

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD PLAINFIELD, IN46168
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey Dates: October 3, 4, 5, 6, & 7, 2011</p> <p>Facility Number : 000121 Provider Number : 155215 AIM Number : 100290940</p> <p>Survey Team: Michelle Hosteter RN TC Heather Lay RN Rita Mullen RN Janet Stanton RN</p> <p>Census Bed Type: SNF/NF : 136 SNF: 11 Total : 147</p> <p>Census Payor Type: Medicare : 19 Medicaid : 103 Other : 25 Total : 147</p> <p>Sample: 24</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/17/11 Cathy Emswiller RN</p>	F0000	<p>Preparation and/or execution of this Plan of Correction in general, or any corrective action does not constitute an admission or agreement by Plainfield Health Care Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws.</p> <p>Plainfield Health Care Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on November 6 th , 2011</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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F0309 SS=E	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>A. Based on record review and interview, the facility failed to ensure licensed nurses notified the physician of a laboratory value and restarting an anticoagulant medication following a "Hold" medication order without the physician's instruction to do so. The deficient practice impacted 1 of 2 residents reviewed who had a "Hold" order for Coumadin [anticoagulant] in a sample of 24 residents reviewed. [Resident #94]</p> <p>B. Based on record review and interview, the facility failed to assess pain levels and pain medication usage and implement timely changes in treatment for 1 of 1 resident who had continued pain in a sample of 24. [Resident #1]</p> <p>C. Based on observation, record review and interview, the facility failed to implement services to prevent recurrent excoriation for 1 or 1 resident reviewed with a diagnosis of "Incontinence Dermatitis" in a sample of 24. [Resident #1]</p> <p>D. Based on record review and interview, the facility failed to follow the bowel</p>	F0309	<p>Corrective Action (F309): It is the policy of this facility to notify the physician of laboratory value and restarting an anticoagulant medication following a "Hold" medication order in a timely manner and assessing resident for bleeding symptoms during period of increased risk of bleeding when receiving anti-coagulant medications. Resident #94 and resident #40 were not negatively affected by this finding. Nursing Administration completed an audit of all current residents who receive Coumadin to ensure that current PT/INR lab orders are correct and physician notification has been completed timely. Nursing Administration or designee will monitor physician notification of lab results including PT/INR's three times weekly to ensure appropriate physician notification and follow-up is completed per the laboratory results. Any concerns will be addressed immediately and corrections will be made. These monitoring will continue until there are four consecutive</p>	11/06/2011	

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	<p>management program for 1 of 1 resident who had a history and was at risk for constipation in a sample of 24 residents reviewed. [Resident #107]</p> <p>E.. Based on record review and interview, the facility failed to ensure licensed nurses consulted with the physician prior to restarting an anticoagulant and failed to assess the resident for bleeding symptoms during periods of increased risk of bleeding for 1 of 2 residents reviewed who were receiving anti-coagulant medications. [Resident #40]</p> <p>Findings include:</p> <p>A. Resident #94's record was reviewed on 10/4/11 at 9:35 A.M. Diagnoses included, but were not limited to, Alzheimer's disease, atrial fibrillation, transient cerebral ischemia, and anxiety.</p> <p>A "Physician's Orders" dated 9/14/11, no time, included, but was not limited to, "Hold Coumadin times 3 days, Re-check Prothrombin-Prottime/International Normalized Ratio [PT/INR] in 3 days..."</p> <p>Upon review of Resident #94's record, no PT/INR lab result was located in the resident's record for 9/17/11.</p> <p>The "Medication Administration Record"</p>		<p>weeks of zero negative findings. Then random monitoring will be done at least weekly. All licensed nursing staff has been in-serviced on PT/INR Lab orders, physician notification and timely response, documentation of physician order per lab results, follow-up labs/fax confirmation, resuming standing orders. Any staff found to be non-compliant with the points of the in-service will be further educated by Nursing Administration and/or progressively disciplined as appropriate. All licensed nursing staff has been in-serviced on documentation of signs and symptoms of bleeding or absence of bleeding for any resident who has a PT/INR result higher than the therapeutic range. Any resident who has a PT/INR result higher than the therapeutic range will be placed on pertinent charting for signs and symptoms of bleeding. Any concerns will be addressed immediately and corrections will be made. The Director of Nursing and/or designee will monitor weekly until there are four consecutive weeks of zero negative findings. Then random monitoring will be done at least weekly. It is the policy of this</p>		

