

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/05/2014
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NAME OF PROVIDER OR SUPPLIER  ST ANTHONY HOME - CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: December 1, 2, 3, 4, &amp; 5, 2014</p> <p>Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780</p> <p>Survey Team: Heather Hite, RN - TC Caitlyn Doyle, RN Julie Ferguson, RN Jennifer Redlin, RN Regina Sanders, RN</p> <p>Census Bed Type: SNF: 24 SNF/NF: 142 NCC: 1 Total: 167</p> <p>Census Payor Type: Medicare: 29 Medicaid: 100 Other: 38 Total: 167</p> <p>NCC Sample: 1</p> <p>These deficiencies reflect State findings</p>	F000000	<p>St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</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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F000241 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 12, 2014, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to provide care for residents to enhance dignity, related to failing to assist a resident to the bathroom upon request for 1 of 4 residents reviewed for dignity of the 4 who met the criteria for dignity. (Resident #215)</p> <p>Findings include:</p> <p>During an observation on 12/3/14 at 10:55 a.m., Resident #215 was calling out to use the bathroom while seated in his wheelchair by the 2 A nurses' station. At that time, CNA #6 walked out of the tub room near the nurses' station and took dirty linens down the hall, during which time Resident # 215 was observed</p>	F000241	<p>1.Regarding resident #215, Unit Manager immediately assisted resident to the toilet. Resident did not void upon taking to bathroom and brief was dry.</p> <p>2.Unit Manager / designee assessed remaining residents regarding completion of resident needs with no deficiencies verbalized at that time. CNA #6 was immediately re-inserviced by Unit Manager / designee. CNA verbalized understanding of the necessity to complete resident needs and to communicate to peers any resident needs before leaving the unit for her break.</p> <p>3.Director of Staff Development (DSD) / designee re-inserviced nursing staff regarding the necessity to complete resident needs and to communicate to peers any resident needs before leaving the unit for breaks. Unit</p>	01/04/2015

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	<p>audibly calling out to use the bathroom. CNA #6 paused, then continued to take the dirty linens down the hallway. After putting the linens in a container, CNA #6 proceeded to use the computer in the hallway. Resident #215 continued to call out to use the bathroom and was also saying a prayer aloud. CNA #6 then walked past the resident and stated, "You already went to the bathroom earlier," got her coat from the nurses' station, and walked down the hallway away from the resident.</p> <p>At 11:00 a.m., the 2 A Unit Manager was notified Resident #215 indicated he had to use the bathroom and CNA #6 did not take him. The 2 A Unit Manager took the resident to his room.</p> <p>A follow up interview with the 2 A Unit Manager at 11:12 a.m., indicated the resident did not urinate but instead wanted to lie down. She further indicated the resident was dry, was wearing a brief, and CNA #6 should have taken the resident to the bathroom before leaving the unit.</p> <p>Interview with CNA #6 at 11:35 a.m., indicated Resident #215 " just went to the bathroom earlier by me and someone else earlier than that, and the resident always calls out to use the bathroom even</p>		<p>Managers / designees will interview a sampling of five (5) residents per unit per week to ensure needs are being met for nine (9) months.</p> <p>4.The DON / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5.Systemic changes will be completed by 1/4/15.</p>				

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	<p>when just taken. " CNA #6 further indicated she had told the other two CNA's on the unit that Resident #215 needed to use the bathroom before she left the unit.</p> <p>Interview with the CNA #7 at 11:48 a.m., indicated she was not told by CNA #6 that Resident #215 had to use the bathroom before leaving the unit.</p> <p>Interview with the CNA #8 at 11:48 a.m., indicated she was not told by CNA #6 that Resident #215 had to use the bathroom before leaving the unit.</p> <p>An interview on 12/4/14 at 9:28 a.m. with the 2 A Unit Manager, indicated there was not a care plan for the repetitive behavior of wanting to use the bathroom, nor was that behavior being followed on the behavior log.</p> <p>Resident #215's record was reviewed on 12/5/14 at 1:35 p.m. Diagnoses included, but were not limited to, non-Alzheimer's dementia, depression, and anxiety.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/7/14, indicated Resident #215 was cognitively impaired, frequently incontinent of urine needing extensive assist of two staff, and on a toileting program.</p>			

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F000250 SS=D	<p>An interview with the resident on 12/4/14 at 11:43 a.m., indicated things were not great. When I try to get something across to someone, they tell me to see someone else. when I have to go "pee-pee", I have to go right now, not tomorrow. That upsets me.</p> <p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of a resident, related to identifying behaviors, thoroughly assessing behaviors, implementing behavioral interventions, and evaluating the outcome of the interventions to support the residents' individual needs, for 1 of 5 residents reviewed for unnecessary medications. (Resident #269)</p> <p>Findings include:</p> <p>Resident #269's record was reviewed on</p>	F000250	<p>1.Regarding resident #269, Social Service Director (SSD) immediately issued a behavior monitoring log for this resident.</p> <p>2.SSD / designee reviewed other residents currently receiving psychotropic medications to ensure behavior logs were in place with no other deficiencies noted.</p> <p>3.SSD re-inserviced social service staff, unit managers and charge nurses regarding the policy and procedure for psychotropic medications and appropriate interventions including behavior monitoring logs. SSD / designee will audit facility new/re-admissions weekly for nine (9) months to ensure policy and procedure for</p>	01/04/2015

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	<p>12/02/2014 at 1:57 p.m. The resident's diagnoses included, but were not limited to bipolar/schizophrenic affective disorder and diabetes mellitus.</p> <p>A care plan, dated 10/29/14, indicated the resident received an antipsychotic medication and was at risk for side effects from the medication. The interventions included to monitor behaviors via the behavior tracking form, notify the physician of any changes in mood and cognition or behavior.</p> <p>A Physician's Order, dated 10/14/14, indicated an order for Seroquel (antipsychotic) 50 milligrams every evening.</p> <p>A Physician's Order, dated 11/03/14 indicated an order for Sertraline (antidepressant) 25 milligrams daily for seven days then increase the medication to 50 milligrams daily.</p> <p>A Physician's Progress Note, dated 11/03/14, indicated the Nurse Practitioner visited the resident and assessed the resident and diagnosed the resident with depression. The Nurse Practitioner wrote an order to start the resident on Sertraline.</p> <p>The Nurses' Progress Notes indicated:</p>		<p>psychotropic medications and appropriate interventions including behavior monitoring logs is followed. Psychotropic medications and appropriate interventions including behavior monitoring logs will be reviewed as part of regularly scheduled interdisciplinary behavior meetings.</p> <p>4. The SSD / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5. Systemic changes will be completed by 1/4/15.</p>		

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	<p>10/25/14 at 2:18 p.m., the resident was anxious often and fidgets with attempts to constantly get out of the chair, when he was sitting in his recliner.</p> <p>11/01/14 at 2:03 a.m., the resident attempted to get up from the wheelchair unassisted several times on the evening shift.</p> <p>11/01/14 at 2:36 a.m., the resident was agitated and combative at times.</p> <p>11/09/14 at 12:31 p.m., the resident was restless and constantly trying to get out of his chair.</p> <p>The Nurses' Progress Notes, lacked documentation to indicate an assessment of the behavior was completed, what interventions were attempted for the behaviors, and effectiveness of interventions attempted.</p> <p>The Social Service Progress Notes, dated 10/21/14, 10/27/14, 10/28/14, 10/31/14, 11/13/14, 11/19/14, and 11/24/14 lacked documentation to indicate the resident had behaviors, assessment of behaviors, interventions for behaviors, and effectiveness of the interventions. The notes had no assessment to indicate the resident had signs and symptoms of</p>			

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	<p>depression.</p> <p>During an interview on 12/03/14 at 8:19 a.m., the First Floor Unit Manager indicated she was unable to find a Behavior Monitoring Log for the resident.</p> <p>During an interview on 12/03/14 at 8:53 a.m., the Third Floor, C-Unit Manager indicated the staff should document the behavior, interventions, and the effectiveness of the interventions on the Behavior Monitoring Forms.</p> <p>During an interview on 12/03/14 at 9:45 a.m., Social Service Director #1 indicated the resident had no Behavior Monitoring Forms and she would initiate a Behavior Monitoring Form for the resident.</p> <p>A facility policy, dated 08/09, titled, "Psychotropic Medications", received from the Third Floor, D-Unit Manager as current, indicated, "...Nursing and/or social services (sic) will specifically identify behavior for which drug is being intended. 2. The interdisciplinary team (sic) will develop non-pharmacological interventions to be implemented and reflect these in the care plans. 3. Documentation of behavior and non-pharmacological interventions and effectiveness of same must support the</p>				

