

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 5, 6, 7, 8, 9, and 12, 2012</p> <p>Facility number: 002667 Provider number: 155678 AIM number: 200300090</p> <p>Survey team: Donna M. Smith, RN, TC (March 5, 6, 7, 8, and 9, 2012) Toni Maley, BSW Tammy Alley, RN DeAnn Mankell, RN (March 5, 6, 7, 8, and 9, 2012)</p> <p>Census bed type: SNF: 40 SNF/NF: 46 Residential: 40 Total: 126</p> <p>Census payor type: Medicare: 40 Medicaid: 31 Other: 55 Total: 126</p> <p>Sample (Stage 2): 40</p> <p>These deficiencies reflect state</p>	F0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance.</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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	findings cited in accordance with 410 IAC 16.2. Quality review 3/21/12 by Suzanne Williams, RN				

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F0223 SS=A	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure abuse did not occur for 1 resident in a sample of 3 resident allegations reviewed. (Resident #7)</p> <p>Findings include:</p> <p>1. An allegation of abuse regarding Resident #7 was reviewed on 3/07/12. According to the allegation, provided by the facility, Resident #7 alleged CNA #7 "slapped her three times in the face."</p> <p>Resident #7's clinical record was reviewed on 3/9/12 at 8:57 A.M. Resident #7's diagnoses included, but were not limited to, cerebrovascular disease, osteoporosis, hemiplegic affect, convulsions, diverticulitis of colon, NIDDM (non insulin dependent diabetes mellitus), anemia, A-Fib (atrial fibrillation), GERD (gastroesophageal reflux disease),</p>	F0223	<p>1. Resident #7 was immediately assessed for any signs of physical harm and for any emotional trauma or anxiety. Staff member was immediately suspended. Resident was assessed and interviewed approximately two hours later for any signs or symptoms of physical or emotional trauma. No visible signs noted.2. Interviews and observations were completed to determine if any other residents were affected.3. Staff have been re-educated on the Campus policy and procedure for abuse investigations. The Executive Director or Designee will review all allegations of abuse to ensure a complete and thorough investigation is completed.4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly.5. April 11, 2012</p>	04/11/2012	

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	<p>and neuropathy.</p> <p>Review of the quarterly MDS (minimum data set) assessment, dated 12/13/11, indicated the resident had a score of 11 on her BIMS (brief interview for mental status) indicating she was moderately impaired for decision making skills.</p> <p>The record had a "Short Portable Mental Status Questionnaire" dated 12/12/11, with a total score of 7. The key for this score indicated the resident was moderately cognitively impaired.</p> <p>The investigation of the allegation of abuse indicated on 12/14/11 Resident #7 "alleged that [CNA #7] became physically abusive and 'slapped her three times in the face."</p> <p>The facility immediately placed CNA #7 on suspension and began an investigation with the following statement, dated 12/14/11, written by CNA #8: ".... [Resident #7] grabbed [CNA #7] arm for support her nails scratched [CNA #7's] arm. [CNA #7] got upset and told her 'Don't put your hands on me again! You are digging your nails into me and I'm not dealing with this anymore.'I headed down to the</p>						

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	<p>dining hall....grabbed some ketchup to take to (name) and proceeded to take it to her.... I could hear [CNA #7] and [Resident #7] being verbally aggressive to each other. So I knocked on [Resident #7's] door and peeked by head in and asked if she [CNA #7] needed my help. [CNA #7] and [Resident #7] didn't hear me.... [Resident #7] put her fist in the air and said 'I'm going to punch you right in the face!' Then [CNA #7] grabbed [Resident #7's] arm and held it down. It seemed to be somewhat of a struggle between the two. I knew for sure at this point neither of them knew I was watching. I shut the door and went down to the dining hall to tell the DON about it....[Resident #7] told the DON that [CNA #7] 'hit her 3 times.'I didn't see [CNA #7] hit [Resident #7] but from the looks of how [CNA #7] was treating [Resident #7] I believe [Resident #7] was telling the truth about what [CNA #7] did to her...."</p> <p>CNA #7 was terminated at the conclusion of this investigation.</p> <p>Review of the "Abuse and Neglect Procedural Guidelines" dated 9/16/2011 and provided by the Administrator on 3/7/11 at 11:10 A.M. indicated "Trilogy Health Services,</p>			

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	<p>LLC, has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...."</p> <p>3.1-27(b)</p>			

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F0225 SS=D	<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 interview, the facility failed to</p>	F0225	1. Resident #95 and #214 have both been discharged from facility.2. Interviews and	04/11/2012			

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	<p>thoroughly investigate allegations of abuse for 2 of 4 residents reviewed with allegations of abuse. (Resident #95 and #214)</p> <p>Findings include:</p> <p>1. Resident #95's closed clinical record was reviewed on 3/8/12 at 10:43 A.M. Resident #95's diagnoses included, but were not limited to, bronchitis, pleural effusion, adult failure to thrive, HTN (hypertension), GERD (gastroesophageal reflux disease), dysphagia, and COPD (chronic obstructive pulmonary disease).</p> <p>Resident #95's admission MDS (minimum data set) assessment indicated a BIMS (Brief Interview for Mental Status) score of 12, which indicated she was moderately cognitively impaired.</p> <p>An allegation of abuse made about Resident #95 was provided by the facility on 3/7/12.</p> <p>The allegation of abuse indicated "Friend of [Resident #95] reported to the DON, on 11/19/11 that at some time earlier in the week, a CNA was asked to come in the room and provide care to the resident and the</p>		<p>observations were completed to determine if any other residents were affected. Staff has been inserviced on the facility's Fraud and Abuse Policy and Resident Rights. The facility's concern/grievance reporting process will be reviewed at admission for new residents and will be reviewed through Resident Council for current residents.3. Staff has been re-educated on the Campus Abuse policy and procedure for abuse investigations. All allegations of abuse will be investigated thoroughly and reported per the Indiana unusual occurrence guidelines. The Executive Director or Designee will review all allegations of abuse to ensure a complete and thorough investigation is completed.4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly.5. April 11, 2012</p>				

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	<p>friend alleges that she overheard the CNA use the term 'lay still' in an overly loud or stern way...."</p> <p>The facility suspended the CNA and an investigation was started.</p> <p>A "Resident Concern Form" dated 11/16/11, was reviewed. This form indicated [Resident #95] was concerned about a call light. There was a notation of "Talking to Res. mean & told res she couldn't have her call light. Told [name of Resident #95] per care giver 'You can't have your call light because you will be pushing on it all night.'" The resolution with the resident was "Met c (with) resident, she stated 'I don't remember,' but I assured her that I will check with her frequently...."</p> <p>The investigation dated 11/18/11 indicated "interviewed staff no (indicated with a line through a circle) findings, interviewed resident no (indicated with a line through a circle) findings, interviewed resident across hall no (indicated with a line through a circle) findings." This investigation lacked the name of the staff or residents interviewed.</p> <p>The follow-up was "care plan - CNA sheets > call light reachable &</p>			

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	<p>accessible by resident at all times."</p> <p>There was an interview with CNA #9 on 11/21/11 at 3:15 P.M. The written interview indicated "Call light - she attached it to the side of her bed. When turning her - stay over there, meant she was turning too early. Tone was abrupt? [CNA #9] states she may have come across that way. She has a cold - and it may have been intrepeted (sic) in a different way."</p> <p>The investigation continued with "[the names of the DON and the Administrator] met with [CNA #9] - We re-communicated the mission of our work, our professionalism, our duty. To always maintain that professionalism at all times. Discussed the fact that she is already on final warning and that we have had many-mini-discussions about care (lack of). While we did not find the allegation to be substantiated in any way, we cannot ignore the fact that her name keeps coming up time after time. She must improve...."</p> <p>2. During an interview with Resident #214 on 3/6/2012 at 10:33 A.M., she indicated CNA #10 was "rude and bossy." She said CNA #10 told her she had to go to breakfast. She said</p>			

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	<p>CNA #10 had pulled the sheets off of her bed while she was moving to get up out of the bed. She indicated she had "told her to stop it." She indicated she had therapy around 9:00 A.M. and when she was "at home I have coffee and I go back to bed and watch TV with my coffee. I don't eat breakfast usually, here she was told she had to get up and go to breakfast. The other morning she indicated CNA #10 told her at 7:00 am she had to take her shower right now. She further indicated CNA #10 is bossy.</p> <p>On 3/6/12 at 3:30 p.m. during an interview, the Administrator was informed of Resident #214's concerns of staff treatment.</p> <p>The Administrator provided an "employee counseling record form" completed on 3/7/12 and provided on 3/7/12, indicating "Resident concern brought forth by ISDH surveyor as part of resident interviews. Concerns that CNA (name of CNA #10) 'bully's' her to get up when her preference is to get up late. Also, she knocks, but then 'storms' in according to resident allegation. Although resident feels it may be more of a 'personality conflict' Part of the improvement plan will include a review of Trilogy src (service) expectations and resident</p>				

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	<p>1st program. CNA suspended 3/7/12, pending investigation." The expected level of improvement of change was "To be colnerent (sic) of our residents' preferences and recognize when our own priorities/perceptions of care needs, such as 'needing' to get someone 'up' for therapy, may be at odds with our residents' wishes at that time...." Type of disciplinary action was a "verbal warning." The Administrator indicated this was his investigation and it was complete.</p> <p>Resident # 214's clinical record was reviewed on 3/7/12 at 8:51 A.M. Resident #214's diagnoses included, but were not limited to, muscle weakness, joint replacement, hypothyroidism. HTN (hypertension), osteoarthritis, GERD (gastroesophageal reflux disease), anemia, right total hip replacement, PVD (peripheral vascular disease), depression, and peptic ulcer disease.</p> <p>Her admission MDS (minimum data set) assessment dated 2/24/12, indicated a BIMS (Brief Interview for Mental Status) of 15, which indicated she had no cognitive impairments.</p> <p>The "Skilled Nursing Assessment and Data Collection" tool dated 3/5/12, noted in the mood and behavior</p>			

