

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
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NAME OF PROVIDER OR SUPPLIER WOODLANDS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN 47304
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN 00138594.</p> <p>Complaint IN 00138594 - Substantiated. Federal/State deficiencies related to the allegations are cited at F226 and F250.</p> <p>Survey dates: November 4, 5, 6, 7 and November 11 and 12, 2013</p> <p>Facility number: 000134 Provider number: 155229 AIM number: 100275430</p> <p>Survey team: Tina Smith-Staats, RN TC Karen Lewis, RN Ginger McNamee, RN (November 6, 7 and 12, 2013) Jason Mench, RN</p> <p>Census bed type: SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 9 Medicaid: 52 Other: 11</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any 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 certification of compliance on or after 12/06/2013.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Total: 72</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure staff were trained in how or where to find the contact information for reporting allegations of abuse when the supervisor or administrator was not on site for 1 of 3 reportable investigations reviewed.</p> <p>Findings include:</p> <p>The Director of Nursing provided the investigations of allegations of abuse reported to the Indiana State Department of Health on 11/7/13 at 10:15 a.m. A report indicated an employee had reported, on 11/2/13, hearing a CNA yelling at a resident, followed by a slapping noise and hearing a resident moaning on 11/1/13. The incident was not reported to the employee's supervisor until 11/2/13.</p> <p>During an interview with the Director of Nursing on 11/7/13 at 12:14 p.m., she indicated the incident was reported the day after it occurred.</p>	F000226	<p>It is the policy of this facility to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property. 1. No resident was directly affected. Dietary staff involved was counseled on proper procedures for timely abuse reporting to the Administrator and DON. 2. All residents have the potential to be affected. No other resident was directly affected. Administrator, DON and all other department head telephone numbers were place in every department to ensure phone numbers are available to all staff. 3. Staff will be re-educated on timely abuse reporting to the Administrator, confidentiality and the contact information of all department heads in order to report such allegations on Dec 4, 2013 by the SDC. Abuse education in-services to be completed quarterly. 4. Reportables will be reviewed by the ED/Designee from time of reportable incident to time of ED/DON notification. Results to be reviewed at monthly PI meeting. Auditing of reporting abuse to be completed x 6</p>	12/06/2013	

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	<p>The Director of Nursing indicated the the event should have been reported on 11/1/13, when it occurred. She indicated the CNA was suspended during the investigation and it was unsubstantiated.</p> <p>During a confidential interview with Employee #6 on 11/12/13 at 1:45 p.m., the employee indicated CNA #7 was overheard yelling at a resident to sit down. The employee heard a slapping noise followed by what sounded like moaning. This was not observed only heard. The employee indicated there had been a confrontation with the nurse earlier and the employee was uncomfortable approaching the nurse about what had been heard. The employee discussed the situation with a coworker and decided to wait and report it to the supervisor the next day. The incident occurred on a Friday evening after the supervisors had left for the day. The employee indicated information had been provided to report suspicions of abuse immediately but not how to contact the administrator. The employee further indicated other staff members were blaming Employee #6 for CNA #7's suspension during the investigation. Employee #6 indicated confidentiality was not maintained</p>		months.				

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	<p>throughout the investigation and the employee feared retaliation should the need to report an abusive situation arise again and would possibly not report it.</p> <p>This federal tag relates to complaint number IN00138594.</p> <p>3.1-28(a)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to assess a resident for the need of one to one monitoring upon the return to the facility from an in patient stay on a psychiatric unit for 1 of 2 resident reviewed for behaviors.</p> <p>Findings include:</p> <p>Resident #D's clinical record was reviewed on 11/6/13 at 10:15 a.m. The resident's diagnoses included, but were not limited to, bipolar/dementia with behavioral disturbance and Alzheimer's disease.</p> <p>The resident had been on Divalproex Sodium ER 250 mg give 1 tablet orally at 5 p.m. for mood stabilization. This order was discontinued 10/10/13.</p> <p>Review of a 10/23/13, 2:21 a.m., Nursing Note indicated the resident was found by CNA #8 in a female resident's room with his pants and brief lowered. Resident #D's penis was in Resident #C's mouth. CNA #8</p>	F000250	<p>It is the policy of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. 1. Resident # D had no negative outcome and is being supervised per the plan of care. 2. Residents returning from in-patient psychiatric stay are at risk.3. Care plan team will be re-educated on Dec 4, 2013 on assessing residents upon return from hospital stays. Residents being re-admitted from psych stay will be assessed for supervision needs. 4. Auditing of return assessments to be completed by Social Service/Designee x 6 months. Results of auditing will be reviewed at monthly PI meeting.</p>	12/06/2013

