

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155361	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2012
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NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 20, 21, 22, 23, 24, 27, 28, 2012</p> <p>Facility number: 000252 Provider number: 155361 Aim number: 100267780</p> <p>Survey team:</p> <p>Carole McDaniel RN TC Terri Walters RN Martha Saull RN Dorothy Watts RN [February 27, 28, 2012]</p> <p>Census bed type: SNF 13 SNF NF 46 Total 59</p> <p>Census Payor type: Medicare 11 Medicaid 26 Other 22 Total 59</p> <p>Stage II Sample: 21</p> <p>These deficiencies reflect state findings</p>	F0000	<p>The submission of this plan of correction does not indicate an admission by the Amber Manor Care Center that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Amber Manor Care Center. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p>	

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

TITLE

(X6) DATE

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

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	cited in accordance with 410 IAC 16.2. Quality review completed 3/1/12 Cathy Emswiller RN			

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F0159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount</p>				

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	<p>in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview, the facility failed to provide access to resident funds on week-ends and evenings for 1 of 5 residents who met the criteria for access to resident funds in the Stage 2 sample of 30. Resident # 45</p> <p>Finding include:</p> <p>During interview on 2/21/2012 at 4:25 P.M., Resident #5 indicated he not did have access to his money on week-ends. He indicated he gets his money from the business office, but it is not open on the week-ends. He indicated, "If you need money on the week-ends, too bad."</p> <p>During interview on 2/27/2012 at 1:45 P.M. the Business Office Manager indicated all the residents know what time we are here in the Business Office and when we leave. Most of the residents know in advance if they are going out over the week-end and will need funds. She also indicated, "If someone needs money in a hurry on the week-end or evening the staff will</p>	F0159	<p>F 159Resident #45 suffered no ill effects from the alleged deficiency.Completion Date 3-23-2012All other residents have the potential to be affected by the alleged deficiency therefore through systemic changes stated below the campus will ensure the campus provides access to the resident funds on weekends and evenings.Completion Date 3-23-2012All nurses have been in serviced on the residents right to access of resident's funds on weekends and evenings and system for this access.Systemic change is there will be an amount of money kept in the west nurse's narcotic box for resident access on weekends and evenings.Completion Date 3-23-2012BOM/designee will complete resident questionnaire on 2 random residents 3x a week x one month concerning access to funds then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completi on Date 3-23-2012</p>	03/23/2012

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	<p>call me and I will come in."</p> <p>During interview on 2/28/2012 at 9:16 A.M., the Business Manager indicated there was no access to funds on week-ends, but she had asked the Internal Audit Office to check into it.</p> <p>3.1-6(f)(1)</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the</p>	F0225	F 225 Resident # 66 and #85 suffered no ill effects from the alleged deficiency. The Executive	03/23/2012			

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	<p>facility failed to ensure all allegations of abuse were identified and reported to the facility administrator for 1 of 1 known allegations of abuse from a Stage 2 sample of 15.</p> <p>Resident #66, Resident #85</p> <p>Findings include:</p> <p>On 2/20/12 at 12:30 P.M. Resident #66 was interviewed. This resident was observed to be in her wheelchair with her oxygen on per nasal canula. The resident indicated her husband is her roommate and they both eat meals in their room. She indicated she had a little girl the other day that was rude to her husband. Resident #66 indicated they didn't give her husband (Resident #85) what was on the menu. She indicated her husband was supposed to get a dessert that was on the menu and a fruit cup. She indicated instead they gave him (Resident #85) Ensure, in place of the dessert and fruit cup. Resident #66 stated "Always before, the staff would go get it (dessert) but this time, they didn't." Resident #66 indicated this CNA (certified nursing assistant) told the resident that she (the resident) would have to go to the kitchen and take care of this. The resident indicated this incident occurred approximately 3 nights ago, maybe and occurred during the evening meal. Resident #66 indicated she didn't know the CNA's (certified nursing assistants) name. Resident #66 indicated she wasn't going to put up with it again. The resident was upset that she got dessert but her husband didn't. Resident #66 indicated she told the staff member QMA #1 about the above incident.</p> <p>On 2/20/12 at 12:50 P.M., the Resident was</p>		<p>Director was informed of the allegation made to the surveyor on 2/20/2012 on 2/24/2012 and the Executive Director then followed the campus policy and reported the incident to the Indiana State Department of Health and began the investigation immediately. Completion Date 3-23-2012 All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure the abuse prevention policy is followed. Completion Date 3-23-2012 All campus staff has been in serviced regarding investigation procedures and requirements of reporting all allegations immediately to the Executive Director. Completion Date 3-23-2012 Systemic change is campus to complete quarterly in service concerning abuse prevention procedure. Completion Date 3-23-2012 ED/designee will administer a post test to 2 random campus staff to verify understanding of abuse prevention procedure 5x a week x one month 3x a week x one month then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 3-23-2012</p>		

