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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155131 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>01/12/2016 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>MUNSTER MED-INN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>7935 CALUMET AVE<br>MUNSTER, IN 46321 |
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| F 0000<br><br>Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00188000 and IN00188017.</p> <p>Complaint IN00188000- Substantiated. Federal/State deficiencies related to the allegations are cited at F312.</p> <p>Complaint IN00188017- Substantiated. Federal/State deficiencies related to the allegations are cited at F166, F246, F309, F312, F315, &amp;, F353.</p> <p>Survey dates: January 4, 5, 6, 7, 8, 9, 10, 11, and 12, 2016.</p> <p>Facility number: 000056<br/>Provider number: 155131<br/>AIM number: 100289450</p> <p>Census bed type:<br/>SNF: 24<br/>SNF/NF: 173<br/>Total: 197</p> <p>Census payor type:<br/>Medicare: 44<br/>Medicaid: 104<br/>Other: 49<br/>Total: 197</p> | F 0000        |   |                      |

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

TITLE

(X6) DATE

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

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| F 0157<br>SS=D<br>Bldg. 00 | <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on January 19, 2016.</p> <p>483.10(b)(11)<br/>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br/>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in</p> |               |   |                      |

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|   | <p>§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to promptly notify the resident's family member of a change in a blood pressure medication for 1 of 6 residents reviewed for unnecessary medications. (Resident #C)</p> <p>Finding includes:</p> <p>The record for Resident #C was reviewed on 1/11/16 at 8:45 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety disorder, and dementia without behavioral disturbance.</p> <p>Physician Orders dated 12/1/15 indicated Metoprolol (a medication used to lower the blood pressure and heart rate) 25 milligrams (mg) daily. On 12/22/15 the Metoprolol 25 mg daily was discontinued by the Physician and the new order was for Metoprolol 25 mg twice daily was.</p> <p>Nurse's Notes dated 12/22/15-1/5/16 indicated there was no documentation the resident's family had been notified of the</p> | F 0157  | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The family for RC was notified of the change in medication dosage. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> <i>The facility has reviewed all new medication orders received since 1/12/2016 to ensure that the family/responsible party has been notified. The family/responsible party was immediately notified with any</i></p> | 02/10/2016           |   |

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| F 0166<br>SS=D<br>Bldg. 00                          | <p>new dosage and the increase of the medication Metoprolol.</p> <p>Interview with the resident's Power of Attorney on 1/10/16 at 3:30 p.m., indicated she was not notified of the increase of the medication. She indicated the resident had been taking 12.5 mg twice a day for a total of 25 mg daily at home, and if she would have known about the increase she would have not given the approval.</p> <p>Interview with Director of Nursing on 1/12/16 at 10:01 a.m., indicated the family was not notified of the dosage change in the Metoprolol medication.</p> <p>3.1-5(a)(3)</p> <p>483.10(f)(2)<br/>RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br/>A resident has the right to prompt efforts by the facility to resolve grievances the resident</p> |   | <p><i>occurrence identified. The facility has reviewed facility events/change in condition that have occurred since 1/1/2016. The family/responsible party will be notified with any occurrence identified by 2/6/2016 The nursing staff will have additional in-servicing completed by 2/6/2016 to address physician and family/responsible party notification with any change in condition. Nursing staff have been in-serviced on notifying the responsible party with new medication orders and that the notification needs to be charted.</i></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b><br/>Unit Manager/designee will audit 3 times a week all new medication orders <i>and any changes in condition</i> to ensure the responsible party was notified and that the notification is charted. DON/designee will present a summary of the audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |                      |   |

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|                    | <p>may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure grievances were documented and followed through from all interested family members for 1 of 2 residents reviewed for social services. (Resident #B)</p> <p>Finding includes:</p> <p>The record for Resident #B was reviewed on 1/06/16 at 3:06 p.m. The resident's diagnoses included, but were not limited to, malaise, difficulty walking, muscle weakness, diabetes type 2, high blood pressure, peripheral vascular disease, cerebral infarction, kidney failure, falls, atrial fibrillation, and age related physical debility.</p> <p>Social Service Progress Note dated 12/2/15 at 9:36 a.m., indicated "This Social Worker attempted to contact the resident's son/responsible party to schedule a family meeting today and address family voiced general concern...." Another entry in Social Service Progress Notes dated 12/2/15 at 11:06 a.m., indicated "Social Services called the resident's son/responsible party again to offer a family meeting to resolving general family concerns...."</p> | F 0166        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Social service completed a grievance form for RB. The facility is working with the family on grievance resolution. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The facility held a resident council meeting to identify any outstanding complaints/grievance. A grievance form was initiated for any outstanding grievances and follow-up was completed. Grievance forms have been posted at each nurse's station for staff, family, and visitors to document grievances. <i>The grievance process will be</i></p> | 02/10/2016           |

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|   | <p>Social Service Progress Note dated 12/2/15 at 3:36 p.m., indicated met with the resident's responsible party to discuss other family members expressed concerns. The responsible party indicated that he was satisfied with the care and he had no concerns. The son indicated the person having the concerns was his niece (his mom's granddaughter).</p> <p>Interview with the Second Floor Unit Social Worker on 1/08/16 at 2:36 p.m., indicated Resident #B's son was her Power of Attorney. She further indicated any family member could voice a concern and the facility would address it. The Social Worker indicated the incident in question happened on the evening shift, therefore, the evening supervisor or the floor nurse would have completed a grievance form.</p> <p>Interview on 1/10/16 at 3:38 p.m., the Social Service Director indicated there have been no documented complaints and grievances from Resident #B's family.</p> <p>Interview with the Director of Nursing on 1/11/16 at 2:36 p.m., indicated there were no documented complaints or grievance from the resident's granddaughter.</p> <p>Interview with the Administrator on 1/12/16 at 10:50 a.m., indicated he was</p> |   | <p><i>reviewed at the resident council meetings including requesting feedback from residents in attendance to determine if staff are completing the grievance form and if their grievances are followed-up. Nursing staff, activity staff, and social services staff have been in-serviced on grievance policy and grievance form. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Social service/designee will review grievance forms weekly to ensure that grievances are documented on the grievance log and resolved in a timely manner. <i>The activity director will immediately notify social service of any grievances or concerns voiced by residents in resident council. In addition, the activity director will provide a summary to the Q/A committee monthly x 9 months for unresolved grievances that were voiced in resident council. The Q/A committee will determine if additional training and follow-up is needed related to the grievance process. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. Social service/designee will present a summary of audits to the QA committee monthly x 9 months. After 9 months, it will</i></i></p> |  |  |   |  |

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| F 0241<br>SS=D<br>Bldg. 00 | <p>aware there had been some family concerns from the resident's granddaughter but a complaint or grievance form had not been completed.</p> <p>The current 12/2004 Filing Grievances/Complaints policy provided by the Director of Nursing on 1/11/16 at 2:36 p.m., indicated "Our facility will assist residents, their representatives (sponsors), other interested family members, or resident advocates in filing grievances or complaints when such requests are made. Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form.</p> <p>This Federal Tag relates to Complaint IN00188017</p> <p>3.1-7(b)</p> <p>483.15(a)<br/>DIGNITY AND RESPECT OF INDIVIDUALITY<br/>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> |               | bedetermined by the Quality Assurance committee if further monitoring shouldcontinue and for what time period.  |                      |

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|   | <p>Based on observation, record review, and interview, the facility failed to promote a resident's dignity related to wearing hospital gowns during the daytime for 1 of 4 residents reviewed for dignity of the 8 who met the criteria for dignity. (Residents #H &amp; #284)</p> <p>Findings include:</p> <p>1. On 1/5/16 at 12:02 p.m., and 2:26 p.m., Resident #H was observed in bed wearing a hospital gown.</p> <p>On 1/06/16 at 9:26 a.m., the resident was observed in bed wearing a hospital gown and her Percutaneous Endoscopic Gastrostomy (PEG) was sticking out from under the gown and could be seen from the hallway.</p> <p>On 1/6/16 at 1:20 p.m., the resident was observed in bed wearing a hospital gown.</p> <p>On 1/7/16 at 10:26 a.m., CNA #6 was observed providing a bed bath for the resident. After the completion of the bed bath, she placed another clean hospital gown on the resident.</p> <p>On 1/8/16 at 2:06 p.m., the resident was again observed in bed wearing a hospital gown.</p> | F 0241  | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The daughter for R-H was interviewed regarding resident preferences for clothing. R-284 was interviewed related to preferences related to clothing.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The facility has completed interviews for residents to determine clothing preferences. These preferences were immediately honored. Residents clothing preferences have been placed on "Who am I" card in resident's room and the care plan has been updated. The responsible party was contacted for residents unable to give a preference. Upon admission and quarter the</p> | 02/10/2016           |   |

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|   | <p>The record for Resident #H was reviewed on 1/06/16 at 1:36 p.m. The resident's diagnoses included, but were not limited to, PEG tube, oxygen dependence, dementia, and Alzheimer's disease.</p> <p>The 6/30/15 Annual Minimum Data Set (MDS) assessment indicated the resident was severely impaired for decision making. The resident nor the family participated in the preference interview, The staff assessment was completed and indicated one of the resident's preferences was choosing clothes to wear.</p> <p>The Quarterly MDS assessment dated 10/6/15 indicated the resident was severely impaired for decision making. The resident was an extensive assist with a one person physical assist for dressing.</p> <p>Interview with the resident's daughter on 1/4/16 at 8:38 p.m., indicated the resident had clothes in her closet and she could be dressed with a shirt or duster. The daughter who was also the resident's Power of Attorney indicated she would not expect the staff to put pants on her mom, but shirts were fine while she was in bed.</p> <p>Interview with the Second Floor Unit Manager on 1/8/15 at 10:00 a.m., indicated the resident could be dressed in</p> |   | <p>resident's "Who am I" care will be updated to indicate residents preferences. Nursing staff and social service staff have been in-services on adhering to resident's preferences and reviewing the "Who am I" card for dressing. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Social service/designee will audit 10 residents weekly to ensure resident's preferences are being adhered to. Social Service/designee will present a summary of audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |                      |   |

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|                    | <p>her clothes. She further indicated there was no special preferences for her to be dressed in the hospital gown.</p> <p>2. Interview on 1/5/16 at 10:07 a.m., Resident #284 indicated she was in her hospital gown all the time, and later that day at 3:24 p.m., further indicated she would like to get dressed, but the staff never ask her to get dressed.</p> <p>An observation was made on 1/6/16 at 1:40 p.m., resident was in her hospital gown.</p> <p>An observation was made on 1/07/16 at 3:24 p.m., resident was in her hospital gown.</p> <p>An observation was made on 1/08/16 at 9:16 a.m. of resident in her hospital gown.</p> <p>The resident's record was reviewed on 1/7/16 at 1:21 p.m. The resident's diagnoses included, but were not limited to, anemia , hypertension, gastritis, morbid obesity, hypothyroidism, rheumatoid arthritis, and osteoporosis.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 7/3/15 indicated the resident was alert and orientated with</p> |               |   |                      |

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|                    | <p>a Brief Interview for Mental Status (BIMS) score of 15. The resident was interviewed for the Preference Section which indicated it was very important to choose what clothes to wear. The Dressing section was completed which indicated the resident needed extensive assist.</p> <p>Interview on 1/7/16 at 3:24 p.m., CNA #4 indicated the resident was always in her hospital gown. She further indicated the resident had clothes in her drawer, but have never seen her in anything but the hospital gown.</p> <p>Interview on 1/11/16 at 1:58 p.m., LPN #1 indicated she knows the resident has clothes she could wear but, was not sure if she has ever seen her dressed. She further indicated she had never asked the resident about getting dressed.</p> <p>Interview on 1/11/16 at 2:04 p.m., the Unit Manager indicated she had never seen her in anything but a hospital gown.</p> <p>On 1/11/16 at 11:00 a.m., the Admission folder documentation, which the residents receive on admission, was reviewed. The documentation was received from Corporate Healthcare Information Consultant, at that time she indicated the information was current.</p> |               |   |                      |

