

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00171032.</p> <p>Survey dates: April 1, 2, 6, 7, & 8, 2015.</p> <p>Facility number: 000031 Provider number: 155076 AIM number: 100266150</p> <p>Census Bed Type: SNF/NF: 104 Total: 104</p> <p>Census Payor Type: Medicare: 10 Medicaid: 78 Other: 16 Total: 104</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's</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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	<p>legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of residents' out of range blood sugars for 2 of 5 residents reviewed for unnecessary medications. (Resident #179 and #111)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #179 was reviewed on 4/2/15, at 11:48 a.m.</p>	F 157	<p>F157</p> <p>It is the practice of this facility to inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative when there is a change in the resident's physical status.</p>	04/26/2015

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	<p>The diagnoses for Resident #179 included, but were not limited to diabetes.</p> <p>The 3/20/15 Physician's Order for Resident #179 indicated a blood sugar testing to be done before meals and at bedtime, and to call the physician if the blood sugar reading was over 225.</p> <p>The March, 2015 MAR (medication administration record) for Resident #179 indicated blood sugar readings of 228 on 3/23/15 at 4:00 p.m., and 228 on 3/23/15 at 8:00 p.m. There was no information in the clinical record to indicate the physician was notified of the two blood sugar readings.</p> <p>An interview was conducted with the DON (Director of Nursing) on 4/8/15 at 10:10 a.m. She acknowledged a lack of physician notification for the two 3/23/15 out of range blood sugar readings.</p> <p>2. The clinical record for Resident #111 was reviewed on 4/6/15 at 2:30 p.m. The diagnoses for Resident #111 included, but were not limited to, diabetes mellitus, depression, and anxiety.</p> <p>A Physician's Order, dated 1/2/15, indicated blood sugar testing every Wednesday three times a day and to notify the MD (Medical Doctor) for a</p>		<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>The physician for residents #111 and #179 was notified on 4/2/15 of two out-of-range blood sugar readings obtained on 3.23.15, one on 3/4/15, and two on 3/11/15.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents have the potential to be affected by the same alleged deficient practice. All residents who had blood sugar readings in March have had their records reviewed to ensure that physician was notified of out-of-range readings. Blood sugar readings will be reviewed daily 5 days a week during clinical start-up to ensure that notification has been made to physicians and family.</p>	

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	<p>blood sugar reading less than 70 and greater than 225.</p> <p>The March 2015 MAR (medication administration record) indicated the following blood sugar test results: 3/4/15 at 4:00 p.m.=253, 3/11/15 at 12:00 p.m.=233, 3/11/15 at 4:00 p.m.=256.</p> <p>MD notification of the above blood sugar test results was not located in the clinical record.</p> <p>During an interview with the Director of Nursing Services (DNS), on 4/8/15 at 10:50 a.m., she indicated the facility was unable to locate information regarding MD notification of the blood sugar test results above.</p> <p>A policy titled, Blood Sugar Monitoring, dated 2006, was received from the DNS on 4/8/15 at 1:17 p.m. The policy indicated, "...If blood glucose level is above or below normal range, document the time the physician was notified...."</p> <p>3.1-5(a)(3)</p>		<p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>Re-in-servicing of nurses was completed on 4/3/15 and 4/4/15 regarding need for follow-through on notification of physician for out-of-range blood sugar readings. Resident's blood sugar readings will be reviewed weekly by the Unit Managers.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Blood sugar reading audits will be completed 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter. Results of audits will be reviewed by the Quality Assurance / Performance Improvement committee monthly and trends or patterns noted, will have an action plan written, and interventions implemented. The</p>	

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F 242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to provide a resident showers as preferenced for 1 of 3 residents reviewed of 6 who met the criteria for choices. (Resident #175)</p> <p>Findings include:</p> <p>The clinical record for Resident #175 was reviewed on 4/2/15, at 10:15 a.m. The diagnoses for Resident #175 included, but were not limited to, bilateral leg</p>	F 242	<p>Executive Director and the Director of Nursing Services will oversee this process.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/26/15.</p> <p>F242</p> <p>It is the practice of this facility to recognize that the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that</p>	04/26/2015	

