

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/27/2013
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 16, 17, 18, 19, 23, 26, 27, 2013</p> <p>Facility number: 012966 Provider number: 155803 AIM number: 201110390</p> <p>Survey team: Diane Hancock, RN TC (December 16, 17, 18, 19, 26, 27) Barbara Fowler, RN (December 16, 17, 18, 19) Denise Schwandner, RN Diana Perry, RN Anna Villain, RN</p> <p>Census bed type: SNF 33 SNF/NF 44 Residential 51 Total 128</p> <p>Census payor type: Medicare: 29 Medicaid: 20 Other: 79 Total: 128</p> <p>These deficiencies reflect state findings cited in accordance with</p>	F000000	<p>This Plan of Correction is prepared and executed because it is required by the Provisions of State and Federal regulations. The Village at Hamilton Pointe maintains that each deficiency does not jeopardize the health and safety of the residents, not is it of such a nature as to limit our capability to provide adequate care.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000250 SS=D	<p>410 IAC 16.2.</p> <p>Quality review completed on January 3, 2014, by Jodi Meyer, RN</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident reviewed for behaviors, in the sample of 1 who met the criteria, was evaluated and received treatment for behaviors. (Resident # 97)</p> <p>Finding includes:</p> <p>During an observation on 12/18/13 at 11:00 a.m., Resident #97 was observed to be in his room in a recliner playing with his blanket.</p> <p>During an observation on 12/19/13 at 9:35 a.m., Resident #97 became very agitated with LPN #2 while care was being performed. Resident #97</p>	F000250	<p>1. The Power of Attorney for Resident #97 refused to allow a psychiatric evaluation. 2. All residents with behaviors were reviewed on December 27, 2013 by the Interdisciplinary Team (IDT) to determine if appropriate interventions are in place. No concerns were noted. 3. Licensed staff and C.N.A.'s will be reeducated regarding appropriate behavior documentation. This reeducation will be completed by January 22, 2014. 4. Director of Nursing/Designee will review behavior documentation for appropriate interventions five (5) times per week for two weeks (2), then one (1) time per week for four (4) weeks, then monthly times three (3) months then quarterly per Quality Control Program. The results of these audits will be reviewed by the</p>	01/23/2014	

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	<p>indicated he wanted LPN #2 to leave him alone when she was observing a rash on his back.</p> <p>Resident #97's record was reviewed on 12/18/13 at 3:00 p.m. Resident #97 had a diagnosis including, but not limited to, Alzheimer's disease.</p> <p>The MDS (Minimum Data Set) assessment, dated 10/20/13, indicated Resident #97 had behaviors directed toward others and rejected care or evaluation.</p> <p>Resident #97 had a physician's order, dated 7/18/13, indicating Resident #97 could have a psychiatric service evaluation and treatment.</p> <p>A nurse's progress note, dated 9/10/13 at 6:24 a.m., indicated Resident #97 was combative when given pericare.</p> <p>A nurse's progress note, dated 9/24/13 at 2:43 p.m., indicated Resident #97 had been very agitated and had inappropriate behaviors.</p> <p>A nurse's progress note, dated 11/9/13 at 9:04 p.m., indicated Resident #97 had shown aggressive</p>		<p>Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>				

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	<p>behaviors, swinging at a CNA (certified nursing assistant) and hitting the CNA at times when transferring the resident to bed.</p> <p>A nurse's progress notes, dated 11/12/13 at 1:58 a.m., Resident #97 had been resistive to care at bed check.</p> <p>A "Behavior Sheet," dated 8/12/13 at 3:30 p.m., indicated Resident #97 had behaviors including hitting others were severe.</p> <p>A "Behavior Sheet." dated 11/9/13 at 11:18 p.m., indicated Resident #97 had behaviors which included grabbing and hitting others.</p> <p>During an interview on 12/19/13 at 2:00 p.m., SW #1 indicated Resident #97 had not had a psychiatric evaluation even though the resident had behaviors.</p> <p>During an interview on 12/19/13 at 2:25., SW #2 indicated Resident #97 had not had a psychiatric evaluation even though he had an order. SW #2 indicated the resident would probably not speak to a psychologist and the resident was already receiving an antidepressant. SW #2 indicated she was aware the</p>			

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F000253 SS=E	<p>resident had behaviors. SW #2 indicated she would notify Resident #97's family regarding the resident's behaviors and have the psychiatrist evaluation performed if the family was in agreement.</p> <p>3.1-34(a)</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure the resident environment was sanitary and orderly, for 8 of 35 residents observed during stage 1, in that personal items were stored uncovered and unlabeled on sinks, toilets, or the floor. (Residents #107, #83, #139, #98, #202, #19, #4, #190)</p> <p>Findings include:</p> <p>1. Resident #107's and #83's room and bathroom, room 305, were observed on 12/17/13 at 8:11 a.m. A denture cup without a name indicated was stored on the rail behind the toilet. A large plastic bag</p>	F000253	<p>1. The Unit Manager removed the denture cup, large plastic bag with an emesis basin containing a toothbrush, toothpaste and wash basin from Room 305 (Resident 107, Resident 83) on December 20, 2013. The Unit Manager removed the toothbrushes, denture cup, powder, toothpaste, barrier cream and body soap from Room 901, (Resident #139) on December 20, 2013. The Unit Manager removed the toothbrush from Room 306 (Resident 98) on December 20, 2013. The Unit Manager removed the denture cup, large plastic bag with an emesis basin containing a toothbrush, toothpaste and wash basin from Room 305 (Resident 107, Resident 83) on December 20, 2013. 2. All resident's rooms</p>	01/23/2014			