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	<p>[MAR] dated 9/1/11 included, but was not limited to, "Warfarin Sodium 4 milligram tablet [Coumadin] give 1 tablet by mouth daily..." The doses for dates 9/14/11 to 9/16/11 were marked as "Hold" and not given to the resident. Daily doses were resumed on 9/17/11 per the MAR.</p> <p>In an interview with ADoN #5 on 10/4/11 at 11:00 A.M., she indicated laboratory results are misplaced at times. ADoN #5 was unable to find the PT/INR at that time.</p> <p>On 10/5/11 at 2:30 P.M., ADoN #5 provided a "Duplicate" copy of a PT/INR with the date of 9/17/11 drawn at 5:40 A.M. and delivery date [fax to facility] of 9/17/11 at 7:48 A.M. She indicated the laboratory had sent the results; however, the results were not reviewed by the facility and the physician was not contacted regarding the PT/INR. The ADoN also indicated the facility did not have a "Hold Medication" policy; however, it is expected that the physician be notified of any labs ordered.</p> <p>A document titled "Physician Notification of Laboratory Results" dated 6/10 was received on 10/7/11 at 3:00 P.M. from ADoN #5 included, but was not limited to, "Purpose: To keep the physician informed of laboratory results as ordered</p>		<p>facility to assess resident pain levels and pain medication usage to ensure timely changes in treatment per physician order. Resident #1 or any other resident was not negatively affected by this finding. Resident #1 has an updated pain assessment and care plan completed in her medical record. Resident use of frequent PRN pain medications has been reviewed with the physician and physician order will continue to be followed. Nursing Administration completed an audit of all residents who receive pain medications to ensure appropriate pain assessments were completed and followed per physician orders. Any concerns will be addressed immediately and corrections will be made. These monitoring will continue weekly until there are four consecutive weeks of zero negative findings. Then random monitoring will be done at least weekly. All licensed nursing staff has been in-serviced on monitoring residents for pain, the use of PRN pain medications, and documentation signs and symptoms of pain. Any staff found to be non-compliant with the points of the in-service will be further educated by Nursing</p>				

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	<p>by the physician... Procedure: Information should be faxed to the physician's office 7 days per week... within a 2 hour timeframe if not otherwise specified by the physician..."</p> <p>At that time, in an interview, ADoN #5 indicated, "It is the expectation with any "Hold" medication order with ordered laboratory testing, the physician is notified of results of the ordered lab prior to restarting the medication on hold..."</p>		<p>Administration and/or progressively disciplined as appropriate. It is the policy of this facility to prevent recurrent excoriation for residents with a diagnosis of Incontinence Dermatitis. Resident #1 was not negatively affected by this finding. Resident #1 has a long history of incontinent dermatitis and a variety of interventions have been implemented. Resident also has a long history of non-compliance with care and behavioral issues which has had a negative impact on the occurrence of incontinent dermatitis. Resident #1 will continued to be turned and provided care for incontinence in a timely manner. Any non-compliance by resident #1 with incontinent care and/or repositioning will be documented in the medical record. Please note, resident #1 has been on a pressure relief specialty mattress for the past few years. Nursing Administration will monitor any resident with recurrent incontinent dermatitis in the weekly SWAT (Skin and Weight Assessment Team) meetings. Any concerns will be evaluated by the facility wound care physician for treatment and interventions. The wound care team makes rounds weekly at</p>		

