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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 09/30/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660 |
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| F 0000 Bldg. 00 | <p>This visit was for the Recertification and State Licensure Survey</p> <p>This visit was in conjunction with the Investigation of Complaint IN00182476.</p> <p>Survey dates: September 22, 23, 24, 28, 29, & 30, 2015</p> <p>Facility number: 000327 Provider number: 155561 AIM number: 100273920</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 6 Medicaid: 57 Other: 15 Total: 78</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on October 7, 2015.</p> | F 0000 | <p>Plan of Correction for Good Samaritan Home 2015 Annual Survey</p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 16th 2015</p> | |
| F 0241 SS=D | 483.15(a) DIGNITY AND RESPECT OF | | | |

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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| Bldg. 00 | <p>INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to maintain resident's dignity during dining for 2 of 16 residents who dined in the restorative dining room. One of the residents was sleeping during the lunch meal and one of the residents was fed the meal with the CNA standing while feeding the resident. (Resident #7, Resident #54)</p> <p>Findings include:</p> <p>1. During an observation on 9/22/15 at 12:30 p.m., Resident #7 was observed to have her lunch sitting, uncovered, on the table. Resident #7 was observed to be asleep. At 12:53 p.m., CNA #3 was observed to attempt to awaken Resident #7. Resident #7 was observed to wake up, momentarily, and CNA #3 was observed to give the resident a spoonful of food to eat. CNA #3 left Resident #7 and began to feed another resident. Resident #7 went back to sleep at the table. At 1:00 p.m., Resident #7 was still asleep at the dining table. CNA #4 was observed to shake Resident #7's arm in an</p> | F 0241 | <p>F241 DIGNITY AND RESPECT OF INDIVIDUALITY It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? ·Resident#7 will be aroused during meal times and offered meal with a staff member seated to encourage intake. If resident wishes to sleep during meal time and have meals at a later time a new meal tray will be offered to the resident at the preferred time. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken ·All residents have the potential to be affected by the alleged deficient practice. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. ·The DNS/designee to in-service all staff by October 16,</p> | 10/16/2015 |
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| F 0250 SS=D Bldg. 00 | <p>attempt to wake the resident. CNA #4 was observed to obtain another resident's tray and proceeded to feed the other resident, leaving Resident #7 asleep.</p> <p>2. During an observation on 9/21/15 at 12:25 p.m., CNA #3 was observed to be feeding Resident #54 his lunch meal. CNA #3 was observed to be standing while feeding the resident his lunch.</p> <p>During an interview on 9/30/15 at 9:23 a.m., CNA #6 indicated when a resident was asleep during a meal, the resident would be taken to their room and placed in bed. CNA #6 indicated when the resident woke up, the staff would obtain another new tray for them to eat. CNA #6 also indicated staff should be seated when feeding a resident.</p> <p>The facility lacked a policy for dignity during dining for the residents.</p> <p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> | | <p>2015 on dining services and dignity for residents during meal times.</p> <p>4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place ·The DNS/designee will monitor weekly using MealObservation CQI tool times 4 weeks, bi-monthly times 2 months, monthly times 4and then quarterly to encompass all shifts until continued compliance ismaintained for 2 consecutive quarters. The results of these audits will bereviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will bedeveloped.</p> <p>5. Datecompletion: October16, 2015</p> | |

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| | <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 6 residents reviewed for behaviors in a total sample of 35 who met the criteria, received medically related social services for behaviors. (Resident #83)</p> <p>Findings include:</p> <p>On 9/23/15 at 1:16 p.m., during Stage 1 interviews Resident #80 was asked if she had seen anyone abused. She answered yes, Resident # 83 had hit and kicked the staff and she had seen that. Resident #80 further indicated she was told by another resident, Resident #83 had a resident in a choke hold on another day. When queried if she had told any staff, she indicated they all knew about him.</p> <p>On 9/24/15 at 2:03 p.m., the clinical record review indicated Resident #83 was admitted on 6/23/15 at 12:00 p.m. The diagnoses included, but were not limited to: psychosis, senile bipolar disorder, episodic mood disorder, obsessive-compulsive personality disorder, unspecified intellectual disabilities, infantile cerebral palsy, and epilepsy.</p> <p>The current physician's order, dated 6/23/15, were as followed:</p> | F 0250 | <p>F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident#83 was sent to behavioral center on 9/30/15. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·Resident#83 is no longer a resident at this facility. ·All residents with behaviors will be reviewed by the behavior management team/IDT by October 16, 2015 and continue daily as needed to determine appropriate actions to take in response to any resident exhibiting behaviors that could be potentially harmful to the resident, another resident, visitors, and or staff members to determine the expeditious actions that need taken for the safety of the resident, other residents, visitors, and or staff members. | 10/16/2015 |

