

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155381	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2016
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NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060
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F 0000  Bldg. 00	<p>This survey was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: February 22, 23, 24, 25, 26, 29, 2016</p> <p>Facility number: 000551 Provider number: 155381 AIM number: 100267400</p> <p>Census bed type: SNF: 15 SNF/NF: 98 Residential: 49 Total: 162</p> <p>Census payor type: Medicare: 12 Medicaid: 78 Other: 72 Total: 162</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on March 8, 2016.</p>	F 0000		
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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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F 0157 SS=D Bldg. 00	<p>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 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 observation, interview, and record review, the facility failed to ensure the physician was notified of a worsening</p>	F 0157	<b>F157 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient</b>	03/30/2016

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	<p>pressure area for 1 of 3 residents reviewed for pressure areas (Resident #107).</p> <p>Findings included:</p> <p>Resident # 107's dressing change was observed on 2/25/16 at 9:32 a.m., with LPN # 6. A pressure area was to her right outer ankle. The skin surrounding the 50 cent size wound, had a bright red, pencil eraser size area to the top right edge and a dark red, pencil eraser size area to the lower left edge. LPN #6 indicated that the bright red area to the top right edge appeared to be open.</p> <p>During an observation on 2/26/16 at 9:47 a.m., of Resident #107's dressing change, the Director of Nursing (DON) measured the bright red area to the top right and indicated a length of 0.2 centimeters (cm) and a width of 0.2 cm. She also measured the dark red area to the lower left edge and indicated a length of 0.8 cm and a width of 0.4 cm.</p> <p>During an interview on 2/26/16 at 9:43 a.m., the DON indicated if LPN #6 was aware of the red areas on 2/26/16, she would have expected documentation of the areas and the wound Nurse Practitioner (NP) to have been notified.</p>		<p><b>practice.</b> Resident 107's physician was notified 2/26/16 of new trauma area superior to pressure wound on right ankle. Resident 107's physician was notified 2/26/16 of new trauma area lateral lower edge of right ankle pressure area. LPN # 6 was re-educated on physician notification of a worsening pressure wound <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents with pressure ulcers have the potential to be affected by this alleged deficient practice. <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Licensed nurses were re-educated on how to determine if a pressure wound is worsening and to notify MD and/or Wound NP if pressure area worsens. <b>IV The facility will monitor the corrective action by implementing the following measures.</b> DON or designee will audit licensed nurses who are performing treatment to determine if nurse recognizes worsening pressure area. The audit will be completed on random nurses 5 x weekly x 30 days, then 3 x weekly x 30 days, then weekly x 30 days, then monthly x 30 days. Results of this audit will be reviewed at the monthly Quality Assurance</p>				

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	<p>During an interview on 2/26/16 at 9:45 a.m., the NP indicated the red areas to the edges of the wound were staged as a stage 2 pressure area in appearance, NP indicated it could have been caused by the foam dressing sticking to areas and then removing the skin when the foam dressing was removed.</p> <p>Resident #107's clinical record was review on 2/24/2016 at 8:19 a.m. Resident #107's current diagnoses included, but were not limited to, cerebrovascular accident (CVA), dementia, and pressure ulcer of right ankle, stage 3.</p> <p>Resident #107's clinical record did not have any indications of physician notification of the change in the pressure area to her right ankle.</p> <p>A document titled, "LICENSED NURSE TREATMENT SKILLS VALIDATION", undated, provided by Nurse Consultant (NC) #1 on 2/26/16 at 12:18 p.m., included the following: "...3. Abnormal findings such as abn. [abnormal] odor, appearance or changes in wound bed reported to physician...."</p> <p>A 2/26/16, "Change in Condition" document, provided by the DON on 2/29/16 at 10:26 a.m., included the</p>		<p>Committee meeting and frequency and duration of reviews will be adjusted as needed. <b>V. Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>	

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	<p>following: "...Possible trauma areas to the right ankle wound above the superior /top [sic] of wound. Area measures 0.2 X [times] 0.2cm. X light pink. New area of dark reddish/purple tissue, closed to lateral just off right ankle wound. Area measures 0.8 cm X 0.4 cm. X closed dark reddish/purple. N.P. notified... Will contact N.P. and see if need to change dressing or current treatment to decrease further trauma to area...."</p> <p>The undated, "Resident Rights Skilled Nursing Facility", document was provided by Nurse Consultant #2 on 2/26/16 at 12:18 p.m. The document indicated the facility would consult with the resident's physician when there was "...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 for of treatment); or treatment...."</p> <p>3.1-5(a)(3)</p>			

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F 0176 SS=D Bldg. 00	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who self administered medications had a current assessment for the self administration of medication for 1 of 1 residents reviewed for self medication administration (Resident #179).</p> <p>Findings include:</p> <p>On 2/25/16, 9:10 a.m., Resident #179 was observed lying in bed with an over the bed table positioned over his lap. The over the bed table had a medicine cup with medicine in the cup. The cup was placed within Resident #179's reach. There were no staff in the room.</p> <p>At 9:20 a.m., LPN #20 entered Resident #179's room. LPN #20 then attempted to assist Resident #179 with taking the medication from the medication cup. Resident #179 refused to take the medicine.</p> <p>At 9:22 a.m., LPN #20 removed the medication cup from Resident #179's</p>	F 0176	<p><b>F176 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident #179's medications are administered by licensed nurses. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents who administer own medications have the potential to be affected by the alleged deficient practice. <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Residents who request to administer own medications will have a Self-administration assessment completed at the time of request. If the resident is determined to be able to self-administer medications the Self-administration Assessment will then be completed quarterly or when there is significant change. Licensed nurses were re-educated on Medication administration and are completing Self-Administration Assessments. <b>IV The facility will monitor the corrective action by</b></p>	03/30/2016
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	<p>room. LPN #20 informed LPN #19 that Resident #179 refused to take his medication.</p> <p>At 9:24 a.m., LPN #19 destroyed the medication in the medication cup she received from LPN #20. The medication was identified by LPN #19 as the following: baclofen 20 mg (for muscle spasms), caltrate 600 + D Plus Minerals 600 mg (for osteoarthritis), casodex 50 mg(prostate cancer), macrobid 100 mg (antibiotic), metoprolol 25 mg (hypertension), oyster shell calcium-vit D3 500 mg (mineral supplement), percocet 7.5-325 mg (narcotic pain medicine), potassium chloride 20 mEq (mineral supplement), pradaxa 150 mg (blood thinner), therems-M 27-0.4 mg (mutivitamins), vitamin C 500 mg, zinc sulfate 50 mg (mineral supplement).</p> <p>Resident #179's record was reviewed on 2/25/16 at 9:33 a.m. Resident #179's diagnoses included, but was not limited to, pneumonia, muscle weakness, paraplegic, neuromuscular dysfunction of bladder, and malignant neoplasm of prostate.</p> <p>During a 2/25/16, 9:25 a.m., interview, Unit Manager LPN #16 indicated LPN#19 should not have left the medication at the bedside unless the</p>		<p><b>implementing the following measures.</b> DON or Designee will conduct random room rounds to ensure medications are not left at bedside unless resident has been assessed and approved to self-administer medications as evidenced by a Self-Administration Assessment in medical record 5 x weekly x 30 days, then 3 x weekly x 30 days, then weekly x 30 days, then monthly x 30 days. DON or Designees will audit random licensed nurses during medication pass to ensure medications are not left at bedside during medication administration 5 x weekly x 30 days, then 3 x weekly x 30 days, then weekly x 30 days, then monthly x 30 days. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. <b>V. Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>	

