

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2016
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NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00196015.</p> <p>Complaint IN00196015 - Substantiated. No deficiencies related to the allegation cited.</p> <p>Survey dates: March 28, 29, 30, 31, April 1 and 4, 2016</p> <p>Facility number: 000359 Provider number: 155566 AIM number: 100274920</p> <p>Census bed type: SNF: 9 NF: 56 SNF/NF: 4 Total: 69</p> <p>Census payor type: Medicare: 9 Medicaid: 56 Other: 4 Total: 69</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>F000 Warsaw Meadows Care Center respectfully requests that the following plan of correction be accepted as proof of compliance and render arevisit unnecessary. Submission of this plan of correction does not constitute an admission by Warsaw Meadows Care Center or their parent companies that the allegations contained in the survey report are a true and accurate portrayal of nursing care and other services at this facility. Nor does this submission constitute an admission of the survey allegations.</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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F 0241 SS=E Bldg. 00	<p>Quality Review completed by 14454 on April 8, 2016.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interviews, the facility failed to ensure staff in 1 of 3 dining rooms served and assisted residents in a dignified manner. This affected 4 of 12 residents who ate meals in the Heritage unit dining room. (Residents #1, #48, #61 and #47)</p> <p>Finding includes:</p> <p>During an observation of the noon meal, conducted on 03/28/16, from 11:33 A.M. thru 12:55 P.M., the following was noted:</p> <p>At 11:44 A.M., drinks were served to all residents in the dining room, except Residents #1, #48, and #61. A QMA (Qualified Medication Aide) #40 instructed the Activity Assistant/CNA (Certified Nursing Assistant) #41 that those residents have to "Wait." Resident</p>	F 0241	<p>F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY It is the practice at Warsaw Meadows Care Center that all residents be treated with the utmost respect and dignity.</p> <p>1. Three residents with the need for thickened liquids were not served drinks at the same time that a tablemate was. Another resident who needs cueing to use silverware was observed eating with her fingers. An Activities Aide that is also a C.N.A. was observed assisting with feeding while standing up.</p> <p>2. All residents with alternate drinking requirements or need for cueing or assistance with eating could potentially be affected.</p> <p>3. The policy "Dining Room Services and Dining Programs" has been updated with the line "Servers are to be seated while assisting residents and be aware of care planned needs"</p>	05/09/2016

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	<p>#48 was not served a drink until 12:02 P.M., even though two other residents seated at the table with him were served beverages. Resident #1 and Resident #61 were served their beverages at 12:08 P.M. and 12:10 P.M.</p> <p>At 12:11 P.M., Resident #47 was given her meal tray. She was not cued and sat with her eyes closed and her meal tray in front of her for several minutes. At 12:24 P.M., she opened her eyes and ate two bites of a bread dressing with her fingers. Although staff were feeding residents at same table as Resident #47 was seated, no staff cued her to use her silverware.</p> <p>At 12:24 P.M., Activity Assistant/CNA #41 was noted to stand over Resident #2 and feed him some food.</p> <p>At 12:28 P.M., Activity Assistant/CNA #41 stood over Resident #47 and attempted to feed her a few bites. CNA #41 then walked back over to Resident #2 and stood to feed him two more bites. CNA #41 then left Resident #2's table and walked over to talk to another resident at a different table. CNA #41 then walked back over to Resident #2's table and stood to feed him a few more bites of food. At 12:37 P.M. QMA #40 was noted to stand and finish feeding Resident #2. CNA #41 had walked over</p>		<p>such as cueing and assistive devices." The policy also had the line added "Each table will be served individually. This includes drinks. Do NOT move on to the next table until everyone has been served everything they are required at each table." In addition, an in-service will be completed on 5/9/16 with all staff on proper procedure for dining services.</p> <p>4. Meals will be audited by the Administrator or designee once a day, 5 days a week for the next 30 days with a goal of 100% correct dining procedures. Results will be included in monthly Process Improvement meeting and added as an area of review for QAPI. If additional actions are needed or a continuation of the audit another 30 days will be added until 100% compliance is achieved.</p> <p>5. Date of Completion: 5/9/16</p>	

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	<p>to Resident #86's table and was standing to assist him with his food.</p> <p>On 03/31/2016 at 8:20 A.M., Resident #47 was observed licking her yogurt from a clear plastic dish. She was not cued by staff to utilize her silverware.</p> <p>On 4/4/16 at 10:36 A.M., the Administrator provided the facility policy and procedure titled "Dining Room Service and Dining Programs," undated", and indicated this was the policy and procedure currently used by the facility. The policy and procedure did not indicate staff would sit to feed residents, nor did it indicate residents seated at the same table would be served at the same time.</p> <p>During an interview, on 04/04/16 at 10:36 A.M., the Administrator indicated he did not necessarily expect staff to sit to feed dependent residents as it "would depend upon the situation." He indicated there were no other, more specific policies and procedures regarding the dining process.</p> <p>3.1-3(t)</p>			

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F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure there was an ongoing program of activities to meet the needs of 3 of 3 residents on the Heritage reviewed for activities. (Residents #1, #48 and #61)</p> <p>Findings include:</p> <p>1. During the daytime hours on 03/28/16, between 8:30 A.M. to 11:30 A.M., and 03/29/16, between 1:00 P.M. and 3:15 P.M., the residents on the secured Heritage unit were not observed to be involved or taken to activities. This included both large, small and individualized activities. The only residents noted to be taken off the unit were 3 residents who required specialized services through an outside resource for intellectual disabilities.</p> <p>The Activity Schedule for 03/30/16 included:</p>	F 0248	<p>F248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACHRESIDENT</p> <p>It is the policy at Warsaw Meadows Care Center thatspecialized and approved programming is performed daily in the Memory CareUnits that is specific to each resident and provides meaningful fulfillment forall.</p> <p>1.Activities staff were observed by the surveyorsof not performing the activities listed on the monthly calendar nor providingalternatives. In addition, care plansdid not accurately portray 3 residents psychosocial need.</p> <p>2.All residents who are not self actualizing oftheir activities could potentially be affected by this citation.</p> <p>3.Warsaw Meadows Care Center has a policy in placefor admissions and discharges to the secured units and proper programming inactivities for these units. A completeoutline of the expectations for this unit and everyone's part</p>	05/11/2016

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	<p>* 9:00 A.M. Coffee and Chat * 1:00 P.M. Craft Circle * 3:00 P.M. exercises.</p> <p>The unit was observed at 9:05 A.M. and there was no "Coffee and Chat" activity noted on the unit. Resident #1 was observed in the hallway in her wheelchair, grunting and gesturing. CNA (Certified Nursing Assistant) #43 was trying to explain to the resident that there were no magazines for her at the time.</p> <p>On 3/30/16 at 1:00 P.M., a craft circle activity scheduled but there was no activity occurring on the secured Harmony, secured Liberty unit or the main floor activity rooms. The Harmony activity/quiet lounge had a radio softly playing, no lights and no staff were observed in the room. At 1:19 P.M., Resident #1 was observed in her wheelchair in the hallway with her purse draped around her.</p> <p>On 03/30/16 at 1:40 P.M., two staff members and one resident were observed playing dominoes on the Harmony unit activity/quiet lounge. The activity staff member, Employee # 42 indicated they had finished their 1:00 P.M. craft already. She indicated the activity had taken place on the Harmony unit for a "few" residents even though no such activity was noted</p>		<p>regarding activities will be completed on 5/9/16 at All Staff Meeting which is mandatory. In addition, a complete audit of activities care plans will be completed by 5/9/16 to ensure proper goals and interventions are recorded. Activities staff will also have an in-service on expectations of their departments specifically when it pertains to residents with special needs on 5/11/16. All care plans have been reviewed and updated to accurately reflect the resident's needs.</p> <p>4. The Administrator, Activities Director, or designee will audit timeliness and content of activities specific to these secured units 5 times a week for 30 days, and once a week an additional 60 days with the goal of structured, meaningful activities being provided daily and as scheduled. These results will be part of the monthly Process Improvement meeting and the quarterly Quality Assurance meeting. Any further instances of noncompliance with the programming policy will result in additional audits and disciplinary actions as needed.</p> <p>5. Date of Completion: 5/11/16</p>	