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| | <p>Ativan (an anti anxiety medication) 1 mg (milligrams), 1 tablet, po (by mouth) every 4 hours for Explosive disorder.</p> <p>Gabapentin (a mood stabilizer) 600 mg, three times per day for pain.</p> <p>Zyprexa (an anti-psychotic), 20 mg, 1 tablet by mouth for psychosis.</p> <p>Lamictal (a mood stabilizer), 25 mg, per day.</p> <p>Rapiflux, 20 mg, 3 tablets, per day, po, for depression.</p> <p>Depakote, 2 capsules - mood stabilizer.</p> <p>Keppra, 100 mg, for seizures daily.</p> <p>Estradiol, 0.025 mg patch, weekly, for inappropriate sexual conduct.</p> <p>Lorazepam (a sedative) 2 mg/ml (milliliter), IM (intramuscularly) every 4 hours as needed for agitation.</p> <p>On 7/14/15 and on 8/6/15 Haldol (an antipsychotic) 2 mg IM one time now for agitation.</p> <p>On 8/26/15, a physician's ordered for psychiatric services ordered was ordered.</p> <p>On 9/24/15 at 2:00 p.m., Resident #83's reportable's were received from the DON. There had been four incidences of resident to resident contact initiated by Resident #83.</p> <p>A nurse's note, dated 7/18/15 at 3:13 p.m., Resident #83 had at several times during the day, today where staff had to</p> | | <p>4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place.</p> <p>·SSD/designee will be responsible for thecompletion of Behavior Management CQI tool weekly times 4 weeks, bi-monthlytimes 2 months, monthly times 4 and then quarterly to encompass all shiftsuntil continued compliance is maintained for 2 consecutive quarters. Therresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is notachieved, an action plan will be developed.</p> <p>5. Datecompletion: October16, 2015</p> | |

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| | <p>move and redirect him and give him personal space due to calling people names and yelling at them, including staff, residents, and visitors.</p> <p>On 7/20/15, the IDT (interdepartmental team) reviewed Resident #83's behaviors. The IDT note, dated 7/18/15 and 7/19/15, indicated Resident #83 had several episodes of calling other people names and yelling out. On 7/19/15, Resident #83 was sit in the hallway when the resident inappropriately touched a female resident. Resident #83 asked for a hug and when the other resident leaned over, the female resident's blouse gapped open, and Resident #83 reached his hand into her blouse. Resident #83 was removed from the area and one on one interventions were begun. The one to one intervention was effective, and after approximately 15 (fifteen) minutes, the resident was started on 15 minute checks</p> <p>A nurse's note, dated 8/8/15 at 7:20 a.m., indicated Resident # 83 had an altercation with another resident.</p> <p>A nurse's note, dated 8/10/15 at 1:45 p.m., indicated Resident #83 was brought from restorative dining room as the resident was acting out, yelling and knocking chairs over.</p> | | | |

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| | <p>A nurse's note, dated 8/12/15 at 9:28 a.m., Resident # 83 was yelling in the hall. A staff member was transferring another resident down the hall when Resident #83 reach over and made open hand contact to the other resident in the back. The residents were separated. Physician and families notified and Resident #83 was referred for psychological services for consult and treatment. One to one intervention was started with Resident #83.</p> <p>A nurse's note, dated 9/4/15 at 8:30 a.m., indicated Resident #83 was observed to be sitting at the dining room table when the resident began yelling and using foul language. Staff intervned and removed resident to nursing desk. Resident #83 propelled himself back into the dining room and proceeded to same assigned table, placing himself at the opposite side of the table. Resident #83 was observed to reach around to the next table, moved his arm and made contact with another resident to the top of her head. Interventions included: Resident #83 would be monitored for behaviors and whereabouts' every 15 minutes.</p> <p>On 9/29/15 at 11:06 a.m., a review of the physician's orders indicated there was not a physician's order for transferring the resident to another facility.</p> | | | |

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| | <p>On 9/28/15 at 10:53 a.m., an interview with the Administrator, DON (Director of Nursing), and Consultant about Resident #83, indicated Resident #80 stated Resident had hit other residents. The Administrator indicated Resident #83 had been scheduled to go to a group home on 10/1/15. The DON indicated behavior monitoring and one on one would be instituted immediately until the resident was discharged to the Group home.</p> <p>On 9/28/15 at 2:03 p.m., the Administrator indicated the resident was going to be sent to a behavioral unit, because they could not take the chance resident would hurt someone.</p> <p>On 9/28/15 at 1:30 p.m., an interview with SS (social services) indicated Resident #83 had come from a behavioral unit with explosive behaviors especially when there was lots of noise he seems to do worse, he would become combative with staff in morning. There were times he would swing arms, she felt mostly from overstimulation. The staff would separate him immediately, and would take Resident #83 to an empty dining room and watch movies and listen to music. She indicated he was a tough one! She indicated he had a stuffed animal, Simba, which you had to talk through</p> | | | |
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| | <p>sometimes. SS called today and he was going to group home. She indicated he would cry a lot for his mom, they would call her for him and he calmed down. Staff were getting better interventions and mom comes a lot, when he needs to quieted down he is not put in his room by himself, that was isolation and she would not let that happen.</p> <p>On 9/29/15 at 9:30 a.m., the Administrator informed one of the others surveyors that he did not want to transfer Resident #83 from the facility as Resident #83 had been so good. The Administrator discussed the resident receiving one on one care for last 24 hours. The Administrator indicated he also didn't know when the resident might lash out at someone. He also indicated the resident would probably be heavily medicated and sent back to the facility anyway.</p> <p>On 09/29/15 at 11:09 a.m., an interview with DON, Consultant and Administrator about Resident #83 order from 8/26/15 to receive psychiatric evaluation and services, and why hadn't that been done? They indicated that SS was waiting for 3 calls back, hoping to be placed in behavior unit today or tomorrow.</p> <p>On 09/29/15 at 11:40 a.m., during an</p> | | | |

