STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/06/2011
NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN46542	

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: October 3, 4, 5, and 6, 2011 Facility number: 000491 Provider number: 155495 AIM number: 100291230 Survey team: Julie Wagoner, RN, TC Tim Long, RN Christine Fodrea, RN Census bed type: SNF: 05 SNF/NF: 46 Total: 51 Census payor type: Medicare: 06 Medicaid: 32 Other: 13 Total: 51 Sample: 13 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/12/11	F0000	This plan of correction is submitted by Lakeland Rehabilitation and Healthcare Center in order to respond to the alleged deficiencies sited during our annual survey which was conducted on October 6, 2011.Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law.Please accept this plan of correction as the provider's credible allegation of compliance effective November 5, 2011.Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Lakeland Rehabilitation and Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of this Plan of Correction.	

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

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

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	Cathy Emswiller RN			
F0157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review, and interview, the facility failed to notify the physician of a need to discontinue a medication for 1 of 4 resident observed	F0157	Resident #14 had Nurse Practioner notified and order received on 10/5/2011 to discontinue Aricept 5 mg po daily. (Upon Director of Health	11/05/2011

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	receiving medications in a sample of 13. (Resident #14) Finding includes: During observation of a medication administration pass, conducted on 10/04/11 at 9:00 A.M., LPN #10 was observed administering morning medications to Resident #14. The clinical record for Resident #14 was reviewed on 10/05/11 at 9:00 A.M. The physician's orders for Resident #14 indicated there was an order for Aricept 5 mg [milligrams] to be given daily, which had been obtained on 09/27/11. Next to the physician's order for the Aricept was the following: "do not start per family's request." Review of the medication administration record for October 2011 indicated the resident had not received any Aricept medication. Review of the nurse's notes from 09/27/11-10/05/11 indicated there was no note to indicate the physician had been notified of the family's request nor was there any discontinue order clarifying the issue. During interview at the time of the medication record review, the Director of Nursing indicated the nursing staff should		Services calling Nurse Practioner about above, Nurse Practioner was already aware of the need for the discontinuation of the medication from 9/27/11 and agreed to clarification order to discontinue the order.)All residents have the potential to be affected by the same deficient practice. The nurse who wrote the original order to stop medication per family request was in-serviced on facility's documentation policy and procedures for physician notification, and documentation in the resident record.1. Licensed Nursing staff will be in-serviced by Director of Health Services/Designee on facility's documentation policy and procedures for physician notification and documenation in the resident record. Licensed Nursing staff will also be instructed on what to do when family is requesting to stop any medications.2. Director of Health Services/Desigee will audit all medication discontinuation orders x 3 days weekly for compliance of documentation and physician notification for 3 months, and then audit 1x weekly thereafter until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility disciplinary policy.Director of	

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	have notified the physician and documented the issue in the nursing notes. 3.1-5(a)(3)		Nursing/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011.	

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview and record review, the facility failed to thoroughly investigate and report an allegation of abuse to state agencies for 1 of 3 residents reviewed for abuse	F0225	No residents were affected by the deficient practice. Resident #45 was assessed and allegations have been fully investigated and reported on 10/6/2011 to appropriate state agencies.All	11/05/2011

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	investigations in a sample of 13. (Resident #45) Findings include: Resident #45 was observed in a wheel chair on the South hallway on 10/4/2011 at 9:30 a.m. Resident #45 was conversing with the Director of Nursing and indicated the evening nurse had pulled on her arm during care and hurt her arm. The Director of Nursing took Resident #45 to the front hallway to wait on transport to a physician's appointment. The clinical record of Resident # 45 was reviewed on 10/5/11 at 10:13 a.m. Resident #45's Minimum Data Set dated 8/6/2011 indicated Resident #45 could correctly answer 15 of 15 questions to determine cognitive function. In an interview on 10/6/2011 at 1:15 p.m. the Director of Nursing indicated she had spoken with Resident #45 in a private area on 10/4/2011 and when questioned, who had pulled on her arm, Resident #45 stated it was the one she didn't like, but could not give the Director of Nursing the name of the employee responsible. When the Director of Nursing asked her if everything was OK, Resident #45 indicated everything was fine. The Director of Nursing indicated Resident		residents have the potential to be affected by the same deficient practice. Director of Health Services, Social Service Director, LPN #1, and COTA #2 were in-serviced on facility policy and procedure of appropriate investigating and reporting of abuse/neglect allegations.1. All Department Leaders will be in-serviced by Executive Director/Designee on facility policy and procedure of appropriate investigating and reporting of abuse/neglect allegations.2. Staff will be inserviced by Executive Director/Designee on facility policy and procedure of appropriate investigating and reporting of abuse/neglect allegations.3. Executive Director/Designee will audit all abuse/neglect allegations for compliance of being investigated completely and reported appropriately and timely per policy.4. Executive Director/Designee will audit all Accident and Incidents, and Concern forms 5x weekly for 1 month for compliance according to policy of appropriate investigation and reporting of any allegations of abuse. Executive Director/Designee to audit 2x weekly thereafter until QA Committee states otherwise.5. Any non-compliance issues will be addressed immediately and staff responsible will be re-educated/disciplined as	

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	#45 did not like a certain staff member and had been angry on the morning of 10/4/2011 because the night shift staff would not allow her to use a bedside commode due to fall risk concerns. The Director of Nursing indicated she did not ask Resident #45 for a description of the staff member and she further did not ask the roommate or any staff on shift at the time. The Director of Nursing additionally indicated a concern form had been filed, but documentation had not been completed because the Interdisciplinary team had not had time to meet regarding the allegation. A review of a concern form dated 10/4/2011 indicated Resident #45 had complained to LPN #1 that a CNA had pulled her. According to the concern form, LPN #1 attempted to discern the identity of the employee and handed the concern to Social Services and Nursing. In an interview on 10/6/2011 at 1:20 p.m. COTA #2 (Certified Occupational Therapy Aide) indicated Resident #45 did not recognize people's names, she only would recognize who people were by their looks. She further indicated she had worked with Resident #45 during the morning on 10/4/2011 to prepare for the physician's appointment . COTA #2 indicated Resident #45 was upset because		appropiate per facility disciplinary policy.Executive Director will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011	