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	<p>need for the drug...8. For residents receiving an antipsychotic drug, social services (sic) will initiate a behavior log, nursing will document behaviors on same, and social services (sic) will review after thirty (30) days to determine effectiveness of drug..."</p> <p>A facility policy, dated 08/09, titled, "Behavioral Documentation Policy and Procedure", received from the Third Floor, D-Unit Manager as current, indicated, "...All residents will be monitored for mental, emotional and behavioral changes as well as physical condition. When a problem behavior has been identified, a plan of action will be developed to hopefully reduce, manage or eliminate the problem behavior...The interdisciplinary team will also take into consideration if the behavior is isolated, and what causative factors or patterns have been established. The interdisciplinary team will determine if the resident's behavior is easily managed through staff approaches. If the above has not been determined, it will be necessary to place the resident on behavior tracking...A Behavior Tracking Log will be initiated...This log will have the specific behaviors listed..."</p> <p>3.1-34(a)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop care plans, related to behaviors and signs and symptoms of depression for 1 of 25 residents reviewed for care plans. (Resident #269)</p> <p>Findings include:</p> <p>Resident #269's record was reviewed on 12/02/2014 at 1:57 p.m. The resident's diagnoses included, but were not limited to bipolar/schizophrenic affective disorder and diabetes mellitus.</p>	F000279	<p>1.Regarding resident #269, Social Service Director (SSD) immediately initiated a care plan which included the current behaviors and interventions for staff to attempt to redirect and / or diffuse any behaviors for this resident.</p> <p>2.SSD/designee reviewed other residents currently receiving antipsychotic medications to ensure that a care plan had been initiated with no other deficiencies noted at that time.</p> <p>3.Resident Assessment Director / designee re-inserviced the inter-disciplinary team (IDT) regarding the policy and</p>	01/04/2015	

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	<p>A care plan, dated 10/29/14, indicated the resident received an antipsychotic medication was at risk for side effects from the medication. The interventions included to monitor behaviors via the behavior tracking form, notify the physician of any changes in mood and cognition or behavior.</p> <p>The record lacked a care plan for the antidepressant medication, Sertraline.</p> <p>There was no care plan in Resident #269's record which indicated what behaviors the resident exhibited or the interventions the staff were to initiate when the behaviors occurred.</p> <p>A Physician's Order, dated 11/03/14 indicated an order for Sertraline (antidepressant) 25 milligrams daily for seven days then increase the medication to 50 milligrams daily.</p> <p>The care plan did not indicate what depressive signs and symptoms the resident exhibited or the interventions the staff were to initiate when the resident had the signs and symptoms.</p> <p>During an interview on 12/03/14 at 8:53 a.m., the Third Floor, C-Unit Manager indicated the resident did not have a care plan for the behaviors and the depression.</p>		<p>procedure for psychotropic medications and appropriate interventions including behavior monitoring logs and care plans. SSD / designee will audit facility new/re-admissions weekly for nine (9) months to ensure policy and procedure for psychotropic medications and appropriate interventions including behavior monitoring logs and care plans is followed. Psychotropic medications and appropriate interventions including behavior monitoring logs and care plans will be reviewed as part of regularly scheduled interdisciplinary behavior meetings.</p> <p>4. The SSD / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5. Systemic changes will be completed by 1/4/15.</p>				

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F000280 SS=D	<p>A facility policy, dated 08/09, titled, "Psychotropic Medications", received from the Third Floor, D-Unit Manager as current, indicated, "...Nursing and/or social services (sic) will specifically identify behavior for which drug is being intended. 2. The interdisciplinary team (sic) will develop non-pharmacological interventions to be implemented and reflect these in the care plans..."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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</p>			

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	<p>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 record review and interview, the facility failed to update and a revise a care plan for a resident related to a pressure ulcer for 1 of 25 residents reviewed for care plans. (Resident #46)</p> <p>Findings include:</p> <p>Record review for Resident #46 was completed on 12/2/14 at 2:47 p.m. The residents diagnoses included, but were not limited to, kyphosis (exaggerated rounding of the back), fracture vertebrae, congestive heart failure, and arthritis. The Minimum Data Set Admission assessment completed on 11/4/14 indicated the resident was cognitively intact. The assessment indicated the resident was an extensive 1 person assist for transfers, bed mobility, locomotion, toileting and hygiene.</p> <p>A care plan with effective dates of 10/29/14-11/12/14 indicated, Pressure Sores/Skin Care/back brace 10/28/14 admit coccyx and upper mid back wound. The Goal was to prevent pressure sores and skin breakdown. The interventions included to follow facility skin care protocol, report to charge nurse any</p>	F000280	<p>1.Regarding resident #46 the Unit Manger updated the wound care plan to reflect that the upper back wound was due to the brace worn by this resident.</p> <p>2.The Unit Managers / designees reviewed the care plans of other residents who have pressure ulcers to ensure their care plan reflected the plan of care with any deficiencies noted corrected at that time.</p> <p>3.Resident Assessment Director / designee re-inserviced the IDT on how to update or revise a care plan when a change in condition is noted as well as when interventions are changed and / or updated. Resident Assessment Director / designee will audit five (5) residents with a wound care plan per unit weekly to ensure accuracy for nine (9) months.</p> <p>4.The DON / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5.Systemic changes will be completed by 1/4/15.</p>	01/04/2015

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	<p>redness or skin breakdown immediately, and treatment as ordered.</p> <p>A wound/skin healing record for a pressure ulcer began on 10/28/14. The record indicated a Stage 1 pressure ulcer began on the upper back on 10/28/14. The size measured 2 cm (centimeters).</p> <p>On 11/6/14 the Wound/Skin healing record indicated the wound had increased to a Stage 2 measuring 1.3 cm x 1.3 cm x &lt;0.1 cm.</p> <p>On 11/10/14 the Wound/Skin healing record indicated the wound had increased to a Stage 3 measuring 2.2 cm x 2 cm x 0.4 cm.</p> <p>The care plan lacked any documentation to indicate it had been updated or revised when the wound went from a Stage 1 to a Stage 2.</p> <p>A care plan dated 11/13/14 indicated, Pressure Sores/Skin care admitted with coccyx and upper back wound on 10/28. The coccyx wound was resolved. The Goal was to heal current wounds and prevent further skin breakdown. The interventions included to follow facility skin care protocol, low air loss mattress, back brace to be donned during ambulation and therapy only. The care</p>			

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F000282 SS=D	<p>plan lacked any documentation to indicate the stage of the back wound.</p> <p>Interview with the 3A Unit Manger on 12/4/14 at 10:33 a.m., indicated she could not find the pressure ulcer care plan had been updated when it went to a stage 2 and it should have been updated.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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, observation, and interview, the facility failed to follow residents' care plans and Physician's Orders, related to nutritional supplements, weights, behaviors, and insulin administration for 3 of 25 residents reviewed for Physician's Orders and care plans. (Residents #105, #119, and #269)</p> <p>Findings include:</p> <p>1. Resident #269's record was reviewed on 12/02/2014 at 1:57 p.m. The resident's diagnoses included, but were not limited to bipolar/schizophrenic affective</p>	F000282	<p>1.Regarding resident #269, the physician was notified by the Unit Manager / designee regarding insulin administration and no adverse reactions were noted. A behavior monitoring form was started related to psychotropic medication usage. Regarding resident #119, the Dining Manager, upon notification, immediately brought the missing Nutrijuice to the resident. The documentation regarding weight loss did not adversely affect the resident as the recorded weight was deemed to be inaccurate. Regarding resident #105, the documentation regarding weight loss did not adversely affect the resident as the recorded weight was deemed</p>	01/04/2015			

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	<p>disorder and diabetes mellitus.</p> <p>A care plan, dated 10/29/14, indicated the resident had diabetes. The interventions included to administer insulin as ordered.</p> <p>A Physician's Order, dated 10/14/14, indicated Humalog insulin was to administered before meals and at night. The results of the resident's blood sugar determined the amount of insulin the resident received (sliding scale). The order indicated: blood sugar (BS) 150-199=1 unit BS 200-249=2 units BS 250-300=3 units BS 301-349=4 units BS 350-400=5 units BS over 400=6 units and call the Physician</p> <p>The Medication Administration Record (MAR), dated 11/14 indicated: 11/18/14 at 9 p.m., the blood sugar was 209 and 3 units of insulin was given 11/22/14 at 6 a.m., the blood sugar was 167 and 2 units of insulin was given 11/22/14 at 9 p.m., the blood sugar was 200 and "200 units" (sic) of insulin was given. (unsure of the amount of insulin actually given) 11/24/14 at 11 a.m., the blood sugar was 245 and "245 units" (sic) of insulin was given. (unsure of the amount of insulin</p>		<p>to be inaccurate.</p> <p>2. Unit Manager / designee reviewed residents requiring an insulin sliding scale for administration accuracy with any deficiencies noted corrected at that time. Registered Dietitian and / or Unit Managers / designees reviewed residents with physician orders for weekly weights to ensure accuracy in physician notification of weight changes with any deficiencies noted corrected at that time. SSD / designee reviewed other residents currently receiving psychotropic medications to ensure behavior monitoring logs were in place with no other deficiencies noted.</p> <p>3. The DSD / designee re-inserviced licensed staff regarding insulin administration and nursing staff regarding weight policy and accuracy of weight documentation in the records. Online educational course of "Diabetes and Controlling Resident Blood Glucose" was included in the monthly assignments for licensed staff for December. The Dining Manager re-inserviced dining staff on review of tray cards during meal service to ensure all supplements are served as ordered by the physician. SSD re-inserviced social service staff, unit managers and charge nurses regarding the policy and procedure for psychotropic</p>	

