

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/13/2013
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 9, 10, 11, 12, 13, 2013</p> <p>Facility number: 000013 Provider number: 155038 Aim number: 100266100</p> <p>Survey team: Karen Lewis, RN, TC Ginger McNamee, RN Tina Smith-Stats, RN Jason Mench, RN</p> <p>Census bed type: SNF: 2 SNF/NF: 64 Total: 66</p> <p>Census payor type: Medicare: 10 Medicaid: 55 Other: 1 Total: 66</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report." We respectfully request that your office will accept this plan as our facility's compliance and that you will consider a desk review as there are no tags deemed to be actual harm or immediate jeopardy. Please review our attachments as each cited deficiency has an audit tool. If you have questions, please contact me at (765)289-3341. Thank you in advance for your immediate attention in this manner</p>	
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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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F000170 SS=C	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>Based on interview and record review, the facility failed to ensure residents received unopened mail for 1 of 20 residents and 3 family members interviewed for non-interviewable residents. This deficiency had the potential to affect 66 of 66 residents that lived in the facility. (Resident #36)</p> <p>Findings include:</p> <p>During an interview on 9/9/13 at 8:00 p.m., Resident #36 indicated he had received a letter which had already been opened by the facility the previous week. He indicated he had brought it to the management's attention, but he had not heard back from them at the time of the interview.</p> <p>During an interview with the Director of Nursing (DoN) on 9/12/13 at 8:50 a.m., she indicated, when she spoke with the Business Office Manager (BoM), the facility did open all mail which looked like it might be a bill and did open the letter of Resident #36.</p>	F000170	Residents, including resident # 36, will receive thier mail un-opened unless otherwise specified by the resident and/or responsible party/guardian/POA. Residents mail processed through the business office will be given to the Activities staff to pass to the residents unless other wise specified. Business Office Personnel and Activity Staff will be re-educated regarding mail distribution policy and procedure.The Interdisciplinary Team will be responsible to conduct rounds weekly for 12 weeks, monthly for 3 months, and then quarterly for 2 quarters to inquire from the residents if there had been any concerns regarding mail distribution. Any concerns noted will be brought to the Administrator and processed through the Resident Concern Policy and Procedure. In addition, should the identified concerns involve staff action, The ADM/designee will immediately address the concern, up to and including 1:1 re-education, and/or disciplinary action.The ADM/designee will review the results of the audits as per the schedule. Results of the review	10/04/2013			

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	<p>During an interview with the BoM and the Administrator on 9/12/13 at 10:46 a.m., the BoM indicated they did open the mail of residents if any piece of mail looked like it is a bill, or from Medicaid.</p> <p>During a chart review for Resident #36 on 9/12/13 at 10:00 a.m., the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 on his Minimum Data Set (MDS) assessment, dated 3/15/13, which indicated the resident was alert and oriented and able to make his own decisions.</p> <p>A 1/2001, procedure for "Mail - Resident Receiving and Sending" provided by the Administrator on 9/12/13 at 10:43 a.m., indicated "Each resident will have privacy in written communication both in receiving and sending. Mail will be delivered to the resident within 24 hours of delivery by the postal service...Deliver the mail, unopened, to the applicable resident's room."</p> <p>3.1-3(s)(1)</p>		will be forwarded to the QPI committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QPI Committee.		

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F000225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	Resident # 20 has been	10/04/2013			

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	<p>interview, the facility failed to ensure the staff immediately reported an allegation of physical abuse to the administrator as required for 1 of 6 residents reviewed regarding allegations of abuse. (Resident #20)</p> <p>Findings include:</p> <p>During an interview on 9/10/13 at 10:20 a.m., Resident #20 indicated he had been hit in the eye by a male staff member on third shift approximately one month ago. Resident #20 further indicated he had informed the staff about being hit in the eye by a male staff member on third shift.</p> <p>During an interview with the Administrator on 9/10/13 at 10:30 a.m., she indicated she was not aware of an abuse allegation regarding Resident #20.</p> <p>During an interview with the Administrator on 9/10/13 at 3:10 p.m., she indicated Resident #20 had bumped his eye in June of 2013. She further indicated the resident had been fixated on the incident since June.</p> <p>Review of a facility incident report provided by the Administrator, on</p>		<p>re-assessed by Social Services to ensure he has been able to express and resolve as able any symptoms of distress. A one time interview process has been completed for the current resident population to ensure staff have been made aware of any outstanding concern. Residents with noted cognitive impairment have had skin assessments completed to ensure Staff have been re-educated on the Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, including injuries of Unknown Source, and Misappropriation of Resident Property, including immediate reporting to the ADM of allegations of abuse. It is the responsibility of the ADM and team to complete a thorough and complete investigation of an allegation of abuse. The ADM will be responsible to ensure witness statements are obtained as necessary from residents, staff, and visitors as applicable to assist with the investigation and determination of the outcome of the investigation. The ADM will be responsible to obtain supportive documentation for an investigation with a reported occurrence daily for 30 days, weekly for 8 weeks, and then monthly for 3 months, and then quarterly for 2 quarters. Any identified concerns will be immediately addressed, up to and including 1:1 re-education, and/or</p>		