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	night shift had not allowed her to use the bedside commode because of fall risk concerns and was upset. COTA #2 additionally indicated Resident #45 complained her arms hurt and she couldn't breathe because someone had pulled her arm during transfer. COTA #2 indicated she did not report this to anyone because the Director of Nursing was there and heard the allegation. In an interview on 10/6/2011 at 1:25 p.m. the Social Services Director indicated She had followed up on the concern by asking Resident #45 how her day was on 10/4/2011. Resident #45 responded her day was OK. The Social Services Director indicated she had not asked how the evening prior had went or asked any specifics regarding staff that had taken care of her the evening before. The Social Services Director indicated she did not refer to her pain or her arm. In an interview on 10/6/2011 at 10:50 a.m., the Director of Nursing indicated she had not reported the allegation to state agencies because Resident #45 had made the same allegation previously, but the Director of Nursing could not remember the date of the allegation. She further indicated after her investigation, she felt the allegation could not be substantiated.			

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	In an interview on 10/6/2011 at 2:15 p.m. the Executive Director indicated investigations usually consist of interviews with the resident and roommate if appropriate, alert and oriented residents on the hall, the staff working on the shift in question, and the physical description of the alleged abuser. A current undated policy titled Accident and Incident Reporting Guidelines provided by the Director of Nursing on 10/6/2011 at 10:00 a.m. indicated names of witnesses and statements as well as circumstances surrounding the occurrence should be collected. 3.1-28(e)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			

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	Based on interview, observation, and record review, the facility failed to report an allegation of abuse to the state agencies for 1 of 3 residents reviewed for abuse investigations in a sample of 13. (Resident #45) Findings include: Resident #45 was observed in a wheel chair on the South hallway on 10/4/2011 at 9:30 a.m. Resident #45 was conversing with the Director of Nursing and indicated the evening nurse had pulled on her arm during care and hurt her arm. The Director of Nursing took Resident #45 to the front hallway to wait on transport to a physician's appointment. The clinical record of Resident # 45 was reviewed on 10/5/11 at 10:13 a.m. Resident #45's Minimum Data Set dated 8/6/2011 indicated Resident #45 could correctly answer 15 of 15 questions to determine cognitive function. A review of a concern form dated 10/4/2011 indicated Resident #45 had complained to LPN #1 that a CNA had pulled her arm. According to the concern form, LPN #1 attempted to discern the identity of the employee and handed the concern to Social Services and Nursing.	F0226	No residents were affected by the deficient practice. Resident #45 was assessed and allegations have been fully investigated and reported on 10/6/2011 to appropriate state agencies.All resident have the potential to be affected by the same deficient practice. Director of Health Services, Social Service Director, LPN #1, and COTA #2 were in-serviced on facility policy and procedure of appropriate investigating and reporting of abuse/neglect allegations to Executive Director and state agencies.1. All Department Leaders will be in-serviced by Executive Director/Designee on facility policy and procedure of appropriate investigating and reporting of abuse/neglect allegations to Executive Director and state agencies.2. Staff will be inserviced by Executive Director/Designee on facility policy and procedure of appropriate investigating and reporting of abuse/neglect allegations to Executive Director and state agencies.3. Executive Director/Designee will audit all abuse/neglect allegations for compliance of being investigated completely and reported appropriately and timely per policy.4. Executive Director/Designee will audit all Accident and Incidents, and Concern forms 5x weekly for 1 month for compliance according to policy of appropriate	11/05/2011

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	In an interview on 10/6/2011 at 1:20 p.m. COTA #2 (Certified Occupational Therapy Aide) indicated she had worked with Resident #45 during the morning on 10/4/2011 to prepare for the physician's appointment . COTA #2 indicated Resident #45 was upset because night shift had not allowed her to use the bedside commode because of fall risk concerns and was upset. COTA #2 additionally indicated Resident #45 complained her arms hurt and she couldn't breathe because someone had pulled her arm during transfer. COTA #2 indicated she did not report this to anyone because the Director of Nursing was there and heard the allegation. In an interview on 10/6/2011 at 1:25 p.m. the Social Services Director indicated She had followed up on the concern by asking Resident #45 how her day was on 10/4/2011. Resident #45 responded her day was OK. The Social Services Director indicated she had not asked how the evening prior had went or asked any specifics regarding staff that had taken care of her the evening before. The Social Services Director indicated she did not report the allegation to the Administrator because she thought the Director of Nursing had already told her. In an interview on 10/6/2011 at 2:15 p.m.		investigation and reporting of any allegations of abuse. Executive Director/Designee to audit 2x weekly thereafter until QA Committee states otherwise.5. Any non-compliance issues will be addressed immediately and staff responsible will be re-educated/disciplined as appropiate per facility disciplinary policy.Executive Director will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011	

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	the Executive Director indicated the allegation made by Resident #45 had not been reported to her until 10/6/2011. In an interview on 10/6/2011 at 2:32 p.m. the Director of Nursing indicated she had informed the Executive Director on 10/4/2011 of the allegation made by Resident #45. A current policy titled Abuse and Neglect Procedural Guidelines dated 9/16/2011 indicated allegations of abuse should be reported to the Executive Director immediately, and to applicable state agencies within 24 hours. 3.1-28(a)			
F0252 SS=E	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation, and interview the	F0252	Residents A, B, C, D, E, F, G and H all have removeable sink	11/05/2011

