

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2015
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NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DR BEDFORD, IN 47421
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F 000 Bldg. 00	<p>This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00162512.</p> <p>Complaint IN00162512 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 19, 20, 23, 24, and 25, 2015.</p> <p>Facility number: 000060 Provider number: 155135 AIM number: 100266600</p> <p>Survey team: Brooke Harrison, RN-TC Angela Patterson, RN Cheryl Mabry, RN Kim Gines, RN Jennifer McElwee, RN</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 18 Medicaid: 46 Other: 9</p>	F 000	Westview Nursing and Rehabilitation Center would like to ask for a Paper Compliance Review. Westview Nursing and Rehabilitation Center is also requesting paper IDR review for F-456 due to facility disagrees with scope and severity.	

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 282 SS=D Bldg. 00	<p>Total: 73</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 03, 2015; by Kimberly Perigo, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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's orders were followed for blood pressure upon return from dialysis for 1 of 1 resident reviewed for dialysis (Resident #125) and failed to ensure care plans were followed for monitoring of medication side effects and for an AIMS (Abnormal Involuntary Movement Scale) assessment having been completed for residents who received anti-psychotic medication for 2 of 5 residents reviewed for unnecessary medication use. (Resident #8, Resident #103)</p>	F 282	<p>F-282 Westview</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #125's blood pressure is being taken after returning from each dialysis visit · Resident # 103 is being monitored for adverse reactions related to anti-psychotic use 	03/27/2015			

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	<p>Findings include:</p> <p>1. Resident #125's clinical record was reviewed on 2/24/15 at 11:04 a.m. Diagnosis included, but were not limited to: end stage renal disease.</p> <p>Current February 2015, Physician's order dated 12/18/14 (date initiated), indicated dialysis 3 times a week on Monday, Wednesday and Friday.</p> <p>Physician's February 2015, orders indicated "...record blood pressure upon return from dialysis. Once A Day on Mon [Monday], Wed [Wednesday], Fri [Friday]; 11:00 A.M.-01:00 PM. ..." The order start date was 12/18/14.</p> <p>On 2/24/15 at 3:30 a.m., the Director of Nursing (DON) indicated, "Her [Name of Resident #125] vital [indicating blood pressure] are taken when she returns from dialysis. The dialysis center will fax over their vital from the dialysis visit."</p> <p>On 2/25/15 at 9:30 a.m., the Moving Forward unit manager provided, "The Medication Administration History (MAH)" dated December 2014, January 2015 and February 2015, the MAH indicated, no blood pressures were taken upon return to the facility on 12/28/14,12/30/14, and 2/11/15, for</p>		<ul style="list-style-type: none"> · Resident # 8 aims test has been completed and will be monitored every 6 months <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practices · 100% audit has been completed by the SSD/MCF/Designee on or before 3/27/15 for residents receiving antipsychotics to ensure monitoring in place for adverse reactions and that a current aims test is in place and/or completed if not current per policy. · 100% audit of all residents receiving dialysis has been completed to ensure blood pressures were obtained on return from dialysis per physician's orders. <p>What measures will be put into place or what systemic changes</p>	

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	<p>Resident #125.</p> <p>The Moving Forward unit manager indicated, according to the MAH no blood pressures were documented for 12/28/14, 12/30/14, and 2/11/15.</p> <p>On 2/25/15 at 11:03 a.m., the Director of Nursing provided policy "Dialysis Care" revision date September 2012, and indicated the policy was the one currently used by the facility. The policy indicated, " ...It is policy of American Senior Communities to ensure that the resident is rendered necessary services for the provision and maintenance of dialysis services through effective communication with the dialysis unit. ...</p> <p>8. An assessment of the resident will be completed upon return from each dialysis visit to include vital signs, ..."</p> <p>2a. Resident #103's clinical record was reviewed on 2/21/15 at 9:05 a.m. Diagnoses included but, were not limited to dementia, nonorganic psychosis, anxiety and depressive disorder.</p> <p>Physicians order dated 2/19/15, indicated Resident #103's medications included but, were not limited to: risperidone tablet (an anti-psychotic medication used to treat schizophrenia and bipolar disorder) 0.125 mg every day for dementia with psychosis.</p>		<p>will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Licensed nurses were educated on or before 3/27/15 by the CEC/designee on dialysis care policy. · Nurses providing care for dialysis residents have demonstrated to the CEC/designee on or before 3/27/15 competency with the policy and procedure on following physician orders for monitoring vital signs on return from dialysis · All new admissions with orders for antipsychotic medications and any new orders received for anti psychotic medications will be reviewed to ensure aims test was completed and orders are in place to assess every 6 months and to ensure monitoring every shift for side effects is in place. · Licensed nurses were educated on or before 3/27/15 on antipsychotic monitoring and aims test assessments by the DNS/designee. · DNS/Designee will review MAR for residents who receive dialysis to ensure Physicians orders are followed regarding blood pressures. · DNS/Designee will review 				

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	<p>Current care plan dated 9/15/14 indicated, "PROBLEM: Resident is at risk for adverse side-effects related to the use of psychotropic (anti-psych, antidepressant, anti-anxiety) APPROACH: document side effects as observed and notify MD [Medical Doctor] Observe for side effects: Antipsychotic meds: dizziness, dry mouth, indigestion, drowsiness, constipation, impaired balance, weight gain, tremors, abnormal involuntary movements"</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copy right 2015, Black Box Warning for risperidone include: " Elderly patients with dementia-related psychosis treated with antipsychotics are at increased risk for death. Drug isn't approved to treat elderly patients with dementia-related psychosisAlert: Watch for evidence of neuroleptic malignant syndrome (extrapyramidal effects, hyperthermia, autonomic disturbance), which is rare but can be fatal."</p> <p>The clinical record lacked documentation which indicated side effects were being monitored for Resident #103's risperidone.</p>		<p>MAR for those residents receiving anti-psychotics to ensure monitoring for adverse reactions are present and addressed.</p> <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the Dialysis CQI tool and the psychotropic management tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>On 2/25/15 at 9:49 a.m., an interview with RN (Registered Nurse) #2 indicated side effects are monitored and put in the computer each shift. RN #2 confirmed a side effect checklist was created on 2/24/15, for resident #103's risperidone and indicated side effects were not being monitored up until that point. RN #2 indicated side effects for risperidone included: lethargy, drunken walk, extrapyramidal side effects, weight gain, sedation and postural hypotension.</p> <p>On 2/25/15 at 10:15 a.m. an interview with the Medical Records Director indicated she had looked through the computer back to Resident #103's admit date of 7/1/14, and side effects had not been monitored on risperidone until 2/24/15.</p> <p>On 2/24/15 at 11:00 a.m., an interview with the ADON (Assistant Director of Nursing) indicated she could not find where side effects were being monitored for risperidone. "They are usually charted on the MAR [Medication Administration Record] but I cannot find them. I will get it put on the MAR today."</p> <p>2b. Resident #8's clinical record was</p>			