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	<p>9/10/13 at 3:15 p.m., indicated the following:</p> <p>The investigation of the incident on 9/10/13 included nurse's notes from the resident's chart dated 6/24/13. The 6/24/13 entry at 2:36 p.m., indicated purple bruising noted under the resident's right eye. The resident indicated to the staff he had gotten into a fight with Mr. Hats and Smiles. The resident further indicated Mr. Hats and Smiles was the man who wears a hat and smiles.</p> <p>During an interview with the Administrator, the Director of Nursing, and the RN Consultant on 9/13/13 at 11:28 a.m., additional information was requested related to the 6/24/13 nurse's note entry at 2:36 p.m.</p> <p>During an interview with the Administrator, the Director of Nursing, Unit Manager #6, and the RN Consultant on 9/13/13 at 3:35 p.m., the Director of Nursing indicated the 6/24/13 allegation of abuse had not been reported to the proper agencies, due to the facility's investigation determining the bruise under Resident #20's eye was from the resident bumping his bedside table.</p> <p>Once aware of the abuse allegation,</p>		disciplinary action. Results of the investigations will be forwarded to the Quality Performance Improvement committee monthly for 6 months, and then quarterly for 2 quarters for review. Any further action will be as determined by the QPI committee.				

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	<p>the facility followed their abuse policy and procedure in a timely and appropriate manner. This indicated there was a 79 day time period delay between the alleged abuse observation and report of the alleged abuse incident.</p> <p>Review of the current facility policy, revised 4/13, subject "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property," provided by the Administrator on 9/12/13 at 7:27 a.m., included, but was not limited to, the following:</p> <p>"Policy Extendicare Health Services, Inc. (EHSI) prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc....</p> <p>...7. b. Notify the Administrator and DON/designee immediately, if alleged abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation and</p>						

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	<p>immediately complete the required reporting to the applicable state and other agencies...."</p> <p>3.1-28(a) 3.1-28(c)</p>				

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F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the staff followed the facility policy and completed thorough investigations for reported allegations of abuse for 6 of 6 residents reviewed regarding allegations of abuse. (Resident #'s 20, 74, 9, 80,100, and 29)</p> <p>Findings include:</p> <p>1.) Review of a facility incident report provided by Administrator, on 9/10/13 at 3:15 p.m., indicated the following:</p> <p>The investigation of the incident on 9/10/13 included nurse's notes from the resident's chart dated 6/24/13. The resident indicated to the staff he had gotten into a fight with Mr. Hats and Smiles. The resident further indicated Mr. Hats and Smiles was the man who wears a hat and smiles. The investigation determined Mr. Hats and Smiles was not a staff member. The investigation failed to eliminate the possibility of Mr. Hats and Smiles being another resident,</p>	F000226	<p>The incidents cited have been reviewed by the ADM/designee. Additional documentation has been obtained if able. In the unfortunate event of an allegation of abuse or resident to resident altercation, witness statements from residents, staff, and visitors will be obtained as per expectation. Staff have been re-educated on the Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, including injuries of Unknown Source, and Misappropriation of Resident Property, including collecting and preserving physical and documentary evidenc, interviewing alleged victim(s) and witness(es), interviewing accused individual(s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source. It is the responsibility of the ADM and team to complete a thorough and complete investigation of an allegation of abuse. The ADM will be responsible to ensure witness statements are obtained as necessary from residents, staff, and visitors as applicable to</p>	10/04/2013	

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	<p>family member, or visitor. The investigation further lacked any interviews visitors and any other staff not directly involved in the incident.</p> <p>2.) Review of three facility incident reports provided by Administrator, on 9/12/13 at 4:37 p.m., indicated the following:</p> <p>2.a. A resident-to-resident incident occurred on 8/12/13 at 6:10 p.m. The incident report indicated without provocation Resident #74 threw a chair towards Resident #100. Resident #74 with her open hand, then struck Resident #100 on the right side of her face. The witness statements from the two staff nurses, indicated the staff did not witness the residents prior to the incident and did not mention a chair having been thrown. The investigation lacked any witness statements from Residents #74 and #100. The investigation further lacked any interviews with other residents and visitors, and any other staff not directly involved in the incident.</p> <p>2.b. A resident-to-resident incident occurred on 8/17/13 at 10:30 a.m. A housekeeper heard arguing in the dining room. The housekeeper walked in the dining room and</p>		<p>assist with the investigation and determination of the outcome of an investigation. The ADM will be responsible to obtain supportive documentation for an investigation with a reported occurrence daily for 30 days, weekly for 8 weeks, and then monthly for 3 months, and then quarterly for 2 quarters. Any identified concerns will be immediately addressed, up to and including 1:1 re-education, and/or disciplinary action. Results of the investigations will be forwarded to the Quality Performance Improvement committee monthly for 6 months, and then quarterly for 2 quarters for review. Any further action will be as determined by the QPI committee.</p>		