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	facility failed to maintain clean air vents on two of three halls in the facility potentially affecting 4 residents on the 300 hall and 27 residents on the 200 hall. The facility further failed to ensure sink stoppers were available in 4 of 10 rooms on the 100 hall, 6 of 14 rooms on the 200 hall, and 2 of 7 rooms on the 300 hall potentially affecting 8 residents on the 100 hall, 12 residents in the 200 hall and 3 residents on the 300 hall. (Resident # #A, Resident #B, Resident #C, Resident #D, Resident #E, Resident #F, Resident #G, and Resident #H) Findings include: 1. During environmental tour on 10/4/2011 at 2:01 PM gray feathery particles were observed on the ceiling air vents by rooms 212, 206, 302, and 307. During initial tour on 10/3/2011 at 10:00 a.m., the facility provided a CNA assignment sheet for each hall. the sheets indicated there were 4 residents on 300 hall and 27 residents on 200 hall. In an interview on 10/4/2011 at 2:01 p.m. the Director of Maintenance indicated the vents were cleaned on a monthly basis. In an interview on 10/6/2011 at 9:00 a.m. the Executive Director indicated there was		stoppers immediately placed in their bathrooms.Gray feathery particles were immediately removed on the ceiling vents by rooms 212, 206, 302, and 307.4 residents on 300 hall and 27 residents on the 200 hall were potentially affected by the vents. 8 residents on 100 hall, 12 residents on 200 hall and 3 residents on 300 hall were potentially affected by the sinks having no stoppers in them.Rooms 102, 103, 106, 107, 204, 206, 207, 209, 211, 213, 303, and 304 all have removeable sink stoppers immediately placed in the bathrooms. All ceiling vents were immediately cleaned in the facilily and a cleaning schedule was implemented by Environmental Services Director for all vents in the facility.1. Environmental Services staff will be inserviced on cleaning schedule and proper cleaning of the vents in the facility by Environmental Services Director/Designee.2. Environmental Services Director will audit 3x weekly for 1 month that vent cleaning schedule is being followed and then weekly thereafter until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility disciplinary policy.4. Plant Ops Director/designee will replace all	

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	no schedule to clean the air vents. 2. During group interview on 10/4/2011 at 10 a.m. 8 of 8 participants (Resident #A, Resident #B, Resident #C, Resident #D, Resident #E, Resident #F) indicated there had been a concern regarding stoppers in the sinks being missing. During environmental tour on 10/4/2011 at 1:58 p.m., the sinks in rooms 107 and 303 were observed to have no stopper. During a tour of resident rooms on 10/5/2011 at 9 a.m. the sinks in rooms 102, 103, 106, 107, 204, 206, 207, 209, 211, 213, 303, and 304 were observed to have no stoppers. In an interview on 10/4/2011 at 2:43 p.m. the Maintenance Director indicated the sink stoppers were taken out when there was an issue with them and the facility had to order new parts and sometimes new sinks to get the stoppers to work properly. He additionally indicated the parts were on order. 3.1-19(f)(5)		removeable sink stoppers in above mentioned rooms with a permanent sink stopper once ordered parts are received. Until then, Plant Ops Director/designee will audit 3x weekly for placement of removeable sink stoppers in above mentioned rooms. 5. Staff will be inserviced on filling out maintenance request forms when they find any resident room without a sink stopper and/or if they see any vent needing to be cleaned and then placing filled out request forms in appropriate designated area.Plant Ops Director/designee will bring all removeable sink stopper audits to QA Committee for review until permanent sink stoppers have been placed in all of the bathrooms.Environmental Services Director will bring all vent cleaning audits to QA Committee to review x 3 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/06/2011
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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview and record review the facility failed to ensure care plans were updated for 1 of 1 residents reviewed for hospice care plans (Resident #43) and 1 of 4 residents reviewed for fall care plans in a sample of 13. (Resident #45) Findings include: 1. Resident #43's record was reviewed 10/5/2011 at 2:10 p.m. Resident #43's diagnoses included but were not limited to high blood pressure, coronary artery disease, and congestive heart failure.	F0280	Resident #43 had updated hospice care plans placed in chart immediately.Resident #45 had updated non-compliance care plan placed in chart immediately.All residents on hospice and any non-compliant resident has the potential to be affected by this deficient practice. All residents on hospice and any non-compliant resident had their care plans reviewed for compliance.1. Licensed Nursing staff will be inserviced by Director of Health Services/Designee on policy and procedure for initiating care plans with focus on non-compliance care planning.2. Director of Health Services/Designee will audit 5	11/05/2011

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	On 10/6/2011 at 9:10 a.m., Resident #43 was observed sitting in a geri-chair in the assisted dining area in front of a television. A review of current care plans dated 8/10/2011 did not indicate Resident #43 was to be placed in a geri-chair. In an interview on 10/6/2011 at 9:28 a.m. the Director of Nursing indicated hospice should have left copies of Resident #43's care plans for the chart. On 10/6/2011 at 9:42 a.m., a copy of updated care plans was received form the Director of nursing indicating Resident #43 was to be placed in a geri-chair. The care plan was dated as updated on 9/27/2011. A copy of the current hospice contract dated as effective 5/4/2004 indicated the hospice company would provide the highest quality and level of services to patients and residents of the facility. The contract further indicated hospice would provide the facility with a copy of the care plan. There was no indication that hospice would update or share updates of the care plans to the facility. 2. Resident #45's record was reviewed on 10/5/2011 at 10:13 a.m. Resident #45's		records on each unit 2x weekly for compliance of care plans for 1 month, then 5 records on each unit 1x weekly thereafter until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be re-educated/disciplined as appropriate per facility disciplinary policy.4. IDT will meet 1x weekly to discuss all changes with any resident with non-compliant behavior and/or on hospice.5. Director of Health Services/Designee will meet with hospice nurse for resident #43 after each visit for any updates and copy of current care plan.Director of Nursing/Designee will bring all audits to QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011	

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	diagnoses included but were not limited to depression, osteoarthritis, and intermittent explosive disorder. Resident #45's fall circumstance report dated 9/11/11 indicated Resident #45 was noncompliant with safety measures. Nurse's notes dated 9/27/2011 indicated Resident #45 fell at 7:45 p.m. in the activity room with her walker on a laminate floor despite having non-skid socks on . The area under IDT Review (Interdisciplinary Team) indicated Resident #45 already had a care plan. A current care plan dated 4/14/2011 and updated 7/13/2011 indicated Resident #45 was at risk for falls. although fall interventions had been added to the care plan on 9/11 and 9/27/2011, there was no note Resident #45 was at higher risk for falls due to her non compliance with safety measures. There was no added interventions to increase supervision or to remind Resident #45 of safety measures. In an interview on 10/6/2011 at 9:40 a.m., the Director of Nursing indicated the company did not want care plans updated to reflect noncompliance, but could not describe how staff would know extra			