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			<p>facility. Nursing staff has been in-serviced on incontinence care, documentation of non-compliance, and following interventions and treatments. Any staff found to be non-compliant with the points of the in-service will be further educated by Nursing Administration and/or progressively disciplined as appropriate. It is the policy of this facility to follow the bowel management program for residents who had a risk for constipation. Resident # 107 was not negatively affected by this finding. No other resident was found to be affected by this finding. Resident #107's prn order for MOM and Dulcolax suppository has been rewritten to avoid confusion and is followed per physician orders. Nursing Administration completed an audit of all current resident prn laxative orders to ensure physician orders are being followed as written and clarify any orders as needed. Any concerns will be addressed immediately and corrections will be made. These monitoring will continue weekly until there are four consecutive weeks of zero negative findings. Then random monitoring will be done at least weekly. All licensed nursing staff has been</p>		

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	<p>B. Record review for Resident #1 was completed on 10/5/11 at 1 P.M. Diagnoses included, but were not limited to, diabetes mellitus, contractures, history of CVA [cerebrovascular accident-stroke], CHF [congestive heart failure], chronic pain and vascular dementia.</p> <p>In an interview with ADON #4 on 10/3/11 at 10:40 A.M., she indicated Resident #1 was incontinent of bowel and bladder. She</p>		<p>in-serviced on the use of prn laxative orders, following orders, and use of bowel and bladder assessment. Any staff found to be non-compliant with the points of the in-service will be further educated by Nursing Administration and/or progressively disciplined as appropriate. At the Quality Assurance meeting held quarterly, the Director of Nursing or designee will review the monitoring of lab results, and physician notification, use of prn laxatives, monitoring of incontinence dermatitis, pain assessments and documentation. Any negative patterns will be reviewed and addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The administrator will monitor the plan weekly until resolution.</p>		

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	<p>indicated the resident had behaviors of hitting staff, and refusing to get out of bed. The resident was a weekly weight currently and had a left arm contracture.</p> <p>The pain assessment dated 5/24/11 indicated, "... no change in the resident's condition...cont[continue] with routine Fentanyl [a narcotic pain medication], prn [as needed] Tylenol and prn hydrocodone [a narcotic pain medication] 10-325 mg q [every] 4 hrs..." No other pain assessment could be found in chart.</p> <p>Nurses Monthly Notes from dated 1/16/11 through 9/15/11 had no entries in regarding the resident's pain regimen or the status of the resident's pain condition.</p> <p>Physician's Progress notes dated 7/11/11, 7/27/11, 8/15/11, and 9/19/11 had no indication there was any concerns regarding pain for Resident #1.</p> <p>The MDS [Minimum Data Set] assessment dated 8/16/11, indicated the resident was severely impaired in her ability to make decisions and had short and long term memory deficits. The pain section indicated the resident reported frequent pain over the last 5 days with a pain scale rating at 9 out of 10.</p> <p>The resident's MAR [Medication</p>				

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	<p>Administration Record] for August 2011 indicated she received Fentanyl 25 mcg [micrograms] [a narcotic pain medication] every 3 days for chronic pain. The resident had received this medication since 5/16/11 according to the physician's recapitulation for October 2011. Resident #1 also had Norco 10/325 mg [milligrams-a narcotic pain medication] every four hours as needed for pain. doses she received for August and September were as follows:</p> <p>August: 1 dose: 1st, 6th, 7th, 8th, 9th, 10th, 13th, 15th, 22nd, 23rd, 25th, 26th, 29th, 30th, and 31st. 2 doses: 2nd, 3rd, 4th, 5th, 11th, 12th, 16th, 18th, 19th, 20th, and 21st. 3 doses: 27th.</p> <p>September: 1 dose: 2nd, 3rd, 7th, 9th, 10th, 12th, 15th 16th, 17th, 18th, 20th, 21st, and 25th 2 doses: 4th, 5th, 6th, 6th, 14th, 23rd, 24th, 26th, 27th, 28th, 29th 3 doses: 8th, 13th, 19th, and 30th.</p> <p>During interview at the daily conference on 10/6/11 at 3:15 P.M. ADON #4 indicated they felt that the resident's pain had been under control and that this was why they had not addressed the issue.</p>				