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| F 0242<br>SS=D<br>Bldg. 00 | <p>Nursing Home Resident Rights...Basic Rights...You have the right to be treated with respect and dignity in recognition of your individuality and preferences.</p> <p>3.1-3(t)</p> <p>483.15(b)<br/>SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br/>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.<br/>Based on record review and interview, the facility failed to ensure the resident's preferences were honored related to bathing for 2 of 3 residents reviewed for choices of the 4 residents who met the criteria for choices. (Resident #I &amp; #229)</p> <p>Findings include:</p> <p>1. Interview with Resident #I on 1/05/16 at 2:05 p.m., indicated she would like to take a shower at least once a week, but that does not always happen. She further indicated her bathing preference was to take a shower not a bath.</p> <p>The record for Resident #I was reviewed</p> | F 0242        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Interviewed both R-1 and R-229 for their bathing preferences. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents have the potential to be</p> | 02/10/2016           |

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|   | <p>on 1/7/16 at 2:12 p.m. The resident's diagnoses included but not were not limited to, physical debility, pressure ulcer right ankle, diaper dermatitis, end stage renal disease, and dependence on renal dialysis.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 12/2015 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was alert and oriented times three. The resident indicated it was very important to choose between a shower or bath. The resident needed extensive assist with bathing.</p> <p>The shower book indicated the resident's shower days were Wednesday and Saturday.</p> <p>The plan of care book which was used by the CNAS to obtain resident information indicated the resident's bathing preference was a shower.</p> <p>The resident was supposed to receive a shower on 12/9, 12/19, 12/23, and 12/26. The shower sheets provided for the month of 12/2015 indicated the resident's skin was checked on those days by the nurse, however, the CNA did not sign to indicate the shower had been completed.</p> |   | <p>affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> All facility residents have been reviewed to determine their bathing preference. The bathing preference for each resident is indicated on their "Who am I card" which is located in each residents room. Preference of bathing will be completed for any new resident at the time of initial admission and quarterly there after and will be documented on the care card. Nursing staff and activity staff have been in-services on adhering to resident's preferences for bathing located on the "Who am I card". <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Activity Director/designee will randomly interview 10 residents weekly to ensure that bathing preferences are being adhered to. The Activity Director/designee will present a summary of audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |                      |   |

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|                    | <p>The point of care sheets provided by the Nurse Consultant were reviewed. The sheets indicated the resident received a complete bed bath rather than a shower on 12/9, 12/19, and 12/23. There was no documentation for 12/26/15.</p> <p>The January 2016 shower sheets were reviewed. The resident was supposed to receive a shower on 1/2/16, however, the CNA did not sign to indicate the shower had been completed. The point of care sheets dated 1/2/16 indicated the resident received a complete bed bath rather than a shower.</p> <p>Interview with the Second Floor Unit Manager on 1/8/16 at 10:40 a.m., indicated the resident's preference for bathing in the CNA plan of care book was to receive shower. She indicated staff should be offering the resident a shower rather than a bed bath unless the resident requested it.</p> <p>2. On 01/05/16 at 10:43 a.m., Resident #229 indicated facility staff sometimes wait until he has changed into his night clothes before offering him his evening shower. The resident was scheduled to shower on Tuesday and Friday on the evening shift.</p> <p>The record for Resident #229 was</p> |               |   |                      |

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|   | <p>reviewed on 01/06/16 at 3:24 p.m. The resident's diagnoses included, but were not limited to, hypertension, depression, asthma, hypothyroidism, and gastroesophageal reflux disease without esophagitis.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 08/20/15 indicated the resident was alert and orientated with a Brief Interview for Mental Status (BIMS) score of 14. The resident was interviewed for the Preference Section which indicated it was very important to choose between a tub bath, shower, and bed bath. The personal hygiene section indicated the resident only needed supervision, and the bathing section indicated the resident only needed physical help in part of the bathing activity.</p> <p>The shower sheets were reviewed on 01/7/16 at 3:14 p.m. The shower sheets had not been signed to indicate the resident had received his shower or refused a shower on the following dates: Tuesday 12/22/15, Friday 12/25/15, Tuesday 12/29/15, and Friday 1/1/16. Further review of CNA Care Cards from October thru January indicated there was no documentation of the resident refusing to shower.</p> |   |   |                      |   |

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|                    | <p>Interview with CNA #4 on 1/7/16 at 3:14 p.m., indicated she knew who received a shower on her shift because it would be on the care card they received at the beginning of their shift. She further indicated, when she gave a shower or bed bath or the resident refused she would make sure she documented it on the care card, the shower sheet, and also let the nurse know. If it was not documented then the resident did not get the shower.</p> <p>Interview with CNA #3 on 1/08/16 at 11:21 a.m., indicated she usually worked the evening shift, and if the shower sheets were not signed off by a CNA then the shower probably was not done.</p> <p>Interview with the Unit Manager 1/08/16 at 11:58 a.m., indicated if the shower sheet was not signed it could indicate the shower was not done or the CNA just forgot to sign the sheet.</p> <p>The Point of Care documentation was reviewed on 1/11/16 at 2:07 p.m., indicated the resident received "other baths" on 12/22 and 12/29, and on 12/25 ad 1/1 had received a "complete bed bath".</p> <p>3.1-3 (u)(1)</p> |               |   |                      |

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| F 0246<br>SS=E<br>Bldg. 00 | <p>483.15(e)(1)<br/>REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br/>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident received reasonable accommodations related to call lights within reach, assistive devices were attached to resident beds, and leg rests were provided to wheelchairs for 4 of 5 residents reviewed for accommodation of needs. (Residents #B, #C, #E, and #F)</p> <p>Findings include:</p> <p>1. On 1/10/16 Resident #C's Power of Attorney (POA) indicated they had requested for some type of assistive device (a side rail) to be placed on her Aunt's bed due to a fracture of the resident's left Humerus (elbow) so it would help her move around better in the bed. The POA indicated she had made the request the day the resident was admitted which was 12/1/15 and it had taken the facility about 2 weeks for the assistive devices to get on her bed. Further interview with the resident's POA indicated they had also requested leg rests for the resident's wheelchair, so they</p> | F 0246        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The calllights for R-B, R-E, and RF have been placed in residents reach. The facility has provided R-C with Halos to the bed and leg rests.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes</b></p> | 02/10/2016           |

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|   | <p>could push her around in the wheelchair and she had been complaining her feet were swollen as well.</p> <p>On 1/10/15 at 5:00 p.m. Resident #C was observed in bed. At that time there were two halos (assistive devices) attached to each side of the bed. The resident indicated she used them to help her turn over in the bed.</p> <p>On 1/12/16 at 8:40 a.m. until 9:00 a.m., the resident was observed sitting up in her wheelchair by her bed in the room. Both of her legs were not elevated on leg rests and the tip of her toes were touching the floor. There were no leg rests on the wheelchair so the resident's feet could be elevated. At 9:05 a.m., the therapy department came to get resident for therapy, and put the leg rests on the resident's wheelchair so her feet were elevated.</p> <p>The record for Resident #C was reviewed 1/11/16 at 8:45 a.m. The resident was admitted to the facility on 12/1/15 from the hospital. The resident's diagnoses included, but were not limited to, displaced fracture of surgical neck of left humerus, high blood pressure, anxiety disorder, dementia without behavioral disturbance, history of falling, and muscle weakness.</p> |   | <p><b>will be made to ensure that the deficient practice does not recur;</b></p> <p><i>The facility has completed an audit of all resident's rooms to ensure that all call light are long enough. Call light cords that do not reach to other side of bed were changed.</i></p> <p><i>The facility has reviewed all residents to ensure that residents requiring leg rests while up in w/c had leg rests available to elevate legs or for transport. All new admissions are assessed by therapy for the need of adaptive equipment, type of transfers, bed mobility equipment, and seating system. All new recommendations are discussed with nursing and then updated on the resident care card. An audit was completed by the HIM coordinator for all new admissions in the past 30 days to ensure that adaptive equipment recommended is in place.</i></p> <p>Nursing staff was in-serviced on timely accommodation of needs:</p> <ul style="list-style-type: none"> <li>· Halos on bed. Maintenance request to be filled out</li> <li>· Leg rests on wheelchair. Utilize therapy for proper fitting if needed. Environmental services to provide leg rest if needed.</li> <li>· Call lights within reach of resident. If longer call cord needed for resident, fill</li> </ul> |  |  |   |  |

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|   | <p>The Admission Minimum Data Set (MDS) assessment dated 12/8/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was an 11, which meant she was moderately impaired for decision making. The resident was coded as having no behaviors. The resident needed extensive assist with a two person physical assist with bed mobility and transfers.</p> <p>The bed mobility system observation reassessed on 12/4/15 indicated the resident was a candidate for some type of assistive device for the bed to increase independence. The bed mobility system assist the resident in turning side to side, moving up and down in bed, holding self on one side, and pulling self from laying to sitting.</p> <p>A Physician Order dated 12/4/15 indicated bilateral halos.</p> <p>A maintenance request was submitted for the halos to be placed on the resident's bed on 12/4/15. The request form indicated the halos were not placed on the resident's bed until 12/9/15.</p> <p>A Nurse's Note documented by the Nurse Practitioner on 1/5/16 at 1:50 p.m. indicated the resident seen and examined.</p> |   | <p>maintenance requestout.</p> <p><i>Addendum staff in-servicingto review additional accommodation of needs including "Rehab AdmissionAssessment and Recommendations to Nursing" will be completed by 2/5/2016.</i></p> <p>How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programswill be put into place;</p> <p>Unit Manager/designeewill randomly audit 5 residents per floor weekly on alternative shifts toensure call lights are within resident's reach, leg rests are on wheelchair,and halos on bed.</p> <p><i>The Health Information Manager/designee will auditall new admissions to ensure that the "Rehab Admission Assessment andRecommendations to Nurses" is completed.</i></p> <p>DON/designee will present a summary of theaudits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committeeif further monitoring should continue and for what time period.</p> |                      |   |

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|                    | <p>The action and plan was to elevate the resident's legs due to mild edema.</p> <p>A Physician Order dated 1/5/16 indicated elevate bilateral lower extremities as much as possible.</p> <p>Interview with the Director of Nursing (DoN) on 1/12/16 at 9:59 a.m., indicated the resident should have her legs elevated and the leg rests should be on the wheelchair.</p> <p>Further interview with the DoN indicated on 1/12/16 at 11:21 a.m., indicated the halos should have been placed on the resident's bed in a more timely manner.</p> <p>2. On 1/05/16 at 2:28 p.m., Resident #B was observed sitting in a wheelchair by the window. The resident's call light was observed laying in the middle of the bed and completely out of reach. When asked if the resident could reach her call light the resident stated "It would be a fight."</p> <p>On 1/07/16 at 9:04 a.m., the resident was observed sitting in her wheelchair by the window. The resident's call light was located on the bed towards the left side rail and completely out of reach for the resident. The resident indicated at that time, she was not able to reach the call</p> |               |   |                      |

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|                    | <p>light from where she was sitting.</p> <p>Interview with the Second Floor Unit Manager on 1/8/16 at 10:30 a.m., indicated the resident was capable of using the call light and it should have been within reach.</p> <p>3. On 1/05/16 at 08:51 a.m., Resident #E was observed sitting in a wheelchair in the room eating breakfast. The resident was positioned by the window next to the bed. The resident's call light was observed attached to the halo (assistive devices attached to the side of the bed) on the other side of the bed. The resident indicated after she was finished eating she was supposed to call so her ears could be flushed by the Doctor. She stated, "As a matter of fact could you get me the call light, it is clear over there, and I cannot reach it. I had a shower this morning and they set me up over here and did not give it to me."</p> <p>Interview with the Second Floor Unit Manager on 1/8/16 at 10:30 a.m., indicated the resident was capable of using the call light and it should have been within reach.</p> <p>4. On 1/4/16 at 6:43 p.m., Resident #F was observed sitting in her wheelchair next to her bed. At that time, the</p> |               |   |                      |