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	<p>reviewed on 02/23/15 at 10:48 a.m. Diagnoses included, but were not limited to: dementia, depressive disorder, delusional, and organic sleep apnea.</p> <p>February 2015, physician's order indicated: December 2013 (date initiated), Resident #8 received Zoloft (anti-depressant) 100 mg (milligram) at bedtime and was decreased on December 2014, to 50 mg at bedtime.</p> <p>September 17, 2014 (date initiated), Resident #8 received Risperidone (antipsychotic) 0.25 mg (milligram) twice daily.</p> <p>March 17, 2014 (date initiated), Resident #8 received Restoril (hypnotic) 7.5 mg (milligram) every bedtime as needed.</p> <p>The current care plan, initiated on 9/6/12, indicated a problem, "The resident is at risk for adverse side effects related to use of psychotropic medication (anti-psych, anti-depression, anti-hypnotic ... Approach: AIMS (Abnormal Involuntary Movement Scale) assessment two times a year."</p> <p>An AIMS assessment was completed on 10/28/13 and 11/26/14. No other AIMS assessment had been completed for 2013</p>			

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F 309 SS=D Bldg. 00	<p>nor 2014.</p> <p>On 02/24/15 10:00 a.m., interview with the MDS (Minimum Data Set) assessment Coordinator indicated an AIMS assessment is completed twice a year. This resident only had one done yearly.</p> <p>On 2/25/15 at 11:03 a.m., the Director of Nursing (DON) provided the policy, "Psychotropic Management Policy" dated 5/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "... An AIMS assessment is required for residents who are taking antipsychotic medication. The assessment should be completed within 48 hours of a new order to initiate an antipsychotic and then every six months..."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>				

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	<p>Based on observation, interview, and record review, the facility failed to ensure communication between the facility and dialysis center was maintained in accordance with the care plan and facility policy for 1 of 1 resident reviewed for dialysis. (Resident #125)</p> <p>Findings include:</p> <p>Resident #125's clinical record was reviewed on 2/24/15 at 11:04 a.m. Diagnosis included but were not limited to: end stage renal disease.</p> <p>The current Minimum Data Set assessment (MDS) dated 2/14/15, indicated a Brief Interview of Mental Status score (BIMS) was 14, with 8-15 being interviewable and cognitively intact.</p> <p>Physician's order dated 12/18/14, indicated dialysis 3 times a week on Monday, Wednesday and Friday.</p> <p>On 2/25/15 at 8:30 a.m., the Director of Nursing indicated, The dialysis center sends the [dialysis] summary back with the resident."</p> <p>The current care plan dated 12/16/14, "Problem: Resident is receiving hemodialysis and is at risk for</p>	F 309	<p>Westview- F-309</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident # 125 did not have a negative outcome related to the alleged deficient practice. Communication is now received from Dialysis with each visit and reviewed and care plan was reviewed by the MDSC. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. 100% audit of residents receiving dialysis to ensure care plan current, accurate and that communications are received from dialysis- <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p>	03/27/2015

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	<p>complications such as fluid imbalance, bleeding or infection sit: Left AV [arteriovenous]GOAL: ...dialysis Monday/Wednesday/Friday, ...12/15/14 APPROACH: Assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warmth, bruit/thrill [Bruits are rushing sounds heard over large and medium-sized arteries as a result of vibration in the vessel wall and buzzing sound] , ... observed for fluid volume deficit such as hypotension, orthostatic hypotension, ..."</p> <p>The clinical record lacked dialysis communication forms. On 2/24/15 at 3:00 p.m., request was made to the Director of Nursing to provide the dialysis communication documentation for Resident #125.</p> <p>On 2/25/15 at 8:26 a.m., the Director of Nursing (DON) provided "Transfer Summary" communication forms from the dialysis center dated: 12/26/14, 12/28/14, 12/30/14, 1/2/15, 1/5/15, 1/7/15, 1/9/15, 1/12/15, 1/14/15, 1/23/15, 1/26/15, 2/9/15, 2/11/15, 2/13/15 and 2/16/15. Theses forms were received by the facility, via fax from the dialysis center, on 2/24/15.</p> <p>On 2/25/15 at 11:03 a.m., the Director of Nursing provided policy "Dialysis Care"</p>		<ul style="list-style-type: none"> · Nurses providing care for dialysis residents have demonstrated to the CEC/designee competency with the policy and procedure on physician's orders for reviewing communication from the dialysis center following treatment and to request information immediately if not present on return from dialysis on or before 3/27/15. · Licensed nurses were re-educated on or before 3/27/15 by the CEC/designee on dialysis care policy. · DNS/Designee will monitor residents Medical Record who receive dialysis to ensure communication is received and documented per policy. <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · To ensure compliance, the DNS/Designee is responsible for the completion of the dialysis-CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then 	