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	<p>section "very hateful about care today."</p> <p>During an interview with LPN #11 on 3/7/12 at 9:34 AM. She indicated Resident #214 was "tricky" and said, "She doesn't like to get out of bed, eat, shower, or do PT (Physical Therapy). Getting up to breakfast is part of her therapy, taking a shower is part of their therapy. PT, OT (Occupational Therapy), and socialization is part of therapy. We can't make them come out of their room, but we encourage them to come out." She indicated Resident #214 had a scheduled shower day, and on the scheduled day she was to have a morning shower. She indicated the schedule is made out by room number with regular shower days, but the resident can change the day, but the resident would have to request the change. She said, "If they request, we will change this around." She indicated on 3/5/12, "She wanted her shower at noon, and all the staff was in the dining room at that time and she (the CNA) couldn't do a shower at noon." She indicated the CNA had told the resident she could do the shower around 9:30 A.M. She indicated Resident #214 likes to lay in bed and they try to get her up and going.</p>			

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	<p>During this interview, LPN #11 indicated the note written on 3/5/12 in the mood and behavior section of "very hateful about care today was about getting up," was about what the CNA had told her, but she (the resident) was very reluctant to do anything. She indicated "This was out of her normal behavior and the resident didn't tell her, LPN #11, that there was anything going on or that there was any problem. LPN #11 said she "didn't know why she lays in bed, but she is not motivated."</p> <p>The facility provided a statement written by CNA #10 on 3/8/12, and dated 3/5/12 at 7:00 A.M., indicating "I took a cup of coffee to (name of Resident #214) like I do every morning.... I went back at about 7:30 A.M. She stated she would take her shower before her therapy at 1:00 P.M. I explained I would be in the dining room at noon and that it would be a bad time to shower. She said she would take one by herself. I explained someone needed to be in the room when she was in the shower for safety reasons. I asked again if she would shower now because this would be a good time to shower. She said yes she would at this time. She set up on the side of the bed. I took a</p>				

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	<p>corner of the sheet off and she said wait a minute I'm trying to get a head start. She got up and took her shower, dressed and therapy came and got her..."</p> <p>The facility provided a statement on 3/8/12 written by LPN #11 and dated 3/7/12 "(Name of CNA #10) reported to me in breakfast on 3/6/12 that (Name of Resident #214) is not happy with her et she wanted to report what happened. She stated that first thing she took coffee into the resident.... stated that the (nursing students) would be back to give her a shower. The students went to give shower et res refused to get out of bed. (Name of CNA #10) then when (sic) she got the time went back into res room et explained that it was time for her shower. Res stated that she didn't want to get out of bed. (Name of CNA #10) reminded her that showers, going to the dining room was all part of her therapy. Res (resident) reluctantly took her shower et bed was stripped. Res refused to get dressed but sat up in a chair in her room in her bath robe. She said she wanted to go back to bed. Therapy has talked with res many times about staying out of bed. (Name of CNA #10) did not make the bed yet so that res could stay up. Res was upset</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>because she lacks motivation to do much."</p> <p>Review of the "Abuse and Neglect Procedural Guidelines" dated 9/16/2011 and provided by the Administrator on 3/7/11 at 11:10 A.M. indicated "Trilogy Health Services, LLC, has a process to investigate allegation of abuse...The Executive Director is accountable for investigating and reporting."</p> <p>3.1-28(d)</p>			

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F0226 SS=D	<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 implement their abuse prevention policy and procedure by failing to thoroughly investigate allegations of abuse for 2 of 4 residents reviewed with allegations of abuse. (Residents #95 and #214)</p> <p>Findings include:</p> <p>1. Resident #95's closed clinical record was reviewed on 3/8/12 at 10:43 A.M.</p> <p>Resident #95's diagnoses included, but were not limited to, bronchitis, pleural effusion, adult failure to thrive, HTN (hypertension), GERD (gastroesophageal reflux disease), dysphagia, and COPD (chronic obstructive pulmonary disease).</p> <p>Resident #95's admission MDS (minimum data set) assessment indicated a BIMS (Brief Interview for Mental Status) score of 12, which indicated she was moderately cognitively impaired.</p>	F0226	<p>1. Resident #95 and #214 have both been discharged from facility. 2. Interviews and observations were completed to determine if any other residents were affected. Staff has been inserviced on the facility's Fraud and Abuse Policy and Resident Rights. 3. Staff has been re-educated on the Campus Abuse policy and procedure for abuse investigations. All allegations of abuse will be investigated thoroughly and reported per the Indiana unusual occurrence guidelines. The Executive Director or Designee will review all allegations of abuse to ensure a complete and thorough investigation is completed. 4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly. 5. April 11, 2012</p>	04/11/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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	<p>An allegation of abuse made about Resident #95 was provided by the facility on 3/7/12.</p> <p>The allegation of abuse indicated "Friend of [Resident #95] reported to the DON, on 11/19/11 that at some time earlier in the week, a CNA was asked to come in the room and provide care to the resident and the friend alleges that she overheard the CNA use the term 'lay still' in an overly loud or stern way...."</p> <p>The facility suspended the CNA and an investigation was started.</p> <p>A "Resident Concern Form" dated 11/16/11, was reviewed. This form indicated [Resident #95] was concerned about a call light. There was a notation of "Talking to Res. mean & told res she couldn't have her call light. Told [name of Resident #95] per care giver 'You can't have your call light because you will be pushing on it all night.'" The resolution with the resident was "Met c (with) resident, she stated 'I don't remember,' but I assured her that I will check with her frequently...."</p> <p>The investigation dated 11/18/11 indicated "interviewed staff no</p>			

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	<p>(indicated with a line through a circle) findings, interviewed resident no (indicated with a line through a circle) findings, interviewed resident across hall no (indicated with a line through a circle) findings." This investigation lacked the name of the staff or residents interviewed.</p> <p>The follow-up was "care plan - CNA sheets > call light reachable & accessible by resident at all times."</p> <p>There was an interview with CNA #9 on 11/21/11 at 3:15 P.M. The written interview indicated "Call light - she attached it to the side of her bed. When turning her - stay over there, meant she was turning too early. Tone was abrupt? [CNA #9] states she may have come across that way. She has a cold - and it may have been intrepeted (sic) in a different way."</p> <p>The investigation continued with "[the names of the DON and the Administrator] met with [CNA #9] - We re-communicated the mission of our work, our professionalism, our duty. To always maintain that professionalism at all times. Discussed the fact that she is already on final warning and that we have had many-mini-discussions about care</p>						

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	<p>(lack of). While we did not find the allegation to be substantiated in any way, we cannot ignore the fact that her name keeps coming up time after time. She must improve...."</p> <p>2. During an interview with Resident #214 on 3/6/2012 at 10:33 A.M., she indicated CNA #10 was "rude and bossy." She said CNA #10 told her she had to go to breakfast. She said CNA #10 had pulled the sheets off of her bed while she was moving to get up out of the bed. She indicated she had "told her to stop it." She indicated she had therapy around 9:00 A.M. and when she was "at home I have coffee and I go back to bed and watch TV with my coffee. I don't eat breakfast usually, here she was told she had to get up and go to breakfast. The other morning she indicated CNA #10 told her at 7:00 am she had to take her shower right now. She further indicated CNA #10 is bossy.</p> <p>On 3/6/12 at 3:30 p.m. during an interview, the Administrator was informed of Resident #214's concerns of staff treatment.</p> <p>The Administrator provided an "employee counseling record form" completed on 3/7/12 and provided on 3/7/12, indicating "Resident concern</p>				

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	<p>brought forth by ISDH surveyor as part of resident interviews. Concerns that CNA (name of CNA #10) 'bully's' her to get up when her preference is to get up late. Also, she knocks, but then 'storms' in according to resident allegation. Although resident feels it may be more of a 'personality conflict' Part of the improvement plan will include a review of Trilogy src (service) expectations and resident 1st program. CNA suspended 3/7/12, pending investigation." The expected level of improvement of change was "To be colnerent (sic) of our residents' preferences and recognize when our own priorities/perceptions of care needs, such as 'needing' to get someone 'up' for therapy, may be at odds with our residents' wishes at that time...." Type of disciplinary action was a "verbal warning." The Administrator indicated this was his investigation and it was complete.</p> <p>Resident # 214's clinical record was reviewed on 3/7/12 at 8:51 A.M. Resident #214's diagnoses included, but were not limited to, muscle weakness, joint replacement, hypothyroidism. HTN (hypertension), osteoarthritis, GERD (gastroesophageal reflux disease), anemia, right total hip replacement, PVD (peripheral vascular disease),</p>			

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	<p>depression, and peptic ulcer disease.</p> <p>Her admission MDS (minimum data set) assessment dated 2/24/12, indicated a BIMS (Brief Interview for Mental Status) of 15, which indicated she had no cognitive impairments.</p> <p>The "Skilled Nursing Assessment and Data Collection" tool dated 3/5/12, noted in the mood and behavior section "very hateful about care today."</p> <p>During an interview with LPN #11 on 3/7/12 at 9:34 AM. She indicated Resident #214 was "tricky" and said, "She doesn't like to get out of bed, eat, shower, or do PT (Physical Therapy). Getting up to breakfast is part of her therapy, taking a shower is part of their therapy. PT, OT (Occupational Therapy), and socialization is part of therapy. We can't make them come out of their room, but we encourage them to come out." She indicated Resident #214 had a scheduled shower day, and on the scheduled day she was to have a morning shower. She indicated the schedule is made out by room number with regular shower days, but the resident can change the day, but the resident would have to request the change. She said, "If</p>			

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	<p>they request, we will change this around." She indicated on 3/5/12, "She wanted her shower at noon, and all the staff was in the dining room at that time and she (the CNA) couldn't do a shower at noon." She indicated the CNA had told the resident she could do the shower around 9:30 A.M. She indicated Resident #214 likes to lay in bed and they try to get her up and going.</p> <p>During this interview, LPN #11 indicated the note written on 3/5/12 in the mood and behavior section of "very hateful about care today was about getting up," was about what the CNA had told her, but she (the resident) was very reluctant to do anything. She indicated "This was out of her normal behavior and the resident didn't tell her, LPN #11, that there was anything going on or that there was any problem. LPN #11 said she "didn't know why she lays in bed, but she is not motivated."</p> <p>The facility provided a statement written by CNA #10 on 3/8/12, and dated 3/5/12 at 7:00 A.M., indicating "I took a cup of coffee to (name of Resident #214) like I do every morning.... I went back at about 7:30 A.M. She stated she would take her shower before her therapy at 1:00</p>			

