

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155292	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2016
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NAME OF PROVIDER OR SUPPLIER  AMERICAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN0189818</p> <p>Complaint IN00189818-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 6, 7, 8, 11, 12, 13 &amp; 14, 2016</p> <p>Facility number: 000189 Provider number: 155292 AIM number: 100267330</p> <p>Census bed type: SNF/NF: 140 Residential: 64 Total: 204</p> <p>Census payor type: Medicare: 40 Medicaid: 83 Other: 17 Total: 140</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after February 5, 2015.</p> <p>This provider respectfully requests a face to face IDR for F244, F412 and F441 as we do not agree with the scope and severity of the identified deficiencies.</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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F 0157 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by 30576 on January 22, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or</p>				

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	<p>interested family member.</p> <p>Based on interview and record review, the facility failed to notify the resident's physician of the inability to start and the delay of ordered peripheral IV (intravenous) fluids for 1 of 2 residents reviewed for death and 1 of 3 residents reviewed for pressure ulcers. (Resident #72 &amp; #136)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #72 was reviewed on 1/12/16 at 10:00 a.m. The diagnoses for Resident #72 included, but were not limited to: history of acute embolism and dementia.</p> <p>The 9/30/15, 5:05 p.m., nurses note, written by LPN #11, indicated, "writer enter (sic) res. (resident's) rm. (room) at this time...noted that res was diaphoretic (sweating), increase (sic) respirations at 40. 02 (oxygen) sats (saturation) 94% on rm (room) air. no change noted in res color. res hob (head of bed) elevated slightly. lung sounds clr (clear) throughout at this time. res alert and responding properly to simple questions. res denies pain at this time. no coughing noted. res denies having a hard time breathing at this time. writer also at this time did an (brand name of blood glucose monitoring device) which was 222.</p>			F 0157	<p><b><u>What did we do to correct the deficient practice for each client cited in the deficiency?</u></b> Resident #72 &amp; 136: In-service education completed for nursing staff 2/2/15 on Resident Change of Condition Policy.</p> <p><b><u>How did we review all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected?</u></b> All residents have the potential for the alleged deficient practice. All new IV's Reviewed for timely placement and Physician notification by nursing manager</p> <p><b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b> In-service education initiated 2/2/16 and ongoing with all nursing staff. Nursing Unit Managers to check placement and review documentation for all IV orders.</p> <p><b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b> The Parenteral Therapy/ PICC/ IV</p>		02/05/2016

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	<p>(Name of physician) office called."</p> <p>The 9/30/15, 5:37 p.m., nurses note, written by RN #12, indicated, "Writer assisted unit manager (UM #13) assess resident at time of noted condition change. Lung sounds clear at time of assessment. Respiratory rate elevated. Oxygen saturation 94% on RA (room air). Unit manager attempted to obtain manual BP (blood pressure) in L (left) arm unsuccessfully. Writer unable to obtain manual BP on R (right) arm. Automatic BP obtained. Writer notified MD of change in condition. New orders obtained to draw labs (CBC c (with) diff (differential), CMP (complete metabolic panel), BMP (basic metabolic panel), UA (urinalysis) C&amp;S (culture and sensitivity) in a.m. 10/1/15, start peripheral IV and run 0.45% NS (normal saline) @ 70 mL/hr x 24 hours, check VS (vital signs) Q (every) shift X 72 hours. Resident currently stable. Family notified."</p> <p>The 9/30/15 Physician's Telephone Order indicated to place a peripheral IV at 0.45% NS @ 70 cc/hr for 24 hours. There was no time indicated on the order.</p> <p>The 9/30/15, 7:00 p.m., nurses note, written by LPN #11, indicated, "Resident unalert (sic). Labored breathing noted at this time. Resident BLE (bilateral lower</p>		<p>Line CQI audit tool will be completed weekly x 4 by Director of Nursing or designee and reviewed monthly x 6 by the QA Committee. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in re-education and training of the responsible employee.</p>	

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	<p>extremities) and BUE (bilateral upper extremities) cold to touch. Face warm. 02 sats and temp (temperature) WNL (within normal limits). HR (heart rate) elevated. Family present. POA (Power of Attorney) notified. Will continue to monitor."</p> <p>The 9/30/15, 7:45 p.m., nurses note, written by LPN #11, indicated, "Respirations cease."</p> <p>The clinical record for Resident #72 did not indicate a peripheral IV was started for Resident #72 or that the physician was notified of an IV not being started.</p> <p>An interview was conducted with RN #12 and UM #13 on 1/12/16 at 11:35 a.m. RN #12 indicated she was usually unsuccessful at starting IV's, so she asked LPN #11 to do it, but could not recall if LPN #11 was able to or not. RN #12 indicated she did not inform the physician an IV was not started for Resident #72. UM #13 indicated she did not start an IV for Resident #72, nor did she inform the physician the IV was not started.</p> <p>An interview was conducted with LPN #11 on 1/12/16 at 2:41 p.m. She indicated an IV was not started for Resident #72 on 9/30/15. She indicated a</p>			

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	<p>company was called to place a PICC (peripherally inserted central catheter), but she didn't remember talking to the company. She indicated she did not recall informing the physician that no IV was started for Resident #72.</p> <p>There was no information in the clinical record to indicate a PICC was ordered for Resident #72.</p> <p>The 10/1/15 Physician Progress Note indicated Resident #72's death was possibly related to DVT (deep vein thrombosis).</p> <p>An interview was conducted with the DON (Director of Nursing) on 1/12/16 at 3:09 p.m. She indicated she would expect to see documentation in the clinical record of nursing's inability to start an IV and for nursing to call the physician for a PICC order.</p> <p>An interview was conducted with the DON on 1/12/16 at 4:15 p.m. She indicated she expected the physician to be notified within 60 minutes of the inability to start an ordered IV for a resident.</p> <p>The Resident Change of Condition policy, revised January, 2015, was provided by the DON on 1/12/15 at 4:15</p>			

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	<p>p.m. It indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place."</p> <p>2.) The clinical record for Resident #136 was reviewed on 1/13/16 at 10:00 a.m. The diagnosis for Resident #136 included, but was not limited to orthostatic hypotension.</p> <p>An event report dated, 1/12/16, indicated Resident #136's blood pressure, heart rate, and respirations were the following:</p> <p>12:30 p.m., blood pressure: 81/60, heart rate: 85, respirations: 30, 12:50 p.m., blood pressure: 70/60, heart rate: 88, respirations: 28, 1:00 p.m., blood pressure: 69/51, heart rate: 90, respirations: 30, 1:55 p.m., blood pressure: 101/79, heart rate: 96, respirations: 28</p> <p>A physician order dated, 1/12/16 p.m., indicated the staff was to obtain a CBC (complete blood count) and BMP (basic metabolic profile) blood draw as soon as possible, encourage Resident #136 to drink fluids, check her vitals (blood pressure, heart rate, respirations, temperatures) every 4 hours for 12 hours, and hold Resident #136's klonopin if she</p>			