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	<p>actually given)</p> <p>11/25/14 at 11 a.m., the blood sugar was 243 and 1 unit of insulin was given.</p> <p>11/26/14 at 6 a.m., the blood sugar was 222, there was no amount of insulin documented as administered.</p> <p>11/26/14 at 11 a.m., the blood sugar was 212 and 1 unit of insulin was given.</p> <p>11/28/14 at 9 p.m., the blood sugar was 330 and 2 units of insulin was given.</p> <p>11/30/14 at 11 a.m., the blood sugar was 352 and 4 units of insulin was given.</p> <p>During an interview on 12/03/14 at 8:53 a.m., the Third Floor, C-Unit Manager indicated the correct doses of insulin were not administered. She indicated on 11/22/14 at 9 p.m., 11/24/14 at 11 a.m., and 11/26/14 at 6 a.m., she could not say how many units of insulin the resident received.</p> <p>A facility policy, dated 07/01/02, titled, "Insulin Injection-Administration", received as current from the Third Floor, D-Unit manager, indicated, "...Determine correct amount of insulin to be withdrawn..."</p> <p>Resident #269"s care plan, dated 10/29/14, indicated the resident received an antipsychotic medication was at risk for side effects from the medication. The interventions included to monitor</p>		<p>medications and appropriate interventions including behavior monitoring logs and care plans.</p> <p>Unit Managers / designees will audit five (5) residents per unit weekly requiring insulin sliding scale for insulin administration accuracy and five (5) residents per unit weekly with physician orders for weights for accuracy for nine (9) months. The Dining Manager / designee will audit five (5) resident trays per unit weekly for supplements served as ordered by the physician. SSD / designee will audit facility new/re-admissions weekly for nine (9) months to ensure policy and procedure for psychotropic medications and appropriate interventions including behavior monitoring logs and care plans is followed. Psychotropic medications and appropriate interventions including behavior monitoring logs and care plans will be reviewed as part of regularly scheduled interdisciplinary behavior meetings.</p> <p>1.The DON / Dining Manager / SSD / designees will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>2.Systemic changes will be</p>				

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	<p>behaviors via the behavior tracking form.</p> <p>The Nurses' Progress Notes indicated:</p> <p>10/25/14 at 2:18 p.m., the resident was anxious often and fidgets with attempts to constantly get out of the chair, when he was sitting in his recliner.</p> <p>11/01/14 at 2:03 a.m., the resident attempted to get up from the wheelchair unassisted several times on the evening shift.</p> <p>11/01/14 at 2:36 a.m., the resident was agitated and combative at times.</p> <p>11/09/14 at 12:31 p.m., the resident was restless and constantly trying to get out of his chair.</p> <p>During an interview on 12/03/14 at 8:19 a.m., the First Floor Unit Manager indicated she was unable to find a Behavior Monitoring Log for the resident.</p> <p>During an interview on 12/03/14 at 8:53 a.m., the Third Floor, C-Unit Manager indicated the staff should document the behavior, interventions, and the effectiveness of the interventions on the Behavior Monitoring Forms.</p>		completed by 1/4/15.	

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	<p>During an interview on 12/03/14 at 9:45 a.m., Social Service Director #1 indicated the resident had no Behavior Monitoring Forms and she would initiate a Behavior Monitoring Form for the resident.</p> <p>2. The record for Resident #119 was reviewed on 12/3/14 at 9:47 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hyperlipidemia, and anemia.</p> <p>Review of the 12/2014 Physician Order Summary indicated an order for Nutrijuice two times daily with lunch and dinner.</p> <p>On 12/4/14 at 12:33 p.m., Resident #119 was observed seated at a table in the Main Dining Room eating lunch. There was no Nutrijuice observed on the resident's tray. Review of the resident's diet card that was sitting on the table next to her indicated she was to have Nutrijuice at lunch and dinner.</p> <p>The resident had a care plan for weight loss. The nursing interventions included, "Diet and supplement as ordered..."</p> <p>The resident had a care plan for therapeutic diet. The nursing interventions included, "...monitor intake, weights, labs. Recommendations as warranted..."</p>			

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	<p>Interview with the Dietary Manager on 12/4/14 at 12:40 p.m., indicated the staff who assist to pass trays in the Main Dining Room change daily and they may not be familiar with what each resident was to receive. She further indicated the resident should have received Nutrijuice with lunch.</p> <p>Review of the Weight Report indicated the following weights: 3/24/14 122.4 lbs (pounds) 4/1/14 125.4 lbs 4/7/14 90.8 lbs 4/14/14 91.2 lbs 5/2/14 120.4 lbs 5/2/14 reweigh 123.3 lbs</p> <p>There was lack of documentation in the record to indicate the resident's 34 pound weight loss from 4/1/14 to 4/7/14 had been addressed.</p> <p>Interview with the Registered Dietician on 12/3/14 at 2:45 p.m., indicated she was not employed at the facility during the time of the resident's weight loss and she was unsure why it had not been addressed. She indicated when she had seen the weights she assumed the 4/7/14 and 4/14/14 weights were errors because the resident's weight on 5/2/14 was similar to her weight on 4/1/14. She</p>			

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	<p>further indicated she could not find any notes regarding the weight loss.</p> <p>Interview with the Director of Nursing (DON) on 12/3/14 at 4:00 p.m., indicated the weights had been done on different scales which could be why there was such a difference. She further indicated she didn't think the 4/7/14 and 4/14/14 weights were accurate.</p> <p>3. The record for Resident #105 was reviewed on 12/3/14 at 9:02 a.m. The resident's diagnoses included, but were not limited to, anemia, atrial fibrillation (irregular heart beat), coronary artery disease, heart failure, hypertension (high blood pressure), end stage renal disease, diabetes mellitus, depression and dementia.</p> <p>The resident's care plan dated 10/14/14 for significant weight loss interventions indicated to monitor intake, weights, labs and skin reports and make recommendations per diet as needed.</p> <p>A physician's order dated 8/21/14 indicated weekly weights on Sundays before breakfast.</p> <p>The weights were as follows: 11/3/14 172.80 11/9/14 144.10--w/c (wheel chair) scale 1 11/16/14 142.20 --w/c scale 1</p>			

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F000309 SS=D	<p>11/23/14 162.00 --Mechanical Lift scale 1</p> <p>On 11/23/14 Registered Dietician note indicate the weight reflects a 20 lb. weight gain in 1 week. Reweigh has been request.</p> <p>An interview on 12/3/14 with the Registered dietician at 2:55 p.m., indicated the resident should have been reweigh on 11/9/14.</p> <p>An interview on 12/3/14 with the Director of Nursing (DON) at 4:00 p.m., indicated the weights were probably a mistake and the nurse used different scales each time.</p> <p>A policy, revised 2/12, titled "Weighing Residents," received from the DON as current, indicated,"...3. All residents who show a five (5) pound gain or loss will be verified by a licensed nurse. 4. All resident's not on the monthly weight schedule who show a five (5) pound gain or loss will have re-weights completed within forty-eight (48) hours...."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility</p>						

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	<p>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 ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 6 residents who met the criteria for non pressure related skin conditions. (Resident #46)</p> <p>Findings include:</p> <p>Observation on 12/2/14 at 8:36 a.m., Resident #46 was sitting in her recliner in her room with a red/purple discoloration noted to top of her right wrist and a red/purple discoloration noted to her right forearm.</p> <p>Observation on 12/2/14 at 2:17 p.m., Resident #46 was sitting in her recliner in her room with red/purple discolorations noted to her right wrist and right forearm. Interview with the resident at the time indicated she wasn't sure how she received the discolorations and may have bumped her arm.</p>	F000309	<p>1.Regarding resident #46, the Unit Manager completed a head to toe assessment. An incident report was completed on the identified areas to the right wrist and forearm. Skin sheets and a care plan were also completed. The physician and family were both notified of the findings. No adverse reactions were noted.</p> <p>2.Unit Managers / designees completed head to toe assessments on all residents to ensure monitoring and assessing for bruising and discolorations had been met with no deficiencies noted.</p> <p>3.DSD / designee re-inserviced nursing staff on the proper procedure when a discoloration is noted, as well as proper monitoring / notification of a found area. The Unit Mangers / designees will assess five (5) residents per unit weekly to ensure discolorations have been identified and documented per policy for nine (9) months.</p> <p>4.The DON / designees will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary</p>	01/04/2015

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	<p>Observation on 12/4/14 at 9:00 a.m., Resident #46 was sitting in her recliner in her room with red/purple discolorations still noted to top of her right wrist and right forearm.</p> <p>Record review for Resident #46 was completed on 12/2/14 at 2:47 p.m. The residents diagnoses included, but were not limited to, kyphosis (exaggerated rounding of the back), fracture vertebrae, congestive heart failure, and arthritis. The Minimum Data Set Admission assessment completed on 11/4/14 indicated the resident was cognitively intact. The assessment indicated the resident was an extensive 1 person assist for transfers, bed mobility, locomotion, toileting and hygiene.</p> <p>Interview with CNA #5 on 12/4/14 at 9:02 a.m., indicated the CNAs are to observe residents skin with resident care. Further indicated the CNAs are supposed to notify the nurse immediately if any discolorations or bruising is noticed.</p> <p>Interview with LPN #1 on 12/4/14 at 9:05 a.m., indicated any bruising would be documented and put into the wound care book. CNAs do skin observations when they do resident care everyday. Any bruises, skin tears, swelling or anything that was different for the resident would</p>		<p>for continued compliance. 5.Systemic changes will be completed by 1/4/15.</p>	