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	<p>C. The clinical record of resident # 1 was reviewed on 10/5/11 at 1 P.M., Resident #1 had a long history of pressure and [IAD] Incontinence Associated Dermatitis. Resident #1's most recent care plan dated 8/11 indicated she had diagnoses which included, but were not limited to, unfavorable weight loss/chronic wound. The care plan indicated the resident refused care often.</p> <p>Wound Progress Notes dated 8/30/10 to current indicate Resident #1 had had IAD since that time. She had the left buttock area resolve [healed] on 12/27/10. The right buttock incontinence associated dermatitis continued to get larger until the facility obtained an order for and anchored a foley on 2/23/11. On 3/14/11 the left buttock IAD occurred again and then resoled 3/22/11. On 5/23/11 documentation indicated the right buttock was healed. On 9/26/11 there was an open area discovered on the sacrum area measuring 1.2 x 0.7 x 0.1 documented as IAD.</p> <p>A bowel and bladder assessment dated 5/24/11 indicated the resident was incontinent of bowel and bladder, the resident's foley catheter had been removed, and the resident was to be toilet every two to four hours and PRN [as needed] res. [resident] incontinent of B/B</p>				

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	<p>[bowel and bladder]..."</p> <p>During observation of Resident #1 on 10/7/11 at 11:05 A.M., Resident #1 was incontinent of bowel when CNA #9 went to turn the resident over. She had a large formed BM which was stuck to the skin of her buttocks and coccyx area. Resident #1's coccyx area was intact and had excoriation and had an irregular border to parameter of the area. In an interview with ADON #5 on 10/7/11 at 11:45 A.M. she indicated the resident had been showered and toileted at 10:15 A. M on 10/7/11.</p> <p>In an interview at 11:45 A.M. on 10/7/11 with ADON #5 (the facility's wound nurse) indicated she would classify Resident's #1's wound as IAD. She indicated when a resident had a diagnoses of IAD the facility would not alter the toileting schedule as they toilet every two to four hours for each resident. She also indicated Resident #1 was frequently incontinent and this morning she had been toileted during shower prior to an observation done of resident's wound and she was again incontinent during the observation. ADON #4 and ADON #5 indicated the resident was resistive to care and refused to be turned and this was what contributed to the difficulty in healing the dermatitis.</p>				

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	<p>D. Record review for Resident #107 was completed on 10/4/11 at 10:35 A.M. Diagnoses included, but were not limited to, dementia, constipation, hypothyroidism, and GERD [Gastro Esophageal Reflux Disease] (acid reflux).</p> <p>The physician orders for treatment of constipation dated 9/23/10 were for Milk of Magnesia [MOM] to give 30 ml by mouth daily as needed for constipation. There was also an order dated 11/10/09 for Bisacodyl 10 mg suppository to be given rectally times one daily as needed for constipation if no results from second dose of MOM.</p> <p>The MAR [Medication Administration Record] indicated the following doses were given of MOM and Bisacodyl:</p> <p>August: MOM (one dose): 2nd, 10th, 14th, 23rd and 28th. Bisacodyl: 3rd, 4th, 16th, and 22nd</p> <p>September: MOM (one dose) : 2nd, 16th, 20th, 27th, and 30th Bisacodyl: 9th, 14th, 15th, and 24th.</p> <p>During an interview with the DON on</p>			