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	<p>observed Resident #9 shove Resident #100. The investigation lacked any witness statements from Residents #9 and #100. The investigation further lacked any interviews with other residents and visitors, and any other staff not directly involved in the incident.</p> <p>2.c. A resident-to-resident incident occurred on 8/30/13 at 9:50 a.m. Resident #80 was holding on to the door of the room and the arm of Resident #29's wheelchair. Resident #29 struck the forearm of Resident #80. The investigation lacked any witness statements from Resident #29 and #80. The investigation further lacked any interviews with other residents and visitors, and any other staff not directly involved in the incident.</p> <p>3. During an interview with the Administrator on 9/13/13 at 2:25 p.m., she indicated she thought the investigations completed for the incidents on 9/10/13, 8/12/13, 8/17/13 and 8/30/13 were thorough investigations.</p> <p>Review of the current facility policy, revised 4/13, subject "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of</p>				

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	<p>Unknown Source, and Misappropriation of Resident Property," provided by the Administrator on 9/12/13 at 7:27 a.m., included, but was not limited to, the following:</p> <p>"Policy Extendicare Health Services, Inc. (EHSI) prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc....</p> <p>...9. A thorough investigation may include: Collecting and preserving physical and documentary evidence; Interviewing alleged victim (s) and witness (es); Interviewing accused individual (s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source;..."</p> <p>3.1-28(a)</p>			

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and chart review, the facility failed to ensure resident dignity was maintained by posing care issues on signs visible to public for 19 of 19 residents reviewed for dignity (Residents #18, # 51, #52, #65, #91, #59, #31, #4, #14, #3, #40, #62, #84, #42, #69, #33, #26, #44 and #36).</p> <p>The facility further failed to ensure resident dignity was maintained by assisting a resident to feed in the dinning room while standing for 1 of 8 residents reviewed. (Resident # 69)</p> <p>Findings Include:</p> <p>1. During observation of breakfast on September 10, 2013, CNA #1 was observed standing while assisting Resident #69 to eat. The resident was sitting in a Broda chair at the table.</p> <p>The clinical record for Resident #69 was reviewed on September 12, 2013, at 2:30 p.m.</p>	F000241	<p>Staff immediately removed any posted information with resident information. Should staff need written information on the care of our residents, said information will be located in a location only available to staff. Staff have been re-educated on not posting resident information, and to their responsibility of maintaining resident dignity. It is the responsibility of the IDT and Supervisory Licensed Nurses to adhere to confidentiality and maintaining resident dignity. The DON/Designee will conduct rounds 3 times weekly for 4 weeks, 1 time a week for 8 weeks, 1 time a month for 3 months, and then quarterly for 2 quarters to ensure posted information does not contain confidential information in public view. Any identified concerns will be immediately addressed, up to and including 1:1 re-education, and/or disciplinary action. The ADM/designee will review the results of the auditing process as completed. Results will be forwarded to the QPI committee monthly for review. Any further action will be as determined by</p>	10/04/2013	

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	<p>Diagnoses for Resident #69 included, but were not limited to Huntington's disease, hypothyroid, pituitary tumor, urinary incontinence, mood disorder, adrenal insufficiency, dementia, seizure, submandibular abscess, depression and hypopituitaryism.</p> <p>During an interview on September 10, 2013 at 8:15 a.m., with CNA #1, she indicated she was being "yelled at" by other staff for feeding a resident while she stood at the table. She explained that she was very short and the resident was tall and it was hard for her to feed him while sitting.</p> <p>During an interview on September 13, 2013 at 8:48 a.m., with the Assistant Director of Nursing, she indicated the CNA's were trained not to stand while assisting residents to feed unless it was care planned for a specific resident.</p> <p>2. During an observation on September 13, 2013 at 9:00 a.m., a sign titled "Good Nights Sleep Program" was observed on the wall of the West nurses station with resident care issues and resident names visible to the public.</p> <p>Residents' #18, # 51, # 52, # 65, #91, # 59, # 31, # 4, #14, # 3, #40, #62,</p>		the QPI committee..				