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	<p>from 1:04 P.M. to 1:45 P.M. Resident #1 was not invited or included in the dominoes activity. She was noted to be in her wheelchair in her room and did give herself a drink from her water pitcher. At 1:48 P.M., therapy staff returned her roommate to her room and Resident #1 stated making noises and propelled herself out of her room and was making a sign and pointing to the storage room door. Staff were alerted and did open the door and retrieved a magazine for the resident. She then took the magazine and propelled herself into the dining room.</p> <p>The Activity Schedule for Heritage unit for 03/31/16 was as follows: *8:00 A.M. Coffee and Chat *10:00 A.M. Bible Study on Freedom hall * 3:00 P.M. Bingo.</p> <p>The following observations were made on 3/31/16:</p> <p>At 8:20 A.M., residents on the Heritage unit were observed in the dining room eating their breakfast.</p> <p>At 9:54 A.M., activity staff member #42 was observed in the front lounge, located on the Freedom hall, with Resident #61 and #47 from the Heritage hall. Resident #42 indicated they were getting</p>			

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	<p>ready to have a Bible study. Resident #1 and #48 were both in their rooms in their beds asleep.</p> <p>At 10:20 A.M., Resident #1 got herself out of bed, was toileted by CNA #43 and given a magazine.</p> <p>At 10:45 A.M., Resident #48 was observed in his wheelchair propelling himself in and out of the dining room and calling out "mom" to anyone he passed along the way.</p> <p>At 11:10 A.M., Resident #61 was brought back to the secured unit from the Bible study activity. Employee #42 indicated she was going to start taking her to activities because she really seemed to enjoy the activity.</p> <p>At 2:30 P.M., there was no activity noted on the secured Heritage unit, the activity lounge lights were off and no one was in the room. Resident #1 was in the dining room in her wheelchair looking at a magazine. Resident #48 was propelling his wheelchair up and down the hallway. An ambulatory resident was walking up and down the hallways, looking out the windows. Resident #61 was in her bed asleep. CNA #44 reentered the unit to "watch" residents while CNA #43 took out the trash and took a break. She asked</p>			

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	<p>Resident #48 if he would like to play catch with a ball. CNA #44 then proceeded to look for a ball. She finally located a large yellow ball in a linen closet but Resident #48 had changed his mind and did not want to play ball.</p> <p>At 2:58 P.M., activity employee #42 and two residents from another unit, entered the Heritage unit and began getting ready for Bingo. Resident #48 was assisted to play Bingo and Resident #1 passively watched the Bingo game. There were 5 residents from the Heritage unit in the dining room for the Bingo activity. At 3:27 P.M., the Bingo activity was over and the Activity staff member exited the Heritage unit.</p> <p>The Activity Schedule for April 1, 2016 was as follows: *10:00 A.M. Coffee and Chat *2:00 P.M. Farm bean bag toss *7:00 P.M. Game night</p> <p>The following observations were made on 4/1/16:</p> <p>At 10:00 A.M., Resident #1 was in her wheelchair in her room with her purse around her neck. Resident #61 was in her wheelchair awake in her room looking at a wall. Resident #48 was in his room asleep.</p>			

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	<p>At 10:01 A.M., activity staff #42 entered the Heritage unit with a cart with two pitchers and Styrofoam cups and started passing out hot beverages. Resident #1 accepted a cup of coffee. Resident #61 was not offered any beverages even though she was awake. Resident #48 was asleep. Activity staff member #42 was not observed to converse with the residents except to ask which type of beverage and how they might want their coffee fixed. Activity staff member #42 left the unit at 10:18 A.M.</p> <p>At 10:18 A.M., Resident #1 propelled herself into the hallway and threw her empty coffee cup into the trash can and started to look at a folded magazine she had in her wheelchair. She then propelled her wheelchair to the dining room door and looked into the empty room.</p> <p>At 2:29 P.M., the Heritage unit was viewed and there was no activity noted on the unit. There were no staff in the room. Resident #61 was in her bed asleep.</p> <p>2. The clinical record for Resident #1 was reviewed on 03/30/2016 at 1:06 P.M. . Resident #1 was readmitted to the facility on 01/04/16, with diagnoses, including</p>			

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	<p>but not limited to: dementia with behavioral disturbance, severe intellectual disabilities, dysphasia, anxiety disorder, obsessive-compulsive disorder, impulse disorder, chronic obstructive pulmonary disease, cataracts, abnormal posture, speech language deficits following cerebral vascular accident, psuedobulbar affect, aphasia, hypothyroidism nonpsychotic mental disorder, osteoarthritis, and personality change due to unknown psychological condition.</p> <p>A quarterly activity note, completed on 02/09/16, indicated the resident liked coffee hour and liked to read magazines. The assessment also indicated Resident #1 liked to fold clothes.</p> <p>The care plans for Resident #1, current through 05/11/16 included the following care plan related to (r/t) activities: The resident has little or no activity involvement r/t Disinterest, Anxiety. The interventions were as follows: "The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date." The goal was for the resident to "participate in activities of choice 3-5 times per week by review date." The interventions included but were not limited to: "The resident needs</p>			

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	<p>assistance/escort activity functions at times, The resident's preferred activities are: going on outings with OBRA (an outside service for residents with developmental disabilities), looking at her magazines, collecting purses and baby dolls, Invite the resident to scheduled activities, Provide with activities calendar. and Notify resident of any changes to the calendar of activities...."</p> <p>3. The clinical record for Resident #48 was reviewed on 03/30/2016 at 1:54 P.M. Resident #48 was admitted to the facility on 05/25/13, and readmitted to the facility on 10/30/14, with diagnoses, including but not limited to: anoxic brain damage, dysphasia, dementia with behavioral disturbances, anxiety disorder, bipolar disorder, psychosis, lack of coordination, cognitive deficits, pseudobulbar affect, contractors, abnormal posture, insomnia, sleep disorder, difficulty walking, chronic pain syndrome, major depressive disorder, alcohol dependence, other psychoactive substance dependence and aphasia.</p> <p>The current care plan for Resident #48 regarding activities, current through 05/12/16, included the following: "Resident has history of yelling out during group activities. Resident has</p>			

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	<p>difficulty with long lasting activities." The goal included the following: "The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date." "The resident will participate in activities of choice 3-5 times per week by review date." The interventions included: Remind the resident that the resident may leave activities at any time, and is not required to stay for entire activity , the resident is able to: Play Bingo, Play cards, Color pictures, the resident needs assistance/escort activity functions, the resident's preferred activities are: Bingo, card games, outdoor activities, coloring pictures and social interaction. When resident is no longer interested in the activity taking place staff will offer a different activity and when resident yells out during activities staff will reassure resident that he is safe. If resident continues staff will ask resident if he is in pain or needs to use the restroom, if resident says yes to these needs activities staff will inform nursing staff.</p> <p>4. The clinical record for Resident #61 was reviewed on 03/30/2016 at 1:32 P.M. Resident #61 was admitted to the facility on 10/28/14, with diagnoses, including but not limited to: dementia with behavioral disturbance, dysphasia,</p>			

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	<p>schizophrenia, psychosis unspecified, delusional disorder, abnormal posture, intellectual disabilities, pseudobulbar affect, osteoarthritis and lack of coordination.</p> <p>An activity quarterly note, dated 03/08/16, indicated the resident attended 3 to 5 activities per week and was normally passive.</p> <p>The resident's favorite activities were sorting objects, coloring pictures, painting, having stories read to her, spending time outdoors and listening to music.</p> <p>The care plan, current through 06/2016, included the following: Resident has history of yelling out during group activities. The goal for the plan was for the resident to attend/participate in activities of choice 3 - 5 times a week by next review date. The resident will maintain involvement in cognitive stimulation, social activities as desired through review date. The interventions were as follows: "Assist with arranging community activities. Arrange transportation, Ensure that adaptive equipment that the resident needs is provided and is present and functional, Provide the resident with materials for individual activities as</p>			