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	<p>with an emesis basin containing a toothbrush and tooth paste was stored on the toilet lid, no name identified. A wash basin was in the floor of the shower with no name indicated. Two residents resided in the room.</p> <p>The same room was observed on 12/18/13 at 10:43 a.m. An unidentified wash basin was on the floor in the shower. A denture cup with no name was on the rail behind the toilet. The open plastic bag was observed on the back of the toilet with a toothbrush, paste, and an emesis basin. There was no identification as to who the items belonged.</p> <p>2. Resident #139's room and bathroom, room 901, were observed on 12/16/13 at 4:00 p.m. The resident shared a room. Toothbrushes and a denture cup were setting on the back of the toilet uncovered, with no names on them. On 12/18/13 at 11:05 a.m., two toothbrushes were observed laying on the sink, behind the faucet. One unlabeled denture cup was setting on the edge of the sink. Powder, toothpaste, barrier cream, and body soap were setting on the grab bar</p>		<p>were checked to ensure all personal items were identified by name, bagged and stored on December 20, 2013, by the Unit Manager/Designee. No concerns were noted. 3. Licensed staff and C.N.A.'s will be reeducated by the Director of Nursing/Designee regarding storing of resident's personal care items. This reeducation will be completed by January 22, 2014. 4. The Director of Nursing/Designee will inspect all rooms for proper storage of personal care items five (5) times per week for two weeks (2), then one (1) time per week for four (4) weeks, then monthly times three (3) months then quarterly per Quality Control Program. The results of these audits will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>				

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	<p>behind the toilet.</p> <p>3. Resident #98's room and bathroom, room 306, were observed on 12/17/13 at 9:25 a.m. The resident shared a room. A toothbrush was observed laying on the sink behind the faucet.</p> <p>4. Resident #202's room and bathroom, room 904, were observed on 12/17/13 at 10:14 a.m. Soiled clothes were in a plastic bag setting on the floor of the bathroom. A toothbrush was observed uncovered on the back of the toilet. On 12/18/13 at 11:19 a.m., a toothbrush was observed on the edge of the sink, uncovered.</p> <p>6. Resident #19's room and bathroom, room 907, were observed on 12/17/13 at 10:35 a.m. A toothbrush was observed uncovered setting on the back of the toilet. On 12/18/13 at 11:21 a.m., a denture brush was observed uncovered on the back of the toilet.</p> <p>7. Resident #4's room and bathroom, room 403, were observed on 12/16/13 at 11:55 a.m. The resident shared a room. Unidentified denture cups were observed on the rail behind the</p>						

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	<p>toilet. A toothbrush was in a cup on the sink, along with body wash/shampoo. The toilet lid was too small for the tank. A bed pan was observed in the floor of the shower. On 12/18/13 at 11:29 a.m., a denture cup was observed on the grab rail behind the toilet. A toothbrush was uncovered and laying on the sink behind the faucet with the bristles down against the sink.</p> <p>8. Resident #190's room and bathroom, room 712, were observed on 12/18/13 at 11:49 a.m. Two toothbrushes and a denture brush were uncovered and setting on the back of the sink. Hair was observed on the denture brush.</p> <p>9. The uncovered and unlabeled items stored on the toilets/sinks was reported to the Administrator on 12/19/13 at 5:00 p.m. She indicated items should not be stored there and should be bagged or covered. On 12/26/13 at 9:30 a.m., she indicated they had issued new toothbrushes and denture brushes and had supplied plastic bags for storage of items. They were also investigating shelves or storage areas for the bathrooms.</p>			

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F000258 SS=D	<p>3.1-19(f)</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to maintain comfortable sound levels for 2 of 35 census sample residents, in that the heat/air unit fans were excessively loud. (Resident #203, #22)</p> <p>Findings include:</p> <p>1. Resident #203 was interviewed on 12/17/13 at 12:53 p.m. The resident indicated the heater was too noisy. The resident's room was</p>	F000258	<p>1. Resident #22 heat/air unit was inspected by the Maintenance Director on January 3, 2014 and the unit was found to be in working order. The outside vent was adjusted to decrease the noise output from the unit. The identifier list does not indicate a Resident #203. 2. All heat/air units were checked by the Maintenance Director on January 3, 2014 and all were found to be within normal sound levels and no issues identified. 3. The Maintenance Director will be reeducated by the Executive Director regarding 483.15 (h)(7) Maintenance of</p>	01/23/2014
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	<p>observed on 12/17/13 at 3:25 p.m. The fan/blower on the heater unit was very loud. On 12/18/13 at 11:56 a.m., Resident #203's heat/air unit was observed to be on. The unit could be heard from outside the room in the hallway. The resident indicated it was very loud.</p> <p>2. Resident #22's room (602) was observed on 12/18/13 at 11:59 a.m. The heat/air unit was very loud. The resident indicated it disrupted her sleep.</p> <p>3. The noisy heat/air units were reviewed with the Administrator on 12/26/13 at 4:15 p.m. She indicated some units were noisier than others.</p> <p>3.1-19(f)</p>		<p>Comfortable Sound Levels. This reeducation will be completed by January 22, 2014. 4. Maintenance Director/Designee will observe two units per hall for twelve (12) weeks to verify if heat/air units are maintaining a comfortable sound level. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a care plan was developed for restorative/functional nursing care and for incontinence for 1 of 33 stage 2 sample residents. (Resident #76)</p> <p>Findings include:</p> <p>Resident #76's clinical record was reviewed on 12/26/13 at 8:56 a.m. The resident had an admission Minimum Data Set (MDS) assessment, dated 8/22/13,</p>	F000279	<p>1. Resident #76's bladder incontinence care plan was developed to include a check and change schedule on December 27, 2013 by the MDS Coordinator. 2. All care plans will be reviewed upon next scheduled review date for accuracy. 3. Licensed staff will be reeducated by the Director of Nursing/Designee regarding initiating care plan upon admission and updating care plans. This reeducation will be completed by January 22, 2014. 4. The Director of Nursing/Designee will review six (6) charts per week times four (4)</p>	01/23/2014	