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	<p>P.M. I explained I would be in the dining room at noon and that it would be a bad time to shower. She said she would take one by herself. I explained someone needed to be in the room when she was in the shower for safety reasons. I asked again if she would shower now because this would be a good time to shower. She said yes she would at this time. She set up on the side of the bed. I took a corner of the sheet off and she said wait a minute I'm trying to get a head start. She got up and took her shower, dressed and therapy came and got her..."</p> <p>The facility provided a statement on 3/8/12 written by LPN #11 and dated 3/7/12 "(Name of CNA #10) reported to me in breakfast on 3/6/12 that (Name of Resident #214) is not happy with her et she wanted to report what happened. She stated that first thing she took coffee into the resident.... stated that the (nursing students) would be back to give her a shower. The students went to give shower et res refused to get out of bed. (Name of CNA #10) then when (sic) she got the time went back into res room et explained that it was time for her shower. Res stated that she didn't want to get out of bed. (Name of CNA #10) reminded her that showers,</p>			

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	<p>going to the dining room was all part of her therapy. Res (resident) reluctantly took her shower et bed was stripped. Res refused to get dressed but sat up in a chair in her room in her bath robe. She said she wanted to go back to bed. Therapy has talked with res many times about staying out of bed. (Name of CNA #10) did not make the bed yet so that res could stay up. Res was upset because she lacks motivation to do much."</p> <p>Review of the "Abuse and Neglect Procedural Guidelines" dated 9/16/2011 and provided by the Administrator on 3/7/11 at 11:10 A.M. indicated "Trilogy Health Services, LLC, has a process to investigate allegation of abuse...The Executive Director is accountable for investigating and reporting."</p> <p>3.1-28(a)</p>				

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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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 record review and interview, the facility failed to ensure residents were allowed to make choices related to their personal care for 2 of 3 residents reviewed for choices in a sample of 21 residents who met the criteria for choices. (Residents #214 and #217)</p> <p>Findings include:</p> <p>1. During an interview with Resident #214 on 3/6/2012 at 10:33 A.M., she indicated CNA #10 was "rude and bossy." She said CNA #10 told her she had to go to breakfast. She said CNA #10 had pulled the sheets off of her bed while she was moving to get up out of the bed. She indicated she had "told her to stop it." She indicated she had therapy around 9:00 A.M. and when she was "at home I have coffee and I go back to bed and watch TV with my coffee. I don't eat breakfast usually, here she was told she had to get up and go to breakfast.</p>	F0242	<p>1. Resident #214 no longer resides in the facility. Resident #217 was interviewed by Social Services and a plan of care developed to reflect the resident wishes for personal care choices.2. Interviews and observations were completed to determine if any other residents were affected.3. Staff has been re-educated on resident rights and the importance of ensuring residents be allowed to make choices related to their personal care. The Executive Director or Designee will review all concern forms to ensure resident choices are being met.4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly.5. April 11, 2012</p>	04/11/2012			

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	<p>The other morning she indicated CNA #10 told her at 7:00 A.M. she had to take her shower right now. She further indicated CNA #10 is bossy. She indicated other CNAs would let her do things the way she wanted to do them, but CNA #10 wouldn't as she had to do things the way CNA #10 wanted her to do things.</p> <p>Resident # 214's clinical record was reviewed on 3/7/12 at 8:51 A.M.</p> <p>Resident #214's diagnoses included, but were not limited to, muscle weakness, joint replacement, hypothyroidism, HTN (hypertension), osteoarthritis, GERD (gastroesophageal reflux disease), anemia, right total hip replacement, PVD (peripheral vascular disease), depression, and peptic ulcer disease.</p> <p>Her admission MDS (minimum data set) assessment dated 2/24/12, indicated a BIMS (brief interview for mental status) of 15, which indicated she had no cognitive impairments. The MDS assessment indicated choices of bedtime, bath, and phone were very important to her.</p> <p>During an interview with LPN #11 on 3/7/12 at 9:34 AM. She indicated Resident #214 was tricky and said,</p>						

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	<p>"She doesn't like to get out of bed, eat, shower, or do PT (Physical Therapy)." She said, "Getting up to breakfast is part of her therapy, taking a shower is part of their therapy. PT, OT (Occupational Therapy), and socialization is part of therapy. We can't make them come out of their room, but we encourage them to come out." She indicated Resident #214 had a scheduled shower day and it was in the morning. She indicated the schedule is made out and they have the regular shower days, but they can change the day, but the resident would have to request the change. She said, "If they request, we will change this around." She indicated on 3/5/12, "She wanted her shower at noon, and all the staff was in the dining room at that time and she (the CNA) couldn't do a shower at noon." She said the CNA told the resident she could do the shower around 9:30 A.M. She indicated Resident #214 likes to lay in bed and we try to get her up and going.</p> <p>LPN #11 indicated the note written on 3/5/12 in the mood and behavior section of "very hateful about care today was about getting up," was about what the CNA had told her, but she (the resident) was very reluctant</p>			

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	<p>to do anything. She indicated this was out of her normal behavior and the resident didn't tell her, LPN #11, that there was anything going on or that there was any problem. LPN #11 said she "didn't know why she lays in bed, but she is not motivated."</p> <p>2. Resident #217 was interviewed on 3/5/12 at 2:40 P.M. She indicated she was gotten up too early in the morning and she wanted to sleep later into the morning. She indicated she had to take a shower when the staff told her to do so, but she preferred to take her shower on her own.</p> <p>Resident #217's clinical record was reviewed on 3/8/12 at 5:18 A.M.</p> <p>Resident #217 had diagnoses which included but were not limited to anemia, GI hemorrhage, History of falls, GERD (gastroesophageal reflux disease), muscle weakness, colon cancer with colostomy, cervical cancer, radiation cystitis, history of hematuria and intermittent urinary retention.</p> <p>The admission MDS (minimum data set) assessment dated 3/3/12, indicated a BIMS (brief interview for mental status) of 13, which indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>she was cognitively alert with no impairment.</p> <p>Resident #217 had a nurses' note written on 2/26/12 "very anxious d/t (due to) change in rtn (routine) et getting up early. easily upset."</p> <p>Review of the admission MDS assessment dated 3/3/12, indicated bathing and bedtime were very important.</p> <p>The record lacked any indication of a care plan meeting with the resident or her son since her admission for her to discuss her concerns.</p> <p>Review of the CNA sheet dated 3/6/12, lacked any indication of the resident's desire to not get up early in the morning.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>						

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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F0244 SS=D	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to respond to food related concerns expressed during residents council for 8 of 9 months when concerns were voiced during the past 12 months reviewed, and for 1 of 1 resident interviewed as a representative of Resident Council (Resident #122). This deficient practice had the potential to impact 7 of the 7 residents, which was the maximum attendance in Resident Council during the one year period.</p> <p>Findings Include:</p> <p>During a 3/8/12, 9:15 a.m. interview with Resident #122, who was identified to be a representative of resident council and determined to be interviewable during the stage 1 survey process, Resident #122 stated, "There have been many food complaints." "I don't remember a response."</p> <p>Review of Resident Council Minutes</p>	F0244	<p>1. Resident #122 was interviewed to ensure any other concerns were addressed.2. The Resident Council minutes for the previous three months were reviewed to ensure resident concerns were resolved.3. The Resident Activity Director was re-educated on the Campus policy and procedure for Resident Council. A copy of all Resident Council concerns will be presented to the Executive Director as well as the appropriate Department Manager specific to the concern. These concerns will be reviewed in the daily Stand-Up meeting until resolved.4. The Resident Activity Director will report concerns with corresponding resolutions from the Resident Council to the QAA committee for review monthly for three months and then quarterly.5. April 11, 2012</p>	04/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>for one year (3/11 through 2/12) contained food related concerns during 9 of the 12 months as follows:</p> <p>a.) 2/13/12- (6 residents in attendance)- "Dietary-....the egg rolls were not good-mushy.'</p> <p>b) 1/9/12-(7 residents in attendance) -"Dietary- more "home" cooking...pork chops hard..."</p> <p>c.) 12/27/11-(7 residents in attendance)- "Dietary-egg rolls on Monday night (12/26/11) was bad, could not chew, ... dressing needs baked longer (it's wet)"</p> <p>d.) 11/29/11-(7 residents in attendance) "Old business- baked potatoes still hard. ... Saturdays are not good in MDR [Main Dining Room] -servers confused...would like "good old fashion cooking"..request dietary manager to attend special food suggestion meeting."</p> <p>e.) 10/31/11- (6 residents in attendance) "Old Business-read food concern-residents feel food is still not good-breakfast. ... Dietary- would like more vegetable soup-[enjoyed it]...baked potatoes chilly"</p> <p>f.) 9/27/11 (4 Residents in</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>attendance) "Dietary-food could always be hotter."</p> <p>g.) 8/30/11(5 residents in attendance) "many dietary issues-concerns written to [Dietary Manager] and [Administrator] considering special meeting in 1-2 weeks."</p> <p>h.) 4/26/11 (3 residents in attendance) "Rice hard at times."</p> <p>i.) 3/29/11 (4 residents in attendance)" ...lots of chicken. ... pork chops (3/28) very tough."</p> <p>Review of Resident Council concern forms for one year (3/11 through 2/12) contained only 1 month of food related concerns being forwarded to the Dietary Department, 8/30/11. The other eight concerns were not forwarded to the dietary department.</p> <p>During a 3/8/11, 10:00 a.m. interview, the Activity Director indicated she had not forwarded all the above concerns to the Dietary Department because she believed the Dietary Department was already aware of the problem or had addressed the issue on the spot. She had developed this belief based on the Resident Council conversation which had occurred during the</p>						