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	<p>again interviewed. She indicated it was permissible to inform the facility of this incident. The resident stated "I'm not going to let myself get that upset again."</p> <p>On 2/24/12 at 10:50 A.M., the Administrator was interviewed. She indicated she was not aware of the above incident.</p> <p>On 2/27/12 8:15 A.M., the Administrator was interviewed. She indicated the facility had started an investigation.</p> <p>On 2/27/12 at 9:15 A.M., the Administrator provided a copy of the following undated document: "Abuse, neglect, misappropriation investigation." This form indicated the following: "Known, alleged, suspicion of abuse, neglect...Immediately...notify ED (Executive Director)..."</p> <p>On 2/27/12 at 2:45 P.M., the Administrator was interviewed. She provided a copy of the facility policy and procedure, dated 9/16/11, titled "Abuse and Neglect Procedure Guidelines." This policy included, but was not limited to, the following: "...Reporting: Any staff member...report known or suspected abuse, neglect...Immediately... complete an initial report..."</p> <p>3.1-28(c)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure all allegations of abuse were reported to the facility administrator according to facility policy and procedure for 1 of 1 known allegations of abuse from a Stage 2 sample of 15.</p> <p>Resident #66, Resident #85</p> <p>Findings include:</p> <p>On 2/20/12 at 12:30 P.M. the resident was interviewed. This resident was observed to be in her wheelchair with her oxygen on per nasal canula. The resident indicated her husband (Resident #85) is her roommate and they both eat meals in their room. She indicated she had a little girl the other day that was rude to her husband. Resident #66 indicated they didn't give her husband what was on the menu. She indicated her husband (Resident #85) was supposed to get a dessert that was on the menu and a fruit cup. She indicated instead they gave him Ensure, in place of the dessert and fruit cup. Resident #66 indicated always before, the staff would go get it (dessert) but this time, they didn't. Resident #66 indicated this CNA (certified nursing assistant) told the resident that she (the resident) would have to go to the kitchen and take care of this. The resident indicated this</p>	F0226	F 226Resident # 66 and #85 suffered no ill effects from the alleged deficiency. The Executive Director was informed of the allegation made to the surveyor on 2/20/2012 on 2/24/2012 and the Executive Director then followed the campus policy and reported the incident to the Indiana State Department of Health and began the investigation immediately.Completion Date 3-23-2012All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure the abuse prevention policy is followed.Completion Date 3-23-2012All campus staff has been in serviced regarding investigation procedures and requirements of reporting all allegations immediately to the Executive Director.Completion Date 3-23-2012Systemic change is campus to complete quarterly in service concerning abuse prevention procedure.Completion Date 3-23-2012ED/designee will administer a post test to 2 random campus staff to verify	03/23/2012			