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	<p>#84, #42, # 69, # 33, # 26, # 44, and # 36 names appeared on the "Good Nights Sleep Program" list posted at the nurses station. The sheet indicated the following information:</p> <p>"The following residents are to be added to the "good nights sleep program" as part of out facility fall reduction plan: ...</p> <p>"Remember: 2nd shift: put a night time brief on these at bedtime (if they wear briefs) they are kept in the med room. Please also use 'blue goo" skin protection at this time.</p> <p>"3rd shift: allow the resident to sleep un-interrupted for the night, do your regular checks for safety, but do not awaken them for toileting/turning or incontinent care. Assist if they are awake on their own. If they have a BM or have "soaked through" provide care and use a regular brief.</p> <p>"Please continue to let me know how this works/doesn't work and suggestions you have. Thank you for your help and suggestions so far!!!" Signed by the Director of Nursing.</p> <p>3.1-3(t)</p>				

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F000334 SS=E	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>				

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to provide education regarding the benefits and potential side effects of the influenza immunization to the residents or resident's legal representatives and obtain consents for the influenza vaccine annually for 4 of 5 residents reviewed. (Residents #36, #8, #61 and #26).</p> <p>Findings include:</p> <p>1. During the record review for Resident #36 on 9/11/13 at 9:58 a.m., the most current consent for the</p>	F000334	Residents # 36, 8, 61, and 26 will be provided current flu information with 2013-2014 CDC flu information with the consent forms requesting or declining the flu vaccinations. A one time audit has been completed regarding flu consent and education for last year. Staff have been re-educated on the Immunization policy and procedure, completion of evidence of education, and maintaining said information on the medical record. It is the responsibility of the center staff to provide annual re-education on current flu concerns as provided by the CDC. The DON/Designee will be responsible to maintain	10/04/2013			

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	<p>pneumococcal and annual influenza vaccine was dated November 17, 2011. The consent did not have the resident's or legal representative signature. A spreadsheet provided by the Director of Nursing on September 11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 15, 2012. No education information was in the medical record for the current or previous vaccination year.</p> <p>2. During the record review for Resident #8 on 9/11/13 at 9:30 a.m., the most current consent for the pneumococcal and annual influenza vaccine was dated November 18, 2011. The consent did not have the resident's or legal representative signature. A spreadsheet provided by the Director of Nursing on September 11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 9, 2012. No education information was in the medical record for the current or previous vaccination year.</p> <p>3. During the record review for Resident #6 on 9/11/13 at 1:17 p.m., the most current consent for the pneumococcal and annual influenza vaccine was dated November 17, 2011. The consent did not have the</p>		<p>accurate records of having provided the re-education to the resident or responsible party prior to the time of the administration of the flu vaccine weekly through March of 2014. Any identified concerns will be immediately addressed, up to and including 1:1 re-education, and/or disciplinary action. The ADM/Designee will be review the results of the monitoring process weekly through to March 2014. Results of the reviews will be forwarded to the QPI committee monthly for 6 months, and then quarterly for 2 quarters. Any further action taken will be as determined by the QPI committee.</p>		

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	<p>resident's or legal representative signature. A spreadsheet provided by the Director of Nursing on September 11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 9, 2012. No education information was in the medical record for the current or previous vaccination year.</p> <p>4. During the record review for Resident #26 on 9/11/13 at 1:30 p.m., the most current consent for the pneumococcal and annual influenza vaccine was dated November 18, 2011. The consent did not have the resident's or legal representative's signature. A spreadsheet provided by the Director of Nursing on September 11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 9, 2012. No education information was in the medical record for the current or previous vaccination year.</p> <p>5. During an interview on September 11, 2013 at 3:00 p.m., with the Director of Nursing, she indicated there was limited information on the vaccination process for the previous year (2012-2013). She provided a spreadsheet that indicated education was given but did not have any signed education sheet to show what</p>						

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	<p>education was given or that the information was received by the resident or their legal representative. She also indicated the consents for the pneumococcal and influenza vaccines were done at the time of admission and were not repeated annually. She indicated anyone who refused the influenza vaccine would be offered it during the next flu season.</p> <p>Review of the current Immunization policy, dated April 1999 and revised October 2010, provided by the Director of Nursing September 11, 2013 at 3:30 p.m., included but was not limited to, the following:</p> <p>"...PROCEDURE...</p> <p>3. Counsel resident and/ or family on the benefits and adverse effects by providing education materials of each vaccine prior to administration of the vaccines.</p> <p>4. Provide the resident and / or family with a copy of the applicable Vaccine Information Statements (VIS).</p> <p>5. Obtain a consent / refusal using the Pneumococcal and Annual Influenza Vaccine - Information and Request form for the annual influenza</p>						