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F 323 SS=E Bldg. 00	<p>revision date 9/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...It is policy of American Senior Communities to ensure that the resident is rendered necessary services for the provision and maintenance of dialysis services through effective communication with the dialysis unit. ... 7. The nurse in charge at time of return will review paperwork for new orders and/or paperwork accompanying the resident."</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the environment remained free of hazards, in that the water temperatures in residents' bathrooms exceeded the allowable maximum temperature as indicated by the facility policy, for 11 of 35 residents reviewed in Stage 1. (Resident #5, Resident #137, Resident #139, Resident #39, Resident #32, Resident #23, Resident #86, Resident</p>	F 323	<p>quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>F-323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The maintenance supervisor immediately adjusted water temperatures for residents #5, #137, #139, #39, #32, #23, #86, #62, #10, #27 and #103 and temperatures continue not to exceed the allowable maximum temperature. How other</p>	03/27/2015			

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	<p>#62, Resident #10, Resident #27, and Resident #103)</p> <p>Findings include:</p> <p>1.) On 2/19/15 at 1:57 p.m., Resident #86's bathroom sink water temperature measured 129.7 degrees Fahrenheit.</p> <p>Resident #86's Minimum Data Set assessment, dated 12/6/14, indicated the resident had a Brief Interview for Mental Status score of 13, with a score of 13-15 being cognitively intact.</p> <p>On 2/20/15 at 4:51 p.m., Resident #86's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 and the surveyor's thermometer measured 125.2 degrees Fahrenheit.</p> <p>2.) On 2/19/15 at 2:28 p.m., Resident #139's bathroom sink water temperature measured 124.6 degrees Fahrenheit.</p> <p>Resident #139's Minimum Data Set assessment, dated 2/12/15, indicated the resident had a Brief Interview for Mental Status score of 5, with a score of 0-7 being severely cognitively impaired, and required extensive assistance of 2 staff members to walk in their room.</p>		<p>residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · Facility has purchased digital thermometers on 2/20/15 to ensure water temp readings are accurate. · Random water checks will be completed daily by the maintenance supervisor/designee to ensure water temperatures do not exceed maximum temperatures- any above the maximum temps will be adjusted immediately. · The Maintenance Supervisor checked all resident rooms water temperatures with a new calibrated thermometer to ensure water temperatures do not exceed allowable maximum temperatures. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · Facility has purchased digital thermometers on 2/20/15 to ensure the reading of water temperatures are accurate. · Water temperatures will be checked twice daily in the affected residents rooms as well as other residents rooms on each unit daily to ensure water temperatures do not exceed maximum temperatures. · Maintenance was educated on calibration of thermometers and 				

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	<p>On 2/20/15 at 4:22 p.m., Resident #139's water temperature was rechecked. The Maintenance Supervisor's (MS) thermometer measured 96 degrees Fahrenheit and the surveyor's thermometer measured 120 degrees Fahrenheit. The MS indicated, "I think this thermometer is broken," and was observed to get a new thermometer from her office.</p> <p>3.) On 2/19/15 at 2:42 p.m., Resident #5's bathroom sink water temperature measured 122.5 degrees Fahrenheit.</p> <p>Resident #5's Minimum Data Set assessment, dated 1/20/15, indicated the resident had a Brief Interview for Mental Status score of 4, with a score of 0-7 being severely cognitively impaired and required extensive assistance of 2 staff members to walk in their room.</p> <p>On 2/20/15 at 4:13 p.m., with the Maintenance Supervisor (MS) present, Resident #5's water temperature was rechecked with the new thermometer. The MS's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 124 degrees Fahrenheit.</p> <p>4.) On 2/20/15 at 10:34 a.m., Resident #23's bathroom sink water temperature</p>		<p>monitoring water temperatures by the ED on or before 3/27/15. · The Maintenance Director/Designee will check and document water temperatures in affected rooms daily to ensure appropriate water temperatures. · Water temperatures will be reviewed by the ED/Designee daily to ensure not to exceed the allowable maximum temperature. How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the Maintenance supervisor/Designee is responsible for the completion of the daily water temperature-CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>measured 132.6 degrees Fahrenheit.</p> <p>Resident #23's Minimum Data Set assessment, dated 1/16/15, indicated the resident had a Brief Interview for Mental Status score of 2, with a score of 0-7 being severely cognitively impaired, and required extensive assistance of 1 staff member to walk in their room</p> <p>On 2/20/15 at 4:45 p.m., Resident #23's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 122.5 degrees Fahrenheit.</p> <p>5.) On 2/20/15 at 11:38 a.m., Resident #27's bathroom sink water temperature measured 133 degrees Fahrenheit.</p> <p>Resident #27's Minimum Data Set assessment, dated 11/15/14, indicated the resident had a Brief Interview for Mental Status score of 14, with a score of 13-15 being cognitively intact.</p> <p>On 2/20/15 at 4:17 p.m., Resident #27's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 133.3 degrees Fahrenheit.</p>			

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	<p>6.) On 2/20/15 at 11:02 a.m., Resident #10's bathroom sink water temperature measured 127.4 degrees Fahrenheit.</p> <p>Resident Minimum Data Set assessment, dated 1/13/15, indicated the resident had a Brief Interview for Mental Status score of 3, with a score of 0-7 being severely cognitively impaired, and required extensive assistance of 1 staff member to walk in their room.</p> <p>On 2/20/15 at 5:03 p.m., Resident #10's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 118 degrees Fahrenheit.</p> <p>7.) On 2/20/15 at 2:40 p.m., Resident #32's bathroom sink water temperature measured 129.7 degrees Fahrenheit.</p> <p>Resident #32's Minimum Data Set assessment, dated 1/28/15, indicated the resident had a Brief Interview for Mental Status score of 15, with a score of 13-15 being cognitively intact.</p> <p>On 2/20/15 at 4:17 p.m., Resident #32's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 125.2</p>			

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	<p>degrees Fahrenheit.</p> <p>8.) On 2/20/15 at 2:42 p.m., Resident #62's bathroom sink water temperature measured 129.6 degrees Fahrenheit.</p> <p>Resident #62's Minimum Data Set assessment, dated 12/7/14, indicated the resident had a Brief Interview for Mental Status score of 8, with a score of 8-12 being moderately cognitively impaired.</p> <p>On 2/2/15 at 4:59 p.m., Resident #62's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 120 degrees Fahrenheit.</p> <p>9.) On 2/20/15 at 2:46 p.m., Resident #137's bathroom sink water temperature measured 129.6 degrees Fahrenheit.</p> <p>Resident's #137's admission assessment, dated 2/10/15, indicated the resident was alert and oriented.</p> <p>On 2/20/15 at 4:17 p.m., Resident #137's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 133.3 degrees Fahrenheit.</p>			