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	<p>is lethargic.</p> <p>A progress note, date 1/12/16 at 12:31 p.m., indicated "res (resident) was observed to be unresponsive in dining room. obtained res bp (blood pressure) was 81/60, 85 (heart rate), 30 (respirations), 99% (oxygen saturations) on ra (room air) and 98.8 (temperature). res was layed back down with legs elevated to assist with elevating bp. lungs clear x (times)5 lobes a&amp;p (anterior and posterior). called and spoke with oncall nurse (name of nurse) in regards to post form. received new orders for stat (as soon as possible) cbc and bmp. attempted to notify poa (power of attorney) to see how much treatment they are wanting but had to leave a message. bmp and cbc obtained".</p> <p>A progress note, dated 1/12/16 at 12:58 p.m., indicated "res became responsive as soon as she was layed in bed. cont to keep legs elevated and bp cont (continues) to stay low. poa phoned back and stated to go ahead with current orders and ok for iv therapy if needed. (name of lab facility) notified to pick up blood specimen. rephoning on call np (nurse practitioner) at this time, awaiting return call. last bp 70/60. res cont.(sic) to be responsive...no distress noted at this time".</p>			

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	<p>A physician order dated, 1/12/16 p.m., indicated the staff was to start normal saline IV fluids at 125 milliliters/hour, administer continuous oxygen at 2 liters, and check Resident #136's oxygen saturations every shift.</p> <p>A progress note, dated 1/12/16 at 1:33 p.m., indicated "attempted to initiate a peripheral IV on left forearm per MD (physician) order, but was not successful. changed the site and attempted on the right forearm without success, contacted the (name of company) for an IV nurse to introduce a peripheral IV".</p> <p>An interview was conducted with LPN #7 at 1/12/16 at 3:20 p.m. She indicated she had not at this time notified the physician she was unable to start an IV. It would be later this evening before the IV nurse would be in to start Resident #136's IV.</p> <p>A progress note, dated, 1/12/16 at 3:36 p.m., indicated "awaiting return call from np in regards to not being able to start ivf (fluids through an IV)".</p> <p>A progress note, dated, 1/12/16 at 4:13 p.m., "spoke with on call np in regards to unable to start a piv (IV)...np wants to cont. (continue) with current orders and</p>			

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F 0226 SS=D Bldg. 00	<p>is aware of (name of IV company) coming out to start piv".</p> <p>An interview was conducted with the Director of Nursing on 1/12/16 at 4:17 p.m. She indicated her expectations were for the staff to notify the physician within 60 minutes if they are unable to start an IV.</p> <p>3.1-5(a)(3)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure staff members received annual abuse inservice education timely for 2 of 11 staff members reviewed for abuse inservice education. (RN #23 and Dietary Aide #24)</p> <p>Findings include:</p> <p>The Employee Records for RN #23 and Dietary Aide #24 were reviewed on 1/14/16 at 9:30 a.m. The Employee Records form indicated RN #23's start</p>	F 0226	<p>RN#23and Dietary Aide #24 <b><u>Whatdid we do to correct the deficient practice for each client cited in thedeficiency?</u></b> RN#23 PRN Staff Member removed from schedule,awaiting availability for staff member to complete required in-services. Dietary Aide#24 In-service education completed onabuse policy. <b><u>Howdid we review all clients in the facility that could be affected by the samedeficient practice, and state, what actions the facility took to correct thedeficient practice for any client the</u></b></p>	02/05/2016

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	<p>date was 12/10/12 and Dietary Aide #24's start date was 10/6/08.</p> <p>The employee personnel files indicated the last annual abuse training for RN #23 was 9/28/14 and Dietary Aide #24's last annual abuse training was 2/28/14.</p> <p>During an interview with the Clinical Educator Coordinator (CEC), on 1/14/16 at 10:27 a.m., the CEC indicated RN #23 and Dietary Aide #24 did not complete annual abuse training since the dates listed above.</p> <p>The New Punch Detail Report received from the Clinical Educator Coordinator, on 1/14/16 at 1:29 p.m., indicated RN #23 worked 389 hours and Dietary Aide #24 worked 1,659 hours since February 1, 2015.</p> <p>A policy titled, Abuse Prohibition Reporting, and Investigation Policy and Procedure, dated 7/2015, was received from the Administrator on 1/6/16 at 12:06 p.m. The policy indicated, "...3. Employees whether direct care, contract staff, ancillary departments, volunteers, or consultants receive instruction/training on abuse during orientation and periodically during ongoing service education..."</p>		<p><b><u>facility identified as being affected?</u></b> All employee files reviewed. New Hire in-service complete upon orientation on abuse policy. All staff members not in compliance provided with in-service education on abuse policy or removed from schedule until completion.</p> <p><b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b> Compliance Report Generated and reviewed weekly by staff development coordinator and Administrator on required in-services. In-services to be offered and provided monthly online and live by Staff Development Coordinator.</p> <p><b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b> Compliance Report Generated and reviewed weekly by staff development coordinator and Administrator on required in-services. In-services to be provided monthly online and live by Staff Development Coordinator.</p>				