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	<p>indicating the resident required extensive assistance of two persons for transfers, bed mobility, and ambulation. The assessment indicated the resident was frequently incontinent of urine and bowel and had no toileting program. A quarterly MDS assessment, dated 11/1/13, indicated the resident required extensive assistance of two persons for transfer and bed mobility and was unable to ambulate. The quarterly MDS assessment indicated the resident was always incontinent of bowel and bladder.</p> <p>The Rehabilitation Director provided a discharge summary from physical therapy, and recommendations for a functional maintenance program for Resident #76, dated 11/6/13. The discharge summary indicated the resident was able to ambulate 75 feet with minimal assistance and required moderate assistance with transfers. The Therapy Referral for Restorative Nursing/Functional Maintenance Program indicated the resident's current functional status as, "Patient able to ambulate [with] RW [rolling walker] with gait belt [with] assist of 1."</p> <p>Problems/needs: "Patient's level of assist varies d/t [due to] level of fatigue. Patient needs (A) [assist] to</p>		<p>weeks to ensure accuracy of care plan then six (6) charts per month for two (2) months. The results of these audits will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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	<p>transfer self - stand @ RW and needs cues to push up from w/c. Patient demo's tight hamstrings." Goals: "Please help patient to maintain current ROM and strength of (B) LE exercises. Please help patient to be able to maintain ability to ambulate." Recommendations/Approaches: "-(B) [bilateral] hamstring stretching -(B) LE [lower extremities] exs [exercises] X 20 reps with cueing (sitting or supine) -Amb. with RW and gait belt X 75' -restorator bike."</p> <p>The resident's record did not include a care plan for exercises or ambulation.</p> <p>On 12/26/13 at 11:10 a.m., CNA #4 was observed to go to the activity room, wheel the resident in his wheelchair back to his room and into the bathroom to be toileted. No ambulation was observed.</p> <p>Interview with the Director of Nurses on 12/27/13 at 9:00 a.m. indicated the discharge plan had been given to the restorative nurse and a care plan had not been developed for the resident.</p> <p>A Bowel and Bladder Evaluation and</p>				

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	<p>Plan, dated 8/22/13 at 5:15 p.m., indicated the resident was incontinent of bowel and bladder. No pattern was identified. The elimination plan for the resident indicated "retraining to return to previous pattern/retraining." The record further indicated, "Resident is cognitively impaired, unable to voice need to void, does have BPH [benign prostatic hypertrophy, and overactive bladder dx [diagnoses]. Will place resident on check and change program" A quarterly re-evaluation, dated 11/15/13 at 10:15 a.m., indicated there was no change and the bowel and bladder management programs were effective.</p> <p>There was no care plan for incontinence.</p> <p>On 12/26/13 at 10:35 a.m., LPN #4 indicated the resident was toileted every two hours. She could not find a care plan for managing incontinence; there was only a plan for needing assistance with toileting.</p> <p>3.1-35(a)</p>			

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F000309 SS=D	<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> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident sampled for dialysis had their access graft assessed for patency, in a total sample of 1 who received dialysis. (Resident #80)</p> <p>Finding includes:</p> <p>During initial tour of the facility on 12/16/13 at 8:55 a.m., LPN #1 indicated Resident #80 received dialysis.</p> <p>The clinical record of Resident #80 was reviewed on 12/17/13 at 9:43 a.m. Resident #80 was admitted with a diagnosis including, but not limited to, ESRD (end stage renal</p>	F000309	<p>1. Resident #80's dialysis access site was checked by the Director of Nursing on December 27, 2013. 2. No other residents receive dialysis at this time. 3. Licensed staff will be reeducated by the Director of Nursing/Designee regarding monitoring dialysis access sites every shift. This reeducation will be completed by January 22, 2014. 4. The Director of Nursing/Designee will review the Treatment Administration Record of Resident dialysis patients to ensure proper monitoring of dialysis patient's dialysis site every shift for five (5) days then every shift three (3) times per week for two (2) weeks and every shift once weekly for three (3) weeks. The results of these audits will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance</p>	01/23/2014
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	<p>disease)</p> <p>A care plan, dated 7/24/13 and reviewed on 10/24/13, indicated Resident #80 needed hemodialysis related to ESRD on Monday, Wednesday, and Friday. The care plan indicated Resident #80 was to have "pre and post dialysis log every dialysis day."</p> <p>Resident #80 had a form titled, "TLC Pre Dialysis Data" and dated 11/27/13, indicating Resident #80 had been assessed prior to having dialysis and Resident #80 had a thrill and bruit present.</p> <p>Resident #80 had a form titled, "TLC Post Dialysis Data" and dated 12/2/13, indicating Resident #80 had been assessed post dialysis and had a thrill and bruit present.</p> <p>During an interview on 12/18/13 at 8:55 a.m., Resident #80 indicated she received dialysis on Monday, Wednesday, and Friday of each week.</p> <p>Resident #80 indicated she had a dialysis access graft in the left forearm but it had clotted off and she now has an access graft in the right upper arm. During an interview on 12/19/13 at 9:22 a.m., LPN #1</p>		<p>Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>				

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	<p>indicated the resident's thrill and bruit were checked on the days the resident received dialysis. LPN #1 indicated resident's grafts were checked before they leave for dialysis and after they return from dialysis.</p> <p>During an interview with the DoN and the Nurse Consultant on 12/19/13 at 10:50 a.m., the Nurse Consultant indicated the nurses had not checked the thrill or bruit every shift.</p> <p>A policy titled, "Monitoring of Dialysis Fistula/Catheter" dated 1/2012, and obtained from the DoN (Director of Nursing) on 12/18/13 at 11:00 a.m., indicated the thrill and bruit of the fistula were to be checked once a shift and documented on the MAR (medication administration record).</p> <p>3.1-37(a)</p>				

