

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2014
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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00157990.</p> <p>Complaint IN00157990-Substantiated. Federal/state deficiencies related to the allegations are cited at F311 and F312.</p> <p>Survey dates: November 12, 13, 14, 15, 16, 17, and 18, 2014</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Survey team: Lara Richards, RN-TC (11/12-11/14 & 11/17-11/18/14) Heather Tuttle, RN (11/12-11/14 & 11/17-11/18/14) Cynthia Stramel, RN (11/12-11/14 & 11/17-11/18/14) Yolanda Love, RN (11/12-11/15 & 11/17-11/18/14) Janelyn Kulik, RN (11/14 & 11/16-11/18/14)</p> <p>Census bed type: SNF: 2 SNF/NF: 84 NCC: 1</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000156 SS=D	<p>Total: 87</p> <p>Census payor type: Medicare: 17 Medicaid: 51 Other: 19 Total: 87</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on November 26, 2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are</p>				

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	<p>included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State</p>			

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	<p>licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure notices were given at the time of discharge indicating how many Medicare days each resident had left for 3 of 3 residents reviewed for liability notices of the 3 who met the criteria for liability notices. (Residents #20, #64 and #97)</p> <p>Findings include:</p> <p>The Liability and Beneficiary Appeal review on 11/18/14 at 2:30 p.m., with the Social Service Director, indicated the following:</p>	F000156	<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or</i></p>	12/18/2014

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	<p>A. Resident #64 was discharged home on 6/6/14. The resident had 50 Medicare days left.</p> <p>B. Resident #20 was discharged to assisted living on 9/16/14. The resident had 24 Medicare days left.</p> <p>C. Resident #97 left the facility against medical advice (AMA) on 7/17/14. The resident had 79 Medicare days left.</p> <p>Interview with the Social Service Director at the time, indicated the above residents were discharged prior to her working at the facility. She indicated that she could not find copies of Medicare Non-coverage letters for the residents.</p> <p>Interview with the Director of Nursing on 11/18/14 at 3:05 p.m., indicated that she was not aware if the above residents received notice of how many Medicare days they had left upon discharge due to this was prior to her start date at the facility.</p> <p>3.1-4(f)(3)</p>		<p><i>executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Residents 64, 20 and 97 have been discharged from the facility.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed of residents that discharged in the last 30 days to ensure that the notices were given 48 hours prior to discharge.</p> <p>3) Measures put into place/ System changes:</p> <p>An audit will be completed weekly of residents that have been</p>	

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving		<p>discharged home or to another facility that were receiving skilled care under their Medicare A benefits to ensure that proper notice was given. Business Office Manager will be responsible for the oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p>		

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	<p>the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the resident's Physician was contacted in a timely manner after a change in condition for 1 of 3 residents reviewed for death of the 3 residents who met the criteria for death. (Resident #110)</p> <p>Finding includes:</p> <p>The record for Resident #110 was</p>	F000157	<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this</i></p>	12/18/2014

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	<p>reviewed on 11/16/14 at 10:32 a.m. The resident's diagnoses, included but were not limited to, altered mental status, rehabilitation, dysphagia, weakness, and atrial-fibrillation (irregular heart beat).</p> <p>A resident progress note dated 10/29/14 at 3:14 a.m., indicated at 1:30 a.m. the resident was noted to have difficulty breathing. LS (lung sounds) bilateral upper lobes (BUL)-2, bilateral lower lobes (BLL)-2. Oxygen checked and was at 72% on room air. Oxygen was started at 3/LPM (liter per minute) via nasal cannula and at 1:45 (a.m. or p.m. was not indicated) the resident's oxygen saturation had risen to 81%. The resident's vital signs were blood pressure-116/71, pulse-83, temperature-96.5, and respirations-22. The resident was monitored throughout this shift and his oxygen saturation was between 86 and 88% with continuous oxygen. The Physician and family were to be contacted in the morning.</p> <p>A resident progress note dated 10/29/14 at 3:59 a.m., indicated the resident's oxygen saturation level was 90% at 3:15 a.m. The oxygen was lowered to 2/LPM. The resident was being monitored. At 7:52 a.m., the resident progress note indicated a message was left for family at 7:50 (a.m. or p.m. was not indicated) to</p>		<p><i>plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident 110 expired.</p> <p>2) How the facility identified other residents:</p> <p>Documentation audit was completed to identify residents with a change in condition and to verify physician notification for the month of November.</p> <p>3) Measures put into place/ System changes:</p> <p>Nurses have been in-serviced on Physician Notification Policy.</p>				

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	<p>phone the facility on a non-emergency incident. The Physician was contacted via pager and followed up by fax. Staff were awaiting a response.</p> <p>At 2:06 p.m., the resident was put on 3 L (liters) of oxygen on the evening shift. The resident's oxygen saturation was now at 98%. The resident had a temperature of 100.5. The resident was given as needed Tylenol at 1:20 p.m. The resident's temperature was rechecked at 1:50 p.m. and the temperature was 99.5, blood pressure-72/47. The resident's blood pressure was rechecked every 15 minutes. At 2:00 p.m. the resident's blood pressure was 80/50. The Physician was paged and a message was left with the family. The staff were still waiting for a response. Documentation at 3:04 p.m., indicated the resident was being transferred to the emergency room at 3:10 (a.m. or p.m. was not indicated) per the Physician. The resident's vital signs were temperature-99.4, oxygen saturation-95% on 3 L of oxygen, heart rate-72, and blood pressure was 70/48 at 3:00 p.m.</p> <p>Interview with the Evening Nurse Supervisor and the Assistant Director of Nursing on 11/18/14 at 2:08 p.m., indicated per the Evening Nurse Supervisor, she could not be sure the Physician was not called but would say it did not appear the Physician was</p>		<p>Documentation will be reviewed on a minimum of 5 residents per week with a change in condition to verify that the physician was notified timely.</p> <p>All missed notifications will be corrected immediately and the responsible nurse will be re-educated/counseled as indicated.</p> <p>Director of Nursing is responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p>	

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F000225 SS=D	<p>contacted and the Physician should have been contacted. The Assistant Director of Nursing also indicated the Physician should have been notified when the change of condition first occurred and the staff should not have waited until the morning to contact the Physician.</p> <p>The facility, Physician Notification For Change In Condition Policy, was provided by the Director of Nursing on 11/17/14 at 9:40 a.m. "Policy: to assure the physician is notified of changes in the patient's condition as determined by the nursing assessment immediately upon observation. The resident's primary physician or designated alternate will be notified immediately of any changes in the resident's physical or mental condition. When it is off hours or on the weekend the physician will be notified or the 'On Call" physician will be contacted."</p> <p>3.1-5(a)(2)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>		12/18/2014				

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	<p>any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to obtain the required pre-screening procedures for all new employees hired by the facility related to criminal history background checks for 1 of 1 contracted employee files reviewed. (Occupational Therapist #1)</p> <p>Findings include:</p>	F000225	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</i></p>	12/18/2014

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F000226 SS=D	<p>The Employee files were reviewed on 11/18/2014 at 10:30 a.m. Occupational therapist #1 was hired on 8/25/14, there was no evidence a criminal history background check had been completed prior to or at the time of employment.</p> <p>Interview with the Physical Therapy (PT) Director on 11/18/14 at 2:32 p.m., indicated there was no criminal history background check in the employee's file. He further indicated the criminal history background check was not completed prior to or at the time of employment.</p> <p>3.1-28(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident</p>		<p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> 1) Immediate actions taken for those residents identified: Background check was completed for Occupational Therapist #1. 2) How the facility identified other residents: An audit completed on all contracted Therapy employee files to ensure that background checks were completed prior to start date. 3) Measures put into place/ System changes: New employee files will be audited to ensure background checks were requested prior to or on hire date. Human Resources Director and Therapy Director will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/18/2014</p>		

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	<p>property. Based on record review and interview, the facility failed to obtain the required pre-screening procedures for all new employees hired by the facility related to criminal history background checks for 1 of 1 contracted employee files reviewed. (Occupational therapist #1)</p> <p>Findings include:</p> <p>The Employee files were reviewed on 11/18/2014 at 10:30 a.m. Occupational Therapist #1 was hired on 8/25/14. There was no evidence a criminal history background check had been completed prior to or at the time of employment.</p> <p>Review of the current Abuse, Neglect, and Misappropriation of Resident Property Policy provided by the Director of Nursing (DON) on 11/17/14 at 9:30 a.m., indicated "The facility will screen all potential employees for a history of abuse, neglect of mistreatment, including attempting to obtain information from previous employers or current employer and checking with appropriate licensing boards and registries."</p> <p>Interview with the Physical Therapy (PT) Director on 11/18/14 at 2:32 p.m., indicated there was no criminal history background check in the employee's file.</p>	F000226	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Background check was completed for Occupational Therapist #1. 2) How the facility identified other residents: An audit completed on all contracted Therapy employee files to ensure that background checks were completed. 3) Measures put into place/ System changes: New employee files will be audited to ensure background checks were requested prior to or on hire date. Human Resources Director and Therapy Director will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting</i></p>	12/18/2014			

