the T strips. The directions indicated the T strip should be placed between the prongs of a fork and be placed inside a drinking glass and ran thru the dishwasher cycles. At that time, 9:25 A.M., after running another T strip through the dishwasher, the strip did not turn green. The T strip had information on each strip that indicated a changing to a green color indicated a temperature of 140 F.</p> <p>On 6/13/13 at 9:48 A.M., Maintenance staff #1 checked the dishwasher temperatures with a digital thermometer and noted a wash temperature of 138 F and rinse temperature of 136F and 137F. Maintenance staff #1 was unaware of</p>		<p>conducted on or before July 14, 2013. This in-service will be by the Dietary manger, Maintenance director and RD. This in-service ensure proper sanitation guidelines and food handling guidelines, Dishwashing, hand washing are in place. Proper Hand washing return demonstration will be conducted to ensure the time guidelines are met. There will be clocks posted at each hand washing center to ensure each team member will wash hands the appropriate time per guidelines. The Dietary manager/designee will conduct observations during each meal to ensure proper dishwashing.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</b></p> <p>To ensure compliance, the Dietary manager/designee will be responsible for completion of the CQI tool weekly x 4 weeks, bimonthly x 2 months, and then quarterly until compliance is maintained for 2 consecutive quarters. The results will be reviewed by the CQI committee overseen by the Executive Director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>CQI tool- Kitchen Sanitation/Environmental Review.</p>				

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	<p>what the wash and rinse temperatures needed to be when interviewed at that time. Documentation was lacking of a facility policy regarding appropriate dishwasher temperatures for the wash and rinse cycles.</p> <p>On 6/13/13 at 9:50 A.M., Maintenance staff #1 located writing on the dishwashing machine that indicated the wash and rinse cycle of the dishwasher needed to be a minimum of 120 F.</p> <p>2. On 6/13/13 at 12:00 P.M., the noon meal preparation was observed in the kitchen area. Dietary staff #3 removed soiled dishes and utensils used in pureed food preparation to the dishwasher area for washing. He then returned to the food preparation area and began working without hand washing.</p> <p>3. On 6/13/13 at 12:05 P.M., Dietary staff #1 was observed, while serving hot dogs, to lay the tongs with the handles in the pan of buns. At that time Dietary staff #2 was observed pouring fruit flavored drinks into individual glasses on a tray being prepared for residents in the main dining room. The tray contained a large amount of spilled fruit drink and</p>						

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	<p>Dietary staff #2 continued to pour and place more glasses on tray with the spilled liquid. The Dietician was made aware of staff placing glasses for service in spilled liquids. She indicated to staff to get a clean tray for drink preparation.</p> <p>4. On 6/13/13 at 12:14 P.M., Dietary staff #1 was observed to use the same tongs to remove hamburgers from a pan of hamburgers, and also placed the tongs directly on buns. She then remove cheese from a tray of cheese slices and place on the hamburgers and then use the same tongs to remove loose lettuce from a pan of lettuce and placed on top of the cheese on hamburgers. The Dietician was made aware of the same tongs being used for placement of the hamburger, cheese, and lettuce. The Dietician at that time indicated to Dietary staff #1 that the food items needed separate tongs for serving.</p> <p>5. Also on 6/13/13 at 12:14 P.M., Dietary staff #2 was observed searching in a drawer of clean scoop utensils for a needed scoop. She was observed touching the inside of the clean scoops with her hands instead of using the handles of the scoops.</p>			