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| F 0247<br>SS=D<br>Bldg. 00 | <p>resident's call light was on the other side of the bed and completely out of reach. The resident stated, "Could you hand it to me because I will need to use the bathroom soon."</p> <p>Interview with the Second Floor Unit Manager on 1/8/16 at 10:30 a.m., indicated the resident was capable of using the call light and it should have been within reach.</p> <p>This Federal Tag relates to Complaint IN00188017</p> <p>3.1-3(v)(1)</p> <p>483.15(e)(2)<br/>RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE<br/>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.<br/>Based on record review and interview, the facility failed to ensure a notice was given to a roommate change for 1 of 3 residents reviewed for admission/transfer/discharge of the 19 residents who met the criteria for admission/transfer/discharge. (Resident #B)</p> <p>Finding includes:</p> | F 0247        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> | 02/10/2016           |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155131 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>01/12/2016 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MUNSTER MED-INN |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>7935 CALUMET AVE<br>MUNSTER, IN 46321 |  |   |  |
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|   | <p>Interview with Resident #B on 01/05/2016 at 10:53 a.m., indicated she had a roommate change in the last nine months. The resident indicated she was not given prior notice of the roommate change.</p> <p>The record for Resident #B was reviewed on 01/08/2016 at 12:49 p.m. The resident received a roommate on 12/17/2015. There was no documentation to indicate the resident was notified about the roommate admission.</p> <p>Interview with the Corporate Social Worker and Corporate Consultant on 01/08/2016 at 12:49 p.m., indicated the resident received a new roommate on 12/17/2015 and there was no notice given to the resident or family prior to the new roommate admission.</p> <p>On 1/11/16 at 11:00 a.m., the Admission documentation, which the residents receive on admission, was reviewed. The documentation was received from Corporate Healthcare Information Consultant, she indicated the information was current. Nursing Home Resident Rights...Living Accommodations and Care, Express preferences with respect to your room and roommate, and be advised in writing before any changes are made.</p> |   | <p>All residentsinvolved were spoken with and no issues with roommate voiced.</p> <p><b>How thefacility will identify other residents having the potential to be affected bythe same deficient practice and what corrective action will be taken;</b></p> <p>All residentshave the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur;</b></p> <p><i>The facility has reviewedall room changes/new admissions that occurred since 1/12/2016 to ensure thatthe roommate was notified of the changes. Social service has met with 2residents identified as not being notified to ensure they are adjusting well tothe new roommate.</i></p> <p>Socialservices/designee will notify the resident of room changes and receiving a newroommate, and document that notification.</p> <p>Nursingstaff and social services in-serviced on notifying the resident of room changesand receiving a new roommate, and</p> |  |  |   |  |

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| F 0282<br>SS=D<br>Bldg. 00                          | 3.1-3(v)(2)<br><br>483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on observation, record review, and interview, the facility failed to ensure Physician Orders were followed as well as the plan of care related to fluids and non pressure ulcer treatments. The facility also failed to ensure only qualified staff members perform certain duties related to a CNA turning off an enteral feeding pump (a machine used to | F 0282  | documenting that notification in the resident progress note.<br><br><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b><br><br>Social Service/designee will audit all room changes weekly and roommate changes to ensure notification was completed and documented.<br><br>Social Service/designee will present a summary of the audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.<br><br>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b> | 02/10/2016           |   |

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|   | <p>infuse nutrition into a feeding tube) while it was infusing. (Residents #H &amp; #284)</p> <p>1. On 1/5/16 at 9:07 a.m., Resident #H was observed in bed wearing a hospital gown. At that time there was a pink foam dressing observed to her left elbow with a date of 12/31/15.</p> <p>Continued observation on 1/5/16 at 10:14 a.m., LPN #4 was performing a skin assessment for the resident. The LPN indicated the left elbow dressing was dated 12/31/15 and was to be changed every three days. She further indicated the resident was supposed to have a pink foam dressing on her buttock area as a preventative treatment. At that time, the resident was rolled onto her right side and had a large amount of brown liquid brown bowel movement in her incontinent brief. After the resident was cleaned, there was no pink foam dressing on the resident or in the dirty brief.</p> <p>Interview with CNA #5 at that time, indicated she had changed the resident by herself about an hour ago, and there was no pink foam dressing on her buttocks at that time. The CNA indicated she was unaware the resident was supposed to have a dressing on her buttocks.</p> <p>On 1/06/16 at 1:20 p.m., the resident was</p> |   | <p><b>practice;</b></p> <p>The dressing to R-H's left elbow and preventative dressing to the buttocks have been discontinued. The care plan has been updated. R-284 has been given fresh water every shift and has been given additional water as requested. Nursing assistant was educated that turning the tube feeding pump on/off is not in her scope of practice.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p><i>Facility rounds were immediately completed for each resident to ensure fresh water was available. All residents that are on a fluid restriction have been identified. Residents that are not on a fluid restriction will be offered fluids throughout the shift by nursing staff.</i></p> |  |  |   |  |

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|   | <p>observed in bed. The resident had a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the resident's stomach used for nutrition) in and infusing an enteral feeding at 45 cubic centimeters (cc) an hour. At that time, CNA #5 was in the room and going to provide incontinence care. The CNA turned off the enteral feeding pump and lowered the head of the bed. The CNA proceeded to provide incontinence care.</p> <p>Interview with CNA #5 at that time, indicated indicated she always turns off the PEG tube before lowering the head of the bed, because the resident could choke.</p> <p>The record for Resident #H was reviewed on 1/06/16 at 1:36 p.m. The resident's diagnoses included, but were not limited to, PEG tube, oxygen dependence, dementia, and Alzheimer's disease.</p> <p>Physician Orders dated 8/11/15 and on the current 1/2016 indicated enteral feeding of Glucerna 1.2 at 45 cc per hour continuously.</p> <p>Another Physician Order dated 11/18/15 and on the current 1/2016 recap indicated cover right buttocks with small pink foam and change every 3 days and as needed if comes off.</p> |   | <p><i>All residents withdressings including preventative have been identified. The dressing wasreplaced for any resident noted without a dressing in place. The care plan hasbeen updated. Nurse are responsible for dressing changes or replacementdressings. CNA's should notify the nursing staff if dressings are missing.</i></p> <p><i>All residents with a tubefeeding have been identified. Nurses are responsible for connecting anddisconnecting the G-tubes.</i></p> <p>Nursingstaff were in-serviced on:<br/>·Following physician orders and plan of care including preventative andnon-pressure ulcer dressings<br/>·Nurses and QMAs are only allowed to turn the tube feeding pump on/off<br/>·Ensure residents have fresh water<br/>C.N.A.staff were in-serviced on:<br/>·Following the resident care card<br/>·CNAs are not allowed to turn the tube feeding pump on/off<br/>·Ensure residents have fresh ice water</p> <p>How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programswill be put into place;</p> |                      |   |

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|   | <p>A Physician Order dated 11/12/15 and on the current 1/2016 recap indicated left medial forearm cleanse with normal saline and pat dry then apply small pink adherent foam every 3 days and as needed for soilage/removal and monitor for changes.</p> <p>The 12/2015 Treatment Administration Record (TAR) was reviewed. The pink foam dressing to the buttock was last signed out as being completed on 12/29/15. The 1/2016 TAR indicated the treatment was last signed out on 1/2/16 as being completed. The 12/2015 TAR for the left medial forearm was last signed out on 12/29/15.</p> <p>Interview with the Second Floor Unit Manager on 1/5/16 at 10:30 a.m., indicated the dressing to the left arm was not changed every 3 days as ordered by the Physician. She further indicated there should have been a pink foam dressing for preventative measures to the resident's buttocks area.</p> <p>2. Interview on 1/5/16 at 10:07 a.m., Resident #284 indicated she does not receive the fluids she wants between meals. She indicated she had asked for water earlier and still had not received</p> |   | <p>Unit manager/designee will audit weekly utilizing the MATRIX facility activity report for new ordersto ensure the order is appropriate and that the plan of care is updated.</p> <p>Wound nurse/designee will audit 5 residents weekly the non-pressure ulcers to ensure treatment is appropriate and that treatment is being completed as ordered.</p> <p>The Administrator/designee will audit 10 random room weekly on alternative shift to ensure that fresh icewater is in place.</p> <p>The charge nurse/designee will observe 5 residents weekly for each unit on alternative shifts to ensure CNA's are not disconnecting/turning off and reconnecting/turning on tubefeedings.</p> <p>The DON/designee will present a summary of the audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |  |  |   |  |

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|                    | <p>the water. The resident complained her lips were dry.</p> <p>On 1/5/16 at 10:09 a.m., the resident was observed in her room and her lips were dry and chapped. At that time, the resident pushed the call light for assistance. At 10:29 a.m., an employee came in looked around the curtain, and turned off the light. The employee did not ask the resident what she needed.</p> <p>Interview with the Unit Manager at that time indicated the employee should have asked what the resident needed.</p> <p>On 1/8/16 at 9:16 a.m., the resident was observed in her room with an empty cup on her bedside table. The resident received water at 9:45 a.m. for the first time.</p> <p>The record was reviewed on 1/7/16 at 1:21 p.m. The resident's diagnoses included, but were not limited to, anemia , hypertension, gastritis, morbid obesity, hypothyroidism, rheumatoid arthritis, and osteoporosis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/25/15 indicated the resident was alert and orientated with a Brief Interview for Mental Status (BIMS) score of 15.</p> |               |   |                      |

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| F 0309<br>SS=D     | <p>The Care Plan dated 7/10/15 indicated the resident was at risk of dehydration due to diuretic therapy. The interventions were to encourage fluid intake and provide assist as needed, and to observe resident for signs and symptoms of dehydration throughout the shift.</p> <p>Interview on 1/7/16 at 3:24 p.m., with CNA #4 indicated the resident was not on a fluid restriction, and the staff pass water once a shift. She further indicated that the staff pass water to her more often because she was always thirsty, and she drinks a lot.</p> <p>3.1-35 (g)(2)</p> <p>483.25<br/>PROVIDE CARE/SERVICES FOR</p> |               |   |                      |

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| Bldg. 00  | <p><b>HIGHEST WELL BEING</b><br/>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the resident received the necessary treatment and services related to ensuring dialysis sheets were completed, legs were elevated to prevent edema, and providing cream and ointments to non pressure areas of the skin for 1 of 1 resident reviewed for dialysis and 2 of 3 residents reviewed for non pressure skin conditions of the 11 who met the criteria for non pressure skin conditions. (Resident #B, #H &amp; #I)</p> <p>Findings include:</p> <p>1. The record for Resident #I was reviewed on 1/7/16 at 2:12 p.m. The resident's diagnoses included but not were not limited to, physical debility, pressure ulcer right ankle, diaper dermatitis, end stage renal disease, and dependence on renal dialysis.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 12/2015 indicated the resident had a Brief Interview for Mental</p> | F 0309  | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Dialysis was called for R-1 and information was obtained for all missing communication forms for dialysis. The family for R-H was notified and asked to take all non-prescribed creams home. Geri-sleeves were replaced. The legs for R-B were elevated immediately. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> All residents on dialysis</p> | 02/10/2016           |   |

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|   | <p>Status (BIMS) score of 15 which indicated she was alert and oriented times three. The resident received dialysis while at the facility.</p> <p>The current plan of care updated 12/2015 indicated the resident has end stage renal disease and was dialysis dependent. The Nursing approaches were check access site for bruit and thrill each shift, coordinate care including lab draws with dialysis center, and vitals and weights per protocol.</p> <p>Physician Orders on the current 1/2016 recap indicated hemodialysis three times a week on Monday, Wednesday and Friday.</p> <p>The dialysis reports were reviewed. The report had a facility side and dialysis side which was to be completed by each one. The facility report indicated the resident vital signs, temp, pulse, blood pressure, new medication or treatment, isolation precautions, and other notes were to be documented, signed and dated by the nurse. That form was to be sent to the dialysis center and the dialysis unit report was to be completed which included pre blood pressure, post blood pressure, new med, isolation , other notes, pre weight, post weight, and dry weight and was to be signed and dated by dialysis nurse.</p> |   | <p><i>have been identified. A communication sheet will be sent with each resident on dialysis days. The facility will contact the dialysis center for any resident that returns without a communication sheet to obtain the communication sheet or the dialysis run report. All dialysis communication sheets/run reports will be uploaded into each residents EMR. All residents requiring Geri-sleeves have been identified and indicated on the resident care card. All soiled/torn Geri sleeves will be immediately replaced. All residents that have a physician's order for a skin treatment have been reviewed. It is the policy of the facility to apply skin protectant cream/lotion as part of care. OTC skin protectant creams/lotions will be kept at the resident's bed side for CNA's to apply during care. Resident may keep personal lotions and creams at the bedside and staff may apply per resident request. Prescription treatments will be kept on the treatment cart unless otherwise specified. The facility has reviewed all residents to ensure that residents requiring leg rests while up in w/c had leg rests available to elevate legs or for transport. Therapy is responsible for assessing all new admissions for the need of adaptive equipment this includes leg rests. All new recommendations are discussed with nursing and then updated on</i></p> |                      |   |