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	<p>incident occurred approximately 3 nights ago, maybe and occurred during the evening meal. Resident #66 indicated she didn't know the CNA's (certified nursing assistants) name. Resident #66 indicated she wasn't going to put up with it again. The resident was upset that she got dessert but her husband didn't. Resident #66 indicated she told the staff member QMA #1 about the above incident.</p> <p>On 2/20/12 at 12:50 P.M., the Resident was again interviewed. She indicated it was permissible to inform the facility of this incident. The resident stated "I'm not going to let myself get that upset again."</p> <p>On 2/24/12 at 10:50 A.M., the Administrator was interviewed. She indicated she was not aware of the above incident.</p> <p>On 2/27/12 8:15 A.M., the Administrator was interviewed. She indicated the facility had started an investigation.</p> <p>On 2/27/12 at 9:15 A.M., the Administrator provided a copy of the following undated document: "Abuse, neglect, misappropriation investigation." This form indicated the following: "Known, alleged, suspicion of abuse, neglect...Immediately...notify ED (Executive Director)..."</p> <p>On 2/27/12 at 2:45 P.M., the Administrator was interviewed. She provided a copy of the facility policy and procedure, dated 9/16/11, titled "Abuse and Neglect Procedure Guidelines." This policy included, but was not limited to, the following: "...Reporting: Any staff member...report known or suspected abuse, neglect...Immediately... complete an initial report..."</p>		<p>understanding of abuse prevention procedure 5x a week x one month 3x a week x one month then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 3-23-2012</p>	

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F0247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review the facility failed to provide notice before roommate change to 1 of 1 resident who met the criteria in a Stage II sample of 21. Resident #74</p> <p>Findings include:</p> <p>During interview on 2/21/12 at 9:01 A.M., Resident # 74 indicated having had roommate changes without notification saying "They (facility staff) just brought them (new roommates) in."</p> <p>On 2/27/12 at 2:30 P.M., the Business Office Manager provided documentation which indicated roommate changes had occurred for Resident #74 on 1/17/12 and 2/06/12. Documentation was lacking in the clinical record to indicate Resident #74 had been notified of roommate changes before they occurred.</p> <p>During interview on 2/27/12 at 3:00 P.M. the Social Service Director indicated during interview that it was her responsibility to notify residents of</p>	F0247	F 247Resident # 74 has suffered no ill effects from the alleged deficient practice.Completion Date 3-23-2012All residents have the potential to be affected by the alleged deficient practice and therefore through alterations in processes and in servicing the campus will ensure it provides notification before a roommate change occurs.Completion Date 3-23-2012The Social Services Director has been in serviced on the need to notify every resident on a roomate change or a room change. Systemic change is the social services director or designee will complete a Notification of a New Roommate form prior to a change occurring and file it in the resident's medical record.Completion Date 3-23-2012ED/designee will audit for completion of the Notification of a New Rommate form for residents 5x week x one month then 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completi on Date 3-23-2012	03/23/2012			

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	<p>roommate changes. She indicate she usually had the resident sign the notification and it was then filed in the consent section of the medical record. She indicated documentation was lacking that she had provided the notices to Resident # 74.</p> <p>3.1-3(v)(2)</p>			

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on interview and record review, the facility failed to ensure a resident's restorative ambulation program was maintained as recommended for 1 of 1 residents reviewed for restorative ambulation in a stage 2 sample of 21. Resident #85</p> <p>Findings include:</p> <p>The clinical record of Resident #85 was reviewed on 2/23/12 at 10 A.M. Diagnoses included but were not limited to, the following: Chronic Obstructive Pulmonary Disease, Hypertension, Carcinoma.</p> <p>A Physical Therapy (PT) Discharge Summary, dated 12/19/11 indicated the following: "D/C (discharge) PT services per pts (patients) family request with restorative nursing to continue for ambulation."</p> <p>A "Restorative Program Plan" form, dated 12/19/11, indicated the following: "Goal: Resident will ambulate 120 feet bid (twice a day)</p>	F0311	<p>F 311 Resident #85 is currently receiving restorative nursing services and documentation is complete Completion Date 3-23-2012 All residents in the campus have the potential to be affected by the alleged deficient practice and through alterations and processes and in servicing the campus will ensure resident restorative programs are implemented timely and maintained. Completion Date 3-23-2012 In service nursing staff on restorative documentation on the kiosk and/or paper. Systemic change campus has initiated a paper form to use for documentation of restorative programs when kiosk is not functioning. ADHS/ designee will audit restorative minutes for compliance. Completion Date 3-23-2012 DHS/designee will perform random audits of 3 residents to assure restorative program is followed per plan of care. 5x a week x one month then 3x a week x one month then weekly thereafter with results being forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further</p>	03/23/2012	