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	<p>amputations and end stage renal disease.</p> <p>An interview was conducted with Resident #175 on 4/2/15, at 10:36 a.m. He indicated he did not choose how many times a week he took a shower. He indicated he would like 3 a week, but only received 2, and that no one at the facility ever asked him his preference for shower frequency.</p> <p>The 3/23/15 Admission Clinical Health Status Assessment for Resident #175 did not indicate a bathing type or frequency preference.</p> <p>An interview was conducted with CNA #5 on 4/7/15, at 10:52 a.m. She indicated she knew when to give a resident a shower by the shower schedule located at the nurses desk. The shower schedule located at the nurses desk was reviewed with CNA #5 at this time. It indicated the shower days for Resident #175 were day shift on Mondays and Thursdays.</p> <p>The shower sheets for Resident #175, since his admission, were requested from and provided by the Rehabilitation Unit Manager on 4/7/15, at 1:38 p.m. There were a total of 2 shower sheets. They were dated 3/31/15 and 4/6/15.</p> <p>An interview was conducted with</p>		<p>are significant to the resident.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #175 is being provided showers as preferred.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents have been audited for bathing type or frequency preference.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p>	

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	<p>Resident #175 on 4/7/15, at 11:03 a.m. He indicated he informed the facility upon admission of his preference for 3 showers weekly, but only received 2.</p> <p>An interview was conducted with the DON (Director of Nursing) on 4/7/15, at 11:28 a.m. She indicated residents were given 2 showers weekly, based on their room assignment. She indicated if a resident wanted more than 2 showers weekly, he or she would have to request it. She indicated a resident could tell any staff member of his or her shower frequency preference, and the staff member would tell the unit manager, who would pass it on to her (the DON). The DON indicated she would then talk to the resident about how often they wanted a shower, and if they wanted one 3 times weekly, she'd change their shower schedule. She indicated there was no process on admission or quarterly, in which to ask a resident of their shower frequency preference. She indicated if a resident told a staff member, and the staff member did not relay the information, the facility wouldn't know to talk to the resident about changing their shower schedule.</p> <p>An interview was conducted with the ED (Executive Director) on 4/7/15, at 11:28 a.m. He indicated there was no process</p>		<p>At the time of admission, when the admission agreements are completed, the Admissions Coordinator will ask about the resident's preference for bathing type and frequency. The Admissions Coordinator will complete the resident's bathing type and frequency preference form, and share this information with the admitting nurse who will include the information in the resident's care plan and the CNA assignments. Admissions Coordinator and back-up staff in-serviced on procedure on 4/22/15.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will audit the inclusion of bathing type or frequency preference in care plans and CNA assignments 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for</p>	

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F 280 SS=D Bldg. 00	<p>in place at resident admission in regards to shower frequency preference.</p> <p>3.1-3(u)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a fall and nutrition care plan were revised for 2 of 26 residents reviewed for care plans. (Resident #'s 139 & 93)</p>	F 280	<p>further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/26/15.</p> <p>F280</p> <p>It is the practice of this facility that</p>	04/26/2015	

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	<p>Findings include:</p> <p>1. The clinical record for Resident #139 was reviewed on 4/7/15 at 10:30 a.m. The diagnoses for Resident #139 included, but were not limited to, intracerebral hemorrhage, psychosis and anxiety.</p> <p>An IDT (Inter-disciplinary Team) Progress Note, dated 3/17/15 at 9:45 a.m., indicated Resident #139 had a fall on 3/14/15. The Progress Note further indicated, "...New intervention to ensure bed is at correct height, not low bed, to assist resident from sitting to standing position,...Careplans updated...."</p> <p>A review of a Fall Care Plan, dated 7/7/14 and remained current at the time of review, indicated an intervention of, "...bed in low position...."</p> <p>During an interview with the Director of Nursing Services, on 4/7/15 at 12:27 p.m., the DNS indicated the Fall Care Plan was not revised appropriately since the intervention of, "bed in low position," was not removed from the care plan.</p> <p>2. The clinical record for Resident #93 was reviewed on 4/6/15 at 9:35 a.m. The diagnoses for Resident #93 included, but</p>		<p>the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and the treatment or changes in care and treatment.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #139 fall care plan updated. Resident #93 nutrition care plan updated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents' fall care plans and nutrition care plans have been audited and updated as needed to reflect current plan of care.</p> <p>What measures will be put into place and the systemic</p>	