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	<p>resident had an order for self administration of medication from a physician.</p> <p>During a 2/26/16, 12:16 p.m., interview, the Director of Nursing indicated Resident #179 did not have an order for self-administration of medication. The Director of Nursing indicated Resident #179 did not have a self administration of medication assessment. <b>Review of the current, undated facility policy, titled "BEDSIDE MEDICATIONS AND SELF-ADMINISTRATION OF MEDICATIONS", provided by NC#2, on 2/26/16 at 12:18 p.m., included, but was not limited to the following:</b></p> <p><b>"POLICY</b> Each resident who desires to self-administer medication will be permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility.</p> <p><b>PROCEDURE</b> 1. Each resident is offered the opportunity to self-administer his/her medications during the routine assessment by the facility's interdisciplinary team (IDT). 2....If the resident desires to</p>			

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F 0241 SS=E Bldg. 00	<p>self-administer medications, an assessment is conducted by the IDT of the resident's cognitive, physical and visual ability to carry out this responsibility (see 'Medication Self-Administration Assessment Form')....</p> <p>...5. The results of the IDT assessment are recorded on the Medication Self-Administration Assessment Form which is placed on the resident's medical record..."</p> <p>3.1-11(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, interview and record review, the facility failed to provide a dignified dining experience regarding assistance to eat, watching other residents being assisted to eat at the same table, and staff assisting multiple residents to eat at different tables as they moved around the dining room on rolling</p>	F 0241	<p><b>F-241</b> We disagree with these findings <b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Manager on Duty, Certified nursing staff and licensed nursing staff will be re-educated on the proper policy and procedure regarding</p>	03/30/2016
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	<p>stools for 9 of 10 residents observed for dignity while dining (Residents #90, #107, #21, #84, #89, #15, #26, #22, and #138).</p> <p>Findings include:</p> <p>During a 2/22/16, 11:53 a.m. to 12:54 p.m., observation of lunch in the Main Dining Room, the following situations were observed:</p> <p>1. At 11:53 a.m., Resident #138 and Resident #107 were already seated facing the dining room table as if ready to dine. There was no TV in the dining room. There was no music playing in the dining room. At 12:40 p.m., 47 minutes later, Resident #138 and Resident #107 received their meals. CNA #15 was seated on a stool with wheels, between Resident #138 and Resident #107. CNA #15 was observed assisting Resident #107 and Resident #138 at the back table in the dining room. CNA #15 rolled herself to the adjacent table located approximately 3 feet away to assist Resident # 84. CNA #15 repeatedly rolled between the two tables assisting the residents.</p> <p>Resident #138's clinical record was reviewed on 2/29/16 at 9:39 a.m. Resident #138 current diagnoses</p>		<p>residents' dignity and feeding. No residents found to be affected by the alleged deficient practice. C.N.A. #5 re-educated on proper policy and procedure regarding residents' dignity and feeding.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents that need assistance during the dining experience have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Manager on Duty, Certified nursing staff and licensed nursing staff will be re-educated on the proper policy and procedure regarding resident's dignity and feeding. Reallocating staff to ensure that residents are assisted to eat with dignity. Reallocating residents table assignments, unless resident or family voice preference for other seating arrangements.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator/Designee will audit systematic changes utilizing an audit tool daily X 4 weeks, weekly X 4 weeks, monthly X 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting.</p>	

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	<p>included, but were not limited to, chronic fatigue, anxiety, Parkinson's disease and dementia.</p> <p>Resident #138 had a current, 2/1/16, quarterly, Minimum Data Set (MDS) Assessment which indicated the resident rarely or never understood, required staff assistance for mobility and required extensive assistance from the staff for eating.</p> <p>Resident #138 had a, 2/1/16, care plan problem/need regarding a risk for weight loss due to medical decline requiring hospice.</p> <p>2. At 12:03 p.m., Resident #15, #22 and #26 were seated at a dining room table as if ready to dine. Resident #15 was holding a purse and looking around. Resident #22 was seated in wheel chair with chin to chest and eyes closed. Resident #26 was seated in a wheel chair with chin to chest and eyes closed.</p> <p>At 12:33 p.m., Resident #15 and #22 were served meal trays. Resident #22 began to eat without staff assistance. Resident #15 did not receive assistance with her meal, and did not initiate eating on her own. Resident #26 received her meal at 12:42 p.m., staff assisted Resident #15 and Resident #26 with</p>		<p>The frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. <b>V. Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>		

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	<p>eating at that time.</p> <p>a. Resident #15 clinical record was reviewed on 2/29/16 at 8:56 a.m. Resident #15's current diagnoses included, but were not limited to, Parkinson's disease, dementia and depression.</p> <p>Resident #15 had a current, 2/15/16, quarterly, Minimum Data Set (MDS) Assessment which indicated had mild cognitive impairment, need cueing only in new situations, was totally dependent on staff for mobility and required extensive assistance from staff for eating.</p> <p>Resident #15's had a current, 2/15/16, care plan problem/need regarding the need for a restorative assistance. This need originated 11/29/15, Approaches to this problem included, but were not limited to, assist with verbal cueing and physical assist as needed.</p> <p>b. Resident #22's clinical record was reviewed on 02/29/2016, 8:23 a.m., Resident #22's current diagnosis included, but were not limited to, Alzheimer's disease, dementia, anxiety, dysphagia, neoplasm of uncertain behavior of skin.</p> <p>Resident #22 had a current, 12/2/15</p>						