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	<p>desired, Provide with activities calendar. Notify resident of any changes to the calendar of activities, Staff will give resident all the time she needs to communicate needs, Thank resident for attendance at activity function," and "When resident is yelling out during an activity, staff will reassure her that she is safe, if resident continues to yell out ask her if she is in pain or needs the restroom if resident does staff will inform nursing."</p> <p>During an interview, on 04/01/16 at 2:41 P.M., Activity staff member #41 indicated she had worked at the facility for 3 weeks. She indicated she did not know of any individualized programming for residents on the Heritage unit. She indicated the activity calendar (with the 3 scheduled group activities) was posted on the bathroom doors in each room. She indicated no one had really informed her of programming. She indicated she made sure the scheduled activities occurred and then she also did extra things if the residents either told her they like certain activities or she tried things and they liked it. She indicated she had put puzzles in front of Resident #47 and she was "happy" for a long time.</p> <p>On 04/01/16 at 11:43 A.M., the RN (Registered Nurse) Consultant #47</p>			

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	<p>provided the policy titled "Warsaw Meadows Criteria for Admission and Discharge to Secured Units," dated 7/15/13, and indicated the policy was currently used by the facility. The policy indicated "...2. The degree of nursing must not outweigh the opportunity for residents to benefit from structured programming...."</p> <p>The RN Consultant #47 also provided the policy and procedure titled "Programming for Dementia Care - Warsaw Meadows," and indicated this policy was currently used by the facility. The policy indicated "...Initial programming starts with understanding a resident's interests, skill leave/functioning, and social skills...Programming is structured around ADLs, meals, and past and current interests...Programming Defined: Structured or unstructured activity, based on familiar, pleasant activities of interest. 1:1, alone, passive, and active participation is considered activities...EVERYONE does programming...Group programming will be structured, unstructured, normalized, address a resident's interest, and allow for spontaneity. Programming should be strength based using the person's abilities focused on their history, have opportunities for success, and tailored to</p>			

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F 0272 SS=D Bldg. 00	<p>specific needs...."</p> <p>3.1-33(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment</p>			

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	<p>performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interviews, the facility failed to ensure a thorough bladder incontinence assessment was completed for 1 of 3 residents reviewed for urinary incontinence. (Resident #46)</p> <p>Finding includes:</p> <p>Resident #46 was observed, on 04/04/16 at 8:30 A.M. lying in her bed awake. The resident had a tracheostomy tube, both upper extremities were contracted at the elbows and hands, her legs were in padded boots and she was lying on a cloth incontinence pad and covered with a blanket. She remained in her bed until 10:14 A.M., when CNA (Certified Nursing Assistant) #43 was observed to dress Resident #46, and change her incontinence brief, which was wet with urine. CNA #43 indicated Resident #46 did not use a bed pan and was not toileted. CNA #43 indicated Resident #46 was totally dependent for care and could answer "yes" and "no" questions with her eyes sometimes and the Activity department would give her Trivia questions to answer.</p>	F 0272	<p>F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>Warsaw Meadows Care Center has a policy in place for Boweland Bladder documentation and has now began using the automated Point ClickCare (PCC) system and it's default documentation to record bowel and bladderneeds.</p> <p>1.A resident who is completely dependent of allADLs and contracted and is incontinent was found not to have a comprehensivebowel and bladder program; specifically they were not assessed for the abilityto sit on a toilet, whether they could non verbally acknowledge need fortoileting, or been assessed for signs or symptoms of a urinary tract infection.</p> <p>2.Residents who are completely dependent of stafffor ADLs have the potential to be affected by this alleged deficiency.</p> <p>3.Warsaw Meadows Care Center no longer uses theforms cited by the surveyors and has switched all documentation to the PointClick Care program which is far more comprehensive and inclusive for bowel andbladder programs. All dependentresidents have been reviewed and care plans updated.</p> <p>4.All nurses were trained on the bowel and bladdersection of PCC</p>	05/03/2016			

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	<p>The clinical record for Resident #46 was reviewed on 04/04/2016 at 8:56 A.M. Resident #46 was admitted to the facility on 03/17/11, and readmitted on 09/12/15, with diagnoses, including but not limited to: hemiplegia, cerebral infarction, diabetes, dementia without behavioral disturbances, and constipation. The resident also had a tracheostomy and contractures of her hand and ankle.</p> <p>A Bowel and Bladder Monitoring Record for 10/05/15 to 10/07/15 was provided by the Assistant Director of Nursing (ADON) on 04/04/16 at 9:20 A.M. The ADON indicated this was the record for the Bladder Incontinence Assessment. The form, which was incomplete for portions of each day, indicated the resident was incontinent of her urine at all times. "Check and Change" was written on a portion of 10/06/15. The bottom of the form indicated the resident had "Functional" incontinence. A handwritten comment on the bottom of the form indicated "Dx [diagnosis] hemiplegia d/t [due to] CVA [cerebral vascular accident]. Requires total assist with all ADL's [Activities of Daily Living]</p> <p>The most recent Minimum Data Set (MDS) assessment, completed on 03/22/16, indicated Resident #46 was</p>		<p>on 5/3/16 as part of an in-service of expectations regarding incontinence. An audit of programs for completely dependent residents will be performed weekly for 90 days by the DON or designee with the results recorded and acted upon at the quarterly Quality Assurance Meeting. Monitoring will be on-going until 100% compliance is complete. 5. Date of Completion: 5/3/16</p>	

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	<p>moderately cognitively impaired, totally dependent for bed mobility and was totally dependent for dressing, toilet and hygiene needs. Resident #46 was always incontinent of her bowel and bladder.</p> <p>During an interview, on 04/04/2016 at 9:27 A.M., the MDS coordinator, LPN (Licensed Practical Nurse) #45, indicated the 3 day voiding pattern form, indicated the resident required total assistance for ADL and was the facility's bladder incontinence assessment. She also provided another form, completed on 10/08/15, which indicated the resident was incontinent due to risk factors of impaired mobility, constipation/fecal impaction, CVA, and history of incontinence and medications. Neither form indicated if the resident was physically capable of sitting on a toilet or bed pan, was aware of her need to urinate or had been assessed for any symptoms of a urinary tract infection. The MDS coordinator, LPN #45, indicated she was trying to add some additional assessment information at the bottom of the 3 day voiding pattern form but she was aware the assessment forms did not answer all pertinent questions regarding incontinence.</p> <p>3.1-31(a)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Intakes: IN00196015</p> <p>Based on interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed for unnecessary medications. (Resident #44)</p> <p>Finding includes:</p> <p>A clinical record review was completed on 3/30/2016 at 12:56 P.M., for Resident #44 and indicated he was admitted on 12/22/2015. His diagnoses included, but were not limited to: alcoholic cirrhosis of liver without ascites, difficulty in walking, chronic viral hepatitis C, elevated white blood cell count, herpesviral encephalitis, dementia in other diseases classified elsewhere with behavioral disturbance, encephalopathy, hyperlipidemia, anemias and major depressive disorder.</p>	F 0282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CAREPLAN</p> <p>1.A lab was found to be missing and not drawn asordered for one resident.</p> <p>2.All residents have the potential to have a labnot drawn as ordered.</p> <p>3.Warsaw Meadows Care Center has a policy in placefor lab draws. An in-service ofexpectations and a management review of procedures was completed on5/3/16. It was found that by using thePO sheet after being signed by the Medical Director rather than writing outeach individual lab eliminated the confusion of keeping up with each sheet andallowed nurses one focal point to see what labs were due. A review of all labs was completed with noother findings of a missed lab.</p> <p>4.An audit of labs will be completed weekly by theDON or designee for 30 days with 100% compliance as the goal. DON or designee will address any</p>	05/03/2016

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F 0323 SS=D Bldg. 00	<p>The pharmacy recommendations indicated Resident #44 had a physician order dated 8/14/2015. The order indicated Resident #44 was to have the following labs completed: Iron Panel, Ferritin, Serum B12, and Serum Folate.</p> <p>There was no documentation to indicate Resident #44 had an iron panel, a serum B12, or a serum folate lab test completed.</p> <p>During an interview on 4/4/2016 at 11:45 A.M., the ADON (Assistant Director of Nursing) indicated Resident #44 did not have an iron panel, a serum B12, or a serum folate lab test completed per physician orders.</p> <p>3.1-35(g)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure interventions were implement to prevent</p>	F 0323	<p>deviancefrom protocol on the spot. In addition,DON will do one lab review monthly an additional 60 days and those results willbe part of the monthly Process Improvement meeting and quarterly QualityAssurance meeting where anything less than 100% compliance will be addressedwith further action. 5.Date of Completion: 5/3/16</p> <p>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1.Surveyor observed a resident with the potentialto fall from an</p>	05/03/2016

