STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 11, 12, 13, 14, 17, & 18, 2014 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Survey team: Rick Blain, RN - TC Tim Long, RN Carol Miller, RN Diane Nilson, RN Census bed type: SNF: 4 SNF/NF: 60 Total: 64 Census payor type: Medicare: 4 Medicaid: 48 Other: 12 Total: 64 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 21, 2014 by Randy Fry	F000000		

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

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

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F000159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.			
	Based on record review and interview, the facility failed to ensure money from personal funds accounts was available to residents on weekends for 3 of 3 residents reviewed for personal funds (Resident #45, Resident #60, and Resident #82). Findings include: Resident #45 was interviewed on 2/12/2014 at 9:55 A.M. During the interview, Resident #45 indicated she had a personal funds account with the facility. Resident #45 further indicated she had attempted to withdraw money from her account on weekends, but the office was closed on weekends and staff told her they did not have access to the money. Resident #60 was interviewed on 2/11/2014 at 11:05 A.M. During the interview, Resident #60 indicated she had a personal funds account	F000159	1.. Residents #45, 60, 82 were educated on the procedure for obtaining week-end funds. No other residents were affected.2. Assistant business office manager or designee will complete facility audit of current residents to explain and distribute the procedure for obtaining weekend funds. re-education of the staff on how residents can obtain funds on the week end will be done.3. A sign informing residents of the weekend procedure has been placed at the business office desk, for their information.The signs will also be placed at the Nurse's stations.The residents who attend resident council monthly will be reminded also. The new procedure for obtaining funds will be placed into the monthly newletter and the admission packets for review upon admission to the facility.4. The ABOM or designee will audit .new admission files to ensure signed copy is in the resident file, results of the weekly audits will be brought to the monthly QMP meetings to ensure compliance. For 6 months5. Completion:	03/14/2014

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	with the facility. Resident #60 further indicated she had requested money from her account on weekends, but was told by nursing staff that they did not have a key to obtain the money from the cash box. Resident #82 was interviewed on 2/11/2014 at 12:11 P.M. During the interview, Resident #82 indicated he had a personal funds account with the facility. Resident #82 further indicated he could not get his money on weekends because the office was not open on weekends. A sign on the wall near the front desk at the entrance to the facility indicated "Banking Hours" were Monday through Friday from 8:30 A.M. until 4:00 P.M. The facility Executive Director (ED) was interviewed on 2/18/2014 at 2:00 P.M. During the interview, the ED indicated resident funds were to be available to residents on the weekends. The ED indicated money was kept in a locked box and the charge nurse was supposed to have a key to the box if a resident wanted money from their account. 3.1-6(f)(1)		3/14/14	

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to offer 1 of 3 residents reviewed for choices (#93), a choice in how many baths or showers she could receive each week. Findings include: On 2/11/14, at 2:11 P.M., an interview with Resident #93 indicated, when asked "do you choose how many times a week you take a bath or shower?" the resident indicated no. Resident #93 then indicated she gets two showers a	F000242	1. Resident #93 was interviewed to update their preferences regarding bathing choices including how many per week and choice of bath or shower. Resident #93 ADL care plan was updated accordingly.2. Facility will interview all residents to obtain their preferences for bathing and update the care plan as needed.3. Nursing staff and Admisson director will be re-educated on providing resident choices for bathing and updating the care plans to indicate preferences for bathing. Facility management will monitor compliance through Angel Rounds 5x weekly. ED/Designee will monitor Angel rounds are completed 2x weekly for 1 month	03/14/2014

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	week and would prefer daily. Review of Resident #93's Customary Routine Activity Care Plan, dated 9/13/13, and revised on 12/13/13, supplied by the Regional Consultant Nurse (R.C.N.) on 2/14/14, at 9:50 A.M., indicated, in the Problem column: Preferences: "Bathe the way I want and when I want". An interview with the activity director (A.D.)on 2/14/14 at 9:38 A.M., indicated she was the staff person who filled out the Customary Routine Activity Care Plan for resident #93 on 9/13/13. The A.D. indicated she routinely interviews residents upon admission within 7 days. The A.D. indicated she asked "how did you bathe at home"? The A.D. indicated she did not ask Resident #93 how many times a week she bathed at home. The A.D. also indicated she did not ask how many times a week Resident #93 would like to be bathed at the facility. And interview with the R.C.N. on 2/14/14, at 9:45 A.M., indicated during the interview conducted for the Customary Routine Activity Care Plan, the resident should have been		then weekly there after.4. Results of audits will be forwarded to the QA&A for tracking and trending monthly for 6 months.5. Completion: 3/14/14	

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	asked how many times a week they would like to be bathed. Review of the undated policy, titled: "Accommodation of Needs Positive Practice", provided by the R.N.C. on 2/14/14 at 9:30 A.M., indicated "The facility staff is instructed to meet resident's personal, mental and physical needs. These include personal grooming, socialization, personal clothing of choice, telephone, marriage privileges, home-like environment, and attempting to honor life routines." 3.1-3(u)(1)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). Based on interview and record review the facility failed to provide a behavior care plan for 1 of 3 residents (#93) reviewed for behavior care plans. Findings include: Resident #93's clinical record was reviewed on 2/13/14 at 9:30 A.M.. The record indicated the resident's most recent readmission to the facility was on 11/6/13. Review of the resident's Minimum Data Set	F000279	1. Resident # 93 care -plan was updated to include resident refusal of medications and restorative therapy.2. Facility will review residents with refusals marked on the most recent MDS to ensure behavior care plans are in place and implement as necessary.3. Licensed staff and SS will be re-educated on developing behavioral care plans for resident with medication and therapy refusals. MDS Coordinator will monitor compliance through routine quaterly MDS completion.4. Results of audits will be forwarded to QA&A for tracking	03/14/2014

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	(MDS) from 12/18/13, indicated under the section: Rejection of Care-Presence and Frequency: "Did the resident reject evaluation or care (e.g., blood work, taking medications, ADL assistance) that's necessary to achieve the resident's goals for health and well being?" Resident #93 scored a (1) which indicated behavior of this type occurred 1 to 3 days during a 7 day evaluation period. Review of the MDS from 1/13/14 under the section: Rejection of Care-Presence and Frequency: "Did the resident reject evaluation or care (e.g., blood work, taking medications, ADL assistance) that's necessary to achieve the resident's goals for health and well being?" Resident #93 scored a (2) which indicated behavior of this type occurred 4 to 6 days during a 7 day evaluation period Review of Resident #93's care plans indicated a care plan for behavior related to potential disturbances as evidenced by false accusations, changing stories. Review of the care plans did not indicate a care plan for rejection of care. An interview with the Social Service Consultant on 2/13/14 at 2:45 P.M.,		and trending monthly for 6 months then quaterly thereafter.5. Completion: 3/14/14	