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	<p>removed Resident #D from the room and he was started on one to one monitoring.</p> <p>A 10/23/13, 11:41 a.m., Nursing Note indicated the resident was transported to a psychiatric unit. The nursing notes indicated the resident returned to the facility on 10/31/13 at 3:10 p.m., with 15 minute checks initiated.</p> <p>An 11/1/13, 9:51 a.m., Nursing Note indicated the resident transferred self and ambulated with a slow steady gait. He remained on 15 minute checks.</p> <p>The nurses notes indicated the resident remained ambulatory with 15 minute checks until 11/5/13 at 4:53 p.m., when the resident was placed on one to one supervision related to the episode on 10/22/13.</p> <p>Review of the Social Services Notes indicated the following: a. 10/23/13 at 1:43 p.m., "Please see nursing note of 10/23/13 at 10:30 p.m. Resident was found to be in compromising position with a female resident. She was also participating with no upset or fear. Resident was admitted to psychiatric unit today and had no recollection of the event of last</p>						

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	<p>evening."</p> <p>b. 10/24/13 at 1:03 p.m., Minimum Data Set note: on 10/18/13, "the resident scored a 7 on the BIMS [Brief Interview for Mental Status.] [indicating he was cognitively impaired]. He wanders on a daily basis. He is pleasant and sociable. There are no plans for discharge."</p> <p>c. 10/25/13 at 4:16 p.m., "The incident with the resident and a female resident was discussed with the family. No worries regarding the incident. The resident appears to have no interest in any of the other females on the unit. He is always drawn to the one female only. He pushes her around in her wheel chair. They hold hands and sit and have separate conversations together. They laugh and appear to enjoy each others company."</p> <p>d. 11/5/13 at 4:47 p.m., "the resident's family was notified the facility was looking for another facility to place the resident in as a result of his recent sexual episode."</p> <p>e. 11/6/13 at 10:30 a.m., "The resident has been placed on one to one. He has a sensor on his door frame to alert staff when/if he leaves</p>						

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	<p>the room at night. He has exhibited no behaviors and has been more quiet."</p> <p>During an interview on 11/6/13 at 10:30 a.m., the Director of Nursing indicated the resident had been on 15 minute checks since his return to the facility.</p> <p>During an interview on 11/6/13 at 10:35 a.m., LPN #9 indicated the resident wandered the halls at night between 2:30 and 3:00 a.m.</p> <p>During an interview with the Nurse Consultant on 11/6/13 at 10:38 a.m., she indicated she had just learned the resident had returned to the facility on 10/31/13. She had thought the resident was still out of the facility. She indicated the resident should have been placed on one to one supervision when he returned to the facility. She indicated she had told the staff to initiate one to one supervision and to start looking for new placement for Resident #D.</p> <p>CNA #8 was interviewed on 11/12/13 at 1:15 p.m. The CNA indicated she was doing 15 minute bed checks when she observed Resident #D in Resident #C's room with his penis in Resident C's mouth. The CNA said</p>			