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>discussion of the concerns.</p> <p>During a 3/8/12, 11:00 a.m., interview, the Dietary Manager indicated the above food concerns had not been presented to him on a form for his response. He indicated he was addressing food concerns when made aware.</p> <p>Review of a current, undated, facility document titled "Resident Council Department Response Form" which was provided by the activity Director on 3/9/11 at 11:10 a.m. indicated a concern expressed in resident council would be routed to the Department Head associated with the concern and a response to the concern would be returned to the Resident Council by an assigned date.</p> <p>The form contained the following documentation at the bottom: " _____ of _____ residents attending Resident Council on _____ agree the issue has been resolved to resident's satisfaction, Resubmit the concern with a request for explanation of he reason or barriers to resolution."</p> <p>Although there was a written response to the 8/30/11 Resident Council food concerns, this portion of</p>						

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	the form was not completed. 3.1-3(l)			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observations and interviews, the facility failed to ensure a clean, safe and sanitary environment for 9 of 41 rooms observed and 1 of 2 shower rooms observed. This deficiency had the potential to impact 76 of 76 residents residing in the facility. (Room #'s 111, 107, 103, 104, 402, 303, 403, 412, and 606; 200 shower room)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/5/12 at 11:48 a.m., Room 111 was observed. The bathroom door was observed with a 4 cm by 2 cm area where the wood of the door was chipped out. This area was located near the bottom hinge on the inside of this door. On 3/5/12 at 11:52 a.m., Room 107 was observed. The facing bathroom door was observed marred and scuffed with paint 18 inches above the floor on both sides. On 3/5/12 at 11:57 a.m., Room 103 was observed. The door facing 	F0253	<ol style="list-style-type: none"> All areas identified in the survey have been cleaned, repaired, or replaced as appropriate. All resident rooms were inspected to determine if any additional cleaning, repair, or replacement was required. The Environmental Services staff was re-educated on the facility policy and procedure for reporting any physical environment concerns. The Environmental Services Supervisor will complete rounds five times weekly to monitor the physical condition of the rooms including bathrooms. A copy of any work order generated will be given to the Director of Plant Operations and the Executive Director to ensure timely completion. These work orders will be reviewed during the daily Stand-Up meeting until resolved. The Director of Plant Operations has been re-educated on the Campus preventative maintenance schedule in order to provide ongoing monitoring and correction. The Environmental Services Supervisor will report the results of these rounds to the QAA committee monthly for three months and then quarterly. April 11, 2012 	04/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>to the bathroom was observed marred with areas of scuffed paint located 18 inches from the floor on up. Wallpaper was observed torn behind the first bed. The wall by the bathroom was observed with a 2 centimeter (cm) by 3 cm chipped area and a 1 cm by 1.5 cm area in the plaster 1 foot from the floor.</p> <p>4. On 3/5/12 at 12:42 p.m., Room 104 was observed. The facing bathroom door was observed marred with chipped paint 18 inches from the floor on both sides.</p> <p>5. On 3/5/12 at 2:38 p.m., Room 402 was observed. The heater's grill was caved in the middle, which left a gap between the grill and inside of the heater.</p> <p>6. On 3/5/12 at 3:00 p.m., Room 303 was observed. The room's and bathroom's door frames were observed chipped. The wall by the bathroom was chipped exposing 4 inches of the exposed base walkabout.</p> <p>7. On 3/5/12 at 3:07 p.m., Room 403 was observed. The heater's grill was "warped" in appearance.</p> <p>8. On 3/6/12 at 8:59 a.m., Room 412</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>was observed. The entrance door to the room would become stuck on the carpeting and not close as one tried to close the resident's door. An unpainted dinner sized drywall patched area was observed next to her bed. The heater was observed with the grill "warped-like" in the middle of the heater.</p> <p>9. On 3/9/12 at 10:10 a.m. with the Maintenance Supervisor and the Director of Environmental Services (DES), the environmental tour was completed. The following was observed:</p> <p>At this same time during an interview, the Maintenance Supervisor indicated he had several grill-like heater covers appearing "warped," and he indicated it was due to heat built up. He also indicated if the belt of the unit was not working correctly or broken, this would cause the heat not to spread out. The heat then would build up and could warp the covers.</p> <p>Room 606 - in the bathroom, at the corner of the shower area, chipped paint was observed at the bottom of this wall; at this same time during an interview, the DES indicated when a resident was discharged, the Housekeeper should be writing up a</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>work order to address these areas. She also indicated a resident may be admitted before the work order gets addressed.</p> <p>200 shower room - the entire white tile floor was observed with discolored to dark gray grout throughout the shower room.</p> <p>In the corner shower stall, 2 two inch corner wall tiles were missing on 1 of the outside corners; four 2 inch tiles in the inside corner of this shower stall was missing grout.</p> <p>In the second shower stall, scattered pencil eraser sizes to dime size orange spots were observed on 1 area of the ceiling; in the corner of this shower, the wall tiles near the floor were observed with a grayish colored grout.</p> <p>In the main area of the shower room above the mirror, a 1/4 inch gap between the wall and ceiling, which was the length of 7 four inch square ceiling tiles, was observed. In this same area, a top row of wall tiles were missing.</p> <p>At this same time during an interview, the Maintenance Supervisor indicated he was unaware of definite plans to remodel this shower room. Also, the DES indicated the shower room would be cleaned first thing in the morning and would be rechecked at</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>the end of the day.</p> <p>400 hall</p> <p>At this same time during an interview in Rm 412, the Maintenance Supervisor indicated he was unaware of the room's entry door catching on the rug and the unfinished area in the resident's room. - showed entry door of room "catches" on the rug when try to close it; also unfinished area on the wall by the chair.</p> <p>3.1-19(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observations, record review, and interview, the facility failed to ensure the physician's order for fluid restriction was followed for 1 of 1 resident reviewed for fluid restriction of 1 resident who met the criteria for fluid restriction related to dialysis. (Resident #48)</p> <p>Findings include:</p> <p>1. Resident #48's record was reviewed on 3/7/12 at 2:37 p.m. The resident's diagnoses included, but were not limited to, chronic renal failure The resident received hemodialysis 3 times a week and was scheduled on Tuesday, Thursday, and Saturday.</p> <p>The physician's order, dated 2/17/12, was 1500 ml fld restriction with the breakdown indicated as 240 milliliter (ml) for breakfast, lunch and dinner meals; from nursing 360 ml for days, 240 ml for evenings, and 120 ml for nights.</p>	F0282	<p>1. Resident #48 discharged to home 3/26/12.2. Residents currently on a fluid restriction have been reviewed and fluids divided out for the amount of cc's allowed per meal, medication pass, and between meals in a 24 hour period. Residents identified have had their care plan, C.N.A assignment sheets, and meal tray cards updated with the amount of cc's allowed per 24 hour period. Resident with fluid restriction do not have water pitchers at bedside.3. All staff have been inserviced that residents on a fluid restriction do not have water pitchers at bedside. Licensed nurses have been inserviced regarding fluid restriction and dividing the total amount of cc's allowed in a 24 hour period to be given at meals, medication pass and in between meals. C.N.A.s have been inserviced for total amount of cc's allowed at meals and in between meals.4. The Director of Health Services or Designee will review documentation of residents with fluid restrictions daily to ensure residents are compliant with amount of fluids per physician order. Fluid restrictions will be audited daily for three months</p>	04/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>The resident's total intake over 1500 ml for 2/12 and 3/1 to 3/7/12 were as follows: 2/17 - 1800 ml (milliliters); 2/20 - 1780 ml; 2/22 - 1560 ml; 2/24 - 1810 ml; 2/26 - 2500 ml; 3/1 - 2160 ml; 3/2 - 1980 ml; 3/7 - 1680 ml.</p> <p>On 3/7/12 at 3:35 p.m., Resident #48 was observed in her bed sleeping. A water pitcher was observed at her bedside. At this same time, the water pitcher was checked and was full of ice water. At this same time during an interview, LPN #21 indicated the resident was on fluid restriction and should not have a water pitcher at her bedside. LPN #21 proceeded down the hallway to remove the water pitcher.</p> <p>On 3/8/12 at 8:55 a.m. during an interview, as Resident #48 indicated she was waiting for her transportation to dialysis, she indicated she would get water at her bedside at times. She also indicated she liked to have the water in case she would start coughing because she used the water to stop the coughing. A water pitcher was observed at the resident's</p>		and results of audits reviewed at the monthly QAA committee meeting monthly for three months and then quarterly.5. April 11, 2012				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>bedside presently, which was two-thirds full of water.</p> <p>On 3/8/12 at 9:00 a.m. during an interview, LPN #5 indicated she was unsure how much water Resident #48 was allowed in her room as she was on fluid restrictions.</p> <p>On 3/8/12 at 9:05 a.m. during an interview, CNA #22 indicated Resident #48 was not allowed a water pitcher in her room as she was only allowed a certain amount of fluids per day. Her CNA assignment sheet indicated the resident was only allowed 1500 cc of fluids with no specifications related to how much fluid was allowed for any shift.</p> <p>On 3/8/12 at 9:42 a.m. during an interview, LPN #24, who was the desk nurse today, indicated the resident would usually request ice chips and was "pretty compliant" with her fluid restriction.</p> <p>On 3/9/12 at 8:40 a.m. during an interview, the DON indicated ice chips should be included with the total fluid restriction. She indicated the fluid restriction is identified on the MAR per shift. At 8:58 a.m. the DON indicated there was no policy and procedure for fluid restrictions.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observations, record review, and interview, the facility failed to fully monitor and evaluate and communicate information related to the resident's weight receiving dialysis for 1 of 1 resident reviewed for dialysis in a Stage 2 sample of 40. (Resident #48)</p> <p>Findings include:</p> <p>1. Resident #48's record was reviewed on 3/7/12 at 2:37 p.m. The resident was admitted on 2/10/12. The resident's diagnoses included, but were not limited to, chronic renal failure, anemia, chronic respiratory failure, pulmonary hypertension, chronic obstructive pulmonary disease, chronic hypoxia, hyperlipidemia, diabetes mellitus, and history of cerebrovascular accident. The resident received hemodialysis 3 times a week and was scheduled on Tuesday, Thursday, and Saturday.</p>	F0309	<p>1. Resident #48 discharged home 3/26/11.2. Current residents receiving hemodialysis have a dialysis communication form sent with them each visit to record before and after weight, vital signs, and assessment of port site.3. Licensed nurses have been inserviced with regards to the dialysis communication form to be sent with resident going to hemodialysis and upon return of resident after hemodialysis to ensure completion of form by dialysis nurses.4. The Director of Health Services or Designee will review the dialysis communication form three times weekly for three months to ensure before and after hemodialysis their weight, vital signs, and assessment of port site is completed including other communication noted and followed through related to hemodialysis. The audit of the dialysis communication form will be reviewed and the results brought to the QAA committee meeting monthly for three months and then quarterly.5. April 11, 2012</p>	04/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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	<p>The physician's order, dated 2/17/12, was 1500 ml fld restriction with the breakdown indicated as 240 milliliter (ml) for breakfast, lunch and dinner meals; from nursing 360 ml for days, 240 ml for evenings, and 120 ml for nights.</p> <p>The resident's total intake over 1500 ml for 2/12 and 3/1 to 3/7/12 were as follows: 2/17 - 1800 ml (milliliters); 2/20 - 1780 ml; 2/22 - 1560 ml; 2/24 - 1810 ml; 2/26 - 2500 ml; 3/1 - 2160 ml; 3/2 - 1980 ml; 3/7 - 1680 ml.</p> <p>The dietary progress notes, dated 3/7/12, indicated a significant weight (wt) loss with the current wt. of 226, which was down 23.5 (9.4%) in 30 days; to contact dialysis on 3/8/12 to determine dialysis dry wt (The dialysis facility was closed today.); Her oral intake was 85 to 100 %, which should not promote significant wt change and "assume fluid related;" to continue as ordered diet and fluid restriction and would add fortified foods to help meet needs; she then indicated she was able to speak with the resident, who indicated per dialysis her dry wt was</p>			