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	indicated resident behaviors are documented in nurse's notes. She provided a copy of a Behavior Notification to Social Services form dated 11/21/13 which indicated the resident resisted care (a treatment). This was the only Behavior Notification to Social Services form provided by the Social Service Consultant. Review of Medication Administration Record (MAR) for January 2014 indicated the resident refused a medication (Propranolol 20 milligrams, a blood pressure medication) on: 1/7/14 at 9:00 A.M.; 1/8/14 at 5:00 P.M.; 1/9/14 at 5:00 P.M.; 1/10/14 at 5:00 P.M.; 1/13/14 at 5:00 P.M.. The 7 day review period was from 1/7/14 to 1/13/14. The 5 refusals for medications during the 7 day review period were the basis for the score of (2) on the Rejection of Care-Presence and Frequency section of the MDS of 1/13/14. An interview with the Regional Consultant Nurse (R.C.N.) on 2/13/14 at 3:05 P.M. indicated a Social Service Assessment was completed on 12/18/13 and indicated Resident #93 had declined restorative therapy service twice			

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	during the assessment period and also declined a shower once. The R.C.N. indicated the review period for the MDS of 12/18/13 was from 12/12/13 to 12/18/13. The R.C.N. indicated this information was the basis for the MDS of 12/18/13 which resulted in the score of (1) on the Rejection of Care-Presence and Frequency. The R.C.N. indicated there should have been a care plan developed for rejection of care by Resident #93, based on the MDS results of 12/18/13 and 1/13/14 which indicated the resident had episodes of rejection of care. 3.1-35(a)			

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F000282 SS=D	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. Based on record review and interview, the facility failed to follow physician orders, regarding insulin dosage, for 1 of 5 residents reviewed for Unnecessary Medications, Resident #9. Findings include: The record for resident #9 was reviewed, at 8:26 a.m., on 2/18/14. Diagnoses included, but were not limited to: Senile dementia and Diabetes Mellitus. Current physician orders, for February, 2014, indicated physician orders for Novolog Insulin on a sliding scale 4 times a day, subcutaneously, at 6:30 a.m., 10:30 a.m., 4:30 p.m., and 9:00 p.m. The protocol for the sliding scale insulin indicated the following: Give novolog insulin for the following blood sugar readings; 0-120 no insulin 121-150 - 2 units insulin	F000282	1. resident #9 was assessed and did not experience any adverse effects. LN was re-educated on following MD orders for giving sliding scale insulin.2. The facility will review sliding scale insulin documentation for the last 30 days for residents recieving sliding scale insulin to ensure proper dosages were given. the facility will contact the MD as appropriate.3. Licensed staff will be re-educated to follow physician orders regarding sliding scale insulin administration. DON/designee will montor sliding scale insulin doseage administration to ensure it is correct 5x weekly x 1 motnh, 2x weekly for 1 month, weekly x 1 month then monthly thereafter.4. Results of audits will be forwarded to QA&A for tracking and trending monthly for 6 months then quarterly thereafter.5. Completion: 3/14/14	03/14/2014

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	151-200 - 4 units insulin 201-250 - 6 units insulin 251-300 - 8 units insulin 301-350 - 10 units insulin if blood sugar greater than 350 call the physician. Review of the Medication Administration Record (MAR), for February, 2014, indicated at 9:00 p.m., on 2/15/14, the resident's blood sugar was 251. LPN #5 documented she had given 4 units of novolog insulin, and not 8 units as the blood sugar protocol indicated. The Director of Nursing Services (DNS) was interviewed, at 11:57 a.m., on 2/18/14 regarding the wrong dose of insulin given and indicated she would investigate. The Assistant DNS was interviewed, at 1:50 p.m., on 2/18/14, and indicated she could find no further documentation regarding the insulin, and confirmed not enough insulin had been given. Review of the Blood sugar Monitoring policy, dated 2006, and provided by the Assistant DNS, at 2:15 p.m., on 2/18/14, and reviewed at this time, indicated			

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	Documentation guidelines which included: Date, time, blood glucose level, method of testing: "If insulin is ordered based on a sliding scale document the type and amount of insulin administered and the site of injection. If blood glucose level was above or below normal range, document the time the physician was notified." 3.1-35(g)(2)			
F000318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to	F000318	1. Resident # 52 ROM was assessed with no adverse effects noted. 2. Facility will review residents receiving Functional	03/14/2014

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	ensure 1 of 1 residents reviewed for Range of Motion (ROM) maintenance/improvement (#52) consistently received services. Findings include: An interview with LPN #12 on 2/11/14 at 3:07 P.M. indicated, Resident #52 had a right arm contracture and did not have a splint in place or receive ROM services. An observation on 2/11/14 at 3:15 P.M. of Resident #52 in his bedroom in bed was made but resident was under covers and refused to let an observation be completed of his right arm. An observation on 2/14/14 at 8:48 A.M. of LPN #3 and 2 CNA's attempting PROM for Resident #52 was incomplete as the resident indicated he did not want an observer. Review of a care plan received 2/14/14 at 2:00 P.M., from LPN #3, indicated the problem as right upper extremity and right lower extremity contractures. The interventions included but were not limited to: PROM (Passive Range of Motion)daily.		maintenance (FMP) in the last 30 days to ensure documentation is present and address as appropriate.3. Nursing staff were re-educated to complete FMP as directed and document participation on the FMP sheet. MDS coordinator will monitor complinace with documentation 2 x weekly.4. Results of audits will be forwarded to QA&A for tracking and trending monthly for 6 months then quaterly thereafter.5. Completion: 3/14/14	

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	Review of a restorative care plan received 2/14/14 at 2:00 P.M., from LPN #3, dated 11/26/13 indicated Resident #52 had contractures of his right lower extremity. The approaches of the care plan included: Passive Range of Motion (PROM) to his right lower extremity at 15 repetitions with no weight to be performed daily x 2 sets. Review of a 2nd restorative care plan received 2/14/14 at 2:00 P.M. from LPN #3, dated 11/26/13 indicated decline with grooming related to contractures. The approaches included, but were not limited to, resident to groom with assist of 1 staff each day. An interview with CNA #13 on 2/14/14 at 1:25 P.M. indicated they attempt during morning care to do PROM services and if Resident #52 refuses they try again in the afternoon. CNA #13 indicated if Resident #52 refuses both times the 2nd shift will try to do the PROM. CNA #3 indicated the 2nd shift CNA's know to attempt to do Resident #52's PROM daily programs by seeing if the first shift completed them on the functional			

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	maintenance log. CNA #13 indicated she documents on the functional maintenance log if the resident completes or refuses services. An interview with LPN #3 (restorative nurse) on 2/14/14 at 1:00 P.M., indicated staff are to attempt PROM daily for resident #52 but the resident often refuses services. LPN #3 indicated Resident #52 is not on a restorative program but is on a functional maintenance program. LPN #3 provided documentation for January and February 2014 for the functional maintenance program forms for resident #52. On the January 2014 form, the sections for grooming as well as bilateral upper and lower extremities range of motion sections were consistently filled out with services being 7 days of week and 15 minutes for each service. The January form was blank for all 3 sections (upper extremity, lower extremity, grooming) sections on 1/17/14, 1/18/14, 1/20/14, 1/21/14 and 1/24/14. The form indicated the resident refused services for all 3 sections on: 1/3/14; 1/6/14; 1/7/14; 1/10/14; 1/13/14; 1/14/14; 1/27/14; 1/28/14. On the February 2014 form, the section for grooming: resident to wash face each morning			