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F 0242 SS=D Bldg. 00	<p>A policy titled, Educational Inservices and Training, dated 10/2015, was received from the CEC, on 1/14/15 at 1:29 p.m. The policy indicated, "...The facility must provide the following State required in-service programs annually i. Understanding Abuse &amp; Neglect...iii. Elder Justice Act..."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident/family's preferences for daily showers and dress in street clothes were honored for 1 of 1 residents reviewed for choices and dignity. (Resident #230)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident #230 was reviewed on 1/12/16 at 2:30 a.m. The diagnoses for Resident #230 included, but were not limited to, traumatic subdural hemorrhage, dementia</p>	F 0242	<p><b><u>Whatdid we do to correct the deficient practice for each client cited in thedeficiency?</u></b> Preferences for Daily Customary Routines Formcompleted for resident #230 indicating residents preference for bathing. Shower schedule updated by nursing toaccommodate resident preference.</p> <p><b><u>Howdid we review all clients in the facility that could be affected by the samedeficient practice, and state, what actions the facility took to correct thedeficient practice for any client the facility identified</u></b></p>	02/05/2016
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	<p>without behavioral disturbances, and hypertension.</p> <p>During an interview with Family Member #18, on 1/7/16 at 2:45 p.m., Family Member #18 indicated her brother's preference would be to have a complete bed bath or shower daily. Family Member #18 further indicated no one at the facility had asked what her brother's preference for bathing would be.</p> <p>During an interview with CNA #20, on 1/12/16 at 2:36 p.m., CNA #20 indicated Resident #30 scheduled shower days were Tuesday and Friday.</p> <p>During an interview with Unit Manager (UM) #13, on 1/12/16 at 2:52 p.m., UM #13 indicated bathing preferences were asked of each resident at admission, during the admission assessment. UM #13 further indicated if a resident was not able to voice their preferences, bathing recommendations were reported to family members/POA (power of attorney) and the family member/POA could change the recommendations if they desired. UM #13 also indicated the facility documented given/attempted showers on Shower Reports.</p> <p>Admission Assessments dated 11/18/15 and 1/6/16 indicated no preferences for</p>		<p><b><u>as being affected?</u></b> Preferences for Daily Customary Routines Formreviewed for all residents to ensure preferences were indicated by ActivityStaff. <b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b> Activities Assistant and Unit Manager to review Preferences for Daily Customary Routine Binder Weekly to ensure resident preferences are communicated and updated. <b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put in place?</u></b> Activity CQI audit tool will be completed monthly x6 months by Activity Director or designee. CQI reviewed monthly x6 by the QA Committee if a 95% threshold is not achieved an action plan will be developed.</p>	

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	<p>bathing.</p> <p>On 1/13/16 at 9:45 a.m., Activity Assistant (AA) #19, indicated when a resident was admitted to the facility she will interview a Resident/Responsible Party and fill out a Preferences for Daily Customary Routines document that indicated how often a resident would prefer to be bathed and when. AA #19 further indicated she just interviewed Family Member #18 and filled out Resident #230's Preference sheet the previous day and the document indicated that daily showers were Resident #230's preference. AA #19 also indicated after she filled out the Preference sheet, she would put the document in a binder at the nurse's desk. She then tells the Nursing staff that the document was placed in the binder and then it was up to Nursing to update shower schedules as needed, for the Resident's preference. AA #19 indicated she will look for Resident #230's previous Preference sheet before he was discharged, as she removed the previous Preference sheet when Resident #230 went out to the hospital.</p> <p>At 12:15 p.m., on 1/13/16, AA #19 indicated she was unable to locate Resident #230's previous Preference sheet (prior to his hospital discharge), but she remembered that Resident #230</p>			
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	<p>wanted to have a daily shower in the morning, just as the family requested with the newest Preference sheet. AA #19 further indicated Resident #230 was able to answer the Preferences for Daily Customary Routines when she previously did the interview, when he was initially admitted.</p> <p>During an interview with the Director of Nursing (DON), on 1/13/16 at 12:20 p.m., the DON indicated Activities fill out a Preference sheet and Nursing was to update the shower schedule to accommodate the Preference.</p> <p>A review of the Shower Reports indicated Resident #230 received the following showers/bed baths since his initial admit on 11/18/15 to his discharge to the hospital on 12/23/15 and his readmittance on 1/6/16.</p> <p>11/18/15 complete bed bath 11/28/15 refused shower 12/2/15 bed bath 12/5/15 complete bed bath 12/9/15 complete bed bath 12/12/15 bed bath, refused shower 12/16/15 complete bed bath 12/19/15 bed bath, 1/8/16 bed bath.</p> <p>On 1/13/15 at 12:40 p.m., UM #13, with the DON, indicated all the Shower</p>			

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	<p>Reports listed above were the only bed baths/showers given to Resident #30, because the facility thought Resident #230 only wanted 2 showers a week.</p> <p>1b. During the following observations, Resident #230 was observed in a hospital gown, laying in bed: 01/07/16 at 02:51 p.m., 01/08/16 at 10:15 a.m., 01/08/16 at 11:08 a.m., 01/08/16 at 2:40 p.m., 01/11/16 at 10:45 a.m., 11/12/16 at 10:30 a.m., 01/12/16 at 2:23 p.m.</p> <p>During an observation on 1/12/16 at 2:30 p.m., with LPN #22, several shirts and pants were observed in Resident #230's closet. LPN #22 indicated she was unsure why Resident #230 was dressed in hospital gown.</p> <p>On 1/12/16 at 2:35 p.m., CNA #20 indicated she works evenings and Resident #230 has been dressed in a hospital gown the last couple of times she has worked in the evenings.</p> <p>At 2:38 p.m., UM #13 indicated Residents were expected to be dressed in street clothes unless they had a preference to wear a hospital gown and Resident #230 did not have a preference for a</p>			

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F 0244 SS=E Bldg. 00	<p>hospital gown.</p> <p>During an interview with the Director of Nursing (DON), on 1/12/16 at 3:14 p.m., the DON indicated Residents were expected to be dressed in street clothes after breakfast unless a Resident had a preference to dress in a hospital gown.</p> <p>During an interview with Family Member #18, at 1:43 p.m. on 1/13/16, Family Member #18 indicated she preferred for Resident #230 to be dressed in his own clothes.</p> <p>A document titled, Resident Rights, no date, was received from the Director of Nursing on 1/13/16 at 11:19 a.m. The document indicated, "Nursing home residents have certain rights and protections under the law....These resident rights include, but aren't limited to:...The right to have a choice over your schedule (for example, when you get up and go to sleep), your activities and other preferences that are important to you..."</p> <p>3.1-3(v)(1)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of</p>			
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	<p>residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to implement an effective plan for the identified grievance of a noisy dining room for 2 of 3 months of the Resident Council minutes reviewed. This had the potential to impact 47 or 47 residents who dined in the main dining room. (November and December, 2015).</p> <p>Findings include:</p> <p>On 1/7/16 at 11:52 a.m., during an interview Resident #3 indicated the dining room was noisy at times.</p> <p>On 1/12/16 at 1:00 p.m., during an interview the Activity Director indicated she had suggested meal managers to assist in controlling the noise in the dining room. She indicated the Administrative staff would meet 4 times a week on each unit at different times of the day to reach all the staff members to address issues or concerns with residents or staff. She indicated these meetings were called "gimba" which meant in Japanese or Chinese "huddle." She indicated there was no formal written topic but would include the Resident Council grievances/concerns. She also</p>	F 0244	<p>This provider respectfully requests a face to faceIDR for deficiency F244 as we do not agree with the scope and severity of the identifieddeficiencies.</p> <p><b><u>Whatdid we do to correct the deficient practice for each client cited in thedeficiency?</u></b> Follow up conducted by Facility Administrator withresident council president and committee about suggestions and concerns broughtup during resident council. Additional managers added to dining room during mealtimes. Consult with sound engineer for dining room noise. Residents bothered by noise offered differentseating placement in dining room. <b><u>Howdid we review all clients in the facility that could be affected by the samedeficient practice, and state, what actions the facility took to correct thedeficient practice for any client the facility identified as being affected?</u></b> All resident s that dine in the Main Dining Roomcompleted QIS interview on noise levels. Management continues do customer carerounds to take any resident concerns. <b><u>Describe the steps or systemic changes the facility has made or will make to ensure thatthe deficient practice does not recur.</u></b></p>	02/05/2016