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	<p>falls and to ensure adequate supervision was provided when a resident tipped in a recliner for 1 of 3 residents reviewed for falls. (Resident #37)</p> <p>Finding includes:</p> <p>On 3/31/16 at 9:04 A.M., a review of the clinical record for Resident #37 was conducted. The record indicated the resident was admitted on 3/24/15. The resident's diagnoses included, but were not limited to: hypothyroidism dementia, anxiety, depression, Parkinson's and dysphagia oropharyngeal phase.</p> <p>A Nurse Fall Investigation Report, dated 3/5/16, indicated at 4:45 P.M., Resident #37 was found on the floor, in front of a lift chair/recliner, in her room. The report indicated the resident's spouse was in the room with her and had the controls to her lift chair/recliner and call light was within her reach. The investigation indicated the resident's husband reported his wife was trying to get out of the recliner. The report indicated the resident was unable to respond to questions regarding the fall (non-verbal resident). The initial interventions were to remove the controller from the spouse and ensure call light was within reach. The report indicated during an Interdisciplinary Team (IDT) meeting, on</p>		<p>easy chair. Theresidents call light was not at hand.</p> <p>2.All residents have the potential to be out ofreach of their call light.</p> <p>3.A splitter call light was immediately installedin the room because the spouse of resident also sits in room throughout the daythough they are not roommates and in this case they had the call light clippedto their chair.</p> <p>4.An audit of call light placement facility widewill be completed daily 5 times a week by management staff for the next 30days. Results will be reviewed at themonthly Process Improvement meeting and quarterly Quality Assurancemeeting. Additional steps will be takenas needed to ensure staff always places call lights within reach and anyspecial need is addressed immediately. Date of Completion: 5/3/16</p>		

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	<p>3/7/16, a review of the incident was conducted and indicated the husband was attempting to use the remote to get Resident #36 up from the recliner and resident slid to the floor. The IDT confirmed the controller should not be with the husband and family was notified for possible removal of chair.</p> <p>A Rehab Screen, dated 3/7/16, indicated the resident was to utilize call light when needing to get up and do not let husband help.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, dated 12/23/16, indicated the resident's BIMS (Brief Interview for Mental Status) score was 10, indicating moderate dementia.</p> <p>A Significant Change MDS Assessment, dated 2/19/16, indicated the resident was unable to complete the Brief Interview Mental Status cognition assessment.</p> <p>A Risk for Fall care plan, revised 2/12/16, indicated the following interventions for a fall: anticipate personal needs, assess injuries and initiate neuro checks if an unwitnessed fall, ensure call light was within reach at all times and encourage resident to use the call light for assistance</p>			

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	<p>On 3/31/16 at 9:15 A.M., resident was observed sitting in her recliner with her feet up, in her room, with call light attached to husband's recliner. The two recliners were positioned beside each other. The resident had the controls to her recliner within reach, however the call light was not within her reach.</p> <p>On 3/31/16 at 10:14 AM, CNA (Certified Nursing Assistant) #2 was observed walking into the resident's room and checking on both the resident's in the room.</p> <p>On 3/31/16 at 10:18 A.M., Activity Assistant #1 was observed going into the Resident's room to offer refreshments. As she walked out of the room there was a loud bang coming from the resident's room. Activity Assistant #1 was observed going into the room and looking at the resident, in the tipped recliner. She walked in front of the resident and asked the resident if she was ok and then walked out of the room and down the hallway. The resident was observed in the recliner with the foot rest in the up position and foot rest was touching the floor. The entire recliner had tipped forward and resident was observed in a slanting position, headed toward the floor. The Resident was observed trying to scoot forward and her husband was</p>			

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	<p>also observed attempting to assist her. The Activity Assistant #1 returned in a minute or 2 with another staff member and they tilted the resident's recliner, with her in it, back into an upright position. The Director of Nursing (DON) entered the room and asked Activity Assistant #1 why she left the resident and indicated she should of used the resident's call light to get assistance, instead of leaving the room. The DON further indicated to Activity Assistant #1 she should not have left the resident alone, in a tilted recliner.</p> <p>A Nurse Fall Investigation Report, dated 3/31/6, added new interventions to prevent future falls. The interventions were to call resident's family regarding the use of the recliner, possible removal of the recliner and/or place chair in corner of room. A splitter call light was added to room so husband and resident would have a call light accessible when they were both in their recliners.</p> <p>On 4/1/16 at 1:35 P.M., Resident #37 was observed sitting in her wheelchair where her recliner had been, with the call light within her reach. The recliner was observed in the far corner of the resident's room.</p> <p>On 4/1/16 at 9:00 A.M., the Director of Nursing provided a policy titled "Fall</p>			

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F 0329 SS=E Bldg. 00	<p>Prevention and Assessment", dated 9/2012, and indicated the policy was the one currently used by the facility. The policy indicated "...5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc...."</p> <p>3.1-45(a)(1)</p> <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</p>			

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	<p>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 observations, interviews and record reviews the facility failed to ensure there were adequate indications for the use of antipsychotic medications for 2 of 5 residents reviewed for unnecessary medication use. (Resident #57 & #60) The facility failed to ensure adequate monitoring was completed for 3 of 5 residents reviewed for unnecessary medication use. (Resident #31 & #57) The facility also failed to ensure a timely dose reduction of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident # 31)</p> <p>Findings include:</p> <p>1. On 3/30/16 at 2:02 P.M., a review of the clinical record for Resident #31 was conducted. The record indicated the resident was admitted on 10/15/14. The resident's diagnoses included but were not limited to: Diabetes, hyperlipidemia, cerebral vascular accident with hemiparesis, expressive aphasia, depressive disorder and kidney disease.</p>	F 0329	<p>F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS It is the practice of Warsaw Meadows Care Center to ensure that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is defined as any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications of use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of these reasons.</p> <p>1. One resident was found to have a continuation of Ativan usage in gel and oral form though behavior monitoring documentation did not indicate need for this antianxiety medication. Another resident was found to have been given Geodon without record of non pharmaceutical interventions.</p> <p>2. All residents who have orders for antianxiety medications have the potential to be affected by this alleged deficiency.</p> <p>3. The facility has a behavior management policy in place with</p>	05/03/2016

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	<p>The current Medication Administration Record (MAR), dated March 2016, indicated the resident's medications, included but were not limited to:</p> <ul style="list-style-type: none"> Risperidone (anti-psychotic medication) 0.25 mg (milligrams) daily for impulse control. *Cymbalta 90 mg daily for depression, neuropathy/chronic pain *Poly-Iron 150 mg daily as a supplement. *Effexor 75 mg daily for depression. *Atorvastatin 20 mg daily for hyperlipidemia *Klonopin (anti-anxiety medication) 0.75 mg at bedtime. *Cyanocobalamin (Vitamin B-12) 1000 micrograms (mcg) Intramuscular injection once monthly. *Novolog 128 Units subcutaneous (subQ) every morning, Novolog 80 Units sub Q at noon, Novolog 110 Units subQ every evening for diabetes *Lantus 128 Units subQ every morning and Lantus 140 Units subQ every evening for diabetes. <p>A care plan for hyperlipidemia, revised on 10/26/15, indicated the resident was to have medications and labs as ordered. Another care plan indicated resident had the potential for an adverse drug reactions and an ineffective drug therapy due to receiving multiple medications.</p>		<p>the addition of "scheduled antianxiety medications" implemented. Licensed nurses and socialservices personnel have been re-educated on this policy. This re-education stressed the continual importance of the provision of non-drug interventions prior to administering psychoactive medications; and the continued need for accurate behavior documentation. The facility will continue an IDT meeting daily (Mon thru Fri) that includes a review of all behaviors and the interventions utilized to manage those behaviors. All psychoactive medications are reviewed weekly by the Pharmacist and IDT and those results are acted upon by the Medical Director or Nurses Practitioners.</p> <p>4. In addition to the process noted above, the SSD or designee is conducting a quality improvement audit to ensure residents are monitored prior to the increase or decrease of psychoactive medications and that the indications for use as well as the non pharmaceutical actions are documented. A random sample of 5 residents receiving psychoactive medications will be monitored 3 times per week for 30 days, then monthly for 6 months. The pharmacy consultant will assist in monitoring during monthly visits. Results of</p>	