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	and after each meal had a single date filled in, 2/11/14, and indicated the service was 15 minutes. The rest of the form was blank as far as services provided. LPN #3 indicated staff should be filling in the forms if the resident refuses services. 3.1-42(a)(2)			
F000323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to supervise and prevent falls with injuries for 2 of 3 residents reviewed for falls. This resulted in Resident #49 falling 10 times and sustaining a hip fracture. Resident # 58 incurred 6 falls, one regarding	F000323	1. Residents #49 and #58 fall interventions were reassessed with revisions implemented as appropriate.2. The facility will review all residents with falss since 1/1/14 ensure appropriate intervetions were in place and care plan was updated as appropriate.3. Nursing staff IDT were re-educated on	03/14/2014

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	lack of a gait belt being used, which resulted in injury to the resident. Findings include: A. Resident #49 was observed in a broda chair, in the secure unit dining room, at lunch time on 2/11/14, being assisted by the Hospice nurse to eat. The resident was observed again, at 10:28 a.m., on 2/12/14, sitting in a broda chair with a lap tray across the chair. The record for Resident #49 was reviewed, at 8:10 a.m., on 2/14/14, and again at 8:17 a.m., on 2/17/14. Diagnoses included, but were not limited to: Advanced dementia, difficulty walking, mental disorder, anxiety, failure to thrive, depression, schizo-affective psychosis, and hip fracture. Review of a fall risk assessment, dated 6/1/13, indicated the resident was a high risk for falls. The Interdisciplinary Team (IDT) Post Occurrence Review documentation was reviewed and revealed the resident had incurred 10 falls, as follows between 5/31/13		implementing fall interventions for residents at risk for falls, providing appropriate supervision when applicable, and using gait belts when transferring residents. DON/Designee will monitor compliance with fall interventions through random audits /observations including all shirts of 3 residents with falls weekly DSD/Designee will montior compliance for gait belt use through random observation, including all shifts, of 3 transfers weekly.4. the results of the audits will be forwarded to QA&A for tracking and trending monthly for 6 months then quarterly thereafter.5. Completion: 3/14/14	

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	and 12/6/13: 5/31/13, 6/4/13, 7/12/13, 8/4/13, 8/11/13, 8/28/13, 9/19/13, 9/24/13, 11/19/13, and 12/6/13. 9 of the 10 falls were listed as unwitnessed falls. Care Plans were reviewed and a care plan originally dated 10/2/12 indicated the resident was at risk for falls and injuries, related to Psychotropic medication, incontinence, cognitive impairment, dementia, poor safety awareness, weakness and history of falls. The care plan was updated on the following dates with interventions including, but not limited to the following: 6/3/12 (sic) Non-compliant with disabling alarms 6/3/12 (sic) ensure resident wore shoes when up in wheelchair 6/3/12 (sic) wedge cushion to wheelchair 6/4/13 non skid slipper socks 6/4/13 non skid strips on the floor by bed 7/12/13 urinalysis and culture and sensitivity to rule out a Urinary tract infection 8/12/13 medication review 8/12/13 Orthostatic Blood pressures every shift for 72 hours			

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	8/12/13 alarms to bed and wheelchair 8/28/13 awaiting therapeutic level of depakote to reach therapeutic level to decrease anxiety 8/28/13 evaluation for anti roll back for wheelchair Another care plan, dated originally on 9/13/13, indicated the resident was at risk for falls related to Psychotropic, cardiovascular, and pain medications, incontinence, unsteady gait, Fracture of hip, pain, cognitive impairment, dementia, poor safety awareness, non-compliance, weakness, and history of falls. The care plan interventions included, but were not limited to: observe for side effects of medications, keep environment clutter free, observe for unsteady gait and balance, assess toileting needs, provide/reinforce use of assistive devices, wheelchair/broda, provide/reinforce use of non-skid foot wear, PT(physical therapy) OT (occupational therapy) ST (speech therapy), pressure sensor pad in bed and wheelchair, mat at bedside when in bed. Additional interventions included, but were not limited to the following: 9/24/13 bolsters to bed 9/24/13 mat to floor			

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	9/24/13 tray on wheelchair when up-for eating meals and drinking 11/19/13 hospice to provide Broda wheelchair 11/21/13 raised edge mattress per hospice 12/8/13 reposition wheelchair back farther to prevent her from sliding out of chair 12/11/13 tray in place to broda chair The IDT Post Occurrence Review documentation and interventions for the falls were reviewed and indicated the following: 1. 6/3/13 - an unwitnessed fall occurred on 5/31/13. The report indicated the resident fell in the hallway in front of the bedroom door. The report indicated the resident was self- ambulating and fell against a linen barrel. Also, the resident was not wearing shoes at the time. The report indicated as a result of the fall the resident incurred a hematoma to the right side of the forehead. IDT recommendations indicated neuro check for 72 hours, monitor hematoma, and make sure the resident wore shoes when up out of bed. The recommendations section also indicated the resident remained noncompliant with disabling alarms, and "wedge cushion w.c.			

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	(wheelchair)." Review of a report of incident SBAR(Situation, background, assessment, recommendation) for an actual or suspected fall, dated 5/31/13, indicated the fall occurred at 5:15 p.m., and the resident was attempting to "put on shoes." Also possible contributing factors included: environment: spills/clutter/lighting, and footwear, also alarm failure or device removal. 2. 6/4/13 - an unwitnessed fall at 5:45 a.m. on 6/4/13 with no injury. The report indicated the resident got herself out of bed, was not wearing shoes, and slid to the floor on her buttocks. The IDT recommendations indicated neuro checks were completed for 72 hrs, and slipper socks were to be worn when in bed. An IDT assessment and progress note, dated 6/17/13, indicated the resident required 1 assist for activities of daily living and transfers, used a wheelchair for ambulation, but was non-compliant with not using call light and transferring self, and was identified as a fall risk.			

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	3. Unwitnessed fall on 7/12/13, the resident fell in another resident room, and indicated she was checking on her kids. She tripped on a low bed and fell. Also, the resident ambulated per self, and no injury was noted. Recommendations indicated neuro checks for 72 hours, and a urinalysis with culture and sensitivity to rule out a urinary tract infection. Review of an incident SBAR form for actual or suspected fall, dated 7/12/13, indicated Wandering or pacing behavior, additional circumstances included device removal, and a brief description which indicated the resident was heard yelling, and found lying on the floor on the left side at the foot of the bed . A Verification of Incident investigation/Administrative Summary report, provided by the DNS and Regional Director, at 10:33 a.m., on 2/18/14, and reviewed at this time, indicated the incident occurred at 8:15 p.m., and indicated the resident was to be referred to therapy for an evaluation. Review of an IDT assessment, dated 7/23/13, indicated the resident had delusions and agitation at times			

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	but was generally redirectable. Also the resident was at risk for falls, required 1 person assist for ADL and transfers, and the resident used a wheelchair for ambulation and was non- compliant. The note indicated the resident would ambulate without any assistance and went into other residents' rooms. 4. Unwitnessed fall, resident self transferred on 8/4/13. Resident was transferring from a chair and lost her balance and fell. Injury: resident had hematoma on the back of her head. IDT recommendations indicated ice was applied to the back of the head, neuro checks for 72 hours,, and tylenol as needed. Review of a Verification of Incident Investigation/Administrative Summary report, provided by the DNS and Regional Director, at 10:33 a.m., on 2/18/14, and reviewed at this time, indicated the incident occurred at 1:35 a.m., the floor was being stripped and all the residents were asleep. Resident #49 woke up and entered the hallway, slipped, and fell. 5. 8/11/13 Unwitnessed fall on 8/11/13, resident self- ambulated, noted sitting on the floor near her bed and indicated she lost her			