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	<p>228 lbs (pounds) (very close to current wt); wt loss was then considered "expected" with the resident had been reported very edematous on admission and was better now.</p> <p>The "SKILLED NURSING ASSESSMENT AND DATA ASSESSMENT" form indicated in the "Elimination" section if the resident was on dialysis, had nausea/vomiting, port site, and if signs and symptoms of infection were present. The information was as follows: On 2/10/12 with time indicated as 2 p.m. to 10 p.m. with no port site information (infor); On 2/12/12 at 4:25 p.m., no infor s/s (signs and symptoms) of infection; On 2/20/12, no information/form was indicated; On 2/15/12 at 9:00 a.m., on 2/16/12 at 6:45 a.m., on 2/18/12 at 9:20 a.m., on 2/19/12 at 7:20 a.m., and on 2/21/12 at 2:55 p.m., no info s/s infect or port site; On 2/22/12 at 5:55 p.m., no infor s/s infect; On 2/23/12 at 8:40 p.m., no infor port site; On 2/26/12 with the time indicated as from 2 to 10 p.m. - no information related to s/s of port infection; On 2/28/12 at 9:30 a.m. - no</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>information related to the port site or s/s of infection; On 3/2/12 at 7:15 a.m. - no information related to the port site; On 3/3/12 at 9:15 a.m. - no information related to the location of chest port and/or s/s of infection; On 3/4/12 at 11:15 a.m. - no information related to the chest port and/or s/s infection.</p> <p>This same form was completed on 2/11/12 at 7:30 a.m. and at 3:20 p.m., on 2/12/12 at 2:20 a.m. on 2/12/12 at 7:45., on 2/13/12 at 6:30 a.m. and at 4 p.m., on 2/14/12 at 6:45 a.m., and on 2/17/12 at 6:45 a.m., on 2/24/12 at 6:30 p.m., on 2/25/12 from 2 to 10 p.m., on 2/27/12 at 6:45 a.m., on 2/29/12 at 6:45 a.m., on 3/1/12 at 7:30 a.m., on 3/5/12 at 7:35 p.m., on 3/6/12 at 3:30 p.m. and on 3/7/12 at 8:00 p.m.</p> <p>The "SKILLED NURSING ASSESSMENT AND DATA ASSESSMENT" form, dated 2/11/12 at 7:30 a.m., indicated at 11:00 a.m. a phone call was received from the physician at dialysis requesting the resident received Xanax (anti-anxiety) medication prior to dialysis.</p> <p>No further information was indicated on the "SKILLED NURSING</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>ASSESSMENT AND DATA</p> <p>ASSESSMENT" form or in the nurse's notes.</p> <p>On 3/7/12 at 3:35 p.m., Resident #48 was observed in her bed sleeping. A water pitcher was observed at her bedside. At this same time, the water pitcher was checked and was full of ice water. At this same time during an interview, LPN #21 indicated the resident was on fluid restriction and should not have a water pitcher at her bedside. LPN #21 proceeded down the hallway to remove the water pitcher.</p> <p>On 3/8/12 at 8:55 a.m. during an interview, as Resident #48 indicated she was waiting for her transportation to dialysis, she indicated she would get water at her bedside at times. She also indicated she liked to have the water in case she would start coughing because she used the water to stop the coughing. A water pitcher was observed at the resident's bedside presently, which was two-thirds full of water.</p> <p>On 3/8/12 at 9:00 a.m. during an interview, LPN #5 indicated she was unsure how much water Resident #48 was allowed in her room as she was on fluid restrictions. She indicated</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>the resident left in the a.m. and returned in the evening for dialysis and was unaware of any follow-up before and after the resident went to dialysis.</p> <p>On 3/8/12 at 9:05 a.m. during an interview, CNA #22 indicated Resident #48 was not allowed a water pitcher in her room as she was only allowed a certain amount of fluids per day. Her CNA assignment sheet indicated the resident was only allowed 1500 cc of fluids with no specifications related to how much fluid was allowed for any shift.</p> <p>On 3/8/12 at 9:40 a.m. during an interview, LPN #23 indicated if a resident went out of the facility for her dialysis, one would communicate by phone between dialysis and the facility with documentation in the nurses' notes.</p> <p>On 3/8/12 at 9:42 a.m. during an interview, LPN #24, who was the desk nurse today, indicated if problems would occur related to Resident #48, it should be documented in nurse's notes. She also indicated the resident would usually request ice chips and was "pretty compliant" with her fluid restriction.</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>On 3/8/12 at 9:45 a.m. during an interview, RN #25, the unit manager, indicated Resident #48 usually came back in the evening with no documentation/assessment required. She also indicated if Resident #48 had a problem, then, one would assess her.</p> <p>On 3/8/12 at 9:46 a.m. during an interview, LPN 5 indicate the Medicare records (SKILLED NURSING ASSESSMENT AND DATA ASSESSMENT) were completed daily on Resident #48, but the time referring to days or evenings, would depend on the week as to which shift was assigned to it.</p> <p>On 3/9/12 at 11:35 a.m. during an interview, the DON (Director of Nursing) indicated the dressing should be checked to be sure intact and for signs of infection after returning from dialysis.</p> <p>On 3/9/12 at 1:55 p.m. during an interview, the DON indicated if there is a problem at dialysis, they would call. No real form of communication concerning weights, vital signs, ect. between the 2 facilities was present. No routine vital signs or weights were taken before/after the dialysis other than the daily medicare form</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
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	<p>completed.</p> <p>On 3/9/12 at 1:00 p.m., information was requested from the DON related to the resident's condition/assessment for 2/20/12.</p> <p>ON 3/9/12 at 2:43 p.m., the DON indicated she had no information concerning 2/20/12 for Resident #48.</p> <p>3.1-37(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observations and interviews, the facility failed to ensure resident's doors were in good repair to prevent the possibility of injury for 2 of 9 rooms observed during the environmental tour. This deficiency had the potential to impact 38 of 76 residents residing in the facility. (Room 111 and 608)</p> <p>Findings include:</p> <p>On 3/9/12 at 10:10 a.m. with the Maintenance Supervisor and the Director of Environmental Services, the environmental tour was completed. The following was observed:</p> <p>Rm 608 - the entry door to the room was observed with a 2 1/2 inch by 1/8 to 1/4 inch wide splintered edge on the outside of the door located in the middle of the door. This area was splintered with sharp points. At this same time during an interview, the Maintenance Supervisor indicated the area could have been from moving a</p>	F0323	<p>1. All areas identified in the survey have been cleaned, repaired, or replaced as appropriate.2. All resident rooms were inspected to determine if any additional cleaning, repair, or replacement was required.3. The Environmental Services staff was re-educated on the facility policy and procedure for daily cleaning and reporting any physical environment concerns. The Environmental Services Supervisor will complete rounds five times weekly to monitor the physical condition of the rooms including resident doors. A copy of any work order generated will be given to the Director of Plant Operations and the Executive Director to ensure timely completion. These work orders will be reviewed during the daily Stand-Up meeting until resolved. The Director of Plant Operations has been re-educated on the Campus preventative maintenance schedule in order to provide ongoing monitoring and correction.4. The Environmental Services Supervisor will report the results of these rounds to the QAA committee monthly for three months and then quarterly.5.</p>	04/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
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	<p>bed. He indicated he was unaware of the damaged door and should have been reported by a work order.</p> <p>Room 111 - the entry door to the room above the lower metal plate was observed with a 3 inch long with a varying width up to 1/4 inch wide. At the widest area in the middle of this damaged area, splinters of wood were present.</p> <p>3.1-45(a)(1)</p>		April 11, 2012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure prior non-chemical interventions, reason for use and effectiveness of medications were attempted and followed up, for 2 of 10 residents reviewed for unnecessary medications. (Resident #215 and #33)</p> <p>Findings include:</p> <p>1. The record for Resident # 33 was</p>	F0329	<p>1. Resident #33 had the medication administration record (MAR) and as needed (PRN) medication tracking form reviewed to ensure documentation of non-pharmacological interventions, reason for use and effectiveness of Ambien is noted on MAR and PRN medication tracking form when administered per physician order. Resident #215 had the medication administration record (MAR) and as needed (PRN) medication tracking form reviewed to ensure</p>	04/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
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	<p>reviewed on 3/6/12 at 8:04 a.m.</p> <p>Current physician orders indicated an order for Ambien (sedative) 5 milligrams every evening as needed for sleep.</p> <p>The Medication Administration Record (MAR) for February 2012 indicated the Ambien was given on 2/11, 12, 13 and 24 with no indication for use, prior interventions for use or the effectiveness of the medications.</p> <p>Additional information regarding the administration of the above Ambien doses was requested from LPN # 1 on 3/9/12 at 8:21 a.m.</p> <p>During an interview on 3/9/12 at 9:16 a.m., LPN # 4 indicated before an as needed sedative was given, the as needed medication tracking form would be completed with prior interventions, reason and effectiveness. She indicated as needed medications are not given without reason.</p> <p>During an interview with the Director of Nursing on 3/9/12 at 10:10 a.m., she indicated she was unable to locate any information regarding prior interventions, reason for use or effectiveness for the use of Ambien.</p>		<p>documentation of non-pharmacological interventions, reason for use and effectiveness of Xanax is noted on MAR and PRN medication tracking form when administered per physician order.2. Current residents that receive as needed (PRN) sedatives such as Ambien or antianxiety such as Xanax have been reviewed to ensure documentation of that classification of medications such as Ambien and Xanax are noted with non-pharmacological interventions, reason for use and effectiveness of sedatives such as Ambien and antianxiety such as Xanax are noted on the MAR and PRN medication tracking form.3. Licensed nurses have been inserviced with regards prior to administration of a sedative medication such as Ambien or antianxiety medication such as Xanax that non-pharmacological interventions are attempted and documented on the PRN form prior to administering the medication as mentioned above per physician order. MAR completed with nurses initials. 4. Director of Health Services or Designee will audit PRN medication tracking form and MAR for administration of PRN sedatives and antianxiety medications three times weekly for 2 months, then two times weekly for 2 months then one time weekly for 2 months</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>2. Resident #215's record was reviewed on 3/8/12 at 1:52 p.m. The resident's diagnoses included, but were not limited to, status post open reduction internal fixation of the left knee patella, debility, and anxiety. The resident was admitted on 2/25/12.</p> <p>The "Medication Record" for 3/12 indicated the resident received Xanax (anti-anxiety) on 3/4/12 with no time and/or information given related to the administration of the Xanax. No information was indicated in the resident's nurse's notes. The resident's "PRN (as needed) MEDICATION TRACKING" indicated no information related to the Xanax given on 3/4/12.</p> <p>On 3/8 at 3:30 p.m. during an interview, LPN #20, who had worked on the unit, indicated when giving a prn medication, for example, Xanax, one would attempt non-medical interventions initially before giving the oral medication. She also indicated this information should be recorded on the "gold sheet," which was identified as the prn medication</p>		<p>until compliance is achieved. Results of audits will be reviewed during the monthly QAA meeting for six months and then quarterly. 5. April 11, 2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>record.</p> <p>On 3/9/12 at 10:00 a.m., information was requested from the DON (Director of Nursing) concerning the Xanax given on 3/4/12.</p> <p>On 3/9/12 at 1:55 p.m. during an interview, the DON indicated she had no information related to the Xanax on 3/4/12.</p> <p>3. An undated policy titled "ADMINISTRATION OF PRN MEDICATIONS GUIDELINE" was provided by the Director of Nursing on 3/9/12 at 9:52 p.m., and deemed as current. The policy indicated: "Purpose: To provide guidelines for the administration of non-routine (PRN) medication administration. Procedure:...2. Non-pharmacological interventions (i.e. activity, food, re-direction, emotional support, position for comfort and other interventions as defined on the individualized plan of care) shall be attempted and documented prior to administration of PRN medications...3. Documentation should reflect the reason for administrating (sic) the PRN medication...5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	effects. 3.1-48(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure it remained free of a medication error rate of 5% or greater for 3 of 50 opportunities and for 2 of 8 nursing staff and for 2 of 10 residents observed during medication pass. The medication error rate was 6%. (Resident #90 and #5) (LPN #2 and QMA #3)</p> <p>Findings include:</p> <p>1. The record for resident # 90 was reviewed on 3/7/12 at 8:45 a.m.</p> <p>Current physician orders for March 2012 indicated an order for Combivent Inhaler 2 puffs by mouth once daily and for symbicort 160/4.5 micrograms inhaler 1 puff by mouth twice daily for Chronic Obstructive Pulmonary Disease.</p> <p>During a medication pass observation with QMA # 3, for Resident # 90 on 3/7/12 at 8:37 a.m., QMA # 3 gave the resident one puff of the Symbicort, then gave the resident one</p>	F0332	<p>1. Resident #90 and resident #5 were assessed and no adverse affects noted in regards to administration of the two inhalers and nasal spray, respectively. 2. Current residents that receive medication via an inhaler and nasal spray have been reviewed and instructions per policy for use of inhaler and nasal spray medications have been added to each medication record book for proper delivery of inhalation (inhalers) and nasal spray medications.3. Licensed nurses and Qualified medication aide (QMA) have been inserviced with return demonstration of use of inhalers and nasal sprays to ensure medication is delivered according to instructions per policy of each medication.4. The Director of Health Services(DHS) or Designee will observe two medication passes related to inhalation medication (inhalers) and nasal medication weekly to monitor compliance. These observations will continue weekly until 100% compliance is achieved and then will be completed at least monthly thereafter. Results of these observed medication passes will be reviewed during the monthly QAA for three months and then</p>	04/11/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>puff of the Combivent, waited 4 seconds and gave the resident the second puff of the Combivent. The time remained at 8:37 a.m. during this administration.</p> <p>2. The record for Resident # 5 was reviewed on 3/7/12 at 11:10 a.m.</p> <p>Current physician orders indicated an order for Flonase 0.05 % nasal spray give one spray in each nostril twice daily for rhinitis.</p> <p>During a medication pass observation with LPN # 2 for Resident # 5 on 3/7/12 at 11:01 a.m., LPN # 2 gave the resident one spray of the nasal spray in both nostrils. She did not hold the opposite nare closed when administering the spray. At this time during interview, LPN # 2 indicated she never held the opposite nostril closed during nasal medication administration.</p> <p>3. The "Geriatric Medication Handbook" eighth edition, indicated on page 123: "Inhaled Medications...spacing and proper sequence of the different inhalers is important for maximal drug effectiveness...SPACING... *Wait 1-2 minutes before administering the next medication...."</p>		<p>quarterly.***Addition per addendum request: DHS or Designee will observe the medication passes related to inhalation medication (inhalers) and nasal medication as noted above and including all three shifts. 5. April 11, 2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>4. A "PDR (Physician's Desk Reference) 2012 EDITION NURSE'S DRUG HANDBOOK", provided by LPN # 1 3/8/12 at 9:58 a.m., indicated on page 303 to give one spray of Combivent then "...wait for 2 minutes before next spray...."</p> <p>5. A 2005 policy titled "Specific Medication Administration (Med-Pass) Procedures" was provided by the Interim Director of Nursing on 3/8/12 at 8 a.m., and deemed as current. The policy indicated: "...4. Nasal inhalers...Procedures...a. Have resident keep head upright. Press finger against side of the nose to close one nostril...spray or inhaler is inserted into the nostril...."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the total number of hours and census information was included on the staff posting for 5 of 5 days observed during the annual survey.</p>	F0356	1. No residents were affected.2. No residents were affected.3. An inservice for the nursing scheduler was given to ensure the daily staffing form includes the total number of hours and census information which is	04/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
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	<p>This deficiency had the potential to impact 86 of 86 residents residing at the facility. (March 5, 6, 7, 8, and 9, 2012)</p> <p>Findings include:</p> <p>On 3/5/12 at 10:30 a.m., on 3/6/12 at 9:30 a.m., on 3/7/12 at 9:00 a.m., and on 3/8/12 at 9:30 a.m., the "Daily Staff Posting" was observed. Review of the posting indicated the census and the total hours worked information were not included on this posting.</p> <p>On 3/9/12 at 2:35 p.m. during an interview, the Administrator indicated this duty was included with the scheduling staff member, who was new. He also indicated she had told him no one had explained to her how to correctly do the staff posting.</p> <p>3.1-13(a)</p>		<p>posted daily.4. The Director of Health Services or Designee will monitor the daily posting five times weekly until 100% compliance is obtained and then at least one time weekly thereafter. The Director of Health Services will present the results of these observations to the QAA committee monthly for three months and then quarterly. 5. April 11, 2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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F0371 SS=F	<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</p> <p>Based on observations, record review, and interview, the facility failed to ensure a clean and sanitary kitchen environment related to equipment storage, closed trash container, linen handling, sanitizing of food thermometers, hair covering, and handwashing for 2 of 2 kitchens observed and to ensure the dishwasher's wash cycle temperature was maintained at the sanitizing temperature for 1 of 2 dishwashers observed. This had the potential to impact 83 of 86 residents residing in the facility.</p> <p>Findings include:</p> <p>1. On 3/5/12 at 9:25 a.m. during the kitchen's initial tour, the following was observed: At this same time during an interview, the Dietary Manager (DM) indicated they were using the "Instant-Off" faucet as a trial. He indicated the water was controlled by a stainless steel rod which controlled the water</p>	F0371	<p>1. No residents were affected.2. No residents were affected3. The Dietary staff were re-educated on the Campus policy and procedures for equipment storage, closed trash containers, linen handling, sanitation of food thermometers, hair coverings, and handwashing. The Dietary Manager or Designee will monitor for compliance five times weekly and document the findings until 100% compliance is obtained and then at least one time weekly thereafter.4. The Dietary Manager will present the results of these observations to the QAA committee monthly for three months and then quarterly.5. April 11, 2012</p>	04/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>when one would wet/rinse their hands. The wastebasket located by the table next to the steamers was open and not in use. Trash was observed inside this wastebasket. In the dry storage area, a scoop was inside the closed flour bin container. At this same time during an interview, the DM indicated the scoop should not be stored inside a container.</p> <p>2. On 3/6/12 at 3:05 p.m., Dietary Aide #29 was observed fanning the tablecloths on the dining room tables. At this same time during an interview, she indicated she did not know why she should not be fanning the tablecloths onto the dining room tables.</p> <p>On 3/7/12 at 11:30 a.m. during an interview, the DM indicated the tablecloths should not be fanned but unfolded on the tables.</p> <p>3. On 3/7/12 at 10:00 a.m., the kitchen was observed as follows: Dietary aide #25 was observed operating the dishwasher. After loading a rack of soiled dishes, he proceeded to remove the clean rack of dishes from the completed dishwashing cycle. No handwashing</p>				