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|                    | <p>Continued review of the dialysis report sheets indicated the only available completed report sheets signed by the facility nurse and the dialysis nurse was on:</p> <p>1/6/16<br/>12/28<br/>12/21<br/>12/7<br/>12/4<br/>11/27<br/>11/16<br/>11/18<br/>11/9<br/>11/4<br/>11/6</p> <p>The resident's dialysis days were 11/2, 11/4, 11/6, 11/9, 11/11, 11/13, 11/16, 11/18, 11/20, 11/23, 11/25, 11/27, 11/30, 12/2, 12/4, 12/7, 12/9, 12/11, 12/14, 12/16, 12/18, 12/21, 12/23, 12/26, 12/28, 12.30, 1/4/16, and 1/6/16,</p> <p>Interview with the The Second Floor Unit Manager on 1/7/16 at 3:00 p.m., indicated they were missing facility report sheets. She indicated sometimes they send sheets and the dialysis center does not send them back and sometimes the resident had them in her bag, or the ambulance driver does not give the dialysis center the paper work. She</p> |               | <p><i>the resident care card. An audit was completed for all newadmissions in the past 30 days to ensure that adaptive equipment recommended is in place. Nursing staff and C.N.A. staff were in-serviced on:</i></p> <ul style="list-style-type: none"> <li>·Dialysis communication sheets filled out completely</li> <li>·Check geri-sleeves to ensure they are on appropriately and in goodcondition</li> <li>·Application of skin barrier creams</li> <li>·Legs are elevated as per care card</li> <li>·Nurses to follow physician treatment orders How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programswill be put into place;</li> </ul> <p>DON/designee will audit allresidents receiving dialysis weekly to ensure dialysis communication sheets arecompleted. Staff assigned to“guardian angel rounds” will observe all residents requiring geri-sleeves onceweekly to ensure geri-sleeves are in good repair. Staff assigned to“guardian angel rounds” will observe for residents requiring leg rests to ensure leg rests are being utilized. DON/designee will audit the treatment administration records for 5 resident’s per floor weekly forresident requiring prescription treatments to ensure have been</p> |                      |

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|   | <p>indicated the 3-11 nurse should be checking for the paper when the resident returns from dialysis because she does not come back until the evening shift.</p> <p>2. On 1/05/16 at 9:07 a.m., 12:02 p.m., and 2:26 p.m., Resident #H was observed in bed. At that time, she was observed wearing geri sleeves (a protective sleeve) to both of her arms and was dressed in a short sleeve hospital gown. The resident's skin from below her elbow to her upper arm above her elbow was exposed on both sides.</p> <p>On 1/06/16 at 9:26 a.m., the resident was observed in bed wearing a hospital gown and had geri sleeves to both of her arms. The left geri sleeve was torn and half of the resident's arm was exposed</p> <p>On 1/6/16 at 1:20 p.m., the resident was observed in bed wearing a hospital gown with short sleeves. The resident was wearing geri sleeves to both arms, however, the left sleeve was torn and 4 inches of her skin was exposed.</p> <p>On 1/7/16 at 10:26 a.m., CNA #6 was observed providing a bed bath for the resident. The CNA applied "Skin repair cream" to the resident's buttocks after providing incontinence care. The CNA was also observed to have applied baby</p> |   | <p>completed. Staff assigned to guardian angel rounds will observe rooms weekly to ensure unnecessary items are removed from resident rooms. The DON/designee will present a summary of the audits/observations to the QA committee monthly x 9months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |  |  |   |  |

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|                    | <p>lotion to both of her legs. After the completion of the bed bath, she placed another clean hospital gown on the resident and the same torn geri sleeves were applied to the resident's arms. The resident' skin was exposed to both of her arms.</p> <p>Interview with CNA #6 at that time, indicated she was able to reposition the resident by herself, however, some smaller CNAS may need help. She indicated she always puts the baby lotion on the resident's legs and arms because she had fragile skin. She further indicated all residents get some sort of incontinence cream applied to their peri area and buttocks after care was provided.</p> <p>On 1/08/16 at 2:06 p.m., the resident was observed in bed. The Director of Nursing was in the resident's room at that time. The resident's bed side drawer was opened and inside were numerous tubes of ointments and creams. There were two tubes of Calmoseptine ointment (a skin protectant ointment) and one jar of Aquaphor (a moisturizing cream). The Director of Nursing indicated both creams could be applied by the CNAS.</p> <p>The record for Resident #H was reviewed on 1/06/16 at 1:36 p.m. The resident's</p> |               |   |                      |

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|                    | <p>diagnoses included, but were not limited to, PEG tube, oxygen dependence, dementia, and Alzheimer's disease.</p> <p>The Quarterly MDS assessment dated 10/6/15 indicated the resident was severely impaired for decision making. The resident was an extensive assist with a two person physical assist for bed mobility. The resident was totally dependent on staff for personal hygiene, dressing and bathing.</p> <p>The current and updated 10/2015 plan of care indicated the resident had bruises to upper bilateral extremities. The Nursing approaches were to keep skin lubricated.</p> <p>Another updated 10/2015 plan of care indicated the resident was at risk for skin tears or cuts related to poor skin integrity. The Nursing approaches were to avoid sheering resident's skin during positioning transferring and turning, dress resident in long sleeve shirts, pants, and protect extremities.</p> <p>Physician Orders dated 7/22/15 and on the current 1/2016 recap indicated Aquaphor with natural healing apply thin layer to all extremities every shift and after bathing. May keep at bedside.</p> <p>A Physician Order dated 1/5/15 and on</p> |               |   |                      |

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|--------------------|---|---------------|---|----------------------|
|                    | <p>the current recap indicated Calmoseptine ointment-cleanse gently with soap and water after each incontinent episode and pat dry. Apply thick layer of Calmoseptine. May keep at bedside. CNA may apply every shift.</p> <p>A Physician Order dated 7/22/15 and on the current 1/2016 recap indicated resident may wear geri sleeves and may remove to provide care.</p> <p>The last weekly skin assessment dated 1/2/16 indicated the resident had bruises and discolorations noted on bilateral upper extremities where healed skin tears were. There was redness to the buttocks and left forearm and both sites were treated with pink foam dressings as per Physician Orders.</p> <p>Interview with the Director of Nursing on 1/8/16 at 2:15 p.m., indicated the resident was supposed to received the Aquaphor cream to the legs and arms and the Calmoseptine cream to her buttocks and peri area after each incontinent episode. She indicated there were too many creams in the resident's drawer. She further indicated the CNAS were able to administer both creams to the resident.</p> <p>3. On 1/5/16 at 2:27 p.m. Resident #B was observed sitting in the wheelchair in</p> |               |   |                      |

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|                    | <p>her room. At that time, both of the resident's legs were not elevated and her feet were touching the floor. The resident's left foot was noted to be swollen and there was a white dressing noted to that foot. There was no sock on the resident's left foot at that time. There were no leg rests observed to the wheelchair, they were laying on the floor next to the chair.</p> <p>On 1/07/16 at 9:04 a.m., and 11:04 a.m., the resident was observed sitting in the wheelchair. At that time, the resident's feet were not elevated and were touching the floor. There were no leg rests observed on the resident's wheelchair.</p> <p>The record for Resident #B was reviewed on 1/06/16 at 3:06 p.m. The resident's diagnoses included, but were not limited to, malaise, difficulty walking, muscle weakness, diabetes type 2, high blood pressure, peripheral vascular disease, cerebral infarction, kidney failure, falls, atrial fibrillation, and age related physical debility.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 12/11/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 10 indicating the resident was moderately impaired for decision making for</p> |               |   |                      |

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|   | <p>cognition. The resident had no mood or behaviors problems. The resident needed extensive assist with a 2 person physical assist for bed mobility and transfers. The resident needed extensive assist with 1 person physical assist for dressing, toilet use and person hygiene. The resident had an indwelling Foley catheter. The resident was also coded as having a surgical wound.</p> <p>The resident was admitted to the facility with a surgical wound to the left foot. The wound was measured on 11/30/15. The wound measured 3.6 centimeters (cm) by 1 cm by 1 cm undermining. The tissue was red and the wound bed had exposed tendons.</p> <p>Physician Orders dated 11/27/15 indicated elevated leg rests: elevated leg rests while in wheelchair every shift.</p> <p>Interview with Wound Nurse #2 on 1/08/16 at 2:14 p.m., indicated the resident was admitted with surgical wound to her left foot. She indicated the resident's legs should have been elevated while she was sitting in the wheelchair, due to her edema in that foot comes and goes.</p> <p>This Federal Tag relates to Complaint IN00188017</p> |   |   |                      |   |

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| F 0312<br>SS=D<br>Bldg. 00                          | <p>3.1-37(a)</p> <p>483.25(a)(3)<br/>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br/>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br/>Based on observation, record review and interview, the facility failed to ensure incontinence care was provided in a timely manner as well as showers being provided for 2 of 6 residents reviewed for activities of daily living. (Residents #D and #G)</p> <p>Findings include:</p> <p>1. On 1/8/16 at 7:24 a.m., Resident #D was seated in a wheelchair across from the Nurses' station. At 8:24 a.m., the resident was taken into the dining room. At 8:49 a.m., the resident was brought out of the dining room and placed across from the Nurses' station. At 9:35 a.m., the resident was taken to her room to receive her morning medications. At 9:37 a.m., the resident was brought back to the area across from the Nurses' station. At 10:20 a.m., the resident was taken to an activity in the Unit dining room. The resident remained in the</p> | F 0312  | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br/><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> R-D was immediately provided incontinent care. R-G was immediately provided a shower. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Rounds were completed on all residents at the time of survey. Immediate care</p> | 02/10/2016   |  |   |  |

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|   | <p>activity until 11:50 a.m. After the activity, the resident was taken back to the area across from the Nurses' station. At 12:21 p.m., the resident remained seated across from the Nurses' station. At 12:28 p.m., the resident was taken to her room by CNA #2. The resident was transferred to bed at this time. The CNA removed the resident's incontinence brief and performed incontinence care. The resident's brief was damp and she was incontinent of stool, part of the stool was dried and adhered to the resident's buttocks.</p> <p>Interview with the CNA at the time, indicated this was the first time she was able to check the resident since she started her shift at 7:00 a.m. The CNA also indicated the resident could not tell staff when she needed to go to the bathroom.</p> <p>The record for Resident #D was reviewed on 1/7/16 at 1:11 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and cognitive deficits following cerebrovascular disease.</p> <p>The 10/7/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident had short term memory problems and was moderately impaired for decision</p> |   | <p><i>was provided to any resident requiring incontinent care or needing a shower. The facility has reviewed the toileting needs of all residents. Residents requiring assistance with toileting and who are incontinent of bowel and bladder will have incontinence checks completed every two hours. All resident care cards have been updated to indicate assistance required.</i></p> <p>Nursing staff and C.N.A. staff in-serviced on:</p> <ul style="list-style-type: none"> <li>·Toileting residents and providing incontinent care</li> <li>·Providing showers and completing shower sheets</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>Unit manager/designee will randomly audit 5 residents per floor weekly on <i>alternative shifts</i> to ensure residents are being toileted and incontinence care is provided, showers are being provided and that shower sheets are completed. DON/designee will present a summary of the audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period</p> |                      |   |