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	balance, no injury. IDT recommendations indicated neuro checks for 72 hours, medication evaluation, orthostatic blood pressures, and alarms to bed and wheelchair. Review of a Verification of Incident Investigation/Administrative Summary, provided by the DNS and Regional Director, at 10:33 a.m., on 2/18/14, and reviewed at this time, indicated the incident occurred at 7:15 p.m. 6. 8/28/13 Unwitnessed fall. Resident fell from the wheelchair and incurred a skin tear to the right forearm. The resident indicated she was reaching for an object and slid out of the wheelchair. IDT recommendations indicated neuro checks for 72 hours, Opsite to the skin tear, nurse to follow up on the resident's depakote-(increased had not reached the therapeutic level yet), "falls D/T(due to) agitation", and anti roll back to wheelchair evaluation to be completed. Review of the Incident SBAR for actual or suspected fall, dated 8/28/13, indicated the incident occurred in the dining room, at 2:30 p.m., the resident's depakote had been increased to three times a day			

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	in the last 2 weeks, the possible contributing factors included a recent medication change, restlessness or anxiousness, and the wheel chair was unlocked. The description of the incident indicated the resident stated she went to reach for an object and the wheelchair slid out from underneath her causing her to slide to the floor. Review of an Interview/Investigative Record, undated, and provided by the DNS and Regional Director , at 10:33 a.m., on 2/17/14, and reviewed at this time, indicated therapy was trialing a tiltback wheelchair without tray with the resident when the fall occurred on 8/28/13. The resident was sitting at the table doing crafts, the tray was not on, and the resident reached for an object and slid out of the wheelchair. An IDT note, dated 9/3/13, indicated the resident required 1-2 person assist with ADLs and transfer, resident able to voice her needs, and continued to have behaviors. 7. 9/19/13 - unwitnessed fall. The resident fell during ambulation. The resident was ambulating in her room and tripped falling on the floor. The resident was wearing shoes, and the			

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	area was clear of debris and was dry. The resident was heard yelling. The CNA (Certified Nursing Assistant) went to the room, and found the resident on the floor . The resident complained of pain in her thigh area. The resident was admitted to the hospital with a hip fracture and surgery to be done on 9/20/13. Review of a Report of incident SBAR- actual or suspected fall, dated 9/19/13 at 1:00 p.m., indicated the resident was noted to be on the floor, lying on her back, with her feet at the end of the bed and head near the bathroom door. Review of a nurse's note, without a resident's name on it, provided by the DNS and Regional Director, at 10:33 a.m., on 2/18/14, indicated the following: "9/19/13 LPN #6 - Resident was anxious and walking around the hall yelling and was uncooperative. Resident would not use her w/c(wheelchair). Resident was in a w/c when she was too weak to ambulate but otherwise she ambulated per self. " Another note on the same form indicated the following: "9/19/13 CNA #14 - Resident was up			

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	ambulating thru the hallway. She was not using the w/c. she would dismantle her alarm to bed and w/c. CNA was in helping another resident lay down. " 8. 9/24/13 Unwitnessed fall from wheelchair. The resident was sitting in her wheelchair , attempted to get up and fell to floor bumping the side of her head. The resident had just returned from the hospital on 9/23/13. She had a right hip fracture, and was on heparin therapy. IDT recommendations indicated the resident was sent to the emergency room for evaluation and treatment, and facility would follow up with orders upon return. Plans included bolsters to bed, pad on floor beside bed, and a lap tray when up in the wheelchair. Review of a Verification of Incident Investigation/Administrative Summary, provided by the DNS and Regional Director, at 10:33 a.m., on 2/18/13, and reviewed at this time, indicated the incident occurred at 2:00 p.m., the resident was trying to get out of her bed, the CNA got her up and she fell from the wheelchair.. Also, the resident attempted to			

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	ambulate, had just returned from the hospital on 9/23/13 due to hip fracture and surgery. The resident fell from her wheelchair and bumped the right side of her head causing a hematoma. She was sent to the emergency room for evaluation. A nurse's note, without a resident's name, provided by the DNS and Regional Director, at 10:33 a.m., on 2/18/14, indicated the following: "9/24/13 Writer was called to West Hall because nurse was trying to finish medpass and (Resident #49) would not stay in w/c and was out at nurse's station. Writer was walking down the hall when alarm sounded. Writer ran down hall and found resident lying on floor in front of w/c c (with) hematoma to head. " This note was signed by The Assistant Director of Nursing Services. Review of an IDT assessment, dated 9/25/13, indicated a behavior review was completed, the resident was taking an antidepressant, and antipsychotic for schizoaffective disorder, and behaviors included verbal aggression and noncompliance. The resident returned from the hospital on 9/23/13 from surgery due to right hip fracture, had a fall on			

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	9/24/13, and interventions included a lap tray on the wheelchair, bolster on bed, and a mat on the floor. On 9/24/13, the resident was In the wheelchair, attempted to transfer self and fell . She had a hematoma to the right side of the head, sent to the emergency room for evaluation and was returned to the facility. Resident required one assist for ADL's and transfers and was able to voice her needs. Staff also meets her needs. Pursuant IDT notes, dated on 9/30/13 and 10/4/13 indicated a behavior and medication review, the resident required 1-2 person assist for ADLs and transfers, and a safety review - chair and bed alarm, continue with therapy, the resident becomes anxious, and had a recent medication change. The resident was on an antidepressant, antipsychotic, antianxiety medication, was on Physical and Occupational therapy, was a fall risk, and had bed and chair alarms. IDT notes on 11/14/13 and 11/18/13, indicated the resident propelled her wheelchair for ambulation, was combative with care, had a weight loss, was refusing food, and was being placed on hospice. Also, the resident had			

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	frequent behaviors, yelling out, cursing and hitting staff, and a decline in all areas of ADLs. The note indicated, "sometimes requires" staff to monitor her frequently, and the family wanted therapy stopped so hospice could evaluate the resident. 9. 11/19/13 Witnessed Fall - Resident fell from wheelchair, was sitting by a staff member, was reaching for eggs , stood up and fell from the wheelchair. No injury, Resident to start Hospice. IDT recommendations indicated Hospice was to provide a new wheelchair. Review of an incident SBAR-actual or suspected fall form, dated 11/19/13, at 8:45 p.m., indicated the resident was in the wheelchair near staff in the dining room, and wanted to go get some eggs. The resident stood up, the wheelchair slid out behind the resident causing the resident to fall to the floor. Review of a Verification of Incident Investigation/Administrative Summary, provided by the DNS and Regional Director, at 10:33 a.m., on 2/18/13, and reviewed at that time, indicated the resident fell from the wheelchair, attempted to ambulate			

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	and her knees gave out, and there was no injury. Follow up actions taken indicated the resident was going to get a new wheelchair from hospice, and to continue with a lap buddy at this time until the wheelchair was replaced. 10. 12/6/13 - Unwitnessed fall. The resident slid out of the wheelchair on to the floor. She had leaned forward to reach an object-slid out of chair. IDT recommendations indicated neuros checks for 72 hours, ice applied to side of forehead, and to make sure wheelchair positioned back farther to prevent resident from sliding out of chair. Review of a report of incident SBAR-actual or suspected fall, dated 12/6/13, at 1:00 p.m., indicated the resident slid out of her chair on the floor in the dining room. The resident had a small abrasion on the left side of the forehead, some swelling. Possible contributing factors indicated "sliding or positioning issue. " The Director of Nursing Services (DNS) and Administrator were interviewed, at 11:30 a.m., on			