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	<p>10.) On 2/20/15 at 2:47 p.m., Resident #39's bathroom sink water temperature measured 129.6 degrees Fahrenheit.</p> <p>Resident #39's Minimum Data Set assessment, dated 12/21/14, indicated the resident had a Brief Interview for Mental Status score of 0, with a total score of 0-7 being severely cognitively impaired and required extensive assistance of 2 staff members to walk in their room.</p> <p>On 2/20/15 at 4:17 p.m., Resident #39's water temperature was rechecked. The Maintenance Supervisor's thermometer measured 100 degrees Fahrenheit and the surveyor's thermometer measured 133.3 degrees Fahrenheit.</p> <p>11.) On 2/20/15 at 3:33 p.m., Resident #103's bathroom sink water temperature measured 124 degrees Fahrenheit.</p> <p>Resident #103's Minimum Data Set assessment, dated 12/7/14, indicated the resident had a Brief Interview for Mental Status score of 7, with a score of 0-7 being severely cognitively impaired and required extensive assistance of 2 staff members to walk in their room.</p> <p>On 2/20/15 at 5:12 p.m., Resident # 103's water temperature was rechecked. The Maintenance Supervisor's thermometer</p>			

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	<p>measured 100 degrees Fahrenheit and the surveyor's thermometer measured 122.2 degrees Fahrenheit.</p> <p>The survey teams' water temperature measurements were verified by using two different calibrated thermometers.</p> <p>Water Temperature Time Required for a 3rd Degree Burn to Occur: A water temperature of 140 degrees Fahrenheit takes 5 seconds for a 3rd degree burn to occur.</p> <p>A water temperature of 133 degrees Fahrenheit takes 15 seconds for a 3rd degree burn to occur.</p> <p>A water temperature of 127 degrees Fahrenheit takes 1 minute for a 3rd degree burn to occur.</p> <p>A water temperature of 124 degrees Fahrenheit takes 3 minutes for a 3rd degree burn to occur.</p> <p>A water temperature of 120 degrees Fahrenheit takes 5 minutes for a 3rd degree burn to occur.</p> <p>During an interview, on 2/20/15 at 3:58 p.m., The Maintenance Supervisor (MS) indicated the hot water line starts at the Vision Hall, then goes to the Augusta</p>			

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F 328 SS=D Bldg. 00	<p>Cottages, and finally wraps around to the Moving Forward Hall at the other side of the building. MS indicated, "We were told to not use the digital thermometers to measure the water temps [temperatures]." The MS was observed to use a dial thermometer to check all of the residents' water temperatures.</p> <p>On 2/20/15 at 4:05 p.m., the Administrator provided the facility's "Daily Water Temperature" policy, undated, and indicated it was the one currently being used by the facility. The policy indicated, "Temperatures between 100-120 should be maintained in resident care areas."</p> <p>3.1-19(r)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and</p>			

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	<p>Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents' portable oxygen tanks were filled with oxygen during a dining observation in the main dining room for 4 of 6 residents who had portable oxygen tanks in the dining room. (Resident #8, Resident #35, Resident #97, Resident #138)</p> <p>Findings include:</p> <p>1. Resident #138's clinical record was reviewed on 2/25/2015 at 9:30 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, and chronic obstructive pulmonary disease.</p> <p>A current physicians order dated 2/17/2015, indicated "Oxygen at 2 liters per nasal cannula. May titrate to keep sats [saturation] > [greater than] 90%."</p> <p>A careplan dated 2/18/2015, indicated a problem: "Resident has potential for impaired gas exchange related to: Respiratory Failure and COPD [chronic obstructive pulmonary disease]. Approach: Administer oxygen as ordered...."</p> <p>On 2/19/15 at 11:42 a.m., an observation of Resident #138's oxygen tank indicated</p>	F 328	<p>F-328- Westview</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Residents #138, #8, #35, and #97 did not have any negative outcomes related to the alleged deficient practice. Portable O2 tanks were filled immediately when identified empty and are checked by a Licensed Nurse/Designee prior to using and filled if needed. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> All residents receiving oxygen have the potential to be affected by the alleged deficient practice. Daily rounds will be completed by a licensed nurse to ensure residents receiving oxygen via 	03/27/2015

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	<p>it was empty while in the main dining room. LPN (Licensed Practical Nurse) #3 removed the tank and brought the tank back refilled.</p> <p>2. Resident #97's clinical record was reviewed on 2/25/2015 at 9:45 a.m. Diagnoses included, but were not limited to, chronic obstructive airway disease.</p> <p>A current physicians order dated 10/16/2014, indicated "Oxygen at 2 liters per nasal cannula."</p> <p>The current careplan dated 8/12/2014, indicated a problem: "Resident has potential for impaired gas exchange related to" COPD [chronic obstructive pulmonary disease], Wears Oxygen. Approach: Administer oxygen as ordered...."</p> <p>On 2/19/15 11:41 a.m., an observation of Resident #97's oxygen tank indicated it was empty. CNA (Certified Nursing Assistant) #1 removed the oxygen tank and brought the tank back filled.</p> <p>3. Resident #8's clinical record was reviewed on 2/25/2015 at 10:00 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, and congestive heart failure.</p>		<p>portable tank are filled</p> <ul style="list-style-type: none"> All portable oxygen tanks were replaced by the oxygen company on or before 3/27/15. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Nursing staff were educated on or before 3/27/15 by the DNS/designee on filling/monitoring portable oxygen tanks. Daily rounds each shift will be completed by a licensed nurse to ensure residents receiving oxygen via portable tank are filled. <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the oxygen-CQI tool weekly times 4</p>	