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	<p>indicated she had been a manager in the dining room recently and had to close the kitchen door due to the noise from the kitchen. She also indicated the meal managers had helped the noise in the dining room.</p> <p>On 1/12/16 at 3:00 p.m., the Resident Council Minutes were reviewed. The Resident Council minutes, dated 11/19/15, indicated after the meeting was opened the new business was the noise level in the dining room and the food temperatures were discussed. The residents attending indicated in general "things have improved." There was no "Resident Council Meeting Follow Up" from the 11/2015 meeting concerns. The Resident Council minutes, dated 12/10/15, indicated the meeting was opened with discussion about the dining room. The residents indicated the noise level was too loud and staff would not always address the residents requests for drinks. Also, the staff would carry personal conversations among themselves while serving. The "Resident Council Meeting Follow Up" form, dated 12/10/15, indicated the residents concern about the noise level in the dining room. The "Action Taken:" was a review with the CNA's during gimba concerning voices that would carry due to the size of the room and to</p>		<p><b><u>including any in-services, but this alsoshould include any system changes you made.</u></b> Activity Director, Administrator and department responsible for concerns brought up during resident council to meet week of resident council meeting and develop action plan to follow up on resident concerns. <b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b> Ongoing, Resident Council Minutes and follow up to be reviewed monthly during QA meeting.</p>	

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	<p>"promptly" meet all residents requests during the meal service. Unit managers and charge nurses were also indicated to be educated.</p> <p>On 1/12/16 at 11:51 a.m., during an interview the Resident Council President (Resident #153) indicated the noise level in the dining room remained a problem. She indicated the staff would continue to talk amongst themselves as meal trays were delivered and would not acknowledge the resident. Resident #153 also indicated because of the staff talking to each other, the residents would not always know if any of their requests would be heard.</p> <p>On 1/13/16 at 2:55 p.m., during an interview the Administrator indicated he did receive the Resident Council meeting minutes, but he did not always go "line by line" to review the issues communicated in the meeting minutes.</p> <p>On 1/14/16 at 9:15 a.m., during an interview Resident #114 indicated the main dining room was frequently noisy due to staff.</p> <p>The policy "Resident Council", dated 3/2012, was received from the Director of Nursing, on 1/12/16 at 2:12 p.m. The policy indicated the following:</p>			

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F 0246 SS=D Bldg. 00	<p>"Policy: The facility will promote and support the residents' right to participate and organize resident council. The council will be used to communicate concerns, give suggestions for future programming and events, and otherwise participate in and guide facility life. Procedure: ...6. Concerns or suggestions from the meeting will be addressed by the appropriate department. The Executive Director will review all minutes and concerns. 7. The facility responses to concerns/suggestions will be reviewed by the Resident Council President and the resident council on their next meeting."</p> <p>3.1-3(l)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure a resident's call light was within reach, as care planned, for 1 of 40 residents observed for call light location. (Resident #14)</p> <p>Findings include:</p>	F 0246	<p><b><u>What did we do to correct the deficient practice for each client cited in the deficiency?</u></b> Resident#114 call light placed within reach. Initiated nursing staff in-service 2/2/16 on call light placement and accessibility. <b><u>How did we review all clients in the facility that could be</u></b></p>	02/05/2016

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	<p>The clinical record for Resident #14 was reviewed on 1/13/16 at 2:00 p.m. The diagnoses for Resident #14 included, but were not limited to: history of falls and impaired vision.</p> <p>The 12/16/15 MDS (minimum data set) assessment indicated Resident #14 required extensive assistance of 2 persons for transferring, extensive assistance of 1 person for locomotion on and off the unit, and locomotion in her room did not occur.</p> <p>The 12/22/15 visual function care plan indicated Resident #14 had impaired vision and to keep her call light in reach at all times.</p> <p>The 12/3/15 falls care plan indicated Resident #14 was at risk for falls with a goal of reducing fall risk factors in an attempt to avoid significant fall related injury An approach was for her call light to be in reach.</p> <p>The 12/3/15 self care deficit care plan indicated Resident #14 was a 2 person assist with transfers.</p> <p>The 12/20/15 Fall Event for Resident #14 indicated she had an unwitnessed fall and was sitting in her wheel chair prior to the</p>		<p><b><u>affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected?</u></b></p> <p>All residents have the potential for the alleged deficient practice. Unit Managers and charge nurses conducted several rounds on unit to ensure call lights are within reach for all residents.</p> <p><b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b></p> <p>Ensuring Call Lights within reach added to Customer Care Rounds Sheet.</p> <p>Customer Care Rounds-Where representatives from other departments in the facility check on their assigned residents on assigned focuses daily for the week.</p> <p><b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b></p> <p>Call Light CQI audit tool will be completed monthly x 6 months by Director of Nursing or designee. CQI reviewed monthly x 6 by the QA Committee if a 95% threshold is not achieved an action plan will be developed.</p>	

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	<p>fall. She was observed sitting on the floor, in her room, next to her bed, with her knees slightly bent, with her feet flat on the floor and her back upright. It indicated Resident #14 was attempting to transfer herself into bed at the time of the fall.</p> <p>An observation of Resident #14 sitting in her wheel chair was made on 1/7/16 at 10:17 a.m. Her call light was wrapped around her bed, not within her reach. Resident #14 indicated she used her call light when she could.</p> <p>An environmental tour of the facility was conducted with the Administrator on 1/13/16 at 2:10 p.m. Resident #14 was sitting in her wheel chair in her room. Her call light was on the far side of her bed, not within reach.</p> <p>An observation of Resident #14 was made with UM (Unit Manager) #17 on 1/13/16 at 2:20 p.m. Resident #14 and her call light were in the same locations as the 1/13/15, 2:10 p.m. observation with the Administrator. Resident #14 indicated she could not reach her call light because of the floor mat next to her bed. Resident #14 unsuccessfully attempted to roll over the floor mat to reach her call light. UM #17 retrieved the call light for Resident #14 and handed</p>			