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	<p>were not limited to, Alzheimer's disease, diabetes mellitus, psychosis, and senile dementia with delirium.</p> <p>The Quarterly Interdisciplinary Resident Reviews, dated 12/10/14 and 3/11/15, indicated Resident #93 had dentures.</p> <p>On 4/1/15 at 1:03 p.m. and 4/6/15 at 1:32 p.m., Resident #93 was observed without her dentures in her mouth.</p> <p>During an interview with LPN #1, on 4/7/15 at 9:40 a.m., LPN #1 indicated Resident #93 does not like to wear her dentures and the dentures have been looked at to determine if they were fitting properly.</p> <p>On 4/7/15 at 9:43 a.m., CNA #2 indicated Resident #93 does not like to wear her dentures. CNA #2 further indicated the staff attempts to put them in every morning and Resident #93 will take them out.</p> <p>A review of Resident #93's care plans, including her Refusal of Care, Nutrition, and Activities of Daily Living care plans, did not include an intervention of Resident #93's preference for no dentures.</p> <p>The Director of Nursing Services (DNS)</p>		<p>changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All nursing staff were in-serviced on 4/20/15 and 4/21/15 on fall and nutrition care plans and updated care plans as changes occur. Fall care plans will be reviewed weekly in clinical start-up with IDT in attendance. Nutrition care plans will be reviewed in weekly weight management meeting with IDT in attendance. All changes to fall interventions made in clinical start-up will be updated in meeting at time of occurrence. All changes to nutrition made in weekly weight management meeting will be updated in meeting at time of occurrence. New diet orders that are changed by physician and not related to weight management committee will be reviewed in daily morning meeting by IDT, and changes in nutritional status to be implemented on care plan in daily morning meeting.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p>	

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	<p>indicated on 4/7/15 at 10:12 a.m., she added the intervention, "...declines to wear dentures...." to her Nutrition care plan.</p> <p>A policy titled, The RAI and Care Planning, dated April 2012, was received from the DNS on 4/7/15 at 3:40 p.m. The policy indicated, "...The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving...."</p> <p>3.1-35(d)(2)(B)</p>		<p>The Director of Nursing Services, Assistant Director of Nursing Services, and RN Assessment Coordinators will audit fall care plans 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter to ensure fall interventions match current fall care plan.</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, and Registered Dietitian will audit nutrition care plans 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter to ensure nutrition intake matches current nutrition care plan.</p> <p>Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/26/15.</p>	

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F 313 SS=D Bldg. 00	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on interview and record review, the facility failed to ensure optometry services were provided for 1 of 1 resident reviewed for vision. (Resident #33)</p> <p>Findings include:</p> <p>The clinical record for Resident #33 was reviewed on 4/1/15 at 1:00 p.m. The diagnoses for Resident #33 included, but were not limited to, epilepsy and acute respiratory failure, and traumatic brain injury. Resident #33 was admitted on 1/9/15.</p> <p>The 1/16/15 Health Services Consent Form indicated Resident #33 approved and signed for eye care.</p> <p>The undated Admission Inventory of Personal Items form did not indicate Resident #33 had eye glasses on</p>	F 313	<p>F313</p> <p>It is the practice of this facility to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of professional specializing in the provision of vision or hearing assistive devices.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p>	04/26/2015	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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	<p>admission.</p> <p>An interview was conducted with Resident #33 on 4/1/15, at 1:43 p.m. Resident #33 indicated his eye glasses were broken prior to coming to the facility. He indicated he informed the facility on admission he was needing eye glasses, and he was told arrangements would be made for him to be seen. Resident #33 indicated he was still waiting to see an eye doctor.</p> <p>During an interview with Resident #33 on 4/6/15 at 11:31 a.m., he indicated he still had not been informed when he would see an eye doctor.</p> <p>An interview was conducted with the Acute Care Director (ACD) on 4/6/15 at 1:33 p.m. She indicated after reviewing the appointment list, Resident #33 was on the list to be seen by the Optometrist on 3/31/15, but was not seen that day. The ACD indicated Resident #33 might have been in activities, but she was not sure why Resident #33 was not seen. The ACD also indicated residents were seen within 30 days of admission for ancillary services.</p> <p>On 4/6/15, at 2:38 p.m., the ACD provided a list of optometrist visits to the facility. It indicated the Optometrist was</p>		<p>Resident #33 was assessed by an optometrist and provided corrective lens glasses on 4/10/15.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents have been audited for proper treatment and assistive devices to maintain vision.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>Social Services staff will assess the need for ancillary professional services including vision care at the time of admission to the facility, and before the monthly optometrist visit for as-needed vision care for all residents. Social Services staff in-serviced</p>	