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| | <p>interview with SS (Social Services), she indicated in her notes the psychiatrist wasn't coming until 10/14/15 and they won't come to see one patient. The SS indicated the Psychiatrist only comes every two months.</p> <p>On 9/29/15 at 11:41 a.m., an interview with SS also indicated that Resident #83 would be transferred tomorrow now (Wednesday) because the behavior unit would have discharges today. Resident #83 would stay on one to one observation.</p> <p>On 9/29/15 at 5:18 p.m., the SS indicated Resident #83 remained in the facility as the resident was unable to be transferred to another behavioral unit due to not the facility not being Medicaid certified and original facility does not have a bed today as originally planned.</p> <p>Resident was observed many times with one on one being implemented. The one on one sheets were obtained by the DON on 9/30/15 at 4:00 p.m., as well as the behavior tracking sheets.</p> <p>On 9/28/15 at 9:41 a.m., the resident was observed sitting in hallway in the wheelchair with a helmet on, asking nurse to turn music off.</p> | | | |

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| | <p>On 9/28/15 1:12 p.m., resident in lunch room eating CNA by his side.</p> <p>On 09/28/15 at 1:14 p.m., Resident #83 in the office of central supply talking with staff member</p> <p>On 9/28/15 at 1:15 with LPN #3 indicated when Resident #83 had bad behaviors they try everything to calm him down, play music, change music, lay him down, talk to him, redirect attention to do different activities</p> <p>On 9/28/15 1:28 p.m., resident was talking to two CNA's and asked to be moved somewhere around corner he stated if they didn't he was getting mad.</p> <p>On 9/28/15 at 4:23 p.m., resident was observed sitting with CNA talking.</p> <p>On 9/29/15 at 9:13 a.m., the DON indicated Resident #83 had been receiving been on one to one observation and would be transferred to another facility for behaviors.</p> <p>On 9/29/15 at 11:43 a.m., Resident #83 was observed sitting at the nurses station with a CNA, playing a fishing game.</p> <p>On 9/29/15 at 11:45 a.m., the Social Service notes indicated the incidences of</p> | | | |

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| | <p>resident to resident contacts. She had set up Resident #83 going to Group home on 10/1/15. An appointment for psychiatric services, 10/14/15 which was as soon as he can be seen.</p> <p>A copy of all care plans was receive from the DON on 9/28/15 at 4:42 p.m. The care plans indicated the following:</p> <p>9/29/15 resident is one on one</p> <p>9/4/15 resident had incident with another resident approach: resident will not have any further altercation approach: resident is eating meals at nurses station as needed if resident is overstimulated in dining room</p> <p>8/26/15 Resident had incident with another resident Goal : resident will have no further behaviors with other residents psych service evaluation and treatment separate resident immediately</p> <p>8/12/15 Behavior: resident becomes extremely agitated with overstimulation of others goal: resident will be calmed with one on one attention in a quiet areas Approach: one to one supervision at all times 24/7</p> | | | |

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| | <p>take resident to quiet area to watch cartoon 's or listen to music one on one attention and conversation talk to (male name) through his stuffed animal Simba</p> <p>8/10/15 Resident altercation with another resident goal: resident to participate in activities such as music , special partied one on one conversation remove area to quiet area for less stimulation</p> <p>7/20/15 Resident had episode of sexually in appropriate behavior goal resident will not have any further episode 15 minute checks resident is not to be seated next to any female residents</p> <p>On 9/30/15 at 10:20 a.m., Administrator queried as if Resident #83 would be leaving; he said hopefully today. SS has already called today awaiting bed. He also indicated he had even called several other units near this area. Believe me I want to get rid of him as bad as you .</p> <p>On 9/30/15 at 1:39 p.m., the survey team was informed by DON and the Consultant, they have received a doctors order to send Resident #83 to the</p> | | | |

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| F 0272 SS=D | <p>behavior unit Emergency Room where he will be admitted. DON also indicated the resident will be admitted back when his behaviors have been controlled.</p> <p>The facility lacked a policy for behaviors.</p> <p>A policy on Abuse Prohibition, Reporting, and Investigation was received from the Consultant on 9/30/14 at 1:05 p.m., which included but was not limited to:</p> <p>It is the policy of [Name of Facility] to protect residents from abuse including physical abuse, sexual abuse mental abuse, neglect, and misappropriation of property and funds.</p> <p>[Name of Facility] will not permit residents to be subjected to abuse by anyone. All abuse allegation must be reported to Executive Director.</p> <p>In the event a behavioral management plan is unsuccessful, or if the team feels that in inappropriate behavior poses a risk to other residents, the facility reserves the right to discharge the resident.</p> <p>3.1-34(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> | | | |

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| Bldg. 00 | <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a comprehensive assessment was accurate for 2 of 33 residents reviewed, as the MDS (minimum data set) assessment was incorrectly entered as none of the above (no issues with teeth) for an edentulous</p> | F 0272 | <p>F272 COMPREHENSIVE ASSESSMENTS</p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents</p> | 10/16/2015 |