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	<p>quarterly, Minimum Data Set (MDS) Assessment which indicated was severely cognitively impaired, rarely or never made decisions, was dependent on staff assistance for mobility and required extensive assistance from staff for eating.</p> <p>Resident #22 had a 1/30/15, care plan problem/need regarding hospice services.</p> <p>Resident #22 had a 1/24/15, care plan problem/need regarding communication deficit related to cognitive impairment.</p> <p>Resident #22 had a 12/22/14, care plan problem/need regarding nutritional status, resident required mechanical soft diet with gravy to her meats, at risk for weight loss due to poor oral intake, routinely consumes less than 50% at meals.</p> <p>Resident #22 had a 12/10/14, care plan problem/need regarding resident cannot independently complete her own Activities of Daily Living (ADL's) related to dementia, weakness, muscle atrophy, anemia, and chronic pain.</p> <p>Resident #22 had a 11/24/14, care plan problem/need regarding resident had a diagnoses of malnutrition and utilized an antidepressant for this diagnosis.</p> <p>3. At 12:13 p.m., Resident #21,</p>			

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	<p>Resident #89 and Resident #84 were seated at a dining room table as if ready to dine. At 12:32 p.m., Resident #21, Resident #89 and Resident #84 received their meals. CNA #14 was seated on a stool with wheels, between Resident #21 and Resident #89.</p> <p>CNA #14 was observed assisting Resident #21 and Resident #89 at the center table in the dining room. CNA #14 rolled herself to the adjacent table located approximately 4 feet away to assist Resident #15 with her meal. CNA #14 repeatedly rolled between the two tables assisting the residents.</p> <p>a. Resident #21's clinical record was reviewed on 2/26/16 at 11:08 a.m. Resident #21's current diagnoses included, but were not limited to, dementia, dysphagia and aphasia.</p> <p>Resident #21 had a current, 1/5/16, annual, Minimum Data Set (MDS) assessment which indicated the resident had severely impaired vision, had severely impaired cognition, rarely or never made decisions, was totally dependent on staff assistance for mobility and required extensive assistance from staff for eating.</p> <p>Resident #21 had an, 1/5/16, care plan</p>			

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	<p>problem/need regarding the need for staff assistance for all activities of daily living (ADL's). This need originated 1/17/13. Approached to this need included, but were not limited to, "anticipate and provide ADL needs."</p> <p>Resident #21 had an,1/15/16, care plan regarding nutritional risk. An approach to this need was "provide physical assistance with meals."</p> <p>b. Resident #89's clinical record was reviewed on 2/26/16 at 11:44 a.m. Resident #89's current diagnoses included, but were not limited to, chronic pain, depression and dementia.</p> <p>Resident #89 had a current, 12/10/15, quarterly, Minimum Data Set (MDS) Assessment which indicated the resident was severely cognitively impaired, rarely or never made decisions, was dependent on staff assistance for mobility and required extensive assistance from staff for eating.</p> <p>Resident #89 had a 12/10/15, care plan problem/need regarding a risk for weight loss due to lymphadema, hospice services and decline in intake. An approach to this need was "provide physical assistance with meals."</p>			

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	<p>Resident #89 had a 12/10/15, care plan problem/need regarding the need for assistance with all activities</p> <p>During a 2/25/16, 11:40 a.m. to 12:51 p.m., observation of lunch in the Main Dining Room, the following concerns were observed:</p> <p>4. At 12:18 p.m., Resident #84, Resident #60, Resident #107 and Resident #15 were seated at a dining room table as if ready to dine.</p> <p>At 12:22 p.m., Resident #107 received her meal and LPN #18 assisted Resident #107 with consuming her meal. LPN #18 was seated on a rolling stool between Resident #107 and Resident #15.</p> <p>At 12:35 p.m., Resident #84 waited at the table from 12:22 p.m. to 12:35 p.m. at which time her meal was served (13 minutes).</p> <p>At 12:38 p.m., Resident #60 waited at the table form 12:22 p.m. to 12:38 p.m. at which time her meal was served (15 minutes).</p> <p>At 12:39 p.m., Resident #15 waited at the table from 12:22 p.m. to 12:39 p.m. at which time her meal was served (17 minutes) .</p>			
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	<p>At 12:39 p.m., LPN #18 finished assisting Resident #107, and began assisting Resident #15.</p> <p>a. Resident #84's clinical record was reviewed on 02/26/2016, 12:27 p.m., Resident #84 current diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, dysphagia, and neoplasm of uncertain behavior of skin.</p> <p>Resident #84 had a current, 12/2/15 quarterly Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, rarely or never made decisions, was dependent on staff assistance for mobility and required extensive assistance from staff for eating.</p> <p>Resident #84 had a 1/30/15, care plan problem/need regarding hospice services.</p> <p>Resident #84 had a 1/24/15, care plan problem/need regarding communication deficit related to cognitive impairment.</p> <p>Resident #84 had a 12/22/14, care plan problem/need regarding nutritional status, resident required mechanical soft diet with gravy to her meats, at risk for weight loss due to poor oral intake, and routinely</p>			

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	<p>consumes less than 50% at meals.</p> <p>Resident #84 had a 12/10/14, care plan problem/need regarding resident cannot independently complete her own ADL's related to dementia, weakness, muscle atrophy, anemia, and chronic pain.</p> <p>Resident #84 had a 11/24/14, care plan problem/need regarding resident has a diagnoses of malnutrition and utilized an antidepressant for this diagnosis.</p> <p>b. Resident #60's clinical record was reviewed on 02/26/2016, 11:40 a.m., Resident #60 current diagnoses included, but were not limited to, Parkinson's, dehydration, depression, adult failure to thrive, dysphagia, and dementia.</p> <p>Resident #60's had a current 1/18/16, annual , Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, rarely or never made decisions, was dependent on staff assistance for mobility and required extensive assistance from staff for eating.</p> <p>Resident #60 had a 1/2/15, care plan problem/need regarding hospice services related to renal failure.</p> <p>Resident #60 had a 8/9/11, care plan</p>						

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	<p>problem/need regarding risk for dehydration due to dysphagia, history of weight loss, Parkinson disease, renal failure, and dementia.</p> <p>Resident #60 had a 9/28/11, care plan problem/need regarding requires mechanically altered diet due to dysphagia. History of holds drinks in mouth and has intermittent cough. History of significant weight loss noted.</p> <p>Resident #60 had a 10/12/09, care plan problem/need regarding impaired cognition.</p> <p>c. Resident #107's clinical record was reviewed on 02/26/2016, 12:00 p.m. Resident #107's current diagnoses included, but were not limited to, encounter for palliative care, vascular dementia, abnormal weight loss, depression, dysphagia, Gastro Esophageal Reflex Disease (GERD).</p> <p>Resident #107 had a current 12/10/15 quarterly, Minimum Data Set (MDS) assessment which indicated cognitive skills for decision making were severely impaired, and functional status for eating required extensive assistance.</p> <p>Resident #107 had a 11/28/14, care plan problem/need regarding chewing</p>			