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F 0278	<p>it to her.</p> <p>An interview was conducted with CNA #10 on 1/14/16 at 9:50 a.m. He indicated Resident #14 usually used her call light to ask for assistance and required assistance to transfer.</p> <p>An observation of Resident #14 was made with CNA #10 on 1/14/16 at 9:55 a.m. Resident #14 was sitting in her wheel chair eating breakfast. Her call light was on the bedside table behind her, not within her reach. CNA #10 retrieved the call light from the bedside table behind and handed it to Resident #14.</p> <p>An interview was conducted with CNA #9 on 1/14/16 at 9:58 a.m. He indicated he just assisted Resident #14 from the restroom and forgot to give her her call light.</p> <p>An interview was conducted with the Social Services Director on 1/14/1 at 11:10 a.m. She indicated there was no facility policy regarding call lights within reach.</p> <p>3.1-3(v)(1)</p> <p>483.20(g) - (j)</p>			

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SS=A Bldg. 00	<p><b>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b> The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure accuracy of the MDS (minimum data set) assessments regarding an explicit terminal prognosis, wandering to a dangerous place and urinary incontinence for 3 of 15 residents reviewed for MDS accuracy. (Residents #120, #218, #118)</p>	F 0278	<p><b><u>What did we do to correct the deficient practice for each client cited in the deficiency?</u></b> Resident#120, 218,118 records modified or updated for proper coding. <b><u>How did we review all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice</u></b></p>	02/05/2016

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	<p>Findings include:</p> <p>1. The clinical record for Resident #120 was reviewed on 1/7/16 at 10:30 a.m. The 11/5/15 MDS Admission assessment indicated Resident #120's wandering placed him at significant risk of getting to a potentially dangerous place.</p> <p>The 11/2/15 elopement risk assessment for Resident #120 indicated he was at risk for eloping from the facility, but had no history of elopement.</p> <p>There was no information in the clinical record indicating resident #120 wandered to a dangerous place (e.g., outside the facility or into the room of another resident with dementia who was known to become physically aggressive toward intruders).</p> <p>An interview was conducted with LPN #7 on 1/12/16 at 10:46 a.m. She indicated she'd seen Resident #120 walk down the halls, but never saw him wander into other resident rooms, nor had she ever heard of him doing that.</p> <p>An interview was conducted with SSA (Social Services Assistant) #6 on 1/12/16 at 11:28 a.m. She indicated she coded Resident #120's MDS as at significant risk of getting to a potentially dangerous</p>		<p><b><u>for any client the facility identified as being affected?</u></b> All residents have the potential for the alleged deficient practice. Hospice residents and bowel and bladder of current residents reviewed for accuracy and coding. <b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b> Social Service Assistant provided in-service education on proper coding and documentation for wandering residents. <b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b> The Assessment audit tool will be completed by MDSCoordinator or designee. The Assessments CQI audit tool to be reviewed monthly by the CQI Committee for six months after which the CQI Committee will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Director of Nursing services/Consultant to conduct random audits to ensure MDS Coordinator is accurately completing the MDS Assessments.</p>	

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	<p>place because he wandered off his locked unit, but never outside.</p> <p>An interview was conducted with SSA #6 on 1/12/16 at 11:34 a.m. She indicated she spoke with her supervisor and was told she was not to code a resident at risk for getting to a potentially dangerous place unless the resident actually got outside or to another dangerous place.</p> <p>Section E1000 of the RAI (Resident Assessment Instrument) was provided by the DON on 1/13/16 at 3:05 p.m. It indicated, "Code 1, yes: if the wandering places the resident at significant risk of getting to a dangerous place (e.g., wandering outside the facility where there is heavy traffic) or encountering a dangerous situation (e.g. wandering into the room of another resident with dementia who is known to become physically aggressive toward intruders)."</p> <p>2. The clinical record for Resident #218 was reviewed on 1/8/16 at 10:31 a.m. The diagnoses for Resident #218 included, but were not limited to: cancer.</p> <p>Section J of the 10/1/15 Admission MDS for Resident #218, completed by MDS Assistant #8 on 10/2/15, indicated he did not have an explicit terminal prognosis.</p>			

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	<p>The 9/29/15 MD progress note indicated Resident #218 had neuroendocrine cancer with no further chemotherapy and required palliative care.</p> <p>The 10/1/15 Physician's Telephone Order indicated to admit Resident #218 to hospice effective 10/1/15.</p> <p>The 10/1/15, 12:25 p.m., IDT (interdisciplinary team) note indicated Resident #218 was being discharged with hospice due to rapid decline and family wanted him home at time of passing.</p> <p>The 10/1/15, 3:18 p.m., social services note indicated Resident #218's spouse reported that she was considering keeping Resident #218 at the facility due to fear he would pass during the transport home and she wanted him to remain comfortable.</p> <p>The 10/01/15 3:47 p.m., Social Services note indicated Resident #218's spouse informed that she elected to keep Resident #218 at the facility and continue with hospice services at this time.</p> <p>The 10/1/15, 6:55 p.m., nurses note indicated, "Respirations cease. Wife and family at bedside. (Name of hospice company) RN and on-call mgr (manager) notified."</p>			

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	<p>The 10/1/15 Hospice discharge summary indicated, An admission nurse tended to this patient today and a skilled hospice nurse attended to the death of this patient this evening. Communications were sent, body was cleaned. Family comforted."</p> <p>An interview was conducted with the MDS Coordinator on 1/11/16 12:23 p.m. She indicated the MDS would be coded a resident has an explicit terminal prognosis if a resident was on hospice. She indicated Resident #218 passed away on 10/1/15, and section J of the MDS was completed on 10/2/15. She indicated Section J1400 should have said yes to an explicit terminal prognosis and section O should have been marked hospice, especially since it was completed on 10/2/15, after Resident #218's passing. She indicated she signed off on the MDS on 10/5/15 and should have caught it.</p> <p>Section J of the RAI (Resident Assessment Instrument) was provided by the MDS Coordinator on 1/11/16 at 1:20 p.m. It indicated, "Code 1 yes: if the medical record includes physician documentation 1) that the resident is terminally ill; or 2) the resident is receiving hospice services." 3. The clinical record for Resident #118 was reviewed on 1/13/16 at 10:00 a.m.</p>			