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| | <p>resident and incorrectly marked as a resident had only one fall. (Resident D, Resident B)</p> <p>Findings include:</p> <p>1. During Stage 1 interview with Resident D on 9/22/15 at 2:53 p.m., it was observed the resident had no teeth or dentures</p> <p>On 9/28/15 review of clinical records indicated Admission MDS indicated under dental category the resident had no problems with teeth, as does the MDS for 5/27/15 and 8/19/15.</p> <p>On 9/28/15 1:00 p.m., resident sitting in room, no teeth noted.</p> <p>On 9/28/15 at 1:15 p.m., SS(Social Service) indicated the Resident was seen by the dentist 8/15/15. The dentist said the resident does not want information about dentures. Patient had no teeth and no dentures. Dentist indicated resident was not a candidate for dentures.</p> <p>On 9/28/15 at 1:21 p.m., an interview with the MDS Coordinator about resident being edentulous. She indicated she only went by what was marked on the nursing assessment. She also indicated she does not physically go check the residents, she</p> | | <p>found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident D's MDS was modified to correct dental status. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> The MDS/designee will conduct a full house audit of all residents to ensure all MDS assessments match current dental status. DNS/designee will conduct in-service with nursing staff by October 16, 2015 on dental status documentation on weekly summary and admission comprehensive assessments. DNS/designee will conduct in-service with MDS by October 16, 2015 on ensuring proper dental status is documented on MDS assessments. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> MDS/designee will be responsible for the completion of Dental Services CQI tool weekly times 4 weeks, bi-monthly times | |

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| | <p>goes off the admission assessment and any other nursing notes or assessments. She indicated that it should be marked he had missing or cracked teeth because it was care planned for that. It should not be marked as having no issue with dental issues.</p> <p>Resident was care planned for: missing teeth and caries, poor oral hygiene: assist with oral care dental consult as indicated observe and document red/bleeding gums. lesions. loose teeth, pain notify MD watch for decrease in food consumption watch for decrease in ability to chew foods</p> <p>2. During an observation on 9/23/15 at 11:26 a.m., Resident B was observed to be lying in bed. Resident B was observed to be asleep and difficult to arouse.</p> <p>The clinical record for Resident B was reviewed on 9/24/15 at 1:12 p.m. Resident B had clinical diagnoses including, but not limited to, dementia with behavioral disturbances, insomnia, anxiety, depressive disorder, and senile psychosis.</p> <p>The progress notes for Resident B indicated the resident had fallen on</p> | | <p>2months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date completion: October 16, 2015</p> | | |

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| F 0280 Bldg. 00 | <p>5/22/15, 5/26/15, 5/27/15, 5/31/15, 6/6/15, and 6/24/15.</p> <p>A significant change MDS assessment, dated 7/15/15, indicated Resident B had one fall since admission/entry or reentry or prior assessment.</p> <p>During an interview on 9/30/15 at 9:30 a.m., the MDS Coordinator indicated the MDS assessment was incorrect. The MDS Coordinator indicated oftentimes she would be going to fast and would enter the wrong assessment.</p> <p>The facility lacked a policy for MDS assessments.</p> <p>3.1-31(a) 3.1-31(c)(9)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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</p> | | | |

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| | <p>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, the facility failed to ensure the care plan was revised for 2 of 3 residents reviewed for falls. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 9/24/15 at 1:12 p.m. Resident B had clinical diagnoses including, but not limited to, dementia with behavioral disturbances, insomnia, anxiety, depressive disorder, and senile psychosis.</p> <p>Resident B's Significant Change MDS (Minimum Data Set) Assessment, dated 7/15/15, indicated Resident B had a BIMS (Brief Interview for Mental Status) indicated moderate cognitive impairment</p> <p>Resident B had a fall on 4/23/15 and 5/8/15.</p> <p>A care plan for falls, dated 4/16/15, had included the following interventions: therapy screen as ordered, personal items</p> | F 0280 | <p>F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident Band C care plans are updated to reflect current interventions. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> DNS/designee will conduct in-service with IDT on IDT Care Plan Review policy by October 16, 2015. | 10/16/2015 |

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| | <p>in reach, non-skid footwear, environmental changes: floors clean and clutter free, and call light in reach.</p> <p>The care plan had no further revisions until 5/11/15. A care plan, dated 5/11/15, included shoes or gripper socks on while out of bed and toilet upon rising, before or after meals, before bedtime, and as needed.</p> <p>During an interview on 9/30/15 at 9:30 a.m., the MDS (Minimum Data Set) Coordinator indicated she usually revised the care plans. She indicated if a problem or intervention was resolved, it would automatically come off of the computerized care plan. She further indicated the care plan history should indicate what had been removed or resolved but she was unable to obtain the history.</p> <p>2. On 9/29/15 at 1:15 p.m., Resident C's clinical record was reviewed.</p> <p>Resident C's MDS (Minimum Data Set) Assessment, dated 6/2/15, indicated Resident C's BIMS (Brief Interview for Mental Status) indicated mild cognitive impairment. The functional status portion, indicated the resident required assistance of one person for transfers.</p> | | <p>4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place</p> <p>·DNS/designee will be responsible for thecompletion of Care Plan Updating CQI tool weekly times 4 weeks, bi-monthlytimes 2 months, monthly times 4 and then quarterly to encompass all shiftsuntil continued compliance is maintained for 2 consecutive quarters. Therresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is notachieved, an action plan will be developed.</p> <p>5. Date completion: October16, 2015</p> | |