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F000241 SS=D	<p>He further indicated the criminal history background check was not completed prior to or at the time of employment.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident maintained their dignity related to being dressed in a hospital gown and affording privacy while providing care for 2 of 3 residents reviewed for dignity of the 5 who met the criteria for dignity. (Residents #B and #61)</p> <p>Findings include:</p> <p>1. On 11/13/14 at 10:33 a.m. and 1:45 p.m., Resident #61 was observed in bed wearing a hospital gown.</p> <p>On 11/14/14 at 9:17 a.m. and 10:13 a.m., the resident was observed in bed wearing a hospital gown. Interview with CNA #5 at that time, indicated the resident gets dressed on her shower days. The CNA indicated there was no reason the resident</p>	F000241	<p>monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/18/2014</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for</p>	12/18/2014

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	<p>was dressed in a hospital gown and further indicated the resident did have clothes in her closet.</p> <p>On 11/14/14 at 1:44 p.m., the resident was observed in bed wearing a hospital gown.</p> <p>The record for Resident #61 was reviewed on 11/14/14 at 9:19 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/5/14, indicated the resident was totally dependent with 2 person physical assist for dressing.</p> <p>The current plan of care updated 9/2014, indicated there was no care plan for being dressed in a hospital gown.</p> <p>Interview with the Assistant Director of Nursing on 11/17/14 at 10:10 a.m., indicated the resident should have been dressed in regular clothes rather than a hospital gown.</p> <p>2. On 11/17/14 at 6:45 a.m., Resident #B was observed during Activities of Daily Living (ADL) care. CNA #4 entered the resident's room and closed the door, she attempted to pull the privacy curtain to honor the resident's privacy, however, the curtain track had tissues stuck within the</p>		<p>those residents identified:</p> <p>Resident #61 out of the facility.</p> <p>Resident B Privacy curtain has been properly repaired.</p> <p>2) How the facility identified other residents:</p> <p>Audit of all resident rooms has been completed to ensure that privacy curtains are in place and are properly working.</p> <p>All residents that are dependent on staff for dressing have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Nursing staff have been in-serviced on the importance of getting residents dressed daily unless their preference is to remain in a hospital gown, and to ensure privacy is provided during care.</p> <p>A minimum of 5 residents per week will be observed during care on varied shifts to ensure privacy is provided during care, and privacy curtains will be checked to ensure that they are working properly.</p>				

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F000242 SS=D	<p>tracks preventing the curtain from being pulled. The resident's roommate was seated in a chair facing the door to the room placing her in full view of the resident. The resident was lifted into a Hoyer (a transferring device) from her bed, as she was being transferred to the bathroom her brief was exposed.</p> <p>Interview with the Director of Nursing (DON) on 11/17/14 at 10:07 a.m., indicated the privacy curtain was not functioning properly and was in need of repair.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care</p>		<p>During rounds a minimum of 5 residents will be observed to ensure that they are dressed appropriately.</p> <p>Any discrepancies will be corrected by staff.</p> <p>Director of Nursing and Administrator will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p>		

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	<p>consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure each resident's choice was honored related to their preference on when to get up in the morning for 1 of 3 residents reviewed for choices of the 7 who met the criteria for choices. (Resident #E)</p> <p>Findings include:</p> <p>Interview with Resident #E on 11/13/14 at 1:21 p.m., indicated the Nursing staff wake her up at 6:15 a.m., to give her medications. She indicated that was too early for her to wake up.</p> <p>Continued interview with Resident #E on 11/17/14 at 9:23 a.m., indicated she does not want to get up before 8:00 a.m. She indicated she used to be a teacher and always got up early but that does not always mean she likes to get up early. She would prefer to be awakened after 8:00 a.m.</p> <p>The record for Resident #E was reviewed on 11/14/14 at 12:41 p.m.</p> <p>The CNA flow sheet, indicated there was</p>	F000242	<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Get up time for resident E has been adjusted to her preference.</p>	12/18/2014

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	<p>no time preference documented on when the resident wished to get out of bed in the morning.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 10/1/14, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 11, which indicated she was cognitively intact. The activity preferences section, indicated it was very important for the resident to choose her own bedtime.</p> <p>The 11/2014 Medication Administration Record (MAR), indicated the resident did receive Levothyroxine (a thyroid medication) and Norco (a pain medication) at 6:00 a.m.</p> <p>Interview with CNA #6 on 11/17/14 at 9:47 a.m., indicated the resident was alert and oriented and requested when she wanted to get up in the morning.</p> <p>Interview with CNA #8 on 11/17/14 at 11:10 a.m., indicated he got the resident up today around 7:20 a.m. He further indicated the resident does not usually request to get out of bed, he just gets the resident up before breakfast. The CNA further indicated if the resident chose to stay in bed a little longer, he would agree and come back in and get her up 20</p>		<p>2) How the facility identified other residents:</p> <p>Interviews have been done with all residents and/or their family to identify their preferences.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff have been in-serviced on Resident Choices.</p> <p>Preference interviews will be done for each resident at admission during MDS assessment period and quarterly thereafter. Get up times will be adjusted to meet the residents' preferences. Activity Director will be responsible for the oversight.</p> <p>Medication Administration times will be adjusted to meet resident preferences where possible. Director of Nursing will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be</p>				

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F000248 SS=D	<p>minutes later but no later than 7:45 a.m., in time for breakfast. He further indicated he had not ever asked the resident her preference on when she wanted to get out of bed.</p> <p>Interview with the Assistant Director of Nursing on 11/17/14 at 11:43 a.m., indicated it should be the resident's choice on what time to get out of bed in the morning. She further indicated the resident's medication times could be adjusted to her schedule.</p> <p>3.1-3(u)(3)</p> <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, record review and interview, the facility failed to ensure activities were provided for 2 of 3 cognitively impaired dependent residents reviewed for activities of the 3 residents who met the criteria for activities. (Residents #D and #103)</p> <p>Findings include:</p>	F000248	<p>reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 12/18/2014</p> <p>F 248</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of</i></p>	12/18/2014	

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	<p>1. On 11/14/14 at 9:22 a.m., 10:23 a.m., and 10:50 a.m., Resident #103 was observed in his room in bed. The resident was awake and looking out of the window. The resident did not have a television in his room and the clock radio on his dresser was not turned on.</p> <p>The record for Resident #103 was reviewed on 11/14/14 at 9:29 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>The 10/24/14 Admission Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems. Review of the Activity preference section, indicated it was somewhat important to the resident to listen to music that he liked.</p> <p>The Activity progress note dated 10/24/14 at 12:54 p.m., indicated the resident enjoyed listening to music and that he needed encouragement and assistance with activities.</p> <p>The Activity progress note dated 10/31/14 at 12:48 p.m., indicated the resident enjoyed listening to music and visits with his family.</p> <p>Interview with the Director of Nursing on</p>		<p><i>compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident D and #103 were provided with music and/or television turned on.</p> <p>2) How the facility identified other residents:</p> <p>Audit completed of dependent residents in bed to ensure that residents were out of bed or had TV or music on per their preference.</p>		

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	<p>11/18/14 at 1:45 p.m., indicated the resident should have had music playing in his room.</p> <p>2. Interview with Resident #D's family member on 11/13/14 at 11:45 a.m., indicated the facility did not get the resident out of her bed, or take her to activities. The family member indicated that staff used to get her up to a wheelchair so she could at least look out the window, but they did not do that any more.</p> <p>On 11/13/14 at 8:30 a.m., the resident was observed in bed. There was a handwritten note taped to the wall next to the resident's bed that indicated to leave the TV on Spanish stations, and to get resident out of bed at least once a day. It was signed by a family member. At 11:25 a.m., the resident was observed in bed wearing a hospital gown, there was no music or TV on. At 2:30 p.m., the resident was again observed in bed, wearing a hospital gown, the TV next to her bed was on. There was a church event being held in the activity area down the hall at that time.</p> <p>On 11/14/14 at 8:45 a.m., the resident was observed in bed, she was wearing a hospital gown, the TV was not on. At 11:15 a.m., she was dressed in a black</p>		<p>3) Measures put into place/ System changes:</p> <p>Random observations will be performed on at least 5 cognitively impaired residents per week at varied times to ensure that activities are provided. Activity Director will be responsible for the oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p>				

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	<p>shirt in bed, there was no TV or music on. There were residents gathered in the activity room down the hall, singing at that time. At 12:28 p.m., she was in bed awake, there was no TV or music on. At 2:20 p.m. the resident remained in bed with no TV or music on.</p> <p>On 11/16/14 at 8:36 a.m., the resident was in bed awake, wearing a hospital gown. There was no TV or music on. At 11:22 a.m., she was up in a reclining wheelchair in her room next to her bed, there was no TV or music on.</p> <p>The record for Resident #D was reviewed on 11/14/14 at 8:00 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>The Quarterly Minimum Data Set assessment dated 9/26/14, indicated the resident had severe cognitive impairment. She required extensive, two person assistance for bed mobility, and was totally dependant for transferring and dressing</p> <p>An Activities care plan originally dated 8/13/13, which was reviewed on 8/14/14, indicated the resident was a passive observer for activities, and staff played Spanish music for her. The goal was for the resident to attend activities as a</p>			

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F000272 SS=D	<p>passive observer for sensory stimulation four times a week. Approaches included to escort her to Catholic mass, sing along's, sensory music and provide Spanish music for the resident.</p> <p>Interview with the Activity Director on 11/14/14 at 2:51 p.m., indicated the family did not want the resident to get out of bed so they were doing one on one activities two times a week. Further interview with the Activity Director on 11/17/14 at 10:30 a.m., indicated they couldn't bring the resident to activities if she was in bed. She indicated it was Nursing's responsibility to get residents out of bed.</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;</p>				