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	<p>problems related to refusal to wear dentures.</p> <p>Resident #107 had a 9/26/14 care plan problem/need regarding risk for weight loss related to altered diet of pureed food, decreased oral intake, dementia, receiving hospice services related to late effect of cerebrovascular disease, and noted weight loss unavoidable due to declined condition.</p> <p>Resident #107 had a 9/9/14, care plan problem/need regarding requires hospice services related cerebrovascular disease.</p> <p>Resident #107 had a 9/16/14, care plan problem/need regarding no natural teeth, refuses to wear dentures.</p> <p>During an 2/22/16, 12:39 p.m., interview, CNA #14 indicated it is normal for her to move from table to table assisting residents with meals.</p> <p>During an 2/25/16,12:44 p.m., interview, the Dietary Manager indicated residents that require assistance are served according to the amount of staff available. She indicated wait time depended on the amount of staff available to assist the residents with eating.</p> <p>During an 2/25/16,1:03 p.m., interview,</p>			

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	<p>the Administrator indicated the independent dining room is served first. Then the main dining room is served starting with the more alert residents, then the residents that require assistance are served last. Each resident at a table should be served before serving another table. Staff should assist only two residents at one time. The Administrator indicated there is a Manager on Duty during lunch. If more staff are needed to assist the residents, the Manager on Duty will go to the office nursing staff and notify them that they are needed in the dining room.</p> <p>During an 2/26/16, 9:54 a.m., interview CNA #15 indicated it is a normal routine for the CNA's to assist more than two residents.5. During a dining observation in the main dining room, on 2/25/16 at 11:46 a.m. the following was observed:</p> <p>Between 12:34 and 12:36 p.m., Resident #135 and Resident #22 received a plate of food. Resident #26, who was sitting at the same table, did not receive a plate of food.</p> <p>At 12:47 p.m.,(11 minutes after the tablemates were served) LPN #5 asked an unidentified staff member if Resident #26 had any food. The unidentified staff member indicated that she did not know.</p>			
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	<p>At 12:50 p.m.,(14 minutes after the tablemates were served) LPN #5 placed a plate of food in front of Resident #26 and began to assist her with eating.</p> <p>a. Resident #26's clinical record was reviewed on 2/26/2016 at 11:45 a.m. Resident #26's current diagnoses included, but were not limited to, hereditary ataxia (lack of voluntary body control), dementia, and dysphagia (difficulty in swallowing).</p> <p>Resident #26 had a current 2/8/16, significant change, Minimum Data Set (MDS) assessment which indicated she had severely impaired cognition, rarely or never made decisions, needed extensive assistance from staff for mobility, and required extensive assistance from staff for eating.</p> <p>Resident #26 had a 10/28/15, care plan problem regarding nutritional risk. An approach to this problem was "provide assistance with meals".</p> <p>The undated, "Resident Rights Skilled Nursing Facility" document was provided by Nurse Consultant #2 on 2/26/16 at 12:18 p.m. The document indicated "...Quality of Life. Our Community must care for you in a manner and in an</p>			

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F 0244 SS=E Bldg. 00	<p>environment that promotes maintenance or enhances your and each resident's dignity and respect in full recognition of your individuality...."</p> <p>The undated, "Procedure #58: Feeding" was provided by Nurse Consultant #2 on 2/26/16 at 12:18 p.m. The procedure indicated staff should sit at eye level with the resident and face them to encourage interaction with resident and placement of the spoon at an appropriate angle. The procedure also indicated staff should make conversation with the resident and the atmosphere should be pleasant to enhance the meal experience and encourage consumption.</p> <p>3.1-3(t)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p>			
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	<p>Based on interview and record review, the facility failed to resolve the grievances of the Resident Council regarding call lights being answered and passing ice water timely for 12 of 13 months of Resident Council minutes reviewed (February 2015 - February 2016).</p> <p>Findings included:</p> <p>During an interview on 2/24/16 at 9:54 a.m., with Resident #57, she indicated there had been monthly complaints about CNA's turning off call lights and saying they would be back, and never returning to help. She also indicated that there had been consistent complaints about ice water not being provided to residents.</p> <p>Resident Council minutes were provided on 2/26/16 at 8:04 a.m., from Nurse Consultant #1. The minutes indicated the following grievances were voiced during the meetings on the following dates:</p> <ol style="list-style-type: none"> <li>2/16/15 - CNA's turned off call lights, exited without providing assistance and did not return.</li> <li>3/24/15 - Call lights were not answered in a timely manner. Water was not being provided between meals.</li> </ol>	F 0244	<p><b>F-244 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Residents will have their grievances resolved. Administrator will audit Resident Council minutes monthly and will ensure grievances are resolved.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> All residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Staff will be re-educated on the proper procedure for providing fresh water to residents. Staff will be re-educated on answering call lights. Staff will be re-educated on responding to complaints and grievances from resident council minutes. Resident Council minutes to be reviewed by the administrator and the following resolution plans will be put into place. · Resident name, room number, date of concern, time of concern, person receiving concern and department responsible for concern will be reviewed · Department head review and action taken · Follow up with Resident Council concern · Concern must be referred to the Administrator for approval. <b>IV</b></p>	03/30/2016			

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	<p>3. 4/20/15 - CNA's turned off call lights, exited without providing assistance and did not return. Some residents had to get their own water or had to ask for it multiple times. The afternoon shift seemed to be the worst regarding providing water between meals.</p> <p>4. 5/18/15 - CNA's turned off call lights, exited without providing assistance and did not return. Not all residents were receiving water between meals.</p> <p>5. 6/18/15 - Water was not being provided between meals or in the evenings and nights. Water was getting warm and fresh water was not being provided.</p> <p>6. 7/23/15 - Water was not being provided between meals. Day shift seemed to be the worst.</p> <p>7. 8/20/15 - CNA's turned off call lights, exited without providing assistance and did not return. Call lights were not being answered in a timely manner.</p> <p>8. 9/15/15 - Water was not being provided, or was provided late.</p> <p>9. 10/15/15 - Water was not being provided, or was provided at inappropriate times. CNA's turned off</p>		<p><b>The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator/Designee will audit systematic changes utilizing and audit tool daily X 4 weeks, weekly X 4 weeks, monthly X 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance <b>V. Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>	