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| | <p>The Fall Event's documentation indicated Resident C had falls on 3/11/15, 3/17/15, 5/4/15, 5/7/15, 5/16/15, 5/20/15, and 6/29/15.</p> <p>The Fall Event's documentation indicated Resident C had fallen on 3/11/15 from her rocker/recliner when the resident leaned forward to stand up. The new intervention to prevent further falls included stop blocks to be applied to the resident's chair to prevent it from tipping forward.</p> <p>The Fall Event's documentation indicated Resident C had fallen on 5/7/15. The IDT note, dated 5/7/15 indicated the resident had fallen on 5/6/15. The note indicated the resident was found on the floor in the bathroom. The note further indicated the new intervention to prevent further falls included to ask the physician for labs and staff members to assist the resident with early morning activities of daily living.</p> <p>The Fall Event's documentation indicated Resident C had fallen on 5/16/15. The IDT note, dated 5/18/15, indicated the resident had fallen on 5/18/15. The note indicated the resident stood up her legs were weak and she had fallen. The new intervention to prevent further falls included, but was not limited to, nursing</p> | | | |

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| | <p>to assess the residents blood pressure every shift for 72 hours and request a medication review by the physician.</p> <p>The Care Plans included, but were not limited to, resident is at risk for falls. The fall care plan lacked the interventions to prevent further falls regarding the falls on 3/11/15, 5/7/15, and 5/16/15.</p> <p>On 9/30/15 at 10:40 a.m., the MDS (Minimum Data Set) Assessment Coordinator indicated she would have to print the care plan to include interventions that could have been completed.</p> <p>On 9/30/15 at 3:05 p.m., the DON indicated she was unable to locate a revised care plan which included the new interventions from the falls on 3/11/15, 5/7/15, and 5/16/15.</p> <p>A policy titled, "IDT Care Plan Review," revised 4/2014, and obtained from the Regional Consultant on 9/30/15 at 1:05 p.m., indicated the care plan problems, goals, and interventions would "be updated based on changes in resident assessment/condition..."</p> <p>3.1- 35(d)(2)(B)</p> | | | |

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| F 0329 SS=D Bldg. 00 | <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to monitor behaviors for psychoactive medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #24)</p> <p>Findings include: On 9/24/15 at 9:06 a.m., Resident #24</p> | F 0329 | <p>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <p>·Resident #24 with behavior</p> | 10/16/2015 |

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| | <p>was observed in the common area with her head on her hand and eyes closed.</p> <p>On 9/24/15 at 9:08 a.m., Resident #24's clinical record was reviewed. Resident #24 was admitted on 6/4/15. Resident #24's diagnoses included, but were not limited to, generalized anxiety.</p> <p>The physician's recapitulation orders, signed 9/3/15, included, but were not limited to: Ativan (an anti-anxiety medication), 1 mg (milligram), take one tablet, by mouth, three times daily, for anxiety/agitation.</p> <p>A telephone order, dated 9/11/15, indicated: Reduce Ativan to 0.5 mg in the morning, and continue Ativan 1 mg twice daily at 1:00 p.m. and 6:00 p.m.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 8/15/15, indicated Resident #24 had received an anti-anxiety medication seven out of seven days during the assessment period.</p> <p>The Care Plans included, but were not limited to: Resident is at risk for signs and symptoms of anxiety. Resident had a diagnosis of anxiety. The interventions included, but were not limited to,</p> | | <p>tracking for anxious behaviors in place.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> All residents that require behavior monitoring will be audited by SSD/designee to ensure that behavior care plans and behavior tracking is in place by October 16, 2015. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> SSD/designee will be responsible for the completion of Behavior Management CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 09/30/2015 | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660 | | | |
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| F 0371 SS=E Bldg. 00 | <p>encourage activities of interest, encourage family support and involvement, maintain a calm environment, and medications per physician's orders.</p> <p>The clinical record lacked documented behavior tracking for anxious behaviors.</p> <p>On 9/28/15 at 1:23 p.m., the SSD (Social Service Director) was interviewed. The SSD indicated Resident #24 had a regular anxiety care plan and it needed to be changed to include behavior tracking.</p> <p>On 9/30/15 at 1:30 p.m., the SSD indicated she had begun tracking anxious behaviors for Resident #24 on 9/28/15.</p> <p>3.1-48(a)(3)</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</p> <p>Based on observation and interview and</p> | F 0371 | <p>5. Date completion: October 16, 2015</p> <p>F371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> | 10/16/2015 | | | |

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| | <p>record review, the facility failed to serve food under sanitary conditions for 2 of 2 kitchen observations and 1 of 2 meal observations, the kitchen floor was soiled and sticky, dirt and debris was built up in the corners and along the edges of the cove base and handwashing was not done while delivering trays and feeding residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 9/22/15 at 9:00 a.m., during the initial tour of the kitchen the tile flooring was observed to be dirty and sticky especially in the corners and edges with dirt and debris build up. On 9/29/15 at 10:26 a.m., an observation of the flooring indicated the flooring to be dirty especially on edges and corners. <p>On 9/29/15 at the same time and Interview with Head of Dietary stated the flooring was fixed by a company and left in worse shape, then a cleaning company came in and tried to steam clean it with a large power steamer. When it would not come clean, they asked Director of Dietary how would she get it clean?</p> <p>On 9/29/15 at 10:14 a.m., the Director of Dietary supplied me with an invoice</p> | | <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> The kitchen floor was deep cleaned. Residents #40 and #54 monitored for infectious processes stemming from observation on 9/22/15 with no noted issues. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> The kitchen floor will be repaired and deep cleaned by October 16, 2015. DNS/designee will conduct in-service with all staff on hand washing, dining services, and dignity during meal services by October 16, 2015. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> DNS/designee will be | |