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	<p>A current physicians order dated 11/22/2013, indicated "Oxygen at 2 liters per nasal cannula as needed to keep sats [saturation] > [greater than] 90%..."</p> <p>The current careplan dated 9/6/2012, indicated a problem: "Resident has potential for impaired gas exchange related to: COPD [chronic obstructive pulmonary disease], CHF [congestive heart failure]. Approach: Administer oxygen as ordered...."</p> <p>On 2/19/2015 at 11:45 a.m., an observation in the main dining room of Resident #8's oxygen tank indicated it was empty. Resident #8's nasal cannula was removed and no oxygen was coming from the nasal cannula. Restorative CNA #1 removed the oxygen tank, refilled and brought it back to Resident #8.</p> <p>4. Resident #35's clinical record was reviewed on 2/23/2015 at 12:49 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disease, and congestive heart failure.</p> <p>A current physicians order dated 1/4/2015, indicated "Oxygen at 2 liters per nasal cannula, keep sats [saturation] > [greater than] 90%."</p>		<p>weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

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F 329 SS=D	<p>The current careplan dated 1/5/2015, indicated a problem: "Resident has potential for impaired gas exchange related to: (COPD [chronic obstructive pulmonary disease], hx [history] of pneumonia, hx of rt [right] lower lobe ectomy). Approach: Resident receives oxygen...Administer oxygen as ordered...."</p> <p>On 2/19/15 at 11:50 a.m., an observation in the main dining room indicated Resident #35's oxygen tank was empty. LPN (Licensed Practical Nurse) #1 indicated, "It's pretty empty." Observed LPN #1 to remove the empty oxygen tank at that time.</p> <p>On 2/25/2015 at 11:03 a.m., the Director of Nursing provided the Filling Portable Oxygen Canister policy, revised on 12/2012, and indicated the policy was the one currently being used by the facility. The policy indicated, "...17. Return filled portable tank to resident...."</p> <p>3.1-47(a)(6)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM</p>			

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Bldg. 00	<p>UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure residents who received an anti psychotic medication were monitored for side effects and an AIMS (Abnormal Involuntary Movement Scale) assessment had been completed as indicated by the facility policy for 2 of 5 residents reviewed for unnecessary medication use. (Resident #103, Resident #8)</p> <p>Findings include:</p> <p>1. Resident #103's clinical record was reviewed on 2/21/15 at 9:05 a.m.</p>	F 329	<p>F-329</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #103 has not had any side effects relating to anti-psychotic use and is now being monitored every shift. · Resident #8 Aims test 	03/27/2015

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	<p>Diagnoses included but, were not limited to dementia, nonorganic psychosis anxiety, depressive disorder.</p> <p>Physicians order dated 2/19/15, indicated Resident #103's medications included but, were not limited to: risperidone tablet (an antipsychotic used to treat schizophrenia and bipolar disorder) 0.125 mg every day for dementia with psychosis.</p> <p>Current care plan dated 9/15/14 indicated, "PROBLEM: Resident is at risk for adverse side-effects related to the use of psychotropic (anti-psych, antidepressant, anti-anxiety)</p> <p>APPROACH: document side effects as observed and notify MD [Medical Doctor] Observe for side effects: Antipsychotic meds: dizziness, dry mouth, indigestion, drowsiness, constipation, impaired balance, weight gain, tremors, abnormal involuntary movements"</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copy right 2015, Black Box Warning for risperidone include: " Elderly patients with dementia-related psychosis treated with antipsychotics are at increased risk for</p>		<p>completed and will be assessed every 6 months</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · 100% audit completed for those residents receiving an antipsychotic to ensure aims test has been completed every 6 months. Those found not to have a current aims test has been completed on or before 3/27/15. · 100% audits also competed for those residents receiving anti psychotics to ensure are monitored every shift for side effects .Those found not to have monitoring will be added to the medication administration record on or before 3/27/15. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p>	

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	<p>death. Drug isn't approved to treat elderly patients with dementia-related psychosisAlert: Watch for evidence of neuroleptic malignant syndrome (extrapyramidal effects, hyperthermia, autonomic disturbance), which is rare but can be fatal."</p> <p>The clinical record lacked documentation which indicated side effects were being monitored for Resident #103's risperidone.</p> <p>On 2/25/15 at 9:49 a.m., an interview with RN (Registered Nurse) #2 indicated side effects are monitored and put in the computer each shift. RN #2 confirmed a side effect checklist was created on 2/24/15, for Resident #103's risperidone and indicated side effects were not being monitored up until that point. RN #2 indicated side effects for risperidone included: lethargy, drunken walk, extrapyramidal side effects, weight gain, sedation, postural hypotension.</p> <p>On 2/25/15 at 10:15 a.m. an interview with the Medical Records Director indicated she had looked through the computer back to Resident #103's admit date of 7/1/14, and side effects had not been monitored on risperidone until 2/24/15.</p>		<ul style="list-style-type: none"> · All new admissions with orders for antipsychotic medications and any new orders received for anti psychotic medications will be reviewed to ensure aims test was completed and orders are in place to assesses every 6 months and to ensure monitoring every shift for side effects is in place. · Licensed nurses were educated on or before 3/27/15 on antipsychotic monitoring and aims test assessments by the DNS/designee. · The DNS/Designee will review MAR for residents receiving antipsychotic medication daily to ensure monitoring for adverse reactions are present and addressed. <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the psychotropic management -CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2</p>	

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F 371 SS=B Bldg. 00	<p>On 2/24/15 at 11:00 a.m., an interview with the ADON (Assistant Director of Nursing) indicated she could not find where side effects were being monitored for risperidone for Resident #103. "They are usually charted on the MAR (Medication Administration Record), but I cannot find them. I will get it put on the MAR today."</p> <p>On 2/25/15 at 12:00 p.m., requested a policy related to monitoring side effect for anti psychotics medications and the facility did not provide one.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure seasonings and spices had open dates and were removed from stock when expired as the manufacturers recommendations indicated for 1 of 1 dry food storage rooms. (Dietary Manager)</p> <p>Findings include:</p> <p>On 2/19/2015 at 10:10 a.m., an observation of the dry storage area</p>	F 371	<p>consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All seasonings and spices</p>	03/27/2015			