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F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for rehabilitation, in a sample of 66 who met the criteria, received treatment and services to maintain or improve his abilities, in that a restorative/functional maintenance program was not developed or implemented following discharge from therapy. (Resident #76)</p> <p>Finding includes:</p> <p>Resident #76's clinical record was reviewed on 12/19/13 at 3:23 p.m. The resident's admission Minimum Data Set (MDS) assessment, dated 8/22/13, indicated the resident required extensive assistance of two persons for bed mobility, transfer, and ambulation. A quarterly MDS assessment, dated 11/1/13, indicated the resident required extensive assistance of two persons for bed mobility and transfers and</p>	F000311	<p>1. Resident #76 was placed on a restorative maintenance program for ambulation and the care plan updated by the Director of Nursing/Designee on December 27, 2013. 2. Residents that have been discharged by therapy within the last thirty (30) days chart was reviewed by the Director of Nursing/Designee on January 16, 2014 to ensure all therapy recommendations were implemented. No concerns were noted. 3. Licensed staff will be reeducated by the Director of Nursing/Designee regarding Restorative maintenance programs. This reeducation will be completed by January 22, 2014. 4. The Director of Nursing/Designee will audit all discharges from therapy to ensure Restorative Maintenance programs that are recommended be implemented weekly for twelve (12). The results of these audit will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous</p>	01/23/2014			

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	<p>was unable to ambulate.</p> <p>The resident had a care plan, dated 9/6/13, for ADL (activities of daily living) Self Care Performance Deficit. The interventions indicated the resident required staff participation with transfers, reposition and turning in bed, using the toilet and personal hygiene and oral care. There was no care plan for exercises or ambulation.</p> <p>The Rehabilitation Director provided copies of the resident's therapy discharge summaries and recommendations for restorative/functional maintenance program for Resident #76.</p> <p>The Physical Therapy Discharge Summary, dated 11/6/13, indicated the resident was able to ambulate 75 feet with minimal assistance and required moderate assistance with transfers. A Therapy Referral for Restorative Nursing/Functional Maintenance Program was dated 11/6/13. The current functional status indicated, "Patient able to ambulate [with] RW [rolling walker] with gait belt [with] assist of 1." Problems/needs: "Patient's level of assist varies d/t [due to] level of fatigue. Patient needs (A) [assist] to</p>		<p>compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>				

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	<p>transfer sit-stand @ RW and needs cues to push up from w/c [wheelchair]. Patient demo's tight hamstrings."</p> <p>Goals: "Please help patient to maintain current ROM [range of motion] and strength of (B) [bilateral] LE [lower extremities] exercises. Please help patient to be able to maintain ability to ambulate. Recommendations/Approaches: "-(B) hamstring stretching -(B) LE exs [exercises] X 20 reps [repetitions] with cueing (sitting or supine) -Amb. with RW and gait belt X 75 ' -restorator bike."</p> <p>There was no care plan indicating provision of exercises or ambulation.</p> <p>LPN #4 was interviewed on 12/26/13 at 11:57 a.m. She indicated the resident did not ambulate, just transferred by standing and pivoting.</p> <p>On 12/26/13 at 11:10 a.m., CNA #4 was observed to go to the activity room, wheel the resident in his wheelchair back to his room and into the bathroom to be toileted. No ambulation was observed.</p> <p>On 12/27/13 at 9:00 a.m., the Director of Nurses indicated the</p>			
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F000323 SS=E	<p>restorative/functional maintenance recommendations had been given to the restorative nurse and the nurse had not developed a plan. They were reviewing all residents discharged from therapy to ensure plans had been continued.</p> <p>3.1-38(a)(2)</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. A. Based on observation, interview and record review, the facility failed to ensure medications and chemicals were kept out of resident areas, for 2 of 35 residents observed during stage 1 sample review. (Residents #132, #130) B. Based on observation, interview and record review, the facility failed to ensure hot water temperatures were maintained at less than 120</p>	F000323	<p>1. Resident #132's triple antibiotic cream was removed from the bathroom December 20, 2013 by the Unit Manager. Resident #130's Lysol and disinfectant spray were removed from the bathroom on December 20, 2013 by the Unit Manager. The temperature of the water in Rooms 307, 604, 608, 610 and 613 was adjusted to 115 degrees by the Maintenance Director on December 20, 2013. 2. All room bathroom sink temperatures were tested on</p>	01/23/2014

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	<p>degrees, for 5 of 35 residents' rooms observed during stage 1 sample review. (Residents #70, #45, #193, #192, #201)</p> <p>Findings include:</p> <p>A1. Resident #132's bathroom, room 505, was observed on 12/16/13 at 3:00 p.m. There was a tube of triple antibiotic cream stored in an emesis basin in the bathroom, on back of the toilet. The cream was labeled "keep out of reach of children."</p> <p>The resident's room was observed again on 12/18/13 at 11:35 a.m. The triple antibiotic cream was still in the bathroom. Resident #132 was observed, at that time, to be wandering about in her wheelchair in the hallway, capable of entering her room and bathroom. She was very confused.</p> <p>On 12/18/13 at 1:30 p.m., Resident #132's Minimum Data Set assessment, dated 9/29/13, was reviewed and indicated she had a Brief Interview for Mental Status score of 3 out of 15, indicating significant cognitive impairment.</p> <p>A2. Resident #130's bathroom</p>		<p>December 20, 2013 and all were found to be within accepted range. 3. Licensed staff and C.N.A.'s will be reeducated regarding chemicals in the room. This reeducation will be completed by January 22, 2014. The Maintenance Director will be reeducated by the Executive Director regarding 483.25(h) Free of Accident Hazards/Supervision/Devices. This reeducation will be completed by January 22, 2014. A letter was sent to all families on January 3, 2014, from the Executive Director to inform them not to bring chemicals into the building without checking with management first. 4. The Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe each room five (5) times per week for two weeks (2), then two (2) times per week for four (4) weeks and weekly for two (2) weeks to verify no chemicals or medications are left in the resident rooms. The Maintenance Director will test two (2) rooms per hall ongoing to verify the bathroom sink temperatures are within acceptable range. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality</p>		