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	<p>Resident #D stepped back and cooperated with her in exiting the room. The CNA indicated she had a couple of residents that get out of bed and wander during the night.</p> <p>During an interview with the Social Service Director on 11/12/13 at 4:15 p.m., she indicated she had probably done an assessment of the resident when he returned to the facility, but she could not remember. She indicated she hoped she had.</p> <p>This federal tag relates to complaint number IN00138594.</p> <p>3.1-34(a)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure interventions identified in the resident's plan of care were in place to help prevent falls for 1 of 3 residents reviewed for falls (Resident #48) and failed to ensure laboratory tests were obtained timely as ordered by the physician for 1 of 5 residents reviewed for laboratory testing related to medication use. (Resident #32)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #48 was reviewed on 11/7/13 at 7:31 a.m.</p> <p>Diagnoses for Resident #48 included, but were not limited to, rheumatoid arthritis, hypertension, and depression.</p> <p>A health care plan problem, dated 8/21/13, indicated Resident #48 was a risk for falls due to multiple health issues including impaired mobility, general weakness, and impaired cognition. Approaches for this</p>	F000282	<p>It is the policy of this facility to provide services by a qualified person in accordance with each residents written plan of care.</p> <p>1. Resident #48 is being toileted per plan of care and is not left alone. Resident #32 had no negative outcomes. Physician was notified of resident #32 missing lab results with no new orders. 2. Other residents identified as requiring staff attendance with toileting and having laboratory tests orders are at risk. Care plans were reviewed for toileting assist. Charts were audited for missing lab results. 3. Nursing staff will be re-educated on the policy of adhering to the residents' plan of care for prevention of accidents and the laboratory policy by the SDC on Dec 4, 2013. Daily, Monday thru Friday audits of providing staff assist with toileting on 4 residents will be completed by the DON/Designee to ensure residents' plan of care is being followed. Lab audits for results will be completed on Monday thru Friday by the Don/Designee.4. Monitoring of toileting and lab results to be completed by the DON/Designee daily Monday thru Friday x 4 weeks, weekly x 8</p>	12/06/2013			

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	<p>problem included, but were not limited to, "Bedside commode in room per resident's request, assist her with toileting and peri care. Stay with resident when she is on bedside commode."</p> <p>Review of the incident report for the 10/11/13 fall indicated the resident had been assisted to the bedside commode and left unattended. Staff heard the resident yelling for help, entered the room and found the resident laying on the floor.</p> <p>During an interview with the Director of Nursing on 11/7/13 at 9:55 a.m., she indicated Resident #48 should not have been left unattended while on the bedside commode.</p> <p>2. The clinical record for Resident #32 was reviewed on 11/6/13 at 2:43 p.m.</p> <p>Diagnoses for Resident #32 included, but were not limited to, hypertension, hypothyroidism, and osteoporosis.</p> <p>The clinical record indicated Resident #32 was to have a Complete Blood Count (CBC) every 4 months due in February, June, and October. The original order date for the laboratory test was 2/22/12.</p>		<p>weeks then monthly x 3 months. Non compliant issues to be addressed during monthly PI meetings.</p>		

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	<p>The clinical record lacked any results for a October, 2013, CBC laboratory test for Resident #32.</p> <p>During an interview with the RN Consultant, on 11/12/13 at 1:50 p.m., additional information was requested related to the lack of an October, 2013, CBC laboratory result for Resident #32.</p> <p>During an interview with the RN Consultant on 11/12/13 at 2:03 p.m., she indicated a CBC laboratory test had not been drawn for Resident #32 in October of 2013.</p> <p>3. Review of the current facility policy, dated 06/08, titled "Diagnostic Services, " provided by RN Consultant on 11/12/13 at 2:28 p.m., included, but was not limited to, the following:</p> <p>"...Procedure</p> <p>Objectives:...</p> <p>...2. Ensure that the residents receive laboratory, radiological, and diagnostic services as ordered by the attending physician...."</p> <p>3.1-35(g)(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 record review and interview, the facility failed to ensure interventions identified in the resident's plan of care were in place to help prevent unassisted toileting and potential falls for 1 of 3 residents reviewed who met the criteria for falls. (Resident #48)</p> <p>Findings include: The clinical record for Resident #48 was reviewed on 11/7/13 at 7:31 a.m.</p> <p>Diagnoses for Resident #48 included, but were not limited to, rheumatoid arthritis, hypertension, and depression.</p> <p>An annual Minimum Data Set assessment, dated 8/21/13, indicated the resident was severely cognitively impaired, and required extensive assistance with 1 member of the staff for transfers, dressing, personal hygiene and toileting.</p> <p>A Fall Risk assessment, dated 8/19/13, indicated the resident was a</p>	F000323	<p>It is the policy of this facility to ensure each resident receives adequate supervision and assistance to prevent accidents.</p> <p>1. Resident #48 is being toileted per plan of care and is not left alone. 2. Residents identified at risk for falls with interventions have the potential to be negatively affected. Fall risk interventions have been reviewed and are currently in place. 3. Nursing staff will be re-educated on Dec 4, 2013 on ensuring fall interventions are in place. DON/Designee will audit for fall interventions daily x 30 days, then weekly x 8 weeks, then monthly x 3 months. 4. Audits of fall interventions will be completed by the DON/Designee daily x 30 days, weekly x 8 weeks then monthly x 3 months. Non compliant issues to be addressed during monthly PI.</p>	12/06/2013	