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	<p>The interventions included but were not limited to: administer medications as ordered, monitor response, attempt dosage reductions, monitor every shift for side effects, monitor labs, pharmacist reviews monthly, quarterly reviews by behavior management committee and refer to psychologist as needed. A care plan for potential for complications related to renal disease with interventions to administer drugs as ordered and labs as ordered.</p> <p>The Routine Physician Orders, dated 3/1/16 thru 3/30/16 on the monthly rewrite, indicated the resident was to have the following lab work: CBC (Complete Blood Count) , CMP (Comprehensive Metabolic Panel) and Lipid Panel annually. Hemoglobin A1C every 3 months. CBC every 3 months. CMP every 6 months.</p> <p>The Lab Draw Reports indicated the resident received the following lab tests: a CBC with Differential, a Hemoglobin A1C, a CMP and a lipid Panel were completed on 2/10/15. An Iron Panel, a Vitamin B12 and Folate test were completed as ordered on 2/18/15. A CBC with Differential and a Hemoglobin A1C were completed as ordered on 2/26/15. A Hemoglobin A1C was completed as</p>		<p>these audits will be reported at the quarterly Quality Assurance meeting. Any negative findings will add another four weeks of audits until 100% compliance is achieved.</p> <p>5. Date of Completion: 5/3/16</p>				

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	<p>ordered on 5/12/15 and 8/10/15. There were no other lab resulted noted in the record.</p> <p>A form titled "Note to Attending Physician/Prescriber", printed on 1/27/16, indicated the resident was a candidate for a dose reduction of his Klonopin from 1 mg to 0.75 mg daily at HS (bedtime). The Physician/Prescriber Response, dated 2/12/16, indicated the physician agreed to the dose reduction recommendation.</p> <p>A physician's order, dated 3/23/16, indicated to decrease Klonopin to 0.75 mg at HS.</p> <p>During an interview, on 3/30/16 at 11:20 A.M., the Assistant Director of Nursing indicated there was a change in the lab provider and the lab orders for Resident #31 had not been implemented, therefore the monitoring of lab work associated with the medications the resident was receiving had not been completed.</p> <p>A current policy received, on 3/31/16, from the Director of Nursing (DON) titled " Laboratory and Radiological Services", dated 5/09. The policy indicated "...The facility must provide or obtain laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness</p>			

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	<p>of the services...."</p> <p>During an interview, on 4/1/16 at 10:05 A.M., the Director of Nursing (DON) indicated the there was no policy regarding the Gradual Dose Reduction form titled "Note to Attending Physician/Prescriber." She further indicated it was the Assistant Director of Nursing (ADON) who received those forms, contacted the physician and the physician or the ADON would write the new order. The DON could not explain why there was a delay from the time the physician agreed to the dose reduction for the resident's Klonopin on 2/12/16 and the time the order was written on 3/23/16.</p> <p>2. On 3/31/16 at 1:55 P.M., record review indicated Resident #57 was originally admitted to the facility on 8/29/13 and readmitted on 11/8/15, with diagnoses including but not limited to: dementia without behavioral disturbance, major depressive disorder, pseudobulbar affect, vascular dementia with behavioral disturbance, anxiety, delusional disorder and diabetes mellitus type II.</p> <p>An admission physician order, dated 11/8/15, indicated Risperidone (an antipsychotic medication) 0.125 mg (milligrams) daily at HS (hours sleep)</p>			

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	<p>with a diagnosis of delusional disorder.</p> <p>A psychiatric progress note, dated 11/25/15, indicated "...He recently returned from hospitalization related to a hip fracture. Per staff he has continued to be combative with care and anxious at times and thus why the physician started him on Ativan [an antianxiety medication] gel as he was not taking oral medication well...Recommendations: Will increase his Ativan gel to 1 mg three times daily and daily as needed and discontinue the PRN [as needed] Ativan 0.5 mg PO (oral) related to his anxiety and agitation...Monitor moods and behaviors...."</p> <p>A physician order, dated 11/25/15, indicated d/c (discontinue) Ativan 0.5 mg TID (three times daily) prn. D/C Ativan gel 2 mg/1 ml (milliliters) give 0.5 ml BID (twice daily). Ativan gel 2 mg/ml apply 0.5 ml topically TID and prn daily for anxiety and agitation.</p> <p>Nurse progress notes dated from 12/1/16 through 12/8/15 indicated no abnormal moods/behaviors were documented.</p> <p>A social service progress note, dated 12/8/15, indicated "continues to display dementia with delusions."</p>						

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	<p>Nurse progress notes, dated 12/10/15 and 12/15/15 indicated there was no documentation of any behaviors.</p> <p>A nurse progress note, dated 12/29/15 at 2:00 P.M., indicated the resident fell at 1:45 P.M., and was found on floor in his room.</p> <p>A nurse progress note, dated 12/30/15 at 4:10 A.M., indicated the resident pleasant mood.</p> <p>A nurse note, dated 1/4/16 at 7:20 P.M., indicated resident had a fall.</p> <p>A psychiatric progress note, dated 1/5/16, indicated "...Per staff he has had several falls recently...Recommendations:... Will have staff monitor for delusions more to see if this is the cause of his restlessness as Risperdal was reduced back in July, to see if this is a contributing factor to his falls and if so will increase Risperdal to 0.25 mg daily...."</p> <p>A nurse progress note, dated 1/6/16, indicated the resident eas pleasant and cooperative with care.</p> <p>A social service progress note, dated 1/6/16, indicated the resident's mood was stable.</p>			

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	<p>A social service progress note, dated 1/7/16, indicated resident remained stable after recent room change and had no signs of discontentment related to move.</p> <p>A social service progress note, dated 1/14/16, indicated the resident "displays mixed emotions with some irritability at times."</p> <p>A nurse progress note, dated 1/17/16 at 12:36 P.M., indicated the resident was combative with care and yelled at staff during care. There was no documentation of any non pharmacological interventions attempted for this behavior.</p> <p>A nurse note, dated 1/21/16, indicated the resident was cooperative.</p> <p>A nurse progress note, dated 1/27/16, indicated the resident had shown no change in mood or behaviors this shift.</p> <p>A psychiatric progress note, dated 1/27/16, indicated "...Per staff he has continued to be restless and agitated and combative with care all the time now and has continued to have falls related to his restlessness...Recommendations: With his continued and escalating behaviors it is necessary to increase Risperdal to 0.125 mg twice daily in an attempt to help with delusions and reduce his risk of</p>			

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	<p>injuring himself more from this...."</p> <p>A nurse progress note, dated 1/28/16 at 8:58 A.M., indicated resident combative at 8:50 A.M. with staff, refused pain medication, spitting it out and yelling at staff. There was no documentation of a non pharmacological interventions attempted for this behavior.</p> <p>Nurse progress notes, dated 1/29/16 through 2/7/16, indicated the resident's mood was stable and had no behaviors.</p> <p>A behavior note, dated 2/8/16 at 10:27 P.M., indicated resident has been showing increased resistance to care and combativeness when being assisted to bed. Spends 1-2 hours after being laid down wanting to stand up and get out of bed. There was no documentation of any non pharmacological interventions attempted for this behavior.</p> <p>A behavior note, dated 2/9/16 at 8:20 P.M., indicated resident "continues to resist care and often has to be coaxed through cleanups and brief/clothing changes. Combativeness and agitation noted during care." There was no documentation of any non pharmacological interventions attempted for this behavior.</p>			

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	<p>A nurse note, dated 2/10/16 at 7:12 P.M., indicated the resident had been compliant with his care this shift</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 2/10/16, indicated Resident #57 was severely cognitively impaired, had no hallucinations or delusions, did not exhibit physical or verbal behavioral symptoms towards others and had not rejected evaluations or care.</p> <p>Nurse progress notes, dated 2/11/16 through 3/22/16, indicated no negative moods/behaviors were exhibited by resident.</p> <p>A monthly behavior/psychotropic monitoring flow record, dated March/April 2016, indicated "Behaviors: 1. History of repeatedly asking for his daughter. 2. States several times daily "I don't know what I did to get me here". 3. Pacing up and down the hallways, at times during the night. 4. Stating several times a day, "I think I'm nuts, I don't know what I am doing". 5. Urinating in trash cans and in the hallway occasionally. 6. Sexual comments or actions towards staff or other residents. 7. Verbally aggressive with staff or other residents. 8. Refusing care, refusing ,meds, refusing meals. 9. Thinking staff</p>			