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	<p>vaccination from the resident or family at the time of admission (or anytime afterwards) and place in the medical record.</p> <p>a. Permit the resident / legal representative to ask and receive answers to any and all questions they may ask....</p> <p>d. A signed "Pneumococcal and Annual Influenza Vaccine Information and Request" form indicates that the resident wishes the vaccine to be administered on an annual basis....</p> <p>9. Offer the resident the Influenza vaccine, annually unless:</p> <p>d. The resident has already been immunized for this time period.</p> <p>10. Document all immunizations on the Immunization Record and maintain in the resident's medical record.</p> <p>a. Do not thin Immunization Record from the medical record...."</p> <p>3.1-18(b)(5)</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was labeled and staff were washing their hands in a manner to prevent the infections for 3 of 3 kitchen observations. (Dietary Staff #2, 3, 4, 5)</p> <p>Findings include:</p> <p>1. The kitchen was observed on 9/9/13 at 6:29 p.m., there was a large uncovered metal bowl filled with a yellow liquid in the "R1" refrigerator. The liquid had reddish brown debris floating on top of it. Dietary Staff #2 indicated the bowl had been in the refrigerator since she had started work at 1:00 p.m., and she did not know what the liquid was. The "F1" freezer had an unidentifiable, unlabeled package of pastry on the bottom shelf. Dietary Staff #2 indicated it was a package of Danish.</p> <p>2. A kitchen observation was made on 9/9/13 at 7:13 p.m., Dietary Staff</p>	F000371	<p>The food was discarded at the time of survey. Staff had been instructed and observed to complete handwashing procedures correctly prior to working with food. A one time audit of food storage has been completed to ensure foods are stored and labeled correctly. The dietary staff has been re-educated regarding hand washing procedures and food storage. It is the responsibility of the dietary staff to store and label food, and complete hand washing as per policy. The dietary manager/designee will observe hand washing and inspect food storage 3 times a week for 8 weeks, 1 time a week for 8 weeks, and 1 time a month for 6 months. Any identified concerns will be immediately addressed, up to and including 1:1 re-education, and/or disciplinary action. The Administrator will accompany the dietary manager on weekly sanitation rounds 1 time a week for 8 weeks, 1 time a month for 4 months, and then quarterly for 2 quarters. Results of the reviews will be forwarded to the QPI for review monthly for 6 months, and</p>	10/04/2013			

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	<p>#4 was observed washing his hands. He completed his hand wash and turned the faucet off with a paper towel. He used the same paper towel to dry his hands, donned gloves and proceeded to handle clean dishes. Dietary Staff #4 removed his gloves and washed his hands at 7:15 p.m. He used a paper towel to turn off the faucet and continued to use the same paper towel to dry his hands again</p> <p>3. An observation of the kitchen was made on 9/12/13 at 10:46 a.m., Dietary Staff #5 was observed washing her hands. She turned off the faucet with a paper towel and proceeded to use the same towel to dry her hands. Dietary Staff #3 was observed during this observation washing her hands at the second hand wash sink. Dietary Staff #3 washed her hands, turned off the faucet with a paper towel and continued to dry her hands with the same paper towel used to turn off the faucet.</p> <p>4. During an interview with the Dietary Manager on 9/12/13 at 10:50 a.m., she indicated staff were to use a clean paper towels to dry their hands.</p> <p>The revised 10/11, "Sanitation Procedure" for Personal Hygiene was</p>		quarterly for 2 quarters. Any further action will be as determined by the QPI committee.				