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	2/17/14 regarding the falls the resident had incurred. The DNS indicated the Interdisciplinary Team (IDT) met after each resident fall and reviewed the fall and made recommendations and interventions which were added to the care plan. The DNS indicated at the time of the fall in June, 2013, the resident was self-ambulating. She indicated after the first fall, a wedge cushion was added to the wheelchair. The Administrator indicated the wedge cushion sloped in the back and rose in the front so made it more difficult for the resident to get up from the wheelchair. She indicated there were also alarms on the bed and wheelchair at this time. The DNS indicated slipper socks in bed were also utilized after this fall. The DNS indicated on 7/12/13, the resident wandered into another resident's room, still ambulated by herself, was confused, and tripped on the resident's bed. She indicated a urinalysis was completed after this fall. The Administrator indicated the resident was in therapy after the fall on 7/12/13, and she provided a copy of the Physical therapy plan of care at 11:45 a.m., on 2/17/14. The Physical therapy(PT) Plan of care assessment, dated 7/17/13,			

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	was reviewed, at 11:45 a.m., on 2/17/14. The PT assessment indicated the following: "PT (physical therapy) impression: patient's cause of fall on 7/12/13 was due to tripping from moderately impaired safety awareness. PT has instructed nursing staff to always provide supervision, because she is not an independent ambulation and her safety awareness does not allow this level anymore. There is, however, decreased strength on BLE (bilateral lower extremities)and decreased balance, which along with her postural deficits, cause increased gait deviation compared to previous discharge from PT program. These deficits, when managed, will aid in reducing fall risk associated with functional ambulation but expectations at discharge remain for patient to require supervision due to her cognitive impairments. " The DNS indicated a medication review was completed on 8/17/13 and medication changes were made, also orthostatic(lying, sitting, standing) blood pressures were checked because the resident had gotten up and lost balance, and the resident was seen by a psychiatrist and a psychologist. The DNS indicated the resident's family wanted to buy an anti-roll			

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	back for the resident's wheelchair, which were like a brake for the wheelchair. The DNS indicated an intervention was added to the care plan on 8/28/13 for an evaluation for the anti roll back for the wheelchair, but she was not sure what resulted from this evaluation. She indicated the Medical Records LPN would know what occurred regarding this. The Medical Records LPN was interviewed, at 12 noon on 2/17/14, and indicated she had given the price of the anti roll back to the resident's daughter, but had not ordered it herself. The DNS indicated there was always staff in the dining room on the secure unit, and the falls listed as unwitnessed only meant someone did not actually see the fall, but could have been in the same room with the resident. The DNS and the RN Regional Director were interviewed, at 10:33 a.m., on 2/18/14, and indicated the resident had seen a psychiatrist on 8/17/13 for her behaviors and delusions, and the resident would remove alarms and hide them. They indicated staff tried to redirect the resident with such things as movies and snacks, would walk with the			

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	resident at times, but she would become verbally and physically aggressive. She was also seen by a psychologist on 8/15/13, who had recommended trying to redirect, and avoid confrontation. The DNS and Regional Director provided additional information about the falls as follows: 6/3/13 - In addition to information already given, the resident was refusing to use her wheelchair and disabled her alarms on her wheelchair and bed. When staff attempted to intervene, the resident indicated she didn't need help and she could walk by herself. 6/4/13 - additional interventions for the care plan included non -skid strips on the floor next to bed. 7/12/13- The intervention from IDT regarding the urinalysis was not an order, but a nursing intervention. The DNS indicated the nurses could do dipsticks to check for a urine infection. She indicated she thought this had been done as per IDT recommendations after this fall on 7/12/13, but could find no documentation it had been done. 8/28/13 The Regional Director indicated at the time of this fall, the resident was in a tilt back wheelchair, which therapy had provided. She indicated there was			

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	no documentation regarding the tilt back wheelchair but LPN #6 had told the Regional Director this, and documented a note regarding this. The DNS indicated on 8/28/13 the resident was sitting at the dining room table doing an activity, and the wheelchair was not locked. She indicated the intervention was to remind staff to lock the wheelchair. She indicated she inserviced staff on the secure unit who were involved in the incident, but indicated the facility also had annual fall inservices with all staff. The DNS indicated the family were going to purchase an anti roll back for the wheelchair, and the Medical Records person had looked up pricing and reported to the family. The daughter and grand-daughter were not sure what kind to get, but ended up not getting the anti roll back because they were debating whether to place the resident on hospice. The DNS indicated she could not find any documentation regarding the anti roll back. She indicated the resident was admitted to hospice on 11/20/13. 9/19/13 The Regional Director indicated there was additional information from nursing notes, which indicated the nurse stated the resident was anxious and walking			

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	around the unit. She was uncooperative and would not sit in her wheelchair, and was yelling in the hallway. Staff attempted to redirect with snacks, puzzles, movies, cards, and coffee without success. 9/24/13 The Regional Director indicated the resident returned from the hospital on 9/23/13 and was placed on the West wing, which is the rehab unit. She had alarms to the bed and wheelchair. On 9/24/13, the resident was sitting in the wheelchair by the nurse's station. The Assistant DNS was coming down to the hall and heard her alarm sounding and found the resident laying on the floor. She indicated the ADNS was called down to the unit to help staff keep an eye on the resident because the nurse was going to lunch. She indicated the aide had just stepped away to answer a call light. Review of a PT progress and discharge summary, dated 7/30/13 (end of care), and provided by the DNS and Regional Director during this meeting, indicated the resident was admitted to therapy on 7/17/13 and discharged on 7/30/13. The progress note indicated the resident was referred to therapy for strengthening and balance			

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	improvement to reduce fall risk associated with gait in memory care unit. Over the course of the two week program, the resident was able to tolerate progression of resistance exercises and balance tasks. At the time of discharge, expectation for supervised level of ambulation had been met. This, however, may change to Stand by assist as the resident could get less alert on some days. Staff had been advised of downgrading to this latter level of assistance as needed. The resident was discharged to the memory care unit , stand by assist to supervision for ambulation without assistive devices, and to have a restorative nursing program. B. The record for Resident #58 was reviewed, at 1:37 p.m., on 2/17/14, and indicated he was admitted to the facility on 6/7/13, with diagnoses including, but not limited to: Dementia with delusions, anxiety, and Cerebral Vascular Accident. Review of the Interdisciplinary Team Post-Occurrence Review notes indicated the following: 1. 6/23/13 Witnessed fall, The resident was assisted to the bathroom by a CNA and assisted off			

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	of the toilet. The resident insisted on fastening his own pants, tried twice, then leaned forward, lost his balance, and fell to his knees, hitting the top of his head on the sink faucet causing a laceration. The report also indicated the resident incurred a skin tear to the right elbow, IDT recommendations indicated the physician was notified, the resident was sent to the emergency room for evaluation and treatment, surgical glue was applied to the top of the head, and an inservice was given on use of gait belts. The DNS was interviewed, at 11:20 a.m., on 2/18/14, and indicated the resident was residing on the rehabilitation wing at the time the incident occurred. She indicated the CNA involved was not using a gait belt on the resident when the incident occurred, and if the CNA had used the gait belt, the resident probably would not have fallen forward. She indicated she did an one on one inservice with the CNA following this incident, but did not document this. 2. 7/15/13 Unwitnessed fall - the resident took himself to the bathroom, was transferring to his wheelchair, and fell in the bedroom.			