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	<p>high risk for falls with a score of 18.</p> <p>A health care plan problem, dated 8/21/13, indicated Resident #48 was a risk for falls due to multiple health issues including impaired mobility, general weakness, and impaired cognition. Approaches for this problem included, but were not limited to, "Bedside commode in room per resident's request, assist her with toileting and peri care. Stay with resident when she is on bedside commode."</p> <p>Review of the incident report for the 10/11/13 fall indicated the resident had been assisted to the bedside commode and left unattended. Staff heard the resident yelling for help, entered the room and found the resident laying on the floor.</p> <p>During an interview with the Director of Nursing on 11/7/13 at 9:55 a.m., she indicated Resident #48 should not have been left unattended while on the bedside commode.</p> <p>3.1-45(a)(2)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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 monitor the blood pressure for a medication which had parameters as to when the medication needed to be given for 1 of 5 residents reviewed for unnecessary medications. (Resident #50)</p> <p>Findings include:</p> <p>The clinical record for Resident #50 was reviewed on 11/7/13 at 1:17 p.m.</p>	F000329	It is the policy of this facility to ensure that wach resident's drug regimen is free from unnecessary drugs.1. Resident #50 had no negative outcome and is having blood pressures taker per physicians orders.2. Other residents receiving anti hypertensive medications are at risk and were reviewed for following physician orders and the documentation of blood pressures.3. Licensed nursing staff will be re-educated on Dec 4, 2013 on following physician orders for obtaining blood	12/06/2013	

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	<p>Diagnoses for Resident #50 included, but were not limited to, hypertension, diabetes, and renal failure.</p> <p>Current signed physician orders included the following:</p> <p>Clonidine (blood pressure medication) 0.1 milligram (mg) by mouth every 8 hours as needed for systolic blood pressure greater than 180 and/or diastolic blood pressure greater than 110. The original date of this order was 10/4/13.</p> <p>Review of the October and November 2013, Medication Administration Records (MAR) lacked a blood pressure result having been documented for every 8 hours.</p> <p>The resident should have had 114 blood pressure results from 10/5/13 to 11/11/13 documented to determine if the as needed blood pressure medication needed to be given to the resident. The resident's record had no blood pressure results documented. This resulted in 114 missed blood pressure results having been documented to determine the need for the as needed blood pressure medication.</p>		<p>pressure in relationship to anti hypertensive medications. Facility wide medication sheet audit was completed to ensure blood pressures ordered were being obtained and documented. 4. DON/Designee will audit medications sheets daily x 1 month, weekly x 8 weeks then monthly x 3 months to ensure blood pressures are being obtained and documented for anti hypertensive medications. Non compliant issues to be addressed during monthly PI meeting.</p>		

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	<p>During an interview with the Director of Nursing on 11/12/13 at 9:41 a.m., additional information was requested related to the blood pressure results for the as needed blood pressure medication.</p> <p>During an interview with the Director of Nursing on 11/12/13 at 10:37 a.m., she indicated blood pressure results were not obtained every 8 hours for Resident #50.</p> <p>Review of the current facility policy, revised 4/2/13, titled "Policies for Medication Administration, " provided by RN Consultant on 11/12/13 at 2:28 p.m., included, but was not limited to, the following:</p> <p>"...Procedure...</p> <p>...17. PRN medication is charted with initials, and time is given in the corner of the box. The following situations require an accompanying note:...</p> <p>...d. Any situation that requires monitoring....</p> <p>...20. Medication that requires blood pressure (BP) parameters is charted in the MAR...."</p> <p>3.1-48(b)(2)</p>			