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F 412 SS=D	<p>in the facility on 3/31/15.</p> <p>The undated Resident Ancillary Services policy was provided by the Director of Nursing on 4/8/15 at 8:47 a.m. It indicated, "The facility must ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities..."</p> <p>3.1-39(a)(1)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL</p>		<p>on procedure on 4/22/15.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will audit all residents' needs for ancillary professional services including vision care 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/26/15.</p>	

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Bldg. 00	<p>SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to ensure dental services were provided for 1 of 1 residents reviewed for dental services. (Resident #33)</p> <p>Findings include:</p> <p>The clinical record for Resident #33 was reviewed on 4/6/15 at 2:00 p.m. The diagnoses for Resident #33 included, but were not limited to, epilepsy and acute respiratory failure, and traumatic brain injury. Resident #33 was admitted on 1/9/15.</p> <p>The 1/9/15 Admission Clinical Health Status Assessment indicated Resident #33 did not have dentures.</p> <p>The undated Admission Inventory of Personal Items form did not indicate Resident #33 had dentures on admission.</p>	F 412	<p>F412</p> <p>It is the practice of this facility to provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident, and must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the dentist's office, and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #33 was assessed by a dentist in the facility and provided</p>	04/26/2015

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	<p>A "Nutrition Assessment", dated 1/15/15, indicated Resident #33's nutrition diagnosis was, "Chewing difficulty related to dentures lost and evidence by edentulous status." The summary indicated Resident #33 inquired about dentures, and he would like top dentures if possible. A dental consult was recommended.</p> <p>An observation was made on 4/1/15 at 1:43 p.m. Resident #33 was missing his top and bottom teeth. At this time an interview was conducted with Resident #33. He indicated he did not have any dentures and had been waiting to see a dentist, since he was admitted to the facility.</p> <p>An interview was conducted on 4/6/15 at 11:31 a.m. Resident #33 indicated he still had not heard anything about being seen by a dentist.</p> <p>An interview was conducted with the Acute Care Director (ACD) on 4/6/15 at 1:33 p.m. She indicated Resident #33 was not on the list to be seen by the dentist, and she did not know why he did not make the list. The ACD also indicated residents are seen within 30 days of admission for services.</p> <p>On 4/6/15 at 2:38 p.m. the ACD provided</p>		<p>dentures on 4/20/15.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents have been audited for the need for routine and emergency dental services.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>Social Services staff will assess the need for ancillary professional services including routine and emergency dental services at the time of admission to the facility, and before the monthly dentist visit for as-needed dental care for all residents. Social Services staff in-serviced on procedure on 4/22/15.</p> <p>How the corrective actions will</p>	

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F 441 SS=D Bldg. 00	<p>a list of when the dentist was in the facility. It indicated the dentist was in the facility on 1/13/15 and 2/10/15.</p> <p>The undated Resident Ancillary Services policy was provided by the Director of Nursing (DON) on 4/8/15 at 8:47 a.m. It indicated, "The facility must provide, or obtain from an outside resource, the following dental services to meet the needs of each resident: Routine dental services...Prompt referral of residents with lost or damage dentures to a dentist."</p> <p>3.1-24(a)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>		<p>be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will audit all residents' needs for ancillary professional services including dental care 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/26/15.</p>	

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	<p>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. Based on observation, interview, and record review, the facility failed to properly disinfect a glucometer (machine used for readings of blood glucose/sugar levels) during random observations for 1 of 2 residents observed for blood sugar testing. (Resident #170)</p>	F 441	F441 It is the practice of this facility to 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. What corrective	04/26/2015