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F 0314	<p>call lights, exited without providing assistance and did not return.</p> <p>10. 12/10/15 - Water was not being provided. Call lights were not being answered in a timely manner and day shift seemed to be the worst.</p> <p>11. 1/14/16 - Water was not being provided. CNA's turned off call lights, exited without providing assistance and did not return.</p> <p>12. 2/5/16 - Water was not being provided. CNA's turned off call lights, exited without providing assistance and did not return.</p> <p>The undated, "Resident Rights Skilled Nursing Facility" document was provided by Nurse Consultant #2 on 2/26/16 at 12:18 p.m. The document indicated "...The Community must develop and implement policies for investigating and responding to complaints and grievances made by an individual resident, resident group, family member, family group or other individual...."</p> <p>3.1-3(l)</p> <p>483.25(c)</p>				

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SS=D Bldg. 00	<p><b>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that necessary treatments were received to promote healing and prevent new sores for 1 of 3 residents reviewed for pressure areas (Resident #107).</p> <p>Findings included:</p> <p>A dressing change by LPN # 6 was observed, on 2/25/16 at 9:32 a.m., of Resident #107's pressure area to her right outer ankle. The skin surrounding the 50 cent size wound, had a bright red, pencil eraser size area to the top right edge and a dark red, pencil eraser size area to the lower left edge. LPN #6 indicated that the bright red area to the top right edge appeared to be open.</p> <p>The Director of Nursing (DON) measured the bright red area to the top right of Resident # 107's ankle during an</p>	F 0314	<p><b>F314</b> We disagree with these findings <b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident 107 had treatments in place to prevent pressure areas. Resident 107 did not acquire a new pressure area. Right ankle pressure sore was identified on 11/18/15 and was receiving treatment. Resident 107 cover dressing to right ankle pressure area was changed to gauze from foam related to 2 closed trauma areas observed on 2/26/16. LPN#6 was re-educated on obtaining treatment from MD/NP on new skin areas. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents with pressure ulcers have the potential to be affected by this alleged deficient practice. <b>III. The facility will put into place the following systematic changes to ensure that the</b></p>	03/30/2016

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	<p>observation on 2/26/16 at 9:47 a.m. She indicated a length of 0.2 centimeters (cm) and a width of 0.2 cm. She also measured the dark red area to the lower left edge and indicated a length of 0.8 cm and a width of 0.4 cm.</p> <p>During an interview on 2/26/16 at 9:43 a.m., the DON indicated if LPN #6 was aware of the red areas on 2/26/16, she would have expected documentation of the areas and the wound Nurse Practitioner (NP) to be notified.</p> <p>During an interview on 2/26/16 at 9:45 a.m., the NP indicated the red areas to the edges of the wound were staged as a stage 2 pressure area in appearance. NP indicated it could be caused by the foam dressing sticking to areas and then removing the skin when the foam dressing was removed.</p> <p>Resident #107's clinical record was review on 2/24/2016 at 8:19 a.m. Resident #107's current diagnoses included, but were not limited to, cerebrovascular accident (CVA), dementia, and pressure ulcer of right ankle, stage 3.</p> <p>Resident #107's clinical record did not have any indications of physician notification of the change in the pressure</p>		<p><b>deficient practice does not recur.</b> Licensed nurses were re-educated on obtaining treatments for new skin areas identified. <b>IV The facility will monitor the corrective action by implementing the following measures.</b> DON or designee will audit licensed nurses while performing treatment to determine if nurse recognizes new skin area and notifies the MD or NP for treatment, the audit will be completed on random nurses 5 x weekly x 30 days, then 3 x weekly x 30 days, then weekly x 30 days, then monthly x 30 days. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting. The frequency and duration of reviews will be adjusted as needed. <b>V. Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>		

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	<p>area to her right ankle.</p> <p>A document titled, "LICENSED NURSE TREATMENT SKILLS VALIDATION", undated, provided by Nurse Consultant (NC) #1 on 2/26/16 at 12:18 p.m., included the following: "...3. Abnormal findings such as abn. [abnormal] odor, appearance or changes in wound bed reported to physician...."</p> <p>A 2/26/16, "Change in Condition" document, provided by the DON on 2/29/16 at 10:26 a.m., included the following: "...Possible trauma areas to the right ankle wound above the superior /top [sic] of wound. Area measures 0.2 X [times] 0.2cm. X light pink. New area of dark reddish/purple tissue, closed to lateral just off right ankle wound. Area measures 0.8 cm X 0.4 cm. X closed dark reddish/purple. N.P. notified... Will contact N.P. and see if need to change dressing or current treatment to decrease further trauma to area...."</p> <p>A 2/22/16, "Prescription Order" document, provided by Nurse Consultant #2 on 2/26/16 at 12:18 p.m., included the following: "Cleanse area to R [right] OUTER ANKLE with NS [normal saline] and pat dry. Apply skin prep to peri wound, then apply nickel thick layer of Santyl [wound debridement] to wound</p>			
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	<p>bed, cover with foam and secure with kerlix...."</p> <p>A 2/23/16, "Skin Condition Assessment Tool" document, provided by nurse consultant #2 on 2/26/16 at 12:18 p.m., included the following: "...Measurement (in centimeters) Length - 2.5 cm [centimeters] Width - 1.7 cm Depth - 0.1 cm...."</p> <p>A document titled, "LICENSED NURSE TREATMENT SKILLS VALIDATION", undated, provided by NC #2 on 2/26/16 at 12:18 p.m., included the following: "...3. Abnormal findings such as abn. [abnormal] odor, appearance or changes in wound bed reported to physician...."</p> <p>A 2/26/16, "Change in Condition" document, provided by the DON on 2/29/16 at 10:26 a.m., included the following: "...Possible trauma areas to the right ankle wound above the superior /top [sic] of wound. Area measures 0.2 X [times] 0.2 cm. X light pink. New area of dark reddish/purple tissue, closed to lateral just off right ankle wound. Area measures 0.8 cm X 0.4 cm. X closed dark reddish/purple. N.P. notified... Will contact N.P. and see if need to change dressing or current treatment to decrease further trauma to area...." The document also indicated that Resident #107 had a</p>						