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	<p>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 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 record review and interview, the facility failed to complete a bladder assessment for those residents who were incontinent for 3 of 3 residents reviewed for urinary incontinence of the 3 residents who met the criteria for urinary incontinence. (Residents #25, #55 and #83)</p> <p>Findings include:</p> <p>1. The record for Resident #25 was reviewed on 11/17/14 at 1:20 p.m. The resident was admitted to facility on 5/30/14. The resident's diagnoses included, but were not limited to, urinary tract infection, bladder cancer, benign prostate hypertrophy, hematuria and kidney stones.</p>	F000272	<p>F 272</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or</i></p>	12/18/2014

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	<p>The Admission Minimum Data Set (MDS) assessment dated 6/6/14, indicated the resident was occasionally incontinent of bladder.</p> <p>The Quarterly MDS assessment dated 9/1/14, indicated the resident was frequently incontinent of bladder, a decline from the previous assessment.</p> <p>Review of the bowel and bladder assessment (not dated), indicated it had not been completed for the resident.</p> <p>Interview with the Director of Nursing (DON) on 11/17/14 at 3:07 p.m., indicated a bladder assessment had not been completed for the resident. She further indicated the bladder assessments were to be completed at the time of admission and quarterly.</p> <p>2. The record for Resident #55 was reviewed on 11/14/14 at 12:25 p.m. The resident's diagnoses included, but were not limited to, dementia and decreased mental status.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated 8/26/14, indicated the resident was always incontinent of bladder.</p>		<p><i>executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Bladder assessments have been completed for residents #25, 55 and 83.</p> <p>2) How the facility identified other residents:</p> <p>Audit completed of in house residents for completion of Bladder Assessments.</p> <p>3) Measures put into place/ System changes:</p> <p>A minimum of 5 residents will have Bladder Assessments done by Restorative or MDS nurse weekly in addition to those due for quarterly assessments per MDS schedule until all have been completed. Bladder assessments</p>	

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	<p>The bladder assessment (no date) indicated it was only half completed and was not dated. The last completed bladder assessment on the chart was dated 5/28/14, which indicated the resident continued to have episodes of incontinence.</p> <p>Interview with the Director of Nursing on 11/17/14 at 3:07 p.m., indicated there was no current bladder assessment.</p> <p>3. The record for Resident #83 was reviewed on 11/16/14 at 8:47 a.m. The resident's diagnoses included, but were not limited to, dyspnea (difficulty breathing), hypertension (high blood pressure), diabetes mellitus, peripheral neuropathy, vertebral compression, and exacerbation of congestive heart failure.</p> <p>There was a bowel and bladder assessment completed on 5/20/14 with a recommendation to monitor voiding times for three days.</p> <p>There was a three day monitoring of voiding started on 6/12/14. There were no documentation of results.</p> <p>A Significant Change MDS (Minimum Data Set) assessment dated 6/18/14, indicated the resident was always continent of urine</p>		<p>will then be done quarterly with MDS or with significant change thereafter. Restorative Nurse will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p>		

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	<p>A Quarterly MDS dated 9/3/14, indicated the resident was occasionally incontinent of urine.</p> <p>A Quarterly MDS dated 11/4/14, indicated the resident was occasionally incontinent of urine.</p> <p>The Bowel and Bladder Assessment Policy was provided by the Director of Nursing (DON) on 11/18/14 at 8:04 a.m. The policy indicated based on the resident's comprehensive assessment the facility will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder function as possible. Each resident will be assessed for 72 hours for bowel and bladder voiding patterns on admission, quarterly, and with significant change in elimination patterns with evaluations for feasibility in training for bowel and bladder control. The licensed nurse will gather information from the chart, the resident's family representative, staff members, from resident observations, and from the review and analysis of the 72 hour voiding patterns. The resident's plan of care will be developed to address the issue, goals and appropriate interventions for elimination program, consult with the Physician or</p>			

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F000280 SS=D	<p>Nurse Practitioner for physical and pelvic exam as needed.</p> <p>Interview with the Director of Nursing on 11/18/14 at 7:45 a.m. indicated, there were no other bowel and bladder assessments completed for Resident #83. She would check to see what the facility policy indicated. Further interview at 8:04 a.m., indicated bowel and bladder assessments should be done quarterly and with significant medical changes.</p> <p>3.1-31(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview,</p>	F000280	F 280	12/18/2014

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	<p>the facility failed notify a resident's family member of care planning conferences for 1 of 1 residents reviewed for care planning participation of the 3 residents who met the criteria for care planning participation. (Resident #D)</p> <p>Findings include:</p> <p>Interview with Resident #D's family member on 11/13/14 at 11:51 a.m., indicated she was not invited to the care plan conferences.</p> <p>The record for Resident #D was reviewed on 11/14/14 at 8:00 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>The Significant Change Minimum Data Set assessment dated 2/13/14, indicated the resident was severely cognitively impaired. The Preference section had been completed with family and indicated it was very important for family to be involved in her care.</p> <p>Interview with the Activity Director on 11/14/14 at 2:51 p.m., indicated letters were sent out to family members prior to care planning conferences. She indicated care plan conferences were held quarterly, the last one for the resident was on 8/14/14. She indicated she was</p>		<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Care Plan Meeting was held with family of Resident D.</p> <p>2) How the facility identified other residents:</p> <p>Unable to determine residents</p>		

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	<p>unable to locate documentation that the resident's family had been invited to any care planning conferences in the past year.</p> <p>3.1-35(d)(2)(B)</p>		<p>affected. Facility did not keep documentation of care plan invitations sent to family or residents. Therefore, all residents have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Care Plan invitations will be provided to resident and/or family/legal representative at least quarterly, and will be documented in resident record.</p> <p>An audit will be completed of at least 5 residents per week who had an MDS completed the previous week to ensure notice was provided. MDS/Care Plan Coordinator will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to ensuring fall precautions were in place for 1 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. The facility also failed to ensure activities were provided for 1 of 3 residents reviewed for activities of the 3 residents who met the criteria for activities, a protective ointment was applied following incontinence care for 1 of 3 residents reviewed for activities of daily living (ADL) assistance of the 3 who met the criteria for ADL assistance, and tracheostomy care not being provided as care planned for 1 of 1 residents reviewed for tracheostomy care. (Residents #D, #80 and #95)</p> <p>Findings include:</p>	F000282	<p>5) Date of compliance:</p> <p>12/18/2014</p> <p>F 282</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	12/18/2014

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	<p>1. On 11/17/14 at 2:15 p.m. and 3:10 p.m., Resident #80 was observed in her wheelchair. The resident was propelling herself with her feet down the hallway. The resident was also observed trying to lift her bottom off of the seat of the wheelchair. At 3:12 p.m., CNA #10 assisted the resident to stand up. There was no dycem (a material to prevent sliding in the wheelchair) on top of the wheelchair seat. There was no wheelchair cushion observed in the resident's wheelchair at this time.</p> <p>On 11/18/14 at 10:27 a.m., the resident was seated in her wheelchair in the Maple dining room. At 10:42 a.m., the resident was assisted to stand by Restorative CNA #1. There was no dycem on top of the resident's wheelchair seat.</p> <p>The record for Resident #80 was reviewed on 11/14/14 at 1:24 p.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease with behaviors.</p> <p>The plan of care dated 8/11/14, indicated the resident was at risk for falls related to poor safety awareness, impaired mobility and psychotropic medication use. The interventions included, but were not limited to, dycem to wheelchair.</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>Resident D was provided incontinence care, ointment provided for application and orders were reviewed by the physician.</p> <p>Resident D was dressed and placed in geri-chair, TV turned on to Spanish station per request.</p> <p>Dycem was placed in the chair for Resident 80.</p> <p>Resident 95 was given proper tracheostomy care.</p> <p>2) How the facility identified other residents:</p> <p>2 residents in the facility have a tracheostomy. Both residents were provided tracheostomy care.</p> <p>All residents with fall prevention devices were checked to ensure devices were in place.</p> <p>Physician orders were checked to identify any other residents with orders for ointments or barrier creams to be applied after incontinence episodes.</p>	

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	<p>Interview with the Director of Nursing on 11/18/14 at 11:10 a.m., indicated the resident should have had the dycem in her wheelchair.</p> <p>2. On 11/17/14 at 2:05 p.m., LPN #2 was observed suctioning Resident #95 by way of a tracheostomy. At that time, the LPN had suctioned the resident four times. After suctioning, she cleaned up the sputum on his chest and removed the split gauze sponge from around the tracheostomy. She then listened to the resident's lungs with a stethoscope. The LPN then replaced the split gauze sponge around the trach with a new one. She then cleaned up the bed side table and threw away her garbage.</p> <p>Interview with LPN #2 at that time, indicated she had just performed trach care. The LPN indicated that was what she does regarding trach care. The LPN was then asked to explain how she would clean around the tracheostomy. She then indicated she would use normal saline and wipe around the trach. The LPN further indicated that she really did not know what to do regarding trach care, since it had been so long since she had to do that. The LPN indicated trach care was supposed to be done one time every shift.</p>		<p>Audit completed of dependent residents in bed to ensure that residents were out of bed or had TV or music on per their preference.</p> <p>Care Plans and orders have been reviewed and been updated.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff have been in-serviced on safety interventions, incontinence care, ADL care including dressing residents daily and getting out of bed for activities, ensuring TV or music is on when residents are in bed during waking hours as per preference or care plan.</p> <p>Licensed staff have been in-serviced on policy and procedures for tracheostomy care.</p> <p>A minimum of 5 residents per week will be observed on varied shifts to ensure safety interventions are in place. The DON or designee will be responsible for oversight.</p> <p>A minimum of 3 licensed nurses will be observed providing</p>		