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F000314 SS=G	<p>be reported to the nurse. She further indicated the bruising to the resident's right wrist and forearm should have been noticed by now and reported to the nurse.</p> <p>A non-pressure skin condition report was filled out on 12/4/14. The report indicated a bruise measuring .4 cm (centimeters) x .4 cm to the right forearm.</p> <p>A non-pressure skin condition report was filled out on 12/4/14. The report indicated a bruise measuring .5 cm x .5 cm to the right forearm.</p> <p>The resident's record indicated the discolorations to the right wrist and right forearm had not been addressed or assessed until brought to the facility's attention.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent</p>						

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	<p>infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to investigate the cause and prevent worsening of an existing pressure ulcer for 1 of 3 residents reviewed for pressure ulcers of the 7 who met the criteria for pressure ulcers. This resulted in a deterioration of the wound from a Stage I when the resident was admitted to a Stage III pressure ulcer. (Resident #46)</p> <p>Findings include:</p> <p>Observation on 12/2/14 at 2:13 p.m., Resident #46 was sitting in a wheelchair in her room with a pillow behind her back.</p> <p>Observation on 12/3/14 at 9:51 a.m., Resident #46 was sitting in a recliner in her room watching television with a pillow placed behind her back.</p> <p>Observation of a Stage 3 pressure ulcer wound and treatment of the wound with LPN #1 and the 3A Unit Manager was completed on 12/4/14 at 11:00 a.m. Resident #46 was sitting in a recliner and leaned forward while LPN #1 began to pull the residents shirt up to get to the bandage of the wound. A bandage with tape was noted to the center of the</p>	F000314	<p>1.Regarding resident #46, the facility did identify the cause (back brace) of this resident's pressure ulcer as stated on the care plan. The attending nurse practitioner wrote a progress note indicating the brace was used to support and enhance quality of living, although high risk of pressure areas was a possibility.</p> <p>2.The Unit Managers / designees reviewed wound records for residents who have pressure ulcers to ensure the areas are assessed and documented per policy with any deficiencies corrected at that time.</p> <p>3.The Wound Nurse / designee re-inserviced licensed staff on the pressure ulcer / wound assessment policy. Facility Nutrition at Risk (NAR) and QAPI Wound Subcommittee will continue to review residents who have pressure ulcers to ensure the areas are assessed and documented per policy. The Unit Mangers / designees will audit residents with pressure ulcers to ensure the assessment sheet is accurate, complete, and notification of any change has occurred weekly for nine (9) months.</p> <p>4.The DON / designees will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor</p>	01/04/2015

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	<p>residents back. LPN #1 began to remove the dressing to the residents back. A wound was observed. The wound was raised with an area measuring approximately the size of half a tennis ball. The wound bed was noted to have green/yellow slough (dead tissue). The area around the wound was reddened and purple with swelling around the site. There was a small amount of red blood noted to the wound. LPN #1 indicated there was no warmth noted to the wound.</p> <p>After the wound observation was completed, Resident #46's back brace was observed. The back brace attached with Velcro around the body and fastened in the front. The back of the brace was noted to have wires that intertwined in the middle of the back.</p> <p>Record review for Resident #46 was completed on 12/2/14 at 2:47 p.m. The residents diagnoses included, but were not limited to, kyphosis (exaggerated rounding of the back), fractured vertebrae, congestive heart failure, and arthritis. The Minimum Data Set Admission assessment completed on 11/4/14 indicated the resident was cognitively intact. The assessment indicated the resident was an extensive one person assist for transfers, bed mobility, locomotion, toileting and</p>		<p>the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5.Systemic changes will be completed by 1/4/15.</p> <p>F314 – Treatment/Services to Prevent/Treat Pressure Sores <b><i>The facility is submitting this document for the Informal Dispute Resolution process for F314.</i></b></p> <p>The facility strongly disputes that there was a deficient practice or substandard quality of care related to R46. The facts indicate that R46 was admitted to the facility on 10/28/2013 with a spinal fracture requiring her to wear a back brace to stabilize the spine and prevent potential damage to the spine resulting in paralysis or other life-threatening issues. The resident's condition with the spinal fracture was compounded by severe kyphosis (curvature of the spine) rendering a back brace difficult to obtain an exact and proper fit.</p> <p>Contrary to what is cited in the 2567 for F314, the facility closely monitored the skin and wounds of R46 throughout the period of time she has been in the facility. The nursing staff contacted her orthopedic physician and even sought the assistance of the Medical Director in an effort to override and to ease the restrictions for R46 in wearing the</p>	

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	<p>hygiene. The resident had two stage 1 pressure ulcers, and one stage 3 pressure ulcer.</p> <p>The resident was admitted to the facility on 10/28/14 with a Physician Order for a back brace to be in place when out of bed due to a diagnosis of a fractured vertebrae.</p> <p>A care plan with effective dates of 10/29/14-11/12/14 indicated, Pressure Sores/Skin Care/back brace 10/28/14 admit coccyx and upper mid back wound. The Goal was to prevent pressure sores and skin breakdown. The interventions included to follow facility skin care protocol, report to charge nurse any redness or skin breakdown immediately, and treatment as ordered. The care plan lacked any documentation to indicate the stage of the back wound.</p> <p>A care plan dated 11/13/14 indicated, Pressure Sores/Skin care admitted with coccyx and upper back wound on 10/28. The coccyx wound was resolved. The Goal was to heal current wounds and prevent further skin breakdown. The interventions included to follow facility skin care protocol, low air loss mattress, back brace to be donned during ambulation and therapy only. The care plan lacked any documentation to</p>		<p>brace except when lying down as ordered by the orthopedic physician.</p> <p>In addition, given the challenges of such a spinal fracture in a person with severe kyphosis, a back brace, while providing stability, has a significant impact on R46's quality of life as would having damage to the spine were the spine not stabilized with the brace. Nevertheless, other issues and risks do come into play in such circumstances and skin integrity is clearly one of them. While there may have been some isolated failures to document completely, those failures did not have a direct impact on the progression of the wound. Despite the missing documentation, at no time did the facility or nursing staff fail to act on behalf of the resident, fail to notify the family or physician of any changes, and did in fact change treatments and schedule for wearing of the brace to ease potential pressure on the wound, reduce the resident's pain thereby improving the resident's quality of life and comfort.</p> <p>The observation on 12/4/14 at 11:00 am indicated "LPN #1 began to remove the dressing to the residents back. A wound was observed. The wound was raised with an area measuring approximately the size of half a tennis ball. The wound bed was noted to have green/yellow</p>	

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	<p>indicate the stage of the back wound.</p> <p>A wound/skin healing record for the pressure ulcer began on 10/28/14. The record indicated a Stage 1 pressure ulcer began on the upper back on 10/28/14. The size measured 2 cm (centimeters). There was no exudate (drainage) or odor. The wound bed had epithelial tissue (tissue covering body). Surrounding skin was pink, surrounding tissue/wound edges were normal for skin. No pain was indicated. The comments section it indicated the periwound measured 6.0 cm x 4.7 cm.</p> <p>A physician order dated 10/28/14 indicated a Mepilex border dressing to area at upper back weekly.</p> <p>A physician order dated 10/29/14 indicated orders for a multivitamin with minerals daily and 120 ml (milliliters) of Resource 2.0 BID (twice a day).</p> <p>On 11/6/14 the Wound/Skin healing record indicated the wound had increased to a Stage 2 measuring 1.3 cm x 1.3 cm x &lt;0.1 cm. There was no exudate or odor noted. The assessment was not completely filled out. No indication of the wound bed, surrounding skin color, wound edges or pain was assessed. The assessment did not indicate the plan of</p>		<p>slough (dead tissue).” However, per the clinical practice guidelines of the National Pressure Ulcer Advisory Panel, the presence of “slough” is considered partial tissue damage and by definition not “dead tissue.” Also, their guidance indicates that wounds are to be cleansed prior to assessment for accuracy due to effects of enzymatic debridement utilized.</p> <p>The facility submits the accompanying documentation to support the assertion that the pressure sore was unavoidable and at risk to deteriorate in spite of the best efforts of the nursing staff to prevent it from doing so. Neither the facility nor the nursing staff has the ability to dictate medical practice to the physician. Yet nursing did in fact contact the physicians involved in caring for R46 repeatedly to ensure they were kept apprised of her general condition, the wounds progress or deterioration and nutritional deficiencies identified, while seeking new orders from the physicians to safely alleviate the pressure caused by the wearing of the brace. The documentation being submitted is irrefutable and overwhelming evidence that the facility did in fact act responsibly and that there is no direct evidence that the facility failed to meet the standard of care for this complex resident.</p>		