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F000371 SS=E	<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 and interview, the facility failed to ensure food was distributed and served under sanitary conditions. This deficient practice had the potential to impact 22 to 25 of 72 residents who were served food in the facility's main dining room.</p> <p>Findings include:</p> <p>During an observation on 11/4/2013 at 10:54 a.m., in the main dining room RCNA #1 (Restorative Certified Nursing Assistant) was observed separating meal tickets after licking her fingers. RCNA #1 then began pouring beverages for the residents without washing her hands or using hand sanitizer. RCNA #1 was further observed transporting the beverages in glasses to the residents by holding the glasses while covering the top of the glasses with her hands and touching the rims with her fingers. She continued to serve beverages without washing her hands.</p>	F000371	<p>It is the policy of this facility to ensure food is distributed and served under sanitary conditions.</p> <p>1. No resident was directly affected.2. All residents have the potential to be affected. No other resident was negatively affected. Staff members involved with the witnessed deficient practice have been re-educated on hand washing policy.3. Staff will be re-educated on the policy and procedure of hand washing on Dec 4, 2013 by the SDC. Staff hand washing be will monitored by DON/Designee 3 x week x 4 weeks then weekly x 8 weeks then monthly x 3 months. Non-compliant issues to be addressed in monthly PI meeting.</p> <p>4. Monitoring of proper hand washing will be monitored 3 x week x 4 weeks then weekly x 8 weeks then monthly x 3 months. Non-compliant issues to be addressed in monthly PI meeting.</p>	12/06/2013	

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	<p>During an observation at 11/4/2013 at 11:17 a.m., RCNA #1 was observed distributing flatware covered in cloth napkins to the residents present in the main dining room. RCNA #1 carried the items in her arms while holding them against her clothing. After distributing the flatware, RCNA #1 immediately began serving trays without washing her hands or using hand sanitizer.</p> <p>During an observation on 11/4/2013 at 11:30 a.m., CNA #1 was observed assisting residents at their tables by adjusting wheelchairs and placing clothing protectors on residents. CNA #1 did not wash her hands between resident contact nor did she use hand sanitizer.</p> <p>During an observation on 11/4/2013 at 11:45 p.m., CNA #1 was observed assisting Resident #18. The resident was not eating at his current table. CNA #1 assisted Resident #18 to another table and began assisting him with his meal. She picked up a piece of bread with her hands to spread some meat salad on it to make a sandwich. CNA #1 had not washed her hands nor had she used hand sanitizer prior to touching the bread.</p>			

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	<p>During an observation on 11/4/2013 at 11:45 p.m., CNA #3 was observed moving a wheelchair for Resident #31, CNA #3 then began preparing coffee for another resident without washing her hands.</p> <p>During an interview on 11/12/13 at 1:18 p.m., when asked how many hand washing inservices the facility had provided recently, RCNA #1 responded "Probably had three so far." When asked when hands must be washed RCNA #1 responded "Before and after each resident contact." When asked when hands must be washed in the dining room, RCNA #1 responded "Before and after resident contact." When asked what the facility's policy was on the number of times hand sanitizer could be used between washing with soap and water, RCNA #1 also responded " I use it (hand sanitizer) twice before I usually wash my hands because it gets sticky."</p> <p>During an interview on 11/12/13 at 1:25 p.m., CNA #1 indicated the facility had provided five to six inservices on hand washing recently. When asked when hands must be washed, CNA #1 responded "Before gloving and after gloving and anytime you do patient care." When asked</p>			

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	<p>when hands needed to be washed in the dining room, CNA #1 responded "After each resident contact." CNA #1 also responded, "I don't use the hand sanitizer."</p> <p>Review of the current facility policy, dated 5/1/2012, titled "Hand Hygiene", provided by the Administrator on 11/12/13 at 9:46 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To decrease the risk of transmission of infection by appropriate hand hygiene.</p> <p>...Handwashing: When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water...</p> <p>...Waterless Handwashing Products: If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations other than listed under "Handwashing" above."</p> <p>3.1-21(i)(3)</p>				