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was observed. After loading another rack of soiled dishes, Dietary Aide #25 was observed to handwash for less than 15 seconds, dried his hands, and then turned the water off with his dried bare hands.</p> <p>In preparation for the pureed servings, Cook #26 was observed to handwash at the "Instant-Off" faucet lathering for 15 seconds, and then, rinsing his hands.</p> <p>As Cook #27 completed her task, she was observed to handwash at the "Instant-Off" faucet and lathered for 15 seconds, and then, rinsed her hands.</p> <p>A measuring cup was observed in the closed powdered milk container under the prep shelf. At this same time, the DM indicated the scoop should not be kept inside the container when not in use.</p> <p>After Cook#26 was observed to put the box of brown sugar away and obtained the celery and the cutting board for his next task. Next, he washed his hands at the "Instant-Off" faucet with soap for fifteen seconds, and then, rinsed. He then prepared the celery. After this was completed, he was again observed to</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>handwashed at the "Instant-Off" faucet and lathered for 15 seconds, and then, rinsed. He proceeded to prepare the onions.</p> <p>Dietary Aide #28 was observed to handwash at the "Instant-Off" faucet and lathered for 15 secs before rinsing.</p> <p>Next, the dishes, which were designated as dried and ready for use, were checked by the DM. As the large cooking sheet pan was removed from the stack, water was dripping from the inside of this pan. The next 2 stacked large cooking sheet pans were checked and were also wet on the inside of these pans. At this same time, the DM informed Dietary Aide #25 to be sure the dishes were dried before storing them.</p> <p>The DM checked the food temperature for the main dish (pork and apples) with his food thermometer. After this, he wiped off his food thermometer with a wash cloth from the countertop, dipped the food thermometer into a red sanitizing bucket solution on the bottom shelf, and proceeded to check the next serving of pureed meat. No drying of the thermometer was observed. At this same time during an interview, he</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>indicated he was sanitizing his food thermometer. This procedure was followed for the next 2 food temperature checks.</p> <p>As Cook #26 prepared to puree his pea serving, he was observed to handwash at the "Instant-Off" faucet lathering for 15 seconds, and then, rinsing. As the DM prepared to check the next food serving, he dropped his food thermometer on the floor, picked it up, dipped it into the wash sink of the 3 compartment sink, and rinsed it at the rinse sink tuning the faucet on. He then dipped it into the same red sanitizing bucket and checked the dish of dressing's temperature. The wash sink of the 3 compartment sink used to wash the food thermometer was observed to be full of food soiled pans with little suds observed.</p> <p>4. On 3/7/12 at 10:45 a.m. during the kitchen observation for Toby Pike, the following was observed: Dietary Aide #31 was observed to handwash at the "Instant-Off" faucet, lathered for 15 seconds, and then, rinsed. She then mixed up the gravy. After checking the gravy temperature, she was observed to handwash at the "Instant-Off" faucet and lathered for 10 seconds, and then, rinsed. She next proceeded to check the food</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>cooking on the oven.</p> <p>The dishwasher was observed with the information the water should be at 150 degrees Fahrenheit for the wash cycle and should be 180 degrees Fahrenheit for the rinse cycle. As the dishwasher was started by the DM, the wash cycle was observed with a wash temperature at 148 degrees Fahrenheit. At this same time during an interview, the Dietary Assistant #32 indicated the dishwasher had been having a low wash temperature recently, and maintenance had looked at it. She indicated it still was low at times with no alternative for washing the dishes indicated. The second dishwashing cycle was observed with the wash cycle at 149 degrees and right before switching to the rinse cycle, the wash temperature flashed 150 degrees.</p> <p>In the dry storage area, no vent covering was observed over the ceiling vent. This ceiling vent was over dry food stored on the shelves. The floor was observed dusty with loose debris and a potato, 2 closed packets of jelly, and a closed package of cracked crackers. Per the Dietary Assistant #32, the room was to be swept daily but it didn't appear it had been done.</p>						