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	<p>The diagnosis for Resident #118 included, but was not limited to chronic kidney disease.</p> <p>A quarterly minimum data set (MDS) dated, 12/1/15, indicated Resident #118's urinary incontinence was coded with a number zero (always continent).</p> <p>A care plan dated, 1/23/14, indicated Resident #118 was incontinent with bladder.</p> <p>An interview was conducted with certified nursing assistant (CNA) #16 on 1/13/16 at 10:00 a.m. She indicated Resident #118 was incontinent all the time.</p> <p>An observation of incontinent care with Resident #118 was made on 1/13/16 at 10:56 a.m. CNA #16 and CNA #21 provided privacy and washed their hands. CNA #16 removed soiled brief and washed her hands. CNA #16 used a wet cloth to provide peri-care to Resident #118. CNA #21 and CNA #16 dried the resident and then placed a clean brief on Resident #118.</p> <p>An interview was conducted with CNA #14 on 1/13/16 at 1:58 p.m. She indicated Resident #118 was always incontinent during her care.</p> <p>An interview was conducted with MDS coordinator #15 on 1/13/16 at 2:38 p.m.</p>			

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F 0282 SS=D Bldg. 00	<p>She indicated Resident #118's urinary continence was entered incorrectly.</p> <p>A MDS coding instruction for urinary continence was provided by the Director of Nursing on 1/13/16 at 3:00 p.m. It indicated, "Coding Instructions Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence. Code 1, occasionally incontinent:...Code 2, frequently incontinent:..., Code 3, always incontinent:..., Code 9:, not rated:..."</p> <p>3.1-31(g)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician orders for insulin coverage were followed correctly based on blood sugar results for 1 of 5 residents reviewed for unnecessary medications. (Resident #234)</p> <p>Findings include:</p> <p>Resident #234's clinical record was reviewed on 01/11/2016 at 10:46 a.m.,</p>	F 0282	<p><b><u>What did we do to correct the deficient practice for each client cited in the deficiency?</u></b> Resident #234 Initiated in-service 2/3/16 on sliding scale insulin and following MD orders. Education and disciplinary action provided to nurses who administered improper dose of sliding scale insulin. <b><u>How did we review all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility</u></b></p>	02/05/2016

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	<p>The resident's diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus type 2, progressive dementia and hypertension.</p> <p>The physician orders, dated 11/25/2015, included but were not limited to: Lantus 100 units/ml amt 10 units subcutaneous daily. Novolog (insulin aspart) per sliding scale: blood sugar less than 70, call MD blood sugar (BS) BS 121-150 give 2 units, BS 151-200 give 3 units BS 201-250 give 4 units BS 251-300 give 5 units BS 301-350 give 6 units BS 351-400 give 7 units if BS is greater than 400, call MD (Name brand of blood glucose machine) four times daily.</p> <p>The insulin coverage discrepancies were as follows: 11/27/15 at 9 p.m., result 151-given 2 units (should be 3) 12/1/15 at 5 p.m., result 226-given 6 units (should be 4 units) 12/14/15 at 12 p.m., result 256-given 4 units (should be 5 units) 12/15/15 at 9 p.m., result 300-given 6 units (should be 5 units) 12/19/15 at 12 p.m., result 123-given zero units (should be 2 units)</p>		<p><b><u>took to correct the deficient practice for any client the facility identified as being affected?</u></b> All residents with order for sliding scale insulin reviewed by Unit Managers for proper insulin dose administration. <b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b> Staff Development Coordinator Initiated in-service 2/3/16 with nursing staff on sliding scale insulin and following MD orders. <b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b> Ongoing, Unit Manager/ Designee to review resident on sliding scale utilizing monthly medication error CQI Tool weekly x 4 then bi monthly x 6 months for proper administration dose. CQI tool to be reviewed by QA Committee. If 95% threshold is not achieved an action plan will be developed by Director of Nursing Services.</p>	

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	<p>12/25/15 at 12 p.m., result 167-no coverage given.</p> <p>01/03/16 at 12 p.m., result 155-2 units given (should be 3 units).</p> <p>On 1/12/16 at 3:29 p.m., during an interview with the Unit Manager #40, she confirmed the above blood sugar and insulin coverage discrepancies for the dates of: 11/27/15, 12/1/15, 12/14/15, 12/15/15, 12/19/15 and 12/25/15.</p> <p>On 01/12/16 at 3:30 p.m., a request for the policy and procedure for and related to insulin coverage and hypo/hyperglycemia was requested from the Director of Nursing (DON).</p> <p>On 01/13/16 at 9:00 a.m., during an interview with the DON, she did not have a policy/procedure regarding hypo/hyperglycemia and insulin coverage. However, she indicated they had a skills validation checklist for medication pass and subcutaneous injections.</p> <p>On 1/14/16, 11:00 a.m., the Clinical Educator Coordinator indicated it was the expectation that Nursing follow Physician's Orders as written.</p> <p>3.1-35(g)(2)</p>			

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F 0412 SS=D Bldg. 00	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to follow up with a dental referral for teeth extraction for 1 of 3 residents reviewed for dental status and services. (Resident #7)</p> <p>Findings include:</p> <p>The clinical record for Resident #7 was reviewed on 1/13/15 at 9:50 a.m. The diagnoses for Resident #7 included, but were not limited to: dementia.</p> <p>An observation of Resident #7's oral cavity was made on 1/7/16 at 3:43 p.m. She was missing some teeth on top and bottom. Resident #7 indicated she was missing most of her teeth and would like dentures, but staff were not taking care of this to her satisfaction.</p> <p>The 12/30/15 Quarterly MDS (minimum</p>	F 0412	<p>This provider respectfully requests a face to face IDR for deficiency F412 as we do not agree with the scope and severity of the identified deficiency.</p> <p><b><u>What did we do to correct the deficient practice for each client cited in the deficiency?</u></b> Resident #7 was referred to oral surgeon and appointment scheduled.</p> <p><b><u>How did we review all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected?</u></b> Full facility audit conducted of all residents receiving dental services to ensure no referrals were left without follow up. 2/3/16</p> <p><b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any</u></b></p>	02/05/2016