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| | <p>dated 9/18/15 of the work that was done and and the cleaning bill. The floor was still dirty with build up of debri and had some chipped tiles.</p> <p>On 9/30/15 at 1:05 p.m. a policy was received from the Consultant which indicated the flooring of the kitchen.</p> <p>3. During an observation of the Restorative dining room on 9/22/15 at 12:41 p.m., LPN #1 was observed to wash her hands for 10 seconds, pulled up her pants, obtained Resident #54's tray and deliver it to the resident. LPN #1 delivered Resident #83's tray and shook the resident's hand. LPN #1 washed her hands for 5 seconds, pulled up her pants and delivered a tray to Resident #40.</p> <p>4. During an observation of the Restorative dining room on 9/22/15 at 12:44 p.m., CNA #3 was observed to wash her hands for 5 seconds. CNA #3 pulled up her pants and proceeded to pour drinks into cups. CNA #3 left the dining room and upon return, washed her hands for 5 seconds before feeding Resident #54. CNA #3 was observed to leave Resident #54 while feeding the resident and fed Resident #7 a bite to eat before continuing to feed Resident #54.</p> <p>During an interview on 9/30/15 at 9:30</p> | | <p>responsible for the completion of Meal Observation CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>·DM/designee will be responsible for the completion of Dietary Cleaning Schedule CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date completion: October 16, 2015</p> | | | | |

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| F 0431 SS=E Bldg. 00 | <p>a.m., CNA #6 indicated staff should sit while feeding the residents and should never stand.</p> <p>On 9/30/15 at 1:05 p.m., the Nurse Consultant provided the Hand Hygiene policy, dated 3/2012. The policy included, but was not limited to, use friction for at least 20 seconds.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt 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</p> | | | |

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| | <p>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, interview, and record review, the facility failed to ensure medications were disposed of when outdated and medications carts were locked when not attended for 3 of 5 medication carts. (Station 1, Station 2, and locked Dementia unit medication carts)</p> <p>Findings include:</p> <p>1. During an observation on 9/28/15 at 4:14 p.m., RN #1 was observed to be administering medications to Resident #97. After obtaining the medication, RN #1 was observed to enter Resident #97's room and administered the medication to the resident. The medication cart was observed to be unlocked, sitting in the hall, out of the view of RN #1 .</p> <p>2. During an observation on 9/29/15 at</p> | F 0431 | <p>F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident#21 Novolog discarded. ·Station 3 medication cart bottle of Timolol Ophthalmic Solution 0.5% with open date of 8/5/15 discarded. ·Risperidone liquid dated 4/1/15 with no open date discarded. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will</p> | 10/16/2015 |

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| | <p>9:32 a.m., LPN #2 was observed to obtain medication from the medication cart on the locked Dementia unit. The medication cart was in the hall of the unit. LPN #2 was observed to leave the medication cart unlocked and unattended.</p> <p>3. During an observation of the Station 1 medication cart on 9/30/15 at 9:20 a.m., Resident #21 was observed to have Novolog Insulin with an opened date of 8/25/15 on the box. The manufacturer's recommendation indicated the insulin should be discarded 28 (twenty-eight) days after opening the medication.</p> <p>4. During an observation on 9/30/15 at 9:30 a.m., Station 3 medication cart had a bottle of Timolol Ophthalmic Solution 0.5% with an open date of 8/5/15 on it. The manufacturer's recommendation indicated the ophthalmic solution should be discarded 4 (four) weeks after opening.</p> <p>5. During an observation on a bottle of Risperidone liquid with no open date on it but the packet indicated the medication had been delivered to the facility on 4/1/15. The manufacturer's recommendation indicated the bottle should be discarded 3 (three) weeks after opening the bottle.</p> | | <p>be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · DNS/designee will conduct in-service with nursing staff on medication storage by October 16, 2015. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · DNS/designee will be responsible for the completion of Medication Storage CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. <p>5. Date completion: October 16, 2015</p> | |

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| F 0441 SS=D Bldg. 00 | <p>During an interview with LPN #3 on 9/29/15 at 9:27 a.m., LPN #3 indicated insulin medications are should be discarded 28 days after opening.</p> <p>During an interview on 9/29/15 at 11:22 a.m., the DON (Director of Nursing) indicated she had spoke with the facility pharmacy representative and the representative had indicated all ophthalmic solutions are good through the date printed on the bottle even after they are opened.</p> <p>A policy titled, "Drug Expiration Date," effective date 2/2014, indicated the expiration dated for opened ophthalmic solutions and ointments were specified on the manufacturer's labeling.</p> <p>3.1-25(o)</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</p> | | | |