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	<p>10/7/11 at 9:30 A.M. she indicated the orders had not been followed as the order was written.</p> <p>E. In interviews during the initial orientation tour on 10/3/11 at 11:50 A.M., Assistant Director of Nursing #4 and R.N. #8 indicated Resident #40 was cognitively impaired, and had experienced some falls.</p> <p>The clinical record for Resident #40 was reviewed on 10/6/11 at 1:55 P.M. Diagnoses included, but were not limited to, senile dementia, C.V.A. [cerebral vascular accident--stroke] with hemiplegia, peripheral vascular disease, and atrial fibrillation with chronic anticoagulation [blood thinning to prevent clots].</p> <p>The October, 2011 physician order recap [recapitulation] sheet listed orders which included, but were not limited to, "9/8/11--Restart Coumadin at 4.5 mg. [milligrams] daily;" "PT./INR. [Prothrombin-Prottime/International Normalized Ratio--blood tests to determine the amount of time it takes for the blood to clot, for people on blood-thinning anticoagulant medications] weekly on Monday."</p> <p>On 8/8/11, the PT. test reported a clotting time of 40.9 (High). The laboratory report indicated the reference range was</p>				

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	<p>18.8-27.5; with "Prottime expected range printed above is the THERAPEUTIC range. The normal range for patients not on an anticoagulant medication is 9.3-11.0." The INR. test reported a results of 3.9 (High); with a reference range of 2.0-3.0. The test results were faxed to the physician on 8/8/11 with a return fax from the physician with an order to "Hold Coumadin times 3 days, repeat PT./INR. in 3 days." On 8/12/11, the PT./INR. test reported values of 16.2/1.5, with a return fax from the physician to restart the Coumadin at the same dose of 4.5 mg. On 8/15/11, the physician increased the dose to 5 mg.</p> <p>A Nurse's Note dated 8/8/11 at 10:00 P.M. indicated "Resident showed this nurse dark brown blood to underwear (small amount). Unable to determine source." There was no documentation to indicate if the resident had been assessed for other signs of bleeding [such as bleeding gums, new bruising, blood in the stool, etc.] A Nurse's Note on 8/9/11 at 6:15 A.M. indicated "Urine obtained per I & O [in and out] cath [catheterization]... No blood in urine or in underwear this shift..." Subsequent notes on 8/12, 8/13, 8/14, 8/15, and 8/29/11 indicated "No blood in urine," or "No blood in underwear." There were no other notes to indicate if the resident had been assessed</p>				

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	<p>for other signs of bleeding.</p> <p>On 9/6/11, the PT./INR. test returned at 58.6 (High)/5.7 (High). The results were faxed to the physician on 9/6/11, with a return fax from the physician with an order to "Hold Coumadin times 3 days, repeat PT./INR. in 3 days." The PT./INR. test on 9/8/11 returned at 34.6 (High)/3.3 (High). The physician was notified by fax on 9/8/11, with a return order to "Restart [Coumadin] at 4.5 mg. daily, PT./INR. in 1 week." The PT./INR. on 9/12/11 was 18.4/1.7</p> <p>The September, 2011 M.A.R. [Medication Administration Record] indicated the Coumadin dose of 5 mg. was held on 9/6, 9/7, and 9/8/11, with a Coumadin dose of 4.5 mg. being given on 9/8/11. The Coumadin medication was held 2 days, instead of 3 days.</p> <p>There were no Nurse's Notes entries from 9/6/11 to 9/12/11 documenting assessment of the resident for any signs of bleeding.</p> <p>On 9/26/11, the PT./INR. test returned at 32.2/3.1. The lab report indicated the physician was faxed on 9/26/11. A return fax/phone call was not found/documentated to indicate how the physician wished to proceed [such as holding the Coumadin,</p>				

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	<p>lowering the dose, etc.]. The September, 2011 M.A.R. indicated the resident continued to receive Coumadin daily from 9/26 to 9/30/11.</p> <p>On 10/3/11, the PT./INR. test returned at 31.9/3.0. The report was faxed to the physician on 10/3/11.</p> <p>There were no Nurse's Notes entries from 9/26/11 to 10/3/11 documenting assessment of the resident for any signs of bleeding.</p> <p>In an interview on 10/7/11 at 1:45 P.M., Assistant Director of Nursing #4 indicated a response from the physician was expected within a couple of hours, following a fax related to PT./INR. levels. If a response had not been received within that time frame, the licensed nurses were expected to call the physician for follow-up.</p> <p>3.1-37(a)</p>				