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	<p>data set) assessment for Resident #7 indicated she required extensive assistance of one person for personal hygiene.</p> <p>The 9/10/15 ancillary services care plan indicated Resident #7 consented to be seen for dental services, with a goal for her to be seen by ancillary services.</p> <p>The 3/18/15 Ancillary Services consent form was located in the clinical record for Resident #7 and included consent for dental services.</p> <p>The 5/8/15 comprehensive dental exam for Resident #7 indicated, "referral written for oms (oral maxillofacial surgery) for extractions of 23, 24, 26, 27, patient has some tenderness and patient states she would like to be sedated to have teeth extracted."</p> <p>The 5/8/15 Oral Surgery Referral for Resident #7 indicated teeth 23, 24, 26, and 27 were to be evaluated for extraction.</p> <p>There was no information in the clinical record to indicate Resident #7's teeth were extracted or follow up was done regarding the 5/8/15 extraction referral.</p> <p>An observation of Resident #7's oral</p>		<p><b><u>in-services, but this also should include any system changes you made.</u></b></p> <p>Meeting scheduled with dental service provider 2/10/16 to develop plan and solution for how referrals are left with facility.</p> <p><b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b></p> <p>The Dental CQI audit tool will be completed by Social Service Director or designee. The Dental CQI audit tool to be reviewed monthly by the CQI Committee for six months after which the CQI Committee will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</p>				

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	<p>cavity was made with the SSD (Social Services Director) on 1/14/16 at 9:30 a.m. Resident #7 indicated "yes and no" to whether her teeth bothered her.</p> <p>The 5/11/15 social services note was reviewed with the SSD immediately following observation of Resident #7's oral cavity. It indicated, "Resident seen by (name of dental provider) on 5/8/15. SS (social services) will continue to provide services and will make referrals as needed." After reviewing the 5/11/15 social services note, the SSD indicated it looked like the referral for teeth extraction was not acknowledged by the social services department on 5/11/15.</p> <p>An interview was conducted with the SSD on 1/14/16 at 12:19 p.m. She indicated an appointment would be scheduled for Resident #7's teeth extractions.</p> <p>The Dental Services policy, revised January, 2006, was provided by the SSD on 1/14/16 at 12:35 p.m. It indicated, "The facility provides dental services to meet the oral health needs of each resident."</p> <p>3.1-24(a)(1)</p>			

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F 0441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <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>Based on observation, interview and record review, the facility failed to ensure</p>	F 0441	This provider respectfully requests a face to face IDR for	02/05/2016	

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	<p>infections control practices were followed during handwashing for 2 of 10 staff members observed and with linen handling for 4 of 4 observations of the distribution of personal clothing. This had the potential to affect 47 of 47 residents who dined in the main dining room and 32 of 32 residents who resided in the Memory Care Unit.</p> <p>Findings include:</p> <p>1. On 01/11/2016 at 9:50 a.m., LPN #1 was observed obtaining a container of lip balm from a uniform pocket and applying the balm to her lips with her finger. Next, she removed mints from her uniform pocket, opened the container and placed a mint in her mouth. After returning her mints to her pocket, she was observed to handwash for 11 seconds. She returned to the medication cart and began to prepare Resident #116's oral medications.</p> <p>On 01/11/2016 at 12:35 p.m., during meal service in the main dining room, LPN #2 was observed to transport Resident #79 to the assist feeding table. She repositioned Resident #79 in her Broda chair and was observed to use hand sanitizer. She was then observed to walk into the common area and retrieve Resident #109 and then positioned the resident at dining table followed by use</p>		<p>deficiency F441 as we do not agree with the scope and severity of the identified deficiency.</p> <p><b><u>What did we do to correct the deficient practice for each client cited in the deficiency?</u></b> In-service education conducted 2/2/16 on handwashing with staff by Staff Development Coordinator. Personal Clothing and linen carts fully covered.</p> <p><b><u>How did we review all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected?</u></b> Skill Validations completed for nursing staff members on proper hand washing 2/2/16. Laundry/ Housekeeping in-serviced on Laundry and linen transport 2/3/16. <b><u>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b> Additional hand washing signs posted at hand washing stations throughout facility. <b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b> Ongoing The Infection Control</p>				

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	<p>of hand sanitizer. She then retrieved Resident #61 and transported her to the assist feeding table where she then opened a can of ensure, placed a straw into the can, and assisted the resident to drink.</p> <p>On 01/11/2016 at 12:58 p.m., Registered Dietician was observed to retrieve a plate from the kitchen with one disposable glove on the plate. She then took the plate to Resident #112's table. She then donned the single glove at the table. She was observed to quickly remove the glove, place it on top of a hamburger she had removed from Resident # 112's plate. She then placed the plate with the hamburger and glove on the dining table and then proceeded to cut a sandwich for Resident # 112. She then removed the hamburger and glove, sanitized her hands and entered the kitchen.</p> <p>On 01/11/2016 at 1:04 p.m., during an interview, the Registered Dietician indicated she would expect the staff to use hand sanitizer for 20-40 seconds or hand wash for 40-60 seconds as needed. She indicated they did not have a policy for hand hygiene during meal service for the number of plates served before hand hygiene was performed. Additionally, she indicated if the staff "touches anything" she would expect them to perform hand</p>		<p>CQI audit tool will be completed monthly by the Staff Development Coordinator or Designee. Infection Control CQI audit tool to be reviewed by QA Committee. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in re-education and training of the responsible employee. Laundry Supervisor or designee to conduct monthly x6 Audit on proper personal clothing and linen transport. The Laundry and Linen Transport audit tool to be reviewed monthly by the CQI Committee for six months after which the CQI Committee will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed by the Laundry Supervisor or designee.</p>		

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	<p>hygiene.</p> <p>2. On 01/11/2016 at 12:42 p.m., the laundry cart of clean clothing and linen was observed being transported past the main dining room with only the tops of the hangers and clothing covered. The linens located on the bottom of the laundry cart are completely uncovered during transport.</p> <p>On 01/12/2016 at 10:39 a.m., an uncovered laundry delivery cart was observed to contain personal clothing and linen on the Cottage 2 (Memory care 300 hall). During an interview at this same time, Laundry aide #3, indicated she should cover the clean clothing on the laundry cart with a sheet to transport it to the unit. When she was in the unit, she would remove the sheet, fold it and place it on the bottom of the laundry cart.</p> <p>On 01/14/2016 at 11:31 a.m., during an interview with Laundry aide #4, she indicated if she observed a resident touching clean laundry while she passed clothing to the residents, she would ask the resident what they might need and help them. She indicated she would not see a reason to re-wash the laundry if a resident touched it.</p> <p>A policy titled LAUNDRY/LINEN, dated</p>			