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	precautions to be taken to prevent falls related to Resident #45's noncompliance. 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to follow physician's orders for three of 13 residents reviewed for physician's orders in a sample of 13.(Residents #17, 5, 14) Findings include: 1. Resident #17's clinical record was reviewed on 10/4/11 at 9:20 A.M.. The record indicated the resident had a physician's order on 9/27/11 to discontinue Citalopram (an antidepressant) and start Paxil 20 (an antidepressant) milligrams (mg) on 9/28/11.	F0282	Resident #17- Order for Citalopram was discontinued on October 5, 2011. No adverse reactions were indicated.Resident #5- Order was received by physician on October 5, 2011 to discontinue moon boots. No ill effects noted.Resident #14 had physician notified and order received on 10/5/2011 to discontinue Aricept 5 mg po daily. (Upon Director of Health Services calling physician about above, physician was already aware of the need for the discontinuation of the medication from 9/27/11 and agreed to clarification order to discontinue the order.)All residents have the potential to be affected by the same deficient practice. The nurse who wrote the original	11/05/2011

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	Review of the medication administration records (MARs) from September and October 2011 indicated Citalopram was not given on 9/27/11, 9/28/11, 9/29/11 and 9/30/11, but was given on 10/1/11, 10/2/11, 10/3/11 and 10/4/11. An interview with the director of nursing on 10/5/11 at 9:45 A.M. indicated the Citalopram was discontinued as ordered from 9/27/11 through 9/30/11 but put on the October MAR and mistakenly given from 10/1/11 through 10/4/11.		order for resident #14 to stop medication per family request was in-serviced on facility's documentation policy and procedures for physician notification, and documentation in the resident record. The nurse who made the monthly P.O.S. change over for resident #17 was inserviced on policy and procedure for proper P.O.S. change over. All P.O.S. were reviewed for proper medication and moon boot orders.1. Licensed Nursing staff will be in-serviced by Director of Health Services/Designee on facility's documentation policy and procedures for physician notification and documenation in the resident record. Licensed Nursing staff will also be instructed on what to do when family is requesting to stop any medications.2. Licensed Nursing staff who complete end of the month P.O.S. change overs will be inserviced on policy and procedure for proper P.O.S. change over by Director of Health Services/Designee.3. Nursing staff will be in-serviced by Director of Health Services/Designee on following physician orders for moon boots.4. Director of Health Services/Desigee will audit all medication discontinuation orders x 3days weekly for compliance of documentation and physician notification for 3 month, and then	

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			audit 1x weekly thereafter until QA states otherwise.5. Director of Health Services/Designee will audit 2x weekly for 1 month all resident with orders for moon boots for compliance and audit 1x weekly thereafter until QA states otherwise.6. Director of Health Services/Designee will audit 12 P.O.S. per unit on the first business day of every month for compliance.7. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility disciplinary policy.Director of Nursing/Designee will bring all audits to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011.	
	2. During observation of a medication administration pass, conducted on 10/04/11 at 9:00 A.M., LPN #10 was observed administering morning medications to Resident #14. The clinical record for Resident #14 was reviewed on 10/05/11 at 9:00 A.M. The physician's orders for Resident #14 was reviewed on 10/05/11 in the A.M. and indicated there was an order for Aricept 5 mg to be given daily, which had been obtained on 09/27/11. Next to the physician's order for the Aricept was the			

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	following: "do not start per family's request." Review of the medication administration record for October 2011 indicated the resident had not received any aricept medication. Review of the nurse's notes, from 09/27/11 - 10/05/11 indicated there was no note to indicate the physician had been notified of the family's request nor was there any discontinue order clarifying the issue. The Director of Nursing indicated the nursing staff should have notified the physician and documented the issue in the nursing notes. 3. Resident #5's record was reviewed ion 10/3/2011 at 1:45 p.m. Resident #5's diagnoses included but were not limited to diabetes, stroke, and spinal stenosis (narrowing). On 10/3/2011 at 1:35 p.m., Resident #5 was observed in a wheelchair in her room watching TV. Resident #5 was wearing moon boots. A current physician's order dated 5/6/2011 indicated moon boots were to be worn at all times. On 10/4/2011 at 9:00 a.m., Resident #5 was observed in a wheelchair in her room			

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	not wearing moon boots. On 10/4/2011 at 2:00 p.m. Resident #5 was observed in a wheelchair in her room not wearing moon boots. On 10/5/2011 at 9:00 a.m. Resident #5 was observed in the assisted dining area in a wheelchair not wearing moon boots. On 10/5/2011 at 1:01 p.m. Resident #5 was observed in bed not wearing moon boots. In an interview on 10/5/2011 at 3;30 p.m. the Director of nursing indicated there should have been an order to discontinue the moon boots. 3.1-35(g)(2)			
F0309 SS=D	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. Based on observation, record review, and interview, the facility failed to ensure an	F0309	Resident #51 documentation cannot be changed due to	11/05/2011

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	infected wound was assessed timely during treatment for 1 of 7 residents reviewed for infections in a sample of 13. (Resident #51) Finding includes: During the initial tour of the facility, conducted on 10/03/11 between 10:30 A.M. - 11:15 A.M., LPN #8, the medical records and wound nurse, indicated Resident #51 had a heel wound and had been treated for an osteomylitis infection of the wound. The clinical record for Resident #51 was reviewed on 10/03/11 at 1:55 P.M. Resident #51 had been admitted to the facility on 04/15/11 with diagnosis, including but not limited to, diabetes, peripheral vascular disease, end stage renal disease, and obesity. The current physician's orders included the following treatment for the residents pressure sore: "Flagyl 500 mg crushed with santyl ointment (an ointment to remove dead tissue) to Left heel wound daily." During the observation of the resident's wound, conducted on 10/04/11 at 10:50 A.M., a quarter-sized pressure ulcer was noted to the resident left heel. The center		occurred prior to survey. Resident wound was fully assessed and documented in nurses notes. Residents physician reviewed residents wound and current treatment plan for the wound. Physician is in agreement with residents treatment plan at this time.All residents with wounds have the potential be affected by the same deficient practice. All residents wounds will be fully assessed and documented in nurses notes. Physicians notifed of current treatment plans for these residents and are in agreement with current treatment plans.1. License Nursing staff will be inserviced on policy and procedure for proper assessing and documentation of a wound by Director of Health Services/Designee.2. New Laminated documentation reference cards will be placed at the nurses station with bullet points of needed documentation for wounds each nurse can use as a guide. Nurses will be inserviced on these reference cards by DHS/Designee.3. Director of Health Services/Designee will audit all residents with wounds for proper assessing and documentation compliance x 5 days weekly for 1 month and 3x weekly thereafter until QA Committee states otherwise.4. Any non-compliance issues will be addressed immediately and staff responsible	