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F 0329 SS=D Bldg. 00	<p>new order for Keflex (an antibiotic) for possible cellulitis and edema and the dressing order was changed to avoid further trauma.</p> <p>A 2/26/16, "Skin Condition Assessment Tool" document, provided by the DON on 2/29/16 at 10:26 a.m., included the following: "...Measurement (in centimeters) Length - 2.8 cm Width - 2.1 cm Depth - 0.1 cm..."</p> <p>A 2/26/16, "Progress Note" created by the NP, provided by the DON on 2/29/16 at 10:26 a.m., included the following: "...I did encourage nursing to reach out to wound NP that is following and consider changing the topical dressing being used now is a foam cover. Consider changing temporary to a gauze dressing, the foam could have adhered to the periwound cause a removal of the top epithelial layer in some small areas...."</p> <p>3.1-5(a)(3)</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 observation, interview and record review, the facility failed to ensure behavioral indicators were documented and a medical assessment was completed prior to obtaining an order for a as needed anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #111)</p> <p>Findings include:</p> <p>On 2/24/16 at 8:28 a.m., Resident #111 was sitting in her wheelchair, in the dining room. No behaviors noted.</p> <p>On 2/24/16 at 2:57 p.m., Resident #111 was in bed with her eyes closed. No behaviors noted.</p> <p>On 2/25/16 at 8:34 a.m., Resident #111</p>	F 0329	<p><b>F329</b> We disagree with these findings <b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Nurse documented on 12/21/15 2pm-10pm shift on Behavior Tracking form that resident was continuously stating that she was, "missing her family" and nursing provided non-med interventions of active listening, involved her in activities, and repositioning. The IDT Medication Management documentation on 12/23/15 showed that the order for PRN Ativan was obtained for restlessness. Resident #111 Ativan was discontinued 3/10/16 due to non-use. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents on</p>	03/30/2016

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	<p>was in bed with staff at the bedside. No behaviors noted.</p> <p>On 2/25/16 at 11:02 a.m., Resident #111 was in her wheelchair, in the lounge with her husband seated beside her. No behaviors noted.</p> <p>On 2/25/16 at 2:40 p.m., Resident #111 was in bed with her eyes closed. No behaviors noted.</p> <p>On 2/29/16 at 7:35 a.m., Resident #111 was in bed with her eyes closed. No behaviors noted.</p> <p>The clinical record for Resident #111 was reviewed on 2/24/16 at 9:03 a.m. Diagnoses for Resident #111 included, but were not limited to, altered mental status, Parkinson's disease, cognitive communication deficit, and pain.</p> <p>Resident #111 had a current physician order for Ativan (an anti-anxiety medication) 0.5 mg, 1 tablet by mouth every 6 hours as needed for anxiety. The original date of this order was 12/22/15.</p> <p>Review of the Interdisciplinary Team form titled "Medication Management", dated 12/23/15, indicated a new order for prn (as needed) Ativan had been obtained. Restlessness was the</p>		<p>anti-anxiety medications have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Social services and licensed nurses were re-educated on documenting the behavioral indicators for anti-anxiety medications prior to obtaining order. Residents receiving anti-anxiety medication will be reviewed by Social Services for behavioral indicators. <b>IV</b></p> <p><b>The facility will monitor the corrective action by implementing the following measures.</b> Residents receiving new orders for anti-anxiety medication will be reviewed daily 5 days a week in am clinical meeting by the Interdisciplinary team (IDT) to determine behavioral indicators. Social services will audit residents with anti- anxiety medications for behavior indicators documented weekly x 4 weeks, bi-monthly x 2 months, monthly x 1 month. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. <b>V.</b></p> <p><b>Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>		

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	<p>associated behavior for the medication use and the behaviors had been "sporadic". The form indicated the "Goal is for resident to have decrease in restlessness." There was no indication of non-pharmacological interventions having been tried.</p> <p>Review of the "Resident Progress Notes", from 12/1/15 to 12/22/15, lacked any documentation of behaviors for Resident #111. The progress notes indicated Resident #111 had documented medical concerns which included, but were not limited to, upper arms itching, pressure ulcer to her sacrum/coccyx, blood sugar concerns, chest x-rays and diuretic medication increased, and Coumadin (a blood thinner medication) dose changed due to lab results. A progress noted dated 12/23/15 at 3:59 a.m., indicated the prn Ativan was administered "due to resident showing signs of anxiety and yelling all evening and night". No non-pharmacological interventions were documented as having been tried prior to the medication having been given.</p> <p>The December 2015 Medication Administration Record (MAR) indicated Resident #111 was given Ativan on 12/22/15 at 11:37 p.m., with the comment of "resident yelling out". On 12/23/15 at 12:11 a.m., the MAR</p>			

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	<p>indicated the result of the "as needed" Ativan was "resident continues to yell". No other interventions were documented as having been tried.</p> <p>Resident #111's clinical record indicated she was seen by the physician on 12/2/15 and 1/6/16 for congestive heart failure, pressure ulcer, pneumonia, hypertension and diabetes follow up. Both physician assessment notes indicated "No Behaviors Present".</p> <p>During an interview on 2/25/16 at 9:49 a.m., LPN #12 indicated Resident #111 had received her as needed Ativan after she had "squirmed or moved around in her seat" or repeated statements over and over. LPN #12 indicated these behaviors were just not "normal" for Resident #111.</p> <p>During an interview on 2/25/16 at 10:40 a.m., SS#13 indicated documentation for Resident #111's prn Ativan use was documented on the "Medication Management" form and in the comment section of the MAR.</p> <p>During an interview on 2/26/16 at 9:04 a.m., LPN #16 indicated behaviors were documented under "events" in the clinical record. LPN #16 indicated non-pharmaceutical interventions needed to be tried before starting a resident on an</p>			

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	<p>anti-anxiety medication.</p> <p>During an interview on 2/29/16 at 9:24 a.m., the Director of Nursing and the Administrator indicated there were no documented behaviors or a medical assessment prior to the use of an as needed anti-anxiety medication for Resident #111.</p> <p>Review of the current facility policy, dated 10/2013, titled "Behavior management program", provided by NC#2, on 2/26/16 at 12:16 p.m., included, but was not limited to the following:</p> <p>"...It is CarDon's policy that each community will have a behavior program that: identifies, monitors, manages and disseminates (whenever possible) all behavioral events by utilizing the least invasive approach based on the individual resident affected. Our goal is to provide the highest level of functioning and wellbeing for each resident we serve....Residents who demonstrate any of the following characteristics should be involved in the behavior program: Any resident demonstrating new or worsening behaviors...Unresolved repetitive behaviors...Currently has a doctor's order to use anti-psychotic, anti-depressant,</p>			
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	<p>sedative or anxiolytic medication to control ongoing symptomology or exacerbations and any of these drugs used PRN must be evaluated by the IDT....New or worsening behaviors will be recognized and reported by all facility staff to the charge nurse by utilizing the new or worsening behavior report....The charge nurse will complete a behavioral event in the electronic medical record for each new or worsening behavior the resident demonstrates. During the clinical meeting, when the IDT (interdisciplinary team) is present, each behavior will be discussed and the team will be apprised of the behavioral event. The IDT will review the potential causative factors that led to the behavior, successful and unsuccessful interventions that were utilized and ensure that the resident care planned nurse aide assignment sheet reflects the residents care needs. It is important that this discussion examines the non-pharmacokinetic intervention used by staff and evaluate their effectiveness especially when a pharmacokinetic intervention was utilized. The IDT will write a note using the post behavior IDT observation on each behavior event summarizing the behavior itself, the etiology of the behavior, evaluate the effectiveness of the current interventions and add any new non-pharmacokinetic</p>			