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F 0502 SS=D Bldg. 00	<p>02/2012, was received from the Director of Nursing, on 1/12/16 at 2:12 p.m. The policy indicated: "POLICY: The laundry staff shall handle, store, process, and transport linen appropriately to prevent the spread of infection, in resident-care areas and in the laundry facility. PURPOSE: To ensure the proper care of linen and laundry to prevent the spread of infection. "...2. a.ii. Carts/racks must be covered...5.f. Cover linen carts/racks, store properly and deliver to units...."</p> <p>3.1-18(l) 3.1-19(g)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to ensure lab draws were performed as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #14).</p> <p>Findings include:  The clinical record for Resident #14 was reviewed on 1/12/16 at 10:30 a.m. The</p>	F 0502	<p><b><u>What did we do to correct the deficient practice for each client cited in the deficiency?</u></b> Resident #14 TSH, CBC Drawn and MD notified <b><u>How did we review all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified</u></b></p>	02/05/2016

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F 9999	<p>diagnoses for Resident #14 included, but were not limited to diabetes mellitus, hypothyroidism, and acute kidney failure.</p> <p>A Nurse Practitioner Progress Note, dated 12/10/15, indicated, "...will check TSH, CBC [lab tests for thyroid function and overall health] [symbol for times] 1..."</p> <p>A Physician's Order, dated 12/10/15, indicated an order for "CBC...TSH [symbol for times] 1 on 12/11/15...."</p> <p>CBC and TSH lab tests for 12/11/15 were not located in the clinical record.</p> <p>During an interview with Unit Manager (UM) #17, on 1/12/16 at 11:50 a.m., UM #17 indicated the above labs were not drawn as ordered. UM #17 further indicated he was unsure as to why the labs were not drawn when the Physician's Orders were linked to report that the lab company received.</p> <p>On 1/14/16, 11:00 a.m., the Clinical Educator Coordinator indicated it was the expectation that Nursing follow Physician's Orders as written.</p> <p>3.1-49(a)</p>		<p><b><u>as being affected?</u></b> Scheduled lab draws were reviewed by NurseManagement for all residents for the past 6months to current.</p> <p><b><u>Describethe steps or systemic changes the facility has made or will make to ensure thatthe deficient practice does not recur, including any in-services, but this alsoshould include any system changes you made.</u></b> Medical Records to generate daily report onscheduled lab draws and provide them to Unit Managers for Review.</p> <p><b><u>Howwill the corrective action(s) will be monitored to ensure the deficientpractice will not recur. i.e., What quality assurance program will be put intoplace?</u></b> Labs and diagnostics CQI audit tool to be completedmonthly x 6 months by Director of Nursing Services or designee. The Labs andDiagnostics CQI audit tool to be reviewed monthly by the QA Committee for sixmonths after which the QA Committee will re-evaluate the continued need for theaudit. If a 95% threshold is not achieved an action plan will be developed byDirector of Nursing Services or designee. Deficiency in this practice willresult in re-education and training of the responsible employee.</p>	

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Bldg. 00	<p>3.1-14 Personnel</p> <p>(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:</p> <p>(1) Residents' rights.</p> <p>(2) Prevention and control of infection.</p> <p>(3) Fire prevention.</p> <p>(4) Safety and accident prevention.</p> <p>(5) Needs of specialized populations served.</p> <p>(6) Care of cognitively impaired residents.</p> <p>(l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel.</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personal assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or</p>	F 9999	<p><b><u>Whatdid we do to correct the deficient practice for each client cited in thedeficiency?</u></b></p> <p>RN#23 PRN Staff Member removed from schedule,awaiting availability for staff member to complete required in-services anddementia training.</p> <p>CNA#25 Completed in-service on resident rights.</p> <p><b><u>Howdid we review all clients in the facility that could be affected by the samedeficient practice, and state, what actions the facility took to correct thedeficient practice for any client the facility identified as being affected?</u></b></p> <p>All employees files reviewed. New Hire in-servicecomplete upon orientation on Resident Rights. All staff members not in compliance provided with in-service on residents rights or removed fromschedule until completion.</p> <p><b><u>Describe the steps or systemic changes the facility has made or will make to ensure thatthe deficient practice does not recur, including any in-services, but this also should include any system changes you made.</u></b></p> <p>Compliance Report Generated and reviewed weekly bystaff development coordinator and Administrator on required statein-services. In-services to be providedmonthly online and live by Staff Development</p>	02/05/2016			

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	<p>preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure staff received annual in-service education on residents rights and dementia for 2 of 11 staff members reviewed for residents' rights and dementia in-service education. (RN #23 and CNA #25).</p> <p>Findings include:</p> <p>The Employee Records for RN #23 and CNA #25 were reviewed on 1/14/16 at 9:30 a.m. The Employee Records form indicated RN #23's start date was 12/10/12 and CNA #25's start date was 5/30/07.</p> <p>The Employee Personnel File for RN #23 indicated RN #23 last completed dementia training on 9/28/14 and there was no record of Resident Rights training for RN #23 for 2015.</p> <p>The Employee Personal File for CNA #25 did not indicate a record of Resident's Rights training for 2015.</p>				<p>Coordinator.</p> <p><b><u>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., What quality assurance program will be put into place?</u></b></p> <p>Compliance Report Generated and reviewed weekly by staff development coordinator and Administrator on required state in-services. In-service education CQI audit tool to be completed monthly x 6 months by Staff Development Coordinator or designee. The In-service education audit tool to be reviewed monthly by the QA Committee for six months after which the QA Committee will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed by the staff development coordinator. Deficiency in this practice will result in re-education and training of the responsible employee.</p>		

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R 0000  Bldg. 00	<p>During an interview with the Clinical Educator Coordinator (CEC), on 1/14/16 at 10:27 a.m., the CEC indicated he was unable to locate documentation that RN #23 completed dementia or Resident Rights training for 2015. The CEC further indicated he was unable to locate annual training for Resident Rights for CNA #15 for 2015.</p> <p>The New Punch Detail Report received from the Clinical Educator Coordinator, on 1/14/16 at 1:29 p.m., indicated RN #23 worked 389 hours and CNA #15 worked 988 hours since February 1, 2015.</p> <p>A policy titled, Educational Inservices and Training, dated 10/2015, was received from the CEC, on 1/14/15 at 1:29 p.m. The policy indicated, "...The facility must provide the following State required in-service programs annually...ii. Resident Rights....4. Dementia Training...iii. 3 hours annually for all employees...."</p> <p>American Village was found to be in compliance with 410 IAC 16.2-5 in</p>	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set	

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	regard to the State Residential Survey.		<p>forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after February 5, 2015.</p> <p>This provider respectfully requests a face to face IDR for F244, F412 and F441 as we do not agree with the scope and severity of the identified deficiencies.</p>	