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	<p>as tol (tolerated), with assistance of 1 staff with use of gait belt and rolling walker."</p> <p>A plan of care, dated 12/19/11, addressed the topic of "Ambulation." The goal was to: "...ambulate 120 feet bid x 7 days a wk (week) as tol (tolerated) by res (resident)."</p> <p>On 2/24/12 at 9:45 A.M., PT #2 was interviewed. She indicated the resident had PT (physical therapy) and OT (occupational therapy) discontinued on 12/19/11. PT #1 was also interviewed at this time. She indicated when a resident is dc'd (discontinued) from therapy, the therapy department completes a "Restorative care program" form. At this time, PT #1 and PT #2 provided a copy of the Restorative Care Program form for this resident. PT #2 indicated the "effective date" on the form, which was 12/19/11, indicated the resident was to have a restorative program started within 3 days of the 12/19/11 dc discharge date.</p> <p>On 2/24/12 at 10:10 A.M., the ADON was interviewed. She indicated the facility did have trouble with Kiosk (facility computer system used to document restorative services) at some point and they had to hand</p>		<p>suggestions/comments. Completion Date 3-23-2012</p>				

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	<p>write information. The ADON indicated the MDS (Minimum Data Set Assessment) Coordinator would look at this resident's file to see if anything was handwritten in regards to his restorative ambulation.</p> <p>On 2/24/12 at 11:25 A.M., the ADON was interviewed. She indicated they are unable to find documentation of the resident's weekly restorative for ambulation due to problems with the Kiosk system from 12/19/11 - 1-8-12.</p> <p>On 2/27/12 at 1:10 P.M., the MDS coordinator was interviewed. She indicated she was unable to locate documentation of the resident receiving and/or being offered ambulation for the time period of 12/19/11 to 1-7-12.</p> <p>On 2/27/12 at 1:15 P.M. the DON (Director of Nursing) and ADON (Assistant Director of Nursing) were interviewed. They indicated they had problems with the facility KIOSK computer program at times and this was the reason the KIOSK system was lacking documentation from 12/19/11 - 1/7/12. . At this time, they were made aware of the following KIOSK records: From the time period of 1/8/12 - 1/31/12 documentation was lacking for the following days of</p>				

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	<p>the resident receiving and/or being offered ambulation: 1/10, 1/11, 1/13, 1/15, 1/26, 1/27. For this time period, only 3 days was the resident documented as having ambulated twice. From the time period of 2/1/12 - 2/24/12 the following was documented: Documentation was lacking of any ambulation for 2/2, 2/18 and 2/23. Only 3 days during this time period was ambulation documented as occurring twice a day.</p> <p>On 2/27/12 at 2:51 P.M. the ADON provided a copy of the current policy for "Nursing Restorative and Functional Maintenance Program." This policy was undated. The policy included but was not limited to, the following: "The program will be supervised by a licensed nurse who will monitor progress and evaluate the program for changes...Restorative nursing will be available six to seven days per week or according to resident need to meet the program plan...Restorative programs will be delivered according to the established program plan..."</p> <p>3.1-31(a)(2)(B)</p>				

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F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with a range of motion impairment received restorative services for 1 of 2 residents who met the criteria for range of motion in the stage 2 sample of 21. Resident # 41</p> <p>Findings include:</p> <p>On 2/24/12 at 11:35 A.M., Resident #41's clinical record was reviewed. His current diagnoses included but were not limited to: CVA (cardiovascular accident/stroke) and left sided hemiparesis. His current Minimum Data Set Assessment (MDS) dated 12/12/11, indicated an impairment of range of motion of on one side of the upper and lower extremities.</p> <p>On 2/21/12 at 1:50 P.M., during interview of Resident #41's nurse, LPN #1 indicated Resident #41 had a contracture of the left lower arm.</p>	F0318	<p>F 318 Resident #41 is currently receiving restorative nursing services per therapy recommendations and documentation is complete Completion Date 3-23-2012 All residents in the campus have the potential to be affected by the alleged deficient practice and through alterations and processes and in servicing the campus will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Completion Date 3-23-2012 In service nursing staff on completion of range of motion assessment. Systemic change is campus will complete range of motion assessment on all residents now and quarterly thereafter to assess needs for a restorative program. Completion Date 3-23-2012 DHS/designee will perform random audits of 3 residents to assure restorative program is initiated if indicated 5x a week x one month then 3x a week x one month then weekly</p>	03/23/2012	