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the consultant pharmacist identified the lack of blood pressure monitoring in regards to as needed blood pressure medication with parameters for use for 1 of 5 residents reviewed for unnecessary medications. (Resident #50)</p> <p>Findings include:</p> <p>The clinical record for Resident #50 was reviewed on 11/7/13 at 1:17 p.m.</p> <p>Diagnoses for Resident #50 included, but were not limited, hypertension, diabetes, and renal failure.</p> <p>Current signed physician orders included the following:</p> <p>Clonidine (blood pressure medication) 0.1 milligram (mg) by mouth every 8 hours as needed for systolic blood pressure greater than 180 and/or</p>	F000428	<p>It is the policy of this facility that the drug regimen of each resident is reviewed at least once per month by a licensed pharmacist, and must report any irregularities to the attending physician, the DON the reports must be acted upon. 1. Resident #50 had no negative outcome and is having blood pressures taken per physician orders and the documentation of blood pressure.2. Other resident receiving anti hypertensive medications are at risk and were reviewed for following physician orders and the documentation of blood pressures.3. Licensed nursing staff will be re-educated on Dec 4, 2013 on following physician orders for obtaining blood pressure in relationship to anti hypertensive medications. Facility wide medication sheet audit was completed to ensure blood pressured ordered were being obtained and documented. Pharmacy supervisor notified of blood pressure documentation discrepancy. Pharmacist to be re educated by her supervisor. 4.</p>	12/06/2013	

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	<p>diastolic blood pressure greater than 110. The original date of this order was 10/4/13.</p> <p>Review of the October and November 2013, Medication Administration Records (MAR) lacked a blood pressure result having been documented for every 8 hours.</p> <p>The resident should have had 114 blood pressure results from 10/5/13 to 11/11/13 documented to determine if the as needed blood pressure medication needed to be given to the resident. The resident's record had no blood pressure results documented. This resulted in 114 missed blood pressure results having been documented to determine the need for the as needed blood pressure medication.</p> <p>During an interview with the Director of Nursing (DoN) on 11/12/13 at 2:36 p.m., recommendations from the 11/8/13 consultant pharmacist's review for Resident #50 related to blood pressure monitoring was requested. The DoN indicated the consultant pharmacist gave no recommendations related to blood pressure monitoring from the 11/8/13 review for Resident #50.</p>		<p>DON/Designee will audit medications sheets daily x 1 month, weekly x 8 weeks then monthly x 3 months to ensure blood pressures are being obtained and documented for anti hypertensive medications. Pharmacist to do exit with DON/Designee to address any irregularities in pharmacy report. Non-compliant issues to be addressed during monthly PI meeting.</p>				

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	3.1-25(i)				

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F000441 SS=E	<p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure the</p>	F000441	It is the policy of this facility to have an infection control program	12/06/2013	

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	<p>disinfecting wipes for cleaning the glucose meters were not expired for 1 of 1 observation of blood sugar monitoring. This had the potential to effect 11 of 11 residents living in the facility with orders for blood sugar monitoring.</p> <p>Findings include:</p> <p>During an observation on 11/5/13 at 11:15 a.m., LPN #1 wiped the glucose meter with a cleaning wipe according to the manufacturer's recommendations. The empty packet of the "Sani-Cloth" wipe used to clean the glucose meter was provided on 11/5/13 at 11:17 a.m. During review of the packet it was noted to have an expiration date of 07/2013.</p> <p>At 11:19 a.m., LPN #1 asked LPN #2 for the cleaning wipes from his medication cart. LPN #2 indicated there were no cleaning wipes in his medication cart. He further indicated he had not performed any glucose testing for the day.</p> <p>LPN #1 retrieved cleaning wipes from the supply closet with the expiration date of 01/2014 at 11:21 a.m.</p> <p>The Director of Nursing was informed of the outdated wipes at 11:22 a.m.</p>		<p>designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. 1. No resident was directly affected.2. Residents having physician orders for glucose monitoring have the potential to be affected. Medication carts were audited for non expired sani-wipes and replaced.3. Licensed nursing staff will be re-educated on Dec 4, 2013 by the SDC on monitoring for expired dates of sani-wipes. Medication carts will be audited weekly x 4 weeks, then monthly x 5 months by the DON/Designees to ensure wipes are not expired.4. Audits of medication carts to be completed weekly x 4 weeks, then monthly x 5 months. Non compliant issues to be addressed at monthly PI meeting.</p>				

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	The additional 2 medication carts in the building were checked and found to have expired cleaning wipes. 3.1-18(b)(4)			