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	of the wound was light gray and had some depth. The edges of the wound were yellow in color and there was a moderate amount of yellow Exudate (drainage) noted on the dressing that was removed. Interview with LPN #8, prior to the dressing change, on 10/04/11 at 10:45 A.M., indicated the resident's wound had been draining such a foul smelling Exudate she had requested the Flagyl (an antifungal medication) to be mixed with the santyl ointment and placed directly into the wound. In addition, the resident had x-rays done and was diagnosed with osteomylitis and placed on antibiotic. LPN #8 indicated she had tried once to see if the resident could be taken off his antibiotics, but the wound got worse and the Exudate and odor increased when the resident was taken off of his antibiotics. She indicated the resident was currently receiving the antibiotic, Augmentin. The medication regimen for Resident #51 included an order, dated 09/26/11 for the antibiotic, Augmentin 500 mg/125 mg to be given in the morning for 8 weeks. The nursing notes, "skin impairment circumstance assessment and intervention, originally initiated on 04/20/11 and present on admission to the facility, did not include a specific description		will be reeducated/disciplined as appropriate per facility disciplinary policy.Director of Health Services/Designee will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Completion: November 5, 2011	

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	assessment of the resident's wound. On a daily basis, 72 hour follow up documentation was completed every shift regarding the resident's need for antibiotic, but the "boxes" for each shift to document had a check mark next to "assessment completed, tx (treatment) checked, clean, dry, intact, no c/o (complaints) pain." Occasionally handwritten in the bottom of the boxes was "malodorous" or "wound nurse changed dressing." but there was no description of the wound, the signs of the infection, including the Exudate, skin condition, and odor of the Exudate completed on a shift by shift or daily basis. The only complete documentation of the resident's heel wound was completed by the wound nurse on a weekly basis. Review of the wound documentation, from 08/29/11 - 10/03/11, indicated the resident had an oblong wound on his lateral heel with thick yellow to white Exudate. The 10/03/11 documentation indicated the wound was 1.8 centimeters by 1.8 centimeters with .2 centimeters depth, with a small amount of thick whitish Exudate. The documentation indicated there was "no infection." Interview with the Director of Nursing, on 10/06/11 at 9:30 A.M., indicated there			

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	was no further documentation regarding any additional assessment of Resident #51's infected wound. 3.1-37(a)			
F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure proper technique for medication administration was followed for 1 of 1 residents with a gastrostomy tube observed during medication administration pass. (Resident #48) Finding includes: During observation of a medication administration pass, conducted on 10/03/11 at 11:00 A.M., LPN #12 was noted to prepare the following medication for administration through Resident #48's gastrostomy tube: Fish oil 1,000 mg, Atenolol 100 mg, amlodipine 10 mg, and Namenda 10 mg. The nurse was noted to	F0322	Resident #48 was reassessed immediately. No ill effects noted.LPN #12 was counseled on improper technique for medication administration on resident #48. LPN #12 was reeducated on policy and procedure for proper technique for medication administration for residents with gastrostomy tubes. Pharmacy was notified and all current medications were verified to be compatible and could all be mixed together as per policy.All residents with gastrostomy tubes have the potential to be affected. All residents had medications verified by pharmacy to be compatible and could all be mixed together as per policy.1. Licensed Nursing staff will be inserviced on policy and procedure for	11/05/2011

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	crush the Atenolol, Amlodipine, and Namenda tablets altogether and placed in plastic medication cup. She then punctured a fish oil capsule and squeezed the contents of the capsule on top of the already, crushed medications. After checking the resident's vital signs, and checking placement of the gastrostomy tube, LPN #12 mixed about 20 cc of water in the medication cup with medicines. After stirring the mixture with the end of the syringe, LPN #12 aspirated the medication into the syringe, also aspirated more water until the syringe was full of water mixed with the medication, and gently pushed the water/medication mixture into the resident's gastrostomy tube. She then proceeded to gently push two and 1/2 more syringe fulls of water into the resident's gastrostomy tube. Interview with LPN #12 immediately proceeding the observation indicated she thought she had "flushed" the gastrostomy tube prior to administering the medications as she had checked the placement with "air." She also indicated she mixed the medications altogether routinely. Finally, she indicated Resident #48 had recently had to have her gastrostomy tube replaced because the previous tube had become "clogged." She indicated Resident #48's tube would not drain with gravity but always had to have		proper technique for medication administration for residents with gastrostomy tubes by Director of Health Services/Designee.2. Licensed Nursing staff will have to pass a skills competency/return demonstration on proper technique for medication administration for residents with gastrostomy tubes with the Director of Health Services/Designee by November 5, 2011. 3. Director of Health Services/Designee will observe Licensed Nursing Staff during med pass of residents with gastrostomy tubes for proper technique 3x weekly for 1 month, and then 1x weekly thereafter until QA Committee states otherwise.4.Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility disciplinary policy.Director of Health Services will bring medication pass observations to QA Committee for review x6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/06/2011
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	medications and water flushes gently pushed into her tube. Review of the physician's orders for Resident #48, reviewed on 10/05/11 at 9:30 A.M. indicated orders, dated 02/11/1,1 for the resident to receive 250 ml of water with each medication pass and "FYI" (for your information) May crush meds and administer together per peg tube when not contraindicated." Review of the facility policy and procedure, undated but presented as current on 10/05/11 at 11:00 A.M., indicated the following: "...8. If mixing medications check with the pharmacy to ensure compatibility of drugs. 9. Dilute medications and flush the tube with room temperature or warm liquids.. 35. Flush tubing with warm water as ordered...39. Administer medication by gravity flow. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of the resident's nose. Open the clamp an deliver medication slowly. Clamp tubing (or being flush) before the tubing drains completely...." 3.1-44(a)(2)			