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	<p>(901) was observed on 12/18/13 at 11:13 a.m. A large can of Lysol disinfectant spray was observed setting on the grab bar in the bathroom. The label indicated it caused moderate eye irritation and to call poison control if swallowed. There was also a large can of Fresh Linen Scent Disinfectant spray on the grab bar, labeled, "causes substantial but temporary eye injury. If swallowed immediately call a poison control center, have person sip glass of water...do not induce vomiting...Note to Physician: Probable mucosal damage may contraindicate the use of gastric lavage."</p> <p>B1. On 12/17/13 at 11:47 a.m., the hot water temperature in Resident #70's bathroom, room 307, was measured at 121.7 degrees Fahrenheit.</p> <p>B2. On 12/17/13 at 12:01 p.m., Resident #45's bathroom sink (Room 604) had hot water measuring 129 degrees Fahrenheit.</p> <p>B3. On 12/17/13 at 11:41 a.m., Resident #193's bathroom sink (Room 608) water temperature was measured at 128 degrees.</p>		Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	

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	<p>B4. On 12/17/13 at 1:07 p.m., Resident #192's bathroom sink (Room 610) hot water measured 123.4 degrees Fahrenheit.</p> <p>B5. On 12/17/13 at 12:03 p.m., Resident #201's bathroom sink (Room 613) hot water temperature measured 130.1 degrees Fahrenheit.</p> <p>B6. On 12/17/13 at 12:17 p.m., the Maintenance Director checked the water temperature in room 604. His thermometer read 124.9 degrees Fahrenheit. He indicated they had been fighting the hot water situation for awhile. He indicated they were replacing mixing valves about one per month.</p> <p>B7. On 12/17/13 at 11:59 a.m., the Maintenance Director indicated he was always checking the hot water heaters to make sure they were not too hot, and then adjusting the temperatures if they were. He was aware the temperature needed to be below 120 degrees. He provided the logs of temperatures checked during the last one month. His logs for the last month indicated they checked one hall every week, 5 rooms per hall. At that rate, each</p>				

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	<p>hall would only be checked every 10 weeks. None of the temperatures documented were above 120 degrees Fahrenheit. He indicated they only recorded the temperatures after adjustments had been made and the temperatures had dropped below 120 degrees. He indicated the rooms checked were used mostly for residents who were in the facility for rehabilitation and plans to return home.</p> <p>3.1-19(r) 3.1-45(a)(1)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident maintained their weight in 1 of 3 residents who met the criteria for weight loss in a total sample of 21. (Resident #107)</p> <p>Findings include:</p> <p>During an observation on 12/18/13 at 9:30 a.m., Resident #107 was observed sitting in the activity room in her wheelchair. Resident #107 did not have her dentures in place.</p> <p>During an observation on 12/19/13 at 9:00 a.m., Resident #107 was observed to be sitting in her wheelchair in the lounge with no teeth.</p> <p>During an observation of the resident's room at 9:05 a.m.,</p>	F000325	<p>1. Resident 107's dentures were applied to her lower gums as observed by the Director of Nursing on 12/20/2013. 2. All residents with dentures were observed to be wearing them on December 27, 2013 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. 3. Licensed staff will be reeducated by the Director of Nursing/Designee regarding review and use of C.N.A. Assignment sheets. This reeducation will be completed by January 22, 2014. 4. Director of Nursing/Designee will observe residents with dentures to ensure proper placement five (5) times per week for two weeks (2), then one (1) time per week for four (4) weeks, then monthly times three (3) months then quarterly per Quality Control Program. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance</p>	01/23/2014	

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	<p>Resident #107's denture cup with her dentures in it was observed to be sitting on the back of the sink in her bathroom.</p> <p>During an observation on 12/19/13 at 11:30 a.m., Resident #107 was observed to be sitting in the lounge in her wheelchair with no teeth in place.</p> <p>During an observation on 12/19/13 at 12:05 p.m., Resident #107 was observed to be sitting in the therapy dining room eating her lunch with no dentures in place.</p> <p>The clinical record of Resident #107 was reviewed on 12/18/13 at 12:10 p.m. Resident #107 had a diagnosis including, but not limited to, dementia with behavioral disturbances.</p> <p>The MDS (Minimum Data Set) assessment, dated 10/5/13, indicated Resident #107 had a BIMS (Basic Interview for Mental Status) score of 3, which indicated Resident #107 had cognitive impairment.</p> <p>Resident #107 had a physician's order for a regular diet with mechanical soft texture and thin consistency. Resident #107 had a</p>		<p>Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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	<p>physician's order for Ensure Plus 1 can (240 cc) daily and the resident was to have her top dentures on place to eat.</p> <p>Resident #107 was admitted on 4/10/13 and weighed 165.4 pounds on admission to the facility. Resident #107 had been gradually losing weight with the current weight being 144.4 pounds.</p> <p>During an interview on 12/19/13 at 9:27 a.m., CNA #1 indicated the night shift did not store Resident #107's dentures in her night stand and the night shift did not insert Resident #107's dentures when they got the resident out of bed.</p> <p>During an interview on 12/19/13 at 11:27 a.m., Resident #107 indicated she did not have her dentures in. Resident #107 indicated she has difficulty chewing and she had "made do" this morning at breakfast.</p> <p>A policy titled, "Personal Hygiene" and dated 6/2013, indicated personal hygiene would be performed 2 times daily in the morning and before bed. The policy further indicated personal hygiene included oral care.</p>			
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F000329 SS=D	<p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 observation, interview, and record review, the facility failed to ensure 2 of 5 residents reviewed for unnecessary medications had indications for use of antianxiety medications and/or attempted gradual dose reductions of</p>	F000329	<p>1. Resident #160's diagnosis for the medication clonazepam was changed from bi-polar to generalized anxiety disorder per doctor on December 27, 2013 by the Unit Manager. Resident #3's medications were reviewed by the Pharmacist on December 27, 2013 and no reductions were</p>	01/23/2014
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	<p>antianxiety medications. (Residents #160, #3)</p> <p>Findings include:</p> <p>1. On 12/16/13 at 2:38 p.m., a family interview was conducted with Resident #160's family member. The resident slept throughout the interview. Resident #160 was observed on 12/18/13 at 10:30 a.m., in the therapy gym, walking with a walker and assistance of the therapist. She appeared sleepy.</p> <p>Initial record review on 12/17/13 at 10:00 a.m. indicated the resident was receiving an antianxiety medication, clonazepam, and an antidepressant, citalopram.</p> <p>Further clinical record review, on 12/19/13 at 11:16 a.m. indicated the resident was admitted to the facility with diagnoses including, but not limited to, pneumonia, muscle weakness, history of transient ischemic attack, esophageal stricture, generalized anxiety disorder, depressive disorder, and congestive heart failure. Admission orders included, but were not limited to, clonazepam 0.5 milligrams (mg) one tablet by mouth daily "related to bipolar disorder."</p>		<p>recommended. 2. 100% chart review of resident's on antipsychotic drugs was completed on December 27, 2013 by the Director of Nursing/Designee to ensure appropriate diagnosis for the antipsychotic medications and to ensure GDR was reviewed by the Pharmacist. 3. Licensed staff will be reeducated by the Director of Nursing/Designee regarding appropriate diagnosis for antipsychotic medications and Gradual dose reductions for antipsychotic medications. This reeducation will be completed by January 22, 2014. 4. Director of Nursing/Designee will review six (6) charts per week times four (4) weeks to ensure accuracy of care plan then six (6) charts per month for two (2) months. The results of these reviews will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>				