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	<p>The record for Resident #95 was reviewed on 11/18/14 at 9:22 a.m. The resident's diagnoses included, but were not limited to, anoxic brain injury, stroke, and chronic respiratory failure.</p> <p>The current 11/2014 Physician order recap, indicated trach care every shift. The original order was 7/31/14.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/5/14, indicated the resident was in a vegetative state and was totally dependent with 2 person physical assist for transfers, bed mobility, dressing, toilet use, and bathing. While a resident in the facility, he required oxygen therapy, suctioning, and tracheostomy care.</p> <p>The care plan dated 8/7/14, indicated potential for complications related to a tracheostomy. The Nursing approaches were to suction daily as ordered and as needed and to provide trach care as ordered.</p> <p>Interview with the Director of Nursing on 11/17/14 at 3:07 p.m., indicated the LPN performed suctioning and not tracheostomy care as ordered by the Physician and as care planned.</p>		<p>tracheostomy care per week on varied shifts. The DON or designee will be responsible for oversight.</p> <p>Incontinence care observations will be done on at least 5 incontinent residents per week on varied shifts to ensure incontinence care is provided properly and ointments/ barrier cream applied as ordered. The DON or designee will be responsible for oversight.</p> <p>Random observations will be performed on at least 5 cognitively impaired residents per week at varied times to ensure that activities are provided. Activity Director will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>	

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	<p>3. On 11/14/14 at 1:23 p.m., CNA #1 was observed performing incontinence care for Resident #D. After cleaning the residents peri-area and buttocks, the CNA applied a clean brief. She did not apply any creams or ointments. She indicated she was not aware if any cream or ointments were to be applied, but would check with the nurse.</p> <p>The record for Resident #D was reviewed on 11/14/14 at 8:00 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>A care plan dated 5/28/14, indicated the resident was incontinent of bladder related to dementia. The goal was to be free from skin breakdown. Approaches included to provide extensive assistance for routine toileting and incontinence care after each incontinent episode.</p> <p>The November 2014 Physician Order Statement indicated, Calmoseptine (a medicated topical treatment) was to be applied to the resident's buttocks each shift and after each incontinent episode.</p> <p>Interview with LPN #1 on 11/14/14 at 2:00 p.m., indicated CNA's were not allowed to apply Calmoseptine, that had to be done by the nurse. She indicated the CNA's should tell the nurse, so the</p>		<p>5) Date of compliance:</p> <p>12/18/2014</p>				

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	<p>nurse could apply the Calmoseptine during incontinence care.</p> <p>Interview with CNA #2 on 11/14/14 at 2:16 p.m., indicated she was familiar with the resident and had previously cared for her. She indicated the resident received a house barrier cream to her buttocks. She was not aware of an order for Calmoseptine. There was a tube of house barrier cream in the resident's bedside table.</p> <p>On 11/13/14 at 8:30 a.m., the resident was observed in bed, there was a handwritten note taped to the wall next to the resident's bed that indicated to leave the TV on Spanish stations and to get the resident out of bed at least once a day. The note was signed by a family member. At 11:25 a.m., the resident was observed in bed wearing a hospital gown, there was no music or TV on. At 2:30 p.m., the resident was again observed in bed, wearing a hospital gown, the TV next to her bed was on. There was a church event being held in the activity area down the hall at that time.</p> <p>On 11/14/14 at 8:45 a.m., the resident was observed in bed, she was wearing a hospital gown, the TV was not on. At 11:15 a.m., she was dressed in a black shirt in bed, there was no TV or music</p>			
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	<p>on. There were residents gathered in the activity room down the hall, singing at that time. At 12:28 p.m., she was in bed awake, there was no TV or music on. At 2:20 p.m., the resident remained in bed with no TV or music on.</p> <p>On 11/16/14 at 8:36 a.m., the resident was in bed awake, wearing a hospital gown. There was no TV or music on. At 11:22 a.m., she was up in a reclining wheelchair in her room next to her bed, there was no TV or music on.</p> <p>An Activities care plan for Resident #D originally dated 8/13/13, which was reviewed on 8/14/14, indicated the resident was a passive observer for activities, and staff played Spanish music for her. The goal was for the resident to attend activities as a passive observer for sensory stimulation four times a week. Approaches included to escort her to Catholic mass, sing along's, sensory music and provide Spanish music for the resident.</p> <p>Interview with Activity Director on 11/14/14 at 2:51 p.m., indicated the family did not want the resident to get out of bed so they were doing one on one activities two times a week. Further interview with the Activity Director on 11/17/14 at 10:30 a.m., indicated they</p>			

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F000311 SS=D	<p>couldn't bring the resident to activities if she was in bed. She indicated it was Nursing's responsibility to get the residents out of bed.</p> <p>3.1-35(g)(2)</p> <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 record review and interview, the facility failed to ensure each resident received a shower at least twice a week for those residents who needed assistance with bathing for 3 of 3 residents reviewed for activities of daily living of the 7 who met the criteria for activities of daily living. (Residents #B, #C and #E)</p> <p>Findings include:</p> <p>1. Interview with Resident #E on 11/13/14 at 1:21 p.m., indicated she did not know how many times a week she took a shower because it changed all the time. She indicated they used to give her showers on Mondays and Thursdays, then it was Tuesdays and Fridays and now she just really did not know when. She indicated she just goes when they come to get her.</p>	F000311	<p>F 311</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state</i></p>	12/18/2014

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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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	<p>Continued interview with Resident #E on 11/17/14 at 9:23 a.m., indicated her shower schedule was always messed up and did not really know when she gets a shower.</p> <p>The record for Resident #E was reviewed on 11/14/14 at 12:41 p.m. The Annual Minimum Data Set (MDS) assessment dated 10/1/14, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 11, indicating she was cognitively intact. Review of the activity preferences, indicated it was very important for the resident to choose between a shower and a tub bath.</p> <p>The CNA flow sheet, indicated the resident's showers were to be given on Wednesday and Saturday evenings.</p> <p>The most recent shower schedule for the resident dated 10/13/14, indicated the resident received her showers on Monday and Thursday evenings.</p> <p>The handwritten shower sheets completed by the CNA's, indicated the only documented showers were on 9/27 and 11/10/14.</p> <p>The shower sheets in the point of care</p>		<p><i>law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Showers were given to Residents C, E, and B.</p> <p>2) How the facility identified other residents:</p> <p>Audit of showers for November completed to identify any other residents affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Nursing staff have been educated on the importance of bathing residents per schedule.</p> <p>Bathing documentation will be reviewed on at least 5 residents per week to ensure bathing schedules are followed. Any discrepancies will be addressed with appropriate education/counseling.</p>	

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	<p>charting (computer) by the CNA's indicated the resident received a shower on 9/3, 9/13 and 9/27/14. She received showers on 10/8, 10/16/14 and on 11/14/14 for the month of November 2014.</p> <p>Interview with the Director of Nursing on 11/14/14 at 11:00 a.m., indicated the resident should have received a shower at least two times a week.</p> <p>2. The record for Resident #B was reviewed on 11/15/14 at 11:00 a.m. The resident's diagnoses included, but were not limited to, major depression, hypertension, and muscle weakness.</p> <p>The Weekly Skin Check sheets, indicated the resident had showers on 10/12/14, 10/20/14, 10/23/14, 10/29/14, and 10/31/14. Review of the Point of Care History, indicated the resident had one shower on 11/14/14.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 10/7/14, indicated the resident required extensive assistance with personal hygiene and physical help in part of bathing.</p> <p>The plan of care dated 10/21/14, indicated the resident had a self care deficit and required assistance with daily</p>		<p>The Director of Nursing will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p>				

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	<p>care needs.</p> <p>The interventions included, but were not limited to, assist in proper grooming/personal hygiene techniques.</p> <p>Interview with the Director of Nursing (DON) on 11/15/2014 at 12:03 p.m., indicated it was her expectation for the residents to be bathed/showered at least twice a week and if they refused to shower they were to be given a bed bath. Further interview indicated there was no documentation in the Nursing progress notes indicating the resident had refused showers. The resident should have been bathed according to her scheduled shower days.</p> <p>3. The record for Resident #C was reviewed on 11/14/2014 at 12:59 p.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's, diabetes, neuropathy, and cellulitis/abscess to the foot.</p> <p>The Point of Care History, indicated the resident had showers on 9/10/14, 9/17/14, 9/24/14, 10/1/14, and 10/8/14. Review of the Shower Skin sheets, indicated the resident had showers on 10/1/14 and 10/22/14.</p> <p>The Quarterly Minimum Data Set (MDS)</p>			