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	<p>care had been updated nor the physician was notified. The assessment was also not signed.</p> <p>A pressure ulcer record sheet dated November 2014 indicated on 11/6/14 the wound was pink/red/purple and an open area was noted. The physician was notified with no change in treatment.</p> <p>On 11/10/14 the Wound/Skin healing record indicated the wound had increased to a Stage 3 measuring 2.2 cm x 2 cm x 0.4 cm. There was a small amount of serosanguineous (blood tinged) drainage. No odor noted. The wound bed was not marked as assessed. The surrounding skin color was dark red/purple. The surrounding tissues/wound edges were maceration (softening and breaking down of skin). Pain indicated yes and was demonstrated by moaning/crying.</p> <p>A Nursing Note dated 11/10/14 at 8:48 p.m., indicated the Nurse Practitioner had seen the resident for complaints of pain during the afternoon. New orders for an x-ray of the thoracic spine and scheduled pain medications was received and noted. The resident was also to lie in bed with brace off for an hour at least twice during the day.</p> <p>A Nursing Note dated 11/11/14 at 2:19</p>		<p>Facts and Supporting Documentation:</p> <ol style="list-style-type: none"> <li>1) Admitted with pressure sore to upper mid-back on 10/28/2014. Wound measured 2.0 cm.</li> <li>2) Care plan 10/29/2014 – 11/12/2014: Missing documentation on care plan of wound staging had no direct impact on care R46 received.</li> <li>3) Care plan dated 11/13/2014: Again, staging of back wound had not direct impact on care received. As stated in 2567, coccyx wound had actually been resolved as of this date indicating that staff was monitoring and treating wounds effectively.</li> <li>4) 11/6/2014: Wound and Skin healing record indicates that while this form was not completed fully, and while the mid-back wound had progressed to a Stage 2, the actual size had decreased to 1.3cm x 1.3cm. There was no indication on this form that the physician was notified of the change, it was documented on the Pressure Ulcer Record sheet that the physician had been notified.</li> <li>5) 11/10/2014: Nursing note indicates that the resident is to have brace off for at least 1 hour twice during the daytime hours.</li> <li>6) 11/11/2014: Nursing notes indicate orthopedic physician was called about the resident's complaints of pain from brace and wound with nursing suggesting/requesting a decrease in the number of hours R46 was</li> </ol>		

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	<p>pm., indicated the resident was complaining of pain to her side and back related to the brace. The Orthopaedic Physician was contacted and made aware of the residents complaints of pain. The nurse suggested a decrease in the number of hours the brace was worn. The Orthopaedic Physician indicated the resident needed to keep the brace on while up in a chair and may have it off if lying down. The Physician was reminded of the wound to the resident's back and possibility of progression. Order to keep brace on remained.</p> <p>A physician order dated 11/11/14, indicated to cleanse the wound on the back with normal saline, pat dry, and to apply Santyl and cover with Mepilex border dressing every 2 days and prn (when necessary) for soilage or removal. The back brace was ordered to be only on when the resident was ambulating and when doing therapy.</p> <p>On 11/13/14 the Wound/Skin healing record indicated the wound was assessed as an unstageable wound measuring 3.2 cm x 2.5 cm and the depth was undetermined. There was a small amount of serosanguineous drainage, with no odor. The wound bed had epithelial tissue, granulation tissue (new tissue), and black/brown eschar (dead tissue).</p>		<p>to wear the brace and to alert the physician to the potential for wound to progressively deteriorate. Physician declined request.</p> <p>7) 11/11/2014: Nursing addressed the same concern of pain and wound deterioration with Medical Director who did agree to modify the wearing of the brace.</p> <p>8) 11/13/2014: Granulation tissue was beginning to form.</p> <p>9) 11/17/2014: Wound bed again documented to have granulation tissue.</p> <p>10) 11/20/2014: Wound bed again documented to have granulation tissue and measured 5.0cm x 3.0 cm.</p> <p>11) 11/22/2014: Nursing notes indicate resident voiced no concern of pain.</p> <p>12) 11/24/2014: Nurse assessed and noted no complaint of pain.</p> <p>13) 11/24/2014: Wound bed again documented to have granulation tissue and now measuring 4.8cm x 2.8cm (a decrease in size).</p> <p>14) 11/28/2014: Measurement - 3.8cm x 1.9 cm (a decrease in size).</p> <p>15) 12/1/2014: Measurement 3.5cm x 2.0cm.</p> <p>16) Lack of investigation as to the cause of the wound: The surveyor appears to conclude on page 22 of 47 of the 2567 that the brace and its configuration were the cause of the skin breakdown at the upper mid-back location on R46. This is the same conclusion</p>	

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	<p>The surrounding skin color was bright red and dark red/purple. The surrounding tissue/wound edges had peripheral tissue edema (swelling) and rolled edges. The assessment indicated pain was not assessed. Under the comments section the periwound measured 6.0 cm x 4.5 cm x undetermined.</p> <p>On 11/17/14 the Wound/Skin healing record indicated the wound was assessed as a stage 3 measuring 5.0 cm x 3.0 cm x undetermined. There was no drainage or odor noted. The wound bed had granulation tissue and 25% slough. The surrounding skin color was dark red/purple. The surrounding tissue/wound edges had peripheral tissue edema. No pain was noted. The response to treatment indicated the wound had deteriorated. Under the comments section the periwound measured 7.5 cm x 6.2 cm.</p> <p>On 11/20/14 the Wound/Skin healing record indicated the wound was assessed as a stage 3 measuring 5.0 cm x 3.0 cm x undetermined. There was no drainage or odor noted. The wound bed had granulation tissue and black/brown eschar. The surrounding skin color was dark red/purple. The surrounding tissues/wound edges had peripheral tissue edema. The pain assessment was not</p>		<p>that was made by the facility nursing staff and the reason for their efforts to decrease the amount of time the resident was to wear the brace. The interview of the Nurse Practitioner also supports that the "wear time" was a contributing factor. While there may be no clear statement in the record that an investigation was conducted of the cause for the skin breakdown, it would seem that multiple reasonable parties (the facility nursing staff, the Nurse Practitioner and the surveyor) came to the same conclusion that the configuration of the brace was the cause.</p> <p>Therefore, based on the above summary of the facts and the supporting documentation submitted, the facility respectfully requests that F314 deficiency citation be deleted.</p>	

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	<p>filled out. Under the comments section the periwound measured 7.6 cm x 6.4 cm.</p> <p>On 11/24/14 the Wound/Skin healing record indicated the wound stage was not filled out. The wound measured 4.8 cm x 2.8 cm. There was no drainage or odor noted. The wound bed had granulation tissue and slough. The surrounding skin color was dark red/purple. The surrounding tissues/wound edges had peripheral tissue edema. The pain assessment was not filled out.</p> <p>On 11/28/14 the Wound/Skin healing record indicated the wound was assessed as a stage 3 measuring 3.8 cm x 1.9 cm x &lt;1.0 cm. There was a small amount of serosanguineous drainage noted with no odor. The wound bed had slough. The surrounding skin color was dark red/purple. The surrounding tissues/wound edges was noted normal for skin. The assessment indicated pain was evident to the wound. The response to treatment was marked as improved.</p> <p>On 12/1/14 the Wound/Skin healing record indicated the wound was assessed as a stage 3 measuring 3.5 cm x 2 cm x undetermined. There was no drainage or odor noted. The wound bed had epithelial tissue and black/brown eschar.</p>			

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	<p>The surrounding skin color was bright red and dark red/purple. The surrounding tissues/wound edges had peripheral tissue edema. The assessment indicated no pain was evident.</p> <p>The record lacked any documentation indicating an investigation was completed as to why the resident had a wound that was deteriorating until the wound became a Stage 3 ulcer.</p> <p>A Physician's Progress Note dated 12/2/14 indicated an exam of a spine wound. The wound was swollen with no drainage or odor. A culture was done for a suspected infection.</p> <p>A Pathology report dated 12/4/14 indicated the culture results were moderate Staphylococcus Aureus, Susceptibility in progress, Culture in progress. The report status was pending.</p> <p>Interview with the Nurse Practitioner on 12/2/14 at 3:26 p.m., indicated the staff told her the wound was caused from wearing the back brace. She further indicated the back brace made the wound increase in stage from wearing it all the time.</p> <p>Interview with 3 B Unit Manager on 12/3/14 at 11:15 a.m., indicated she</p>			

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	<p>assumed the wound progressing from a stage 1 to a stage 3 was from the back brace, but nothing was done about the brace until the wound went to a Stage 3. She further indicated she spoke with the orthopaedic doctor when the wound went to a Stage 3 and the doctor did not want to do anything with the brace. She then indicated she spoke with the medical director on 11/11/14 and the order was changed for back brace to be worn only with therapy and ambulation.</p> <p>The record lacked any documentation indicating an investigation of the brace as being the cause of the wound until the wound progressed to a Stage 3.</p> <p>Interview with the 3 B Unit Manager on 12/4/14 at 10:28 a.m., indicated when the residents wound went to a stage 2 on 11/6/14 and the wound progress assessment report should have been completed and signed but was not done.</p> <p>Interview with the 3A Unit Manger on 12/4/14 at 10:33 a.m., indicated she could not find the pressure ulcer care plan had been updated when it progressed to a stage 2 and it should have been updated.</p> <p>Interview with LPN #1 and the 3A Unit Manager on 12/4/14 11:00 a.m., indicated the wound was noticed on 12/2/14 to be</p>			

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	<p>reddened/purple and elevated. The Nurse Practitioner examined the resident and ordered a culture to be done and an antibiotic given for possible abscess.</p> <p>Interview with the resident on 12/4/14 at 11:34 a.m., indicated when she first started wearing the brace she told the nurses it hurt, but the nurses told her she had to wear the brace. The resident indicated the wires in the back of the brace rubbed her back.</p> <p>Interview with PT #1 on 12/5/14 at 9:07 a.m., indicated the resident was in therapy for strengthening, gait training, and bed mobility. He further indicated the resident complained of pain with the brace and he let the nurses know the resident had complained of pain.</p> <p>Interview with COTA #1 on 12/5/14 at 9:13 a.m., indicated the resident was in therapy for strengthening, endurance, balance, transfers and bed mobility. She further indicated the resident would complain of pain with the brace. She indicated she would readjust the brace, because sometimes it would ride up on the resident and then she would let the nurse know the resident was complaining of pain.</p> <p>A policy titled Pressure Ulcer/Wound</p>			