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	<p>indicated:</p> <p>Curry powder with a delivery date of 7/1/2010, with no open date.</p> <p>Fine ground sage with a delivery date of 5/10/12, with no open date.</p> <p>Dill weed with a delivery date of 7/30/2007, with no open date.</p> <p>Ground basil with a delivery date of 11/28/08, with no open date.</p> <p>Ground thyme with a delivery date of 2/10/2011, with no open date.</p> <p>Ground white pepper with a delivery date of 4/29/2010, with no open date.</p> <p>Leaf tarragon with a delivery date of 12/28/2007, with no open date.</p> <p>Whole bay leaves with a delivery date of 9/9/2010, with no open date.</p> <p>Leaf marjoram with a delivery date of 7/27/2011, with no open date.</p> <p>On 2/19/2015 at 10:15 a.m., an interview with the Dietary Manager indicated the spices and seasonings are good for a year after opening. At that time, the Dietary Manager was observed to remove the seasoning and spices from stock.</p> <p>On 2/23/2015 at 9:15 a.m., the Administrator provided the manufacturers' shelf life recommendations, dated 2013, and indicated the policy was the one currently being used by the facility. The policy indicated, "...2 Year Shelf Life: Whole</p>		<p>without open dates and those with expired open dates were immediately removed and destroyed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · Dietary staff was educated by the Dietary Manager/designee on or before 2/26/15 regarding expiration dates and open dates for seasonings and spices. · All other seasonings and spices were checked by the Dietary Manager to ensure they were not expired. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All seasonings and spices will be checked monthly by the Dietary Manager/designee to ensure not 	

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F 441 SS=D	Herbs; Ground Spices: Dehydrated Garlic/Onion; Dehydrated Vegetables; Chives; Parsley; Seasonings. 3 Year Shelf Life: Whole Seeds; Pure & Imitation Extracts...." 3.1-21(i)(2) 483.65 INFECTION CONTROL, PREVENT		expired – those found to be expired will be removed and destroyed. How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the Dietary Manager/Designee is responsible for the completion of Short sanitation form weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Transfer technique skills validation check will be completed on all shifts daily for one week, bi weekly for 1 week, weekly times 2 week, and monthly for six months by DNS/Designee . Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance.		

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Bldg. 00	<p>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 -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(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.</p> <p>(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.</p> <p>(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 infection control practices were followed</p>	F 441	F-441- Westview	03/27/2015

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	<p>as indicated by facility policy and Center for Disease Control related to hand washing and glove change during personal care and wound care for 1 of 1 resident observed for pressure ulcers (Resident #125) and 1 of 1 randomly observed resident for personal care. (Resident #125) (CNA #1, CNA #2, CNA #3, RN #1, Executive Director)</p> <p>Finding include:</p> <p>1). On 2/25/25 at 11:50 a.m., RN #1 was observed to provide wound care on Resident #125's right foot amputee. She put on gloves and cleansed area with iodine, then placed a Vaseline gauze on, wrapped with kerlix, and secured with tape. No change of glove nor handwashing was observed at that time. She removed the gloves and placed in a trash can. RN #1 entered the bathroom and handwashed. RN #1 walked over to the wall and retrieved a pair of gloves and put them on. She applied skin prep to the left ear. No handwashing nor change of gloves observed. RN #1 applied skin to both heels and then with dirty gloves still on she positioned Resident #125's heels on a cushion and covered with the bed spread. She then removed the dirty gloves and went into the bathroom to handwash. She removed the trash bag from the trash can. She then</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident # 125 had no negative outcome related to the alleged deficient practice and is receiving dressing changes and personal care per infection control procedures. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice A review of all residents requiring dressing changes/personal care has been completed on or before 3/27/15 by the DNS/designee to ensure proper infection control measures are in place and maintained <p>What measures will be put into</p>				

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	<p>removed the dirty towels from the bedside table with the iodine gauze remaining on the towel and placed the items a plastic bag to take to laundry. No handwashing was observed. RN #1 was observed to exit the room at that time.</p> <p>On 2/25/15 at 12:03 p.m., RN #1 indicated, "You should handwash after removing soiled dressing, after applying clean dressing, from clean to dirty, I was not aware that iodine was cleansing, it is part of her treatment. I did place the dirty iodine gauze on the towel. I should have hand washed after removing trash and the towel."</p> <p>2). On 2/19/15 at 2:45 p.m., the Executive Director (ED) was observed to enter the room of Resident #4 to answer the call light. No handwashing was observed. Resident #4 indicated, "I need to get off the bedpan." At that time the ED was assisting Resident #4 and 3 Certified Nursing Assistants (CNA) were observed to enter the room to assist. CNA #3 was observed to assist in removing the bedpan from underneath Resident #4 while the ED was holding Resident #4 on her side. CNA #3 walked into the bathroom with her dirty gloves on and moved the electric wheelchair out of the way. CNA #3 was observed to empty the bedpan and with the dirty</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All nurses and ED providing dressing changes/personal care were educated by the DNS/designee on or before 3/27/15 for dressing changes, perineal care, hand washing and glove use. · All c.n.a.'s providing personal care were educated on or before 3/27/15 by the DNS/designee for perineal care, hand washing and glove use to ensure infection control practices are followed · Skills validation checks for all nurses on dressing changes, perineal care, hand washing and glove use will be completed by the CEC/DNS/Designee to ensure proper infection control measures are followed. · Skills validation skills for all c.n.a.'s on perineal care, hand washing and glove use will be completed by the CEC/DNS/Designee to ensure proper infection control measures are followed. · DNS/Designee will conduct rounds each shift to ensure infection control practices are followed per policy. 	