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|   | <p>making.</p> <p>The resident was an extensive assist of one for toilet use and was always incontinent of bladder and bowel.</p> <p>The plan of care dated 7/28/15 and reviewed October 2015, indicated the resident was at risk for skin breakdown related to limitations in mobility and incontinent episodes. The interventions included, but were not limited to, keep resident as clean and dry as possible to minimize skin's exposure to moisture and provide incontinence care after each episode of incontinence.</p> <p>The 7/16/15 Admission Bladder assessment, indicated the resident had functional incontinence and was to be monitored and changed every two hours.</p> <p>The 10/6/15 Quarterly Bladder assessment, indicated the resident remained with functional urinary incontinence. No additional interventions were documented.</p> <p>Interview with the Director of Nursing on 1/8/16 at 2:00 p.m., indicated the resident should have been checked for incontinence in a more timely manner.</p> <p>2. On 1/7/16 at 10:00 a.m., Resident #G</p> |   |   |                      |   |

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|                    | <p>was observed seated in her wheelchair parked outside of her bedroom door. Here fingernails were long and untrimmed with a brown substance underneath, there was food debris in and around her mouth, and there was a strong odor of feces noted.</p> <p>The record for Resident #G was reviewed on 1/6/16 at 3:04 p.m. Her diagnoses included, but were not limited to, anorexia, major depression, pain, anxiety, and adult failure to thrive.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 12/7/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident's cognition was severely impaired. The resident was an extensive assist with a two person physical assist with toilet use, personal hygiene, and transfers. The resident was totally dependent with bathing. The resident had no behaviors of rejection of care.</p> <p>The current care plan indicated the resident was limited in ability to maintain grooming and personal hygiene related to generalized weakness. The approaches included, but were not limited to, provide the amount of assist needed</p> |               |   |                      |

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|                    | <p>to complete task.</p> <p>The Shower Book indicated the resident was to receive a shower on Sunday and Wednesday during the day.</p> <p>The December 2015 Bath and Skin Report Sheet indicated the resident was last bathed on 12/27/15. The resident's fingernails were last trimmed on 12/23/15.</p> <p>The January 2016 Bath and Skin Report Sheet indicated no documentation of a shower or fingernail trimming.</p> <p>Interview with LPN #3 on 1/7/16 at 11:03 a.m., indicated she was unsure when the resident was last bathed. Observation at the time further indicated the resident's fingernails were untrimmed with a brown substance underneath and she had and odor of feces.</p> <p>Interview with the Unit Director on 1/7/16 at 1:30 p.m., indicated the resident had not been bathed since 12/27/15, the resident should have been bathed according to her shower schedule, which included her hair being washed and her fingernails being cleaned and trimmed.</p> <p>This Federal tag relates to Complaint IN00188000 and Complaint IN00188017.</p> |               |   |                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>MUNSTER MED-INN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>7935 CALUMET AVE<br>MUNSTER, IN 46321 |
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| F 0315<br>SS=D<br>Bldg. 00 | <p>3.1-38(a)(2)(A)<br/>3.1-38(a)(3)(C)</p> <p>483.25(d)<br/>NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a Foley catheter had an appropriate diagnosis/reason for the catheter for 1 of 1 resident's reviewed for Foley catheters. (Resident #B)</p> <p>Finding includes:</p> <p>Interview on 1/6/16 at 10:41 a.m., with the Second Floor Unit Manager indicated Resident #B had a Foley catheter due to the diagnoses of bladder cancer and urinary retention.</p> <p>On 1/06/16 at 1:25 p.m., Resident #B was observed in bed. At that time the</p> | F 0315        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> R-B's foley catheter was discontinued. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents who have a foley catheter have the potential to be affected by the same alleged</p> | 02/10/2016           |

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|   | <p>resident was observed with an indwelling Foley catheter.</p> <p>The record for Resident #B was reviewed on 1/06/16 at 3:06 p.m. The resident's diagnoses included, but were not limited to, malaise, difficulty walking, muscle weakness, diabetes type 2, high blood pressure, peripheral vascular disease, cerebral infarction, kidney failure, falls, atrial fibrillation, and age related physical debility.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 12/11/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 10 indicating the resident was moderately impaired for decision making for cognition. The resident had no mood or behaviors problems. The resident needed extensive assist with a 2 person physical assist for bed mobility and transfers. The resident needed extensive assist with 1 person physical assist for dressing, toilet use and person hygiene. The resident had an indwelling Foley catheter. The resident was also coded as having a surgical wound.</p> <p>A Bladder observation (assessment) dated 11/27/15 indicated the resident had an indwelling catheter for stage 2-4 pressure ulcer and a history of urinary</p> |   | <p>deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing was in-serviced on obtaining appropriate diagnosis/reason for foley catheter. All residents with foley catheters in facility were audited for appropriate diagnosis/reason for foley catheter. For any resident with a foley in which urinary retention is discovered, a bladder scan will be obtained from hospital and/or post residual urine of 200 cc or more documented in order to keep Foley. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Unit Manager/designee will audit weekly foley catheters to ensure there is appropriate diagnosis/reason for foley catheter and it is documented. DON/designee will present a summary of the audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |                      |   |

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|                    | <p>retention.</p> <p>A wound observation report dated 11/30/15 indicated the resident was admitted with a pressure sore classified as a deep tissue injury to the coccyx that measured 4 centimeters (cm) by 4 cm. Another wound observation report dated 12/22/15 indicated the deep tissue injury to the coccyx had healed.</p> <p>Physician Orders dated 11/27/15 and on the current 1/2016 recap indicated indwelling Foley catheter 18 French and 30 cubic centimeters (cc) balloon.</p> <p>The hospital history and physical notes were reviewed. There was no evidence the hospital did a bladder scan or checked for a post void residual to determine the resident had urinary retention.</p> <p>Physician Progress Notes were reviewed from 11/27/15 through 1/7/16 and there was documentation the resident had the diagnosis of urinary retention.</p> <p>Nurse's Progress Notes dated 11/27/15 through 1/7/16 indicated there were no documented attempts to remove the catheter to see if the resident could urinate or had urinary retention.</p> <p>Interview with Director of Nursing on</p> |               |   |                      |

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| F 0323<br>SS=G<br>Bldg. 00 | <p>1/11/16 at 1:22 p.m., indicated there was no bladder scan or post void residual catheterization competed at the hospital to determine the diagnosis of urinary retention. She further indicated there were no attempts to remove the Foley catheter during her stay at the facility.</p> <p>This Federal Tag relates to Complaint IN00188017</p> <p>3.1-41(a)(1)</p> <p>483.25(h)<br/>FREE OF ACCIDENT<br/>HAZARDS/SUPERVISION/DEVICES<br/>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure resident were free from accidents related to a fall out of bed which resulted in a fracture and failed to ensure the correct wheelchair and interventions were in place for a resident with a history of falls for 2 of 3 residents reviewed for accidents. (Resident #23 and #169)</p> <p>Findings include:</p> | F 0323        | <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R-23 was sent to hospital for evaluation, and facility completed investigation for fall. R-169</b></p> | 02/10/2016           |

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|   | <p>1. On 1/06/16 at 1:19 p.m., Resident #23 was observed sitting up in a broda wheelchair. At that time, the resident was observed with a sling to the right arm.</p> <p>The record for Resident #23 was reviewed on 1/07/16 at 1:44 p.m. The resident's diagnoses included but were not limited to, displaced fracture of right humerus, right sided hemiplegia, weakness, dysphasia, high blood pressure, pulmonary embolism, traumatic subdural hemorrhage, chronic pain, and muscle weakness.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 12/15/15 indicated the resident was severely impaired for decision making. The resident needed extensive assistance with a 2 person physical assist for bed mobility, transfers, and dressing. The resident had no history of falls since admission.</p> <p>A fall risk assessment dated 12/8/15 indicated the resident was a high risk for fall with a score 18.</p> <p>The current plan of care dated 12/17/15 indicated the resident was at risk for falls related to the medication profile and disease process.</p> |   | <p><b>dycem was given to the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who are a fall risk have the potential to be affected by the same alleged deficientpractice. What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur; Thefacility staff (guardian angels) completed rounds on all facility residents toensure that interventions listed on the resident care cards are in place. Anyintervention found not to be in place was immediately corrected. Nursingstaff routinely observes residents in bed during rounds. Resident noted to bein need of repositioning are immediately repositioned. Nursingstaff and C.N.A. staff were in-serviced on:</b></p> <ul style="list-style-type: none"> <li>·Properly positioning residents in center of the bed before leavingresident room.</li> <li>·Checking care card and ensuring fall interventions are in place forresident – in their room, wheelchair, etc. How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programs will be</li> </ul> |                      |   |

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|   | <p>Nurse's Notes dated 12/17/15 at 12:10 p.m., indicated "Writer seen by wound nurse. Resident placed on right side in middle of bed and noted to be in need of complete change. Writer went to get supplies and help. Writer returned and resident has slid from bed unwitnessed onto floor. No bleeding or apparent injuries noted. Physician notified and resident sent out for X-rays and evaluation." (sic)</p> <p>The resident returned to the facility on 12/23/15 with a new diagnosis of fracture of the right humerus. The X-ray report dated 12/17/15 from the hospital of the right shoulder indicated "post fall with injury. Impression: Non displace acute fracture through the greater tuberosity of the right humerus.</p> <p>The fall audit provided by the Director of Nursing was reviewed on 1/08/16 at 11:08 a.m. The report indicated the resident had slipped off the air mattress and fell to the floor on 12/17/15 at 12:10 p.m.. The resident was found on the floor, laying on the right side (weak side) in the resident room alone and unattended. The resident was not in the middle of the bed when left alone. The resident was left in bed on her side near the edge and rolled off bed.</p> |   | <p>put into place;</p> <p>The unit manager/designee will observe 5 residents in bed per floor weekly on alternative shifts to ensure residents are properly positioning in the bed. Any resident found to be improperly positioned will immediately be repositioned by staff. Unit manager/designee will randomly audit 5 residents per floor weekly on alternative shifts to ensure that fall interventions are in place and is on the care card.</p> <p>DON/designee will present a summary of the audits/resident observations to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. <b>INFORMAL DISPUTE RESOLUTION F323</b></p> <p>It is the position of Munster Med-Inn that the findings reported in the Annual Survey are incomplete and in places inaccurate. The facility is presenting compelling information to dispute the deficiency of F323 and respectfully requests your careful consideration in reducing the scope and severity of the tag.</p> <p>On 1/12/2016 ISDH completed an annual survey citing the facility F323 at a 'G' level alleging the facility failed to:</p> <ul style="list-style-type: none"> <li>·Ensure resident was free from accidents related to a fall out of bed which resulted in fracture.</li> </ul> <p>Munster Med-Inn contends they</p> |                      |   |

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|   | <p>Interview with the Restorative Nurse on 1/08/16 at 11:38 a.m., indicated the resident was not a large person, but had a bigger abdomen and being left on one of her sides was too close to the edge of the bed and she had a greater chance of rolling out of bed. She indicated the resident did not have side rails on the bed just assist rails (Halos). She further indicated the resident had right sided weakness and therefore could not move her arm on that side. The Restorative Nurse indicated the wound nurse should have repositioned the resident back to the middle of the bed and on her back to ensure she was in the middle of bed before she left the room to get more supplies.</p> <p>Interview with the Director of Nursing on 1/11/16 at 11:20 a.m., indicated the resident should have been placed on her back and not left on her side when the nurse had left the room.</p> <p>Interview with Wound Nurse #1 on 1/12/15 at 8:50 a.m., indicated she was the wound nurse taking care of the resident that day. She further indicated the resident was left on her right side when she left the room and was not placed in the middle of the bed.</p> |   | <p>provided a safeenvironment and adequate supervision and assistance as possible to preventaccidents for R23. As stated in the 2567, R23 has right sided hemiplegia. Also stated in the 2567, the nurse's note dated 12/17/15 at 12:10pm, indicated that the wound nurse placed R23 onto her right side in the middle of bed and noted to be in need of complete change. Wound nurse went to get supplies and help. Upon wound nurse return, R23 had slid from the bed unwitnessed onto floor. No bleeding or apparent injuries noted. Physician notified and R23 sent out for x-rays and evaluation. These statements from the surveyor clearly shows that R23 was positioned onto her right side andwas in the middle of the bed. What the 2567 fails to mention is that R23'sphysician was in the facility on 12/17/15 after the incident occurred, and assessed R23 prior to her being sent to the hospital. As per physician progress note, there was no obvious signs of trauma or hematoma or bleeding (Attachment A). In the 2567, it is written that R23 returned tothe facility on 12/23/15 with fracture of the right humerus. What the 2567 fails to mention is that resident was seen by an orthopedic physician in the hospital and no surgical intervention was needed for the right humerus. Intervention that</p> |                      |   |