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	<p>6. On 6/13/13 at 12:18 P.M., Dietary staff # 1 was observed to lay the tong used for serving lettuce in the lettuce pan with the handle lying in the lettuce. The Dietician at that time indicated the tong handles should not have had contact with lettuce.</p> <p>7. On 6/13/13 at 4:25 P.M., during interview with the Dietician, she was made aware of the problem during noon meal preparation regarding tong use, drink preparation and hand washing. She indicated she had observed same problems during the preparation of the noon meal.</p> <p>8. On 6/14/13 at 9:16 A.M., Dietary staff #1 indicated dietary staff was using a digital thermometer to check dishwasher temperatures instead of the dial on the dishwasher. On 6/14/13 at 9:20 A.M., Maintenance staff #1 checked the wash and rinse cycle of the dishwasher with a digital thermometer. The wash cycle was 133 F and the rinse cycle was 125 F.</p> <p>9. On 6/14/13 at 9:30A.M., Dietary staff #1 indicated facility had talked to GFS (Gordon Food Service/company that serviced the facility dishwasher) yesterday and they indicated the wash and rinse temperatures need to</p>						

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	<p>be a minimum of 120 F and not over a temperature of 150 F for the dishwasher chemicals to work.</p> <p>10. 6/14/13 at 3:38 P.M., the Administrator and Dietician were interviewed. The Administrator indicated GFS would be checking the dial of the dishwasher to make sure the dial was working properly. The Administrator indicated at the facility was now checking the dishwasher temperatures using the dial on the dishwasher and digital thermometer for a double check. The Administrator indicated she had checked the dishwasher temperatures that afternoon using a dial and a digital thermometer with different temperatures of 130 F and 129 F obtained.</p> <p>11. On 6/13/13 at 2:57 P.M., the FSM provided the facility policy entitled " Cleaning Dishes and Dish Machine (Revision date: 05/06). The policy included but was not limited to: " ... 5. Check temperature and pressure. Follow manufactures ' ' recommendations..." The policy lacked documentation of dishwasher temperatures.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>						

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F000518 SS=E	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>Based on observation interview and record review, the facility failed to ensure all staff working in the laundry was aware of and understood the emergency procedures for fire safety related to the gas laundry dryers.</p> <p>Findings include:</p> <p>During an interview on 6/13/13 at 12:15 P.M., Maintenance Assistant/Laundry Aide #1(MA/LA) was working in the laundry room. He was unloading clothing from the washers and loading the clothing into the dryers. MA/LA #1 was working in the laundry by himself. MA/LA #1 indicated he did not know if the dryers were gas or electric. MA/LA #1 opened the door next to the dryers looked behind the dryers and said they were electric. MA/LA #1 was made aware of the flexible gas pipe connecting each dryer to the main gas line in the building. When MA/LA #1 was queried on how to turn the gas off in</p>	F000518	<p><b>F 518</b></p> <p><b>COMPLETION DATE: 7/14/2013</b></p> <p><b>Plan of Correction Text:</b></p> <p>It is the intent of this community that all team members be trained in emergency procedures.</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>MA/LA #1 was immediately re-educated on the equipment and emergency procedures in the immediate work area.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected however, none were at this time.</p> <p><b>What measures will be put in place</b></p>	07/14/2013	

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	<p>the event of fire, he indicated he did not know where the gas shut off valve was located and that he would need to call the Maintenance Supervisor to find out.</p> <p>During an interview with the Maintenance Supervisor on 6/14/13 at 3:05 P.M., the Maintenance Supervisor indicated that the MA/LA #1 had been trained and that he should have known how to turn the gas off.</p> <p>3.1-51(b)</p>		<p><b>or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>A mandatory in-service for all team members will be conducted on or before July 14, 2013. This in-service will be conducted by the Maintenance director and Executive director regarding emergency procedures in the laundry room</p> <p>Laundry team members will be interviewed weekly by ED/Designee to ensure all team members are aware of the proper emergency procedures.</p> <p>This verification process will ensure that all team members are aware of the emergency plan, location of shut off valves/devices, and emergency procedure drills to ensure the safety of all members of this community.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</b></p> <p>The IDT team will monitor the process to identify the potential for deficient practices. To ensure compliance, the Maintenance director/designee will be responsible for completion of the CQI tool weekly x 4 weeks, bimonthly x 2 months, and then quarterly until compliance is maintained for 2</p>		

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			<p>consecutive quarters. The results will be reviews by the CQI committee overseen by the Executive Director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>CQI Tool—Safety/hazardous</b></p>	