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F 0371 SS=E Bldg. 00	<p>intervention in an attempt to alleviate the causative factors that led to the behavior....It is CarDon's policy to ensure that the etiology of a residents behavior is thoroughly investigated, documented and care planned to rule out underlying causative factors that may exit outside of a medical diagnosis...."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure safe and sanitary handling of food during two of four dining observations. This had the potential to impact 63 of 63 residents eating in both dining rooms. (Main Dining Room, Cherished Memory Unit</p>	F 0371	<p><b>F-371 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> No residents were found to be affected by the alleged deficient practice. DA #1 was re-educated on hand washing procedure C.N.A. #2</p>	03/30/2016

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	<p>Dining Room). Findings include:</p> <p>1. On 2/25/2016 from 12:11 p.m. to 12:56 p.m., during a dining observation on the Cherished Memory unit the following was observed:</p> <p>Dietary Assistant (DA #1) washed hands, turned off the faucet with his bare hand, and then, dried his hands. Next, DA #1 was observed to scoop food from the steam table and place it into larger bowls, which were being served to the residents.</p> <p>Next DA # 1 washed his hand for less than 10 seconds, turned the faucet off with his bare hands. He then dried his hands. Following this, he served pie to Resident #145, who kissed the back of DA's #1 right hand. The DA #1 then served pie to Resident #143.</p> <p>DA #1 again washed his hands for fifteen seconds. He then turned off the water with his bare hand. The DA#1 continued to serve pie to the remaining residents in dining area.</p> <p>2. CNA #2 held Resident 140's bread roll with her bare hand. She then cut the roll in half. This roll was returned to Resident 140's plate, and the resident ate the roll.</p>		<p>was re-educated on hand washing procedure C.N.A. #2 was re-educated on proper food handling procedure LPN #5 was re-educated on proper food handling procedure <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> All residents have the potential to affected by the alleged deficient practice. <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Facility staff was re-educated on correct hand washing procedure and food/plate handling during meal service. Signs were posted at hand washing stations to remind staff of the appropriate length of time to wash hands. <b>IV The facility will monitor the corrective action by implementing the following measures.</b> The SDC/designee will perform a random audit of hand washing/handling of food at meal service 7 x week x 4 weeks, weekly x 4 weeks, then monthly x 4 months for nursing. The Dietary Manager will perform a random audit of hand washing/handling of food at meal service 7 x week x 4 weeks, weekly x 4 weeks, then monthly x 4 months for dietary. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and</p>	

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NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060			
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	<p>On 2/22/16 at 12:20 p.m., during an interview, DA #1 indicated hand washing should be done for twenty seconds. He also indicated one should rinse one's hands before turning off the water with his hand, and then dry hands with a paper towel. He indicated hands should be washed any time after touching things and after going to the rest room.</p> <p>On 2/22/16 at 2:26 p.m., CNA #2 indicated she was just made aware by her charge nurse to not use her bare hands to handle resident's food, and she was to use utensils instead of touching food with her bare hands.</p> <p>On 02/22/16 at 11:45 a.m., during an interview LPN#11 indicated there were only 18 residents on the unit at this time who ate lunch in the dining room.</p> <p>3. During a dining observation on 2/25/16 at 12:51 p.m., LPN #5 picked up a dinner roll using her bare hand and gave Resident #26 a bite.</p> <p>The "PROCEDURE #3: HANDWASHING/HANDRUB" policy was provided by the NC#2 on 2/26/16 at 12:18 p.m. This current policy indicated "...#11. Rinse hands with water down from wrist to fingertips...#12. Dry thoroughly with single use towels...#13.</p>		<p>frequency and duration of reviews will be adjusted as needed. V. <b>Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>				

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	<p>Use towel to turn off faucet and discard towel...."</p> <p>A document titled "Food Preparation and Safety", dated 2012, provided by Nurse Consultant #2 on 2/26/16 at 12:18 p.m., included the following: "...Policy: Single use disposable gloves are used in food preparation and handling, as necessary, to prevent contamination of food. Gloves are always used when working with ready-to-eat [RTE] items. The 2005 FDA Food Code forbids bare hand contact with RTE foods (i.e. food that is eaten without further washing or cooking)... Procedure:...3. Disposable gloves are used to perform a single task....They are then discarded to prevent cross-contamination...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>						
F 0431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt</p>						

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	<p>and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an accurate narcotic count for medication was used regarding medications being signed out at the time of administration.</p> <p>Findings Include:</p> <p>On 2/25/16 at 11:15 a.m., during the</p>	F 0431	<p><b>F431</b> We disagree with these findings <b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Residents # 1, 29, 8, 40, narcotics were signed out on narcotic record on 2/25/16 at approximately 11:30 am by LPN# 4. LPN# 4 was re-educated on completing the narcotic count</p>	03/30/2016

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	<p>narcotic count on the west hall Licensed practical nurse (LPN) #4 indicated the narcotic count would be incorrect because she had not signed out a number of the medications when she administered them. These were the following:</p> <ol style="list-style-type: none"> <li>Resident #1's Tramadol HCL 50 MG tab (pain medication) medication card was observed with no pills, and the narcotic count form indicated there were two tabs present. LPN #4 indicated the Tramadol had been given to Resident #1 at 7:00 a.m.</li> <li>Resident #29's VIMPAT (lacosamide) 100MG tab (anticonvulsant), medication card was observed with twelve tabs present, and the narcotic count form indicated there were thirteen tablets. LPN #4 indicated the VIMPAT was administered at 9:00 a. m.</li> <li>Resident #8's Hydrocodone/Acetaminophen 5-325 mg (pain medication) medication card was observed medication card with eight tablets present, and the narcotic count form indicated there were nine tabs present. LPN #4 indicated the Hydrocodone/Acetaminophen 5-325 mg as administered between 8:30 a.m., and 9:00 a.m.</li> </ol>		<p>form immediately when removing narcotics from card or package.  <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents receiving narcotics have the potential to be affected by this alleged deficient practice.  <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Licensed nurses were re-educated on signing out narcotics at the time of removal from the card or package.  <b>IV. The facility will monitor the corrective action by implementing the following measures.</b> DON or designee will audit licensed nurses during medication pass to determine if nurse immediately sign out narcotics once removing from package or card, the audit will be completed on random nurses 5 x weekly x 30 days, then 3 x weekly x 30 days, then monthly x 30 days. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.  <b>V. Plan of Correction completion date.</b> Plan of Completion date is March 30th.</p>	