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	The alarm was activated. The resident was found on his right side, complained of hip and joint pain, and incurred a small skin tear to the right lateral hand. IDT recommendations indicated neuro checks for 72 hours, Opsite to the skin tear, the resident was non-compliant with using the call light and waiting for assistance, and the staff were inserviced on not leaving the resident alone in the bathroom. The DNS was interviewed, at 11:20 a.m., on 2/18/14, and indicated the resident was still residing on the rehabilitation hall at the time of this fall. She indicated the resident was a one person assist for ADLs, but the resident had taken himself to the bathroom, so staff was unaware. She indicated she did an inservice just to make sure if staff accompanied the resident to the bathroom, they would stay with him. 3. 10/25/13 Unwitnessed fall - the resident attempted to get out of bed, and fell to the floor. The resident had removed his alarms. He bumped his forehead and incurred a laceration to the bridge of his nose. IDT recommendations indicated the resident was sent to the emergency room, bolsters were placed on the			

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	bed, the alarm replaced, and he was to continue with therapy. 4. 10/27/13 Unwitnessed fall - 8:30 p.m., the resident was noted to be on the floor beside his bed. He had attempted to self- transfer, and incurred a small abrasion to his forehead. IDT recommendations indicated steri strips were applied to the forehead, and a mat was placed on the floor beside his bed. 5. 11/6/13 Witnessed fall - the resident was taken to the bathroom, was aggressive with staff grabbing and punching them. He was continuing to attempt to get out of his wheelchair, pulled his alarm off and stood up from the wheelchair, then slid down to the floor. IDT recommendations indicated the resident was placed on 15 minute checks for 72 hours, and there was no injury. 6. 12/29/13 Unwitnessed fall- the resident stood up from his wheelchair, and lost his balance, no injury. The review of safety device section indicated there was an alarm failure. IDT recommendations indicated the alarm battery was replaced, and the			

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	resident was referred for therapy. The DNS was interviewed, at 11:30 a.m., on 2/18/14, and indicated the resident had been in therapy but discharged earlier, and now was being referred again. She also indicated alarms were checked by staff every shift for functioning, but the battery had to be replaced on this one. 7. 2/7/14 Unwitnessed fall - the resident was in the dining room (on the secure unit), in his wheelchair. The nurse was in the dining room, talking to the hospice nurse when the resident called" hey", and was noted to be on the floor. The resident had a tab alarm on, but the clip did not hold. IDT recommendations indicated a new clip was placed on the alarm cord, the resident continued in therapy, and the alarm was changed to a sensor pad. Care plans were reviewed for Resident #58 and indicated the following: The resident had dementia with delusions, anxiety, behavior disturbances, was exit seeking, and verbally and physically aggressive. A restorative care plan, dated			

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	12/2/13 indicated joint mobility decline, weakness, and ambulation with a rolling walker 10-20 feet daily. This was updated to March 2014, and indicated the resident walked with assistance of one staff, had a self care deficit, staff were to provide cues, the resident had impaired decision making, was an extensive assist of one person for transfer and ambulation, had one side rail used on bed, and had a wheelchair alarm. The care plan also indicated the resident was at risk for falls due to psychotropic, cardiovascular, and pain medications, incontinence, seizures, dementia, Cerebral Vascular Accident, weakness, and a history of falls. Interventions indicated the call light was to be kept in reach, monitor for unsteady gait, PT and OT evaluations, referral to therapy on 12/20/13, alarms, pressure sensor pad on bed, bolsters, and a mat on the floor. The resident was observed in his bed, at 1:57 p.m., on 2/17/14, one side rail on the wall side, a mat on the floor, and a bolster pad on the other side of the bed nearest the door. The call light was within reach.			

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	LPN #6 was interviewed, at 9:37 a.m., on 2/18/13, and indicated the resident was presently receiving speech therapy and Occupational therapy, which was helping him. She indicated he had quit feeding himself, but now was better. Review of gait belt use policy, dated 2008, and provided by the DNS, at 12 noon on 2/18/14, and reviewed, at 12:20 p.m., on 2/18/14, indicated, "It is the policy of this facility that staff will help control and balance (by using a gait belt) residents who require assistance with ambulation and transfer." Review of the Falls Management Policy, dated October 2010, and provided by the DNS, at 12 noon on 2/18/14, and reviewed at 12:20 p.m., on 2/18/14, indicated the fall prevention procedure: "1. Evaluate risk factors for sustaining falls upon admission, with comprehensive assessments, and while conducting interdisciplinary care plan reviews. 2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. 3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries."			

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	3.1-45(a)(2)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observations, interviews, and record review, the facility failed to ensure the kitchen ceiling light covers were free and clean from	F000371	1.The dietary department staff, were re-educated on the policy and procedure for the use of hairnets. the fan in the dishroom was removed immediately and is	03/14/2014

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	dust and a fan located in the dishwasher room was clean. In addition, dietary staff failed to correctly wear hair restraints, the baseboard molding located between the floor and the wall just outside the walk-in freezer was missing and there was a dried dingy brown substance adhered to the wall where the baseboard molding was missing. In the dry storage room there was molding that was pulled away from one corner of the inside wall. This deficiency potentially affected 63 of 63 residents who received their meals from the kitchen. Findings include: During the kitchen sanitation tour conducted on 2/11/14 at 9:15 a.m., accompanied by the Certified Dietary Manager (CDM) , the following was observed, the CDM had a hair net on but the hair was not completely covered by the hair net and wisps of hair were protruding out from under the hair net on both sides of the temple. In the dishwasher room a wall fan had a moderate build up of brown dust located outside on the fan guard and inside on the fan blades. The fan was not running at the time of the observation.		out of use, the light covers, were cleaned immediatley by maintenance and dietary.The baseboard has been replaced. Molding in the dry storage room was repaired immediately. 2.No negative outcome to residents, A audit of residents food committee has been done by the dietary manager to ensure quailty of sanitation during meal service.3. The dietary manager will daily audit and document the proper use of hairnets for her staff. The Maintnenace/DM or designee will do an audit of the light covers and kitchen maintnance weekly, 4. The dietary department will now use the white boufont hair covers in the kitchen in order to be sure that the hair is covered entirely. the ED/Dietary Manager or designee will do and random sanitation walk thru weekly, to ensure compliance for 6 months. A QA action plan has been established and will be monitored the audits will be brought to the QMP committee for review to ensure compliance. 5.Completion: 3/14/14	

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	An interview on 2/11/14 at 9:15 a.m., with the CDM indicated the fan is cleaned once a month by maintenance. On 2/11/14 at 10:55 a.m. Cook #1 was observed in the kitchen as she served food. Her hair net was on, but the hair was not completely covered by the hair net, and her hair was protruding out from the front of her hair net. On 2/14/14 at 10:45 a.m. another kitchen observation was conducted with the CDM and Consultant Dietician present. The baseboard molding located between the floor and the wall just outside the walk-in freezer was missing and there was a dried dingy brown substance adhered to the wall where the baseboard molding was missing. The dry storage room had molding pulled away from one corner of the inside wall and 4 of 6 ceiling light covers above the food preparation and serving area were dusty and a fan located in the dish washer room was dusty. Cook #1 had her hairnet on but the hair was not completely covered by the hair net. Her hair was protruding out from the front of her hair net.			