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>A. Based on observation and interview, the facility failed to ensure foods stored in a unit pantry were dated and labeled with the Resident's name. This affected 1 of 3 unit pantries and the potential to effect 28 of 28 residents on the Orchard Drive unit.</p> <p>B. Based on observation and interview, the facility failed to serve foods at or above 135 degrees Fahrenheit (F). This had the potential to affect 146 of 147 residents who received meals from the facility kitchen.</p> <p>Findings include:</p> <p>A. During the environmental tour with the Director of Maintenance and the Director of House Keeping, on 10/4/11 at 9:00 A.M., the pantry refrigerator on the Orchard Drive unit had a half gallon container of tea and a styrofoam bowl of cottage cheese and fruit. Neither the container of tea or the bowl of cottage cheese and fruit were dated or were labeled with the name of the resident.</p> <p>During an interview with LPN #2, on 10/4/11 at 10:15 A.M., she indicated the</p>	F0371	<p>Corrective Action (F 371): It is the policy of this facility to ensure foods stored in a unit pantry are dated and labeled with the Resident's name. All residents have the potential to be affected by this finding. Nursing staff has been in-serviced on ensuring resident food stored in the unit pantries are dated and labeled with the resident's name. Any staff found to be non-compliant with the points of the in-service will be further educated by nursing administration and/or progressively disciplined as appropriate. The Housekeeping Supervisor or designee will make facility rounds five times weekly to ensure resident food is dated and labeled correctly in all of the unit pantries. Any concerns will be addressed immediately and corrections will be made. These monitoring will continue until there are four consecutive weeks of zero negative findings. Then random monitoring will be done at least weekly. At the Quality Assurance meeting held quarterly, the Housekeeping</p>	11/06/2011	

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	<p>containers should be dated and labeled with the person's name.</p> <p>B. During the Group meeting, on 10/5/11 at 10:00 A.M., 8 residents indicated the food served at the facility was not always hot. [Resident's #'s 200, 201, 202, 203, 204, 205, 206, and 207]</p> <p>A test tray was requested, on 10/6/11 at 11:15 A.M. During observation, the test tray was placed on the cart for the Orchard Drive unit at 11:20 A.M. with the resident food trays. The cart arrived on the Orchard Drive unit at 11:30 A.M. The test tray was the last tray to be removed from the cart at 11:35 A.M.. Food temperatures of the test tray were as follows:</p> <p>Hamburger patties in mushroom gravy: 120 degrees F. This was below the 135 degrees F for the serving temperature of hot foods.</p> <p>During an interview with the Facility Administrator, on 10/6/11 at 3:15 P.M., he indicated the system they had in place should have kept foods at the appropriate serving temperature.</p> <p>3.1-21(i)(2)</p>		<p>Supervisor or designee will review the monitoring of the unit pantries and any negative patterns will be reviewed and addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The administrator will monitor the plan weekly until resolution. It is the policy of this facility to serve resident meals at an acceptable temperature. All residents have the potential to be affected by this finding. Dietary staff has been in-serviced on ensuring meals are prepared at acceptable temperature ranges, proper use of plate heater, proper use of Dinex Smart Therm System, and timely serving of meal trays. Any staff found to be non-compliant with the points of the in-service will be further educated by the Dietary Supervisor and/or progressively disciplined as appropriate. Nursing staff has been in-serviced on timely passing of resident meal trays, ensuring resident meals are at acceptable temperature when passed, and correcting any concerns residents have with meal temperatures. Any staff found to be non-compliant with the points of the in-service will be further educated by Nursing Administration and/or</p>		

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			progressively disciplined as appropriate. The Dietary Supervisor or designee will make rounds three times weekly to ensure resident food is dated and labeled correctly in all of the unit pantries. Any concerns will be addressed immediately and corrections will be made. These monitoring will continue until there are four consecutive weeks of zero negative findings. Then random monitoring will be done at least weekly. At the Quality Assurance meeting held quarterly, the Dietary Supervisor or designee will review the monitoring of resident food temperature and any negative patterns will be reviewed and addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The administrator will monitor the plan weekly until resolution.		