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	<p>4. Resident #40 's Lorazepam 0.5 mg tab(anti anxiety ) medication card was observed with twenty seven tabs present, and the narcotic count form indicated there indicated twenty eight tablets present. LPN #4 indicated the Lorazepam was given before the resident went to the hospital at 9:10 a.m., on 2/25/16.</p> <p>Resident #40's Oxycodone/ Acetaminophen 5-325 mg (pain medication) medication card was observed with twenty one tabs present, and the narcotic count form indicated there was twenty two tabs present. LPN #4 indicated the Oxycodone/ Acetaminophen 5-325 mg tab was given before the resident went to the hospital at 9:10 a.m., on 2/25/16.</p> <p>On 2/25/16 at 11:52 a.m., during a interview LPN #4 indicated narcotics were to be signed out at the time of removal from the medication cart.</p> <p>On 2/25/16 at 1:15 p.m., during a interview the Director of nursing (DON) indicated the facility policy indicated a nurse should immediately sign the controlled substance record after removing from package.</p> <p>The "MEDICATION ADMINISTRATION SKILLS</p>			

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F 0441 SS=E Bldg. 00	<p>VALIDATION" policy was provided by the DON ON 2/25/16 at 1:12 p.m. This current policy was "#42. Controlled substances record signed immediately after removing from package...."</p> <p>3.1-25(n)</p> <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 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash</p>			

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	<p>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. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing during personal care for 1 of 3 residents observed, personal laundry distribution for 2 of 2 observations and cleaning of equipment during 1 of 1 ice water distribution observed in memory unit. (CNA # 9, LA#8, CNA, #2) (Resident #95)</p> <p>Findings Include:</p> <p>1. On 2/22/16 at 11:50 a.m., Certified nursing assistant (CNA) #2 was observed at the sink removing and then pouring the liquid from the cups with straws down the sink drain. Next, she threw these same cups and straws into the trash can in the dining room. The bedside table used was transported by CNA #2 to Resident # 159's room. No disinfection of the table was observed.</p> <p>On 2/22/16 at 11:55 a.m., during a interview CNA #2 indicated she had just passed out fresh ice water to the</p>	F 0441	<p><b>F441</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident's # 95, 159, 107, and 102 had no adverse reaction based on the alleged deficient practice.</p> <p>CNA #9 was re-educated on handwashing, glove use and removal of gloves.</p> <p>CNA #2 was re-educated on proper sanitization of equipment and proper ice pass.</p> <p>LA #3 was re-educated on proper handling and transport of personal laundry.</p>	03/30/2016

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	<p>residents, and the cups that were observed being emptied were the previously used cups collected from the residents rooms.</p> <p>On 2/29/16 at 2:55 p.m., during a interview the DON indicated the bed side table should have been cleaned after use by CNA #2.</p> <p>The "CLEANING AND DISINFECTION OF EQUIPMENT" policy was provided by the DON ON 2/29/16 at 2:59 p.m. This current policy was "#(2) (d). Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) ...."</p> <p>2. On 02/26/2016 at 10:13 a.m., Resident #95's personal care was observed. While cleaning the rectal area, Resident #95 was incontinent of a large, brown bowel movement. After the cleansing of the incontinent bowel movement, using the same contaminated gloves, CNA #9 assisted the resident with dressing, transferring the resident per stand up lift and repositioning the resident in his wheelchair before her gloves were removed and hands washed.</p> <p>On 2/26/2016 at 10:33 a.m., during an interview CNA #9 indicated hand</p>		<p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents in the facility have the potential to be affected by this alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Nursing staff were re-educated on handwashing, glove use and removal of gloves.</p> <p>Laundry staff were re-educated on proper handling and transport of personal laundry.</p> <p>Nursing, activities, and Caring</p>	

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	<p>washing should be done before putting on gloves and upon removal of gloves.</p> <p>The "PROCEDURE #3: HANDWASHING/HANDRUB" policy was provided by the Nursing Consultant (NC) #2 on 2/26/16 at 12:18 p.m. This current policy was "...#11. Rinse hands with water down from wrist to fingertips....#12. Dry thoroughly with single use towels....#13. Use towel to turn off faucet and discard towel...."</p> <p>3. On 2/23/16 at 1:10 p.m., as Laundry aide (LA) #3 entered Resident #95's room carrying personal laundry. She held this same laundry next to her uniform, letting the clothing touch the front of her shirt. The personal laundry cart was also observed uncovered with other personal laundry hanging.</p> <p>The "SAFE HANDLING OF LINENS" policy was provided by the NC #1 ON 2/29/16 at 10:34 a.m. This current policy was "...#2. Transferring clean linens and residents laundry should be done separately in a clean cart that has a cover... #8. Nursing staff when acquiring and transporting linens to resident's rooms must carry the linens away from their bodies and above the waist. (clean linens can also be bagged and carried to prevent contamination)...."</p>		<p>Hearts Representatives were re-educated on proper ice pass and sanitizing equipment.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON or designee will audit random resident care to ensure handwashing and glove use is done properly. The audit will be completed on random nursing staff 5 x weekly x 30 days, then 3 x weekly x 30 days, then weekly x 30 days, then monthly x 30 days.</p> <p>Laundry Department director or Designee will audit random laundry aides for proper transport and handling of residents' personal laundry. The audit will be completed on random laundry aides 5 x weekly x 30 days, then 3 x weekly x 30 days, then weekly x 30 days, then monthly x 30 days.</p>	

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R 0000  Bldg. 00	<p>4. During observation of linen being passed on 2/24/16 at 1:35 p.m., the following was observed: Laundry Aide #3 transported uncovered clothing on hangers down the East hallway. The uncovered clothing brushed against Laundry Aide #3's shirt before she took it into Resident #107's and Resident #102's room.</p> <p>During an interview with Laundry Aide #3 on 2/24/16 at 1:36 p.m., she indicated that was how she normally transported personal clothing.</p> <p>3.1-18(l) 3.1-19(g)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 49 Sample: 7</p>	R 0000	<p>Administrator or designee will audit random ice pass to determine if ice was passed utilizing proper infection control procedures, 5 x weekly x 30 days, then 3 x weekly x 30 days, then weekly x 30 days, then monthly x 30 days.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is March 30th.</p>	

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	Harbour Manor Health and Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.				