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	<p>assessment dated 9/23/14, indicated the resident required limited assistance with personal hygiene and physical help in part of bathing.</p> <p>The plan of care dated 6/26/14, indicated the resident had a self care deficit and required supervision to limited assist with dressing and grooming needs. The resident required hands on assist with bathing needs.</p> <p>The interventions included, but were not limited to, provide assistance for self care needs.</p> <p>Interview with the Director of Nursing (DON) on 11/15/2014 at 12:03 p.m., indicated it was her expectation for the residents to be bathed/showered at least twice a week and if they refused to shower they were to be given a bed bath. Further interview indicated, there was no documentation in the Nursing progress notes indicating the resident had refused showers. The resident should have been bathed according to her scheduled shower days.</p> <p>This Federal tag relates to Complaint IN00157990.</p> <p>3.1-38(a)(2)(A)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to provide at least two showers a week for a dependant resident for 1 of 3 residents reviewed for activities of daily living (ADL'S) of the 7 who met the criteria for ADL's. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 11/14/14 at 8:00 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/26/14, indicated the resident had severe cognitive impairment. She required extensive, two person assistance for bed mobility, and was totally dependant for transferring, bathing and dressing.</p> <p>A care plan originally dated 5/28/13, and reviewed on 8/14/14, indicated the</p>	F000312	<p>F 312</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for</p>	12/18/2014
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	<p>resident had functional deficits and was not able to perform captivities of daily living (ADL's). The approaches included to provide extensive assistance with bed mobility, bathing, dressing, grooming and incontinence needs.</p> <p>The CNA flowsheet indicated, the resident was scheduled to receive showers two times a week on Wednesday and Saturday. The shower sheets and Point of Care history for the resident's showers since 9/1/14 were reviewed. There was no documentation the resident received a shower as scheduled on 9/3, 9/13, 10/22, 10/25, 10/29, 11/1, 11/8 and 11/15/14.</p> <p>Interview with the MDS Coordinator on 11/18/14 at 9:30 a.m., indicated there was no additional documentation related to the resident's showers.</p> <p>This Federal tag relates to Complaint IN00157990.</p> <p>3.1-38(a)(3)</p>		<p>those residents identified:</p> <p>Shower was given to Residents D.</p> <p>2) How the facility identified other residents:</p> <p>Audit of showers for November completed to identify any other residents affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Nursing staff have been educated on the importance of bathing residents per schedule.</p> <p>Bathing documentation will be reviewed on a minimum of 5 residents per week to ensure bathing schedules are followed. Any discrepancies will be addressed with appropriate education/counseling.</p> <p>The Director of Nursing will be responsible for oversight of these audits.</p>		

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F000323 SS=D	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, record review and interview, the facility failed to ensure fall prevention measures were in place as ordered for a resident who had a history of falls as well as providing supervision for a resident who had a history of falls for 2 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Residents #53 and #80)	F000323	<p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p> <p>F 323</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the</i></p>	12/18/2014
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	<p>Findings include:</p> <p>1. On 11/17/14 at 2:15 p.m. and 3:10 p.m., Resident #80 was observed in her wheelchair. The resident was propelling herself with her feet down the hallway. The resident was also observed trying to lift her bottom off of the seat of the wheelchair. At 3:12 p.m., CNA #10 assisted the resident to stand up. There was no dycem (a material to prevent sliding) on top of the wheelchair seat. There was no wheelchair cushion observed in the resident's wheelchair at this time.</p> <p>On 11/18/14 at 10:27 a.m., the resident was seated in her wheelchair in the Maple dining room. At 10:42 a.m., the resident was assisted to stand by Restorative CNA #1. There was no dycem on top of the resident's wheelchair seat.</p> <p>The record for Resident #80 was reviewed on 11/14/14 at 1:24 p.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease with behaviors.</p> <p>An entry in the Nursing progress notes dated 9/24/14 at 4:15 p.m., indicated the resident was observed sitting on the floor</p>		<p><i>center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident 53 was encouraged to stay in public areas, redirected as needed by staff.</p> <p>Resident 80 dycem was placed in her wheelchair.</p> <p>2) How the facility identified other residents:</p> <p>Review of falls for November to identify other residents.</p>	

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	<p>in front of her wheelchair in the hallway. The resident indicated she slid out of her wheelchair onto the floor. Dycem was placed in the resident's wheelchair at this time.</p> <p>Review of the 9/24/14 Fall assessment indicated the resident scored a "20" which indicated that she was high risk.</p> <p>An entry in the Nursing progress notes dated 11/9/14 at 4:45 a.m., indicated at 2:00 a.m., the CNA found the resident sitting on the floor next to her bed.</p> <p>The 11/3/14 Quarterly Minimum Data Set (MDS) assessment, indicated the resident needed extensive assist with transfers. The resident was also identified as having two or more falls with no injury since her last assessment.</p> <p>The plan of care dated 8/11/14, indicated the resident was at risk for falls related to poor safety awareness, impaired mobility and psychotropic medication use. The interventions included, but were not limited to, dycem to wheelchair.</p> <p>Interview with the Director of Nursing on 11/18/14 at 11:10 a.m., indicated the resident should have had the dycem in her wheelchair.</p>		<p>3) Measures put into place/ System changes:</p> <p>Nursing staff will be in-serviced on the importance of ensuring safety measures are in place and redirecting residents with history of falls to supervised areas.</p> <p>During routine rounds a minimum of 5 residents per week who have a history of falls will be observed at varied times/shifts to ensure that safety interventions are in place and that residents are in a supervised area. Director of Nursing will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p>	

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	<p>2. On 11/17/14 at 9:36 a.m. and 10:55 a.m., Resident #53 was seated in his wheelchair at the end of the hall by himself and out of view in the Chapel area. The resident had a self releasing alarm belt in use as well as a chair alarm and anti-tippers to his wheelchair. The resident was touching various objects in the area.</p> <p>The record for Resident #53 was reviewed on 11/14/14 at 10:25 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral control, muscle weakness, non-organic psychosis and Alzheimer's disease.</p> <p>The plan of care dated 10/9/14, indicated the resident was at risk for falls related to poor safety awareness, impaired mobility and psychotropic medication use. The resident was to be assisted with all transfers and ambulation.</p> <p>An entry in the Nursing progress notes dated 10/24/14 at 7:22 a.m., indicated at 6:40 a.m. the resident's alarm was sounding. The resident was observed on the floor in his room on his right side with the wheelchair on top of him. 15 minute checks were initiated at that time.</p> <p>The 11/2/14 Quarterly Minimum Data Set (MDS) assessment, indicated the</p>		12/18/2014				

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F000328 SS=D	<p>resident had short and long term memory problems and was extensive assistance of two people for transfers.</p> <p>Interview with the Director of Nursing on 11/18/14 at 11:10 a.m., indicated the resident should have not been left unattended in the chapel area for over an hour.</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to provide tracheostomy care per the policy and procedure for 1 of 1 residents reviewed for tracheostomy. (Resident #95)</p> <p>Findings include:</p>	F000328	<p>F 328</p> <p>The facility requests paper compliance for this citation.</p>	12/18/2014

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	<p>On 11/17/14 at 2:05 p.m., LPN #2 was observed suctioning Resident #95 by way of a tracheostomy. At that time, the LPN had suctioned the resident four times. After suctioning, she cleaned up the sputum on his chest and removed the split gauze sponge from around the tracheostomy. She then listened to the resident's lungs with a stethoscope. The LPN replaced the split gauze sponge around the trach with a new one. She then cleaned up the bed side table and threw away her garbage.</p> <p>Interview with LPN #2 at that time, indicated she had just performed trach care. The LPN indicated that was what she does regarding trach care. The LPN was then asked to explain how she would clean around the tracheostomy. She then indicated she would use normal saline and wipe around the trach. The LPN further indicated that she really did not know what to do regarding trach care, since it had been so long since she had to do that. The LPN indicated trach care was supposed to be done one time every shift.</p> <p>Continued observation at that time, indicated there was a plastic bag observed hanging on the enteral feeding pole. Inside the bag there was an ambu</p>		<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident 95 was provided with tracheostomy care.</p> <p>2) How the facility identified other residents:</p> <p>Facility has 2 residents with tracheostomies. Both residents were provided</p>				

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	<p>bag as well as two extra tracheostomies, one was a size 6 and the other was a size 8. Interview with LPN #2, indicated she did not know why there were two trachs in the bag but thought the resident used a number 8 size trach.</p> <p>The record for Resident #95 was reviewed on 11/18/14 at 9:22 a.m. The resident's diagnoses included, but were not limited to, anoxic brain injury, stroke, and chronic respiratory failure.</p> <p>The current 11/2014 Physician order recap, indicated trach care every shift. The original order was 7/31/14. Further review of Physician Orders indicated the resident's tracheostomy size was a #8.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/5/14, indicated the resident was in a vegetative state and was totally dependent with 2 person physical assist for transfers, bed mobility, dressing, toilet use, and bathing. While a resident in the facility, he required oxygen therapy, suctioning, and tracheostomy care.</p> <p>The care plan dated 8/7/14, indicated potential for complications related to a tracheostomy. The Nursing approaches were to suction daily as ordered and as needed and to provide trach care as</p>		<p>tracheostomy care.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed Nurses in-serviced on policy and procedures for tracheostomy care.</p> <p>A minimum of 3 licensed nurses will be observed providing tracheostomy care per week on varied shifts. The DON or designee will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p>				