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|   | <p>2. On 1/11/16 at 10:54 a.m., in the dining room, Resident #169 was observed in a wheelchair without a Dycem (non slip mat) to sit on.</p> <p>Interview with Unit Manager at that time, indicated the chair the resident was sitting in was not the resident's chair. The resident's chair had been washed over night and was placed in the shower room to dry. She further indicated that the resident should have a Dycem in the chair.</p> <p>Interview on 1/11/16 at 11:00 a.m., with LPN #2 indicated the resident had been up in the wheelchair about an hour.</p> <p>The resident's record was reviewed on 1/8/16 at 12:04 p.m. The resident's diagnoses included, but were not limited to, heart failure, hypertension, hip fracture, non Alzheimer dementia, unspecified dementia with behavioral disturbance, muscle weakness, heart murmur, pacemaker, and difficulty walking.</p> <p>The 14 day Minimum Data Set (MDS) assessment dated 12/25/15, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 with severe impairment.</p> |   | <p>was put in place for R23's right arm was to protect right arm with a sling (Attachment B). Also in the hospital x-ray report of the right shoulder stated that the resident has severe arthritic changes, calcifications, and sclerosis (Attachment C). Also the resident has a diagnosis of osteoarthritis that was not mentioned in the 2567 but is on R23's facility face sheet (Attachment D). In addition, it is written in the 2567 that the resident was not in the middle of the bed when left alone, and that the resident was left in bed on her side near the edge and rolled off bed. This is inaccurate. The 12/17/15 fall event and progress note completed by the wound nurse states that R23 was being seen for wound care. R23 was placed onto her right side in middle of the bed when noted R23 was in need of complete change (Attachment E and F). So R23 was positioned appropriately in the bed, she was turned towards her right side (weakside). R23 has bilateral halos on bed and is able to hold on to halo with left hand. Prior to the wound nurse leaving the room to gather additional supplies and assistance, R23 was on her right side in the middle of the bed. As written in the 2567, interviews were completed by the surveyor separately with the restorative nurse, director of nursing, and wound nurse #1 in regards to</p> |  |  |   |  |

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|   | <p>The Care Plan dated 12/12/15 was reviewed. It indicated the resident was at risk for further falls related to the education profile and disease process. The resident has a history of falls with hip pinning. The interventions were to apply bed bolsters to residents bed, place floor mats next to bed while resident was in bed, keep call light in reach at all times, and maintain bed in lowest position. The care plan interventions were updated on 1/2/16 to include a Dycem in the resident's wheelchair.</p> <p>Nursing Progress Notes dated 1/2/16 at 9:00 a.m., indicated while resident was sitting up in her wheelchair near nurses station she was noted reaching for something on the floor (nothing on floor) and accidentally fell out of her wheelchair. Resident was assessed and noted to have a 1.0 cm x 0.5 cm laceration above right eye with some swelling, and small amount of bleeding. No further injuries noted, residents range of motion within normal limits, no complaints of pain, resident said she did not know what she was reaching for. Called Physician and received orders for Bacitracin and band aid to area above right eye. Called son POA (Power of Attorney) and informed.</p> <p>Another entry in Nursing Progress Notes</p> |   | <p>R23's incident. The interviews that are in the 2567 is a short summarization of what the surveyor paraphrased and does not include the entire interview and/or additional information that was discussed with these employees. The employees mentioned in the 2567 (restorative nurse, director of nursing, and wound nurse #1) was interviewed by facility staff and said, after they read the 2567, that their statements to the surveyor was "misquoted" and is "inaccurate" (Attachment G,H, and I). Further, the 2567 also fails to mention that the 12/17/15 fall was reported to ISDH. The initial report was sent to ISDH on 12/18/15 and the final report was sent to ISDH on 12/22/15. Facility completed investigation. Nurse interviewed and she stated she was preparing to complete a dressing change for R1. The nurse left the room to get additional supplies. Upon return, R1 was lying on the floor next to the bed. R1 was assessed by the nurse and no apparent injury noted. R1 is aphasic and unable to state how she fell. Physician assessed R1, and requested R1 to be sent to hospital for evaluation. R1 was admitted to the hospital with a right humerus fracture. R1 also has a recent history of CVA and is on Plavix 75mg daily. R1 remains out at the hospital at this time. R1's assessment and care plan to be</p> |                      |   |

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| F 0329<br>SS=D<br>Bldg. 00                          | <p>dated 1/3/16 at 8:40 a.m., indicated safety devices in place as ordered resident was alert and verbally confused, neurological checks were within normal limits.</p> <p>The facilities investigation dated 1-2-16 at 9:00 p.m., indicated the resident reached down to the ground and fell near the wheelchair. The mental status of the resident was confused and her psychological status was alert. The floor was dry and resident had shoes on. The last time the resident was taken to the toilet was at 6:30 p.m. The fall was witnessed by a staff member. Interventions for the future was to monitor the resident closely. Care plan updated. Falls team meeting notes was to add Dycem to the resident's wheelchair.</p> <p>3.1-45 (a)(2)</p> <p>483.25(l)<br/>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br/>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> |   | updated accordingly upon her return to the facility (Attachment J). The facility has shown compelling evidence that they provided a safe environment and adequate supervision and assistance as possible to prevent accidents for R23. It is with this in mind that we respectfully request that the scope and severity of F323 violation be reduced. |                      |   |

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|--------------------|--|---------------|--|----------------------|
|                    | <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 provide an adequate indication for the increase of Metoprolol (a medication used to lower the blood pressure and heart rate) for 1 of 6 residents reviewed for unnecessary medications. (Resident #C)</p> <p>Finding includes:</p> <p>The record for Resident #C was reviewed on 1/11/16 at 8:45 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety disorder, and dementia without behavioral disturbance.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 12/8/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was an 11, which meant she was moderately impaired for decision making. The</p> | F 0329        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>R-C's medication was reviewed with nurse practitioner, pharmacist, and family. The medication was adjusted.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> | 02/10/2016           |

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|--------------------|---|---------------|--|----------------------|
|                    | <p>resident was coded as having no behaviors. The resident needed extensive assist with a two person physical assist with bed mobility and transfers.</p> <p>The current plan of care dated 12/14/15 indicated the resident had the diagnosis of high blood pressure. The Nursing approaches were to administer Antihypertensive medication as ordered and monitor blood pressure as ordered.</p> <p>Physician Orders dated 12/1/15 indicated Metoprolol (a medication used to lower the blood pressure and heart rate) 25 milligrams (mg) daily. On 12/22/15 the Metoprolol 25 mg was discontinued by the Physician and the new order was for Metoprolol 25 mg twice daily.</p> <p>Nurse's Notes dated 12/22/15 at 6:58 p.m., indicated "Dr. (name) in facility, new order received for Metoprolol Tartrate 25 mg BID (twice daily)."</p> <p>Physician Progress Notes were reviewed. The first and last documented progress by the above mentioned Physician was on 12/3/15 and there was no information as to why the Metoprolol medication would have been increased.</p> <p>Nurse's Notes dated 1/5/16 by the Nurse Practitioner at 1:50 p.m. indicated</p> |               | <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The consultant pharmacist has reviewed all residents' medications since 1/1/2016. The pharmacist did not identify any resident that did not have a documented reason for the medication. All pharmacy recommendations will be given to the physicians/NP for review. The physician, nurse practitioner, or charge nurse is responsible for the documentation related to new medication orders or changes in medication dosages.</p> <p>The consultant pharmacist reviews each resident's medications monthly. This review includes medication interactions, side effects, diagnosis, behaviors, falls, use of psychoactive, lab and blood sugar results, and review post hospital for discrepancies, and reasons for use.</p> <p>The DON and In-service coordinator has inserviced the charge nurses, physicians and nurse practitioners regarding documentation required for any new medications and medication changes.</p> <p><b>How the corrective action(s) will be monitored to ensure the</b></p> |                      |

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|   | <p>resident seen and examined. The action and plan was "bradycardia decrease Metoprolol to 12.5 mg BID needs follow up with cardiology status post MI (Myocardial Infarction).</p> <p>The current 1/2016 Medication Administration Record indicated the resident was receiving Lisinopril (a medication used to lower blood pressure) 10 mg daily.</p> <p>The 12/2015 MAR indicated the resident's blood pressure was recorded once daily starting on 12/13/15. The resident's blood pressure was as followed:<br/>12/13-110/72<br/>12/14-118/78<br/>12/15-124/80<br/>12/16-126/82<br/>12/17-122/74<br/>12/18-120/74<br/>12/19-118/72<br/>12/20-126/78<br/>12/21-120/80<br/>12/22-120/65</p> <p>The resident's heart rate was not documented with the blood pressure.</p> <p>The vital signs were reviewed. The resident's pulse was documented two times after the increase of Metoprolol as followed: 12/26-60 and 12/27-60. There</p> |   | <p><b>deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>The consultant pharmacist will review 15 residents every month that have been prescribed a new medication or have had a change in medication to ensure reason for new medication or change in medication is documented. DON/designee will present a summary of the reviews to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |  |  |   |  |

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|                    | <p>was no further documentation of the resident's pulse in Nurse's Notes or in the vital signs after 12/27/15.</p> <p>Interview with the resident's Power of Attorney on 1/10/16 at 3:30 p.m., indicated she was not notified of the increase of the medication. She indicated the resident had been taking 12.5 mg twice a day for a total of 25 mg daily at home, and if she would have known about the increase she would have not given the approval.</p> <p>Interview with Director of Nursing on 1/12/16 at 11:22 a.m., indicated she had spoken with the Nurse Practitioner and she had no reason why the Physician would have increased the Metoprolol. The DoN also indicated the resident's heart rate was not monitored after the increase of medication and there was no documentation by the Physician on why medication was increased.</p> <p>Further interview with the DoN on 1/12/16 at 11:40 a.m., indicated the resident's Physician had just sent her a text message indicating his rationale for the medication increase was to better control her blood pressure.</p> <p>3.1-48(a)(4)</p> |               |   |                      |

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| F 0353<br>SS=E<br>Bldg. 00                          | <p>483.30(a)<br/>SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review and interview, the facility failed to ensure sufficient staffing was provided related to meal service on the units for 2 of 2 meals observed on the Second and Third floors. The facility also failed to ensure incontinence care was provided in a timely manner for 1 of 6 residents reviewed for activities of daily living. (The Second and Third floor and Resident #D)</p> <p>Findings include:</p> | F 0353  | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Obtained assistance of non-clinical staff to assist with passing trays. Resident was immediately toileted.</p> | 02/10/2016           |   |

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|                    | <p>1. On 1/5/15 the first meal cart arrived to the second Floor at 12:00 p.m. and the second cart arrived at 12:05 p.m. The first tray passed to the residents in their rooms was at 12:27 p.m. A CNA indicated the room trays were passed first to those residents who can feed themselves and then the trays were passed to the residents who needed to be fed. At 12:43 p.m., the first lunch tray was passed to the residents in the second floor dining room. The last tray passed to those residents who required assistance was at 12:56 p.m.</p> <p>2. On 1/07/16 at 9:02 a.m., CNA #6 was just passing the meal trays to the residents in the second floor dining room. The CNA indicated at that time, the trays arrived around 7:30 a.m., and they were just getting around to pass the trays to the residents who needed to be fed.</p> <p>Continued interview with CNA #6 on 1/7/15 at 10:30 a.m. stated "We get our assignments so late and there are residents that have to be up because of swallowing issues so we get them up first. We know the meal carts are sitting there, but we have to get up those residents first. When it starts to get later, we start to panic because the trays have not been passed. There are too many</p> |               | <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Nursing staff, C.N.A. staff, and non-clinical staff were in-serviced on meal service adjustment:<br/>         · Re-evaluated the amount of residents needing feeding assistance and staff was evenly distributed to assist residents with eating<br/>         · Non-clinical staff were assigned to floors to assist with passing off trays<br/>         · Seating was rearranged in dining rooms</p> <p>Nursing staff and C.N.A. staff were in-serviced on:<br/>         · Nursing assistant was assigned to assist with answering call lights and toileting residents during meal time.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p> |                      |