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	<p>or residents are in his house and yells at them to get out. 10. Physically aggressive with staff-hitting. Interventions: 1. Report to the nurse on duty. 2. Offer snack/drink loves Mountain Dew and chips. If up at night offer a peanut butter sandwich and warm milk or graham crackers. 3. Offer activity as available. 4. Orient to his room and belongings. 5. Likes to talk about [name of a store], fishing and hunting squirrels and deer. 6. Likes to go outside for walks. 7. Leave bathroom light on at night for direction. 8. Redirect from female residents and gently remind of appropriate behavior. 9. Tell him that [name] has people here to fix things so he doesn't have to. 10. Allow to self calm." The bottom of the paper form was blank, there was no documentation that any behaviors had occurred during March or April 2016.</p> <p>On 3/31/16 at 10:00 A.M., Resident #57 was observed sitting in his wheelchair in his room, the blinds were pulled and the room was dark and the television was on. The resident was not agitated or anxious.</p> <p>During an interview, on 3/31/16 at 10:05 A.M., the DON (Director of Nursing) indicated the resident had not had any behaviors in the last 3 months.</p> <p>On 3/31/16 at 2:00 P.M., Resident #57</p>			

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	<p>was assisted to the activity room by a CNA (Certified Nursing Assistant) to play bingo. The resident was not agitated or combative.</p> <p>During an interview, on 3/31/16 at 2:38 P.M., LPN (Licensed Practical Nurse) #20 indicated if the resident had any behaviors the CNA would notify the nurse and the nurse would document the behavior either in the behavior book or in the electronic charting. She further indicated the resident was combative with care at times and sometimes he thinks he is still in the Navy.</p> <p>On 4/1/16 at 11:02 A.M., Resident #57 was observed sitting in his wheelchair in his room watching his television. The resident was calm and no agitation or anxiety was observed.</p> <p>A care plan, dated 8/14/14 and revised on 3/22/16, indicated "resident episodes of anxiousness will occur fewer than 3 times per week through next review." The interventions included but were not limited to: "Administer medications per MD order. Assure safety and things are paid for. Notify social service of behaviors via behavior log. Offer snacks and drink of choice. Reassure him that everything is fine. Redirect to activities of choice when seen pacing. Refer to</p>			

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	<p>psych services as needed. Show him where his room is and show him the picture of the ship on his wall. He likes to talk about the Navy. Talk to him about outdoors and what it is like that day outside."</p> <p>On 4/1/16 at 11:27 A.M., LPN #21 provided a policy titled "Antipsychotic Medication Use",undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks...4. Nursing staff will document a individual's target symptom(s). 5. The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. 6. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medication...."</p> <p>In addition, a Note to Attending</p>			

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	<p>Physician/Prescriber, dated 12/30/15, indicated "please consider checking an A1C [lab for blood sugar] to help evaluate if sliding scale could be reduced or even discontinued in the future. Physician response: AGREE."</p> <p>A physician order, dated 1/10/16, indicated lab to draw HgBA1C. No lab result could be found for a HgBA1C on Resident #57's chart for January 2016. There was a lab dated 4/17/15 indicating a HgBA1C was completed on that date.</p> <p>During an interview, on 4/4/16 at 11:15 A.M., RN #22 indicated the order that was written on 1/10/16 for a HgBA1C was transposed incorrectly by the nurse and the lab drew a hemoglobin test instead of a hemoglobin A1C test. She further indicated the error was not caught and "apparently no one questioned it."</p> <p>A care plan, dated 11/30/15 and revised on 3/22/16, indicated blood sugars will be within normal limits for resident. The interventions included but were not limited to: "...Monitor blood sugars per MD [Medical Doctor] order...."</p> <p>3. A clinical record review was conducted on 3/30/2016 at 1:58 P.M., for Resident #60 and indicated he was admitted on 5/1/2015 and readmitted on 2/1/2016. His diagnoses included, but</p>			

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	<p>were not limited to: dementia, Parkinson's, dementia with lewy bodies, delusional disorders, abnormalities of gait and mobility, age-related osteoporosis without current pathological fracture, urinary tract infection, enlarged prostate without lower urinary tract symptoms, cognitive communication deficit, major depressive disorder, hypotension unspecified, difficulty in walking, dysphagia oropharyngeal phase and chronic kidney disease.</p> <p>A physician order, dated 2/20/2016, indicated Resident #60 was to have Geodon (an antipsychotic medication) 10 mg (milligrams) IM (intramuscular) every two hours as needed for agitation.</p> <p>A physician order, dated 2/26/2016, indicated Resident #60 was to have levofloxacin (an antibiotic medication) 500 mg once a day for six days due to a UTI (urinary tract infection).</p> <p>The February Medication Administration Record (MAR) for Resident #60 indicated he was given a dose of the PRN (as needed) Geodon on 2/27/2016.</p> <p>Review of Resident #60s behavior charting indicated he did not have any behaviors supporting the use of geodon.</p>			

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F 0356 SS=B Bldg. 00	<p>During an interview on 4/1/2016 at 9:02 A.M., the DON (Director of Nursing) was unable to indicate that Resident #60 was experiencing behaviors to support the use of geodon while he had a UTI.</p> <p>On 4/1/2016 at 11:03 A.M., the Social Service Director provided the policy titled "Antipsychotic Medication Use," undated, and indicated this was the policy currently used by the facility. The policy indicated "...j. Medical illnesses or delirium with manic or psychotic symptoms and/or treatment-related psychosis or mania (e.g., thyrotoxicosis, neoplasms, high dose steroids) AND were these meet the following criteria: (1) The symptoms (such as auditory, visual, or other hallucinations; delusions (such as paranoia or grandiosity) are identified as being due to mania or psychosis)."</p> <p>3.1-48(6)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p>			

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	<p>o Facility name.</p> <p>o The current date.</p> <p>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview the facility failed to differentiate between Registered Nurses (RN's), Licensed Practical Nurses (LPN's), Qualified Medication Aide (QMA's) and Certified Nursing Aides (CNA'S) on their posted Daily Staffing. The facility also failed to provided the actual hours worked by the RN's, LPN's, QMA's and CNA's. This had the potential to affect all residents.</p>	F 0356	<p>F356 483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The policy at Warsaw Meadows Care Center is that staffing information be provided at the nurses station in accordance with State and Federal guidelines.</p> <p>1. Surveyors found the sheet for staffing at the nurses station did not break down RN hours from LPN hours.</p> <p>2. No residents would be</p>	05/03/2016

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	<p>Finding includes:</p> <p>During the initial tour, on 3/28/16 at 10:20 A.M., the facility's posting of the daily nursing staff was not located on any unit/hallway or entrance way.</p> <p>On 3/29/16 at 11:15 A.M., a form titled Warsaw Meadows Care Center-Daily Staffing was located at the nurses station on the Freedom hallway. The form indicated the following:</p> <p>-1st shift "...3 Licensed Nursing Staff Working on Floor RN's/LPN's...Total Working Hours of Licensed Staff 24...7 Certified Nursing Staff Working on Floor QMA's/CNA's...Total Working Hours of Certified Staff on Floor 52.5...."</p> <p>-2nd shift "...4 Licensed Nursing Staff Working on Floor RN's/LPN's...Total Working Hours of Licensed Staff 32...7 Certified Nursing Staff Working on Floor QMA's/CNA's...Total Working Hours of Certified Staff on Floor 52.5...."</p> <p>-3rd shift "...2 Licensed Nursing Staff Working on Floor RN's/LPN's...Total Working Hours of Licensed Staff 16...4 Certified Nursing Staff Working on Floor QMA's/CNA's...Total Working Hours of Certified Staff on Floor 30...."</p> <p>The form did not differentiate between how many Registered Nurses (RN) and Licensed Practical Nurses (LPN) were</p>		<p>affected by this alleged deficiency.</p> <p>3. Form was corrected on the spot and is now being supplied by HR daily shift to shift through the timeclock system.</p> <p>4. DON or designee will ensure staffing sheet is accurate daily. The DON or designee will monitor that the sheet is updated as required daily and any findings that it has not been will be reported to the Quality Assurance Meeting staff. A negative finding will institute a daily audit of the sheets for 30 days with those findings being related to the Process Improvement Meeting group. A negative finding will extend the audit another 30 days until 100% compliance for the entire 30 days is complete.</p> <p>5. Date of Completion: 5/3/16</p>	