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>5. On 3/8/12 at 8:20 a.m. during the kitchen observation, the following was observed:</p> <p>Two pieces of silverware were observed in the handwashing sink. After Dietary Aide #30 loaded the dishwasher with a rack of soiled dishes, he was observed to handwash for less than 15 seconds before returning to the dishwasher where he began to put clean dishes away. During this observation, he removed his beard cover as he continued to work at the dishwasher for a short period. After returning cooking sheets to the dishwashing area, he again readjusted his beard cover. After he cleaned a cart, he was observed to fan a cover onto the top shelf of this cart. Next, he placed cleaned water cups/pitchers and basket with accessories onto the top of this shelf.</p> <p>After assisting with a task, the DM was observed to handwash for 15 seconds. The DM was then observed to check food temperatures for breakfast. After checking the oatmeal, he was observed to dip the thermometer into the red disinfectant bucket and dried it off with a cloth on the counter. When questioned</p>						

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
---	---

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	<p>concerning using the disinfectant, which he identified as QUAT, to disinfectant the thermometer, the DM indicated it was how he disinfected his food thermometer. After checking the cream of wheat, the DM was then observed to rinse his food thermometer with water only. He continued to rinse his food thermometer with the water between checking the food temperatures of the scrambled eggs, bacon, and sausage.</p> <p>6. On 3/9/12 at 10:10 a.m. during an interview, the Maintenance Supervisor indicated he was working with adjusting the water for the Legacy's dishwasher and had to readjust it yesterday again. He indicated he would need to check on the dishwasher temperature again to see if that worked.</p> <p>7. On 3/9/12 at 3:40 p.m. during an interview, the Director of Nursing indicated 3 residents were NPO (nothing by mouth) and did not eat presently.</p> <p>8. The "Handwashing" policy, which was the 410 IAC 7-24-128 Hand cleaning and drying procedure, was provided by the DM on 3/7/12 at 3:55 p.m. This current policy was as</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>follows:</p> <p>"Sec. 128 (a) Food employees shall,...clean their hands an exposed portions of their arms...by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water...."</p> <p>The "Food Temperatures - Serving Line" policy was provided by the DM on 3/7/12 at 3:55 p.m. This current policy indicated the following: "POLICY: The temperatures of all foods on the serving line will be measured and recorded at every meal. PROCEDURE: ...5. Proper procedures are used so that measured temperatures are accurate and contamination is prevented: ...B. Thermometers are clean, rinsed , and sanitized before, after, and in between use. An alcohol swab may be used to sanitize the thermometer between uses at one meal....."</p> <p>The "HARD SURFACE SANITIZER" was provided by the DM on 3/8/12 at 10:50 a.m. This current information indicated the following: "DIRECTIONS FOR USE: ...To Sanitize: ...Apply use solution...by immersion. Let air dry. Do not rinse....KEEP OUT OF REACH OF CHILDREN...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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	<p>The dishwashing temperature log at Legacy were as follows: 3/7/12 (no time) - the wash temperature was indicated at 140 with a rinse temperature of 179; maintenance was notified and "corrected;" 3/8/12 (no time) - the wash temperature was 150 (with a down arrow) indicated the temperature dropped; 3/9/12 (no time) - wash temperature was 149.</p> <p>3.1-21(i)(3) 5-5.1(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview, the facility failed to ensure medications were available for administration for 1 of 10 resident reviewed for medications. (Resident #33)</p> <p>Findings include:</p> <p>The record for Resident # 33 was reviewed on 3/6/12 at 8:04 a.m.</p> <p>Current physician orders indicated an order for Protonix 40 milligrams daily and Klonipin 0.5 milligrams three times daily.</p>	F0425	<p>1. Resident #33 received Protonix 40mg and Klonipin 0.5mg as ordered. 2. No residents were affected. 3. Licensed nurses have been inserviced on the appropriate way of ordering and obtaining medications. The Director of Health Services or Designee will audit medication administration records (MARS) and delivery sheets from pharmacy to ensure delivery of medications three times weekly for two months, then two times weekly for two months, then weekly for two months until compliance is achieved.4. The Director of Health Services will present the results of these</p>	04/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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	<p>The Medication Administration Record (MAR) for February 2012 indicated the Protonix was not available for administration on 2/24 and 2/25. The MAR indicated the Klonopin was not available for administration on 2/14/12 at 5 a.m., 1/11/12 at 1 p.m., and 1/29/12 at 5 a.m. The MAR indicated the medication was not available from the pharmacy.</p> <p>A form titled "Waterford Place Pyxis" (medication delivery system) was provided by LPN # 1 on 3/8/12 at 9:30 a.m.. The form indicated Protonix 40 milligrams was available in the pyxis.</p> <p>Additional information regarding the above unavailable medications was requested from LPN # 3 on 3/9/12 at 8:21 a.m.</p> <p>During an interview on 3/9/12 at 9:16 a.m., LPN # 4 indicated, when a medication is unavailable, she would check the emergency drug kit and the pyxis system first to see if the medication was there, then she would call the pharmacy for delivery.</p> <p>During an interview with the Interim Director of Nursing on 3/9/12 at 2 p.m., she indicated the pharmacy had</p>		audits to the QAA committee monthly for six months and then quarterly. 5. April 11, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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	<p>record the Klonopin was delivered from the back-up pharmacy on 2/12/12 and 1/11/12 and she indicated the a pyxis report did not indicate the Protonix was utilized from the system on 2/24 or 2/25/12.</p> <p>An undated policy titled "ADMINISTRATION OF PRN MEDICATIONS GUIDELINE" was provided by the Interim Director of Nursing on 3/9/12 at 9:52 p.m., and deemed as current. The policy indicated: "Purpose: To provide guidelines for the administration of non-routine (PRN) medication administration. Procedure:...2. Non-pharmacological interventions (i.e. activity, food, re-direction, emotional support, position for comfort and other interventions as defined on the individualized plan of care) shall be attempted and documented prior to administration of PRN medications...3. Documentation should reflect the reason for administrating (sic) the PRN medication...5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects.</p> <p>3.1-25(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure schedule 2 medications were double locked for 2 of 3 medication</p>	F0431	<p>1. No residents were affected2. The refrigerator narcotic box labeled 100 hall for 100/200/300 hall and transitional care unit are locked with a pad lock to ensure</p>	04/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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	<p>rooms observed. This deficiency had the potential to impact 67 of 86 residents residing in the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a medication room observation on 3/5/12 at 9:57 a.m. for the 100/200/300 halls, with LPN # 1, a metal box labeled 100 hall was in the refrigerator and was not locked. The box contained 4 bottles of oral ativan (anti-anxiety), 12 phenergan suppositories (treatment of nausea) and 2 Diastat injectable's (treatment of hypoglycemia). At this time during interview, LPN # 1 indicated the ativan was used this morning and the box should be locked after use. 2. During a medication room observation and narcotic count on 3/8/12 at 5:59 a.m., with LPN # 5 and LPN # 6 on the transitional care unit, a metal box was retrieved from the refrigerator. The box was not locked and contained 30 milliliters of ativan. At that time during interview, LPN # 5 indicated she was unsure if the medication was to be locked since the door to the medication room was locked. LPN # 6 indicated the box did lock and locked the box with a key that was on her key ring. 		<p>the double lock is maintained in the locked medication room. 3. Licensed nurses have been inserviced on the refrigerator narcotic box being locked with a pad lock and one nurse has the key to the pad lock on the 100/200/300 hall medication room and the refrigerator narcotic box is locked with a pad lock and one nurse has the key to the pad lock on the transitional care unit. Shift to shift narcotic count will be completed verifying the contents of the refrigerator narcotic box on each of the aforementioned medication rooms on the hall/unit and the on coming and off going nurses will sign the narcotic sheet as proof of counting the narcotic boxes every shift. 4. The Director of Health Services or Designee will audit the locked refrigerator narcotic box on each hall/unit ensuring it is locked in the medication room and the narcotic shift to shift count sheet is completed three times weekly for two months, two times weekly for two months, and one time weekly for two months until compliance is achieved. The Director of Health Services will present the results of these audits to the QAA committee monthly for six months and then quarterly. 5. April 11, 2012</p>	