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	<p>On 2/24/12 at 9:10 A.M., CNA #1 was interviewed regarding Resident #41's nursing care. She indicated she and another CNA had assisted the resident after breakfast by a mechanical lift to bed. She indicated at this time that the resident had fed himself breakfast with his right hand. She also indicated that at times his left arm and hand had given him some discomfort.</p> <p>On 2/24/12 at 10:20 A.M., the Assistant Director Of Nursing (ADON) was interviewed regarding restorative care for Resident #41. The ADON indicated at this time a new resident restorative list had been initiated on 2/17/12.</p> <p>On 2/24/12 at 10:55 A.M., Resident #41 was observed holding his left hand in a closed position with the fingers and thumb extended but touching. The ADON was able at this time to slowly open the resident's closed left hand. She indicated at this time the resident was not on the facility 's current restorative program for range of motion or ambulation. She then provided a copy of the most current documentation of a restorative program for Resident #41. This documentation was a Physical</p>		<p>thereafter with results being forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 3-23-2012</p>		

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	<p>Therapy discharge summary dated 9/19/08. This discharge summary dated 9/19/08, had recommended range of motion for bilateral lower extremities.</p> <p>On 2/24/12 at 12:50 P.M., the ADON indicated that she would have the therapy department screen Resident #41 for a restorative program.</p> <p>2/27/12 at 8:27 A.M., Resident #41- was observed being pushed in his geri-chair by staff , his left hand was in a supine position with his hand closed and fingers and thumb touching.</p> <p>On 2/27/12 at 2:55 P.M. during interview with the ADON, she indicated the therapy had evaluated Resident #41. She indicated therapy had recommended bilateral range of motion of his upper and lower extremities to maintain current status. She indicated therapy would be inservicing staff regarding his range of motion program.</p> <p>3.1-42(a)(2)</p>				

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure drugs were necessary for 1 of 16 residents who met the Stage II criteria for unnecessary drug administration. Resident #52</p> <p>Findings include:</p> <p>The clinical record of Resident #52 was reviewed on 2/24/12 at 1:00 P.M. Diagnoses included but were not limited to Morbid obesity, Coronary</p>	F0329	F 329Resident #52 suffered no ill effects from the alleged deficiency. Completion Date 3-23-2012All residents have the ability to be affected by the alleged practice and through systemic changes below the campus will ensure each resident's drug regimen is free from unnecessary drugs.Completion Date 3-23-2012All nursing staff will be in serviced on the use of change of condition forms. Systemic change is use of the change of condition forms when a new	03/23/2012	

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	<p>Artery Disease, Type II Diabetes, Chronic Obstructive Airway Disease, Hypothyroidism, Chronic Back pain, Hypertension, Stress incontinence, Atrial fibrillation, Chronic Kidney Disease, Anxiety and Osteoarthritis.</p> <p>There was a physician order on 11/04/11 for Ativan 0.5 mg 3 times per day for 3 days. On 11/10/11 there was a physician order to continue the drug Ativan 0.25 mg twice daily on a routine basis for anxiety.</p> <p>Documentation was lacking to indicate what symptoms or behaviors had precipitated the orders, the onset of any problems, the response to the first 3 days of drug administration, or rationale for continuing routine dosage. Documentation was lacking of assessment to determine etiology or factors impacting the condition for which the resident was being treated.</p> <p>On 1/20/12 the Care Plan addressed Psychotropic Drug use for anxiety with a goal of keeping the resident free from drug related side effects and ensuring minimal doses. Interventions were related to those goals and included "educate resident/family on potential risks/benefits of psychotropic drug</p>		<p>antipsychotic medication is ordered. Social services will review all new psychotropic medication orders in the morning meeting. Completion Date 3-23-2012 SSD/designee will audit 3 random residents new psychotrpoic medication orders to assure appropriate assessment completed concerning psychosocial needs 5x a week then 3x a week x one month then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Competio n Date 3-23-2012</p>		