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	<p>working each shift and the form did not differentiate between the Qualified Mediation Aide (QMA) and Certified Nursing Aides (CNA) either. The form failed to have the actual hours worked by each RN, LPN, QMA and CNA for each shift. The form indicated total working hours of certified staff.</p> <p>On 3/30/16 at 2:02 P.M., a Daily Staffing form was located at the nurses station on the Freedom hallway. The form did not differentiate between how many Registered Nurses (RN) and Licensed Practical Nurses (LPN) were working each shift and the form did not differentiate between the Qualified Mediation Aide (QMA) and Certified Nursing Aides (CNA) either. The form failed to have the actual hours worked by each RN, LPN, QMA and CNA for each shift.</p> <p>On 3/31/16 at 9:04 A.M., a Daily Staffing form was located at the nurses station on the Freedom hallway. The form did not differentiate between how many Registered Nurses (RN) and Licensed Practical Nurses (LPN) were working each shift and the form did not differentiate between the Qualified Mediation Aide (QMA) and Certified Nursing Aides (CNA) either. The form failed to have the actual hours worked by</p>			

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F 0371 SS=F Bldg. 00	<p>each RN, LPN, QMA and CNA for each shift.</p> <p>During an interview, on 4/1/16 at 9:10 A.M., the Director of Nursing (DON) indicated the form did not differentiate between the RN's and LPN's and the form did not have the actual hours worked by each RN, LPN, QMA and CNA for each shift. The DON further indicated the Daily Nurse posting was posted only on the Freedom Hallway, at the Nurse's Station.</p> <p>On 4/3/16 at 9:35 A.M., the Administrator indicated there was no policy addressing the Daily Staff posting.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure that food was prepared in a sanitary manner.</p>	F 0371	F371 483.35(i) FOOD PROCURE/STORE/PREPARE/SERVE - SANITARY	05/03/2016			

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	<p>In addition, the facility failed to ensure that kitchen equipment and utensils were clean and sanitary in 1 of 1 kitchen. This had the potential to affect 68 of 69 residents that receive meals from the kitchen.</p> <p>Findings include:</p> <p>1. On 3/28/16 from 10:05 A.M. to 10:45 A.M., the initial kitchen tour was conducted with the Dietary Manager and the following was observed:</p> <p>Two hand held mixers and 1 food processor were stored away as clean in a stainless steel cabinet, each of the mixers had a dried brown substance splattered all over the outside of them. The food processor had a dried brown and white substance splattered all over the inside of it.</p> <p>Two metal cookie sheets were stored in a cabinet as clean, both had a dried brown substance on the edges of them.</p> <p>One plastic measuring container stored in a cabinet as clean had a dried brown substance on the inside of it.</p> <p>Six metal mixer beaters were observed in a small metal bowl, the beaters were put away as clean. Four of the six beaters had</p>		<p>The policy at Warsaw Meadows Care Center is that all utensils whether in use or in storage are clean and dry, this includes equipment such as microwaves and other cooking implements.</p> <p>1. Surveyors found dried substances on several stored items that had not been wiped down after being ran through the washer. They also found the microwave and one refrigerator was in use but had something spilled in them.</p> <p>2. All residents could be potentially affected by this alleged deficiency.</p> <p>3. The facility has a policy in place "Dish and Utensil Procedure" that outlines "dishes and utensils shall be routinely checked for stains or spots." Dietary staff were re-educated on the policy and procedure along with facility expectations for cleanliness on 5/3/16. A new microwave was purchased and put into use the day of the surveyor's observation.</p> <p>4. An audit of cleanliness to include items in storage will be completed daily for next 30 days, and monthly for an additional six months by the Dietary Manager or designee. Results of these audits will be reported at the quarterly Quality Assurance meeting. Any negative findings will add another four weeks of daily review until 100% compliance is achieved.</p> <p>5. Date of Completion: 5/3/16</p>		

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	<p>a tan sticky substance on them.</p> <p>A reach in refrigerator in the food prep area of the kitchen was observed to have a brown sticky substance on the inside of the door, on all 3 shelves and on the bottom of the refrigerator.</p> <p>The microwave was observed to have dried food splatter all over the inside including the inside of the door. The outside of the microwave had a greasy substance on it.</p> <p>A food cart used to deliver trays to the Independence/Freedom hallways was observed to have 14 prepared trays with food items loaded in the cart ready to be delivered to the hallways. A brown sticky substance was observed on the bottom edge of the cart by the door.</p> <p>During an interview, on 3/31/16 at 2:10 P.M., the Dietary Manager indicated her expectation for the storage of kitchen utensils and equipment is that it would be cleaned prior to storage.</p> <p>On 3/31/16 at 2:15 P.M., the Dietary Manager provided a policy titled "Dish and Utensil Procedure", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...4. Dishes and utensils shall be</p>			

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F 0428 SS=D Bldg. 00	<p>routinely checked for stains or spots...."</p> <p>On 3/31/16 at 2:20 P.M., the Dietary Manager provided a policy titled "Microwave Oven", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Sanitation of Equipment Frequency: Daily wipe down inside with special attention to inside of oven door to provide adequate seal to prevent microwave leakage...."</p> <p>2. On 03/31/2016 at 12:02 P.M., Activity Assistant, Employee #42 had donned gloves, touched the outside of a coffee cup, a plastic spoon, the outside of Tupperware container with thickener in it, reached in with gloved hands, touched a plastic spoon which was laying on top of the thickener powder in the container, used it to scoop out some thickener then dropped the spoon back on top of the thickener powder.</p> <p>3.1-21(i)(2)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p>			

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	<p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure pharmacy recommendation related a medication dose reduction was acted upon timely for 1 of 5 residents reviewed for unnecessary medications. (Resident #31)</p> <p>Finding includes:</p> <p>1. On 3/30/16 at 2:02 P.M., a review of the clinical record for Resident #31 was conducted. The record indicated the resident was admitted on 10/15/14. The resident's diagnoses included but were not limited to: diabetes, hyperlipidemia, cerebral vascular accident with hemiparesis, expressive aphasia, depressive disorder and kidney disease.</p> <p>The current Medication Administration Record (MAR), dated March 2016, indicated the resident's medication, included but was not limited to: Klonopin (anti-anxiety medication) 0.75 mg (milligrams) at bedtime.</p> <p>A form titled "Note to Attending</p>	F 0428	<p>F428 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>1. One resident was found to have an order lowered dosage of Klonopin that was not acted on immediately.</p> <p>2. All residents could potentially be affected by this alleged deficiency.</p> <p>3. The facility has a gradual reduction policy that includes the need to immediately act on physician orders or pharmacy recommendations. Medication changes are discussed daily in IDT meeting (Mon thru Fri) and follow up is the responsibility of the DON and ADON or Program Director in Memory Care. An in-service with all nurses will be conducted on 5/9/16 that will include this policy. A review of all pharmacy recommendations has been completed with no other negative findings.</p> <p>4. An audit of medication reductions will be performed weekly for 30 days, and once a month an additional six months by the DON or designee. The results of this audit will be part of the monthly Process</p>	05/09/2016

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	<p>Physician/Prescriber," printed on 1/27/16, indicated the resident was a candidate for a dose reduction of his Klonopin from 1 mg to 0.75 mg daily at HS (bedtime). The Physician/Prescriber Response, dated 2/12/16, indicated the physician agreed to the dose reduction recommendation.</p> <p>A physician's order, dated 3/23/16, indicated to decrease Klonopin to 0.75 mg at HS.</p> <p>During an interview, on 4/1/16 at 10:05 A.M., the Director of Nursing (DON) indicated the there was no policy regarding the Gradual Dose Reduction form titled "Note to Attending Physician/Prescriber." She indicated it was the Assistant Director of Nursing (ADON) who received those forms, contacted the physician and the physician or the ADON would write the new order. The DON could not explain why there was a delay from the time the physician agreed to the dose reduction for the resident's Klonopin on 2/12/16 and the time the order was written on 3/23/16.</p> <p>3.1-25(i)</p>		<p>Improvement meeting and quarterly Quality Assurance meeting. Any negative findings will result in an additional weekly audit in 30 day increments until 100% compliance is achieved.</p> <p>5. Date of Completion: 5/9/16</p>		