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	<p>3. A policy titled "MEDICATION STORAGE IN THE FACILITY" was provided by the Interim Director of Nursing on 3/8/12 at 7:30 a.m., and deemed as current. The policy indicated: "1. MEDICATION STORAGE Policy Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...3. CONTROLLED MEDICATION STORAGE...Procedure...INDIANA LAW...Refrigerated drugs in Schedule II, III, IV or V are stored in a refrigerator under double lock...."</p> <p>3.1-25(m)</p>			

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901		
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F0465 SS=C	<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 observations and interviews, the facility failed to ensure a clean, safe and sanitary environment for 1 of 2 laundry rooms observed. This deficiency had the potential to impact 76 of 76 residents residing in the facility. (main building's laundry room)</p> <p>Findings include:</p> <p>1. On 3/9/12 at 10:10 a.m. with the Maintenance Supervisor and the Director of Environmental Services (DES), the environmental tour was completed. The laundry room was observed. In the clean linen area, a row of several irregular lines extending the length of seven 12 inch floor tiles were observed with gray to black accumulation inside the gaps. Next to the clean linen shelves with clean linen on these shelves, an accumulation of gray dust and debris was observed under the wire basket/cart and around the base of the large fan; also, the large fan was operating and was blowing over 1 large bin of clean clothes awaiting to be folded and put away; the blowing</p>	F0465	<p>1. All areas identified in the survey have been cleaned, repaired, or replaced as appropriate.2. All laundry rooms were observed to determine any other areas requiring cleaning or repair.3. The Environmental Services staff was re-educated on the facility policy and procedure for daily cleaning and reporting any physical environment concerns. The Environmental Services Supervisor will complete rounds five times weekly to monitor the physical condition of the laundry area. A copy of any work order generated will be given to the Director of Plant Operations and the Executive Director to ensure timely completion. These work orders will be reviewed during the daily Stand-Up meeting until resolved. The Director of Plant Operations has been re-educated on the Campus preventative maintenance schedule in order to provide ongoing monitoring and correction.4. The Environmental Services Supervisor will report the results of these rounds to the QAA committee monthly for three months and then quarterly.5. April 11, 2012</p>	04/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2012
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	<p>fan was also observed with gray dust blowing from the grill of this fan; in the area in front of the washers, at least 5 twelve inch floor tiles were observed with a 1/4 inch gap at the end of the row of tiles; gray substance was present in this gap; In soiled area a second fan, which was presently not being used, was located by the sink with debris and dust around the fan base and in this area.</p> <p>2. On 3/9/12 at 2:10 p.m. during an interview, the Administrator indicated the residents in the Legacy building had their own laundry with the main laundry room utilized for the rest of the residents.</p> <p>3.1-19(f)</p>			

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F0520 SS=F	<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 interviews, the facility failed to identify and implement a plan of action related to dialysis services, thorough abuse investigation, and medication availability. This deficiency had the potential to impact 86 of 86 residents residing in the facility.</p> <p>Findings Include: During a 3/9/12 , 9:47 a.m., interview,</p>	F0520	<p>1.A. Resident #48 discharged home 3/26/11.B. Resident 33 received Protonix 40mg and Klonopin 0.5mg as ordered.C. Resident #95 and #214 no longer reside in the facility.2.A. Current residents receiving hemodialysis have a dialysis communication form sent with them each visit to record before and after weight, vital signs, and assessment of port site.B. No other residents were affected.C. Interviews and observations were completed to</p>	04/11/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012
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	<p>the Administrator was queried regarding the QAA committee and the identified concerns of the survey team. The Administrator indicated the following:</p> <p>a.) Specialized care areas such as dialysis and hospice are not specifically reviewed by QAA on any schedule. A concern in those areas would be identified by the Interdisciplinary Team and brought to QAA as a concern.</p> <p>When queried if there was a process to audit, evaluate and/or assess these areas before a concern developed, the Administrator indicated there was not a formal plan to evaluate dialysis care and services provided by the facility. The Administrator indicated the QAA committee had not identified a concern with dialysis residents and fluid restricted diets and had not developed a plan of action in this area.</p> <p>b.) Medication administration and medication availability are audited by QAA. Additionally, nurses must communicate concerns in this area to the Director of Nursing who will further investigate concerns and bring these concerns to the QAA committee. He additionally indicated</p>		<p>determine if any other residents were affected.3. A. Licensed nurses have been inserviced with regards to the dialysis communication form to be sent with resident going to hemodialysis and upon return after hemodialysis.B. Licensed nurses have been inserviced on the appropriate way of ordering and obtaining medications.C. The staff was re-educated regarding the Campus Fraud and Abuse reporting procedures and resident rights with emphasis on ensuring residents be allowed to make choices related to their personal care.4. A. Director of Health Services (DHS)/designee will review the dialysis communication form three times weekly for three months to ensure before and after hemodialysis their weight, vital signs, and assessment of port site is completed including other communication noted and followed through related to hemodialysis. The audit of the dialysis communication form will be reviewed and the results brought to the QAA committee meeting monthly for three months and then quarterly.B. The Director of Health Services or Designee will audit medication administration records (MARS) and delivery sheets from pharmacy to ensure delivery of medications three times weekly for two months, then two times weekly for two months, then</p>		

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	<p>the QAA committee had not identified any concerns with medication availability.</p> <p>When queried regarding the medication availability issues for Resident #33, he indicated those concerns had not been identified in QAA. The committee had not developed a plan of action in the area of medication availability.</p> <p>c.) The Administrator indicated the QAA committee reviewed all reportable incidents and allegation of abuse as part of the committee process.</p> <p>When queried regarding the concerns with a complete and thorough investigation of allegation involving residents #95 and #214, the Administrator indicated the facility had not identified concerns with thorough investigations of abuse or neglect or developed a plan of action to address concerns in this area.</p> <p>3.1-52(b)(2)</p>		<p>weekly for two months until compliance is achieved. The Director of Health Services will present the results of these audits to the QAA committee monthly for six months and then quarterly.C. The Executive Director or Designee will review all concern forms to ensure resident choices are being met. The results of these reviews will be brought to the daily Stand-Up meeting for review until resolved. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly.***Addition per addendum request: The facility will collect and analyze data from several sources when identifying a quality of care concern. These sources include, but are not limited to, medical record audits of all new admissions within 72 hours, dialysis communication and tracking logs, resident concern forms, incident reports, consultant reports, etc. The identification of quality of care concerns will also be brought forth through the facility daily clinical stand-up meeting, behavior meeting, Clinically At Risk (CAR) meeting, and daily manager stand-up meeting. Once a quality of care concern has been identified, the QA Committee will focus on the root cause or causal factor that led to the confirmed deficient quality outcome. The QA Committee will</p>		

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			then develop a Plan of Action that may include the re-education or improved training of staff, a revision to current policies and procedures, the revision of current protocols or standards of practice, or plans to purchase or repair equipment. The implementation of the facility's Plan of Action will be accomplished through staff training and deployment of changes to procedures, monitoring of outcomes and resident feedback, i.e. internal Customer Satisfaction Survey outcomes, and will include revising Plans of Action if it is determined the current Plan(s) are not achieving or sustaining the desired outcomes.5. April 11, 2012	