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	<p>use." The Care Plan did not provide psychosocial support interventions related to anxiety prevention and or coping mechanisms.</p> <p>Social Service Director (SSD) progress notes on 11/15/11 and 1/31/12 failed to address any issues related the onset of psychotropic drug use or anxiety.</p> <p>On 2/27/12 at 1:30 P.M. the SSD and the Director of Nursing were interviewed regarding the use of Ativan for Resident #52. They indicated it had been determined a family member had called the resident's physician and reported anxiety and neither the nursing staff nor social service had been involved in assessment, family or resident interview or counseling or development of strategies to ensure the necessity of the drug use. The SSD indicated she had not been informed the drug was ordered.</p> <p>3.1-48(a)(6)</p>				

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure the kitchen was maintained in a sanitary manner for 3 of 3 kitchen tours and the facility was using pasteurized eggs for 2 of 2 residents requesting soft cooked eggs and/or dispose of expired foods and/or label/date opened potentially hazardous foods. This deficient practice had the potential to effect 58 of the 59 residents who received food from the kitchen. Resident #5, Resident #22</p> <p>Findings include:</p> <p>During initial tour of the kitchen on 2/20/12 at 9:30 A.M. with the FSM (food service manager), the following was observed: The handwash sink was observed with a grayish tinge to the interior portion of the sink bowl. The faucet had a buildup of a tan colored residue around the edge and base of the handle mechanism. The ice machine, which was observed to have dried spills and splashes of white and dark matter scatter on the</p>	F0371	<p>F 371Residents # 5 and #22 suffered no ill effects from the alleged deficiencies. The kitchen has been cleaned and all items addressed on 2567 have been cleaned. Completion Date 3-23-2012All residents have the potential to be affected by the alleged deficiency therefore through systemic changes stated below the campus will ensure the kitchen is maintained in a sanitary manner. Completion date 3-23-2012All kitchen staff have been in serviced on policies concerning cleaning schedules, pasteurized eggs, dating and disposing of food, and storage of food items. Systemic change is a weekly sanitation audit by a manager Completion Date 3-23-2012ED/designee will complete a sanitation audit 5x a week x one month then 3x a week x one month then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 3-23-2012</p>	03/23/2012	

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	<p>exposed side. The ice machine was positioned on a divider wall between the cooking area and the dish room. The ice machine was located at the end of the wall, which was perpendicular to the clean dish area. The wall behind the ice machine was observed to have a covering of thick, clumpy dust. Several three tiered carts were observed in the kitchen. One cart was observed to be in the clean dish area of the kitchen and was observed to have clean, stacked dishes on trays sitting on the tiers of the cart. The cart was observed to have dried spills and spatters of varying color, dark, white throughout the base, handles and sides of the cart. Another 3 tiered cart, sitting beside the fryer, had a full tray of coffee mugs, positioned bottom side up on the bottom tier of the cart. This tray was observed to have a thick layer of dust on the edges and exposed area of the base of the tray. In the walk in freezer on a shelf was observed a shallow cookie sheet type pan which had several rolls of frozen ground beef stacked on it. The exposed area of the cookie sheet, which was approximately 6 inches, was littered with crumbs and other debris. The deep fryer was positioned directly next to the flat top grill in the kitchen. The exposed side</p>			

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	<p>of the grill was observed to have a thick build up of yellowish residue/grease and crumbs covering the exposed area,</p> <p>On 2/20/12 at 10 A.M., the walk in refrigerator was toured with the FSM (food service manager). An opened, large box of shelled eggs was observed on the bottom shelf. The box the eggs were stored in lacked documentation of the eggs being pasteurized. No markings were observed on the shelled eggs. The FSM was interviewed at this time and indicated the shelled eggs were supposed to be pasteurized and these were not. The FSM indicated if eggs were pasteurized it would be indicated on the egg or the box.</p> <p>At this time, a liquid egg container was observed opened and are labeled as pasteurized. No open date was documented on the container. The FSM indicated these were opened this morning and they aren't dated as they "go through them so fast." The FSN stated they do serve soft cooked eggs in the dining room upon request.</p> <p>At this time, a large pan of cooked meat loaf, was covered and dated 2/12/12. The FSM indicated this</p>			