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F000329 SS=D	<p>ordered.</p> <p>The current and undated tracheostomy care policy provided by the Director of Nursing, indicated remove inner cannula and suction the resident. Clean outside of outer cannula as needed before replacing inner cannula using cotton tipped applicators. Use diluted hydrogen peroxide (diluted with 1/2 water) on cotton tipped applicators, or tap water as needed. Replace gauze tracheostomy dressing under tracheostomy tube with opening at top of tube.</p> <p>Interview with the Director of Nursing on 11/17/14 at 3:07 p.m., indicated the LPN should have followed the facility's policy and procedure for tracheostomy care. She further indicated the area under and around the tracheostomy should have been cleaned with hydrogen peroxide and rinsed with normal saline.</p> <p>3.1-47(a)(4)</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</p>						

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	<p>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 an appropriate diagnosis was obtained and a gradual dose reduction was attempted for a resident receiving an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #80)</p> <p>Findings include:</p> <p>The record for Resident #80 was reviewed on 11/14/14 at 1:24 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease with behaviors and depression.</p> <p>The November 2014 Physician's order summary (POS), indicated the resident had an order for Seroquel (an</p>	F000329	<p>F 329</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required</i></p>	12/18/2014

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	<p>antipsychotic) 25 mg at night for Alzheimer's disease with behaviors. The resident had been receiving the Seroquel since 2/7/12.</p> <p>There was no documentation in the resident's record indicating if a gradual dose reduction (GDR) had been attempted.</p> <p>The 8/11/14 plan of care, indicated the resident was at risk fro adverse reactions/side effects related to psychotropic medication use due to the diagnosis of Alzheimer's disease with behaviors/depression. The interventions included, but were not limited to, gradual dose reduction as indicated.</p> <p>The Director of Nursing (DON) provided a Pharmacy recommendation dated 1/30/13 indicating information was needed as to why a GDR was clinically contraindicated. Documentation was completed by the Physician on 2/7/13 indicating "do not decrease or do GDR on this. Doing so poses undo hazards." The DON indicated no additional GDR attempts had been made since.</p> <p>Interview with the Director of Nursing on 11/18/14 at 3:05 p.m., indicated a recent attempt at a GDR should have been completed as well as obtaining an</p>		<p><i>by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #80- diagnoses were reviewed. Requested an order for GDR from physician.</p> <p>2) How the facility identified other residents:</p> <p>An audit of residents receiving antipsychotic medication will be completed by Pharmacist to ensure there is an appropriate diagnosis for use, GDR was attempted or appropriate GDR contraindication statement within the last 12 months is present. Recommendations will be submitted to physicians as indicated.</p> <p>3) Measures put into place/ System changes:</p>	

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	appropriate diagnosis for the Seroquel. 3.1-48(a)(2) 3.1-48(a)(4)		All residents receiving antipsychotic medication will be reviewed on a monthly basis to ensure there is an appropriate diagnosis for use, GDR has been attempted per guidelines or GDR contraindication within the last 12 months is present. The Director of Nursing is responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/18/2014		
F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.				

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	<p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 7 residents observed during medication pass. Two medication errors were observed during 26 opportunities for error in medication administration. This resulted in a medication error rate of 7.69%. The errors involved one resident. (Resident #27)</p> <p>Findings include:</p> <p>On 11/17/14 at 8:47 a.m., RN #1 was observed pouring and preparing medications for Resident #27. At that time, she removed the medication of Carb-Levo (Sinemet) (a medication used for Parkinson's disease) 25-100 milligrams (mg) one tablet and Carb-Levo 25-200 mg one tablet and placed them into a medication cup. Review of the medication labels for both medications, indicated to give the medication 30 minutes prior to meals. She then crushed the medications and placed them in chocolate pudding. At that time, the resident was sitting at the dining room table and had just finished eating breakfast. The RN walked over to the resident and administered the medications to him.</p> <p>Interview with RN #1 at that time,</p>	F000332	<p>F 332</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Physician notified and orders clarified for Resident 27.</p>	12/18/2014

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	<p>indicated the medication was scheduled for 8:00 a.m. on the Medication Administration Record (MAR). She further indicated she was not aware it should have been given 30 minutes prior to meals.</p> <p>The record for Resident #27 was reviewed on 11/18/14 at 8:51 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease.</p> <p>The Physician Orders dated 3/5/14 and on the current 11/2014 recap, indicated Carb/Levo tab 25-100 milligrams (mg) one tablet by mouth three times a day. Give 30 minutes before meals. Further review of Physician Orders dated 3/6/14 and on the current 11/2014 recap, indicated Carb-Levo 50-200 mg one tablet by mouth three times daily. Give 30 minutes before meals.</p> <p>Interview with the Timbre Unit Manager on 11/18/14 at 9:00 a.m., indicated the Carb-Levo (Sinemet) should have been given before meals. She further indicated she had instructed RN #1 to notify the Physician for further orders regarding the administration times for the medication.</p> <p>3.1-48(c)(1)</p>		<p>2) How the facility identified other residents:</p> <p>Audit will be completed to identify any residents with orders to administer meds before meals.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed Nurses and QMA's will be in-serviced on Medication Administration including following physician orders related to timing of medications before meals, and medications that cannot be crushed.</p> <p>Medication Pass observations will be done a minimum of 3 times per week on varied shifts. Any errors will be documented per policy and staff will be re-educated/counseled as appropriate.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance</p>		

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure residents were free from significant medication errors related to the crushing of a time release tablet for 1 of 7 residents observed during medication pass. (Resident #27)</p> <p>Findings include:</p> <p>On 11/17/14 at 8:47 a.m., RN #1 was observed pouring and preparing medications for Resident #27. At that time, she removed the medication of Carb-Levo (Sinemet) (a medication used for Parkinson's disease) 25-100 milligrams (mg) one tablet and Carb-Levo 25-200 mg one tablet and placed them into a medication cup.</p>	F000333	<p>Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 12/18/2014</p> <p>F 333</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or</i></p>	12/18/2014	

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	<p>Review of the medication labels for both medications, indicated to give the medication 30 minutes prior to meals and do not crush. She then crushed the medications and placed them in chocolate pudding. At that time, the resident was sitting at the dining room table and had just finished eating breakfast. The RN walked over to the resident and administered the medications to him.</p> <p>Interview with RN #1 at that time, indicated the medication was scheduled for 8:00 a.m. on the Medication Administration Record (MAR). She further indicated she was not aware it should have been given 30 minutes prior to meals.</p> <p>The record for Resident #27 was reviewed on 11/18/14 at 8:51 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease.</p> <p>The Physician Orders dated 3/5/14 and on the current 11/2014 recap, indicated Carb/Levo tab 25-100 milligrams (mg) one tablet by mouth three times a day. Do not crush. Give 30 minutes before meals. Further review of Physician Orders dated 3/6/14 and on the current 11/2014 recap, indicated Carb-Levo 50-200 mg one tablet by mouth three times daily. Do not crush. Give 30</p>		<p><i>executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Physician notified and orders clarified for Resident 27.</p> <p>2) How the facility identified other residents:</p> <p>Audit will be completed to identify any residents who receive medications crushed.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed Nurses and QMA's will be in-serviced on Medication Administration including following physician orders related to timing of medications before meals, and medications that cannot be crushed.</p>				

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F000371 SS=D	<p>minutes before meals.</p> <p>The current 6/2014 Medication Crushing policy provided by the Director of Nursing, indicated "In the case that solid medications cannot be administered to the resident, the medication may be crushed, only when the following criteria are met: Medication is NOT FOUND on the 'Do Not Crush' list on the following pages. Medications not to be crushed Sinemet due to time release form."</p> <p>Interview with the Timbre Unit Manager on 11/18/14 at 9:00 a.m., indicated the Carb-Levo (Sinemet) should have been given before meals and should not have been crushed. She further indicated she had instructed RN #1 to notify the Physician for further orders regarding the administration times for the medication.</p> <p>3.1-48(c)(2)</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</p>				<p>Medication Pass observations will be done a minimum of 3 times per week on varied shifts. Any errors will be documented per policy and staff will be re-educated/counseled as appropriate.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/18/2014</p>		

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	<p>under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to ensure food was served under sanitary conditions related to the proper temperature and touching food with bare hands for 2 of 2 meals observed. (The breakfast and lunch meal)</p> <p>Findings include:</p> <p>1. On 11/13/14 at 7:53 a.m., in the Rehab dining room, the breakfast meal was observed. At that time, Dietary Aide #1 was observed preparing the meal. The Dietary Aide was observed cooking eggs made to order, pancakes, french toast and hash browns. At that time, she was observed to pick up the plates and handle utensils with her bare hands. She then picked up a container of butter and poured it onto the electric skillet. The Dietary Aide then opened a loaf of bread and took four slices of bread out of the bag with her bare hands and placed them in the toaster. She was not observed to wash her hands or use alcohol gel prior to picking up the bread.</p> <p>Continued observation on 11/13/14 at 8:07 a.m., indicated the Dietary Aide had walked over to the wall dispenser of alcohol gel and applied it to both of her hands. She then walked back over to the</p>	F000371	<p>F 371</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Dietary aide re-educated on proper manner to prepare and serve food.</p> <p>Steam table checked for proper food holding temperatures.</p>	12/18/2014	