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	<p>gloves on received clean wash cloths from CNA #2. With the dirty gloves still on CNA #3 was observed to wet the clean wash cloths. She removed one dirty glove and walked back to the bedside with one dirty glove still on. CNA #3 was observed to place a second glove on and began personal care for Resident #4. After completing personal care CNA #3 and the ED were both observed with dirty gloves on to assisted Resident #4 up in bed. CNA #3 with the dirty gloves on covered Resident #4 with a blanket that was on her bed. The ED was observed to remove her gloves, and enter the bathroom and handwash for 10 seconds.</p> <p>CNA #2 indicated, "We should handwash upon entering the room, after care and when in doubt handwash." CNA #3 indicated, " I should handwash anytime I change my gloves. I didn't change my gloves nor handwash after I contaminated them." CNA #1 was observed to get clean linen to change the bedding on Resident #4's bed.</p> <p>On 2/25/15 at 11:03 a.m., the Director of Nursing provided policy "HAND HYGIENE" review date 03/2012, and indicated the policy was the one currently used by the facility. The policy indicated, " Procedure Steps: ...6. Use friction for at</p>		<p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the infection control CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>Dressing change, hand washing, glove use and perineal skills validation checks will be completed on all shifts daily for one week, bi weekly for 1 week, weekly times 2 week, and monthly for six months by DNS/Designee . Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance.</p>	

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F 456 SS=C Bldg. 00	<p>least 20 seconds. ...5 Moment of required hand hygiene: ...After body fluid exposure risk, After patient contact, After contact with patient surroundings."</p> <p>On 2/26/15, review of Center for Disease Control at www.cdc.gov/handwashing/, dated December 16, 2013 indicated, " When should you wash your hands? ...food Before and after caring for someone who is sick, Before and after treating a cut or wound, After touching garbage, ...How should you wash your hands?Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. ... "</p> <p>3.1-18(1)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review, and interview, the facility failed to ensure the dishwasher maintained minimum temperatures during the wash cycle as the manufacturers label indicated for 1 of 1 dishwashers in 1 of 1 kitchen. (Dietary</p>	F 456	<p>F-456 Requesting paper IDR review due to disagree with scope and severity</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the</p>	03/26/2015

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	<p>Manager).</p> <p>Findings include:</p> <p>1. On 2/20/2015 at 10:25 a.m., an observation of the dishwashers wash cycle indicated the temperature measured 150 degrees Fahrenheit. Dietary Cook #1 was observed to rerun the dishwasher and the temperature measured 152 degrees Fahrenheit. The manufacturers label on the dishwasher indicated the minimum temperature for the wash cycle was 155 degrees Fahrenheit.</p> <p>On 2/23/2015 at 9:30 a.m., an observation of the dishwasher operation with the Dietary Manager indicated the wash cycle measured 152 degrees Fahrenheit. At that time, an interview with the Dietary Manager indicated the dishwasher company had someone come out and work on the dishwasher.</p> <p>On 2/24/2015 at 10:30 a.m., an observation of the dishwasher operating during its wash cycle indicated it measured 160 degrees Fahrenheit. At that time, an interview with the Dietary Manager indicated they turned up the temperature on the thermostat.</p> <p>On 2/25/2015 at 11:09 a.m.. an interview</p>		<p>deficient practice?</p> <ul style="list-style-type: none"> The Maintenance Supervisor immediately increased the temperature of the thermostat on the dishwasher and is now maintaining temperatures exceeding manufacturers guidelines. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice Dishwasher temps will be checked every meal by the Dietary Manager/designee to ensure dishwasher temps exceed manufactures guidelines. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Dietary staff were in-serviced by the Dietary Manager on or before 2/23/15 regarding recording and 				

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	<p>with the Dishwasher Service person indicated, he was here on the 12th of February and the dishwasher temperature measured 152 degrees Fahrenheit. He indicated he was trained it was ok as long as the temperature is within 5 degrees of the optimal temperature posted on the side of the dishwasher and that's why he didn't turn up the thermostat.</p> <p>On 2/25/2015 at 11:10 a.m., the Administrator indicated the facility does not have a copy of the Manufacturer's instructions for the dishwasher, nor a policy related to dishwasher temperatures.</p> <p>3.1-19(bb)</p>		<p>reading the guage on the dishwasher.</p> <p>Dishwasher temps will be checked every meal by the Dietary Manager/designee to ensure dishwasher temps exceed manufactures guidelines.</p> <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the Dietary Manager/Designee is responsible for the completion of the dishwasher temperature log CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>Transfer technique skills validation check will be completed on all shifts daily for one week, bi weekly for 1 week, weekly times 2 week, and monthly for six months by DNS/Designee . Results of the skills validation will be reviewed by the</p>		

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			<p>CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance.</p> <p><u>Westview Nursing and Rehabilitation Center IDR Informal Dispute Resolution for Recertification and Licensure Survey 2-25-15 Westview Nursing and Rehabilitation is requesting Paper IDR review</u></p> <p>Westview Nursing and Rehabilitation Center respectfully requests additional evidentiary information be considered to reduce or delete F 456 from the 2567. The current statement of deficiency on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents. F456 §483.70(c)(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Probes: §483.70(c) (2) Is essential equipment (e.g., boiler room equipment, nursing unit/medication room refrigerators, kitchen refrigerator/freezer and laundry equipment) in safe operating condition? Is equipment maintained according to manufacturers recommendations. State Operations Manual definition of severity: B. Guidance on</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>Severity Levels There are four severity levels. Level 1, no actual harm with potential for minimal harm; Level 2, no actual harm with potential for more than minimal harm that is not immediate jeopardy; Level 3, actual harm that is not immediate jeopardy; Level 4, immediate jeopardy to resident health or safety. These four levels are defined accordingly:</p> <p>1. Level 1 is a deficiency that has the potential for causing no more than a minor negative impact on the resident(s). 2. Level 2 is noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. The deficient practice statement states: Based on observation, record review, and interview, the facility failed to ensure the dishwasher maintained minimum temperatures during the wash cycle as the manufacturers label indicated for 1 of 1 dishwashers in 1 of 1</p>	