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	The CDM had a hair net on but the hair was not completely covered by the hair net and wisps of hair were protruding out from under the hair net on both sides of the temple. On 2/14/14 at 11:05 a.m., an interview with the Consultant Dietician indicated all hair should be restrained under a hair net. The policy titled Personnel Sanitation Standards updated on 2/2009 was received from the Administrator on 2/14/14 at 11:45 a.m. and indicated " ... Hair must be restrained or covered...." On 2/17/14 at 2:00 p.m. The Maintenance Director indicated the ceiling light covers in the kitchen were cleaned every 6 months, and he was unsure when the ceiling light covers were cleaned last. 3.1-21(i)(3)			

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, interviews, and record review, the facility failed	F000441	1. Resident # 1 and #103 oxygen equipment and nasal cannulas	03/14/2014

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	to ensure resident oxygen equipment and nasal cannula were stored to prevent potential contamination for 2 of 3 residents reviewed for resident care equipment (Resident #103 and Resident # 1). The facility further failed to ensure staff wore gloves during oral care for 2 of 2 observations of oral care (Resident #4 and Resident #49) and failed to store a toothbrush to prevent potential contamination for 1 of 1 observations of toothbrush storage (Resident #4). The facility further failed to ensure staff washed hands before and after wearing disposable exam gloves and properly disposed of used exam gloves during 1 of 1 dressing change observations (Resident #48). Findings include: 1. On 2/11/14 at 4:02 p.m. during an interview with Resident #103, oxygen tubing and cannula were observed in Resident #103's wheelchair and not secured in a bag. On 2/12/14 at 8:30 a.m. a continuous positive air pressure (cpap) mask was observed in Resident #103's room on top of the		were placed in bags. No adverse effects were noted.The staff members who provided oral care for residents #4 and # 49 were re-educated to wear gloves during oral care. Neither resident experienced any adverse effects. Resident 4 toothbrush was stored in a manner to prevent contamination. the staff member who completed the dressing change for reident #48 was re-educated on the proper procedure for hand washing when completing a dressing change..2. Facility will review residents with nasal cannulas and cpaps to ensure items are in bags when not in use. The facility will observe all resident toothbrushes to ensure they are stored in a manner to prevent contamination. Residents receiving oral care and dressing changes have the potential to be affected..3. Nursing staff will be re-educated reguarding the the proper way to store cpap to ensure items are in bags when not in use.Nursing staff will be re-educated on providing oral care including when to wear gloves and storage of toothbrushes. Nursing staff will be re-educated on proper procedure for disposal of gloves during dressing changes. Nursing staff will be re-educated on when to wash hands when caring for a resident. Facility management will monitor compliance with cpap mask, nasal cannula, and toothbrush storage during Angel	

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	cpap machine and the cpap mask was not secured in a bag. 2. On 2/12/14 at 10:02 a.m. resident #1 was observed with a oxygen cannula on her chin and not in her nose. On 2/18/14 at 10:45 a.m. an interview with LPN #2 indicated the resident's care equipment, which included oxygen tubing nasal cannula and cpap mask, should have been in a bag to keep the resident care equipment clean. On 2/18/14 at 11:a.m. Resident #1's oxygen tubing and nasal cannula was observed on the resident's bed. Resident #1 was not in her room at the time of the observation. On 2/18/14 at 1:15 p.m. an interview with the Nurse Consultant indicated the facility did not have a policy regarding keeping resident care items such as oxygen tubing and cpap mask cleaned and bagged. 3. CNA #7 was observed doing oral care on Resident #4, at 8:50 a.m., on 2/14/14. The CNA gathered supplies, including a small plastic glass into which she poured Sparkle		rounds 5 x weekly . DSD/Designee will monitor compliance with wearring of gloves during oral care through random observations of 3 instances of oral care weekly on 3 different shifts. Don/Designee will monitor compliance with hand washing during 3 random ADL observations on all shifts.DON/Designee will monitor compliance with gloves disposal practices during dressing changes through 2 random observations weekly.4. The reults of audits will be forwarded to QA&A for tracking and trending monthly for 6 months then quarterly there after.5: Completion: 3/14/14	

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	fresh(a mouth wash/rinse), a plastic glass of water, and a tube of toothpaste. She was then observed to wash her hands in the resident's bathroom, donned gloves, explained to the resident what she was going to do, and began performing mouth care on the resident. She put toothpaste on the toothbrush, brushed the resident's teeth, explained that she was going to give the resident a drink to rinse her mouth then told the resident to spit in the small basin the CNA was holding. The CNA finished mouth care, and stored the uncovered toothbrush, tube of toothpaste, and bottle of mouth rinse in the same basin, and placed it into the top drawer of the resident's dresser. The drawer was noted to contain several pairs of socks. The CNA then finished cleaning everything up after removing her gloves, placed the hand towels she used for care in a plastic bag and proceeded out of the resident's room to the soiled utility room with the plastic bag, without washing her hands. She then went into the bath/shower room next to the soiled utility room and washed her hands. The CNA was interviewed, at 9:15 a.m., on 2/14/14, and indicated she would normally cover the toothbrush			

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	with the plastic wrap it came in, but she had thrown the wrap away. She also indicated she replaced the toothbrush weekly. 4. CNA #7 was observed during oral care, on Resident #49, at 9:04 a.m., on 2/14/14. The CNA was observed to wash her hands, explained to the resident what she was going to do, then brushed the resident's teeth, assisted the resident to rinse her mouth, and asked the resident to spit into the basin. The CNA did not wear gloves during the procedure. When she completed oral care, she wiped the resident's mouth with a hand towel, rinsed the basin, and placed the basin in the top bedside table. She placed the toothbrush so the brush side was laying inside of a small plastic cup in the basin, where she also stored the bottle of mouthrinse and tube of toothpaste. When queried regarding glove usage, the CNA indicated she had laid the gloves on the resident's broda chair tray, but forgot to wear them during oral care. The Regional Director was			

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	interviewed at 9:35 a.m. on 2/14/14, and indicated the facility did not have a policy for placement of toothbrushes, but indicated the used toothbrush should be placed in a plastic bag, or covered. The policy "Oral Hygiene" dated 2006, was provided by the Regional Director at 9:30 a.m. on 2/14/14. Review of the policy at 11:18 a.m. on 2/14/14, indicated to drape the resident with a towel, put on gloves, wet the toothbrush with tepid water and put a small amount of toothpaste or powder on the brush. 5. ON 2/14/2014 at 9:20 A.M., RN #9 and CNA #8 were observed performing a dressing change on a skin wound for Resident #48 in his room. CNA #8 was observed to enter the resident's room and close the door behind her. CNA #8 was observed to put on a pair of disposable exam gloves and assist in positioning the resident. CNA #8 was not observed to wash her hands or to use hand cleaning gel after entering the room prior to putting on the gloves. After assisting in positioning the resident, CNA #8 was observed to remove the gloves and to leave the room to obtain			