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	<p>provided by the Dietary Manager on 9/12/13 at 1:09 p.m. The procedure indicated to dry hands with paper towels and turn faucets off with the paper towel.</p> <p>During an interview with the Dietary Manager at 9:11 a.m. on 9/13/13, she indicated 63 of 66 residents receive trays from the dining room.</p> <p>3.1-21(i)(3)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure resident rooms were properly maintained and in good repair for 8 of 34 resident rooms observed. This affected 8 of 34 rooms observed. (Room # 214, 311, 107, 110, 210, 220, 102, and 114)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation and interview of resident #39 on 9/9/13 at 8:57 p.m., the over the bed light and the floor lamp at the head of the bed did not function. He indicated his over the bed light had not worked for a long time. He resided in room # 214. 2. Resident room #311 was observed on 9/10/13 at 9:47 a.m., gouges and missing paint were present on the runner board along the wall in the room. 3. Resident room #107 was observed on 9/10/13 at 10:26 a.m., the grout around the base of the toilet was discolored a rust color and the bathroom had missing pieces of the 	F000465	<p>Resident room (room#214, 311, 107, 100, 210, 220,102 and 114) have been reviewed and corrected. A one time room audit has been completed to identify any issues related to the environment. The Maintenance Director has been re-educated regarding expectations related to the environmental standard expectations. It is the responsibility of the Maintenance staff and team to maintain and repair environmental concerns. The Maintenance Director/designee will be responsible to tour the building 1 time a week for 16 weeks, twice a month for 1 month, monthly for 2 months, and then one time per quarter for 2 quarters, to inspect rooms and any identified concerns will be corrected by the Maintenance Director. As part of a daily Interdisciplinary rounds, any identified environmental concerns will be put on a "Building Services Work Order Request" form and given to the Maintenance Director for immediate correction. Failure to identify and correct any environmental concerns in a timely manner will lead to corrective disciplinary action, up to and including termination. The ADM/Designee</p>	10/11/2013
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	<p>cove base next to the handle side of the bathroom door.</p> <p>4. Resident room #110 was observed on 9/10/13 at 12:34 p.m., gouges and chips were present on the back of the door and the opening edge of the bathroom door of the room.</p> <p>5. Resident room #210 was observed on 9/10/13 at 1:03 p.m., the wall just below the over the bed light was not painted.</p> <p>6. Resident room #220 was observed on 9/10/13 at 1:32 p.m., the wall at the foot of the bed had 4 small areas of chipped paint.</p> <p>7. Resident room #102 was observed on 9/10/13 at 1:41 p.m., gouges were present on back of the bathroom door facing the resident room and the lower corner of the main door had chips missing on the resident room side of the door.</p> <p>8. Resident room #114 was observed on 9/11/13 at 7:56 a.m., missing paint and scrape marks were on the back of the bathroom door facing the room and on the far wall of the inside of the bathroom.</p> <p>9. During an interview with the</p>		<p>will be responsible to review 10 random rooms weekly for 16 weeks, twice a month for 1 month, monthly for 2 months, and then one time per quarter for 2 quarters, to ensure maintainance and environmental concerns are corrected and work order requests have been completed as per expectation. Results of the reviews will be forwarded to the QPI Committee monthly for 7 months, and then quarterly for 2 quarters. Any further action will be as determined by the Quality Performance Improvement Committee.</p>				

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	<p>Maintenance Director on 9/13/13 4:15 p.m., the resident room concerns were discussed and he indicated he was unaware of any of the concerns and they would need to be repaired.</p> <p>3.1-19(f)</p>			

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to identify and put in place action plans to address the following concerns: following their policy of investigating and reporting allegations of abuse affecting 6 of 6 residents and opening of resident mail affecting 1 of 34 residents interviewed; to ensure resident dignity was maintained by not posting care issues visible to the public affecting 19 of 19 residents; to</p>	F000520	Action plans have been put into place for the following areas: Following policy of investigating and reporting allegations of abuse, mail delivery process, maintaining resident dignity, and the provision of education of benefits and potential side effects to residents or resident responsible party. Staff have been re-educated on the Quality Performance Improvement process, in making good faith attempts to identify and correct areas of concern, as well as the	10/04/2013	

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	<p>provide education regarding the benefits and potential side effects of the influenza immunization to the residents or resident's legal representative affecting 4 of 5 residents reviewed. (Resident #'s 20, 74, 9, 80, 100, 29, 36, 18, 51, 52, 65, 91, 59, 31,4, 14, 3, 40, 62, 84, 42, 69, 33, 26, 44, 36, 8, 61, 26)</p> <p>Findings include:</p> <p>1. Review of a facility incident report provided by Administrator, on 9/10/13 at 3:15 p.m., indicated the following:</p> <p>The investigation of the incident on 9/10/13 included nurse's notes from the resident's chart dated 6/24/13. The resident indicated to the staff he had gotten into a fight with Mr. Hats and Smiles. The resident further indicated Mr. Hats and Smiles was the man who wears a hat and smiles. The investigation determined Mr. Hats and Smiles was not a staff member. The investigation failed to eliminate the possibility of Mr. Hats and Smiles being another resident, family member, or visitor. The investigation further lacked any interviews visitors and any other staff not directly involved in the incident.</p>		<p>action plans and re-education on the noted areas. It is the responsibility of the center staff and Interdisciplinary Team to make good faith attempts to identify and correct areas of concern. The Center Management Staff will be responsible to conduct Quality Performance Improvement Committee meetings twice a month for 2 months, monthly for 4 months, and then quarterly for 2 quarters. Failure to make a good faith attempt to identify and identify areas of concern will result in 1:1 re-education, and/or disciplinary action. The ADM/designee will be responsible to review the good faith attempts of the QPI Committee twice a month for 2 months, monthly for 4 months, and then quarterly for 2 quarters. Any further action will be as determined by the ADM/designee.</p>				