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	<p>Assessment and received from the Director of Nursing on 12/3/14 at 3:22 p.m., indicated..."Policy: Wound assessment is a continuous process that serves to provide information about wound status, staging, its etiology, and the efficacy of the interventions"... "Pressure ulcers/wounds shall be measured and assessed weekly. Stage II through Stage IV pressure areas will be assessed daily to determine healing/deterioration"... "Record and date all information and document on the Pressure ulcer record. Notify physician when the condition warrants"</p> <p>An email was received from the Director of Nursing on 12/5/14 at 5:25 p.m. This information was received after the survey team had completed the exit conference and left the facility. The email included an Unavoidability Statement for Impaired Skin Integrity signed by the Nurse Practitioner dated 12/5/14. The statement indicated the resident had intractable back pain with a compression fracture and accentuated Kpyhotic curvature of thoracic spine. The patient was seen by the orthopaedic to wear back brace at all times when out of bed to give support of compression fracture, back pain, and to assist with activities of daily living and care. The benefits of wearing the brace out weigh the risks of not</p>			

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F000325 SS=D	<p>wearing it. The patient had developed a pressure area from wearing brace constantly while out of bed. The patients risk of pressure was high secondary to kyphosis, low zinc level and low pre-albumin level. The patient had previous pressure area to kyphosis in thoracic area. The brace was used to support and enhance quality of living although high risk of pressure to area is possibility.</p> <p>3.1-40(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to provide acceptable parameters of nutrition related to providing a dietary supplement as ordered, not monitoring and assessing for weight loss for 2 of the 4 residents reviewed for nutrition. (Resident #105 and Resident #119)</p>	F000325	<p>1.Regarding resident #105 and #119, both were added to the weekly weight program and will be monitored for at least four (4) weeks or until their weight stabilizes. Regarding resident #119, the Dining Manager, upon notification, immediately brought the missing Nutrijuice to the resident.</p> <p>2.The Registered Dietitian (RD)</p>	01/04/2015

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	<p>Findings include:</p> <p>1. The record for Resident #105 was reviewed on 12/3/14 at 9:02 a.m. The resident's diagnoses included, but were not limited to, anemia, atrial fibrillation (irregular heart beat), coronary artery disease, heart failure, hypertension (high blood pressure), end stage renal disease, diabetes mellitus, depression and dementia.</p> <p>The resident's care plan dated 10/14/14 for significant weight loss interventions indicated to monitor intake, weights, labs and skin reports and make recommendations per diet as needed.</p> <p>A physician's order dated 8/21/14 indicated weekly weights on Sundays before breakfast.</p> <p>The weights were as follows: 11/3/14 172.80 11/9/14 144.10--w/c (wheel chair) scale 1 11/16/14 142.20 --w/c scale 1 11/23/14 162.00 --Mechanical Lift scale 1-- Registered Dietician note indicate the weight reflects a 20 lb. weight gain in 1 week. Reweigh has been request.</p> <p>An interview on 12/3/14 with the Registered dietician at 2:55 p.m., indicated the resident should have been</p>		<p>completed a house wide review of weights with reweights requested for any identified discrepancies.</p> <p>3.DSD / designee re-inserviced nursing staff on proper weighing procedures and reporting procedures. Weekly weights will be reviewed in NAR meeting with Unit Managers to ensure follow up with reweighs are completed and accurate. The Dining Manager re-inserviced dining staff on review of tray cards during meal service to ensure all supplements are served as ordered by the physician. The Dining Manager / designee will audit five (5) resident trays per unit weekly to ensure supplements are served as ordered by the physician for nine (9) months.</p> <p>4.The RD / Dining Manager / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5.Systemic changes will be completed by 1/4/15.</p>		

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	<p>reweigh on 11/9/14.</p> <p>An interview on 12/3/14 with the Director of Nursing (DON) at 4:00 p.m., indicated the weights were probably a mistake and the nurse used different scales each time.</p> <p>2. The record for Resident #119 was reviewed on 12/3/14 at 9:47 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hyperlipidemia, and anemia.</p> <p>Review of the 12/2014 Physician Order Summary indicated an order for Nutrijuice two times daily with lunch and dinner.</p> <p>On 12/4/14 at 12:33 p.m., Resident #119 was observed seated at a table in the Main Dining Room eating lunch. There was no Nutrijuice observed on the resident's tray. Review of the resident's diet card that was sitting on the table next to her indicated she was to have Nutrijuice at lunch and dinner.</p> <p>The resident had a care plan for weight loss. The nursing interventions included, "Diet and supplement as ordered..."</p> <p>The resident had a care plan for therapeutic diet. The nursing interventions included, "...monitor intake,</p>						

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	<p>weights, labs. Recommendations as warranted..."</p> <p>Interview with the Dietary Manager on 12/4/14 at 12:40 p.m., indicated the staff who assist to pass trays in the Main Dining Room change daily and they may not be familiar with what each resident was to receive. She further indicated the resident should have received Nutrijuice with lunch.</p> <p>Review of the Weight Report indicated the following weights: 3/24/14 122.4 lbs (pounds) 4/1/14 125.4 lbs 4/7/14 90.8 lbs 4/14/14 91.2 lbs 5/2/14 120.4 lbs 5/2/14 reweigh 123.3 lbs</p> <p>There was lack of documentation in the record to indicate the resident's 34 pound weight loss from 4/1/14 to 4/7/14 had been addressed.</p> <p>Interview with the Registered Dietician on 12/3/14 at 2:45 p.m., indicated she was not employed at the facility during the time of the resident's weight loss and she was unsure why it had not been addressed. She indicated when she had seen the weights she assumed the 4/7/14 and 4/14/14 weights were errors because</p>						

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F000364 SS=E	<p>the resident's weight on 5/2/14 was similar to her weight on 4/1/14. She further indicated she could not find any notes regarding the weight loss.</p> <p>Interview with the Director of Nursing (DON) on 12/3/14 at 4:00 p.m., indicated the weights had been done on different scales which could be why there was such a difference. She further indicated she didn't think the 4/7/14 and 4/14/14 weights were accurate.</p> <p>A policy, revised 2/12, titled "Weighing Residents," received from the DON as current on 12/3/14 at 2:32 p.m., indicated,"...3. All residents who show a five (5) pound gain or loss will be verified by a licensed nurse. 4. All resident's not on the monthly weight schedule who show a five (5) pound gain or loss will have re-weights completed within forty-eight (48) hours...."</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p>			

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	<p>Based on observation and interview, the facility failed to serve food at a warm temperature for 1 of 2 meals observed on 2 of 9 Units. (The lunch meal, 1A Unit and 3A Unit) This had the potential to affect 13 residents who received their lunch meal on the 1A Unit and 22 residents who received their lunch meal on the 3A Unit.</p> <p>Findings include:</p> <p>1. Interview with a Confidential, alert, and oriented resident on 12/01/14 at 3:06 p.m., indicated the resident ate all meals in the resident's room. The resident further indicated the food was served cold for all meals.</p> <p>On 12/4/14 at 11:52 a.m., the 1A Unit cart of lunch trays was delivered to the unit. At that time, some of the trays were passed to resident's in the 1A Dining Room and the other trays were room trays.</p> <p>The last tray was passed at 12:10 p.m. At that time, temperatures were taken of the food on the test tray that had been placed on the cart and delivered with the residents' trays. The chicken was 117 degrees Fahrenheit (F), the roasted potatoes were 113 F, and the green beans were 111 F.</p>	F000364	<p>1.Regarding the residents on the 1A and 3A units, food found to be at unsatisfactory temperatures was discarded and new trays were assembled with food that met proper temperature. The plate warming equipment was tested and found to be malfunctioning; the equipment has been repaired.</p> <p>2.The RD / designee interviewed residents on other units to ensure proper temperature of food was being served with any deficiencies noted corrected at that time.</p> <p>3.The DSD / Dining Manager / designee re-inserviced dining staff and nursing staff regarding serving food at appropriate temperatures. The Dining Manager / designee will test and record the temperature of the pellets and plate warmers before meal service begins prior to each meal. The Dining Manager / designee will audit five (5) resident trays per unit weekly to ensure food temperatures are within acceptable ranges and meet resident's expectations throughout the campus.</p> <p>4.The Dining Manager / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued</p>	01/04/2015			

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	<p>Interview with the Dietary Manager on 12/4/14 at 12:14 p.m., indicated the chicken, potatoes, and green beans should have been served at a warmer temperature. She further indicated the service of staff delivering the trays to the residents took too long and she would have to change the pace of service on the floors. She indicated the food should be at least 140 F when served.</p> <p>2. Interview completed on 12/1/14 at 11:10 a.m. with Resident #46 indicated when she received food to her room it was only warm and never hot.</p> <p>Record review for Resident #46 was completed on 12/2/14 at 2:47 p.m. The residents diagnoses included, but were not limited to, kyphosis (exaggerated rounding of the back), fracture vertebrae, congestive heart failure, and arthritis. The Minimum Data Set Admission assessment completed on 11/4/14 indicated the resident was cognitively intact. The assessment indicated the resident was a limited one person assist for eating.</p> <p>A test tray was taken off the cart by Cook #1 on 12/4/14 at 12:08 p.m. The CNAs then began to take the remaining trays off the cart to serve to the residents. The dining service assistant began to take</p>		<p>compliance. 5.Systemic changes will be completed by 1/4/15.</p>	