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	<p>cooking area and picked up plates and utensils with her bare hands. She opened the loaf of bread and set it down on the cart and placed more bacon on a plate for a resident. She then reached into the loaf of bread with her bare hands and removed four more slices of bread and placed them into a container with an egg mixture to make french toast. She then used the utensils to saturate the bread with the mixture and placed the bread onto the skillet. The Dietary Aide reached back into the bag with the bread and pulled out two more slices of bread with her bare hands and placed them into the toaster. Before touching the bread she did not wash her hands with soap or water or use alcohol gel.</p> <p>Further observation on 11/13/14 at 8:15 a.m., Dietary Aide #1 was observed to apply alcohol gel to both of her hands. She then was observed to touch a pitcher of pancake batter with her hands as well as touching plates and utensils with her bare hands. She then opened the bag of bread and grabbed two more pieces of bread with her bare hands and placed them into the toaster.</p> <p>2. On 11/17/14 at 12:10 p.m., Dietary Aide #1 was observed preparing the lunch meal on the Rehab Unit. She had washed her hands with soap and water</p>		<p>2) How the facility identified other residents:</p> <p>All residents that receive oral diet have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Dietary Staff in-serviced on hand washing, glove changing and the correct temperatures for food holding on steam table.</p> <p>Form used for recording food temperatures has been reviewed and updated to reflect the temperature range for food holding on the steam table as stated in facility policy.</p> <p>Random observation audits will be completed at least 3 times per week at varied meals and locations to ensure that food handling policy is</p>	

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	<p>first before starting to serve the meal. She then touched and removed a stack of plates and placed them on the steam table with her bare hands. She was also observed to pick up the resident tray cards and read them. She then picked up the tongs and removed a hot dog bun from the package. She placed the hot dog bun on the plate and opened it up with one of her bare hands and added the bratwurst. The Dietary Aide continued to serve the residents their lunch by repeatedly opening the hot dog bun with one of her bare hands.</p> <p>Review of the current and undated Dietary Department Guidelines provided by the Director of Nursing, indicated handling of food items during the preparation process will be minimized. This may be accomplished by using clean kitchen tools or by wearing gloves for each task.</p> <p>Interview with Assistant Dietary Manger on 11/18/14 at 11:10 a.m., indicated the Dietary Aide should not have used her bare hands to touch any food.</p> <p>3. The steam tray temperatures were observed being taken in the Rehab dining room on 11/17/14 at 12:10 p.m. Dietary Aide (DA) #1 was taking the hot food temperatures, she indicated the</p>		<p>being followed related to use of gloves.</p> <p>Temperature logs for steam tables will be checked and random temperature checks completed prior to meal service a minimum of 3 times per week at varied meals and meal locations to ensure food is held at the appropriate temperature.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 12/18/14</p>		

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F000428 SS=D	<p>temperatures should be between 160-180 degrees. The temperatures for pureed meat, pureed vegetable and vegetable were recorded at 150 degrees. The Daily Food Temperature Log indicated the recommended temperatures should be between 160-180 degrees. The DA indicated the temperature of the cheesecake was below 50 degrees, so it was okay. She indicated it should be between 35-41 degrees, but her thermometer only went to 50 degrees. DA #2 then gave her another thermometer. DA #1 checked the cheesecake again and indicated the temperature was 45 degrees. DA #1 prepared to serve the food.</p> <p>Interview with DA #1 at that time, indicated if food was below temperature, they would stir it up and recheck the temp. DA #2 was standing nearby and indicated if the food was not at temperature, it needed to be sent back to the kitchen. She indicated the food needed to be returned to the kitchen.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a</p>			

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	<p>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 record review and interview, the facility failed to ensure Pharmacy recommendations were carried out in a timely manner for 2 of 5 residents reviewed for unnecessary medications. (Residents #65 and #80)</p> <p>Findings include:</p> <p>1. The record for Resident #65 was reviewed on 11/17/14 at 9:45 a.m. The resident's diagnoses included, but was not limited to, diabetes mellitus.</p> <p>A Pharmacy recommendation dated 7/29/14 indicated the following: the resident is currently receiving Lantus (an insulin) 35 units at bedtime and Novolog (an insulin) sliding scale. The resident also receives the oral agents Metformin (an oral diabetic medication) 500 milligrams (mg) daily and Januvia (an oral diabetic medication) 50 mg daily. Generally oral anti-diabetic agents are used to delay the use of insulin and once insulin is initiated oral anti-diabetic agents are discontinued. Please evaluate the continued use of Metformin and Januvia and determine if they should be</p>	F000428	<p>F 428</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Pharmacy recommendations for</p>	12/18/2014	

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	<p>discontinued.</p> <p>Interview with the Director of Nursing on 11/18/14 at 2:00 p.m., indicated the recommendations were just being carried out today. She indicated the facility had a new pharmacy and the old pharmacy was contacted for previous recommendations. The previous pharmacy was contacted and the recommendations dated 7/29/14 were faxed over.</p> <p>2. The record for Resident #80 was reviewed on 11/14/14 at 1:24 p.m. The resident's diagnosis included, but was not limited to, anemia.</p> <p>A Pharmacy recommendation dated 7/29/14, indicated to "please consider drawing a CBC and lipid panel yearly."</p> <p>Interview with the Director of Nursing on 11/18/14 at 2:00 p.m., indicated the recommendations were just being carried out today. She indicated the facility had a new pharmacy and the old pharmacy was contacted for previous recommendations. The previous pharmacy was contacted and the recommendations dated 7/29/14 were faxed over.</p> <p>3.1-25(i)</p>		<p>Residents 65 and 80 have been addressed by the physician.</p> <p>2) How the facility identified other residents:</p> <p>All pharmacy recommendations for the month of July were reviewed to identify any other residents affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed Nurses have been in-serviced on the importance of having the physicians address recommendations timely.</p> <p>Pharmacy recommendations will be reviewed monthly to ensure all recommendations have been addressed timely.</p> <p>The Director of Nursing will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p>				

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>		<p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 12/18/2014</p>		

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	<p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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> <p>Based on observation, record review, and interview, the facility failed to ensure infection control practices were maintained related to handwashing being completed after glove removal, between resident contact, and during dining room assistance for 5 residents observed for infection control. The facility also failed to ensure all new employees received a second step tuberculin test after hire for 1 of 10 employee files reviewed. (Residents #B, #54, #76, #95, and #103) (Employee OT #1)</p> <p>Findings include:</p> <p>1. On 11/17/14 at 10:57 a.m., LPN #1 was observed preparing medications for Resident #54. At that time, she first performed a glucometer check for the resident. She had used alcohol gel to</p>	F000441	<p>F 441 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: First and second step tuberculin test was administered to OT Employee #1. Residents B, 54, 76, 95 and 103 are without adverse effects related to hand washing and glove changing errors. Wash</p>	12/18/2014

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	<p>both of her hands prior to the glucometer. She removed the glucometer, lancet, and strips out of the medication cart. She obtained an alcohol pad as well. She then donned clean gloves to both of her hands and walked into Resident #54's room. She wiped the resident's finger with an alcohol pad, pricked her finger with the lancet, and obtained blood and placed it on the strip. The blood glucose reading was 214 which required a sliding scale insulin injection. The LPN then walked out of the room with her gloves on her hands, placed the lancet and strip into the sharps container on the side of the cart and removed her gloves and threw them away in the trash can on the side of the cart. She then opened the cart and removed a germicidal wipe to clean the glucometer. She picked up the glucometer with her bare hands and walked back into the room to obtain another pair of gloves and a paper towel. The LPN donned the gloves to her hands, wrapped the glucometer in the germicidal wipe and placed it on the medication cart. She then removed her gloves and threw them away. The LPN pulled out a pen and signed out the glucometer. The LPN did not wash her hands with soap and water or use alcohol gel after she removed her gloves.</p> <p>Continued observation at that time,</p>		<p>basins, urinals and bedpans were cleaned and put away per policy. 2) How the facility identified other residents: Employee files were audited to ensure that all had 1st and 2nd step tuberculin testing. All residents that require glucometers, medications via peg-tubes, suctioning, require assistance with eating, incontinence care and tracheostomy care have the potential to be affected. Rounds were completed to ensure all wash basins, urinals and bedpans were stored properly. 3) Measures put into place/ System changes: New hire employee files will be audited weekly to ensure that all have received a first and second step tuberculin test. First step tuberculin test will be placed prior to or on hire date, and second step will be placed 7-21 days later if first step results are negative. Any discrepancies will be addressed immediately. The Human Resources Director will be responsible for oversight of these audits. Nursing staff have been in-serviced on proper hand washing, glove changes and storage of wash basins, urinals and graduated cylinders. A minimum of 5 employees per week will be observed on varied shifts for</p>	

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	<p>indicated the LPN opened the medication cart and removed a bottle of insulin and a needle. She then drew up the insulin, walked back into the room, applied clean gloves, and administered the insulin in the resident's abdomen. The LPN then walked out of the room, disposed of the needle syringe in the sharps container and removed her gloves and threw them away into the trash can on the side of the cart. She then signed out the insulin. At no time, did the LPN wash her hands with soap and water or use alcohol gel after the removal of the gloves. LPN #2 then prepared an oral medication for the resident and administered it as well.</p> <p>Interview with the Director of Nursing on 11/17/14 at 3:07 p.m., indicated the LPN should have washed her hands with soap and water or used the alcohol gel after removing gloves from her hands.</p> <p>2. On 11/17/14 at 2:05 p.m., LPN #2 was observed pouring and preparing medications for Resident #95. The LPN had used alcohol gel to both of her hands prior to preparing the medication. She then crushed the medication as it was to be administered by the way of a Percutaneous Endoscopic Gastrostomy (PEG) tube. She entered the room and applied clean gloves to both of her hands. She then removed the enteral feeding</p>		<p>proper hand washing and glove changing techniques. Any observed deficiencies will be addressed with education/counseling as appropriate. Random rounds will be completed on varied shifts at least 3x/week to ensure that all wash basins, urinals and graduated cylinders are properly stored. Any discrepancies will be corrected immediately. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/18/2014</p>	