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	<p>2.) Review of three facility incident reports provided by Administrator, on 9/12/13 at 4:37 p.m., indicated the following:</p> <p>2.a. A resident-to-resident incident occurred on 8/12/13 at 6:10 p.m. The incident report indicated without provocation Resident #74 threw a chair towards Resident #100. Resident #74 with her open hand, then struck Resident #100 on the right side of her face. The witness statements from the two staff nurses, indicated the staff did not witness the residents prior to the incident and did not mention a chair having been thrown. The investigation lacked any witness statements from Residents #74 and #100. The investigation further lacked any interviews with other residents and visitors, and any other staff not directly involved in the incident.</p> <p>2.b. A resident-to-resident incident occurred on 8/17/13 at 10:30 a.m. A housekeeper heard arguing in the dining room. The housekeeper walked in the dining room and observed Resident #9 shove Resident #100. The investigation lacked any witness statements from Residents #9 and #100. The investigation further lacked any</p>						

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	<p>interviews with other residents and visitors, and any other staff not directly involved in the incident.</p> <p>2.c. A resident-to-resident incident occurred on 8/30/13 at 9:50 a.m. Resident #80 was holding on to the door of the room and the arm of Resident #29's wheelchair. Resident #29 struck the forearm of Resident #80. The investigation lacked any witness statements from Resident #29 and #80. The investigation further lacked any interviews with other residents and visitors, and any other staff not directly involved in the incident.</p> <p>3. During an interview with the Administrator on 9/13/13 at 2:25 p.m., she indicated she thought the investigations completed for the incidents on 9/10/13, 8/12/13, 8/17/13 and 8/30/13 were thorough investigations.</p> <p>Review of the current facility policy, revised 4/13, subject "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property," provided by the Administrator on 9/12/13 at 7:27 a.m., included, but was not limited to, the</p>			

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	<p>following:</p> <p>"Policy Extendicare Health Services, Inc. (EHSI) prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc....</p> <p>...9. A thorough investigation may include:</p> <ul style="list-style-type: none"> Collecting and preserving physical and documentary evidence; Interviewing alleged victim (s) and witness (es); Interviewing accused individual (s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source;..." <p>4. During an interview on 9/9/13 at 8:00 p.m., Resident #36 indicated he had received a letter which had already been opened by the facility the previous week. He indicated he had brought it to the management's attention, but he had not heard back from them at the time of the interview.</p>				

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	<p>During an interview with the Director of Nursing (DoN) on 9/12/13 at 8:50 a.m., she indicated, when she spoke with the Business Office Manager (BoM), the facility did open all mail which looked like it might be a bill and did open the letter of Resident #36.</p> <p>During an interview with the BoM and the Administrator on 9/12/13 at 10:46 a.m., the BoM indicated they did open the mail of residents if any piece of mail looked like it is a bill, or from Medicaid.</p> <p>During a chart review for Resident #36 on 9/12/13 at 10:00 a.m., the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 on his Minimum Data Set (MDS) assessment, dated 3/15/13, which indicated the resident was alert and oriented and able to make his own decisions.</p> <p>A 1/2001, procedure for "Mail - Resident Receiving and Sending" provided by the Administrator on 9/12/13 at 10:43 a.m., indicated "Each resident will have privacy in written communication both in receiving and sending. Mail will be delivered to the resident within 24 hours of delivery by the postal</p>			

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	<p>service...Deliver the mail, unopened, to the applicable resident's room."</p> <p>5. a. During observation of breakfast on September 10, 2013, CNA #1 was observed standing while assisting Resident #69 to eat. The resident was sitting in a Broda chair at the table.</p> <p>The clinical record for Resident #69 was reviewed on September 12, 2013, at 2:30 p.m.</p> <p>Diagnoses for Resident #69 included, but were not limited to Huntington's disease, hypothyroid, pituitary tumor, urinary incontinence, mood disorder, adrenal insufficiency, dementia, seizure, submandibular abscess, depression and hypopituitaryism.</p> <p>During an interview on September 10, 2013 at 8:15 a.m., with CNA #1, she indicated she was being "yelled at" by other staff for feeding a resident while she stood at the table. She explained that she was very short and the resident was tall and it was hard for her to feed him while sitting.</p> <p>During an interview on September 13, 2013 at 8:48 a.m., with the Assistant Director of Nursing, she indicated the CNA's were trained not to stand while</p>				