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			<p>kitchen. (Dietary Manager) Evidence to refute the finding: The type of the dishwasher at Westview is a CMA-180 High Temperature Single Rack Dishwasher. It has a stationary rack with spray arm system and dual temperatures. (Attachment 1) Below is an excerpt from the state food code rule: 410 IAC 7-24-284 Dishwashing machine; wash solution temperature Sec. 284. (a) The temperature of the wash solution in spray-type dishwashing machines that use hot water to sanitize may not be less than: (1) for a stationary rack, single temperature machine, one hundred sixty-five (165) degrees Fahrenheit; (2) for a stationary rack, dual temperature machine, one hundred fifty (150) degrees Fahrenheit; (3) for a single tank, conveyor, dual temperature machine, one hundred sixty (160) degrees Fahrenheit; or (4) for a multitank, conveyor, multitemperature machine, one hundred fifty (150) degrees Fahrenheit. (b) The temperature of the wash solution in spray-type warewashing machines that use chemicals to sanitize may be not less than one hundred twenty (120) degrees</p>	

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			<p>Fahrenheit. Hot Water Machine Type Type of Temperature Wash Temperature of Machine Sanitization Temperature of the Machine Stationary Rack Single Temperature 165°F 165°F Stationary Rack Dual Temperature 150°F 180°F Single Tank Dual Temperature 160°F 180°F Multitank Multitemperature 150°F 180°F Chemical Machine 120°F Not Applicable</p> <p>(c) For purposes of this section, a violation of subsection (a) or (b) is a noncritical item. The facility logs the temperature of the wash cycle and the sanitation cycle as evidence by the temperature log. (Attachment 2). Conclusion: The dishwasher at Westview is a CMA-180 High Temperature Single Rack Dishwasher. Dishes go through a wash cycle and a rinse sanitization cycle. Based on the food code rule, the temperature of the dish cycle met the food code rule of 150 degrees per log and 2567. The rinse cycle was not cited in the 2567 which is considered the sanitization cycle and met the food code rule. Since the sanitation cycle was adequate, the scope should be considered level 1 - that has the potential for causing no more than a minor negative impact on the resident(s). Therefore Westview is requesting F 456 be</p>	

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F 465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure staff maintained clean privacy curtains, repaired damaged wallpaper, repaired doors, and replaced stained ceiling tiles for 7 of 10 residents observed for room furnishings. (Resident #86, Resident #72, and Resident #31, Resident #60, Resident #41, Resident #103, and Resident #27)</p> <p>Findings include:</p> <p>1.) On 2/19/15 at 1:57 p.m., Resident #86's bedroom door was observed to be very hard to close. The resident indicated, "You have to really push to get the door to close all of the way."</p> <p>2.) On 2/19/15 at 2:19 p.m. Resident #60's wallpaper on the wall behind the bed was observed to be wrinkled up and torn. There were 6 ceiling tiles observed to have light brown stains varying in size and 3 ceiling tiles had punctures in the bedroom.</p>			F 465	<p>reduced in scope or be deleted. Thank you for your consideration</p> <p>F- 465</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #86 door was replaced · Resident #60 and #27 ceiling tiles and wall paper were replaced · Resident #31's room door was repaired · Resident #72's privacy curtain was changed out · Resident #103's wall was repaired · Resident #41's wallpaper in room and bathroom was repaired 		03/27/2015

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	<p>3.) On 2/19/15 at 2:25 p.m., Resident #31's room door was observed to have multiple large gouges and jagged wood exposed to the outside bottom half of the door.</p> <p>4.) On 2/19/15 at 2:26 p.m., Resident #41's wallpaper was observed to be torn, in the bathroom, above the soap dispenser and scuff marks were observed on the wall that adjoins the hallway next to resident's bed.</p> <p>5.) On 2/20/15 at 11:33 a.m., Resident #72's privacy curtain was observed to be dirty with black marking at bottom.</p> <p>6.) On 2/20/15 at 11:25 a.m., Resident #27's wallpaper was noted to be wrinkled up by the head of the bed and above the heater. Two ceiling tiles by the winder were observed to be stained light brown and varying in size.</p> <p>7.) On 2/20/15 at 3:32 p.m., Resident 103's bedroom was observed to have a scuff marks and two half-dollar sized unfinished patches on the wall which adjoined the hallway.</p> <p>During a tour with the Maintenance Supervisor (MS), on 2/24/15 at 11:15 a.m., she indicated the facility will be going through renovations within the</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · All resident doors were inspected for gouges and jagged wood- those found with these issues were repaired. · The Maintenance Supervisor/designee checked all the resident rooms to ensure doors, ceiling tiles, wall paper, privacy curtains etc. are clean, replaced and or repaired. Those found not to be will be repaired, replaced and or properly cleaned immediately. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Maintenance supervisor/designee educated all housekeeping and Customer Care representatives on or before 3/27/15 		

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	<p>next year. The following interviews took place:</p> <p>On 2/24/15 at 11:18 a.m., when closing Resident #86's door, the MS indicated, "It feels like the door has failed."</p> <p>On 2/24/15 at 11:22 a.m., Resident #31 door was observed with the MS and she indicated, "It looks like the door has probably gotten chipped from moving the beds in and out."</p> <p>On 2/24/15 at 11:16 a.m., Resident #72 privacy curtain was observed with the MS and she indicated, "It look like those are ink stains from a pen." She also indicated the curtains were cleaned monthly.</p> <p>On 2/24/15 at 3:12 p.m., the Administrator (ADM) provided the facility's "[Facility Name]; 2015 Budget Scope 6/11/14," and indicated the renovations listed would be provided by the corporation and would take place over the next year. The budget did not address repairing or replacing the wallpaper or ceiling tiles in the residents' rooms. The ADM indicated the the facility was also renovating rooms personally, but she was unable to provide any information regarding when the facility's personal renovations would take</p>		<p>to check resident rooms assigned to them for environmental issues and to report to Maintenance immediately.</p> <ul style="list-style-type: none"> · Customer Care Reps/Designee will complete a check list daily to ensure resident rooms are safe, functional and sanitary. Any concerns will be reported to applicable staff and ED for appropriate follow-up. · The ED/Designee will follow-up to ensure necessary repairs/cleaning is completed. <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the Maintenance Supervisor/Designee is responsible for the completion of the environmental-CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>				

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	<p>place, or what rooms it would affect. She indicated they planned to renovate rooms as they could "get to them."</p> <p>On 2/25/14 at 9:48 a.m., the Administrator and the MS indicated the facility did not have a policy regarding maintenance of the facility.</p> <p>3.1-19(f)</p>						