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|   | <p>residents who need to be fed. The nurses do not help pass the trays."</p> <p>3. On 1/08/16 at 7:25 a.m., the first meal cart arrived to the second floor. At that time, the CNAS had just received their assignments and were looking at the plan of care book regarding their residents. At 7:36 a.m., the second meal cart arrived to the second floor. At that time, the CNAS had begun getting residents up, and both nurses on the floor were starting to pass their medications. Both carts were plugged into the wall and left in the hallway.</p> <p>Continued observation indicated the first room tray out of the odd cart was at 7:48 a.m. by the Administrative Manager. Another CNA/Activity Aide and a Restorative CNA were observed passing the room trays to those residents who could feed themselves. At 7:56 a.m., the Social Worker for the second floor and the Administrative Manager were observed passing trays to the residents who could eat by themselves on the even side of the hall. At 8:21 a.m., the Social Worker indicated all the meal trays left in both carts (the odd and even) were for the residents who needed to be fed.</p> <p>Continued observation at 8:24 a.m., indicated the first tray was passed to the</p> |   | <p>i.e., what quality assurance programs will be put into place;</p> <p>Dietary Manager/designee will audit weekly for timeliness of meal pass for all meals.</p> <p>Unit manager/designee will audit weekly to ensure that call lights are answered and residents are toileted as needed during meal times.</p> <p>DON/designee will present a summary of the audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |                      |   |

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|                    | <p>residents in the second floor dining room. The last tray from both carts was passed at 8:49 a.m., to a resident in their room who required assistance and to be fed.</p> <p>Interview with the Second Floor Unit Manager on 1/8/16 at 9:00 a.m., indicated she was aware the meal service was slow. She further indicated there were 14 residents on the floor who needed to be fed. She indicated she was aware there was not enough staff to feed all those residents at the same time.</p> <p>Interview with the Director of Nursing (DoN) on 1/11/16 at 11:30 a.m., indicated there were 14 residents on the second floor and 7 residents on the third floor who were in need of being fed their meals. The DoN indicated there were other residents who needed assistance as well on both floors. She further indicated she would staff the unit with more CNAS but she did not have the staff to do it.</p> <p>4. On 1/7/16 at 12:34 p.m. the lunch trays were observed on the 3 odd hall. Trays were not being passed as this time. The Unit Manager took one tray from the cart and took it down the hall. At 12:37 p.m., residents were being taken into the 3rd floor dining room. Trays had not been passed in the unit dining room. At</p> |               |   |                      |

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|                    | <p>12:42 p.m., 13 residents were in the 3rd floor dining room. They still had not been served. The food cart on the even hall had not been served at this time as well. At 12:42 p.m., a CNA returned to the unit from lunch. Two CNA's started serving room trays from the odd hall cart. At 12:49 p.m., the Unit Manager took clothing protectors into the unit dining room which had still not been served. At 12:58 p.m., room trays were still being passed. At 1:02 p.m., the first tray was taken into the unit dining room. At 1:08 p.m., 34 minutes later, the last tray was taken into the unit dining room.</p> <p>5. On 1/8/16 at 7:55 a.m., both breakfast tray carts were delivered to the Third floor. At 7:56 a.m., the CNA Scheduler passed the first tray to Room 301. The next room tray served on the odd hall was Room 309 at 8:04 a.m. One CNA was passing room trays on the odd hall at this time. The Restorative aide was passing room trays on the even hall along with another CNA.</p> <p>A third CNA was also passing room trays on the even hall while one CNA continued to pass room trays on the odd hall. While the room trays were being passed, the CNA's often had to stop and get assistance for repositioning residents in bed. The two Nurses' on the unit were passing medications and were not able to</p> |               |   |                      |

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|                    | <p>help pass trays. The first tray taken into the dining room was at 8:28 a.m., 33 minutes after the trays arrived on the unit. Four residents ate in the unit dining room, the rest of the residents ate in their rooms. At 8:35 a.m., room trays were still being passed on both halls. At 8:46 a.m., CNA #7 indicated the last tray on the cart belonged to a resident who was a "feed" and she couldn't feed her yet. At 8:51 a.m., CNA #7 proceeded to help pick up hall trays instead of taking the tray to the resident's room. At 8:58 a.m., 63 minutes later, the last tray was served on the unit from the time carts arrived to the floor.</p> <p>6. On 1/8/16 at 7:24 a.m., Resident #D was seated in a wheelchair across from the Nurses' station. At 8:24 a.m., the resident was taken into the dining room. At 8:49 a.m., the resident was brought out of the dining room and placed across from the Nurses' station. At 9:35 a.m., the resident was taken to her room to receive her morning medications. At 9:37 a.m., the resident was brought back to the area across from the Nurses' station. At 10:20 a.m., the resident was taken to an activity in the Unit dining room. The resident remained in the activity until 11:50 a.m. After the activity, the resident was taken back to the area across from the Nurses' station.</p> |               |   |                      |

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|                    | <p>At 12:21 p.m., the resident remained seated across from the Nurses' station. At 12:28 p.m., the resident was taken to her room by CNA #2. The resident was transferred to bed at this time. The CNA removed the resident's incontinence brief and performed incontinence care. The resident's brief was damp and she was incontinent of stool, part of the stool was dried and adhered to the resident's buttocks.</p> <p>Interview with the CNA at the time, indicated this was the first time she was able to check the resident since she started her shift at 7:00 a.m. The CNA also indicated that she had two or three more residents to get out of bed and it was hard to get things done with only four CNA's scheduled on the unit.</p> <p>Interview with the Director of Nursing on 1/8/16 at 2:00 p.m., indicated the resident should have been checked for incontinence in a more timely manner.</p> <p>This Federal Tag relates to Complaint IN00188017.</p> <p>3.1-17(a)</p> |               |   |                      |

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| F 0371<br>SS=E<br>Bldg. 00                          | <p>483.35(i)<br/>FOOD PROCURE,<br/>STORE/PREPARE/SERVE - SANITARY<br/>The facility must -<br/>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br/>(2) Store, prepare, distribute and serve food under sanitary conditions<br/>Based on observation, record review and interview, the facility failed to ensure left over food was discarded as well as food being dated when opened. The facility also failed to ensure staff did not touch food while being served from the the steam table for 1 of 1 meals observed in the Main Dining Room. (The Main Kitchen and the Main Dining Room)</p> <p>Findings include:</p> <p>1. During the Initial Kitchen Sanitation tour on 1/4/16 at 6:15 p.m., with the Clinical Dietary Manager, indicated the following:</p> <p>a. A plastic container in the reach in cooler contained mandarin oranges. The oranges were covered with plastic wrap and dated 12/30/15.</p> <p>b. In the walk in cooler, a stainless steel container was observed with diced ham. The top of the container was not covered all the way and the writing on the plastic wrap indicated "diced ham for breakfast</p> | F 0371  | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>1. The Following were discarded immediately during the initial Observation, Mandarin Oranges, Dated 12/30/15, Diced Ham dated 12/28/15, Lima Beans dated 12/30/15 and the Bag of Chicken Tenders with No Date</p> <p>2. Dietary Employee #1 and the rest of Dietary Staff was reeducated on the following Policy and Procedure</p> <ul style="list-style-type: none"> <li>· Dating and Labelling Food (Opened and Unopened)</li> <li>· Leftover Policy</li> <li>· Safe Food Preparation and Handling</li> </ul> <p>1. New date marking system implemented.</p> <p>2. Staff education given on the proper use of each label and the Use by Date chart explained</p> | 02/10/2016           |   |

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|   | <p>and dated 12/28/15.</p> <p>c. There was a stainless steel container of lima beans dated 12/30/15.</p> <p>d. A clear plastic bag of chicken tenders was half full and not dated.</p> <p>Interview with the Clinical Dietary Manager at the time, indicated left overs should not be kept for more than three days.</p> <p>The facility "Leftover" policy was reviewed on 1/11/16 at 12:10 p.m., the policy was provided by the Dietary Food Manager and identified as current. The policy indicated leftover foods may be stored at 41 degrees Fahrenheit in the refrigerator for up to 3 days (72 hours) and then must be discarded.</p> <p>The facility "Labeling and Dating Foods" policy was reviewed on 1/11/16 at 12:12 p.m., the policy was provided by the Dietary Food Manager and identified as current. The policy indicated commercially processed foods that have been prepared and packaged by a food processing place will be labeled with the date it is opened. This will be discarded by the 3rd day or by "Best Used By" date.</p> <p>2. On 1/5/16 at 12:00 p.m., Dietary</p> |   | <p>3. Designated staff will be responsible to check the refrigerator and freezer to ensure that all foods are properly labeled and discarded based on the use by date timely.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents in the facility have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>1. The Dietary Manager and dietary staff have been re-educated regarding the importance of dating and labelling all unopened and opened food items timely.</p> <p>2. A Designated staff will be in charge to check the refrigerator and freezer during the initial round to ensure that all food items have proper labels and food discarded based on the use by date, prior to closing.</p> <p>3. Dietary Manager will continue education on a monthly basis for a minimum of 3 months.</p> <p>4. Meal Rounds will be conducted to ensure proper utensils are being used during Meal Service</p> <p><b>How the corrective action(s) will be monitored to ensure the</b></p> |                      |   |

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|   | <p>Employee #1 was observed serving food from the steam table in the Main dining room. The Dietary Employee was wearing a pair of blue disposable gloves. As she was serving, she would touch the edge of the plates, serving utensil handles and get items out of the reach in cooler. The Dietary Employee was not observed to change her gloves. At 12:14 p.m., the Dietary Employee was observed to place tongs into a bag of rolls, however, after the roll was removed, the employee touched the roll with her gloved hand and put it on the plate. She continued to do this for the duration of the tray line.</p> <p>Interview with the Dietary Food Manager and the Dietary Consultant on 1/11/16 at 11:15 a.m., indicated the server should not have touched the roll with her gloves after touching everything else.</p> <p>The facility "Safe Food Preparation and Handling" policy was reviewed on 1/11/16 at 12:10 p.m. The policy was provided by the Dietary Food Manager and identified as current: The policy indicated strict personal hygiene will be followed. Employees will avoid direct contact (i.e.) using bare hands with ready to eat foods. If gloves are used, they will be single-use gloves.</p> <p>3.1-21(i)(3)</p> |   | <p><b>deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>1. Dietary Manager/designee, will perform at least four random audits on a weekly basis for a minimum of three months to ensure dietary staff compliance that all food items either opened or unopened has proper labels.</p> <p>2. Designee, will record these audits on the "Dating and Labelling Audit Tool Form. Included will be any issues that were discussed and addressed with the dietary staff for further counseling and education.</p> <p>3. The findings of these audits will be reviewed at the Quality Assurance Committee meetings throughout the next quarter and then will be determined if there is a need for continuation.</p> <p><b>Completion Date: 2/1/2016</b></p> |  |  |   |  |

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| F 0441<br>SS=E<br>Bldg. 00 | <p>483.65<br/>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br/>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread</p> |               |   |                      |

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|   | <p>of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure hand washing was completed after glove removal for 2 of 4 observations of incontinence care. The facility also failed to ensure urinals, bed pans and wash basins were stored properly on 3 of 5 units throughout the facility. (Residents #D and #H and the 1st, 2nd and 4th floors)</p> <p>Findings include:</p> <p>1. On 1/7/16 at 2:15 p.m., CNA #1 was observed providing incontinence care for Resident #D. The resident was soiled with stool at this time. While providing incontinence care, stool got on the CNA's disposable glove. At 2:28 p.m., the CNA removed her gloves and then left the resident's room to obtain more linen. After returning to the resident's room, the CNA put on another pair of gloves. The resident was repositioned in bed at this time. After repositioning the resident, the CNA removed her gloves, took the pillow case which contained the soiled linen and went to the Soiled utility room. The CNA again did not wash her hands nor use an alcohol based hand gel prior to leaving the room.</p> <p>Interview with the Director of Nursing on</p> | F 0441  | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Employees were educated on hand washing when it occurred. Items were removed from the rooms. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursing staff and C.N.A. staff were in-serviced on:</p> <ul style="list-style-type: none"> <li>·Glove removal and hand washing</li> <li>·Storage of wash basins, urinals, and bed pans</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>Staff Developer/designee will randomly audit 15 staff members</p> | 02/10/2016   |  |   |  |