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	<p>assisting residents to feed unless it was care planned for a specific resident.</p> <p>5.b. During an observation on September 13, 2013 at 9:00 a.m., a sign titled "Good Nights Sleep Program" was observed on the wall of the West nurses station with resident care issues and resident names visible to the public.</p> <p>Residents' #18, # 51, # 52, # 65, #91, # 59, # 31, # 4, #14, # 3, #40, #62, #84, #42, # 69, # 33, # 26, # 44, and # 36 names appeared on the "Good Nights Sleep Program" list posted at the nurses station. The sheet indicated the following information: "The following residents are to be added to the "good nights sleep program" as part of out facility fall reduction plan: ...</p> <p>"Remember: 2nd shift: put a night time brief on these at bedtime (if they wear briefs) they are kept in the med room. Please also use 'blue goo" skin protection at this time.</p> <p>"3rd shift: allow the resident to sleep un-interrupted for the night, do your regular checks for safety, but do not awaken them for toileting/turning or incontinent care. Assist if they are</p>						

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	<p>awake on their own. If they have a BM or have "soaked through" provide care and use a regular brief.</p> <p>"Please continue to let me know how this works/doesn't work and suggestions you have. Thank you for your help and suggestions so far!!!" Signed by the Director of Nursing.</p> <p>6. a. During the record review for Resident #36 on 9/11/13 at 9:58 a.m., the most current consent for the pneumococcal and annual influenza vaccine was dated November 17, 2011. The consent did not have the resident's or legal representative signature. A spreadsheet provided by the Director of Nursing on September 11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 15, 2012. No education information was in the medical record for the current or previous vaccination year.</p> <p>6.b. During the record review for Resident #8 on 9/11/13 at 9:30 a.m., the most current consent for the pneumococcal and annual influenza vaccine was dated November 18, 2011. The consent did not have the resident's or legal representative signature. A spreadsheet provided by the Director of Nursing on September</p>						

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	<p>11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 9, 2012. No education information was in the medical record for the current or previous vaccination year.</p> <p>6.c. During the record review for Resident #6 on 9/11/13 at 1:17 p.m., the most current consent for the pneumococcal and annual influenza vaccine was dated November 17, 2011. The consent did not have the resident's or legal representative signature. A spreadsheet provided by the Director of Nursing on September 11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 9, 2012. No education information was in the medical record for the current or previous vaccination year.</p> <p>6.d. During the record review for Resident #26 on 9/11/13 at 1:30 p.m., the most current consent for the pneumococcal and annual influenza vaccine was dated November 18, 2011. The consent did not have the resident's or legal representative's signature. A spreadsheet provided by the Director of Nursing on September 11, 2013 at 3:00 p.m., indicated the resident received the influenza vaccine October 9, 2012. No</p>				

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	<p>education information was in the medical record for the current or previous vaccination year.</p> <p>6.e. During an interview on September 11, 2013 at 3:00 p.m., with the Director of Nursing, she indicated there was limited information on the vaccination process for the previous year (2012-2013). She provided a spreadsheet that indicated education was given but did not have any signed education sheet to show what education was given or that the information was received by the resident or their legal representative. She also indicated the consents for the pneumococcal and influenza vaccines were done at the time of admission and were not repeated annually. She indicated anyone who refused the influenza vaccine would be offered it during the next flu season.</p> <p>Review of the current Immunization policy, dated April 1999 and revised October 2010, provided by the Director of Nursing September 11, 2013 at 3:30 p.m., included but was not limited to, the following:</p> <p>"...PROCEDURE...</p>			

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	<p>3. Counsel resident and/ or family on the benefits and adverse effects by providing education materials of each vaccine prior to administration of the vaccines.</p> <p>4. Provide the resident and / or family with a copy of the applicable Vaccine Information Statements (VIS).</p> <p>5. Obtain a consent / refusal using the Pneumococcal and Annual Influenza Vaccine - Information and Request form for the annual influenza vaccination from the resident or family at the time of admission (or anytime afterwards) and place in the medical record.</p> <p style="padding-left: 20px;">a. Permit the resident / legal representative to ask and receive answers to any and all questions they may ask....</p> <p style="padding-left: 20px;">d. A signed "Pneumococcal and Annual Influenza Vaccine Information and Request" form indicates that the resident wishes the vaccine to be administered on an annual basis....</p> <p>9. Offer the resident the Influenza vaccine, annually unless:</p> <p style="padding-left: 20px;">d. The resident has already been immunized for this time period.</p> <p>10. Document all immunizations on the Immunization Record and</p>				

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	<p>maintain in the resident's medical record.</p> <p>a. Do not thin Immunization Record from the medical record...."</p> <p>7. Interview with the Administrator, on 9/13/13 at 4:30 p.m., indicated the facility had not addressed any of the noted concerns with an action plan through their quality assessment program.</p> <p>3.1-52(b)(2)</p>			