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	<p>Orders were received on 12/17/13 to give the clonazepam 0.5 mg by mouth at bedtime, related to bipolar disorder.</p> <p>The resident's admission Minimum Data Set (MDS) assessment, dated 12/4/13, indicated a Brief Interview for Mental Status score of 8 out of 15 indicating some cognitive impairment. The MDS indicated the resident had hallucinations and was on antianxiety medication 7 days and antidepressant medication 7 days.</p> <p>The resident had a care plan, dated 12/12/13, for "...moderately severe signs/symptoms of depression...and anxiety state." Interventions included, but were not limited to, "Administer medications as ordered. Monitor/document for side effects and effectiveness. Arrange for psych services as needed to assist with anxiety, depression, and/or confusion...pharmacy review monthly or per protocol...Resident may need time to talk as needed. Encourage resident to express her feelings as needed."</p> <p>Social Service notes, dated 12/4/13 at 10:23 p.m., indicated, "Narrative:</p>			

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	<p>MDS completed on this date at 1053 by this writer with resident and her husband...Resident was observed by this writer to be falling a sleep repeatedly during her assessment and sometimes in the middle of answering questions...Resident stated, 'I think my medication is making me sleepy. I'm glad I didn't take my sleeping pill today.'</p> <p>Daily skilled charting on the following dates identified no behaviors or depression, and no antianxiety medications: 12/6/13 6:30 p.m., 12/8/13 6:49 p.m., 12/9/13 6:49 p.m., 12/10/13 6:49 p.m., 12/15/13 6:15 p.m., 12/16/13 6:15 p.m., 12/17/13 8:15 p.m.</p> <p>An interdisciplinary Psychopharmacological Review, on 12/18/13 at 10:05 p.m., indicated the following: Medications/Dose and Frequency of Antianxiety Clonazepam tablet - Give 0.5 mg by mouth at bedtime related to bipolar disorder unspecified. Behavior target to quantify: nothing documented. Indications for use: bipolar disorder. Goals for antianxiety therapy: alleviate/eliminate symptoms of distress, promote relaxation or pain</p>						

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	<p>control.</p> <p>Anxiolytic Criteria: None documented.</p> <p>IDT (interdisciplinary team)</p> <p>Recommendations:</p> <p>"-Both of these meds need clarification for use as resident and her husband report no h/o [history of] bipolar and PASRR [preadmission screening and resident review] noted that she did not have bipolar D/O [disorder]. Resident's Dx [diagnosis] of Bipolar D/O somehow was not added to her Dx list yet her meds still say for bipolar.</p> <p>-Resident continues to display bizarre affect/verbals at times</p> <p>-Res continues to have falls due to not using call light and getting up -yet struggles getting up during therapy."</p> <p>RN #2 was interviewed on 12/26/13 at 11:30 a.m. She indicated the reason the resident was on clonazepam was for bipolar disorder. She indicated they changed it from morning to night because she was getting too sleepy during the day and it was interfering with therapy and lunch.</p>			
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	<p>2. On 12/17/13 at 11:46 a.m., attempted interview with Resident #3; the resident awakened when spoken to and then closed eyes again. No verbal response was given.</p> <p>On 12/18/13 at 8:48 a.m., Resident #3 was observed sleeping in bed.</p> <p>On 12/18/13 at 9:10 a.m., Resident #3's clinical record was reviewed:</p> <p>Resident #3 was admitted on 7/26/13.</p> <p>Physician's orders included, but were not limited to, Klonopin (antianxiety medication) 0.5 mg (milligram) three times daily for anxiety.</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, dated 11/19/13, indicated Resident #3 had no behaviors.</p> <p>Care plans included, but were not limited to: Uses psychotropic medications. Interventions included, but were not limited to, consult with pharmacy and physician to consider dosage reductions when clinically appropriate.</p>			

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	<p>On 12/19/13 at 11:57 a.m., DON (Director of Nursing) indicated only Vitamin E gradual dose reduction recommended for resident.</p> <p>On 12/19/13 at 3:50 p.m., EMR (Electronic Medical Records) Coordinator #1 provided document which indicated order Klonopin 0.5 mg po (by mouth) three times daily ordered on 7/30/13. On 9/26/13 the order changed to Klonopin 0.5 mg via J (jejunum) tube three times daily. No attempts at reduction were noted.</p> <p>3.1-48(a)(4) 3.1-48(b)(2)</p>			