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	<p>temperatures of the food off of the test tray and an interview followed after each temperature was taken. The food temperatures were as follows:</p> <ul style="list-style-type: none"> <li>-chicken temperature was 112 F (Fahrenheit), she indicated the temperature was supposed to be at 140 F</li> <li>-potatoes temperature was 117 F, she indicated the temperature was supposed to be at 140 F</li> <li>-green beans temperature was at 116 F, she indicated the temperature was supposed to be at 140 F</li> <li>-pineapple temperature was at 61 F, she indicated the temperature was supposed to be at 40 F</li> </ul> <p>Interview with the 3A Unit Manager on 12/4/14 at 3:16 p.m., indicated the room cart comes up and delivers the room trays first then the dining room. She further indicated 22 of the 24 residents on the unit receive a tray from the cart.</p> <p>A food service policy titled Safety &amp; Sanitation and received from the Administrator on 12/4/14 at 12:30 p.m., indicated..."HACCP Food Safety Recipe Guidelines...Holding: All food must be held at greater than 135 degrees at all times."</p> <p>3.1-21(a)(2)</p>			

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>Based on observation, interview and record review, the facility failed to ensure food was served and stored under sanitary conditions related to dirty meat slicer, low chemical concentration in the sanitization bucket for the prep area, unlabeled and uncovered food in food storage in the kitchen for 1 of 1 kitchens observed and uncovered food during serving of the 3 C and 3 D unit room trays. (The Main Kitchen, 3 C, and 3 D Units)</p> <p>1. During the Brief Kitchen Tour, with the Director of Dining Services and the Executive Chef, on 12/1/14 from 8:53 a.m. to 9:22 a.m. the following was observed:</p> <p>A. In the dairy cooler, in bowels, on a cart, there were uncovered and undated peaches, jello and applesauce.</p> <p>B. In the freezer, frozen to touch and the thermometer inside the freezer read zero</p>	F000371	<p>1.Regarding the unlabeled / uncovered food noted during kitchen tour, all identified items were immediately discarded. Regarding the food debris noted on the meat slicer, the meat slicer was dismantled and thoroughly cleaned. Regarding the sanitation solution concentration, the sanitizer was discarded and a new bucket with the proper amount of sanitizer was prepared. Regarding food items being uncovered during delivery to identified residents, identified staff were immediately reminded to push the cart down the hallway rather than walking the trays down the hallway with uncovered items.</p> <p>2.The Dining Manager / designee made rounds in the entire kitchen with no other issues being noted related to unlabeled / uncovered food, food debris on equipment and sanitation solution concentration. There were no adverse / negative outcomes noted to any residents. Regarding food items being uncovered during delivery to</p>	01/04/2015

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	<p>degrees Fahrenheit, there were open to air and undated fish, sweet potatoes fries, and pizza dough. There was ice build up on the floor under the ceiling fans and on the ceiling itself. An interview at the time of the observation, the Executive Chef indicated the freezer was in need of repair.</p> <p>C. The meat slicer had visible dried food derbies. During the observation, the Executive Chef indicated the meat slicer should be cleaned after each use and the last time the slicer was used was yesterday.</p> <p>D. In the prep area, the chemical in the sanitization bucket was 100 ppm (parts per million). The Executive Chef indicated at that time, the sanitization bucket should be at least 200 ppm and changed every 2 hours.</p> <p>E. In the dry storage area, the powdered milk bag was open to air, the confectioner sugar had no open date. On a tray, on a shelf, several different types of cereals were covered and undated, and multi-colored pasta, elbow macaroni and egg noodles had no open date. During this observation, the Director of Dining Services indicated all packages should be covered or closed and dated.</p>		<p>identified residents, remaining identified staff working were verbally reminded to push the cart down the hallway rather than walking the trays down the hallway with uncovered items.</p> <p>3. The Dining Manager / designee re-inserviced dining staff regarding dating and labeling of food items, proper preparation and monitoring of sanitation solution concentration in buckets, and proper cleaning procedures for the meat slicer. The closing supervisor will audit those areas as part of closing procedures, and the Dietary Manager / designee will conduct random audits of those areas for compliance three (3) times weekly for nine (9) months. The DSD / designee re-inserviced nursing staff regarding food items being uncovered during meal delivery. The Unit Managers / designees will audit five (5) random meals weekly per unit to ensure food items not uncovered during meal delivery for nine (9) months.</p> <p>4. The Dining Manager / Unit Managers / designees will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5. Systemic changes will be completed by 1/4/15.</p>				

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	<p>An undated policy, titled "U Labeling Procedures", was received from the Administrator on 12/4/14 at 12:30 p.m. and deemed as current. This policy indicated, "Purpose: To assure that all food and beverage items that are either stored, opened, prepared or leftover in our kitchens/storage areas and/or delivered...will be clearly identified as to the item name/product, the production or opened dated and the use by use."</p> <p>2. During an observation on 12/01/14 at 12:07 p.m., the food cart had been delivered to the Third Floor C-Unit. The staff were observed taking the tray with the lunch meal out of the cart and delivering the tray to the residents who remained in their rooms for the lunch meal.</p> <p>CNA #1 removed a tray from the cart and delivered the tray to the dining room, which was approximately five feet away from the cart. The pineapple desert was not covered. CNA #1 then carried a tray approximately 10 feet down the hall to room #365. The Jello on the resident's tray was not covered.</p> <p>During an interview at the time of the observation, CNA #1 indicated none of the deserts on the lunch trays were covered.</p>			

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F000441 SS=E	<p>During an observation on the Third Floor D-Unit on 12/01/14 at 12:40 p.m., CNA #3 carried meal trays down the hall to room #377, the coffee and the pineapple desert were not covered. CNA #3 then delivered a tray to room #384, which was approximately five feet from the cart. The jello and coffee were not covered.</p> <p>The Registered Dietician, then removed a tray from the cart, which was sitting outside room #377 and carried the tray down to room #396. The jello was not covered.</p> <p>During an interview on 12/05/14 at 10:19 a.m., the Dietary Manager indicated the food and drinks were not to be carried down the hallway uncovered.</p> <p>A facility policy, dated 08/04, titled, "Table and Tray Service", received from the Administrator as current, indicated, "...Cover liquids individually in a secure manner. Cover all foods and utensils on resident trays..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an</p>			

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	<p>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, record review, and interview, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease</p>	F000441	1.Regarding residents in rooms 105, 328, 381, 365, 368, 384, 390, and 396, follow up by Unit Managers / designees was completed with no adverse	01/04/2015

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	<p>and infection, related to hand washing during meal service, which had the potential to affect 18 residents who eat their meals on the Third Floor C-Unit, 10 residents who eat their meals on the Third Floor D-Unit, and 19 residents who eat their meals on the Second Floor A-Unit, storage of bedpans and a sitz bath, and storage of resident tooth brushes in the bathrooms on 3 of 3 floors. (First, Second, and Third)</p> <p>Findings include:</p> <p>1. During the lunch meal tray pass on 12/01/14 the following was observed:</p> <p>Third Floor C-Unit:</p> <p>During an observation on 12/01/14 at 12:15 p.m., CNA #2 delivered a tray to room #368. The CNA repositioned the resident's call light button, set up the resident's meal on the tray, then adjusted the resident's over bed table. The CNA then walked out of room #368, without washing her hands and retrieved another meal tray from the food cart and delivered the lunch meal to room #365. CNA #4 then entered room #365 and assisted CNA #2 with repositioning the resident in the room. CNA #4 then washed her hands and left the room. CNA #2 then placed a towel on the</p>		<p>reactions noted related to hand washing practices during meal service. Identified staff were immediately verbally reminded of proper hand washing procedures during meal service. Regarding the residents in rooms 115, 200, 222, 232, and 312, the Unit Managers discarded the toothbrushes, the bed pans and the sitz bath. New toothbrushes, bed pans and sitz bath were provided. Toothbrushes were placed in small basins in the medicine cabinets. Bed pans were placed in plastic and stored behind the commode. Sitz bath was placed in a plastic bag in the bath tub. No adverse reactions were noted.</p> <p>2. Remaining identified staff working were verbally reminded of proper hand washing procedures during meal service. The Unit Managers / designee completed an audit in all resident rooms to ensure no other toothbrushes, bed pans or sitz baths were improperly stored with any deficiencies noted corrected at that time.</p> <p>3. The DSD / designee re-inserviced nursing staff regarding proper hand washing procedures during meal service. The Unit Managers / designees will audit five (5) random meals weekly per unit to ensure proper hand washing procedures during meal service for nine (9) months. The DSD / designee re-inserviced nursing staff regarding proper</p>	

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	<p>resident's chest area and left the room without washing her hands. CNA #2 then walked up to the Nurses' Station and made a phone call to order food for a resident. CNA #2 then went back to the tray cart and retrieved another tray from the cart and delivered the tray to a resident in the dining room. CNA #2 still had not washed her hands.</p> <p>During an interview on 12/01/14 at 12:36 p.m., CNA #2 indicated they were to wash their hands in between rooms, when soiled, and after repositioning a resident.</p> <p>Third Floor D-Unit:</p> <p>During an observation on 12/01/14 at 12:40 p.m., CNA #3 delivered a meal tray to room #378. CNA #3 set up the resident's meal then left the room without washing her hands.</p> <p>CNA #3 then delivered a meal tray to room #381, moved the over the bed table closer to the resident, removed items from the table and placed them on the bed, set up the tray for the resident and walked out of the room without washing her hands.</p> <p>CNA #3 then delivered a tray to room #384, place the over the bed table in front of the resident, rearranged the resident's</p>		<p>placement / storage of toothbrushes, bed pans and sitz baths. The Unit Managers / designees will assess five (5) resident rooms weekly per unit to ensure proper placement / storage of toothbrushes, bedpans and sitz baths for nine (9) months.</p> <p>4. The Dining Manager / Unit Managers / designees will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5. Systemic changes will be completed by 1/4/15.</p>	