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| | <p>Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to 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, interview, and record review, the facility failed to provide a safe and sanitary environment for 1 of 6 residents observed for care. Hands were not washed and gloves were not changed from dirty to clean tasks. (Resident #71)</p> <p>Findings include:</p> <p>On 9/29/15 at 9:02 a.m., CNA #1 and</p> | F 0441 | <p>F441 DRUG INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <p>·Resident#71 monitored for infectious process with no noted issues.</p> <p>2: How other residents having the</p> | 10/16/2015 |

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| | <p>CNA #2 were observed to provide care for Resident #71. CNA #2 was observed to perform hand hygiene for 15 seconds and then donned gloves. CNA #1 was observed to perform hand hygiene and then also donned gloves. CNA #1 and #2 assisted the resident with dressing. CNA #2 provided peri care for Resident #71 were discharge was visible. CNA #2 continued to cleanse Resident #71's buttocks. CNA #2 applied a clean brief, assisted in turning the resident the other direction and pulled up the resident's pants. CNA #2 removed the gloves and applied a new pair. CNA #1 and CNA #2 placed a lift pad under Resident #71. CNA #2 removed her gloves and applied a new pair. CNA #1 brought the lift machine and wheelchair into the residents room. CNA #1 and CNA #2 transferred Resident #71 to the wheelchair. CNA #2 removed her gloves, adjusted the resident's clothing, combed her hair, sprayed her perfume, and placed jewelry on the resident. CNA #2 adjusted Resident #71's legs and performed hand hygiene for 15 seconds.</p> <p>On 9/30/15 at 9:43 a.m., LPN #1 indicated hands should be washed for 30-40 seconds. LPN #1 further indicated</p> | | <p>potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> DNS/designee will conduct in-service with nursing staff on hand washing and infection control practices by October 16, 2015. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> DNS/designee will be responsible for the completion of Infection Control CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. <p>5. Date completion: October 16, 2015</p> | |

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| F 0465 SS=E Bldg. 00 | <p>gloves should be changed and hands should be washed between dirty and clean tasks.</p> <p>On 9/30/15 at 1:05 p.m., the Nurse Consultant provided the Hand Hygiene policy, dated 3/2012. The policy included, but was not limited to, use friction for at least 20 seconds.</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment in 15 of 28 rooms. Resident rooms had chipped paint, marred and gouged walls, and scraped doors. Resident bathrooms had soiled commodes with covers that did not fit properly, The bathroom floors had stains on them, and the over commode seats were bent and the lids which did not fit properly. (Room 206, 207, 210, 212, 214, 216, 306, 103, 109, 101, 116, 110, 402, 401, 404)</p> | F 0465 | <p>F465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? ·In room 206 the commode was repaired, cleaned, and recaulked. ·In room 208 (Room 207 identified on 2567. Actual room 208. 207 is non-existent room)</p> | 10/16/2015 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 09/30/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660 |
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| | <p>Findings include:</p> <ol style="list-style-type: none"> During an observation on 9/22/15 at 9:33 a.m., Room 206 was observed to have the entry door with wood chipped off. The commode lid did not fit properly and the caulking around the base of the commode was cracked and soiled. A black smear was observed on the outside of the commode. The same was observed on 9/28/15 at 9:47 a.m. During an observation on 9/23/15 at 9:31 a.m., Room 207 was observed to have the wood chipped off of the closet door. A white adhesive padded rectangle was loose on the back of the closet door. An unmarked, unlabeled black denture cup was observed on the bathroom sink. The commode was stained and there was an strong odor of urine in the bathroom. The bathroom was shared with Room 209. The same was observed on 9/28/15 at 9:44 a.m. During an observation on 9/22/15 at 11:22 a.m., Room 210 was observed to have gouges in the wall and the wall was marred outside of the bathroom door. A gray cover was observed next to the bed B and the wall had a loose strip of black Velcro on it. The paint was chipped next to bed B. The cover to the air | | <p>thepadded rectangle was replaced. Denture cup discarded and resident provided witha new denture cup. Commode and bathroom deep cleaned.</p> <ul style="list-style-type: none"> In room210 the loose strip of Velcro was replaced. The cover to the PTAC unit wasreplaced. The commode lid was replaced and the leak fixed. Touch up paintingcompleted. In room212 the holes under the television and closet were repaired. Touch up paintprovided to wall and doors. In room214 the bathroom was deep cleaned. The commode lid was replaced. The bathroomfaucet was repaired. Touch up paint provided to door. In room216 the bathroom was deep cleaned. In room306 the comb was labeled properly. The faucet was repaired. The paper toweldispenser was refilled. In room101 touch up paint completed to door and tape residue removed. In room103 touch up paint completed to door and tape resident removed. In room109 the sink was repaired to drain properly. In room116 the toilet was repaired/tightened and caulked. In room404 the screws at the base of the commode were replaced. In room402 the screws at the base of the commode were replaced. | |