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F0367 SS=E	Therapeutic diets must be prescribed by the attending physician. Based on observation, interview and record review the facility failed to provide therapeutic diets as ordered by a physician for five of five residents (#50, 31, 27, 10, 1) on pureed consistency foods in the facility. Findings include: During observation of food preparation in the kitchen on 10/5/11 at 11:05 A.M. cook #7 prepared food for five residents receiving all or part of their meal pureed consistency foods. The menu, reviewed at the time of the preparation observation above, for residents #50, 31, 27, 10, 1 receiving pureed lunch included a 3" x 5" square pureed patty melt sandwich. The preparation for the patty melt sandwiches by cook #7 included 4 whole prepared patty melt sandwiches put into a food processor along with a total of 14 ounces of gravy until the patty melts reached a desired consistency. An interview with cook #7 during preparation of the pureed patty melt sandwiches indicated he used 4 prepared	F0367	Resident #50, 31, 27, 10 and 1 had no harm or ill effects noted. Cook #7 was counceled on following puree recipes to ensure proper pureed consistency as ordered by physician. Cook #7 was re-inserviced on following puree recipes to ensure proper pureed consistency, and was able to show Dietary Manager a return demonstration of following a pureed recipe correctly.All residents on puree diet have the potential to be affected by same deficient practice. We have no other residents on puree diets at this time.1. All Cooks will be inserviced on following puree recipes to ensure proper pureed consistency by Dietary Manager.2. All Cooks will pass a return demonstration by correctly preparing a pureed recipe with Dietary Manager/designee by November 5, 2011.3. Dietary Manager/Designee will observe the Cook on duty for following puree recipes correctly 3x weekly for one month, and 1x weekly thereafter until QA Committee states otherwise.4. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facililty disciplinary policy.Dietary	11/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/06/2011
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	patty melt sandwiches as the menu called for 3/5's of a sandwich per serving for residents on a pureed diet. Review of the facility supplied recipes on 10/5/11 at 3:00 P.M. indicated for preparation of the 5 pureed consistency patty melt sandwich servings: 5- 3.2 ounce beef patty's; 5 slices of Swiss cheese;5-1.4 ounce slices of dark rye bread; 1 pound of Spanish onions. The recipe indicated the bread layer of the recipe was to be prepared as: bread slices were to be added to 13 ounces of water and 3 ounces and 1 and 1/2 tablespoons of "Puree Appeal" and processed in the food processor until mixed, then spread into a steam table pan coated with liquid food release. The recipe indicated the meat layer was to be prepared as: Measure amount of cooked beef patties (5 ounces) and onions (1 pound) needed; add 1 and 1/2 quarts hot water and process until smooth in consistency; add 7 ounces, 1 tablespoon "Puree Appeal" and process briefly until mixed. Spread meat mixture over bread layer. Arrange cheese slices on top of beef layer. Bake at 350 degrees until a minimum of internal temperature of 165 degrees for a minimum of 15 seconds. Let set 5-10 minutes before cutting into 3" x 5" squares. Serve 1 square cut in half diagonally.		Manager/Designee will bring all observations of the meal preparation for puree recipes to the QA Committee for review x 6 months and quarterly thereafter until 100% compliance is achieved.Date of Compliance: November 5, 2011.	

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	3.1-21(b)			
F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			

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	Based on observation, record review and interview, the facility failed to implement contact isolation precautions for one resident (#17) with possible clostridium difficile (c-diff) of 7 residents reviewed for possible infections. The facility also failed to clean glucometers for testing blood glucose levels in two of two observations of nurses affecting three residents (#23, 32, 50) in a total sample of 13. The facility further failed to ensure A. linen was handled to prevent contamination in the shower area for 2 of 2 shower areas reviewed and B. air vents were cleaned routinely on the clean laundry area. This had the potential to affect 51 of 51 residents residing in the facility. Findings include: 1. Resident #17's clinical record was reviewed on 10/4/11 at 9:20 A.M.. The record indicated on 9/28/11 a physician's order was received to collect a stool sample to check for c-diff due to loose stools. An interview with LPN #8 on 10/4/11 at 9:35 A.M. indicated the stool specimen results had not been received. LPN #8 indicated an initial specimen was contaminated and a 2nd specimen was obtained on 10/3/11 and no results were	F0441	Resident #17 was immediately put in contact isolation and precautions placed per policy. Resident had lab result and is negative for c-diff.Resident #23, 32, 50 had no harm or ill effects noted. LPN #6 and LPN#7 were inserviced on proper cleaning of glucometers which included the instructions on back of the Sani-cloth disinfectant wipes used of "...the surface should remain visibly wet for 3 minutes...".Linens in shower rooms were removed immediately and air vents on clean laundry area were cleaned immediately.All residents have the potential to be affected by same deficient practice. All air vents were cleaned immediately and new vent cleaning schedule was put into place. Shower aide responsible for leaving clean linen in shower rooms was inserviced on not leaving linen in shower rooms between residents. No other residents requiring contact isolation at this time. All residents requiring glucometer checks have the potential to be affected by the same deficient practice.1. Environmental Services staff will be inserviced on cleaning schedule and proper cleaning of the vents in the facility by Environmental Services Director/Designee.2. Environmental Services Director will audit 3x weekly for 1 month that vent cleaning schedule is being followed and then weekly thereafter until QA Committee	11/05/2011