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	<p>Findings include:</p> <p>1. A random observation of blood sugar testing for Resident #36 was done, on 4/6/15 at 11:00 a.m., with LPN #3. LPN #3 performed the blood sugar testing on Resident #36 and wiped the glucometer for 5 seconds with a [name of company] Bleach Germicidal Wipe and the glucometer dried within 1 minute 45 seconds. LPN #3 indicated at this time that staff were instructed to wipe the glucometer and let the glucometer dry for 3 minutes prior to using the glucometer again. LPN #3 then placed the glucometer in the medication cart. LPN #3 went into Resident #170's room, on 4/6/15 at 11:20 a.m., and placed the glucometer on the bedside table. LPN #3 proceeded to prepare the glucometer for blood glucose testing, by placing the blood glucose testing strip into the glucometer and wiping Resident #170's finger with an alcohol pad. LPN #3 picked up the blood glucose needle to obtain a sample of blood and was holding Resident #170's finger out to be pricked by the needle. Prior to pricking Resident #170's finger, LPN #3 reviewed the [name of company] Bleach Germicidal Wipe packaging and proceeded to wipe the glucometer for 3 minutes. LPN #3 then proceeded to perform the blood</p>		<p>actions will be accomplished for those residents found to have been affected by the deficient practice are as follows: Resident #170 blood glucose level was obtained. LPN #3 in-serviced on the blood glucose monitoring decontamination policy. How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows: All residents receiving blood glucose monitoring identified. Physician notified of deficient practice. Residents reviewed with no adverse outcomes noted. What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows: All licensed nursing staff have been re-in-serviced on 4/6/15 and 4/7/15 to glucometer decontamination policy and return/demonstrate proper cleaning of the machine. How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: The Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will observe licensed nursing staff</p>	
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F 463 SS=D Bldg. 00	<p>sugar testing for Resident #170.</p> <p>The packaging for the [name of company] Bleach Germicidal Wipes indicated to disinfect a surface, the surface needed, "...to remain visibly wet for the contact time listed on the label...."</p> <p>The label indicated Clostridium difficile, tuberculosis, and fungi needed a 3 minute contact time.</p> <p>A policy titled, Blood Sampling-Capillary (Finger Sticks), dated August 2012, was received from the Director of Nursing Services on 4/7/15 at 10:40 a.m. The policy indicated, "...8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use...."</p> <p>3.1-18(a)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure a resident's call light was working for 1 of 26 residents whose call lights were checked.</p>	F 463	<p>properly clean the glucometer and perform glucometer testing on residents receiving blood glucose monitoring 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter. All inaccurate cleaning/testing visualized will be immediately addressed by observer with action taken, including disciplinary. Findings of the observations will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations. By what date the systemic changes will be completed is as follows: 4/26/15.</p> <p>F463</p> <p>It is the practice of this facility that the nurses' station must be</p>	04/26/2015

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	<p>Findings Include:</p> <p>On 4/1/15 at 1:55 p.m., during an observation, Resident #4 was lying in a bed in her room with a call light cord lying across her lap. The call light button on her bed was not functioning properly as the call light button on the call light cord was not able to be pressed. The call light system would not activate when the button was pressed. The call light indicator outside the resident's door was not lit after the button was pressed, nor was any sound heard which indicated Resident #4's call light had been pressed.</p> <p>On 4/2/15 at 10:12 a.m., during an observation, Resident #4's call light button was not functioning properly. The button on the call light cord was not able to be pressed to activate the system. The call light indicator outside the resident's door was not lit after the button was pressed, nor was any sound heard which indicated Resident #4's call light had been pressed.</p> <p>On 4/6/15 at 10:03 a.m., during an interview with the Maintenance Director (MD) and a Maintenance contractor, the MD indicated a maintenance staff contractor replaced the call light for Resident #4 on 4/2/15 as a part of random room call light checks on the</p>		<p>equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>The resident call light for resident #4 has been replaced.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All resident call lights have been checked to verify proper functioning.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p>	

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	<p>resident's unit. The Maintenance contractor indicated "the button wouldn't press when I tried it" so he informed another facility Maintenance employee who replaced the call light cord on 4/2/15. The MD indicated he did not have any maintenance log requests to repair Resident #4's call light.</p> <p>On 4/6/15 at 11:41 a.m., during an interview, LPN #3 indicated Resident #4 was able to press her call light button to request staff assistance.</p> <p>A facility policy titled, "Call Light, Use of" and dated 1/26/15, indicated "...Procedure Purpose: ...To assure call system is in proper working order..." and "...Equipment: ...Bedside call light in functioning order..." and "...Procedure Details: ...All facility personnel must be aware of call lights at all times..." and "...For bedside call lights, a light and a sound will appear and be heard over the door of the resident's room..." and "...Notify the maintenance department and enter defective call light location(s) in the maintenance log..."</p> <p>3.1-19(u)(1)</p>				<p>In-servicing of staff was completed on 4/20/15 and 4/21/15 on checking call lights every shift and reporting any proper functioning issues promptly to Maintenance staff.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Call light proper functioning audits will be completed 5 times per week x 4 weeks, 3 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter. Results of audits will be reviewed by the Quality Assurance / Performance Improvement committee monthly and trends or patterns noted, will have an action plan written, and interventions implemented. The Executive Director and the Director of Nursing Services will oversee this process.</p> <p>By what date the systemic changes will be completed is as follows:</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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