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation and interview, the facility failed to follow-up on a Health Risk assessment, for an employee with a history of a positive Tuberculin skin test. This impacted 1 of 3 employees, with a</p>	F0441	Corrective Action (F441): It is the policy of this facility to follow-up on all Health Risk Assessments for employee with a history of a positive Tuberculin skin test. All	11/06/2011

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	<p>history of positive Tuberculin skin tests, reviewed. [Activities Director]</p> <p>B. Based on observation and interview, the facility failed to ensure a shower head was not left resting on the shower room floor. This impacted 1 of 5 shower rooms and the potential to effect 17 of 18 residents on the Maple Lane unit.</p> <p>Findings include:</p> <p>A. During the review of employee records, on 10/5/11 at 10:00 A.M. the employee record of the Director of Activities' Annual Health Screen for employees with a history of a positive tuberculin skin test, dated 6/27/11, indicated a persistent productive cough lasting up to three weeks. There was no information to indicated a follow-up of the symptom of active tuberculosis was investigated.</p> <p>During an interview with Human Resources #1 , on 10/5/11 at 2:00 P.M., she indicated the Director of Activities had told her she had a cold so the symptom was not investigated.</p> <p>During an interview with the facility Administrator, on 10/7/11 at 9:10 A.M., he indicated the results of the TB skin tests and the Annual Health Screens are</p>		<p>residents who have contact with employees have the potential to be affected by this finding. The Activity Director received a physician statement stated that she has no symptoms of TB and is able to return to work. The Human Resource Director or designee is responsible for tracking and monitoring all employees who must complete annual Health Risk Assessment forms. A new Health Risk Assessment Form was developed to ensure appropriate monitoring of employees with a history of positive Tuberculin skin tests. A licensed nurse will review all health risk assessment forms at time of completion and sign-off on assessment. Per the Health Risk Assessment, any employee who exhibits symptoms of TB will be required to have a physician statement clearing employee to come back to work before being allowed back to work. The Human Resource Director or designee will audit all employees who require an annual Health Risk Assessment to ensure appropriate interventions have been taken. Any Health Risk Assessments not completed accurately will be immediately corrected. At the Quality Assurance meeting held</p>		

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	<p>turned into the department heads for follow-up.</p> <p>B. During the environmental tour with the Director of Maintenance and the Director of House Keeping, on 10/4/11 at 9:00 A.M., one of the shower heads, on the Maple Lane unit, was observed to be resting on the shower stall floor.</p> <p>During an interview with the Director of Housekeeping, on 10/4/11 at 9:45 A.M., she indicated the shower heads were not suppose to be left resting on the shower stall room floors, they should be hung-up on the hooks.</p> <p>3.1-18(b)(2) 3.1-18(k)</p>		<p>quarterly, the Human Resource Director or designee will review the monitoring of Employee Health Risk Assessments and any negative patterns will be reviewed and addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The administrator will monitor the plan weekly until resolution. It is the policy of this facility to ensure all resident shower rooms do not have any shower heads left resting on the shower room floor. All residents who receive showers have the potential to be affected by this finding. The Maintenance Director replaced all shower heads and no shower head is now able to rest on shower floor. Nursing staff and Housekeeping staff has been in-serviced on appropriate placement of shower heads, ensuring shower heads do not rest on shower room floor, and notification to the maintenance department if shower heads are broken. Any staff found to be non-compliant with the points of the in-service will be further educated by Nursing Administration and/or progressively disciplined as appropriate. The Housekeeping Supervisor or designee will</p>		