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NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567		
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	<p>meat loaf needed to be thrown out. The FSM indicated there was 3/4 loaf of meat loaf left. Sitting beside this pan, was an opened bag of bologna. This bag was undated per the FSM.</p> <p>Just inside the walk in freezer on a shelf, were several stacked boxes with two bags of chicken tenders sitting in front of them. Both bags of chicken tenders were opened to air, not sealed. The FSM (food service manager) removed these bags. The top box, which had the flaps of cardboard torn off, contained frozen corn dogs. The bag of corn dogs was also opened to air. The FSM removed the box of corn dogs to reveal underneath another box of frozen hamburger patties. The inner bag of plastic, was opened, so the hamburgers were open to air. The FSM then, covered the hamburger patties, corn dogs and chicken tenders with plastic wrap.</p> <p>At 9:50 A.M., crumbs were observed on the shelves throughout the kitchen, under food prep tables and storage tables.</p> <p>On 2/20/12 at 10:40 A.M., the FSM and Cook #1 were interviewed. Cook #1 indicated there were usually 3 residents who requested soft cooked</p>				

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	<p>eggs in the morning. He indicated today, he could only remember 2 residents who got the soft cooked eggs. These were Resident #5 and Resident #22. At this time, was interviewed. She indicated the facility didn't have any residents currently with gastrointestinal signs and symptoms.</p> <p>On 2/20/12 at 11:10 A.M. a copy of the facility policy and procedure was obtained from the FSM (food service manager) titled "Eggs." This policy and procedure was undated but was identified by the FSM as current. This policy indicated that "egg products shall be obtained pasteurized."</p> <p>On 2/24/12 at 8:40 A.M. slices of commercially prepared cream pie were observed on sheet pans in the walk in refrigerator, which were uncovered.</p> <p>On 2/24/12 at 9:10 A.M. a copy of the facility policy and procedure for "Frozen Storage" was received. This policy was dated 2009. This policy indicated the following: "All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn. Items are labeled and dated...Frozen food equipment is routinely cleaned..."</p>				

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	<p>On 2/24/12 at 1:30 P.M., the Administrator was made aware of the continued observations of the initial tour of the kitchen. The bottom shelf, underneath the food prep table was observed to have clean, overturned pans resting directly on the shelf. Surrounding the exposed shelf surface around the overturned clean pans, was observed dust and crumbs. When a finger was drug over the exposed surface, clean tracks were visible and dirt/dust accumulation was observed on the finger. When a finger was also drug across the exposed surface of the tray on the bottom shelf of a cart, housing clean, overturned coffee mugs, clean tracks were observed, with accumulation of dust observed on the finger. Slices of the commercially prepared cream pie observed in the walk in refrigerator this morning at 8:40 A.M. were still observed uncovered at this time.</p> <p>At this time, the Administrator provided copies of the cleaning schedules which were hanging on the back door of the kitchen. This log was titled "Kitchen Cleaning/Walk Through List - A.M. Must be done before you leave." This form included, but was not limited to, the following months: December 2011 and January and</p>						

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	<p>February 2012. For the December 2011 log, of the 31 days, 9 were left blank regarding the check off of the completion of these tasks. For the January 2012 log, of the 31 days, 24 were left blank. On the February log, of the 24 days to date, 16 were left blank. This form included, but was not limited to, the following tasks: "clean out all sinks."</p> <p>The other log on the door, was titled "Kitchen Cleaning/Walk through - PM - Must be done before you leave." January 2012 log indicated 5 days of the 31 days, the cleaning had been documented as done. For the February 2012 log, two days were documented as having had cleaning done.</p> <p>On 2/28/12 at 10:30 A.M., the FSM provided a current copy of the "Deep Cleaning Schedule" for the kitchen. Documentation was lacking as to cleaning of the deep fryer and the carts. The FSM indicated the deep fryer is cleaned at least once a week and more often if necessary.</p> <p>3.1-21(i)(1) 3.1-21(i)(3)</p>				

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