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	received yet. An interview with the (Director of Nursing) DN on 10/5/11 at 10:10 A.M. indicated a stool specimen was obtained on 10/1/11 and sent to lab and the results were just being processed then. The DON did not know why the staff did not obtain the stool specimen sooner. An interview with the DN on 10/5/11 at 10:25 A.M. indicated the stool specimen was not obtained and sent to the lab until 10/2/11 at 4:00 P.M.. The DN indicated the resident was okay to leave his bedroom as he was a check and change for toileting, indicating he wore an adult diaper, so stool would be contained. The DN indicated his linens should be placed in a red bag to prevent the spread of possible infection. Observations of resident #17 on 10/4/11 at 9:25 A.M. indicated he was sleeping in his bed in his bedroom. There was no sign on the door to indicate a possible infection and no red biohazard bag for special handling of soiled items Observations of resident #17 on 10/5/11 at 10:30 A.M. indicated he was sleeping in his bed in his bedroom. There was no sign on the door to indicate a precaution sign, and no red biohazard bag for special		states otherwise.3. Staff will be inserviced on no linens left in shower rooms between residents by Director of Health Services/Designee.4. Environmenal Services Director/Designee will audit 3x weekly for 1 month that no linens are left in shower rooms between residents and then weekly thereafter until QA Committee states otherwise.4. Licensed Nursing Staff will be inserviced on new procedure of each resident requiring glucometer checks will have their own, and the cleaning and storing of these glucometers by Director of Nursing/Designee.5. Licensed Nursing staff will have to pass a skills competency/return demonstration on proper technique for glucometer procedure and cleaning with the Director of Health Services/Designee by November 5, 20116. Director of Health Services/Designee will observe Licensed Nursing Staff for proper procedure and cleaning of glucometer 2x weekly for 1 month, and then 1x weekly thereafter until QA Committee states otherwise.7. Staff will be inserviced on policy and procedure for contact isolation and precautions for c-diff by Director of Nursing/Designee.8. Director of Health Services/Designee will audit all residents with diagnosis of c-diff and/or orders to rule out c-diff for	

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	handling of soiled items An observation on 10/5/11 at 1:00 P.M. indicated staff took a trash can with a red bag into resident #17's bedroom. An observation on 10/5/11 at 1:05 P.M. indicated a sign was place on the resident's door indicating a precaution sign and visitors were to check with a nurse before entering the room. Review of the facility undated policy "Guideline for Management of Residents with Clostridium Difficile" indicated the purpose was to prevent the transmission of C-diff to other residents and staff. The procedure included "contact precautions will be initiated at the onset of diarrhea of unknown origin and continue until disease is ruled out or resolved" Review of the undated policy "Guidelines for Contact Precautions" included, but was not limited to: #5: "Personal Protective Equipment: a. Wear gloves when entering the room before contact with the resident or environmental objects. Change gloves and wash hands after having direct contact with the resident, possible infective material, or potentially contaminated environmental objects and between each resident care intervention. Dispose of		compliance with policy and procedure of contact isolation and precautions being in place 5x weekly for 1 month and then 3x weekly thereafter until QA Committee states otherwise. 9. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility disciplinary policy.Director of Health Services/Designee and Environmental Services Director/Designee will bring all audits and/or observations to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Completion: November 5, 2011	

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	gloves contaminated with blood or body secretions in a biohazard container." #6 "Precaution sign: Post a sign at the resident's door to advise the visitors to consult with the Charge Nurse before entering the room". #11. "Environmental Control: a. Rooms will be cleaned daily and upon discharge of the resident with a facility approved disinfectant-detergent solution." 2. During observation of a medication administration pass, conducted on 10/04/11 at 11:47 A.M., LPN #6 was observed obtaining the blood glucose level of Resident #23. The nurse wiped the glucometer with a disinfectant wipe, let the glucometer dry for approximately 2 minutes before she proceeded to utilize the glucometer. After obtaining Resident #23's blood glucose level and administering insulin to her, LPN #6 prepared to obtain the blood glucose level of Resident #50. LPN #6 again wiped the glucometer with a disinfectant wipe and waited 2 minutes before she utilized the machine again. During observation of a medication administration pass, conducted on 10/06/11 at 11:15 A.M., LPN #7 was observed obtaining the blood glucose level of Resident #32. After she had obtained Resident #32's glucose level,			

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	LPN #7 was noted to wipe the glucometer machine briefly with a disinfectant wipe and then proceeded to obtain supplied to check the blood glucose level of Resident #50. There was only 2 minutes time between the time she wiped the glucometer and the time she obtained the blood glucose level of Resident #50. She had handled the glucometer machine with her gloved hands after only 1 minute of time had elapsed. Review of the back of the container of Sani-cloth disinfectant wipes indicated the following instructions for disinfecting hard surfaces: "...the surface should remain visibly wet for 3 minutes...." Review of an undated facility policy, titled, "glucometer cleaning guidelines" presented by the Director of Nursing, on 10/06/11 at 1:30 P.M. indicated the following: "1. If glucometers are used from one resident to another they should be cleaned and disinfected after each use...3. If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal or HBV/HIV label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration.			

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	(NOTE: recommend the Sani-cloth bleach wipe by PDI ordered through our clinical medical supplier)...Directions for glucometer disinfection vary between manufacturers and models within brands...." 1. A. During environmental tour on 10/4/2011 at 2:05 p.m. 9 towels and 2 washcloths were observed in the South hall shower room. The linens were uncovered. In an interview on 10/4/2011 at 2:05 p.m., the Housekeeping Supervisor indicated staff always placed linen in the shower area to be used throughout the day. During environmental tour on 10/4/2011 at 2:43 p.m. 1 towel and 4 washcloths were observed on the East shower room. The linens were uncovered. In an interview on 10/5/2011 at 3:00 p.m. the Director if Nursing indicated linens were not to be stored in the shower area between residents. A current policy dated 11/2010 titled Guidelines for Handling Linen indicated Linen should be made available for each room but should not be stored in the resident room. There was no indication how to handle linen for bathing.			