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F0505 SS=D	<p>The facility must promptly notify the attending physician of the findings.</p> <p>Based on record review and interview, the facility failed to notify the resident's physician of a physician ordered laboratory result. The deficient practice impacted 1 of 2 resident's reviewed from a sample of 24 with a Prothrombin-Protime/International Normalized Ratio [PT/INR] laboratory test drawn. [Resident #94]</p> <p>Findings include:</p>	F0505	<p>make rounds three times weekly to ensure shower heads are not resting on the floor in the shower rooms. Any concerns will be addressed immediately and corrections will be made. These monitoring will continue until there are four consecutive weeks of zero negative findings. Then random monitoring will be done at least weekly. At the Quality Assurance meeting held quarterly, the Housekeeping Director or designee will review the monitoring of shower rooms and any negative patterns will be reviewed and addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The administrator will monitor the plan weekly until resolution.</p> <p>Corrective Action (F505): It is the responsibility of the facility to notify the resident's physician of PT/INR laboratory tests and ensure the physician orders resulting from the laboratory test are timely followed and documented in the resident's medical record. Resident #94 was not negatively affected by this finding. All residents have the potential to be affected by this</p>	11/06/2011	

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	<p>Resident #94's record was reviewed on 10/4/11 at 9:35 A.M. Diagnoses included, but were not limited to, Alzheimer's disease, atrial fibrillation, transient cerebral ischemia, and anxiety.</p> <p>A "Physician's Orders" dated 9/14/11, no time, included, but was not limited to, "Hold Coumadin times 3 days, Re-check PT/INR in 3 days..."</p> <p>Upon review of Resident #94's record, no PT/INR lab result was located in the resident's record for 9/17/11.</p> <p>The "Medication Administration Record" [MAR] dated 9/1/11 included, but was not limited to, "Warfarin Sodium 4 milligram tablet [Coumadin] give 1 tablet by mouth daily..." The doses for dates 9/14/11 to 9/16/11 were marked as "Hold" and not given to the resident. Daily doses were resumed on 9/17/11 per the MAR.</p> <p>In an interview with ADoN #5 on 10/4/11 at 11:00 A.M., she indicated laboratory results get misplaced at times. ADoN #5 was unable to find the PT/INR at that time.</p> <p>On 10/5/11 at 2:30 P.M., ADoN #5 provided a "Duplicate" copy of a PT/INR with the date of 9/17/11 drawn at 5:40</p>		<p>finding. All licensed nursing staff has been in-serviced on PT/INR Lab orders, physician notification and timely response, documentation of physician order per lab results, follow-up labs/fax confirmation, resuming standing orders. Any staff found to be non-compliant with the points of the in-service will be further educated by Nursing Administration and/or progressively disciplined as appropriate. Nursing Administration completed an audit of all current residents who receive Coumadin to ensure that current PT/INR lab orders are correct and physician notification has been completed timely. Nursing Administration or designee will monitor physician notification of lab results including PT/INR's three times weekly to ensure appropriate physician notification and follow-up is completed per the laboratory results. Any concerns will be addressed immediately and corrections will be made. These monitoring will continue until there are four consecutive weeks of zero negative findings. Then random monitoring will be done at least weekly. At the Quality Assurance meeting held quarterly, the Director of</p>		

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	<p>A.M. and delivery date [fax to facility] of 9/17/11 at 7:48 A.M. She indicated the laboratory had sent the results; however, the results were not reviewed by the facility and the physician was not contacted regarding the PT/INR.</p> <p>A document titled "Physician Notification of Laboratory Results" dated 6/10 was received on 10/7/11 at 3:00 P.M. from ADoN #5 included, but was not limited to, "Purpose: To keep the physician informed of laboratory results as ordered by the physician... Procedure: Information should be faxed to the physician's office 7 days per week... within a 2 hour timeframe if not otherwise specified by the physician..."</p> <p>3.1-49(f)(2)</p>		<p>Nursing or designee will review the monitoring of lab results and physician notification. Any negative patterns will be reviewed and addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The administrator will monitor the plan weekly until resolution.</p>		