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	<p>wheelchair, set up the resident's tray, then the CNA used the alcohol gel to wash her hands.</p> <p>CNA #3 then delivered a meal tray to room #390, moved the over the bed table in front of the resident, and informed the resident she would be back to feed him. The CNA then left the room without washing her hands, moved the tray cart to room #396, poured a cup of coffee for the resident, then used alcohol gel on her hands.</p> <p>During an interview on 12/05/14 at 9:48 a.m., the Third Floor, D-Unit Manager indicated the staff were to wash their hands if they touched a resident or any of the resident's items in the room.</p> <p>2. On the 2 A Unit on 12/1/14 at 11:56 a.m., during the dining services, the following was observed:</p> <p>CNA #9 pushed the food cart down the 2 A Unit's hallway, stopped at Room 205, pulled the tray out for this resident, placed the room tray on resident bedside table, removed the newspapers on table, opened the resident's milk, open and put creamer into the resident's coffee, and then left the room. The CNA #9 was not observed to have washed her hands or use hand sanitizer after using carrying tray into the resident's room or removing</p>			

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	<p>the newspapers from the bedside table. After the observation, the CNA #9 was interviewed and indicated she does not use hand sanitizer and per the facility's policy, only had to wash her hands after three meal tray passes.</p> <p>During the 2 A dining room meal service on 12/1/14 from 12:05 p.m. until 12:20 p.m., CNA #7 placed Resident #2 oxygen in her nose, adjusted Resident #105's position in her Broda chair then proceeded to feed Resident # 105's ice cream to her. An interview at that time with CNA #7 indicated she should have used hand sanitizer after handling each resident.</p> <p>A policy, updated, titled "HACCP Food Safety Recipe Guidelines," received from the Administrator on 12/4/14 at 12:30 p.m. and indicated was current. This current policy indicated, "...Basic HACCP GUIDELINES, Wash hands before starting work, as often as needed during work, after break time, after touching any source of contamination...Sources of hand contamination include touching your hair, face...dirty equipment, dirty utensils or trash...."</p> <p>3. During the environmental tour on 12/04/14 at 2:37 p.m. through 4:28 p.m.,</p>			

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	<p>with the Housekeeping Supervisor, Assistant Maintenance Director, and the Administrator present, the following was observed:</p> <p>Room #115 had an uncovered bedpan stored in the bathtub of the room</p> <p>Room #200 had an uncovered bedpan stored on the side of the bathtub</p> <p>Room #222 had an uncovered bedpan stored on the rail of the bathtub</p> <p>Room #232 had a toothbrush stored on the back of the sink, uncovered and not in a container.</p> <p>Room #312 had an uncovered toothbrush stored on the back of the sink, not in a container and a sitz bath was stored uncovered in the bathtub.</p> <p>During the observations the Housekeeping Supervisor, Assistant Maintenance Director and the Administrator acknowledged the above findings.</p> <p>A facility policy, dated 05/10, titled, "Bedpan", received as current from the Administrator, indicated, "...Return the bedpan to storage..."</p>			

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F000465 SS=E	<p>3.1-18(b)(1)</p> <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.</p> <p>Based on observation and interview, the facility failed to maintain an environment that was safe, clean, and in a state of good repair, related to marred and splintered doors, cracked and sharp edges on door covers, rusted and dirty door vents, a cracked window, splatters on walls, black marks on floors, stained ceiling tiles, stained call light cords, a broken outlet cover, chipped paint and cove base pulled away from the wall, for 2 of 3 floors. (Second and Third)</p> <p>Findings include:</p> <p>During the environmental tour on 12/04/14 at 2:37 p.m. through 4:28 p.m., with the Housekeeping Supervisor, Assistant Maintenance Director, and the Administrator present, the following was observed:</p> <p>Second Floor:</p> <p>Room 200 had a cracked window in the</p>	F000465	<p>1.Regarding the cracked window found in room 200, the crack was immediately covered with tape to ensure the stability of the glass. A local glass contractor was immediately contacted about the repair needed. Regarding doors in rooms 213, 239, 269, 307, and 312, any splintering / sharp edges were immediately addressed by Maintenance by filling with wood putty, and sanded / filed to a smooth surface / edge with finish applied. Regarding identified stains / holes in 203, 222, 239, 279, 296, 307, and 332, all were immediately cleaned / fixed by Environmental / Maintenance staff. All identified stained ceiling tiles in rooms 245, 250, 253, 256, 257, 260, 263, 265, 267, and 291 were changed immediately by Maintenance staff. The cove base found to be pulling away from the corners in 298 was immediately re-glued. The soiled cove base in 269 was cleaned by Environmental staff immediately. All identified floors with black marks in rooms 307, 239, 332, and 350 were stripped and re-waxed by Environmental staff.</p>	01/04/2015
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	<p>bathroom and there was a piece of pipe insulation on the hand rail of the bathtub.</p> <p>Room 203, the doors to the closet and the bathroom were marred and had scratches and the wall near the head of the bed was marred.</p> <p>Room 213, the bathroom door was marred on the inside and outside of the door at the bottom of the door there was splintering of the wood on the door.</p> <p>Room 222, had a hole in the wall behind the hallway door.</p> <p>Room 232 had rust on the side vent in the bathroom. The inside bathroom door was splintered.</p> <p>Room 238 had a brown stained cord from the call light in the bathroom, the inside of the bathroom door was splintered, the outside of the bathroom door was marred, and the vent on the bathroom door was dirty.</p> <p>Room 239 had rust on the vent in the bathroom, the inside of the bathroom door was splintered at the bottom, the wall by the entrance door was marred, there were black marks on the floor, and the bathroom call light cord had brown stains.</p>		<p>All noted rusted / soiled vents in bathrooms and on doors were cleaned or repainted by Environmental staff and / or Maintenance staff. The over bed table was immediately removed from room 381. The two (2) identified stained call cords in rooms 238 and 269 were immediately replaced. The outlet cover plate in room 345 was immediately replaced.</p> <p>2. Assistant Plant Supervisor conducted a house wide audit of all resident rooms to observe condition of all bathroom, closet and entry doors and windows. Environmental Supervisor conducted a house wide audit of all resident rooms to observe cleanliness of resident room walls, call cords and bathrooms. No other windows were noted to be cracked or broken. Any other noted marring / scratching / gouging of doors / walls will be addressed by Maintenance by filling with wood putty, and sanded / filed to a smooth surface / edge with finish applied. The DON / designee completed a house wide audit of over the bed tables. No other chipped tables were noted.</p> <p>3. Environmental Supervisor / Plant Supervisor / designee re-inserviced Plant and Environmental staff on reporting on daily rounds sheets any damage to walls, windows, floors, vents, call cords, over bed tables and doors. Environmental</p>	

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	<p>Room 245 had chips on the bathroom door and the entry door next to the door handles. There were water stains on the ceiling tiles.</p> <p>Room 269 had stains to the molding between the door and the closet, marred closet doors, gouges on the inner bathroom door, which were splintered. The bathroom call light cord had brown stains.</p> <p>There were water stains on the ceiling tiles outside of rooms 250, 253, 256, 257 260, 263, 265, and 267.</p> <p>Room 279 had marred closet doors and chipped paint on the wall by the closet.</p> <p>Room 291 had a brown stain on the ceiling.</p> <p>Room 296 had marred wall by the closet.</p> <p>Room 298 cove base was pulling from the wall in the corners of the room.</p> <p>Third Floor:</p> <p>Room 303 the inside bottom of the bathroom door was marred.</p> <p>Room 307 the bottom of the bathroom</p>		<p>Supervisor / Plant Supervisor / designees will audit these areas five (5) resident rooms per unit weekly for compliance and to ensure repairs are being reported and repaired in a timely manner for nine (9) months.</p> <p>4. The Environmental Supervisor / Plant Supervisor / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.</p> <p>5. Systemic changes will be completed by 1/4/15.</p>	

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	<p>door was marred, there was paint chipping on the wall to the entryway of the room and sharp edges on the cover of the door to the room. There were black marks on the floor.</p> <p>Room 310 the bathroom door was marred.</p> <p>Room 312, the bottom inside of the bathroom door with gouges. There were sharp edges on the cover of the door to the room.</p> <p>Room 332, the wall by the bathroom had brown splatter marks.</p> <p>Room 345, on the wall behind the bed the wires to the phone cord were bare and the outlet cover was broke. The bathroom door had gouges out and the vent was dirty and the paint was chipped.</p> <p>Room 350 had scuff marks and putty on the closet doors.</p> <p>Room 381 there was an over the bed table with a chip out of it.</p> <p>The Housekeeping Supervisor, Assistant Maintenance Director, and the Administrator acknowledged the above findings.</p>			

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	3.1-19(f)				