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	supplies for the nurse. CNA #8 was not observed to wash her hands or to use hand cleaning gel after removing the gloves prior to leaving the room. CNA #8 was then observed to re-enter the resident's room with the supplies, close the door, and put on a new pair of exam gloves. CNA #8 was not observed to wash her hands or to use hand cleaning gel after entering the room prior to putting on the gloves. Before changing the resident's dressing, RN #9 was observed to clean the over-bed table with disinfectant, place a clean cloth on the table and place the dressing supplies on the cloth. After cleaning the wound, RN #9 was observed to remove one of her disposable exam gloves by turning it inside out. RN #9 was then observed to place the used exam glove on the over-bed table. RN #9 was then observed to wash her hands, put on a new pair of disposable exam gloves, and proceed with the dressing change. RN #9 was observed to remove the used exam glove from the over-bed table and discard it into the trash after completing the dressing change. The Director of Nursing (DON) was interviewed on 2/14/2014 at 10:15			

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	A.M. During the interview, the DON indicated staff were to wash hands with soap and water immediately before putting on gloves and immediately after removing gloves. The DON further indicated used gloves were to be immediately discarded in to the appropriate trash receptacle. A facility policy entitled "Glove Use", dated 2012 and provided by the facility Nurse Consultant on 2/18/2014 at 11:00 A.M., indicated "hand hygiene" was to be performed before and after using gloves. The policy further indicated, when removing gloves, staff were to use one hand, pull the cuff down over the opposite hand turning the glove inside out and then "discard the glove into a designated waste receptacle". 3.1-18(b)(2) 3.1-18(l)			

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations, interviews, and record review, the facility failed to ensure the ceiling air vent located in the Main Dining Room was free and clean from dust. This deficiency potentially affected 5 of 5 residents whose tables were close to the ceiling air vent. The facility further failed to maintain a clean and comfortable environment for 19 of 64 resident's reviewed for personal environment. Findings include: On 2/11/14 at 10:00 a.m. a dusty ceiling air vent was observed in the Main Dining Room, located 4 feet away from 2 empty tables. On 2/11/14 at 12:00 p.m. the dusty ceiling air vent was observed in the Main Dining Room where 5 residents were sitting at the 2 tables eating their lunch. On 2/12/14 at 12:15 p.m. the dusty ceiling air vent was observed with the Administrator in the Main Dining Room where 5 residents were sitting at the 2 tables eating their	F000465	1. All ceiling air vents were checked or cleaned thru out the facility immediately. All Overhead bed lights were checked and or repaired thru out the facility, Rooms 217, 312,309,107,105 were repaired immediately, 2.The other residents with a potential to be affected., were identified thru a facility wide audit per the ED/Housekeeping supervisor and extra cleaning and preventative maintenance was done to the resident bathrooms3. Ceiling air vents will be checked/cleaned by Housekeeping/Maintnenace weekly, thru out facility. Overbed lights and facility bathrooms will be inspected weekly thru out facility on inspection by Housekeeping/Maintnenace supervisors. 4. Audit tool for Housekeeping/Maintnenace supervisor will be turned in weekly to ED or designee to ensure compliance. random checks will be done by ED or designee monthly or more with either Housekeeping or Maintenance supervisors. This will be a written QA action plan. Results of the weekly audits will be, monitored by the QMP committee and reviewed per monthly meetings for 6 months.5.	03/14/2014

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	lunch. On 2/17/14 at 10:30 a.m. an invoice from an outside vendor was received from the Administrator, and indicated the air vent was last cleaned on 2/10/14. On 2/17/14 at 2:00 p.m. an interview with the Maintenance Director indicted the dusty ceiling vent is an intake air vent and was last cleaned on 2/10/14. 2. During an environmental tour on 2/18/14, between 10:45 A.M. to 11:00 A.M., with the Maintenance Director, Housekeeping Supervisor, and the Administrator, the following rooms were noted for environmental concerns: Room 217: The caulking around the bathroom sink was cracked. Room 309: The personal overhead bed light for Resident #4, was noted to be without a string attached to the chain to turn on and off the light. Room 312: The personal overhead bed light for Resident #58, was noted to be without a string attached to the chain to turn on and off the light. In addition caulking around the		Completion: 3/14/14	

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	bathroom sink was noted to be cracked. Room 107: The wall in the Resident #105's room to the right of the window was noted to have 2 dime sized holes. The ceiling in Resident #105's room was noted to have a minimal to moderate amount of light gray clumps of dust. In addition a significant amount of dirt was noted behind the toilet and along the metal threshold strip between the bathroom and the bedroom. Resident #105 was interviewed on 2/12/2014 at 11:15 A.M. During the interview, the resident indicated that she was concerned about the amount of dust on her ceiling since she had a tracheostomy and was concerned about the dust falling onto her. Room 203: The bathroom in Resident #45's room was noted to have significant amount rust/tan discoloration on the tile around the toilet. Also noted was the baseboard pulling away from the wall by the toilet. In addition, the sink had cracked caulk. Room 206: The bathroom for resident #66 had a significant amount of dirt behind the toilet on			

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	the floor. In addition, the caulking around the sink was cracked. Room 312: The personal overhead bed light for Resident #58, was noted to be without a string attached to the chain to turn on and off the light. Room 216: The bathroom for resident #26 was noted to have cracked tile around the toilet bowl and the inner toilet bowl was noted to have a brownish discoloration. In addition, the cold water in the sink had very little pressure. 3.1-19(f)			

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F000520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to ensure the facility's Quality Assessment and Assurance (QAA) committee identified concerns regarding general cleanliness in resident rooms and also in the kitchen and main dining room. This deficiency potentially affected 9 of 35 resident rooms reviewed for personal environment and also 63 of 63 residents who received their meals	F000520	1. The 9 residents identified rooms were immediately deep cleaned, the kitchen areas, lights, vents and the main dining room areas were immediately cleaned, the overbed light cords were replaced. 2. Other residents who would have the potential to be affected were identified by a facility wide audit of resident rooms and common areas by the Housekeeping supervisor and the ED, And are scheduled or have been completed by housekeeping	03/14/2014

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	from the kitchen. Findings include: The facility's Executive Director (ED) was interviewed on 2/18/2014 at 2:00 P.M. During the interview, the ED indicated the facility had a QAA committee that met monthly to identify and correct facility quality concerns. The ED indicated all departmental managers were members of the committee. During the interview, the ED indicated although the facility environment was generally discussed, and some concerns had been identified, the QAA committee had not identified concerns regarding general cleanliness in resident rooms, in the main dining room, or in the kitchen. A facility policy titled "Quality Management Program", dated January 2012, indicated "it is a policy that a functional Quality Management Program is maintained to monitor and evaluate the quality of resident care services, pursue methods to improve quality and all areas of organizational functioning, and to promote safety by using a systemic problem identification and resolution process."		or maintenance services. 3. The ED/designee will do random weekly audits with the Housekeeping or Maintnenace Supervisor, to ensure compliance and timeliness, and completion. 4. The Housekeeping and Maintnenace supervisors will do a QA action plan for the continued deep cleaning of the residents rooms and the common areas, bring to the monthly QMP meetings for report and for review by the committee. To ensure compliance For 6 months.5. Completion: 3/14/14	

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	3.1-52(b)(1) 3.1 52(b)(2)			