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| | <p>conditioner/heater controls was missing. The lid to the commode did not fit properly. The same was observed on 9/28/15 at 9:50 a.m., as well as the commode would run continuously.</p> <p>4. During an observation on 9/22/15 at 3:06 p.m., Room 212 was observed to have holes in the bedroom wall under the television. The wall next to Bed A and at the foot of the bed had chipped paint. The closet door had a hole in it and the bathroom and entry room doors had wood scraped and marred. The same was observed on 9/28/15 at 9:40 a.m.</p> <p>5. During an observation on 9/23/15 at 10:16 a.m., Room 214 was observed to paint chipped from the entry room door. The bathroom had stagnant, odorous urine in it, the base of the commode had a white stain around it, and the commode seat lid was broke. The bathroom faucet would not turn off correctly. The same was observed on 9/28/15 at 9:52 a.m. The bathroom was shared with Room 216.</p> <p>6. During an observation on 9/22/15 at 9:22 a.m., Room 216 was observed to have a wet washcloth in the floor of the bedroom. Brown splatters were observed to be on the outside of the bathroom floor.</p> | | <p>·In room401 the screws at the base of the commode were replaced.</p> <p>·In room119 touch up paint completed to doorframe.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>·All residents have the potential to be affected by the alleged deficient practice.</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>·Maintenance Director/designee will complete full house environmental round by October 16, 2015.</p> <p>·Resident care reps will conduct daily resident rounds to ensure environmental issues are addressed Monday through Friday and the Manager on Duty will conduct resident rounds on Saturday and Sunday.</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>·Maintenance Director/designee will be responsible for the completion of Environmental Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is</p> | |

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| | <p>7. During an observation on 9/23/15 at 11:42 a.m., Room 306 was observed to have a black comb on the sink with no name on it. The faucet was loose from the sink and the hot water faucet was dripping. The paper towel dispenser was empty.</p> <p>8. On 9/22/15 at 11:51 a.m., Room 109 was observed to have a sink draining very slowly. Recheck of the room on 9/24/15 indicated the sink was still draining slowly.</p> <p>9. On 9/23/15 at 2:00 p.m., Room 101 was observed to have an entry door with chipped wood and tape residue on it. Re-observation on 9/24/15 indicated the same.</p> <p>10. On 9/23/15 at 3:10 p.m., Room 103 was observed to have an entry door with chipped wood and much tape residue on it. Re-observation on 9/24/14 door was found to be the same.</p> <p>11. On 9/23/15 at 1:27 p.m., Room 116 was observed to have the toilet loose when sat on as complained of by resident. No caulking was under the toilet. Re-observation of the toilet on 9/24/15 indicated the same to be true.</p> <p>12. On 9/22/15 at 12:00 p.m., Room 404</p> | | <p>maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>DNS/designee will be responsible for the completion of Resident Care Rounds CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date completion: October 16, 2015</p> | |

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| F 9999 Bldg. 00 | <p>was observed. The screws at the base of the commode were observed to be exposed. On 9/30/15 at 9:38 a.m., the same was observed.</p> <p>13. On 9/22/15 at 3:58 p.m., Room 402 was observed. The screws at the base of the commode were observed to be exposed. On 9/30/15 at 9:37 a.m., the same was observed.</p> <p>14. On 9/23/15 at 9:39 a.m., Room 401 was observed. The screws at the base of the commode were observed to be exposed. On 9/30/15 at 9:36 p.m., the same was observed.</p> <p>15. On 9/23/15 at 9:28 a.m., Room 119 was observed. The bathroom doorframe was observed with chipped pain. On 9/30/15 at 9:43 a.m., the same was observed.</p> <p>3.1-19(f)</p> <p>3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a department, for example, director of nursing or food</p> | F 9999 | F9999 FINAL OBSERVATIONS It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. 1: What corrective action(s) will be | 10/16/2015 |

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| | <p>service supervisor, during the same hours, The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:</p> <p>(D) major accidents</p> <p>If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number (317) 383-6144) of the division.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to report a major accident for 1 of 3 residents reviewed for falls. A resident had a fall which resulted in a fractured eye orbit, a right radial fracture, and a subdural hematoma. (Resident B)</p> <p>Findings include:</p> <p>During an observation on 9/23/15 at 11:26 a.m., Resident B was observed to be lying in bed. Resident B was observed to be asleep and difficult to arouse.</p> | | <p>accomplished for those residents found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident B no longer resides in the facility. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ED/designee will in-service IDT over ISDH reportable incidents by October 16, 2015. DNS/designee will audit falls with injuries within the last 12 months to ensure all incidents that need reported to ISDH have been reported appropriately by October 16, 2015. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> DNS/designee will be responsible for the completion of Fall Program CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance | |

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| | <p>The clinical record for Resident B was reviewed on 9/24/15 at 1:12 p.m. Resident B had clinical diagnoses including, but not limited to, dementia with behavioral disturbances, insomnia, anxiety, depressive disorder, and senile psychosis.</p> <p>A progress note, dated 8/1/15 at 8:24 a.m., indicated Resident B had a fall on 8/1/15 at 8:24 a.m. The progress note indicated Resident B had attempted to stand without assistance and fell on the left side of the face. The progress note indicated Resident B had a laceration to the left side of the face which measured 3 inches and a 4 inch bruise to the cheek. The progress note further indicated Resident B had been sent to the emergency room. The progress note indicated Resident B had sustained a fractured eye orbit, a right radial fracture, a laceration to the left side of the head, and a subdural hematoma.</p> <p>During review of the facility's reportable incidents, obtained from the Administrator on 9/24/15 at 2:00 p.m., the fall with injuries report to Resident B was not included.</p> <p>During an interview with the Administrator on 9/30/15 at 2:15 p.m.,</p> | | <p>is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date completion: October 16, 2015</p> | |

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| | the Administrator indicated the reportable incidents for the last 6 (six) months were accurate and complete. | | | | |