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	1.B. During environmental tour on 10/4/2011 at 1:58 p.m. the air vent over the clean linen area was observed to have gray feathery particles on and around the air vents blowing in the clean laundry area. In an interview on 10/4/2011 at 2:01 p.m. the Maintenance Director indicated the vents were cleaned on a monthly basis. In an interview on 10/6/2011 at 9:00 a.m. the Executive Director indicated there had been no vent cleaning schedule, but the vents should be maintained in a clean condition. 3.1-18(j) 3.1-19(g)(1) 3.1-19(g)(2) 3.1-19(g)(3)			
F0502 SS=D	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 record review and interview, the facility failed to obtain a physician order laboratory test, stool specimen for	F0502	Resident #17 had lab test for stool specimen done and results received on 10/5/2011. Resident was negative for c-diff.All	11/05/2011

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	clostridium difficile (c-diff), for one resident (#17) of 13 residents reviewed for lab tests in a sample of 13. Findings include: 1. Resident #17's clinical record was reviewed on 10/4/11 at 9:20 A.M.. The record indicated on 9/28/11 a physician's order was received to collect a stool sample to check for c-diff due to loose stools. Review of the resident's clinical record indicated the results for An interview with LPN #8 on 10/4/11 at 9:35 A.M. indicated the stool specimen results had not been received. LPN #8 indicated an initial specimen was contaminated and a 2nd specimen was obtained on 10/3/11 and no results were received yet. An interview with the (Director of Nursing) DN on 10/5/11 at 10:10 A.M. indicated a stool specimen was obtained on 10/1/11 and sent to lab and the results were just being processed when she had contacted them a few minutes before. The DON did not know why the staff did not obtain the stool specimen sooner. An interview with the DN on 10/5/11 at 10:25 A.M. indicated the only stool		residents with orders for stool specimen to be collected have the potential to be affected by same deficient practice. We have no residents with orders for stool specimens.1. Licensed Nursing Staff will be inserviced on management of residents with c-diff and collection process for obtaining stool specimen by Director of Health Services/Designee.2. Director of Health Services/Designee will audit all orders for stool specimen for lab testing for accuracy and compliance 5x weekly for 1 month, then audit 3x weekly thereafter until QA Committee states otherwise.3. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility disciplinary policy.Director of Health Services/Designee will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Completion: November 5, 2011	

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	specimen was not obtained and sent to the lab until 10/2/11 at 4:00 P.M.. 3.1-49(a)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure complete vital sign documentation for 1 of 1 closed records reviewed for vital sign documentation in a sample of 13 (Resident #60). The facility further failed to ensure physician's orders and restraint consents were available on the resident record for 1 of 1 residents reviewed for complete physician's orders and 1 of 1 residents reviewed for restraint consents in a sample of 13. (Resident #43) Findings include: 1. Resident #60's record was reviewed 10/6/2011 at 10:35 a.m. Resident #60's	F0514	Resident #60 is no longer in the facility.Resident #43 has physician order for geri chair immediately. Resident has consent for use of geri chair by responsible party and possible adverse effects of geri-chair use was explained to responsible party.All residents on blood pressure medications requiring pulse vitals and/or residents using a geri chair have the potential to affected by the same deficient practice. Nurse responsible for not documenting the pulse vitals before administering blood pressure medication to resident #60 was counseled and reeducated on proper procedure for administering blood pressure medications requiring pulse	11/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/06/2011
NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN46542	

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	diagnoses included but were not limited to gallbladder cancer, high blood pressure, and chronic pain. Resident #60's physician's order dated 8/24/2011 indicated Resident #60 should receive cardizem (a medication for high blood pressure) 240 milligrams daily. the order further indicated the medication should be held if Resident #60's pulse was less than 50. A review of Resident #60's Medication Administration Record dated September 2011 revealed pulses were not recorded for the dates of 9/8, 9/9, and 9/12/2011. In an interview on 10/6/2011 at 11:30 a.m. the Director of Nursing indicated the pulses should have been documented on the Medication record. A request was made to review the documentation policy on 10/6/2011 at 11:30 a.m. and 2:00 p.m. No policy was received for review. 2. a. Resident #43's record was reviewed 10/5/2011 at 2;10 p.m. Resident #43's diagnoses included but were not limited to high blood pressure, coronary artery disease, and congestive heart failure. On 10/6/2011 at 9:10 a.m., Resident #43		vitals. All residents utilizing a geri chair have physician orders, responsible party consents and documentation of responsible party notification of possible adverse effects of geri chair usage.1. Licensed Nurse Staff will be inserviced on policy and procedure of medication administration of meds requiring pulse vitals by Director of Health Services/Designee.2. Licensed Nurse Staff will be inserviced on need to obtain physician order and responsible party consent for residents using a geri chair. Nurses will also be inserviced on reviewing and documenting the possible adverse effects of geri-chair usage with responsible party by Director of Health Services/Designee.3. Director of Health Services/Designee will audit 5 residents medication administration records on each unit for compliance of administering blood pressure medications requiring pulse vitals per policy 3x weekly for 1 month, and audit 1x weekly thereafter until QA Committee states otherwise.4. Any non-compliance issues will be addressed immediately and staff responsible will be reeducated/disciplined as appropriate per facility disciplinary policy.Director of Health Services/Designee will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of	

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	was observed sitting in a geri-chair in the assisted dining area in front of a television. A review of current physician's orders dated 8/10/2011 did not indicate Resident #43 was to be placed in a geri-chair. In an interview on 10/6/2011 at 9:28 a.m. the Director of Nursing indicated hospice should have gotten physician's orders for Resident #43 to use a geri-chair and provided a copy for the chart. On 10/6/2011 at 10:28 a.m., a copy of a physician's order indicating Resident #43 could be placed in a geri-chair was received. The order was dated was dated on 9/27/2011. The fax date time stamp in the upper left hand corner of the page was noted to be 10/6/2011 at 10:27 a.m. 2.b. A review of Resident #43's record revealed no consent for the use of the geri-chair. In an interview on 10/6/2011 at 9:28 a.m. the Director of Nursing indicated hospice should have gotten responsible party consent for Resident #43 to use a geri-chair and provided a copy for the chart. On 10/6/2011 at 10:28 a.m., a copy of		Completion: November 5, 2011	

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	responsible party consent for Resident #43's use of the geri-chair was received. The consent was signed and was dated 8/10/2011. The fax date time stamp in the upper left hand corner of the page was noted to be 10/6/2011 at 10:27 a.m. The consent outlined various services provided by the Hospice company but did not outline information regarding geri-chair use and possible untoward effects of geri-chair use. 3.1-50(a)(2) 3.1-50(f)(3)			