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F 0441 SS=D Bldg. 00	<p>483.65 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 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>			
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	<p>Based on observation and record review, the facility failed to ensure infection control practices regarding indwelling catheter tubing were followed for 3 of 4 residents with catheters. (Residents #3, #65 and #86)</p> <p>Findings include:</p> <p>During the noon meal observation in the Heritage unit dining room, conducted on 03/28/16 from 11:33 A.M. to 12:28 P.M., the following was observed: Resident #86 was pushed to the dining room table in his wheelchair. The two urinary collection bags underneath his wheelchair were dragging on the floor as he was pushed to his table. Nursing staff did not adjust his catheter collection bags. Resident #3's catheter tubing was lying on the floor underneath her wheelchair.</p> <p>On 03/31/2016 at 9:20 A.M., Resident #86 was seated in his wheelchair in hallway talking with CNA #43. His catheter tubing was on the floor and his urine collection bag was also touching the floor. The staff member did not notice the tubing and did not adjust the tubing or bag.</p> <p>During the observation of the noon meal service on the Heritage unit dining room,</p>	F 0441	<p>F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>1. Residents were observed in wheelchairs who had catheters that the tubing was touching the floor.</p> <p>2. All residents with catheters have the potential to be affected by this alleged deficiency.</p> <p>3. New containment bags were purchased to ensure no part of the catheter has the ability to touch the floor and were installed on the wheelchairs of all residents with catheters that used this mode of conveyance.</p> <p>4. An audit of compliance with the Infection Control policy regarding catheters will be completed daily for 30 days, and once a month spot checked for an additional six months. The Central Supply Manager or designee is responsible for this audit. The results will be reviewed as part of the monthly Process Improvement meeting and quarterly Quality Assurance meeting. Any negative results will warrant an additional daily review for another 30 days until 100% compliance is achieved.</p> <p>5. Date of Completion: 5/9/16</p>	05/09/2016	

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	<p>conducted on 03/31/16 from 11:32 A.M. to 12:25 P.M., the following was noted:</p> <p>At 11:32 A.M., CNA #43 pushed Resident #65 into the dining room in his wheelchair. His indwelling urinary catheter tubing was dragging along the floor as she pushed him into the dining room. CNA #43 did not notice or adjust the tubing.</p> <p>At 11:36 A.M., Resident #86 propelled himself into the dining room. His indwelling catheter bag and tubing were both dragging on the floor.</p> <p>At 11:45 A.M., CNA #43 pushed Resident #3 into the dining room with her catheter tubing dragging the floor. Once she had placed Resident #3 at the dining table, she attempted to move Resident #86 up to the table and rolled his wheelchair wheel over the catheter tubing twice. She then realized the catheter tubing was dragging and bent down and attempted to readjust the tubing and bag but left some of the tubing touching the floor. CNA #43 did not attempt to fix the catheter tubing for Resident #3, who was noted to step on the tubing with her shoes while she ate.</p> <p>During a meal observation in the Heritage Hall dining room, conducted on</p>			

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NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580		
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F 0464 SS=D	<p>04/01/16 at 8:03 A.M., the following was noted:</p> <p>Resident #3's catheter tubing was lying on the floor underneath her wheelchair. She was noted to step on the tubing with her left foot.</p> <p>Resident #86's catheter bag was dragging the floor underneath his wheelchair as he was propelling himself into the dining room.</p> <p>A policy was provided by the assistant director of nursing on 4/4/2016 at 10:00 A.M., titled "Catheter Care, Urinary," undated, and indicated this was the policy currently used by the facility. The policy indicated "...11. Be sure the catheter tubing and drainage bag are kept off the floor...."</p> <p>3.1-18(a)</p> <p>483.70(g) REQUIREMENTS FOR DINING &</p>				

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Bldg. 00	<p>ACTIVITY ROOMS</p> <p>The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation and record review, the facility failed to ensure a dining table height was appropriate for 1 of 12 residents eating in 1 of 3 dining rooms. (Resident #2)</p> <p>Finding includes:</p> <p>During the meal services, observed on 03/28/16 at 11:30 A.M. and 03/31/16 at 8:20 A.M. Resident #2 was observed seated in his wheelchair at a dining room table. The table height was at the resident's neck height. Resident #2 was observed to be able to hold a handled cup and drink by himself. The table height made it difficult for him to reach his cup and put it on or off the table. The resident was assisted with his meals.</p> <p>A policy provided by the Administrator on 4/4/2016 at 10:30 A.M., titled "Dining Room Service," undated, and indicated this was the policy currently used by the facility. The policy indicated "...4. Dining room tablets should be adequate in height so that wheelchairs can fit</p>	F 0464	<p>F464 483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS</p> <p>1. Surveyor felt one resident was having difficulty managing eating implements at table due to height of table.</p> <p>2. All residents have the potential to be affected by this alleged deficiency.</p> <p>3. A smaller table has been provided to this resident and additional tables will be ordered as needed or any other equipment that will assist in safety and comfort.</p> <p>4. Residents will be monitored for positioning and ease of effort while eating by the Therapy department and Nursing. Any identified area of concern will be brought to the Administrator and addressed as soon as possible. This is an on-going function of the facility and its staff. Staff were re-educated on the need for daily observation of dining during the All Staff on 5/9/16. Seating needs are presented to the Administrator in Morning Stand Up daily (Mon thru Fri) to be acted upon. An audit of seating needs will be completed by the Program Director weekly for the next 30</p>	05/09/2016

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F 0465 SS=D Bldg. 00	<p>underneath them for more comfortable eating...." There were no specific instructions to ensure the height was not too high for residents seated in wheelchairs.</p> <p>3.1-19(w)(5)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a residents faucet was free from leaks, a residents toilet was secure and one room was free from odors. This affected 3 resident rooms out of 35 rooms observed.</p> <p>Findings include:</p> <p>On 3/29/2016 at 11:42 A.M., the tank of the toilet in the restroom of room 23 was observed to be loose.</p> <p>On 3/29/2016 at 11:53 A.M., the restroom faucet in room 25 was observed to be leaking when turned on.</p>	F 0465	<p>days, and monthly for an additional six months. Those results will be presented to the Quality Assurance group and a negative finding that has not been acted upon will result in an additional 30 day audit until 100% compliance is complete, including any new equipment needed and therapy interventions.</p> <p>5. Date of Completion: 5/9/16</p> <p>F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>1. Surveyor found one toilet bowl that was moveable, one sink leaking, and one bathroom that needed a toilet replacement.</p> <p>2. All residents have the potential to be affected by this alleged deficiency. Resident was moved from room with the toilet that needed replaced. A bariatric toilet was ordered and contractors were selected to tear out the tile and renovate the entire bathroom. Toilet bowl and sink were tightened on the spot.</p> <p>3. An audit of plumbing will be conducted by the Maintenance</p>	05/09/2016	

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	<p>On 3/29/2016 at 11:58 A.M., the restroom in room 42 was observed to have a strong odor.</p> <p>During an environmental tour on 4/4/2016 at 11:04 A.M., the following was noted: A toilet with the tank loose in room 23. A faucet was leaking in the restroom of room 25. Room 42 restroom was observed to have a strong odor.</p> <p>During an interview on 04/04/2016 at 11:04 A.M., the Maintenance Director indicated he was aware of the loose toilets and was in the process of getting them replaced. He further indicated he had been replacing the faucets and had plans of replacing the tile in the restroom with odors.</p> <p>3.1-19(f)</p>		<p>Director or designee daily for 30 days regarding any loose or broken sink or toilet. Broken parts will be replaced to include entire sink or toilet as necessary. All staff and orientees are trained and have been re-educated on the use of the Work Order Books stationed at both nurses stations and know that is where they notify the Maintenance Director of any issues. An additional in-service was completed on 5/9/16 to reemphasize this requirement. Results of this audit will be part of the monthly Process Improvement meeting. Negative results will warrant an additional daily audit for another 30 days until 100% compliance is achieved. A weekly review of plumbing systems was already being conducted and will continue.</p> <p>4. Date of Completion: 5/9/16</p>		