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	<p>from the PEG tube and placed it on the towel. She checked for placement of the PEG with a stethoscope. The LPN removed her gloves and threw them away in the trash can. At that time, she did not wash her hands or use alcohol gel after administrating the medication via the PEG tube.</p> <p>The LPN was further observed at that time, suctioning the resident by the way of a tracheostomy. She had opened the suctioning kit and applied the gloves (that were in the kit) to both of her hands. The LPN still had not washed her hands with soap and water or used alcohol gel after the administration of the medication through the PEG tube. She was then observed to suction the resident four times and wiped up the sputum on his chest. She removed the split gauze sponge from around the trach and then removed her gloves. She then donned clean gloves to both of her hands. At that time, she did not wash her hands or use alcohol gel. The LPN replaced the split gauze sponge around the tracheostomy, cleaned up the table and walked into the bathroom and removed her gloves. Afterwards, she left the room and walked to her medication cart. At that time, and before leaving the room, she did not wash her hands with soap and water or use alcohol gel to both of her hands.</p>						

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	<p>Interview with the Director of Nursing on 11/17/14 at 3:07 p.m., indicated the LPN should have washed her hands with soap and water or used alcohol gel after removing her gloves.</p> <p>3. On 11/16/14 at 8:20 a.m., CNA #9 was observed assisting Resident #76 with her breakfast. Resident #103 was sitting at a different table with his head bent down. There was a clear substance hanging one inch off of his nose. Resident #103 was observed to release his Velcro belt and an alarm sounded. CNA #9 stopped assisting Resident #76 and went over and re-fastened Resident #103's Velcro belt. CNA #9 then returned to the table and sat next to Resident #76. She picked up the resident's juice glass and handed it to the resident and attempted to get her to finish her juice. CNA #9 then picked up the resident's milk glass and handed it to Resident #76 and attempted to get the resident to finish her milk. Resident #76 indicated she was finished. CNA #9 left the table and went to a closet.</p> <p>Interview with CNA #9 on 11/16/14 at 8:25 a.m., indicated she had not washed her hands after assisting Resident #103 and before assisting Resident #76 with her drinks. The CNA further indicated</p>						

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	<p>she should have washed her hands before returning to help Resident #76.</p> <p>4. On 11/17/14 at 6:45 a.m., Resident #B was observed during Activities of Daily Living (ADL) care which was being performed by CNA's #3 and #4. CNA #3 was observed providing peri-care for the resident. Upon completing peri-care, CNA #3 walked out of the bathroom to retrieve a Hoyer (a transferring device), she did not remove her gloves or wash her hands. She returned to the bathroom with the Hoyer, she did not wash her hands and the gloves remained unchanged.</p> <p>Review of the current Hand Washing Policy dated 4/2012, provided by the Director of Nursing (DON) on 11/17/14 at 9:40 a.m., indicated "To ensure proper hand washing before and after produces and/or resident care to prevent the spread of infection." At minimum hands should be washed, "before putting on and after taking off gloves."</p> <p>5. The Employee files were reviewed on 11/18/2014 at 10:30 a.m. Occupational Therapist #1 was hired on 8/25/14, there was no evidence of the employee's 2nd step Tuberculosis (TB) skin test.</p> <p>Interview with the Physical Therapy (PT)</p>						

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	<p>Director on 11/18/14 at 2:32 p.m., indicated there was no 2nd step TB in the employee's file. He further indicated the TB was not completed after employment.</p> <p>6. During the initial tour of the facility on 11/12/14 at 7:00 p.m., the following was observed:</p> <p>a. Room 1, there was a urinal and a graduated container unwrapped stored on the back of the toilet. There were two pink wash basins on the floor, unwrapped next to the toilet. Three residents resided in the room.</p> <p>b. Room 2, there was a bedpan unwrapped and stored on top of the toilet. Three residents resided in the room.</p> <p>c. Room 8, there were two pink wash basins unwrapped and stored on top of the toilet. There was a peg (percutaneous endoscopic gastrostomy) tube flush container and syringe lying on the bedside table unwrapped. Two residents resided in the room.</p> <p>Review of the current Giving and Removing Urinal and Giving and Removing Bedpan policies provided by the DON on 11/17/14 at 2:01 p.m., indicated urinals should be cleansed and returned to the bedside unit. The bed</p>			

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F000465 SS=E	<p>pans should be rinsed and returned to unit.</p> <p>Interview with the Director of Nursing (DON) on 11/18/14 at 9:45 a.m., indicated the above items should have been cleaned and put away per facility policy.</p> <p>3.1-14(t)(2) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a functional and sanitary environment related to marred walls, marred doors, holes in doors, and white patches on bedroom and bathroom walls on 4 of 5 units throughout the facility. (Pines, Rehab., Maple and Linden units)</p> <p>Findings include:</p> <p>1. During the Environmental Tour on 11/18/14 at 8:57 a.m., with the Maintenance Director, the following was observed:</p> <p>Pines unit:</p>	F000465	<p>F 465</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts</i></p>	12/18/2014

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	<p>a. Room 01, there were white patches on the bathroom wall. The bathroom wall was marred. Three residents resided in the room.</p> <p>b. Room 02, there was a rusty toilet riser over the toilet. The bathroom door and walls were marred. Three residents resided in the room.</p> <p>c. Room 05, there was a dime size hole in the bathroom door. There was a rusty area on the floor beneath the radiator. The bathroom door was marred. Four residents resided in the room.</p> <p>d. Room 07, the resident's name was written in black marker on the built in drawers. The bathroom walls, doors, and radiator were marred. There were white patches on the bathroom wall. Three residents resided in the room.</p> <p>e. Room 08, the bedside mat was ripped in several places. There was a light brown substance on the wall behind the bed. There was a dime size hole in the bathroom door. There were white patches on the bathroom wall, and the walls and the door were marred. Two residents resided in the room.</p> <p>f. Room 15, the bathroom walls and door</p>		<p><i>alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>a) Room 01 bathroom wall has been painted.</p> <p>b) Room 02 rusty toilet riser was removed and walls were painted in bathroom.</p> <p>c) Room 05 hole in bathroom door was repaired, walls were painted.</p> <p>d) Room 07 resident name was removed from the built in drawers. Bathroom walls, doors and radiator were cleaned and/or painted.</p> <p>e) Room 08 bedside mat was replaced, wall behind the bed was cleaned, hole in bathroom door was repaired, and bathroom wall and door was painted.</p> <p>f) Room 15 bathroom walls and door were painted.</p> <p>g) Room 172 bathroom door</p>	

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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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	<p>were marred. Four residents resided in the room.</p> <p>Rehab unit:</p> <p>a. Room 172, the bathroom door was marred and gouged.</p> <p>Maple Unit:</p> <p>a. Room 257, there were white patches on the bathroom wall. There was Lime build-up inside the shower stall. Two residents resided in this room.</p> <p>b. Room 254-2, the wall by the bed was marred. Two residents resided in this room.</p> <p>c. Room 263, there were white patches on the bathroom wall. Two residents resided in this room.</p> <p>Linden unit:</p> <p>a. Room 269, there were white patches on the bathroom wall. The wood finish was peeling off of the top of the bed side dresser. Two residents resided in this room.</p> <p>b. Room 272, there were white patches on the bathroom wall. One resident resided in this room.</p>		<p>repaired and painted.</p> <p>h) Room 257 bathroom wall painted and lime build up removed from inside shower stall.</p> <p>i) Room 254-2 wall by bed was cleaned.</p> <p>j) Room 263 bathroom walls were painted.</p> <p>k) Room 269 bathroom walls were painted. Peeling wood finish on bedside dresser was repaired.</p> <p>l) Room 272 bathroom walls were painted.</p> <p>m) Room 276 bathroom walls were painted.</p> <p>n) Room 277-2 wall next to heater, behind chair, near window and bathroom walls were cleaned and/or painted.</p> <p>2) How the facility identified other residents:</p> <p>Audit will be completed of all resident rooms available for occupancy to identify any other environmental concerns.</p>	

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	<p>c. Room 276, there were white patches on the bathroom wall. Two residents resided in this room.</p> <p>d. Room 277-2, the wall was marred next to the heater and behind the chair. There were white patches on the wall near the window and in bathroom. One resident resided in this room.</p> <p>Interview with the Maintenance Director at the time, indicated the above items were in need of painting and/or repair.</p> <p>3.1-19(f)</p>		<p>3) Measures put into place/ System changes:</p> <p>Maintenance department will develop a schedule to complete inspection and repairs on at least 3 resident rooms per week until all rooms available for occupancy are completed.</p> <p>Schedule will then be implemented for inspection and repairs on all rooms available for occupancy at least semi-annually for routine maintenance and upkeep thereafter.</p> <p>Department managers will perform rounds on assigned rooms at least 3x/week. Work orders will be written and submitted to maintenance for any issues requiring immediate attention.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>	

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			5) Date of compliance: 12/18/2014		