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rates of five percent or greater, for 2 of 8 residents observed during medication administration, in that 2 errors were made out of 25 opportunities for error, resulting in an error rate of 8 percent. Two of 6 licensed nurses observed made errors. (Residents #18, #199) (LPN #5, RN #2)</p> <p>Findings include:</p> <p>1. LPN #5 was observed administering medications to Resident #18 on 12/18/13 at 4:42 p.m. The LPN administered Ferrous Sulfate 325 milligrams (mg) one tablet by mouth with water. No food was provided. At 5:24 p.m., the resident still had not been provided food/dinner.</p> <p>On 12/19/13 at 9:35 a.m., Physician's orders for Resident #18 were reviewed. The physician's orders dated 11/30/13 indicated the</p>	F000332	<p>1. Unable to correct #1 and #2 happened in the past. 2. The Director of Nursing observed medication pass on 12/27/13 and noted that food was given to Resident #18 with the Ferrous Sulfate. Resident #199 discharged on 12/23/2013 (prior to survey exit). 3. Licensed staff will be reeducated by the Director of Nursing/Designee regarding following doctor's order for medication administration. This reeducation will be completed by January 22, 2014. 4. Director of Nursing/Designee will observe medication pass to ensure the physician order is followed five (5) times per week for one (1) week, then two (2) time per week for four (4) weeks, then weekly for seven (7) weeks. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will</p>	01/23/2014
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	<p>resident was to receive Ferrous Sulfate 325 mg by mouth twice a day with food.</p> <p>2. RN #2 was observed administering dicloxacillin (antibiotic) 250 mg by mouth to Resident #199 on 12/19/13 at 8:27 a.m. The resident had eaten some of his breakfast and continued eating after administration of the medication. The resident indicated, at that time, the medication was supposed to be given on an empty stomach but he always received it with food at the facility.</p> <p>Physician's orders for Resident #199 were reviewed on 12/19/13 at 9:35 a.m. Current orders were for Dicloxacillin 250 mg by mouth twice daily for "staff" (sic) infection in knee.</p> <p>The Electronic Medical Records Coordinator provided information from the facility pharmacy on 12/26/13 at 2:30 p.m. The information included, but was not limited to, the following regarding use of dicloxacillin: "Take dicloxacillin by mouth on an empty stomach at least 1 hour before or 2 hours after eating."</p>		<p>consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	

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	3.1-25(b)(9) 3.1-48(c)(1)			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview,</p>	F000441	1. Unable to correct #1, #2, #4 it happened in the past. Resident	01/23/2014			

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	<p>and record review, the facility failed to ensure the infection control program was maintained to prevent potential infections, for 2 of 2 residents observed during blood sugar checks, for 4 of 35 stage 1 sample residents observed, and for 1 randomly observed resident, in that the nurse was not going to sanitize the blood glucometer, catheter bags were observed on the floor, glove changes and handwashing were not completed as needed. (Residents #17, #147, #173, #17, #80, #3, #90)</p> <p>Findings include:</p> <p>1. On 12/18/13 at 5:04 p.m., RN #2 was observed checking Resident #17's blood sugar using a blood glucometer from the medication cart. She returned the glucometer to a plastic bag on the medication cart. At 5:10 p.m. on 12/18/13, RN #2 prepared to enter Resident #147's room with the blood glucometer to check the resident's blood sugar. She was stopped and asked about procedures involving the blood glucometer. She indicated she usually used a disinfectant wipe between residents but sometimes only used it every couple times.</p>		<p>#3 and #90's urinary drainage bag was removed from the floor, placed in a dignity bag and hung on the bed by the Unit Manager on 12/20/13. 2. The Director of Nursing observed medication pass on 12/27/13 and noted that glucometer was disinfected in between residents. The Director of Nursing observed incontinent care on 12/27/13 and proper hand washing procedures were followed. The residents with urinary drainage bags were observed by the Director of Nursing on 12/27/13 and the urinary drainage bags were noted to be covered and not on the floor. No concerns were identified. 3. Licensed staff will be reeducated regarding glucometer disinfecting. Licensed staff and C.N.A.'s will be reeducated regarding proper hand washing procedures, proper incontinent care procedure and storage of urinary drainage bags. This reeducation will be completed by January 22, 2014. 4. Director of Nursing/Designee will observe a medication pass to ensure proper cleaning of glucometers, observe incontinence care to ensure proper hand washing procedures and placement of urinary drainage bags to ensure proper placement five (5) times per week for two weeks (2), then one (1) time per week for four (4) weeks, then monthly times three (3) months then quarterly per Quality</p>				

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	<p>2. On 12/26/13 at 10:46 a.m., CNA #4 was observed providing care to Resident #173. The resident had been incontinent of a large amount of feces. The CNA wore the same gloves to wash, rinse, and dry the resident. She then put lotion into the palm of her hand, with the same gloves on, and rubbed the lotion on the resident. The wash basin used was placed on the overbed table. Water was observed to splash on the table.</p> <p>CNA #4 took the gloves off after placing the lotion. No handwashing completed. The resident was dressed, transferred to a wheelchair and taken to the bathroom, and shaved. Gloves were removed and the CNA took the resident to the activity room. At that time, she took Resident #17 from the activity room to his room. She put gloves on and was preparing to take Resident #17 to the bathroom. She was stopped and asked about procedures to complete between residents. She took the gloves off and indicated she was supposed to wash her hands.</p> <p>3. On 12/16/13 at 9:40 a.m., observed Resident #3's urinary catheter bag on the floor.</p>		Control Program. The results of these audits will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.		