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|   | <p>1/11/16 at 10:00 a.m., indicated the CNA should have washed her hands after removing her gloves.</p> <p>2. On 1/6/16 at 10:39 a.m., two bed pans were stored inside each other and placed behind the towel rack in the bathroom of Room 104. One resident resided in this room.</p> <p>3. On 1/6/16 at 8:37 a.m., a urinal was on the over bed table in Room 113. There was urine in the urinal and the lid was not closed. The resident's breakfast tray was also on the over bed table at this time. At 8:45 a.m., the resident's breakfast tray was removed from his room but his urinal was not emptied. One resident resided in this room.</p> <p>4. On 1/6/16 at 8:47 a.m., a urinal in the bathroom of Room 115 was hanging from the grab bar in the bathroom and was not covered. One resident resided in this room.</p> <p>5. On 1/5/16 at 2:25 p.m., two pink wash basins were located on the shelf in Room 215. The wash basins were not covered at this time.</p> <p>On 1/11/16 at 1:45 p.m., two pink wash basins were stacked inside each other on the shelf in the room. Two residents</p> |   | <p>weekly on alternative shifts to ensure appropriate glove removal and handwashing technique is demonstrated. Director of Environmental Services/designee will randomly audit 30 rooms weekly to ensure wash basins, urinals, and bed pans are stored properly in resident's room. Staff Developer/designee will present a summary of the audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |  |  |   |  |

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|                    | <p>resided in this room.</p> <p>6. On 1/6/16 a 9:14 a.m., a urinal was hanging from the grab bar in the bathroom of Room 401. The lid was open and the urinal was not covered. Two residents resided in this room.</p> <p>Interview with the Director of Nursing on 1/11/16 at 3:20 p.m., indicated the bedpans, urinals, and wash basins should have been stored properly.</p> <p>The Bedpan/Urinal, Offering/Removing policy was reviewed on 1/11/16 at 3:20 p.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated the following:</p> <p>- "If the resident keeps his urinal at his bedside, check it frequently. Empty and clean it as necessary."</p> <p>- "Assistance with a bedpan: Remove the bedpan from the bedside stand."</p> <p>- "Clean wash basin and return to designated storage area."</p> <p>7. On 1/05/16 at 10:14 a.m., Resident #H was observed in bed laying on her back. At that time, LPN #4 was performing a skin assessment on the resident. The</p> |               |   |                      |

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|                    | <p>LPN donned a pair of clean gloves and placed them on both of her hands. The Second Floor Unit Manager and the LPN rolled the resident onto her right side to remove the incontinent brief. The brief was soiled with a large amount of brown liquid bowel movement. The LPN indicated she would have to get some supplies to change the resident. The LPN removed her gloves and threw them away, walked out of the room to the clean linen cart. She then proceeded to lift the cart cover and touch the clean linens on the cart and obtained a couple of towels and washcloths. She walked back into the room and donned another pair of clean gloves. The LPN did not wash her hands with soap and water or use alcohol gel to either one of her hands after she removed the gloves and before she donned another pair of clean gloves to her hands.</p> <p>Interview with LPN #4 on 1/12/16 at 8:40 a.m., indicated hands were to be washed with soap and water or hand gel after the removal of gloves.</p> <p>The current 11/2013 Hand washing/Hand Hygiene Policy indicated "When hands are not visibly soiled, employees may use an alcohol-based hand rub containing 60-95% ethanol or isopropanol in all of the following situations: before donning</p> |               |   |                      |

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| F 0465<br>SS=B<br>Bldg. 00 | <p>gloves and after removing gloves."</p> <p>Interview with the Director of Nursing on 1/12/16 at 10:09 a.m., indicated the nurse should have washed her hands with soap and water or used alcohol gel before and after glove removal.</p> <p>3.1-18(b)(1)</p> <p>483.70(h)<br/>SAFE/FUNCTIONAL/SANITARY/COMFOR<br/>TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional environment related to marred walls, mirrors, cracked light fixtures, and lime build up on faucets on 3 of 5 units throughout the facility. (The 2nd, 3rd, and 4th floors)</p> <p>Findings include:</p> <p>1. During the Environmental tour on 1/11/16 at 1:40 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>The Second floor</p> | F 0465        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Specific corrective action 2nd floor 1A, 1B, 1C, 1D, 1E, 3rd floor 1B and 1C. Faucets in rooms 209, 211, 215, 223, 224, 309 and 310 were replaced. 2nd floor 1A and 1B. Faucet stem in room 209 and 211 replaced to increase flow of hot water. 3rd floor 1A. Towel</p> | 02/10/2016           |

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|   | <p>a. There was lime build up on the bathroom sink faucets in Room 209. The stream for the hot water was also slow. Two residents resided in this room.</p> <p>b. There was lime build up on the bathroom sink faucets in Room 211. The stream for the hot water was also slow. Two residents resided in this room.</p> <p>c. There was lime build up on the bathroom sink faucets in Room 215. Two residents resided in this room.</p> <p>d. There was lime build up on the bathroom sink faucets in Room 223. Two residents resided in this room.</p> <p>e. There was lime build up on the bathroom sink faucets in Room 224. Two residents resided in this room.</p> <p>The Third floor</p> <p>a. The towel rack in the bathroom of Room 301 was loose. Two residents resided in this room.</p> <p>b. There was lime build up on the bathroom sink faucet in Room 309. The plastic light cover in the bathroom was also cracked. Two residents resided in this room.</p> |   | <p>rack tightened in room301 bathroom. 3rd floor 1B,1D. Plastic light cover in bathroom ofroom 309 and 327 was replaced. 3rdfloor 1C Mirror in bathroom of room310 replaced. 4th floor1A Wall behind head of bed one in room405 has been repaired 4thfloor 1B. The areas behind head of bed and under hand washing sink in room 409repaired.</p> <p><b>How the facility will identify other residents having the potential to be affected bythe same deficient practice and what corrective action will be taken;</b></p> <p>All residentshave the potential to be affected by the same alleged deficient practice. Maintenanceand Environmental Services have performed rounds on each unit to ensure a safe,functional, sanitary and comfortable environment.</p> <p><b>What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur;</b></p> <p>Nursingand environmental services staff have been in-serviced on the procedure ofnotifying maintenance of any necessary repairs.</p> <p><b>How the corrective action(s)</b></p> |                      |   |

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| F 0520<br>SS=E<br>Bldg. 00                          | <p>c. The mirror in the bathroom of Room 310 was discolored around the edges. There was also lime build up on the bathroom sink faucet. Two residents resided in this room.</p> <p>d. The plastic light cover in the bathroom of Room 327 was cracked. Two residents resided in this room.</p> <p>The Fourth floor</p> <p>a. The wall behind the head of bed one in Room 405 was marred and the base board was loose and peeling away from the wall. Two residents resided in this room.</p> <p>b. Large areas of white spackle were observed behind the head of bed one in Room 409. The wall below the hand washing sink was scratched and marred. Two residents resided in this room.</p> <p>Interview with the Maintenance and Housekeeping Supervisors at the time, indicated all of the above areas were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.75(o)(1)<br/>QAA COMMITTEE-MEMBERS/MEET<br/>QUARTERLY/PLANS</p> |   | <p><b>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Environmental Services Supervisor/designee will audit 6 rooms per week, per unit, for maintenance repairs, forwarding any identified concerns to Maintenance for correction.</p> <p>Environmental Services Supervisor will submit the weekly audit results to the Administrator.</p> <p>Administrator/designee will present a summary of audits to the QA committee monthly x 9 months. After 9 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> |                      |   |

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|                    | <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 record review and interview, the facility failed to identify non-compliance for sufficient staffing during meals and providing incontinence care timely through the quality assurance protocol.</p> <p>Findings include:</p> <p>1. Interview with the Administrator on 1/12/16 at 10:40 a.m., indicated the facility's Quality Assurance Committee meets every month and consists of himself, the Director of Nursing (DoN), the Medical Records Supervisor and</p> | F 0520        | <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Facility held QAPI meeting. The alleged staffing concerns were addressed to develop a system related to having a sufficient number of staff for meals and daily care of residents. Obtained assistance</p> | 02/10/2016           |

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|   | <p>department heads. The Medical Director and the Pharmacy met with the facility on a quarterly basis. The Administrator indicated at that time, sufficient staffing had not been formally discussed, addressed or identified as being a problem in Quality Assurance. He further indicated there had been no action plan or system put into place to identify the problem of sufficient staffing to provide timely meal service and daily care for the residents.</p> <p>Interview with the Medical Records Supervisor at that time, indicated the last Quality Assurance meeting was on 12/23/15. She indicated they had just started talking about and looking looking for an action plan to place a non nursing manager on each floor to help with meal service. She indicated they were trying to get a group together for tray pass process for management staff to assist with meals but nothing had been put into action at that time.</p> <p>Interview with Director of Nursing on 1/11/16 at 11:30 a.m., indicated there were 14 residents on the second floor who were in need of being fed their meals. She further indicated she would staff the unit with more CNAS but she did not have the staff to do it.</p> |   | <p>of non-clinical staff to assist with passing trays. Resident was immediately toileted. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Nursingstaff, C.N.A. staff, and non-clinical staff were in-serviced on meal serviceadjustment:</p> <ul style="list-style-type: none"> <li>·Re-evaluated the amount of residents needing feeding assistance and staffwas evenly distributed to assist residents with eating</li> <li>·Non-clinical staff were assigned to floors to assist with passing oftrays</li> <li>·Seating was rearranged in dining rooms Nursingstaff and C.N.A. staff were in-serviced on:</li> <li>·Nursing assistant was assigned to assist with answering call lights and toileting residents during meal time. How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programs will be put into place;</li> <li>Dietary Manager/designee will audit weekly for timeliness of meal pass. Unit</li> </ul> |                      |   |

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|                    | <p>Continued interview with the Director of Nursing on 1/12/15 at 10:50 a.m., indicated the facility has had job fairs, increased the wages for Licensed staff only and just recently authorized a sign on bonus for CNAS.</p> <p>2. On 1/07/16 at 9:02 a.m., CNA #6 was just passing the meal trays to the residents in the second floor dining room. The CNA indicated at that time, the trays arrived around 7:30 a.m., and they were just getting around to pass the trays to the residents who needed to be fed.</p> <p>Continued interview with CNA #6 on 1/7/15 at 10:30 a.m. stated "We get our assignments so late and there are residents that have to be up because of swallowing issues so we get them up first. We know the meal carts are sitting there, but we have to get up those residents first. When it starts to get later, we start to panic because the trays have not been passed. There are too many residents who need to be fed. The nurses do not help pass the trays."</p> <p>Interview with the Second Floor Unit Manager on 1/8/16 at 9:00 a.m., indicated she was aware the meal service was slow. She further indicated there were 14 residents on the floor who needed to be fed. She indicated she was aware there</p> |               | <p>manager/designee will audit weekly to ensure that call lights are answered and residents aretoileted as needed during meal times. DON/designee will presenta summary of the audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for whattime period. Review of staff levels and census levels to ensure required staffing levels are maintained. This included looking at staff recruitment, resident acuity, etc. This will be ongoing</p> |                      |

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|   | <p>was not enough staff to feed all those residents at the same time.</p> <p>Interview with the Director of Nursing (DoN) on 1/11/16 at 11:30 a.m., indicated there were 14 residents on the second floor and 7 residents on the third floor who were in need of being fed their meals. The DoN indicated there were other residents who needed assistance as well on both floors. She further indicated she would staff the unit with more CNAS but she did not have the staff to do it.</p> <p>3.1-52(b)(2)</p> |   |   |                      |   |