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F000465	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to identify a fall hazard in the main hallway of the facility. This had the potential to affect 11 ambulatory residents residing in the facility, visitors, and staff. Findings include: Upon entering the facility on 11/4/13 at 9:00 a.m., the front hallway floor was observed to be uneven due to being a tiled floor with two areas which had the tile removed and replaced with two carpet inlays, one measuring 12 feet by 6 feet with a depth of 3/8th inch and the other carpeted area measuring 24 feet by 12 feet with a depth of 3/8th inch. This hallway connected to the entry way, main dining room and 2 high traffic hallways of the facility. On 11/5/13 at 8:44 a.m., during an interview with Resident #50, she indicated she is transported to dialysis 3 times a week by ambulance. She further indicated she experienced discomfort during the</p>	F000465	<p>It is the policy of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.1. Resident # 50 will be transported out of the building thru another door to prevent further discomfort from the uneven floors.2. Other residents have the potential to be affected.3. Signage placed at entrance of facility to alert visitors and staff of the uneven flooring. The facility is replacing carpet inserts to include an additional level of sub flooring to remove the unevenness of the flooring. Replacement carpet ordered Nov 27, 2013. Floor repair will be completed by January 31, 2014.4. Maintenance staff will complete weekly audits x 4 weeks then monthly x 5 months of flooring to ensure no fall hazard. Non-compliant issues to be addressed at monthly PI meeting.</p>	12/06/2013			

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	transport on a stretcher due to the uneven flooring. 3.1-19(f)			

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F000520	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility Quality Assessment and Assurance Committee failed to identify a fall hazard in the main hallway of the facility potentially affecting the safety of 11 ambulatory residents residing in the facility, visitors and staff; the facility failed to ensure the disinfecting wipes for cleaning the glucose meters were not expired for 1 of 1 observation of blood sugar monitoring</p>	F000520	It is the policy of this facility to maintain a quality assessment and assurance committee consisting of the director of nursing, physician and 3 other members of the staff. 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. 1. No negative resident outcome due to deficient	12/06/2013	

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	<p>potentially affecting 11 of 11 residents living in the facility with orders for blood sugar monitoring.</p> <p>Findings include:</p> <p>1. Upon entering the facility on 11/4/13 at 9:00 a.m., the front hallway floor was observed to be uneven due to being a tiled floor with two areas which had the tile removed and replaced with two carpet inlays, one measuring 12 feet by 6 feet with a depth of 3/8ths inch and the other carpeted area measuring 24 feet by 12 feet with a depth of 3/8ths inch. This hallway connected to the entry way, main dining room and 2 high traffic hallways of the facility.</p> <p>2. During an observation on 11/5/13 at 11:15 a.m., LPN #1 wiped the glucose meter with a cleaning wipe according to the manufacturer's recommendations. The empty packet of the " Sani-Cloth " wipe used to clean the glucose meter was provided on 11/5/13 at 11:17 a.m. During review of the packet it was noted to have an expiration date of 07/2013.</p> <p>At 11:19 a.m., LPN #1 asked LPN #2 for the cleaning wipes from his medication cart. LPN #2 indicated</p>		<p>practice.2. All residents have the potential to be affected.3. Staff will be in-serviced on Dec 4, 2013 in regards to communicating concerns to ED and or those associated with the PI committee. We will utilize the existing comments/concern forms located throughout the building.4. Concerns are reviewed each morning Monday through Friday during daily department head meeting. It is the responsibility of the ED/Designee to follow up on concerns. Concerns presented to ED and/or PI committee will be reviewed at each monthly PI meeting x 6 months utilizing the concern log.</p>	

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	<p>there were no cleaning wipes in his medication cart. He further indicated he had not performed any glucose testing for the day.</p> <p>LPN #1 retrieved cleaning wipes from the supply closet with the expiration date of 01/2014 at 11:21 a.m.</p> <p>The Director of Nursing was informed of the outdated wipes at 11:22 a.m. The additional 2 medication carts in the building were checked and found to have expired cleaning wipes.</p> <p>3. During an interview with the Administrator on 11/12/13 at 3:44 p.m., the Administrator indicated the facility's Quality Assurance and Assessment Committee had not identified problems with the uneven flooring and the expired disinfecting glucometer wipes.</p> <p>3.1-52(b)(2)</p>				