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	<p>On 12/18/13 at 8:48 a.m., observed Resident #3's urinary catheter bag on the floor.</p> <p>4. On 12/19/13 at 10:38 a.m., observed care for Resident #80. Observed CNA #2 hand wash for seven seconds.</p> <p>5. On 12/19/13 at 12:12 p.m., observed LPN #3 hand wash. LPN #3 turned the faucet off with bare hands.</p> <p>6. On 12/19/13 at 2:26 p.m., randomly observed Resident #90's urinary catheter bag on the floor.</p> <p>7. On 12/19/13 at 3:21 p.m., CNA #3 was interviewed. CNA #3 indicated hands should be washed for 30 seconds. CNA #3 indicated urinary catheter bags should be hung on side of bed and should not be placed on floor.</p> <p>8. The Director of Nursing provided a policy and procedure for Hand Washing, dated 4/2012, on 12/27/13 at 9:30 a.m. The policy and procedure included, but was not limited to, the following: "1. Wet hands with water. Leave water running.</p>						

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	<p>2. Apply soap. Using friction, rub hands together, cleaning under nails and between fingers thoroughly and up to wrist for 20 seconds.</p> <p>3. Rinse hands well without touching the inside of sink or faucet. Leave water running.</p> <p>4. Dry hands well with paper towel. Use clean paper towel to turn off faucet. Discard paper towel in trash receptacle."</p> <p>"When to wash Hands (at a minimum):</p> <ul style="list-style-type: none"> -before putting on and after taking off gloves... -before and after each resident contact..." <p>3.1-18(b)(1) 3.1-18(l)</p>			

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	This Plan of Correction is prepared and executed because it is required by the Provisions of State and Federal regulations. The Village at Hamilton Pointe maintains that each deficiency does not jeopardize the health and safety of the residents, not is it of such a nature as to limit our capability to provide adequate care.		
R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and	R000117	1. Unable to correct,	01/23/2014	

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	<p>interview, the facility failed to ensure that a first aid certified employee was present at all times, for 14 of 14 days reviewed. (12/1/13-12/14/13)</p> <p>Findings include:</p> <p>On 12/26/13 at 2:00 p.m., the Assisted Living schedule was reviewed for the time period of 12/1/13-12/14/13. The facility's records for CPR (cardiopulmonary resuscitation) and First Aid certifications were reviewed as well. The schedule indicated the facility lacked an employee on night shift with first aid certification for the dates 12/1/13 through 12/14/13.</p> <p>On 12/27/13 at 10:00 a.m., the Administrator was interviewed and indicated the list of employees with CPR and first aid certifications was complete and correct.</p>		<p>happened in the past. 2. All employee records were reviewed for CPR/First Aid Certification on 1/10/14 by the Human Resources Coordinator. Regularly scheduled night shift licensed nurses who do not hold a First Aid Certification will obtain the certification by January 22, 2014. The Quality Assurance Performance Improvement Nurse will obtain CPR/AED/First Aid instructor certification on January 28, 2014 to ensure continued compliance. 3. The Human Resources Coordinator will be reeducated by the Administrator regarding 410 IAC 16.2-5-1.4(b) Personnel by January 22, 2014. 4. The Human Resources Coordinator will review schedules to ensure a staff member with First Aid Certification is on site at all times interventions five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these audits will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the</p>		

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance</p> <p>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on interview and record review, the facility failed to ensure weights were evaluated semi-annually for 3 of 7 residents reviewed. (Resident #205, #211, #210).</p> <p>Findings include:</p> <p>1. On 12/23/13 at 10:00 a.m., Resident #205's clinical record was reviewed. Resident #205 admitted 10/19/12. Resident #205's weight was recorded on 10/19/12. No weights were recorded after that date.</p>	R000216	<p>Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>1. Resident's 205, 210, 211 were weighed on January 2, 2014. 2. All resident records were reviewed for timely weights on December 27, 2013 by the LPN Unit Manager or Charge Nurse. All residents that had not been weighed within six (6) months were weighed. 3. The LPN Unit Manager will be reeducated by the Director of Assisted Living regarding 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation by January 22, 2014. 4. The Director of Assisted Living or LPN Unit Manager will audit resident weights monthly for (3) months to ensure all weights have been taken within six (6) months of previous weight. The results of</p>	01/23/2014			

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	<p>2. On 12/23/13 at 12:00 p.m., Resident #210's clinical record was reviewed. Resident #210 was admitted on 10/2/12. The resident's weight was recorded on 10/2/12. No weights have been recorded since then.</p> <p>3. On 12/23/13 at 12:15 p.m., Resident #211's clinical record was reviewed. Resident #211 was admitted on 10/31/12. The resident's weight was recorded on 11/13/12. No weights have been recorded since then.</p> <p>4. On 12/26/13 at 9:00 a.m., the AL (Assisted Living) Unit Manager was interviewed. The AL Unit Manager indicated weights were measured only as needed.</p>		<p>these audits will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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R000356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure that a current Emergency Information File was immediately accessible for each resident, in case of emergency. This affected 4 of 5 residents reviewed .(Residents # 205, #206, #208, and #209.)</p> <p>Findings include: On 12/23/13 at 12:05 p.m., the Emergency Information File for Assisted Living Residents was requested from the Administrator. The Administrator was unsure of what was being requested. The</p>	R000356	<p>1. The Emergency binder is current as evidenced by the Director of Assisted Living on December 23, 2013. 2. The Emergency binder is current as evidenced by the Director of Assisted Living on December 23, 2013. 3. The LPN Unit Manager will be reeducated by the Director of Assisted Living regarding 410 IAC 16.2-5-8.1(i)(1-8) by January 22, 2014. 4. The Director of Assisted Living or LPN Unit Manager will audit new admissions to ensure their information and picture are in the Emergency Binder five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8)</p>	01/23/2014	

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	<p>Administrator indicated she had a census list and facesheets for all assisted living residents. She was unaware of an Emergency Information File but would look and ask around. No information was received on 12/23/13.</p> <p>On 12/26/13 at 8:10 a.m., the Emergency Information File was again requested from the Administrator. The files were received in three blue binders, 1st floor, 2nd floor, and Reagan Place (Alzheimer's Unit) at 8:25 a.m.</p> <p>On 12/26/13 at 9:27 a.m. copies were requested for residents #205, #207, #208, and #209. The information in the emergency files had been printed out on 12/23/13, after requested.</p> <p>On 12/26/13 at 9:39 a.m., during interview with RN #1, she indicated that all files were kept in nurses drawers and the nurses were responsible for obtaining the books in case of emergency. She indicated they updated the files when they could; "residents come and go so much it is hard to get a picture." Other things were updated if there was a change in condition. When asked, she indicated some</p>		<p>weeks. The results of these audits will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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	files had just been updated on 12/23/13.			